Notice of Meeting

Health and Wellbeing Board

Date and Time	Place	Contact	Web:
Wednesday, 21 June 2023 2.00 pm	Surrey County Council, Council Chamber, Woodhatch Place, 11 Cockshot Hill, Reigate, Surrey, RH2 8EF	Amelia Christopher amelia.christopher@surreycc.gov.uk	Council and democracy Surreycc.gov.uk **Twitter:** @SCCdemocracy

Board Members

Bernie Muir (Chair)	Member for Epsom West, Surrey County Council
Dr Charlotte Canniff (Vice-Chair)	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	Deputy Chief Executive Officer, Surrey and Borders NHS Foundation Trust and SRO Mental Health, Frimley ICS / Joint Strategic Commissioning Conveners, Surrey County Council and Surrey Heartlands (Priority 2 Co-Sponsors)
Mari Roberts-Wood	Managing Director, Reigate and Banstead Borough Council (Priority 3 Sponsor)
Tim Oliver	Leader of Surrey County Council
Fiona Edwards	Chief Executive of the Frimley Integrated Care System
Jason Gaskell / Sue Murphy and Rosemarie Pardington	CEO, Surrey Community Action / Chief Executive Officer, Catalyst / Director of Health, Research & Compliance/Deputy CEO Young Epilepsy (VCSE Alliance Co-Representatives)
Dr Russell Hills	Executive Clinical Director, Surrey Downs Health and Care Partnership
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 Surrey Heartlands ICS
Rachael Wardell	Executive Director for Children, Families and Lifelong Learning

Professor Claire Fuller	Chief Executive Officer, Surrey Heartlands Integrated Care System
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	Deputy Leader and 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
Tim De Meyer	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
Jo Cogswell	Place Based Leader, Guildford and Waverley Health and Care Alliance
Dr Pramit Patel	East Surrey Place Representative and ICS Primary Care Clinical Leader, Surrey Heartlands ICS
Lisa Townsend	Police and Crime Commissioner for Surrey
Professor Monique Raats	Co-Director, Institute for Sustainability; Professor; Director of the Food, Consumer Behaviour and Health Research Centre, University of Surrey
Siobhan Kennedy	Homelessness, Advice & Allocations Lead, Guildford Borough Council (Associate Member)

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If you would like to attend and you have any special requirements, please email Amelia Christopher on amelia.christopher@surreycc.gov.uk. Please note that public seating is limited and will be allocated on a first come first served basis.

AGENDA

1 APOLOGIES FOR ABSENCE

To receive any apologies for absence and substitutions.

2 MINUTES OF PREVIOUS MEETING: 15 MARCH 2023

(Pages 1 - 14)

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 *(15 June 2023).*

b PUBLIC QUESTIONS

The deadline for public questions is seven days before the meeting (*14 June 2023)*.

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 15 - 32)

This paper provides an overview of the progress of local shared projects and communications activity supporting delivery of the Health and Wellbeing Strategy (HWB Strategy) as of 30 May 2023. The Board is also asked to note the disbanding of the Surrey Local Outbreak Engagement Board.

6 HEALTH AND WELLBEING STRATEGY SUMMARY IMPLEMENTATION PLAN JUNE 2023 (Pages 33 - 68)

This report provides the latest summary of the programmes engaged in implementing the Surrey Health and Wellbeing Strategy.

7 COMMUNITY SAFETY ASSEMBLY AND IMPLEMENTATION PLANS (Pages 69 - 106)

This short paper updates the Health and Wellbeing Board members on the developments under the Priority 3 outcome – 'People are safe and feel safe' - and in particular presents the Terms of Reference for the Community Safety Assembly and the proposed implementation plans.

8 SURREY WIDE DATA STRATEGY - UPDATE (Pages 107 - 160)

This paper aims to provide an update to the Board on the current progress and implementation for the Surrey Wide Data Strategy, as well as providing an insight into the challenges faced at this time.

9 MENTAL HEALTH IMPROVEMENT PLAN - UPDATE (Pages 161 - 170)

The Mental Health Improvement Plan (MHIP) is the Surrey system's 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. The plan has been reset into four programmes the detail of which, with brief updates, is included in this report.

10 BETTER CARE FUND (BCF) PLAN 2023-25 AND BCF END OF YEAR REVIEW 2022/23 (Pages 171 - 254)

The Board is asked to approve the proposed Surrey 2023-25 Better Care Fund (BCF) Plan. The Adult Social Care Discharge Fund is incorporated into the BCF Plan for the first time this year. The BCF Plan has been developed in collaboration with partners across the system and represents the Surrey plan for resource allocation and outcome delivery.

11 SYSTEM PLANNING: SURREY HEARTLANDS DRAFT JOINT FORWARD PLAN (JFP) 2023 - 2028 (Pages 255 - 356)

Surrey Heartlands Integrated Care System (ICS) Strategy, which draws on the Surrey Health and Wellbeing strategic priorities, was agreed by the Integrated Care Partnership in December 2022. The Joint Forward Plan is the five-year strategic delivery plan for the ambitions set out in the ICS strategy.

12 SYSTEM PLANNING: FRIMLEY DRAFT JOINT FORWARD PLAN (JFP) 2023 - 2028 (Pages 357 - 374)

The Frimley Integrated Care System (ICS) Strategy, which aligns with the Surrey Health and Wellbeing strategic priorities, was agreed by the Integrated Care Partnership in May 2023. The Joint Forward Plan is the five-year strategic delivery plan as agreed between the NHS organisations within the Frimley ICS geography.

13 INTEGRATED CARE SYSTEMS (ICS) UPDATE (Pages 375 - 380)

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.

14 DATE OF THE NEXT MEETING

The next meeting of the Health and Wellbeing Board will be on 20 September 2023.

Joanna Killian
Chief Executive
Published: Tuesday, 13 June 2023

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QUESTIONS AND PETITIONS

Cabinet and most committees will consider questions by elected Surrey County Council Members and questions and petitions from members of the public who are electors in the Surrey County Council area.

Please note the following regarding questions from the public:

1. Members of the public can submit one written question to a meeting by the deadline stated in the agenda. Questions should relate to general policy and not to detail. Questions are asked and answered in public and 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 an 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 Cabinet 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 Cabinet members may decline to answer a supplementary question.

MINUTES of the meeting of the **HEALTH AND WELLBEING BOARD** held at 2.00 pm on 15 March 2023 at Council Chamber, Woodhatch Place, 11 Cockshot Hill, Reigate, Surrey, RH2 8EF.

These minutes are subject to confirmation by the Committee at its next meeting.

Board Members:
(Present = *)
(Remote Attendance = r)

* Tim Oliver (Chairman)
* Dr Charlotte Canniff (Vice-Chairman)
* Karen Brimacombe
* Professor Helen Rostill (Co-Sponsor)
r Liz Williams (Co-Sponsor)
r Kate Barker (Co-Sponsor)
* Mari Roberts-Wood
Fiona Edwards
r Jason Gaskell (Co-Representative)
* Rosemarie Pardington (Co-Representative)
Sue Murphy (Co-Representative)
* Dr Russell Hills
* Kate Scribbins
* Ruth Hutchinson
Liz Bruce
* Rachael Wardell
Professor Claire Fuller
* Graham Wareham
* Joanna Killian
* Mark Nuti
* Sinead Mooney
* Denise Turner-Stewart
Jason Halliwell
Carl Hall
Gavin Stephens
Borough Councillor Hannah Dalton
Steve Flanagan
r Jo Cogswell
* Dr Pramit Patel
Lisa Townsend
Professor Deborah Dunn-Walters
r Siobhan Kennedy (Associate Member)

Substitute Members:
* Cate Newnes-Smith - Chief Executive Officer, Surrey Youth Focus
* Tracey Faraday-Drake - Director for Children and Young People and All Age Learning Disabilities and Autism / Place Convenor for Surrey Heath, NHS Frimley Integrated Care Board
* Gemma Morris - Detective Superintendent, Surrey Police

The Chairman welcomed a new Board member:

- Dr Pramit Patel - East Surrey Place representative / Primary Care Clinical Leader, Surrey Heartlands ICS.

The Chairman thanked a departing Board member:

- Gavin Stephens, the outgoing Chief Constable of Surrey Police, for his significant contribution over the last few years to the Board, who led on the merger with the Community Safety Board and the work on data integration; the new Chief Constable, Tim De Meyer, would be in post in early April.

1/23 APOLOGIES FOR ABSENCE [Item 1]

Apologies were received from Borough Councillor Hannah Dalton, Sue Murphy - Cate Newnes-Smith substituted, Fiona Edwards - Tracey Faraday-Drake substituted, Gavin Stephens - Gemma Morris substituted, Liz Bruce, Carl Hall, Jason Halliwell, Professor Deborah Dunn-Walters, Steve Flanagan, Professor Claire Fuller, Jo Cogswell (remote), Liz Williams (remote), Kate Barker (remote), Jason Gaskell (remote), Siobhan Kennedy (remote).

2/23 MINUTES OF PREVIOUS MEETING: 21 DECEMBER 2022 [Item 2]

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

3/23 DECLARATIONS OF INTEREST [Item 3]

There were none.

4/23 QUESTIONS AND PETITIONS [Item 4]

a Members' Questions

None received.

b Public Questions

None received.

c Petitions

There were none.

5/23 HEALTH AND WELLBEING STRATEGY HIGHLIGHT REPORT [Item 5]

Witnesses:

Karen Brimacombe - Chief Executive, Mole Valley District Council (Priority 1 Sponsor)
Ruth Hutchinson - Director of Public Health, Surrey County Council
Professor Helen Rostill - Deputy Chief Executive Officer, Surrey and Borders Partnership NHS Foundation Trust / Senior Responsible Owner for Mental Health, Frimley ICS (Priority 2 Co-Sponsor)
Mari Roberts-Wood - Managing Director, Reigate and Banstead Borough Council (Priority 3 Sponsor)
Sarah Haywood - Partnership and Community Safety Lead, Office of the Police and Crime Commissioner for Surrey

Key points raised in the discussion:

Priority 1

1. The Priority 1 Sponsor noted that:
   - The report produced by the Surrey Coalition of Disabled People on the cost-of-living crisis and the true cost for disabled people outlined negative experiences: 97% said that the crisis had impacted them, 45% reported having gone without food, 76% said that they did not turn their heating on, 43% were no longer able to meet the additional costs as a disabled person, 62% were relying on community fridges, warm hubs and food banks, and 35% had borrowed money to help pay their bills. Compared to Surrey County Council's recent survey on the cost-of-living, where around 8% reported that they had not eaten for a day because they did not have enough money and around 13% had gone a day without using energy.
   - The Coalition was asking partners to recognise that disabled people had been disproportionately impacted by the crisis, for the County Council and borough and district councils to bear disabled people in mind when allocating household support funding. The Coalition asked for more communication about where the warm hubs and community fridges were in Surrey and to indicate if the warm hubs were accessible.
2. The Director of Public Health (SCC) noted that:
   - Regarding the 'In the Spotlight: Bridge the Gap outreach service' section, that cohort with multiple disadvantages faced challenges with engaging with services, yet that population was known to many services but helped by few. Outcomes showed that the service was a prevention programme helping to reduce health inequalities for those vulnerable populations and saved money for the system. The Alliance sought support beyond March 2024.
3. A Board member noted that upon hearing the insights from the disabled people, it would be helpful to have a standardised offer particularly in Surrey's libraries, but in every borough and district in Surrey around community fridges and warm hubs. Greater visibility and awareness of knowing where to go for support was essential and needed to be developed. She asked whether there was support and funding beneath the 'Bridge the Gap' layer with 60 vulnerable people, for the large cohort that did not qualify for that level of intervention.
   - The Director of Public Health (SCC) reiterated that 'Bridge the Gap' was part of the Changing Futures programme which was aligned to Surrey Adults Matter (SAM) that worked closely with a larger cohort of people and both programmes were complementary. There were more residents that needed intensive support compared to the resources available, that was part of the evaluation of how to be more efficient as a system going forward.
   - The Priority 1 Sponsor noted that between the County Council and the borough and district councils, there was a good coverage of warm hubs and community fridges. She noted that the problem was that vulnerable cohorts were not being targeted for that support offer and she would follow up with the communications officers across the councils to liaise with each other to discuss the need for targeted communications and indicating accessibility.
   - The Vice-Chairman requested that the councils' communications officers link up with the NHS communications officers.
4. A Board member noted that she had previously visited the inspiring team at 'Bridge the Gap' and people benefiting from that intense support provided and

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those around them. She highlighted that focusing on the outreach support to homeless people and their mental health, was a benefit of that service.

5. A Board member welcomed the 'data, insights and challenges' column in the Highlight Report drawing insights from a range of organisations, however after each of those sections she noted that the reporting was inconsistent as to whether there was any action plan attached; some had an action plan and a contact name and others did not. How to take insights forward within the system was crucial, and she asked whether there could be consistency on how insights were taken forward, with a link to the action plan; also indicating that there was not an action plan was useful so the Board could follow those insights up.

Priority 2

6. The Priority 2 Co-Sponsor noted that:
   - The Mental Health: Prevention Oversight and Delivery Board's (MHPODB) work plan was agreed in January and sought to drive forward the programmes in the four areas, identifying and addressing gaps in primary prevention or under resourced areas, looking at existing programmes and thinking about measuring impact within the system. The evidence and good practice gathered would be reported at June's Board meeting. There also had been close learning with the Mental Health Investment Fund.
   - Regarding outcome one around ensuring that those with or at risk of anxiety, depression or mental health issues get the right help, men's mental health was an important area, it was underreported and three quarters of suicides in the UK were committed by men. Resources available for men had been mapped and a mental health champion had been identified.
   - Regarding outcome two about supporting the emotional health of parents, babies and children, AFloaT was a new service providing support for individuals who had negative mental health experiences related to maternity.
   - Regarding the 'In the Spotlight: Your Life Beyond Care' section, the report was focused on the feedback from 128 Looked After Children and 180 Care Leavers, positives were that Looked After Children felt safe in their placements and trusted their families and social workers, 93% of Care Leavers felt they had been fully involved in the pathway planning of leaving care and that they had access to their leaving care workers. Areas for improvement for those children and young adults concerned friendships as making and maintaining friends was a challenge compared to their peers, especially those placed outside of county.
7. A Board member noted that it was extremely important to hear the voices of children and young adults in Surrey who had care experience and to learn from their feedback. She noted that it was vital to connect what the report was saying with other strategies and work in progress such as the sufficiency strategy around children's placements, responding to what had been identified in the survey and ensuring that there are enough foster carers and children's residential homes in Surrey to meet those children's needs. Returning to Surrey from out of county placements can interrupt friendships, so too in the case of children moving around several placements; young people required a place to stay where they could create stable bonds and connect to their communities.
8. Regarding Looked After Children and Care Leavers a Board member wondered whether all the organisations across the county with placements supporting those young people or that they had moved on from, whether those

children and young people could be connected via an electronic pen pal arrangement so they could have similar social media type conversations as their peers.

- A Board member agreed with the importance of supporting young people to try and maintain their friendships and connections. Social media was a mixed blessing and needed to be carefully managed, she highlighted the emotional wellbeing and mental health challenges for those young people, some of which were driven by social media. She supported that suggestion of enabling young people to maintain their connections through whatever means works best for them.

9. Referring to the mapping exercise of existing mental health and wellbeing support specifically around men, in terms of general mental health and wellbeing support, a Board member asked whether that map was overlaid where the levels of high incidents were occurring so gaps could be identified and interventions deployed such as social prescribing and other partnership collaboration work; to have an insightful understanding of where that work needed to be focused.
    - The Priority 2 Co-Sponsor noted that the MHPODB was undertaking that work, looking at the heat map generated through the Joint Strategic Needs Assessment (JSNA), which showed where the areas of highest need were and looking at the work already underway within those areas through the priority neighbourhoods work. That would be collated and gaps identified, reported back to the Board later in the year.
10. A Board member highlighted that mental health issues had a disproportionate impact on the LGBTQ+ community, regarding the mapping exercise he asked for that population to be captured.
    - The Priority 2 Co-Sponsor welcomed that comment, noting that all the priority populations would be considered when undertaking that mapping.
11. A Board member highlighted an example in the third sector which was an exciting new project by Home-Start supporting dads' mental health, particularly in the perinatal period, that would be launched in April looking at attachment, bonding and parental mental health, and signposting to services.

Priority 3

12. The Priority 3 Sponsor noted that:
    - Regarding outcome four 'people are safe and feel safe', the new Serious Violence Duty required all specified organisations to work together to prevent and reduce serious violence: police, probation, prison service, fire and rescue service, integrated care boards, borough and district councils, the County Council and schools. No lead authority was specified, it was up to all to define the governance structure, Police and Crime Commissioners in September were given notice they would receive funding to support the implementation of the Duty.
13. The Partnership and Community Safety Lead (Surrey OPCC) noted that:
    - The two pieces of work to be completed were: a strategic needs assessment and a strategy. Data and evidence were being gathered for the strategic needs assessment to create a picture of what serious violence looks like in Surrey and to identify what the causal factors and wider determinants are that lead people to become offenders or victims of violence. More evidence was needed in some areas particularly around youth violence and place-based violence. Board members and organisations were asked to get in touch if they wanted to be part of the operational group or if they had any data or information useful to that work. The strategy was to be completed by 31 January 2024, however as there

was funding attached to the Duty it was likely that it needed to be completed within the financial year. She was happy to circulate a presentation providing more detail on the Duty.

- The Community Safety Assembly (CSA) was to meet on 17 April and it was looking to agree the partnership agreement which had to be returned to the Home Office, that would set out the governance structure and what the individual roles and responsibilities are around the Duty. Board members were welcome to contact her for more information on the CSA.

14. The Chairman sought clarification on whether that document to be sent to the Home Office should be signed off by the Board.
    - The Partnership and Community Safety Lead (Surrey OPCC) responded that she would come back with several documents over the course of the year, the partnership agreement would be received by the Board to approve after being reviewed by the CSA; followed by the strategic needs assessment and the strategy. She noted that the Home Office was clear that it was down to local determination to design the governance structure, to set out how the requirements of the strategic needs assessment would be met and how the strategy would be set.
15. Regarding the request around data sharing, the Vice-Chairman noted that the health system had a lot of data some of which was confidential, she did not know what could or could not be shared in relation to creating that strategy of what serious crime looks like in Surrey, she would be happy to put the Partnership and Community Safety Lead (Surrey OPCC) in touch with the correct people in the NHS system for those conversations to be had. Hospitals admitted people daily who had been victims of serious crime and in some cases the police would not be aware of those victims especially in the case of domestic violence.
    - The Partnership and Community Safety Lead (Surrey OPCC) responded that the police was not always aware of those victims as for example exploited people would not necessarily disclose that to them. She was happy to liaise with the relevant contact provided by the Vice-Chairman.
16. Regarding recommendation three on the sharing of the Health and Wellbeing Strategy engagement slide deck, she noted that the Voluntary, Community and Social Enterprise (VCSE) Alliance was keen to share it with their membership and suggested that could be done via a webinar which they would set up. She sought support from Board members to present the slide deck to the VCSE Alliance.
    - The Priority 3 Sponsor was happy to liaise with the Board member on that.

RESOLVED:

1. Noted progress of the Strategy in the Highlight Report.
2. Utilised the links to the refreshed Health and Well-being Strategy and Highlight Reports to increase awareness through their organisations and elicit support for reducing health inequalities.
3. Ensured member organisations are utilising the HWB Strategy engagement slide deck on the SCC Community Engagement sharepoint site to provide active leadership around the mission to reduce health inequalities within their own organisations and across the system.
4. Undertook to complete the Health and Wellbeing Board/Strategy Delivery review survey by the deadline of 24 March 2023.
5. Noted the consideration of the Towns as a spatial layer for partnership working to reduce health inequalities by the Surrey Heartlands Integrated Care Partnership.

6. Agreed the proposal by the Health and Wellbeing Strategy's System Capability Lead for Empowered & Thriving Communities (Marie Snelling, Executive Director Customer & Communities, Surrey County Council) that Dr Gillian Orrow (Growing Health Together Director in East Surrey & GP) takes on the role of clinical lead for the Empowered and Thriving Communities system capability.

Actions/further information to be provided:

1. The Priority 1 Sponsor will follow up with the communications officers across the councils - County Council and district and borough councils - and the NHS communications officers to liaise with each other to discuss the need for targeted communications and indicating accessibility of warm hubs and community fridges.
2. The Priority 2 Sponsor will ensure that the evidence and good practice gathered by the MHPODB will be reported at June's Board meeting.
3. The Priority 2 Sponsor and Board member (Rachael Wardell) will follow up the Board member's (Rosemarie Pardington) suggestion of having an electronic pen pal arrangement for Looked After Children and Care Leavers.
4. The Priority 2 Sponsor will report to the Board later in the year around the findings from the mapping exercise of existing mental health and wellbeing support; to include all priority populations including the LGBTQ+ community.
5. Board members and organisations will contact the Partnership and Community Safety Lead (Surrey OPCC) if they want to be part of the operational group or if they had any data or information useful to the work around the Serious Violence Duty, and if they want more detail on the Community Safety Assembly.
6. The Partnership and Community Safety Lead (Surrey OPCC) will circulate a presentation providing more detail on the Duty.
7. The Partnership and Community Safety Lead (Surrey OPCC) will update the Board on several documents over the course of the year including the partnership agreement, the Duty's strategic needs assessment and the strategy.
8. The Vice-Chairman will provide the Partnership and Community Safety Lead (Surrey OPCC) will the relevant contact concerning data sharing regarding the Duty.
9. The Priority 3 Sponsor will liaise with the Board member (Rosemarie Pardington) on resolution three on the sharing of the Health and Wellbeing Strategy engagement slide deck, presenting the slide deck to the VCSE Alliance.
10. The three Priority Sponsors will follow up the ask by the Board member (Kate Scribbins) around including in the 'data, insights and challenges' column in the Highlight Report whether there was or was not an action plan and including a link to that if available and the relevant contact name, ensuring consistency.

6/23 HEALTH AND WELL-BEING STRATEGY INDEX [Item 6]

Witnesses:

Uma Datta - Assistant Director - Data and Insights, Surrey County Council
Richard Carpenter - Data Scientist, Surrey County Council

Key points raised in the discussion:

1. The Assistant Director - Data and Insights (SCC) noted that:

- Since the September Board, the indicators had been reviewed and some merged if similar. The focus had been on where there was good data that could be monitored and refreshed regularly, mapped to the three priorities and priority populations. The Strategy Index was constructed similarly to the Surrey Index, whereby the indicators were mapped to a priority, giving a priority level score and the three priority level scores added up to a Surrey level score, which could be monitored over time. Feedback was welcomed on the ease of navigating the Strategy Index and on how it was constructed.

2. The Data Scientist (SCC) provided a demonstration of the draft Strategy Index:
   - From the long list of indicators, a draft Index at the borough or district level had been created using the easily available indicators. The draft Index was organised into the three priorities in the Strategy, within each priority there were different outcomes and indicators, each indicator had a percentage value, a score - 0 to 100 and had a traffic light colour system - and a rank - 0 to 11. The values for all the indicators within an outcome were added up, giving an outcome score and rank. The outcomes within a Priority were added up and gave an overall score and rank for that Priority.
3. The Chairman noted that as the draft Index website was publicly available, he asked what for example the Active Adults indicator showed to a resident.
   - The Data Scientist (SCC) explained that due to the space restrictions, the full description of indicators was not included on the titles, hovering over the coloured circles provided the information on the indicators for example Active Adults: the percentage of adults doing more than 150 minutes of physical activity a week; assigned a value, score and rank. The draft Index was built by taking all the indicators and the best and worst case scenario for each indicator was looked at, bad scores were closer to 0 and good scores closer to 100. Like the Surrey Index, on the home page of the final version of the Strategy Index, information would be provided on how to interpret the results.
   - The Assistant Director - Data and Insights (SCC) added that there would be a readme document available for the final version, information could be downloaded to make calculations and compare data.
4. Regarding the ability to compare data between borough and district level, the Vice-Chairman queried what if all had bad scores and she asked whether there was national benchmarking in terms of what a good score would be. To show progress, she noted that it would need to be developed adding up and down arrows. She queried whether the index presented at the Health Protection Board should overlay with the Strategy Index.

Joanna Killian joined the meeting at 2.50 pm.

- The Assistant Director - Data and Insights (SCC) recognised the need to focus on what good looks like, who does Surrey compare itself to, for example via a national average and then a county average. A target would then need to be set on where Surrey wanted to be and how far away it was from that, it was a continuing discussion.
- A Board member noted that there was a suite of resources and intelligence, and that it would be useful to outline in the explanation page how the Strategy Index aligned to the JSNA and other publicly available dashboards and to show progression. She noted that currently the Strategy Index was at the borough and district level, as with the JSNA where the data could be toggled down to the Lower layer Super Output Areas (LSOAs), Primary Care Networks and towns; she noted that it would be useful to flag that

other geographical levels would be coming soon to the Strategy Index. When indicators were ranked as red, there needed to be a mechanism to cross reference between the two sub-boards and how those related to the priorities.

5. A Board member enjoyed the interaction with the draft Index and asked whether residents had been engaged with as part of its development on how easy it was to use, thinking particularly about vulnerable residents.
   - The Data Scientist (SCC) noted that the indicators included were those with readily available data. He noted that the list of indicators reflected what the Board felt was relevant for residents. Whilst residents had not been engaged with on its design and content the learning from the Surrey Index was used to inform the Strategy Index, engagement had been undertaken on the Surrey Index around its design and operability via engagement sessions. Concerning vulnerable residents there was an accessible version available.
6. A Board member made a plea for co-design on the Strategy Index and offered to provide support on that, particularly if it was to be genuinely usable by residents and to show them performance against the Health and Wellbeing Strategy, holding the Board accountable for that. Asking residents what it means for them and to have some visible links with the indicators back to what residents said was important to them years ago when the Strategy was first developed.
7. A Board member reflected on the so what point, noting that the focus should be on the individual characteristics of a person who might have a whole range of issues or a single issue. For example, the system reflected that it was doing badly on alcohol, so responded with providing a reducing drinking service; she stressed that it was not right to take a siloed approach to some of those indicators. She was concerned that the data did not inform about individual cases and what they need, often there were complex problems and that required complex whole system solutions as opposed to a simple response and solutions.
8. A Board member welcomed the simplicity of the tool, however she noted that unless the deprivation data was layered across that, the draft Index would not provide a real picture of how well the system was performing or what the target should be for some of those vulnerable communities - for example people with learning difficulties where there was a large gap around life expectancy - so that there is a more level playing field. She also asked whether officers were receiving the Frimley data to feed into the Surrey Heath part of Surrey.
   - The Assistant Director - Data and Insights (SCC) confirmed that the Strategy Index would be looked at it in terms of the lowest possible geography where the data was available, which was LSOAs and that was based on deprivation. Regarding vulnerable communities, where available the data would be looked at for those with serious mental illnesses for example within the priority populations. She noted that she could provide an update in the quarterly Highlight Report on the intelligence being gathered at lower geographical levels.
   - The Data Scientist (SCC) confirmed that the Frimley data was included and noted that a lot of different data sources had contributed to the draft Index.
9. A Board member queried how the draft Index could be used in terms of triangulating it with the Graphnet dashboard to then identify those groups of people that the system could start to work with on the ground. He welcomed the bird's-eye view through the tool but asked how it connected to the work being undertaken by the health system.

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- A Board member noted that the draft Index had the potential to do two things. Firstly, to alert the Board to where things were going well and where they were not. Secondly, where to look even further especially as the draft Index provided a bird's-eye view, cross referencing needed to be done to other parallel and complementary data sources such as the JSNA or tools like Graphnet, to enable a deeper dive.

10. The Chairman emphasised the need to have one place to go to rather than trying to look at multiple databases and so on, building the data around the towns footprint would be useful as it was a key geography for the delivery of services.

RESOLVED:

1. Reviewed, provided feedback and promoted awareness of the metrics within their organisation to enable a common understanding and assessment of progress.

Actions/further information to be provided:

1. The Assistant Director - Data and Insights (SCC) will outline in the explanation page how the Strategy Index aligned to the JSNA and other publicly available dashboards and will show progression; she will flag that other geographical levels such as the Lower layer Super Output Areas (LSOAs) will be coming soon to the Strategy Index.
2. The Assistant Director - Data and Insights (SCC) will follow up the offer by the Board member (Kate Scribbins) regarding co-designing the Strategy Index with residents.
3. The Assistant Director - Data and Insights (SCC) will provide an update in the quarterly Highlight Report on the intelligence being gathered at lower geographical levels, such as Primary Care Networks and towns.

7/23 WIDER DETERMINANTS OF HEALTH: SURREY SKILLS PLAN [Item 7]

Witnesses:

Michael Coughlin - Executive Director - Partnerships, Prosperity and Growth, Surrey County Council
Sarah Randall - Economy Lead (Skills), Surrey County Council

Key points raised in the discussion:

1. The Executive Director - Partnerships, Prosperity and Growth (SCC) noted that:
   - The Chancellor of the Exchequer's budget statement made the link between good employment and health in terms of encouraging people back into work.
   - Good employment facilitated by the right skills was a significant contributor to the wider determinants of health: mental, physical and preventive.
   - Surrey on average had a highly skilled population, however businesses and some parts of the public sector - particularly the health sector - had identified the genuine skills gap in Surrey in certain places and sectors.
   - The national skills system was fragmented, complex and difficult for some people to navigate through, the Surrey Skills Plan was a response to those issues, developed as part of an overall programme linking to Surrey's

lifetime of learning education strategy and the ambition to have improved careers education promoting routes such as T-Levels and Apprenticeships.

- The Surrey Skills Plan has four main elements: supporting businesses and the local economy to attract and enable them to engage with those who have the skills needed to support their businesses, supporting people into meaningful employment that often is the source of routine and self-worth, it was a foundation for collaboration across businesses and further education providers, it was future proofed by casting forward the skills that would be needed in the future economy such as the green skills agenda.
- The Plan sought to bring together the different routes and providers, it was a chapter within the Local Skills Improvement Plan (LSIP) around post-16 technical education, put together by the Surrey Chambers of Commerce.
- A challenge was around how to maintain the partnership effort needed to deliver the Plan, a detailed action plan was underway and Board members were asked to consider how they would engage.

2. The Chairman noted that there had been national conversations about the number of economically inactive people due to ill-health and wondered whether the budget statement would address that. Surrey had a lot of people that had retired early for a variety of reasons and trying to get them back into employment to help fill some of those skills gaps was important.
3. The Vice-Chairman asked how the Plan aligned with the United Surrey Talent strategy, co-developed between the local authority and health around developing the future workforce; particularly around skills development in health.
   - The Executive Director - Partnerships, Prosperity and Growth (SCC) responded that the United Surrey Talent strategy was one element of the Plan in terms of delivering a particular set of skills within a particular sector along with the work by Surrey's academies and other further education providers, university courses; amalgamated into a cohesive Plan. The Plan was initiated originally by the private sector highlighting that they were struggling with work readiness and the right level of skills needed.
4. A Board member noted that employment rates for people with mental health needs was down 10%, he asked how health inequality was being looked at noting the need to be assertive and proactive in identifying those groups. There were around 65,000 people between primary and secondary healthcare that the Surrey and Borders Partnership (SABP) was working with; he asked whether a package could be tailored for those people to try and help them get jobs.
   - The Executive Director - Partnerships, Prosperity and Growth (SCC) welcomed that suggestion, he noted that one of the foundational principles of the Plan was around supporting people and inclusion. There had been discussions around those who had either long-term debilitating conditions - particularly around mental health - and the levels of support that they might need to encourage them back into work, the approach to focus on the routine of work and less around technical skills. From discussions with the Department for Work and Pensions (DWP) he noted the need to develop further the approach of referring people with mental health issues into voluntary sector bodies who would provide wraparound support to help them into the role of work, rather than support focusing on the acquisition of skills.
   - The Economy Lead (Skills) (SCC) flagged the importance of in-work progression support enabling people to stay in their jobs to prevent a churn in the workforce, through an increased focus on supporting local

businesses and how they grow their workforce to keep those people in businesses.

5. The Priority 1 Sponsor noted that in Mole Valley and probably across the other borough and district councils, there was the Employment and Skills Hub that provided support to all but with a focus on those with complex needs either to get into their first job or re-enter employment if they had been out for employment for some time; she was happy to share the detail on the work of the Hub.
6. The Priority 2 Co-Sponsor in terms of retaining people in the workforce - not necessarily people with a known mental health problem - regarding the emotional wellbeing of the workforce and how people are equipped to remain in the work, to thrive and to be open to skills development, she wondered how the work underway could be connected to the joint programme of work with the Public Health team (SCC) around workforce wellbeing.
   - The Executive Director - Partnerships, Prosperity and Growth (SCC) responded that there was an opportunity to build on what had been put in place already and to explore those opportunities, he would liaise with those Board members. He noted that several employers including the County Council did a huge amount of work around staff wellbeing.
7. A Board member referred to a visit that morning to one of Surrey's special schools, Portesbery School, post-16 they had to offer work experience opportunities within the school running enterprise opportunities like the mobile tuck shop, because of a reduction in those opportunities externally post-pandemic. Under the Plan, she noted that it would be brilliant to see a reopening of those opportunities by all organisations for those young people.
8. The Chairman encouraged organisations to feedback on ways to help the delivery of the Plan, particularly to provide mutual support around getting people into work. He noted the comments on the Teams meeting chat about care leavers and people with autism and hoped that the Plan would be as comprehensive as possible.

RESOLVED:

1. Noted progress against the implementation of the Surrey Skills Plan.
2. Considered how HWB members and organisations can engage with delivering the Surrey Skills Plan ambitions.

Actions/further information to be provided:

1. The Executive Director - Partnerships, Prosperity and Growth (SCC) will liaise with the Board member (Graham Wareham) on his suggestion of having a tailored package for those people with mental health needs in healthcare that the SABP was working with, to try and help them get jobs.
2. The Priority 1 Sponsor will provide the detail on the work of Mole Valley District Council's Employment and Skills Hub.
3. The Executive Director - Partnerships, Prosperity and Growth (SCC) will liaise with the Priority 2 Co-Sponsor and the Director of Public Health (SCC) on the joint programme of work around workforce wellbeing.

8/23 INTEGRATED CARE SYSTEMS (ICS) UPDATE [Item 8]

Witnesses:

Dr Charlotte Canniff - Joint Chief Medical Officer, Surrey Heartlands Integrated Care System / HWB Vice-Chairman

Dr Pramit Patel - East Surrey Place representative / Primary Care Clinical Leader, Surrey Heartlands Integrated Care System
Tracey Faraday-Drake - Director for Children and Young People and All Age Learning Disabilities and Autism / Place Convenor for Surrey Heath, NHS Frimley Integrated Care Board

Key points raised in the discussion:

1. The Joint Chief Medical Officer (Surrey Heartlands ICS) / Vice-Chairman outlined the Surrey Heartlands ICS update adding that there were significant pressures in the NHS around demand and capacity, a briefing had been provided around the current industrial action underway by junior doctors.
2. The East Surrey Place representative / Primary Care Clinical Leader (Surrey Heartlands ICS) added that:
   - Since the publication of the 'One system, One Plan' document in response to the Fuller Stocktake, the four places in Surrey Heartlands ICS undertook work around the key workstreams: streamlining access, complex care management, how to prioritise those cohorts and be more proactive within the prevention agenda. It required a whole system response, for example through the Growing Health Together initiative in East Surrey.
   - Of the approximately 62,000 high users of healthcare services, 624 or 1% were very high users in terms of: A&E attendances, outpatient appointments, admissions and general practice contacts. Multi-disciplinary integrated neighbourhood teams needed to be created to support those cohorts across Surrey, work was underway via the anticipatory care hubs and a reduction had been seen in attendances and admissions.
3. The Chairman noted that the Hewitt Review would be published on 29 March, it had sensible recommendations that would help inform local strategies. A key part of the request and the evidence heard through that Review had been to empower ICSs to manage their own systems, moving decision-making closer to residents. He noted that the towns work was a positive step forward, building multi-disciplinary teams around the geographical cohorts.
4. The Director for Children and Young People and All Age Learning Disabilities and Autism / Place Convenor for Surrey Heath (NHS Frimley ICB) outlined the Frimley ICS update adding that:
   - Operational planning and budget setting for next year had been challenging due to the huge priorities and challenges around NHS funding.
   - The joint forward plan was being developed and welcomed the chapter on neurodiversity; more work needed to be done on that across Surrey particularly around children and young people and Special Educational Needs and Disabilities.
   - The draft Frimley ICS Strategy had six ambitions: starting well, living well, people, places and communities, our people, leadership and cultures, and outstanding use of resources; feedback was welcomed, ensuring that it was aligned with other Surrey organisations' strategies.
   - The ICB was focused on prioritising the reduction of health inequalities and its next meeting would be a development day.
5. A Board member noted that the system was not going far enough in the right direction. To save money and for people to have better lives, focus needed to be on looking beyond services; working with communities to enable them to have better lives for example the asset-based community development learning programme. She noted that there were many VCSE organisations who had been working with communities for many years, it was vital to work with them, commissioning them to do further work as necessary. Her concern

was replacing that work via the public sector whose personnel would be more expensive.

- The Priority 3 Sponsor highlighted an example of asset-based community development work underway in East Surrey with colleagues in Tandridge, empowering residents within those communities to identify what prevention looks like at place/neighbourhood level. The work in Merstham was about the public sector and organisations across the system enabling and facilitating what communities want to do for themselves.
- The East Surrey Place representative / Primary Care Clinical Leader (Surrey Heartlands ICS) noted the importance of understanding how data is used and empowering teams within neighbourhoods to have a large impact in terms of prevention and wellbeing. For example, 80% of residents in Nailsworth Crescent, Merstham, are smokers, that data enabled targeted work to happen with the Merstham Community Hub to start proactively inviting those people to start using the One You Surrey service - which was underutilised - becoming the highest referrer into that service.
- The Chairman highlighted the work of the Leatherhead Community Hub which was undertaking some fantastic work. He noted that there was a multitude of good work underway but some of it was unknown and he emphasised that the VCSE sector was a key part of the work.

RESOLVED:

1. Noted 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; including the update on both systems' implementation of the 'Next steps for integrating primary care: Fuller stocktake report'.

Actions/further information to be provided:

None.

9/23 DATE OF THE NEXT MEETING [Item 9]

The date of the next public meeting was noted as 21 June 2023.

Meeting ended at: 3.31 pm

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Chairman

Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Health and Wellbeing Strategy Highlight Report
HWBS Priority populations:	All
Priority 1, 2, 3:	All
Outcome(s)/System Capability:	All
Principles for Working with Communities:	• Community capacity building: 'Building trust and relationships' • Co-designing: 'Deciding together' • Co-producing: 'Delivering together' • Community-led action: 'Communities leading, with support when they need it'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions • Community Led interventions
Author(s):	Helen Johnson, Senior Policy and Programme Manager - Health and Wellbeing, Surrey County Council; Helen.Johnson1@surreycc.gov.uk
Board Sponsor(s):	• Karen Brimacombe, Chief Executive, Mole Valley District Council (Priority 1 Sponsor) • Professor Helen Rostill, Deputy CEO Surrey and Borders NHS Foundation Trust and SRO Mental Health, Frimley ICS; Kate Barker and Liz Williams SCC/Surrey Heartlands Joint Conveners (Priority 2 Sponsors) • Mari Roberts-Wood (Priority 3 Sponsor), Managing Director, Reigate and Banstead Borough Council
HWB meeting date:	21 June 2023
Related HWB papers:	HWBS Summary Implementation Plan (item 6) Community Safety Assembly & Implementation Plans (item 7)
Annexes/Appendices:	**Annex 1**: Highlight Report including JSNA progress and Communications Update

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2. Executive summary

This paper provides an overview of the progress of local shared projects and communications activity supporting delivery of the Health and Wellbeing Strategy (HWB Strategy) as of 30 May 2023. The Highlight Report now provides an overview of activity against Health and Wellbeing Strategy's Summary Implementation Plan (see item 6), describes what has been achieved against outcomes, how collaborative working has aided this progress and identifies new data and insights that have been released in the previous quarter. It also has a section on communication activity associated with the HWB Strategy's priority populations and priorities and a section on the progress of the review of the Joint Strategic Needs Assessment (JSNA) – chapters already published/in development. From September there will be a section on the implementation of the Health in All Policies (HiAP) implementation plan.

The Board is also asked to note the disbanding of the Surrey Local Outbreak Engagement Board.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Note progress against the delivery of the Strategy in the Highlight Report.
2. Utilise the links to the refreshed Health and Well-being Strategy and Highlight Reports to increase awareness through their organisations and elicit support for reducing health inequalities.
3. Ensure member organisations are utilising the HWB Strategy engagement slide deck on the SCC Community Engagement sharepoint site to provide active leadership around the mission to reduce health inequalities within their own organisations and across the system.
4. Note the disbanding of the Surrey Local Outbreak Engagement Board.
5. Note that with the appointment of a new Chair, the Terms of Reference of the Board will now be reviewed at the September Board meeting.

4. Detail

All project /programme implementation plans that sit behind the Highlight Report have now been reviewed, with new plans added, ensuring the content of the Highlight Reports that are reported to the Board all meet the Programme Management Guidance of the Strategy:

- Reduce a health inequality via prevention interventions within (a) HWB Strategy Priority Population(s)
- Address an agreed, significant need that can only be met through Board members working in partnership
- Prioritise community led interventions (aspirational), alongside civic/system level and service-based interventions
- Measure inputs, outputs, outcomes, impact in a way that is meaningful to communities (Logic Model)
- Be evidence-based and/or add to the evidence base

- Have deadlines for completion, key milestones and an SRO
- Be appropriately resourced or be looking for commitment to appropriate resourcing

These project/programme implementation plans will not only feed into the Highlight Reports with risk ratings/summaries escalated as necessary, but also into a HWB Strategy Summary Implementation Plan progress report which will come annually to the HWB Board (see item 6).

For Priority One a focus is given in the Highlight Report to the Surrey Breastfeeding strategy 2023-2028 which is now published, after a successful launch event in March. The Strategy aims to build on the good practice and work that has taken place to date to improve breastfeeding initiation and continuation rates, which could lead to the following benefits:

- Reduces the odds of overweight and obesity, even after adjustment for socioeconomic status
- Improving breastfeeding rates in lower socioeconomic groups and young parents can play an important role in reducing health inequalities
- Benefits against the risk of respiratory infections, gastroenteritis, ear infections, improved oral health and reduced tooth decay
- Reduces the risk of Sudden Infant Death Syndrome, childhood diabetes and leukaemia
- Uses marginal resources and produces minimal or zero waste, which is environmentally friendly.

The Breastfeeding Strategy's milestones appear in the **Whole System Approach to Obesity Implementation Plan.** While Surrey's breastfeeding rates compare well to England, there are geographic patches of Surrey with poorer outcomes and lower continuation rates. The Strategy proposes a proportionate universalism approach with equitable access to information and support for all women and birthing people and an emphasis on priority population groups. Partners should also be supported in the breastfeeding journey - including young parents, and those with protected characteristics.

The Breastfeeding Strategic Group will now finalise the action plan, define realistic timeframes and assign key leads for delivery. Partners are encouraged to champion breastfeeding and consider opportunities for multi-agency working to enable breastfeeding-friendly communities. For more information, please contact Adam Letts at adam.letts@surreycc.gov.uk.

For Priority Two a focus is given to 'Embedding Green Health and Well-Being in the Surrey System' - the progress of the **Green Health and Well-being Implementation Plan.**

Surrey Heartlands was one of seven national test and learn sites for 'green social prescribing', with national funding ending in March 2023. The ambition is now to embed the value of nature, and health and wellbeing benefits of green space, into 'business as usual' across Surrey Heartlands Integrated Care System (ICS) aiming to:

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- Embed the **value of nature** for health & wellbeing into the Surrey Heartlands health and care system.
- Develop **place-based prevention strategies** that utilise community assets, including green and blue spaces, and **incorporate the health benefits of nature connection** into local health inequalities and population health management plans.
- Utilise innovative approaches to supporting **diverse populations** with nature-based health and wellbeing.

Green Health & Wellbeing initiatives are working with virtually all the HWB Strategy Priority Populations – including projects in Key Neighbourhoods, including Court, Stoke, Sheerwater - and in Spelthorne. For more information, please contact Jane Soothill at Jane.Soothill@surreycc.gov.uk .

For Priority 3 a focus is given to the Community Sparks Funding**,** which features in the **Empowered and Thriving Communities Implementation Plan.** This funding programme has been created to support small scale, meaningful community-led initiatives, primarily (but not exclusively) in the 21 Key Neighbourhoods identified in the HWS Strategy and by this Board as Priority Population.

This funding looks to create opportunities and support the Surrey system's ambition to create Empowered and Thriving Communities. The funding will be invested in resident and community led activity that will benefit residents and neighbourhoods. Charities that support and work with the voluntary, community and faith sector in Surrey and work closely with public partners can apply for up to £2,000, although in some cases this can be increased. Where possible the activities funded will help build community connection and resilience, mitigate the impact of the cost-of-living and catalyse further activity. Locally, contact should be made via the relevant VCSE organisation depending on the geographic area, as detailed in the Highlight Report. For more information, please contact Saba Hussain at saba.hussain@surreycc.gov.uk

See Highlight Report at Annex 1.

For the Board's further awareness:

The Surrey Local Outbreak Engagement Board (LOEB) has been disbanded. LOEB was a member-led public facing oversight board in place throughout the pandemic. The LOEB was a sub-committee of the Surrey Health and Wellbeing Board and its primary role was to have oversight of the Surrey Local Outbreak Management Plan, outbreak response, resource allocation, and to provide direction and leadership for community engagement. The LOEB met bi-monthly and in total the LOEB met as a formal committee eleven times.

The final meeting of the LOEB took place on 21 April 2022, where it was agreed that the board would be kept on hold for the remainder of the year and that oversight of Surrey's response to COVID-19 would be overseen by Surrey Heartlands Emergency Preparedness, Resilience and Response Board. The need did not arise for the Board to reconvene therefore April's meeting was officially the last. Multiple debriefs were undertaken by system partners during the course of the pandemic and

lessons learnt are being coordinated by Surrey Local Resilience Forum in preparation for the COVID-19 Public Inquiry.

The Terms of Reference of the Health and Wellbeing Board will now be an item at the September, rather than the June meeting. A third of the Board members responded to the survey circulated before the March Board meeting. The results of this survey have been compiled and applied to a new draft Terms of Reference, which will now be brought to the Board in September.

5. Opportunities/Challenges

Opportunities this quarter

Priority 1:

- **Making Every Contact Count**: Train the Trainer: Launch of train the training programme providing opportunities for partners to upskill workforce to engage in healthy behaviour discussions with clients/residents (HiAP).

Priority 2:

- **Mental Health:** The Mental Health Investment Fund Round 2 is now open until 11 July.

Priority 3:

- **Wider determinants:** SCC Public Health Wider Determinants of Health Research Collaboration across Council directorates and in partnership with Voluntary Community and Social Enterprise (VCSE), Reigate and Banstead Borough Council and University of Surrey has been asked to submit a stage two funding application to the NIHR Health Determinants Research Collaboration (NIHR HDRC).
- **Empowered communities**: Community Sparks Funding programme – small community grants – is now available.
- **Poverty:** The Cost of Living/Impact on Health and Well-being ethnographic research will now inform the exploration of a whole system approach to poverty in Surrey.

Challenges this quarter:

Priority 1:

- **Cardio-Vascular Disease (CVD)**: Surrey Heartlands Clinical Leads have left their posts. Strong clinical leadership is important to drive engagement and system change in relation to CVD prevention. Until a replacement is recruited there is a risk to delivery.
- **Substance Misuse:** Recruitment of skilled workforce is a challenge. Waiting for NHSE & Health Education England to develop a workforce programme for substance misuse.
- **Smoking:** Respiratory Clinical Lead for Surrey Heartlands has stepped down. This post chairs the Surrey Heartlands NHS 'in-house' smoking cessation

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steering group. Strong clinical leadership is important to drive engagement and system change in relation to Surrey's smokefree ambitions. Until a replacement is recruited there is a risk to delivery.

Priority 2:

- **System Capacity:** Some programmes are reporting capacity (incl staffing) is limiting the speed at which they are able to progress, affecting projects within the Long Term Conditions and serious mental illness programme, the Emotional and Mental Wellbeing in Key Neighbourhoods programme and in addressing repeat removals of babies due to safeguarding (part of the Surrey Heartlands Best Start Strategy).
- **Green Health and Well-Being:** Following the learning from the Green Social Prescribing pilot, funding is yet to be identified by key system partners to enable the proposed broader Green Health and Wellbeing programme delivery.

Priority 3:

- **Domestic Abuse**: There is a lack of clarity around the delivery/funding of the national Safe Accommodation Strategy and therefore the Hospital Independent Domestic Violence Advocates service from 2025 onwards.

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

- All Board members are requested to share the Highlight Reports widely within their respective organisations and utilise the HWB Strategy engagement slides as appropriate.
- The Health and Wellbeing Board's Communications Group met in March and May and now have a list of prioritised issues to focus on in the implementation of the 2023 Communications Plan, presented to the Board at the December 2022 meeting.

7. Next steps

- The Highlight Report is now available on the Healthy Surrey web page.

Annex 1

Health and Wellbeing Strategy: Priority 1- Supporting People to Live Healthy Lives

IMPACT SUMMARY Improved physical health through the prevention of physical ill-health & promotion of physical well-being	WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?	HOW HAS COLLABORATIVE WORKING BETWEEN HWB BOARD ORGANISATIONS ADDED VALUE?	DATA, INSIGHTS AND CHALLENGES: Healthwatch research into the experiences of unpaid carers
OUTCOMES: By 2030 the following outcomes will be met for the Priority Populations: • 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 **WHO IS LEADING THIS?** **Priority sponsor:** Karen Brimacombe. Chief Executive, Mole Valley District Council **Programme Manager:** Jason Ralphs, 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	The Community Vision for Surrey describes what residents and partners think Surrey should look like by 2030: 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. 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. 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: • 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	**Prevention of Type 2 Diabetes** Active Surrey, with Surrey Heartlands ICS partners, hosted a two-part, free information session for the prevention and management of Type 2 Diabetes for people from South-Asian communities. The sessions were led by a registered Dietitian, focusing on South-Asian diets, and a GP specialising in diabetes. Participants received useful and practical information on the condition in general and how eating well and moving more can help them manage type 2 diabetes/prediabetes. **Changing Futures and Bridge the Gap** ECINS Digital Referral Module procured and mobilised from March 2023. The referral module is being used by the wider system to refer clients to Bridge the Gap Trauma Informed Assertive Outreach Services. The Changing Futures Programme has contributed to the co-design and delivery of Trauma Informed Training to 1400 people within Surrey's wider system. **Cooking for Health** A training session for system partners to support families to cook on a budget is being planned with Surrey Heartlands. **Liver Health** Surrey Minority Ethnic Forum have worked with Royal Surrey Hospital to raise awareness about Liver Health with different BAME community groups to educate and raise awareness about liver disease and related conditions including benefits of research and clinical trials around liver disease.	Since April 2022, Healthwatch Surrey have been listening to the experiences of unpaid carers under the Giving Carers a Voice Contract. In the past year we have attended 172 events and heard from 649 people. The key findings are that: 1) People can be slow to self-identify as carers. The reasons identified were: -Not feeling they do enough to count as a "carer"; expected in their family role. -Emotional and Cultural resistance – resisting the change in relationship and status -Infrequent signposting from frontline/clinical staff 2) Understanding of the support and benefits available to carers appears to be weak for those who do not identify as carers. 3) Different people have different needs and strengths and find value in different types of benefits or support. It can be helpful to consider a "value equation" i.e. is the practical, emotional/intellectual or financial cost of accessing a service "paid off" by the benefits? 4) The benefits/services we heard about most often were: - Action for Carers - Any form of respite - GPs – clear call to action for registration; for most the benefits received were limited. Recommendations 1. Recognise that new carers are unlikely to self-identify and self-present. Maximise "recruitment" through media; by encouraging word-of-mouth among carers. 2. Ensure frontline staff "think carer" – recognise carers, are confident in starting conversations, and know where to signpost. 3. Review the accessibility of support and benefits: how easy are they for someone time-poor, overwhelmed or on a limited budget to find, apply for or use? Are those "costs" balanced with the benefit to the carer and for person?

WHAT HAS BEEN ACHIEVED THIS QUARTER UNDER REFRESHED PRIORITY 1 OUTCOMES?

People have healthy weight and are active

- Surrey now a registered centre for Royal Environmental Health Institute of Scotland to offer Food for Health training to those who care for people with learning disabilities. Training material will be tailored to meet the needs of those living in Surrey.
- Active Surrey have launched a new Health Hub containing training, e-learning national and local resources for professionals and volunteers to upskill themselves on the health benefits of being physically active.
- Registrations for The Surrey Youth Games have exceeded last year's event and training has started in advance of the event on 17th June. The Games are for beginners who may not get the chance to attend clubs or are inactive and put off by the thought of competing against others. The focus is on joining in, having a go and having fun in order to learn new skills and boost confidence.
- 12,796 Holiday Activity with Food places were funded at Easter across Surrey, enabling children to access nutritious food and engage in physical activity during the school holidays. The summer provision is currently being planned and will be available for booking in June.
- **Substance misuse is low**
- Combatting Drugs Partnership is working with the Office for Health Improvement and Disparities as a priority partnership to host workshops and develop plans to increase the numbers of people in treatment.
- Surrey is contributing to a guidance document for South East schools in relation to young people vaping that will include tools and guides. Drug education workplans are also being updated with smoking and vaping included and support from Surrey Healthy Schools.

The needs of those experiencing multiple disadvantage are met

- Surreys Emergency Accommodation Cabin initiative shared by the NHSE Lead for Migrant Health Response and Homelessness and given accolade for "inspiring work on setting up winter cabins". The cabins closed in March, having accommodated 190 individuals with multiple disadvantages across four sites since November 2022. Residents were supported by Bridge the Gap Trauma Informed Services.
- The Changing Future's Lived Experience Project Manager has recruited new members to join the Changing Futures Lived Experience network. Two Lived Experience Forums facilitated by the Lived Experience Project Manager have taken place, both with very positive outcomes.

Serious conditions and diseases are prevented

- NHS health check dashboard has been developed, showing clinical information and demographic data, which will be a valuable tool to evaluate the impact of the NHS health check service.
- Surrey Heartlands selected for the Core20+5 accelerator programme, which will focus on improving the uptake of cancer screening for those with Learning Disabilities.
- Alzheimer's Society training offered to primary care teams to support the identification of different types of Dementia and improve diagnosis rates.

People are supported to live independently for as long as possible

- 2,600 Fall-proof packs distributed through community centres, u3a, housing associations and other partners to prompt people to work on strength and balance when undertaking everyday activities at home. The effectiveness of the campaign is now being measured.
- 'Placed based' social prescribing communities of practice are now established and meeting on a quarterly basis. The aim is to enhance collaboration across professions.
- Young Carers Action Day seminar took place in March to emphasise the importance of making time for young carers to support their education and emotional health and wellbeing.
- **5-11th June 2023 was Carers Week**. Activities and educational events took place online and across Surrey, including launch of Staff carers survey to obtain input from working carers.

IN THE SPOTLIGHT: Surrey Breastfeeding Strategy Launch

The Surrey Breastfeeding strategy 2023-2028 is now published, after a successful launch event in March.
The Strategy aims to build on the good practice and work that has taken place to date to improve breastfeeding initiation and continuation rates, which could lead to the following benefits:

- Reduces the odds of overweight and obesity, even after adjustment for socioeconomic status (WHO)
- Improving breastfeeding rates in lower socioeconomic groups and young parents can play an important role in reducing health inequalities (OHID)
- Benefits against the risk of respiratory infections, gastroenteritis, ear infections, improved oral health and reduced tooth decay (OHID)
- Reduces the risk of Sudden Infant Death Syndrome, childhood diabetes and leukaemia (NHS)
- Uses marginal resources and produces minimal or zero waste, which is environmentally friendly (BMJ)

While, Surrey's breastfeeding rates compare well to England, there are geographic patches of Surrey with poorer outcomes and lower continuation rates. The strategy proposes a proportionate universalism approach with equitable access to information and support for all women and birthing people and an emphasis on priority population groups. Partners should also be supported in the breastfeeding journey - including young parents, and those with protected characteristics. By delivering the Breastfeeding strategy in Surrey, the vision is that:

- Every child in Surrey has the best start in life
- Parents are supported throughout their entire breastfeeding journey and Surrey's acute and community settings welcome and support all breastfeeding mothers/birthing people
- Every Surrey family can access consistent information, free support and help they need, when they need it
- Every Surrey family is fully aware of the health, environmental and financial benefits of breastfeeding their baby

The Breastfeeding Strategic Group will now finalise the action plan, define realistic timeframes and assign key leads for delivery. Partners are encouraged to champion breastfeeding and consider opportunities for multi-agency working to enable breastfeeding-friendly communities.

For more information, please contact Adam Letts at adam.letts@surreycc.gov.uk.

Health and Wellbeing Strategy: Priority 2 - Supporting Mental Health and Emotional Wellbeing

IMPACT SUMMARY Improved mental health through the prevention of mental ill-health & promotion of emotional well-being	WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?	HOW HAS HWBB COLLABORATIVE WORKING BETWEEN HWB BOARD ORGANISATIONS ADDED VALUE?	DATA, INSIGHTS AND CHALLENGES: Our Voice Matters Survey – Children and Young People
 **OUTCOMES: By 2030 the following outcomes will be met for the Priority Populations:** • 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 **WHO IS LEADING THIS?** **Priority sponsors:** Professor Helen Rostill, Deputy CEO Surrey and Borders NHS FT and SRO Mental Health, Frimley ICS Kate Barker - Joint Strategic Commissioning Convener: Children and all age Mental Health Liz Williams - Joint Strategic Commissioning Convener: Learning Disability and Autism and all age Mental Health **Programme Manager:** Jason Lever, 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	The Community Vision for Surrey describes what residents and partners think Surrey should look like by 2030: *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.* 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. 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: • 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.	**The Mental Health: Prevention Oversight & Delivery Board (MHPODB)** meets on a six-weekly basis. Its membership has increased to 12 with further VCS representation, from the children's and young people's sector. In recent meetings, system-wide strategies have been brought for final review prior to finalisation – including the Suicide Prevention Strategy 2023-26 and Protocol; Children & Young People's Emotional Wellbeing & Mental Health (EWMH) Strategy, 2022-27; Trauma Informed Care Strategy & Toolkit; and Workplace Wellbeing Programme. **MHPODB Work Plan Progress Report** sets out the key insights and analysis from delivery of the board's four work areas. There are proposed actions for Surrey organisations and boards, and the whole system, including for MHPODB itself which would constitute a continuing work plan. If agreed, this will be considered within the board's planned review of its functioning in September. **Mental Health Investment Fund (MHIF),** MHPODB members have provided insights and steers on what would be beneficial to see in successful applications to MHIF's round two which is now open. This was informed by the MHIF team's analysis of the coverage of round one projects. In future, MHPODB will provide guidance and challenge in support of the MHIF team's performance management of funded projects, to help ensure effective programme delivery and appropriate use of funds.	Our Voice Matters Survey is a publication by Surrey Youth Voice which is a partnership between young people in Surrey and the User Voice and Participation Team (UVP) at SCC. The partnership worked together to empower children and young people to share their views and opinions about the services they use. The young people represented in this survey were from 10 Districts and Boroughs, between 8 to 25 years, and included Looked After Children, Care Leavers, Young Carers, Children with Additional Need and Disabilities. The report highlighted the following: **Mental Health** More than half of the young people, especially care leavers, reported that they had high levels of anxiety. However, most of children and young people know where they could access support for their mental health and wellbeing, including what mental health support was available at their schools or colleges. **Living in Surrey** Overall, children and young people like living in Surrey. They noted that the parks are very green, there are a lot of playgrounds and parks to play in but there is also a decent amount of litter in Surrey. The children and young people also like living in Surrey because they feel part of the Community and feel safe living in Surrey. **Cost of Living** Many looked after children and 18-25-year-olds, including Care Leavers said they are concerned about the cost-of-living crisis and that they did not feel like there is enough financial support available. **Employment and Apprenticeships** Young people who are employed or on apprenticeship like their jobs or apprenticeships and scored above average for how supported they feel by their employers. However, most young people who are unemployed do not feel well supported when it comes to searching for a job. For more information, please contact: user.voice@surreycc.gov.uk.

WHAT HAS BEEN ACHIEVED THIS QUARTER UNDER REFRESHED PRIORITY 2 OUTCOMES?

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

-The Children and Young People's Emotional Wellbeing & Mental Health (EWMH) Strategy was taken for review to the MHPODB's May meeting prior to its finalisation and publication. An action plan has been established across its six themes.

- New guidelines and resources for 'Online Safety and Social Media Use', were presented at the Co-production & Insight Group in April. This was one theme of the EWMH Strategy, to support children, young people and families to keep themselves and others safe online.

- As part of improving access to preventative emotional and mental wellbeing, phase 1 of the Community Arts Hope programme in priority neighbourhoods has completed and Catalyst's Butterfly Hope project had publicity on local and national radio, TV and social media.

- The Suicide Prevention Strategy 2023-26 is now published and its Protocol launched with the Suicide Prevention Partnerships, with modifications to support children, young people and adult use. Rethink is mobilised to run the suicide bereavement postvention support service.

- An evidence based Sleep Plan was developed and sleep management/ early help campaign was launched, with articles read by over 18k residents and professionals across Surrey.

- Mentell is ahead of its targets in delivery of the men's mental health prevention programme. Over 200 people from Councils, NHS and VCSE had mental health training in 2022/2023.

-The prototype for prevention and early help around 'Long Term conditions and mental and emotional wellbeing' is planned with East Surrey Place, and neighbourhood profiles and a needs assessment are under development.

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

-The Best Start Strategy was due to be published in May, as part of which is an approach to reduce repeat removals of babies due to safeguarding. The focus is on supporting women who experience, or are at risk of, repeated pregnancies, with early mental health support.

Isolation is prevented and those that feel isolated are supported

See right – Green Health and Well-being

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

- Workplace Wellbeing Standards for large businesses are finalised and toolkit is being developed. The men's health engagement lead is co-designing small business standards.

- Reducing Stigma programme measures are embedded into Workplace Wellbeing Standards to allow scale up of approach. Drama-based training delivered to 30 fire & rescue managers.

- A behavioural insights and research worker was recruited to support with co-production of community led resilience interventions.

- Mapping has started for a high-level needs assessment of the Reducing Gambling Related Harm programme, alongside establishing a system wide, strategic action plan.

- NatureWell's evaluation report of first three cohorts to participate (two primary care teams, one CAMHS team) shows improvement in staff wellbeing and increase in their nature connection.

IN THE SPOTLIGHT: Embedding Green [illegible]nd Wellbeing in the Surrey system

Surrey Heartlands was one of seven national test and learn sites for 'green social prescribing', with national funding ending in March 2023. The ambition is now to embed the value of nature, and health and wellbeing benefits of green space, into 'business as usual' across the ICS aiming to:

- Embed the **value of nature** for health & wellbeing into the Surrey Heartlands health and care system.
- Develop **place-based prevention strategies** that utilise community assets, including green and blue spaces, and **incorporate the health benefits of nature connection** into local health inequalities and population health management plans.
- Utilise innovative approaches to supporting **diverse populations** with nature-based health and wellbeing.

SCC contracted Unity Insights to run a logic model workshop with a range of cross-sector colleagues to co-design the key impacts and outcomes. It gave the opportunity to share, discuss and improve the aims towards a broader Surrey-wide approach to Green Health & Wellbeing.

The workshop also formed part of the Strategy implementation plan refresh and its outputs helped to define new milestones that show how a Green Health & Wellbeing programme contributes towards the Priority 2 outcome that 'Isolation is prevented', including:

- **Access to nature-based provision is increased for people with mental health needs.**
- **Nature-based approaches are embedded into workplace wellbeing plans.**
- **People with mental health needs have access to supported volunteering and green skills.**

Activities include delivering:

- Sustaining and scaling up 'A Dose of Nature' as a primary care mental health pathway.
- 'First Step Volunteering', supported placements for young people, people with mental health needs and for minority ethnic groups (75 participants to date in partnership with 9 VCSE organisations)..
- Targeted Virtual Reality nature pilots

Green Health & Wellbeing initiatives are working with virtually all the HWB Strategy Priority Populations – including projects in Key Neighbourhoods, including Court, Stoke, Sheerwater, and Spelthorne. The programme led a 'Cultivating a Green Health & Wellbeing Movement in Surrey' conference on 23 May at WWF's Living Planet Centre, Woking.

For more information, please contact Jane Soothill at Jane.Soothill@surreycc.gov.uk .

Health and Wellbeing Strategy: Priority 3 - Supporting People to Reach their Potential

IMPACT SUMMARY People reach their potential	WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?	HOW HAS COLLABORATIVE WORKING BETWEEN HWB BOARD ORGANISATIONS ADDED VALUE?	DATA, INSIGHTS AND CHALLENGES:
 **OUTCOMES: By 2030, the following outcomes will be met for the Priority Populations:** • 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) **WHO IS LEADING THIS?** **Priority sponsor:** Mari Roberts-Wood, Managing Director, Reigate and Banstead Borough Council **Programme Manager:** Olusegun Awolaran, 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	The Community Vision for Surrey describes what residents and partners think Surrey should look like by 2030: 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. 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. 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: • 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.	**Wider Determinants of Health Research Collaboration** SCC Public Health have set up a Wider Determinants of Health Research Collaboration across Council directorates and in partnership with Voluntary Community and Social Enterprise (VCSE), Reigate and Banstead Borough Council and University of Surrey. This Wider Determinants of Health Research Group has been asked to submit a stage two funding application to the NIHR Health Determinants Research Collaboration (NIHR HDRC), for a programme to build research capacity, increase the local evidence-base and translation of research into policy development to address the wider determinants of health. **Individual (Employment) Placement and Support in Primary Care (IPSPC)** Surrey County Council and system partners have been successful in securing a £6.3m grant by the Department for Work and Pensions to roll out Individual Placement and Support in Primary Care (IPSPC). The IPSPC is a proven model of employment support aimed at adults who have a physical or mental health disability or long-term condition. This programme is designed to support 2,882 people to access and maintain work and will run from October 2023 to March 2025. In Surrey, this programme will include targeted support for people in the HWB Strategy's top five Key Neighbourhoods and with the Priority Populations and will be delivered in partnership with Surrey Heartlands and Frimley ICS. For more information please contact Rebecca Brooker at rebecca.brooker@surreycc.gov.uk .	**NOLB Employment & Skills Network Research** The discovery research commissioned by the No-one Left Behind Skills and Employment Network has been completed. The research sought to understand the needs and experiences of residents who are furthest from the workforce; the existing provision around skills and employment and how well this is currently meeting the needs of residents; and to support the improvement/development of employment services. The preliminary results show that: • Most participants had worked in some way and often were motivated to work • Participants experience multiple and compound challenges to getting and maintain work • Most prevalent challenge relates to the attitudes of the respondents. Furthermore, the results show that around Surrey, there is a wide range of support available but only few of these support services addressed attitudinal challenges. The key recommendations were to implement services which addressed the attitudinal issues which prevented people from getting or maintaining jobs and to provide greater awareness of the support that already exists in Surrey. For more information, please contact Rebecca Brooker at rebecca.brooker@surreycc.gov.uk. **Cost of Living / Impact on Health and Well-being ethnographic research in 5 HWB Strategy Key Neighbourhoods** This research has been completed. Recommendations include: 1) Connecting with, finding and helping the very stuck who are not getting any support through community organisations 2) Protecting and supporting community organisations to continue their work 3) Radical suggestions that deal with the systemic causes of the problem For a copy of this powerful report and more information contact Abigail Linyard-Tough at Abigail.LinyardTough@surreycc.gov.uk. (This report will come to th… WB Board)

WHAT HAS BEEN ACHIEVED THIS QUARTER UNDER REFRESHED PRIORITY 3 OUTCOMES?

People's basic needs are met

-Since the launch of the Warm Hubs across Surrey, more than 480,000 households were provided with winter resilience, Priority Services Register, Carbon Monoxide safety and energy advice information via direct mailer. More than 16,000 visits were made to the safe and warm place during the winter months. Furthermore, more than 2,500 residents were supported with face-to-face energy & debt advice, while over 600 residents accessed personalised online advice. General enquiries and more information about the recent evaluation can be directed to: warmhubs@surreycc.gov.uk

Children, Young People and adults are empowered in their community

-Following a dynamic and interactive 'data safari' with Surrey Minority Ethnic Forum's Ecowarriors, which challenged some of the existing data about ethnic minority attitudes to the natural environment, the Muslim women's group have been sharing their global connections to the impact of climate change. The Ecowarriors have used these engagement exercises to inform their research interests and shape the agenda for their peer research training day at the University of Surrey on 8th June.

-A successful multiagency bid has been made to the National Institute of Health Research for another youth peer research programme with a focus on neurodiverse young people and young carers.

-An innovative Community Participatory Budgeting project in Sheerwater has delivered 17 projects, funded by a small NW Local Joint Commissioning Group grant. Roll out of the approach is planned.

Access to training and employment

-Frimley Anchor Project have now agreed the recruitment details for the position of 'Strategic Employment and Skills Officer' with joint reporting arrangement with Frimley ICS/Surrey Heath Borough Council. *Also see NOLB Employment and Skills Network Research above.*

People are safe and feel safe

-A Surrey Domestic Abuse Immigration Project has been accepted through the Safe Accommodation grants process to the national Government. This project will provide highly specialised casework required to support individuals who experience both domestic violence and complex immigration, nationality and asylum challenges.

-A further property has now been secured for Refuge for All, making the total of 7 units now available for women and children go when they are fleeing severe domestic abuse.

-Hospital Independent Domestic Violence Advocates (HIDVA) funding has been secured from the Department for Levelling Up, Housing and Communities for 1 year, through the Safe Accommodation grants. For more information, please contact Sonia Knight at Sonia.Knight@surreycc.gov.uk

The benefits of healthy environments for people are valued and maximised

-To increase Surrey resident's levels of walking, cycling, scooting and e-biking, SCC working with the Active Travel England are developing safe, attractive, high-quality routes, directly serving journeys that people want to make, developed following the latest design standards and guidance.

-With the new funding from the national Government secured, plans are in train to design local cycling and walking corridors in Elmbridge, Runnymede, Spelthorne and liveable neighbourhoods in Egham and Sunbury-on-Thames. For more information, please contact Lyndon Mendes at lyndon.mendes@surreycc.gov.uk

IN THE SPOTLIGHT: Community Sparks Funding

The Community Sparks funding has been created to support small scale, meaningful community-led initiatives, primarily (but not exclusively) in the 21 Key Neighbourhoods identified by the Health and Wellbeing Board as priorities. This funding looks to create opportunities and support the Surrey system's ambition to create Empowered and Thriving Communities. The funding, among others, should be invested in resident and community led activity that will benefit residents and neighbourhoods. Charities that support and work with the voluntary, community and faith sector in Surrey and work closely with public partners can apply for up to £2,000, although in some cases this can be increased. Where possible the activities funded will help build community connection and resilience, mitigate the impact of the cost-of-living and catalyse more extensive activity. Interested parties should contact the relevant organisation depending on the area in which they are based (links below):

- For projects and ideas relating to Elmbridge, Epsom & Ewell and Mole Valley, contact **Central Surrey Voluntary Action**
- For projects and ideas related to Spelthorne, Runnymede and Surrey Heath contact **Voluntary Support North Surrey**
- For projects and ideas related to Guildford & Waverley contact **Voluntary Action South West Surrey**
- For projects and ideas relating to Reigate & Banstead contact **Voluntary Action Reigate & Banstead**
- For projects and ideas related to Tandridge please contact **Tandridge Voluntary Action**
- For projects and ideas related to Woking contact **Surrey Community Action**

For more information, please contact Saba Hussain at saba.hussain@surreycc.gov.uk

Joint Strategic Needs Assessment: Progress as of May 2023

For further information please contact the PH Intelligence Team at jsnafeedback@surreycc.gov.uk

Chapters published in last Quarter: 2

	Chapters published
Priority 2	***Emotional and Mental Wellbeing in Surrey Adults*** We have now published our JSNA chapter focusing on emotional and mental wellbeing in Surrey adults. This JSNA considers social and environmental influences on the mental health of Surrey residents, provides an overview of services in place in Surrey and also considers the mental health of the key population groups in Surrey, many of which form part of the Surrey Health and Wellbeing Strategy priority populations. The chapter is informed by the Mental Health Tableau Dashboard developed by the Public Health Intelligence and Insight Team. The Mental Health: Prevention Oversight & Delivery Board reviewed it and will oversee progress of recommended actions. A further chapter on Children and Young People's Mental Health is in development.
Priority Populations	***People with learning disabilities*** We have now published our JSNA chapter focusing on people in Surrey with learning disabilities which outlines what we know about this population, their health outcomes and access including the experience of COVID-19, social care needs and provision, their living circumstances, education and employment and how much of a voice they have in their lives, services they use and their communities. The previous version of this chapter also incorporated people living with Autism, which will now be treated separately/update pending.

Planned JSNA chapters to be published by September 2023 / development started

	Chapter to be published
Priority 1	***Screening services –*** Publication scheduled for May 2023 ***Substance use –*** Publication of full chapter scheduled for July 2023. Visualisations of data surrounding substance use of adults and young people in Surrey were updated and published in 2022. ***Multiple disadvantage*** (including those experiencing a combination of homelessness, domestic abuse, contact with the criminal justice system, with drug/alcohol and/or mental health issues) - Development started
Priority 2	***Mental Health of children & young people –*** Development started
Priority 3	***Economy –*** Development started ***Housing –*** Development started ***Community Safety –*** Development to start Summer/Autumn 2023
Priority Populations	***See Multiple Disadvantage above***
Other	***Armed Forces and Military Veterans –*** *Development planned to start in 2023* **Migrant Health** - Responding to recent international developments, the JSNA has added a 'rapid needs assessment' to those completed during the pandemic, exploring Migrant Health. This will be delivered in several phases with the focus of phase one being on asylum seekers and refugees which will reference the Afghan and Ukrainian support schemes that are currently in place. Phase one of the needs assessment is now published. Due to the sensitive and dynamic nature of this area of healthcare only an Executive Summary will be published via the JSNA website. To discuss in more detail please contact Qanita Vora at qanita.vora@surreycc.gov.uk.

NOTE: Latest Census 2021 analysis can be found here on Surrey-i

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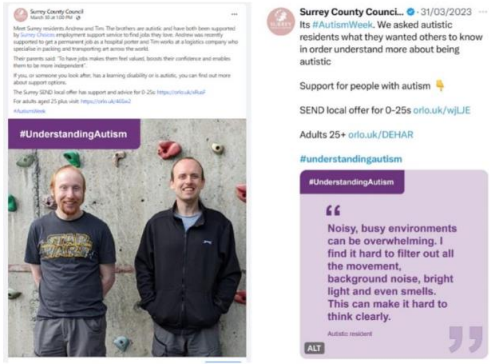
Communications Update – Priority Populations

People with Long Term Conditions - Dementia Action week

A national awareness-raising campaign took place in May to encourage individuals and organisations to "act on dementia". With the focus this year on encouraging people and families to seek a timely diagnosis and avoid reaching crisis point, residents in Surrey were signposted to details of dementia support in the county. Surrey Fire and Rescue Service were among organisations supporting the campaign, as those with dementia are statistically more likely to be involved in domestic dwelling fires. Their video, produced with Surrey charity Dementia First, signposts support available from the service.

Adults with learning disabilities and/or autism/Children with additional needs and disabilities - Autism Week

In support of Autism Acceptance Week, a national initiative, activity in Surrey aimed to raise understanding and acceptance of autism. Content that was shared during the week included a video which explained some simple ways we can all support the estimated 11,000 autistic people living in Surrey. Autistic people also shared their thoughts on what they would like others to know about autism in order to understand more about being autistic. Signposting was to web pages which have details of support for autistic people in Surrey, for both children and adults.



Carers and Young Carers – Carers Week

In preparation for Carers Week in June, activity has been underway to promote local events and activities and organisations have also been raising awareness of the support available to working carers through internal communications channel

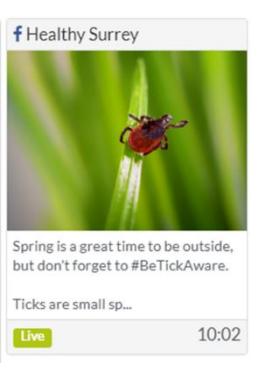
Young people out of work - Naturally Talented Me

Naturally Talented Me is a free-to-use online platform which matches people to jobs using a profile of their hobbies, interests and talents. The initiative is intended to help those furthest from the job market – because of health issues, disabilities, caring responsibilities or other circumstances - improve their chances of finding employment in Surrey. The county council linked with Naturally Talented Me, a Community Interest Company, to promote the opportunity and contribute towards the overarching aim of making sure No One is Left Behind. A set of creatives was developed, and a comms toolkit shared with Surrey partner organisations. Promotional work prompted a spike in profiles being added to the platform with further activity planned.

Communications Update - Priority 1: Supporting people to lead healthy lives

Working together across the ICB partnership, we highlighted the new offer of COVID-19 Spring boosters and continued to encourage people who have not yet had their 1st or 2nd vaccine to take up the offer before it ends 30th June. This included a focus on older people and people who are immunosuppressed, where work continues to increase uptake. We delivered a targeted door drops to 47,842 households in April and use of ad vans in areas of lower uptake, which includes some more deprived areas, all supported by out-reach work with harder to reach communities.

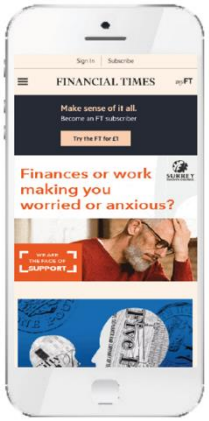
With an increase in the number of measles cases reported in England, we reminded residents of the importance of vaccination in preventing serious illness especially in our priority population of children with additional needs, disabilities and long-term health conditions. As a result of these comms we saw double the number of people visiting the Healthy Surrey immunisation page in May compared to March. In May we started our summer health communications, reminding people about ways in which they can stay healthy through the summer months. We included information regarding ticks, being sun safe, food hygiene and farm visits.

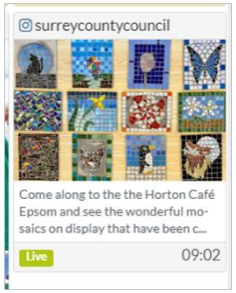


Communications Update - Priority 2: Supporting people's mental health and emotional well-being

We launched a new in-App advertising campaign targeting 3 specific audiences to support men's mental health. This campaign aims to support suicide prevention, in particular audiences. The campaign concentrated on the 3 topics of relationships, job and money worries, and loneliness/bereavement. The campaign directed people to support services including talking therapies and the SCC community helpline for older audiences. Specific demographic and geographic audiences were targeted. The adverts were shown 418k times over 2 weeks, resulting in 3,364 people clicking on the adverts for more information. This result is +47% on the industry average of people engaging with adverts like this. In addition to this campaign, we highlighted support to all residents during **Mental Health Awareness month** in April.

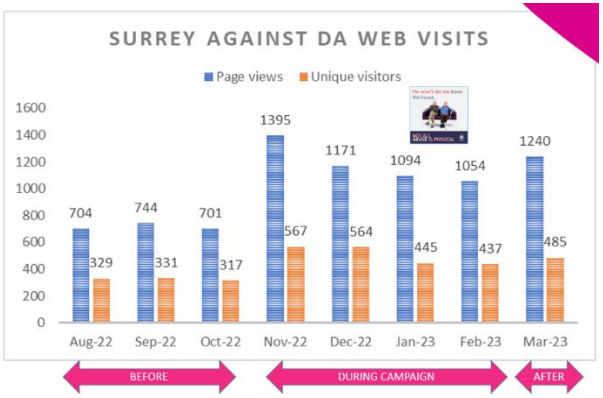
The SCC Hope project supported selected local charities to provide creative workshops and improve people's mental health and tackle loneliness and reducing the risk of serious mental ill health. This included poetry, mosaic creation and crochet butterflies which appeared across Surrey encouraging people to share their messages of hope.

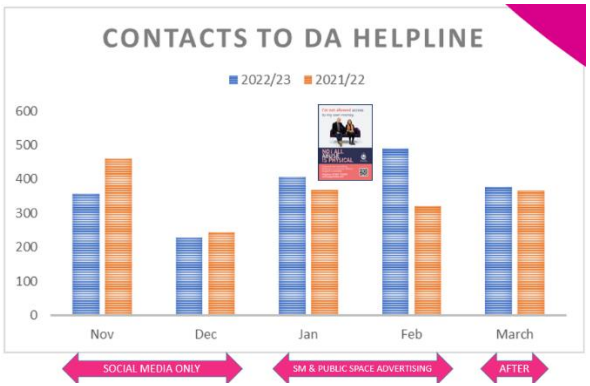




Communications Update: Priority 3 – Supporting People to Reach their Potential

We would like to highlight the results of the campaign and the importance of raising awareness of the support available through a wide-reaching campaign. The campaign had a direct impact on the number of people visiting the web pages Surrey Against Domestic Abuse | Healthy Surrey. We also saw an increase in the number of contacts to the Surrey DA helpline compared to the previous year when both social media and outdoor billboard advertising were combined. This increase continued in the month following the campaign. 80 people scanned the QR code on the billboards to immediately access support.



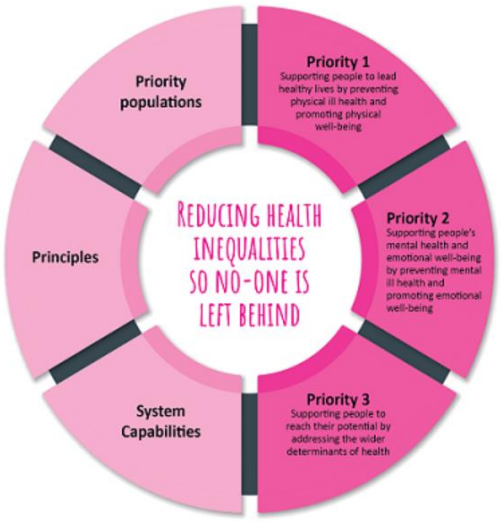


Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Health and Wellbeing Strategy Summary Implementation Plan June 2023
HWBS Priority Populations:	All
HWBS Priority - 1, 2 and/or 3:	All
HWBS Outcomes/System Capabilities:	• All Outcomes • Programme Management system capability
HWBS Principles for Working with Communities:	• Community capacity building: 'Building trust and relationships' • Co-designing: 'Deciding together' • Co-producing: 'Delivering together' • Community-led action: 'Communities leading, with support when they need it'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions • Community Led interventions
Author(s):	Phill Austen-Reed, Principal Lead - Health and Wellbeing, Surrey County Council; phillip.austenreed@surreycc.gov.uk
Board Sponsor(s):	Ruth Hutchinson, Director of Public Health, Surrey County Council
HWB meeting date:	21 June 2023
Related HWB papers:	Health and Wellbeing Index development March 23 Health and Well-being Strategy Indicators: Review and Refresh (September 22)
Annexes/Appendices:	**Appendix 1:** Surrey Health and Wellbeing Strategy – Summary Implementation Plan **Appendix 2:** Health and Well-Being Strategy Priority Populations, Priorities, Outcomes and Impact Indicators **Appendix 3:** Health in All Policies Progress update **Appendix 4:** Key Proposed Actions from the MHPODB Work Plan Progress Report (Priority 2)

2. Executive summary



This report provides the latest summary of the programmes engaged in implementing the Surrey Health and Wellbeing strategy. The summary, in Appendix 1, outlines which programmes are engaged in the strategy's aim of reducing health inequalities through a focus on Priority Populations and Key Neighbourhoods, as aligned with the three strategy priorities, and the 14 respective Outcomes.

Alongside delivery, these programmes are engaged in understanding their impact on the outcomes and impact indicators being developed for the strategy (see related papers). They are used to inform the Highlight Reports that outline delivery each quarter alongside informing future items on the forward plan for the board and related sub-boards in relation to challenges and issues arising in relation to delivery.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Recognise the range of current and developing programmes currently within scope of the implementation of the Health and Wellbeing Strategy priorities and outcomes. These programmes are also related to the impact indicators previously shared with the board (see related Health and Wellbeing Board papers above).
2. Recognise the progress made in highlighting the range of programmes that focus resource on Priority Populations including the Key Neighbourhoods.
3. Support the continued collaborative oversight of programmes alongside action to address barriers and challenges within the three priorities through:
    i. the Prevention and Wider Determinants Board (Priority One and Priority Three) and
    ii. the Mental Health: Prevention and Oversight Delivery Board (MHPODB) (Priority Two) (See Appendix 4 for actions in its first year's progress report).
4. Raise any obvious or significant omissions with the Health and Wellbeing Programme team via publichealth@surreycc.gov.uk and the relevant senior lead for follow up.

4. Reason for Recommendations

This is an opportunity for Board members to have an overview of the programmes of delivery that are currently actively engaged in relation to implementation of our Health and Wellbeing Strategy Priorities and Outcomes. These programmes not only

inform what is highlighted as being delivered each quarter but more importantly provide a channel for challenges and issues to inform the forward plan of the Board and its two sub-boards.

5. Detail

The updated Health and Wellbeing Strategy summary implementation plan (Appendix 1) provides an outline of the programmes in Surrey that contribute to the delivery of the Health and Wellbeing Strategy which was last provided in December 2021. In this latest snapshot, following the update to the strategy in 2022, Senior Responsible Officers (SRO) for each programme have been engaged to understand how programmes address key elements related to the delivery of the strategy:

- Focusing on reducing health inequality within the Priority Population(s) including the Key Neighbourhood(s)
- Addressing a significant need that can only be met through Board members' partnership working
- Prioritising community-led approaches, alongside civic /system level and service-based interventions
- Working to understand and measure inputs, outputs, outcomes, impact in a way that is working towards being more meaningful to communities
- Having deadlines for completion, key milestones and an SRO
- Being evidence-based
- Being appropriately resourced or be looking for commitment to appropriate resourcing

The programmes included are regularly reviewed by the Prevention and Wider Determinants of Health Board (Priority One and Three) and Mental health: Prevention Oversight and Delivery Board (Priority Two) through engagement with the SROs. This is to ensure they remain relevant to the overarching ambition of our Health and Wellbeing Strategy, communicate progress, and identify key challenges that need collaborative action at a community, service and system level. This is done through inclusion in the Health and Wellbeing Strategy highlight reports and through input into HWB forward plan items.

The latest iteration of plans has also utilised logic model (see Figure 1) workshops in some programme areas as good practice in understanding the connection between the programme, indicators and the outcome / impact against it is seeking to have within the HWBS priorities. This approach will continue to be used with additional programmes when they are going through relevant times of review (such as updating to a strategy or implementation plan).

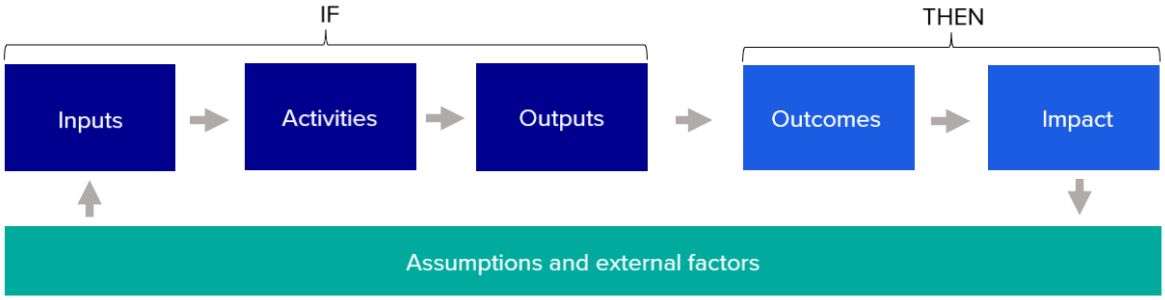


Figure 1. Summary of factors considered in development a programme logic model

5.1 Priority Populations

In line with the 2022 update of the Health and Wellbeing Strategy and the focus on reducing health inequalities, the summary in Appendix 1 shows the number of programmes within each priority that focus on each of the Priority Populations including the Key Neighbourhoods.

Encouragingly this shows that all Priority Populations and Key Neighbourhoods have some level of focus within the programmes currently provided in the snapshot. If members would like to understand more detail on this information please contact the Health and Wellbeing Programme team via publichealth@surreycc.gov.uk. This information will further drive engagement across partners where we are seeing lower number of programmes focusing on particularly Priority Populations. For example, Looked After Children and Adults with Care Experience in relation to Priority Three only currently has one linked programme in scope. If there are obvious programmes that are omitted that Board members feel would meet the elements related to delivery of the strategy, please contact the Health and Wellbeing Programme team on publichealth@surreycc.gov.uk so that we can bring these into scope and consider how the Board can support.

5.2 Priority One (Supporting people to lead healthy lives)

For Priority One, there are 17 programmes engaged in contributing towards the five outcomes and aligned with the strategy's focus on reducing health inequalities. They are varying in stages of development and delivery from the early engagement on the Food Strategy that was recently shared with the Board to the established Movement for Change strategy that is well into implementation.

Following the initial phase of engagement with SROs to update this summary, logic model guided workshops are continuing to be used by programmes such as within the integrated reablement service and delivery of the End of Life Strategy to understand what broader system partners may be able to offer and how Board partners may be able to contribute.

5.3 Priority Two (Supporting people's mental health and emotional well-being)

For Priority Two, there are 13 programmes demonstrating how they contribute towards delivery of the four Priority Two outcomes, with evidence of measuring their outcomes and impact based on a logic models or similar approaches. Two programmes that are still being explored further includes Mindworks provision for children and young people alongside new pilot projects within the Community Mental Health Transformation

Programme (where these have a connection to prevention). It is evident that there is a gap in programmes relating to outcome three that focuses on preventing isolation. This need has also been highlighted in the recommendations of the recently updated Adults Emotional Health and Wellbeing Joint Strategic Needs Assessment chapter and the separate chapter that is planned for 2023 on loneliness and isolation. This is not to suggest there is not a significant amount of work happening on this, particularly led by VCSE partners, however it highlights the need to understand further which programmes can be better supported through collaborative working and ensuring this is focused on health inequalities as per the focus of the Board and Health and Wellbeing Strategy. Importantly it is expected that the introduction of the Mental Health Investment Fund which is now in its second round will support this outcome particularly given the strong alignment that has been made between that Fund and the Priority Two outcomes, Priority Populations and Principles for Working with Communities.

5.4 Priority Three (Supporting people to reach their potential by addressing the wider determinants of health)

For Priority Three, there are 11 programmes included and whilst this is a lower number than under the other two priorities, they have a greater strategic focus given this is particularly where the wider determinants of health are included. This is also where we see significant links with the work of our local Growth Board and Greener Futures Board. Whilst a full understanding of the opportunities within some of these areas are still being explored it is clear there are exciting further opportunities to consider how a focused approach linked to health inequalities can be used within delivery planning for example within the Community Safety Agreement and the implementation of Environment, Transport and Infrastructure programmes. Reference is also made here to the development of the Lifetime of Learning Strategy 2030 which whilst at its very early stages does already recognise the link to reducing health inequalities as it develops.

5.5 Health in All Policies (HiAP)

Following engagement of the Health and Wellbeing Board over the past 12-18 months the HiAP plan is now incorporated in this summary of strategy implementation for the first time. This includes programmes that cut across health determinants and the three priorities of the Health and Wellbeing Strategy to impact on health inequalities.

The plan was informed by a workshop held with HWB members and subsequent consultation with the HWB and wider partners. It delivers system and civic level interventions by:

- Identifying and responding to issues that are cross-cutting with health and addressed by multiple key players: for example: planning, workplaces, transport, air quality.
- Simultaneously and positively impacting on other important priorities, such as those of the Greener Futures Board.
- Fostering approaches for how resources can be shared, and duplication reduced, retaining a focus on joint outcomes to improve health and wellbeing.
- Promoting health, equity, sustainability and inter-sectoral collaboration for improving population health and wellbeing.

- Making sure interventions make a real difference for those groups within the population who need more support so no-one is left behind.

The plan is focussed predominantly at the civic and system level and overlaying themes span the three priorities of the Health and Wellbeing Strategy to create the best conditions for improving physical and mental health, population well-being, and tackling wider determinants of health. Civic/system level interventions and approaches primarily look to achieve impact at a whole population level.

There have been challenges in the past 12 months with progressing some aspects of air quality work particularly including that the SCC bid (with five other Local Authorities) for a DEFRA air quality grant on 'Clean Air Night' to raise awareness of domestic wood burning was unsuccessful (February 2023); and whilst public health capacity has been an issue previously to progress engagement with relevant partners, as the various health protection issues now begin to settle, we anticipate there will be sufficient capacity back in place for taking forward air quality interventions with partners through 2023-24.

Current progress on delivery on this plan is included within Appendix 3 and will be updated quarterly going forwards through our regular Highlight Reports. The next steps for this HiAP Plan however include:

Healthy Built Environment

- Deliver a workshop for Planners and other stakeholders by Summer 2023 to explore next steps for embedding Health Impact Assessments in development proposals.

Healthy Transport and Streets:

- See Health and Wellbeing Strategy Highlight Report update.

Healthy Workplaces

- Ensure 'Reducing Stigma' programme measures are embedded into Workplace Wellbeing Standards to inform the scaling up of this approach.
- Deliver the 'How are you Surrey?' standards pilot of our approach for large business with the Adult Social Care and Public Health workforce in Summer / Autumn 2023, with the wider approach for a pilot at place in Surrey to follow in 2023.

Making Every Contact Count

- Train 120 - 150 staff in Train the Trainer courses during 2023-2024. (Making Every Contact Count)
- Evaluate Healthy Conversations pilots.

Air Quality

- Continue to work through the Surrey Air Alliance, including with the provision of professional Public Health advice and input on indoor and outdoor air quality.

5.6 Outcomes and Impact Indicators

The impact indicators that have previously been shared with the Board are aligned with the priorities and outcomes of the strategy within the Summary Implementation Plan however this also indicates where there is a link between indicators and particular Priority Populations. This is either through a direct link such as health checks for Adults with Learning Disabilities and/or Autism or through a subset of the data such as prioritisation of smoking cessation for particular Priority Populations. These indicators are therefore being developed as part of the Health and Wellbeing Index discussed at our March meeting at a local and Key Neighbourhood level and will be used going forward alongside local insight to indicate how we are progressing in our ambition to reduce health inequalities experienced by these populations. This will be important in understanding where we may need to have a particular focus and the intent is to highlight progress based on these indicators and additional insight more explicitly through the quarterly Highlight Reports from September 2023.

5.7 Oversight of delivery

For Priority One, and Three, regular oversight and engagement between these programmes is enabled via the established Prevention and Wider Determinants of Health Delivery Board. This provides an opportunity for ensuring delivery via cross cutting work and sharing alongside enabling a focus on our Priority Populations including the Key Neighbourhoods and how they are being supported in practice.

For Priority Two, this is via the Mental Health: Prevention Oversight and Delivery Board (MHPODB) established in September 2022, which has a smaller membership reflecting its close working relationship with the Co-production and Insights Group under mental health system governance that has many VCSE and wider stakeholders. Membership is now however developing in line with its work programme and purpose of taking oversight and driving prevention and early intervention work in relation to mental health. Given its introduction over the past 10 months additional detail on planned actions for 2023/24 are available in Appendix 4. In addition to providing oversight to the programmes delivering against this priority, the actions of the delivery Board are further developing local evidence base of need; public mental health evidence of effective preventative interventions; application of place based mental health approaches and strategies; and supporting delivery of the Mental Health Investment Fund.

In addition to the work done through MHPODB on the implementation plan refresh of projects for Priority Two, the report sets out further planned actions for this Delivery Board, the MHPODB and wider Surrey system that will drive the Delivery Board's forward plan. These are based on local partner priorities for mental health prevention and the insights and analysis resulting from its work to date.

6. Challenges

- Ensuring the Health and Wellbeing Strategy's Principles of Working with Communities are fully embraced as part of our ambition towards increased community led programmes and use of resources.

- Identifying the appropriate forums for consideration of sustainable funding for short to medium term programmes that are more innovative and demonstrating successful outcomes against the Strategy's priorities and outcomes.

7. Timescale and delivery plan

Whilst programmes are at a range of stages in terms of delivery, all are known to be progressing and have some level of resource to progress. The focus of current and future Highlight Reports will be on these listed programmes, and how key milestones are being met, outcomes achieved and any key risks or challenges to delivery included in our forward plan.

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

The Summary Implementation Plan has is the result of wide engagement with programme SROs and also with partners through the Prevention and Wider Determinants of Health Board and Mental Health: Prevention Oversight and Delivery Board.

9. Next steps

- Maximise delivery of programmes through the collaboration of all partners engaged in Board and its related sub-boards.
- Continue to progress logic model planning with SROs when appropriate within programme planning cycles.
- Further enhance the quality and meaningfulness of medium / long term impact indicators as part of assessing progress against the Health and Wellbeing Strategy's outcomes.

Appendix 1: Surrey Health & Well-being Strategy Implementation (see slide deck Appendix 1)

Appendix 2 - Health and Well-Being Strategy Priority populations, Priorities, Outcomes and Impact Indicators

Priority Populations

People across Surrey who experience the poorest health outcomes:

- Carers and young carers
- Looked after children and adults with care experience
- Children with additional needs and disabilities
- Adults with learning disabilities and/or autism
- People with long term health conditions, disabilities or sensory impairment
- Older people 80+ and those in care homes
- Black and Minority Ethnic groups
- Gypsy Roma Traveller community
- Young people out of work
- People experiencing domestic abuse
- People with serious mental illness
- People with drug and alcohol problems
- People experiencing homelessness

People living in geographic areas which experience the poorest health outcomes in Surrey

Please note: the top 5 are the initial priority areas

Lower Super Output Area (ranked on IMD score)	IMD Decile (lower is more deprived)	Electoral Ward/Key Neighbourhoods	District / Borough	Primary Care Network	Health Areas Surrey Heartlands/ (SH) Frimley
1. Reigate / Banstead 008A	2	Hooley, Merstham and Netherne	Reigate and Banstead	Horley	East Surrey (SH)
2. Woking 004F	2	Canalside	Woking	WISE 3	NW Surrey (SH)
3. Guildford 012D	2	Westborough	Guildford	GRIPC	Guildford and Waverley (SH)
4. Guildford 007C	2	Stoke	Guildford	GRIPC	Guildford and Waverley (SH)
5. Spelthorne 001B	3	Stanwell North	Spelthorne	SASSE Network 3	NW Surrey (SH)
6. Mole Valley 011D	3	Holmwoods	Mole Valley	Dorking	Surrey Downs (SH)
7. Reigate / Banstead 005A	3	Tattenham Corner & Preston	Reigate & Banstead	Banstead Healthcare	Surrey Downs (SH)
8. Epsom and Ewell 007A	3	Court	Epsom & Ewell	Epsom	Surrey Downs (SH)
9. Spelthorne 002C	3	Ashford North and Stanwell South	Spelthorne	SASSE Network 3	NW Surrey (SH)

Lower Super Output Area (ranked on IMD score)	IMD Decile (lower is more deprived)	Electoral Ward/Key Neighbourhoods	District / Borough	Primary Care Network	Health Areas Surrey Heartlands/ (SH) Frimley
10. Woking 005B	3	Goldsworth Park	Woking	WISE 3	NW Surrey (SH)
11. Runnymede 002F	3	Englefield Green West	Runnymede	Windsor	Windsor and Maidenhead (Frimley)
12. Elmbridge 004B	3	Walton South	Elmbridge	Walton	NW Surrey (SH)
13. Reigate and Banstead 018D	3	Horley Central & South	Reigate and Banstead	Care Collaborative	East Surrey (SH)
14. Waverley 002E	3	Farnham Upper Hale	Waverley	Farnham	North East Hampshire and Farnham (Frimley)
- Spelthorne 001C	3	Stanwell North (already included above)	Spelthorne	SASSE Network 3	NW Surrey (SH)
15. Waverley 010A	3	Godalming Central and Ockford	Waverley	East Waverley	Guildford & Waverley (SH)
16. Runnymede 006D	3	Chertsey St. Ann's	Runnymede	COCO	NW Surrey (SH)
17. Reigate and Banstead 010E	3	Redhill West & Wray Common	Reigate and Banstead	Care Collaborative	East Surrey (SH)
18. Guildford 010C	3	Ash Wharf	Guildford	Surrey Heath	Surrey Heath (Frimley)
19. Elmbridge 008A	4*	Walton North	Elmbridge	Walton	NW Surrey (SH)
20. Elmbridge 017D	4**	Cobham and Downside	Elmbridge	Leatherhead	Surrey Downs (SH)
21. Surrey Heath 004C	4**	Old Dean	Surrey Heath	Surrey Heath	Surrey Heath (Frimley)

* Overall IMD decile 4 and in decile 1 (highest 10% nationally) for IMD supplementary index on Income Deprivation Affecting Children
** Overall IMD decile 4 and in decile 1 (highest 10% nationally) for IMD domain Education, Skills and Training.

Outcomes

Priority 1 Outcomes

- People have a healthy weight and are active
- Substance misuse is low (drugs/alcohol/smoking)
- The needs of those experiencing multiple disadvantage are met

- Serious conditions and diseases are prevented
- People are supported to live well independently for as long as possible

Priority 2 Outcomes

- 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

Priority 3 Outcomes

- 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 (including through transport/land use planning

System Capabilities

- Empowered and Thriving Communities
- Clear Governance
- Estate Management
- Workforce Recovery and Development
- Programme Management
- Equality, Diversity and Inclusion incl. digital
- Data, Insights and Evidence
- Integrated Care

Impact Indicators: Being incorporated into new Health and Wellbeing Index

Indicator	Priority	Outcomes
Inequality in Life expectancy (Male)	Overarching	NA
Inequality in Life expectancy (Female)	Overarching	NA

Inequality in Healthy Life expectancy (Male)	Overarching	NA
Inequality in Healthy Life expectancy (Female)	Overarching	NA
% of inactive adults	1	P1/O1
% active adults	1	P1/O1
% active Children	1	P1/O1
% children aged 5 with 2 doses of MMR	1	P1/O4
GP QOF hypertension % Prevalence	1	P1/O4
GP QOF Diabetes % Prevalence	1	P1/O4
under 75 mortality from colorectal cancer	1	P1/O4
under 75 mortality from breast cancer	1	P1/O4

6

incidence of homelessness - households owed a duty under the Homelessness Reduction Act	1,3	P1/02 and P3/O1
Rate of Domestic Abuse Incidents	3	P3/O4
Deaths from drug misuse	1	P1/O2
Alcohol related hospital admissions	1	P1/O2
Reduction in smoking in Priority Populations (COPD, Pregnancy, Routine & Manual workers), SMI, BAME	1	P1/O2
emergency admission rates of people with dementia	1	P1/O1
% of deaths in usual place of residence	1	P1/O5
Rate of physical health checks for those with MH issue	1	P1/O4
Adults with MH in appropriate accomodation	2,3	P1/02
Self reported - anxiety	2	P2/O1
Access to IAPT services	2	P2/O1
Proportion of children receiving a 12-month review with their Health Visitor	2	P2/O2
percentage of adult carers who have as much social contact as they would like (18+ yrs)	2	P2/O3
Children 0-15 or 19 in absolute /relative low-income/ couple/lone families (8) Annual	3	P3/O1

Households in Fuel Poverty	3	P3/O1
% Children FSM achieving 5 A* - C GCSE	3	P3/O2
Children FSM achieving good level of development at KS 2 /4	3	P3/O2
Unemployment rate	3	P3/O3
Participation rate training/education 16-18	3	P3/O3
Employment and Support Allowance claimants aged 16-24	3	P3/O3
Job seekers over 12 months	3	P3/O3
Community safety (feeling safe in community)	3	P3/04
Violent crime	3	P3/O4
Active Travel Walking	3	P3/O5
Active Travel Cycling	3	P3/O5
The number of appropriate and detailed referrals due to better identification of neglect and its impact on families.	3	P3/O4
Adults with LD in settled accomodation	3	P3/O1
Effectiveness of reablement services	1	P1/O5

Use of outdoor space for exercise	1	P1/O1
Gap in the employment rate between those with a learning disability and the overall employment rate	3	P3/O3
Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2, 3	P3/O3
Healthy life expectancy	Overarch	NA

Appendix 3 – HiAP Progress update

The Plan is focussed predominantly at the civic and system level and overlaying themes span the three priorities of the HWB Strategy to create the best conditions for improving physical and mental health, population well-being, and tackling wider determinants of health. System level interventions and approaches primarily look to achieve impact at the level of population health.

Updates under the five themes are provided below:

Theme	Overview	Progress
Healthy Built Environment	Healthier built environments promote and improve health and wellbeing & The benefit of healthy built environments are realised and maximised.	The Health and Planning Forum has further embedded health and wellbeing into planning policies and decisions. 'Creating healthier environments strategic guidance' has been revised to support this work. Guest presenters at the Forum have included the national Planning and Health lead from the Office of Health Improvement and Disparities (OHID). OHID agreed in May 2023 to support Surrey to deliver a Health Impact Assessment (HIA) workshop for stakeholders including planners. The aim of this workshop is to support HIAs to be more systematically considered as part of the planning policy and development management process. We have been consulted recently on a HIA model that will be delivered as a part of the proposed redevelopment of the Science Capabilities for Animal Health (SCAH) site at Weybridge. It is intended that learning from this HIA which will be delivered in the next quarter will also inform the development of a Surrey HIA model.
Healthy Transport and Streets	System planning for improving the uptake of health promoting modes, improvement of physical activity, and the delivery of healthy streets.	Health input has informed the Healthy Streets for Surrey Principles & the Design Guide (affecting new streets and the retrofitting of existing streets), with the aim of improving local environments by providing more space for walking and cycling, and better public spaces where people can interact more. This aspect has evolved and been incorporated into a wider approach for how the HWB works with the SCC Environment, Transport, and Infrastructure (ETI) Team. ETI have embedded healthy transport and streets in their wider implementation business plan, which was reviewed by the ETI senior leadership team on 10th May at an Away

		Day event at the Eco Park – this includes healthy streets and other interventions which cut across the three HWB strategy priorities.
Healthy Workplaces	Enabling workplaces and workforces to be healthier, supportive, inclusive, and happier leading to better mental health and wellbeing.	Our programme is focused on achieving a system-level approach to create the right conditions for mental wellbeing at work. Workplace Wellbeing Standards for Large Business are finalised. These presented for final sign off at the Health and Wellbeing Board in May, and a toolkit is being developed. We are embarking on the 'How are you Surrey?' standards pilot of our approach for large business with the Adult Social Care and Public Health workforce which will begin in Summer / Autumn 2023, with the wider approach for a pilot in a priority neighbourhood at Place in Surrey to follow in 2023. The men's health engagement lead is currently engaging small business to develop standards. A robust healthy workplace accreditation system informed by our Charter and learning from the pilots will be in development from Q4 of 2023.
Making Every Contact Count (and Healthy Conversations)	Maximising 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 / growing our Health	Making Every Contact Count (MECC) enables health and care and other officers to engage people in conversations about improving their health by addressing risk factors such as alcohol, diet, physical activity, smoking and mental wellbeing. To broaden our reach of MECC, the Public Health Team has commissioned a Train the Trainer (TtT) programme for staff based within key stakeholder organisation including NHS primary and secondary care, boroughs and districts, and voluntary sector organisations. The TtT programme will upskill a range of staff across the civic system to be competent and confident to deliver MECC Level 1 Training, enabling those trained to cascade the MECC training approach further throughout their respective organisations. This aims to

	Inequalities capabilities when targeted.	train between 120 and 150 staff over a 12-month from 2023-2024. The TtT training has launched across the system for partners and stakeholders to access. https://www.healthysurrey.org.uk/professionals/making-every-contact-count/training Adult Social Care have drawn on and expanded the MECC approach that primarily targets professional stakeholders to deliver innovative pilots for supportive Healthy Conversations with cohorts of residents. This includes trialling the enhancing of healthy conversation skills with learning disability cohorts and in a priority neighbourhood (Merstham). Evaluation of these and other pilots with targeted cohorts will inform our evolving and developing approach.
Air Quality	Reducing the impact of poor air quality	Poor air quality can cause and worsen health effects in all individuals, and particularly in the most vulnerable populations. Work includes reducing the impact of poor air quality by working with the Surrey Air Alliance: Joint Global Action Plan. Gatwick Expansion Proposals: We continue to input into the consultation for the Gatwick expansion proposals. The Health and Major Accidents and Disasters Topic Working Group (TWG) have reviewed the scope/structure and ways of working for preparation of first draft of a Statement of Common Ground, including quantitative analysis of air quality effects, use of WHO guideline and UK statutory air quality thresholds, and technical methods for Equality Impact Assessment (EIA) Air Quality assessments to be agreed through the Air Quality TWG.

Appendix 4 - Key Proposed Actions from the MHPODB Work Plan Progress Report (Priority 2)

The full MHPODB Work Plan Progress Report, which also contains insights and analysis reflecting the work undertaken in its first ten months, is available from the Programme Manager, Jason.Lever@surreycc.gov.uk.

Work area 1: Steer and oversee the HWB Strategy Implementation Plans for Priority Two projects and programmes, in alignment with the MHIP's early intervention and prevention deliverables.

Ensuring clarity for the core list project and programmes (Priority 2) in scope
Production of a refreshed list of projects and programmes for Priority 2 by the PMO with lead officers and SROs (during January – May 2023), including new reporting milestones to the HWB Board against the four outcomes. *(Action lead: Health and Wellbeing Programme team Surrey system)*

Correlate the newly collated data from these projects and programmes within Priority 2 and across all three Priorities on the Priority Populations and Key Neighbourhoods being served, and the high-level / long-term indicators in the new Strategy Index, to yield new insights, identify gaps and ensure a common long-term view across the system of the progress being made towards supporting them. *(Action lead: HWBS team/ MHPODB)*

The MHPODB will continue to promote a more preventative and early help approach across
Surrey's emotional wellbeing and mental health system and work towards a shared, co-
produced vision for emotional wellbeing and mental health, as recommended in the 2021
review and reflected in the MHIP. *(Action lead: MHPODB/MHSDB)*

The list of projects and programmes going to the HWB represent a live snapshot at summer 2023 and will continue to be reviewed and updated over the year to follow, to reflect any new projects or programmes in development meeting the refresh criteria coming on stream, and including those which receive MHIF funding. *(Action lead: HWBS team/ MHPODB)*

Cross-check the list of programmes and projects with other related delivery areas (including through the MHIP and HWB Strategy Priorities One and Three) on an on-going basis, and especially to ensure that emotional wellbeing and mental health provision addresses specific needs and demands coming from the impact of pandemic and current cost of living pressures. *(Action lead: HWBS team/ MHPODB)*

Provide oversight and scrutiny for the Suicide Prevention Partnership, including Suicide Prevention Strategy, Protocol and supporting delivery Plans, and other strategies and new programme outlines requiring input and/ or approval. *(Action lead: MHPODB)*

Work area 2: Identify gaps in provision or under-developed support for Surrey residents as priorities for investment, including through working with communities on an enhanced understanding of Place, HWB Strategy Priority Populations and Key Neighbourhoods.

Steer and support the Mental Health Investment Fund (MHIF)

The successful Mental Health Investment Fund (MHIF) bids will have a contract set up and an agreed process of reporting on outcomes and delivery (likely to be quarterly) and - as agreed at the December 2022 HWB Board - the MHPODB (or a sub-committee of members) will:

- receive performance reports from the successful organisations and provide guidance and challenge for the MHIF team to ensure effective delivery of the programme and appropriate use of funds; and
- provide insight and guidance around interlinking the JSNA and MH Improvement Plan with the MHIF to ensure it is being used to prioritise the most urgent areas of need.

(Action lead: MHPODB/ MHIF team)

Place based mental health approaches and strategies]

The infrastructure for engagement, capacity building and co-production of prevention interventions for priority neighbourhoods has been established in several areas. Plans are in place by the Mental Health team (in PH), with the learning from prototype work, to scale up in other priority areas in 2023/24. *(Action lead: PH team/ Places/ Boroughs/ Districts)*

HWB Board members to acknowledge the value of evidenced, Place-based work on prevention interventions, and endorse further roll out based on learning from the prototype. *(**Action lead: HWB Board**)*

Work area 3: Continue to develop improved and shared approaches to measuring, monitoring and reporting impact of projects and programmes, within and across the HWBS and MHIP.

Maintain and develop the HWB Strategy implementation plan refresh for Priority 2

Exercise oversight over, and support to, lead officers and SROs of the June 2023 list of projects and programmes with their on-going measurement of outcomes and identifying where there is the greatest impact contributing to the 4 outcome areas of Priority 2. *(Action lead: MHPODB)*

Following the higher-level Priority 2 indicators currently being integrated into the Strategy Index and published alongside Surrey-I, promote their usage at Place-based and lower geographical levels where they can inform service development and delivery. *(**Action lead: HWB Board/ MHPODB**)*

Identify any gaps in relation to meeting the Priority 2 outcomes (for example, in outcome 3 around isolation), including whether there are further indicators that would be appropriate for inclusion in the Strategy Index. *(Action lead: MHPODB)*

MHPODB will support the Prevention Spend Mapping initiative to build the whole system picture, in relation to developing spending insights that will inform prevention priorities and planning in the mental health area. *(Action lead: SCC Insights/ MHPODB)*

Work area 4: Collate, assess, share and draw on new regional, national or international research and report findings as appropriate, within the Surrey Data Strategy approach.

Joint Strategic Needs Assessment (JSNA): Emotional and Mental Wellbeing Adults
Tailor, develop and promote Place-based population wellbeing approaches including the determinants of wellbeing. *(Action lead: Surrey system)*

Utilise research and co-production of wellbeing and mental health services with people with lived experience, residents (via community development) and VCSE sector provision. *(Action lead: Surrey system)*

Address current and predicted unmet need with further equality impact assessments in key areas. *(Action lead: Surrey system)*

Engagement of HWB Board Members on their role in supporting delivery of Priority 2 of the HWB Strategy, including communication with Central Government. ***(Action lead: HWB Board)***

Public mental health evidence of effective preventative interventions
Continue to present the case at Surrey boards and other forums on adopting key principles of effective preventative interventions that are evidenced, including at scale. *(Action lead: PH MH team/ MHPODB)*

Continue widely to apply the Population Intervention Triangle and its focus on reducing health inequalities and the role of the wider determinants of health, in driving the prevention of mental ill health within delivery of the HWB Strategy. ***(Action lead: HWB Board/ MHPODB/ Surrey system)***

Ensure that MHPODB work planning, and wider system capabilities, provide the local infrastructure to embed new NHSE guidance on delivering the 'key NHS Long Term Plan ambitions and transforming the NHS' (in particular, '2A. Mental health' and '2C. Embedding measures to improve health and reduce inequalities') *(Action lead: MHPODB/ Surrey system)*

Working with communities to identify gaps in or under-developed support needs
Develop more effective mechanisms with CPIG members and through Empowering and Thriving Communities (ETC) workstreams to implement the 'the four Cs' principles (see Integrated Care Strategy) – including taking pro-active, co-production opportunities with residents having lived mental health experience and consulting with communities. *(Action lead: MHPODB/ CPIG/ ETC partners/ PH MH Team)*

Seek to enable the emotional well-being of, and prevent poor mental health, of Surrey citizens within planned (ETC) work *(Action lead: MHPODB/ ETC partners/ PH MH Team)*

6

MHPODB to adopt at least one culture priority to be incorporated into its prevention work plan, as drawn from the high level findings of the Surrey Mental Health Partnership Cultural Review. *(Action lead: MHPODB)*

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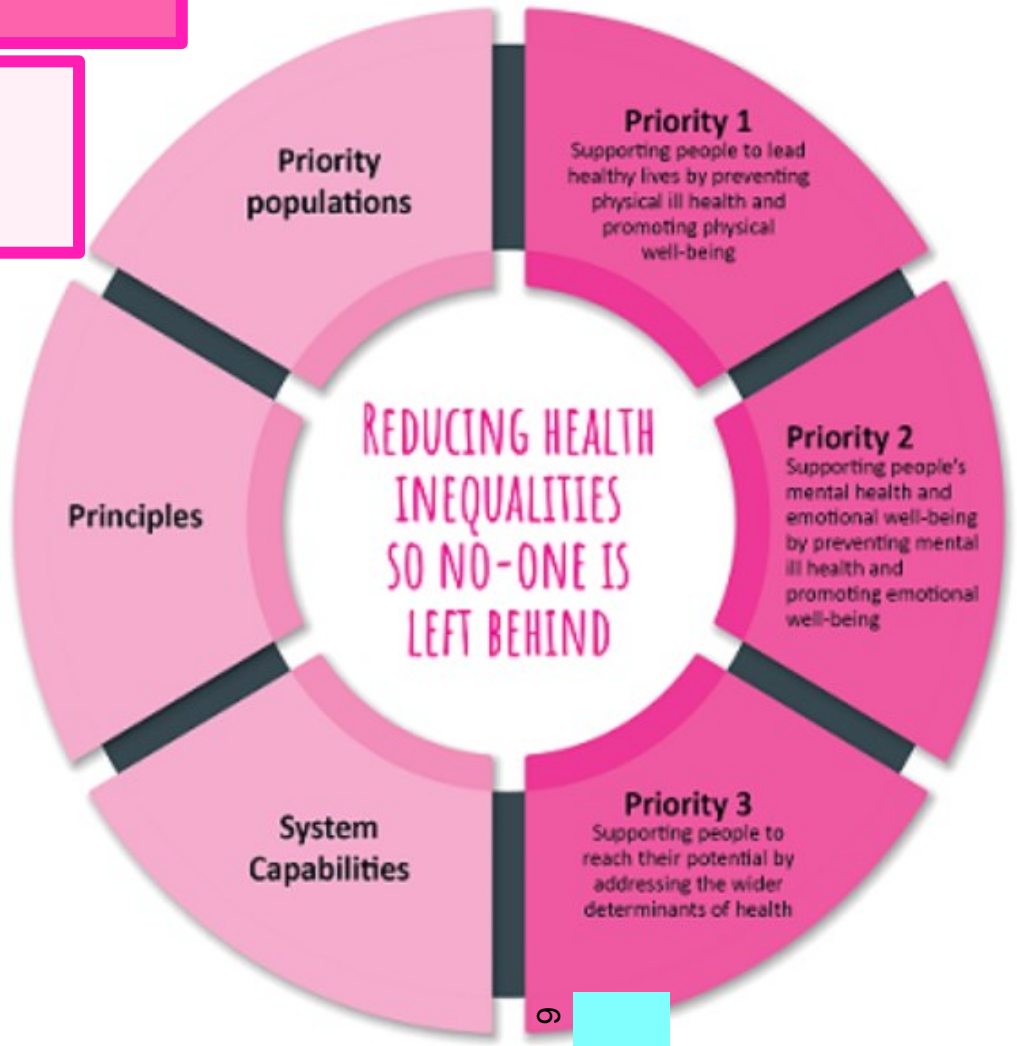
Surrey Health & Well-being Strategy Implementation

Local programmes delivering our focus on the Priority Populations, Priorities & Outcomes

SUMMARY: JUNE 2023



Context

The overarching ambition of the Health and Well-being Strategy is to reduce Health Inequalities through a focus on prevention with the Priority Populations including the Key Neighbourhoods.

Many programmes and projects are happening across Surrey to deliver outcomes for our Priority Populations. Rather than being a complete picture of all that contributes to this across Surrey, the following summary is intended to be a snapshot of programmes delivering for them against Priority One, Two and Three of the Strategy. These are drawn from a summary understanding of implementation resulting from liaison with programme SROs.

Importantly they are programmes* that are contributing to our Health and Well-being Strategy outcomes **and** meeting / working towards the following key elements, agreed by the Board:

- Focusing on reducing a health inequality within (a) Priority Population(s)
  - Addressing a significant need that can only be met through Board members' partnership working
  - Prioritising community-led approaches, alongside civic /system level and service-based interventions
  - Working to measure inputs, outputs, outcomes, impact in a way that is meaningful to communities
  - Being evidence-based
  - Having deadlines for completion, key milestones and an SRO
  - Being appropriately resourced or be looking for commitment to appropriate resourcing

*programmes are at a range of stages from early strategic development / exploration to wide ranging delivery, however milestones are available across the programmes to understand how each is progressing whilst being at different stages and how they are being focused on reducing health inequalities

Overview of Priority One, Priority Two and Priority Three

41 programmes are currently in scope of this Summary Implementation Plan across the 3 Priorities and 14 Priority Populations

Priority One: Supporting People Live Healthy Lives

OUTCOMES BY 2030:

- **People have a healthy weight and are active**
- **Substance misuse (drugs/ alcohol/ smoking) is low**
- **The needs of those experiencing multiple disadvantage are met**
- **Serious diseases are prevented through vaccination and early diagnosis**
- **People with a disability or lifelong limiting illness are supported to live independently for as long as possible**

WHO IS LEADING THIS?

Priority Sponsor:
Karen Brimacombe, Chief Executive, Mole Valley District Council
Programme Manager:
Jason Ralphs, Surrey County Council

Priority Two: Supporting People's Mental Health and emotional well-being

OUTCOMES BY 2030:

- **Adults, children and young people at risk of and with depression, anxiety and mental health issues have access the right early help and resources**
- **The emotional wellbeing 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**

WHO IS LEADING THIS?

Priority Sponsors:
Professor Helen Rostill, Deputy CEO Surrey and Borders NHS FT and SRO Mental Health, Frimley ICS
Kate Barker, System Convenor for Surrey County Council and Surrey Heartlands
Liz Williams, System Convenor for Surrey County Council and Surrey Heartlands
Programme Manager:
Jason Lever, Surrey County Council

Priority Three: Supporting People to reach their potential

OUTCOMES BY 2030:

- **People's basic needs are met**
- **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**
- **The benefits of healthy environments for people are valued and maximised**

WHO IS LEADING THIS?

Priority Sponsor:
Mari Roberts-Wood, Managing Director, Reigate and Banstead Borough Council
Programme Manager:
Olusegun Awolaran, Surrey County Council

PRIORITY POPULATIONS AND RELATED IMPACT INDICATORS ACROSS ALL PRIORITIES

SURREY HEALTH AND WELLBEING STRATEGY

Subset of HWBS impact indicators with link to the Priority Populations

Priority Population	Related Impact Indicators
Carers and young carers	• Percentage of adult carers who have as much social contact as they would like (18+ yrs)
Looked after Children and Adults with Care experience	• Reviewing and awaiting outcome of children's national social care framework and dashboard as part of understanding relevant indicators*
Children with additional needs and disabilities	• Reviewing and awaiting outcome of children's national social care framework and dashboard as part of understanding relevant indicators**
Adults with LD and/or autism	• Rate of LD Health Checks
People with long-term health conditions, disabilities or sensory impairment	• under 75 mortality from colorectal cancer • under 75 mortality from breast cancer • GP QOF hypertension % Prevalence • GP QOF Diabetes % Prevalence
Older people 80+ and those in care homes	• Dementia diagnoses rate • % of deaths in usual place of residence • Effectiveness of short-term reablement services leading to nil or lower level ongoing support (%)
Black and Minority Ethnic groups	• Reduction in smoking in Priority Populations BAME and people with serious mental illness (plus those with COPD, in pregnancy, routine & manual workers) • Completing rate of weight management programme
Gypsy Roma Traveller Community	• Reduction in smoking in Priority Populations BAME and people with serious mental illness (plus those with COPD, in pregnancy, routine & manual workers)

Priority Population	Related Impact Indicators
Young people out of work	• Participation rate training/education/ employment 16-18
People experiencing domestic abuse	• Rate of Domestic Abuse Incidents
People with serious mental illness	• SMI health check • Reduction in smoking in priority populations BAME and people with serious mental illness (plus those with COPD, in pregnancy, routine & manual workers)
People with drug and alcohol problems	• Deaths from drug misuse • Alcohol related hospital admissions • Reduction in smoking in priority populations BAME and people with serious mental illness (plus those with COPD, in pregnancy, routine & manual workers)
People experiencing homelessness	• Homelessness - households owed a duty under the Homelessness Reduction Act
Key neighbourhoods	• Inequality in prevalence of obesity • Reduction in smoking in Priority Populations BAME and people with serious mental illness (plus those with COPD, on pregnancy, routine & manual workers) • Completing rate of weight management programme

*possible relevant indicators include progress and attainment in Key Stage results of children in care, % of care leavers in education, employment or training, % of care leavers in higher education, % of care leavers in apprenticeships, % of care leavers in unsuitable accommodation

**possible relevant indicators include % of referrals which are repeat referrals

Programmes and Priority Populations

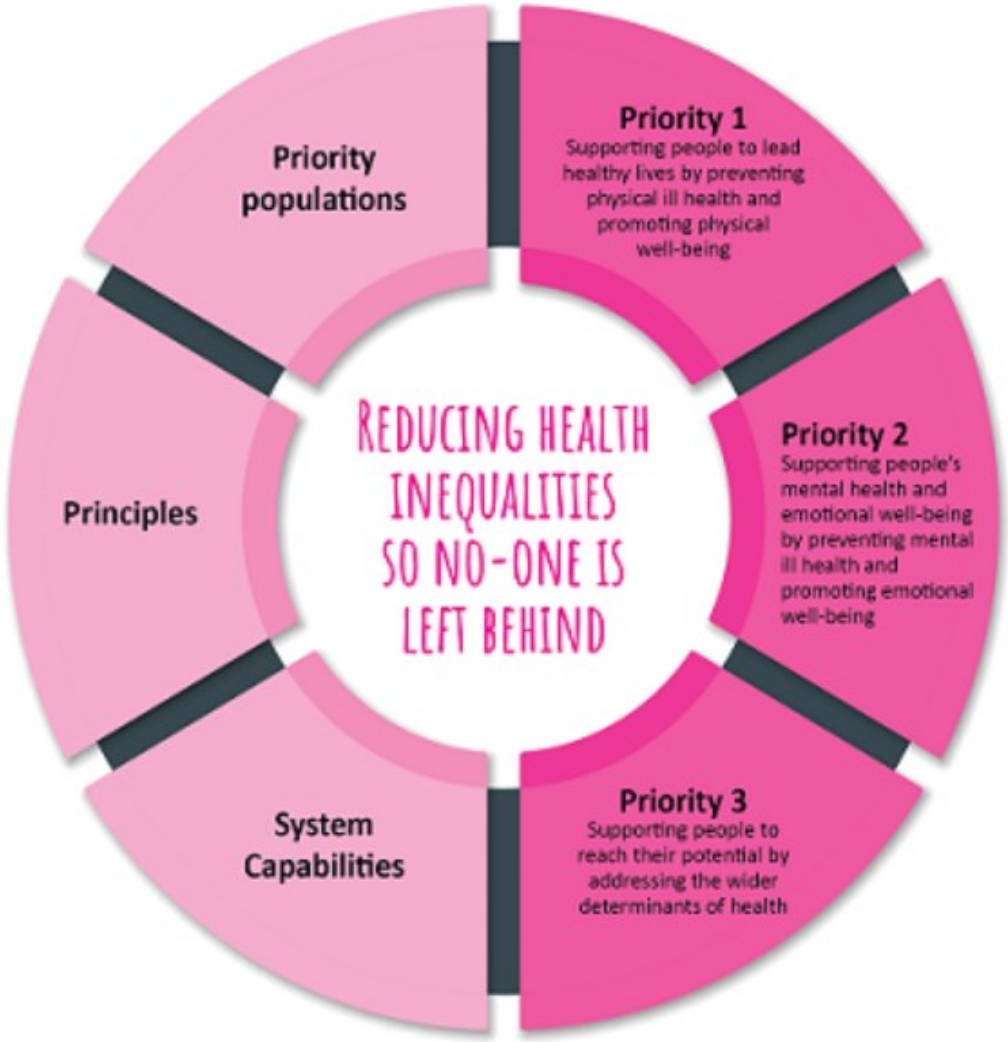
Liaison with programmes has highlighted that many programmes, particularly those operating across Surrey have indicated relevance to a significant proportion of the Priority Populations. The following however summarises where specific resource and action has been highlighted to enable effective access and / or engagement by (a) Priority Population(s)

		No. of programmes with a focus on each Priority Population		
Priority Population	**Total**	**P1**	**P2**	**P3**
Carers and young carers	21	6	13	2
Looked after children /Adults with care experience	12	3	8	1
Children with additional needs and disabilities	12	2	9	1
Adults with LD and/or autism	23	10	10	3
People with long-term health conditions, disabilities or sensory impairment	27	10	14	3
Older people 80+ and those in care homes	15	5	8	2
Black and Minority Ethnic groups	22	7	12	3
Gypsy Roma Traveller Community	18	4	12	2
Young people out of work	15	2	11	2
People experiencing domestic abuse	13	2	8	3
People with serious mental illness	21	8	12	1
People with drug and alcohol problems	17	5	10	2
People experiencing homelessness	12	5	6	1
Key neighbourhood(s)	28	12	11	5

SURREY HEALTH AND WELLBEING STRATEGY

PRIORITY ONE

Supporting People to Live Physically Healthy Lives



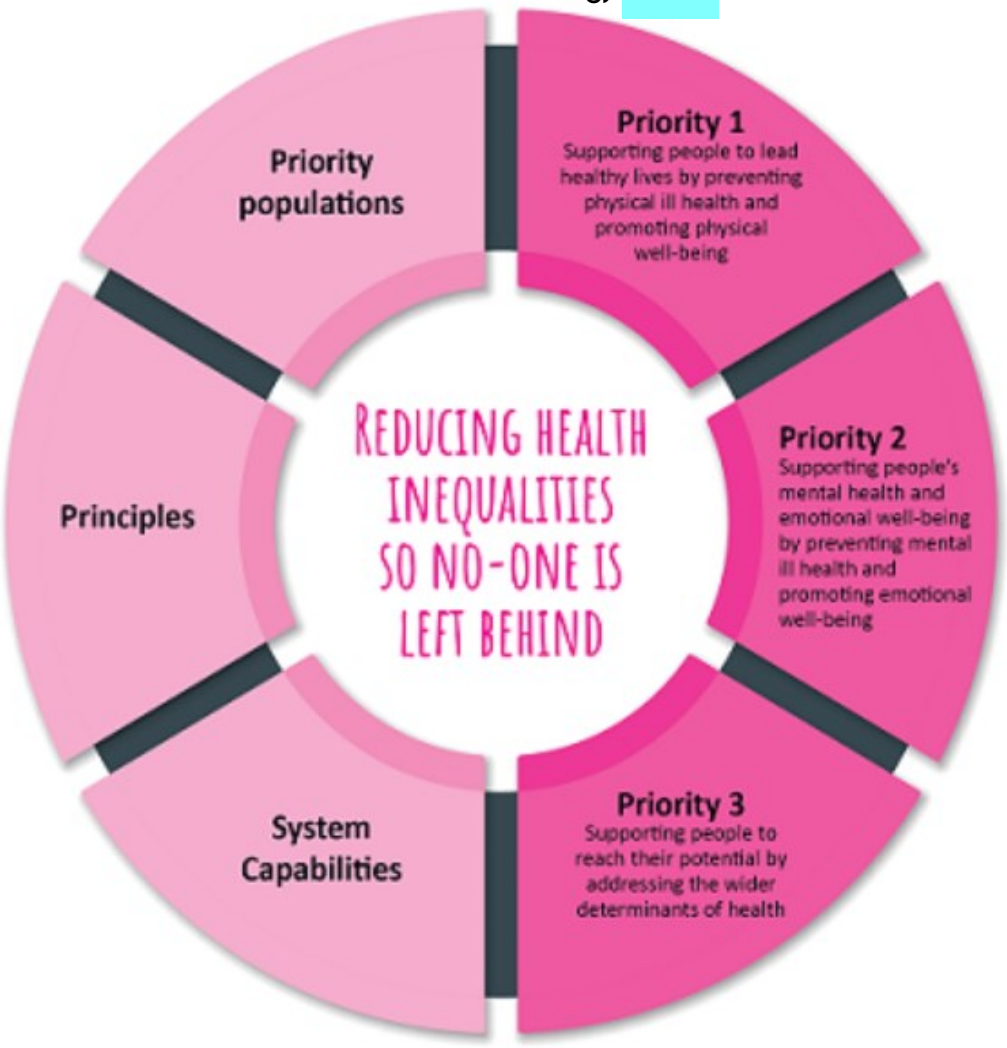
PRIORITY ONE: OUTCOMES, IMPACT INDICATORS AND RELATED PROGRAMMES

Outcome	Impact Indicators	Related Programmes
1. People have a healthy weight and are active	• *Use of outdoor space for exercise* • *Inequality in prevalence of obesity* • *% of inactive adults* • *% active adults* • *% active children* • *Completion rate: weight management programme*	1. Implementation of the Movement for Change physical activity strategy 2. Implementation of a whole systems approach to healthy weight, including targeted intervention programmes for obesity 3. Development and Implementation of the Surrey Food Strategy
2. Substance misuse is low (drugs/alcohol/smoking)	• *Deaths from drug misuse* • *Alcohol related hospital admissions* • *Reduction in smoking in priority populations (COPD, Pregnancy, Routine & Manual workers), SMI, BAME*	4. Development and implementation of the Combatting Drugs Partnership to reduce substance use 5. Development of the SmokeFree Strategy and delivery of effective and targeted smoking cessation services
3. The needs of those experiencing multiple disadvantage are met	• *Homelessness - households owed a duty under the Homelessness Reduction Act*	6. Implementation of the SAMs and Changing Futures programmes *(linkages to P2 and P3)*
4. Serious conditions and diseases are prevented	• *GP QOF hypertension % Prevalence* • *GP QOF Diabetes % Prevalence* • *% children aged 5 with 2 doses of MMR* • *under 75 mortality from colorectal cancer* • *under 75 mortality from breast cancer* • *Rate of LD Health Check* • *Rate of physical health checks for those with MH condition* • *Dementia diagnosis rate*	7. Delivery of the diabetes prevention programme 8. Implementation of CVD prevention programme and delivery of targeted health checks 9. Delivering the joint health and social care Dementia Strategy for Surrey – focusing on public health information and communications (links to P2) 10. Development and Implementation of a cancer screening programme to reduce cancer related inequalities *11. Delivery of Immunisations programme**
5. People are supported to live well independently for as long as possible	• *% of deaths in usual place of residence* • *Effectiveness of short-term reablement services leading to nil or lower level ongoing support (%)* • % of adult carers who have as much social contact as they would like (18+ yrs)	12. Implementation of an integrated reablement service that maximises the independence of Surrey residents *13. Implementation of the End of Life Strategy, including bereavement support** 14. Implementation of Live Longer Better to support the prevention of falls *15. Implement hoarding protocol and development of a panel to enable multi-agency discussion and solutions** 16. Delivery of the social prescribing service 17. Implementation of the Surrey Carers' and Young Carer's Strategies

**programme alignment with HWBS still being explored to understand cross c[illegible]opportunities*

PRIORITY TWO

Supporting People's Mental Health and Emotional Well-Being



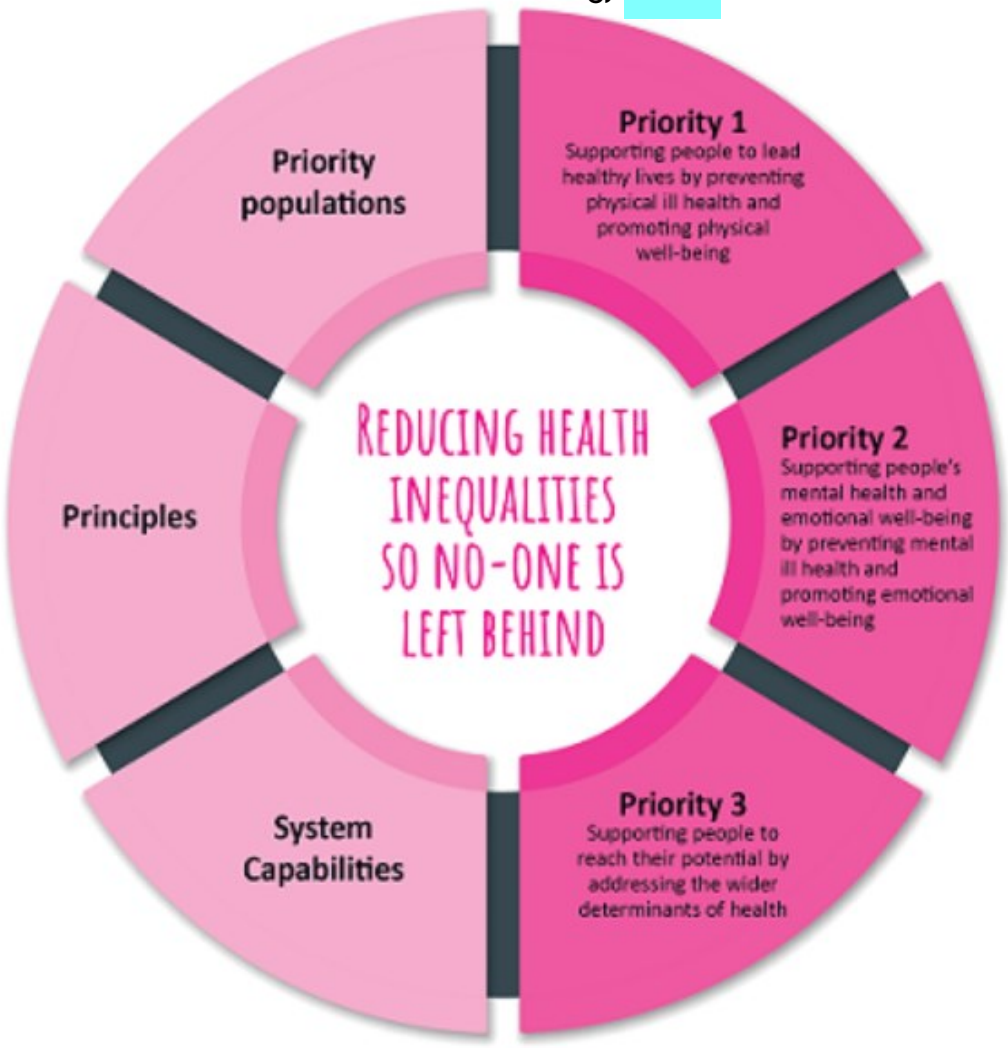
PRIORITY TWO: OUTCOMES, IMPACT INDICATORS AND RELATED PROGRAMMES

Outcome	Impact Indicators	Programmes
1. Adults, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources	• Self-reported wellbeing - people with a low worthwhile score • Self-reported wellbeing - people with a low satisfaction score • Self-reported wellbeing - people with a high anxiety score • Self-reported wellbeing - people with a low happiness score • Access to IAPT services: people entering IAPT as % of those estimated to have anxiety/depression (in a financial year) (%)	1. Improved Access to Preventative Emotional and Mental Wellbeing Support (Wellbeing Front Door Service Phoneline) 2. Development and delivery of Suicide Prevention Strategy and Protocol 3. Development of understanding to address Gambling related harms in Surrey 4. Development of population level communications campaign for primary and secondary prevention, including sleep hygiene 5. Embedding of Prevention and Early Help for mental health in in Long Term Conditions and SMI 6. Development of Mental and Emotional Wellbeing Training through Collaborative for Surrey 7. *Delivery of prevention related aspects of Community Mental Health Transformation Programme, focusing on new/ pilot projects (Primary Care Citizens Advice Mental Health Caseworker Service, Primary Care Enablement Pilot Service & Lived Experience Practitioners Service)**
2. The emotional well-being of parents and caregivers, babies and children is supported	• Proportion of children receiving a 12-month review with their Health Visitor	8. Development of practice to address repeat removals of babies due to safeguarding (Pause project) within delivery of Best Start Strategy 9. Delivery of the Children and Young People's Emotional Wellbeing & Mental Health (EWMH) strategy, 2022-27, with key partners 10. Delivery of *Mindworks (Surrey's Children and Young People's Emotional Wellbeing and Mental Health Service)**
3. Isolation is prevented and those that feel isolated are supported	• % of adult carers who have as much social contact as they would like (18+ yrs)	11. Delivery of Green health & wellbeing programme (formerly green social prescribing) P3 programmes significantly contributing
4. Environments and communities in which people live, work and learn build good mental health	• Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate • Adults with MH in appropriate accommodation	12. Development of community capacity building for emotional and mental wellbeing (addressing wider determinants of health) in Key Neighbourhoods 13. Delivery of Workplace Wellbeing Programme in large (including Health, Social Care and Education) and small businesses in Key Neighbourhoods P3 programmes significantly contributing

**programme alignment with HWBS still being explored to understand/ find[illegible]ss cutting opportunities*

PRIORITY THREE

Supporting People to Reach Their Potential



PRIORITY THREE: OUTCOMES, IMPACT INDICATORS AND RELATED PROGRAMMES

Outcome	Impact Indicators	Programmes
1. People's basic needs are met (food security, poverty, housing strategy etc)	• % Children aged 0- 19 in relative low-income families • Households in Fuel Poverty • Adults with LD in settled accommodation • Adults with MH in appropriate accommodation	1. *Exploration of Whole system approach to poverty*** - Implementation of the Fuel poverty and Achieving Energy Efficiency Action Plan - Development and Implementation of the Food Security element of Food Strategy (see P1) 2. Implementation of programmes to support vulnerable residents as outlined in the Housing Strategy in relation to Multiple Disadvantage
2. Children, young people and adults are empowered in their communities	• % Children FSM achieving 5 A* - C GCSE • Children FSM achieving good level of development at KS 2 /4	3. Implementation of programmes to enable Empowered and Thriving Communities System Capability *4. Development of Lifetime of Learning Strategy 2030**
3. People access training and employment opportunities within a sustainable economy	• Unemployment rate • Gap in the employment rate between those with a learning disability and the overall employment rate • Participation rate education, training and employment – 16-18yrs • Employment and Support Allowance claimants aged 16-24 • Job seekers over 12 months • Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	5. Implementation of the Surrey Skills Plan around support for inclusive access to improved careers education, information and guidance 6. Implementation of Programmes via the No-One Left Behind Skills and Employment Network
4. People are safe and feel safe	• Community safety (feeling safe in community) - from Residents Survey • The percentage of enquiries where the individual or individual's representative were asked what their desired outcomes were • The percentage of enquiries where individuals or individual's representatives were partially or fully met • Domestic abuse-related incidents and crimes • Violent crime - violence offences per 1,000 population	Implementation of the Community Safety Agreement (including) 7. Serious Violence Duty 8. Community Harm Reduction (ASB) Strategy 9. Violence against Women and Girls Strategy 10. Implementation of programmes to address Domestic Abuse
5. The benefits of healthy environments for people are valued and maximised	• Proportion of adults who cycle for travel purposes	11. *Implementation of the aligned SCC Environment, Transport & Infrastructure delivery*, including:* STP Delivery Plan (Active Travel schemes inc. schools, Highways Safety, Low Traffic Neighbourhoods) , Climate Change Delivery Plan (Community volunteering, decarbonisation, green skills, eco schools), Improved access to countryside , Nature Recovery Strategy, Healthy Streets Implementation, Climate Change Adaptation Plan

*programme alignment with HWBS still being explored to unde[redacted] cross cutting opportunities

HEALTH IN ALL POLICIES (HIAP)

Summary of Civic / System Level Interventions cutting across the HWB Strategy Priorities that have developed as part of our local HiAP plan.

Related Programmes	Impact Indicators	Outcome
1. Healthy Built Environments are planned	• Use of outdoor space for exercise • Proportion of adults who cycle for travel purposes	• The benefits of healthy environments for people are valued and maximised (P3) • People have a healthy weight and are active (P1) • Serious conditions and diseases are prevented (P1) • Environments and communities in which people live, work and learn build good mental health (P2)
2. Healthy Transport options are available and utilised	• Use of outdoor space for exercise • Proportion of adults who cycle for travel purposes	• The benefits of healthy environments for people are valued and maximised (P3) • People have a healthy weight and are active (P1) • Serious conditions and diseases are prevented (P1) • Environments and communities in which people live, work and learn build good mental health (P2)
3. Healthy Streets programme is implemented	• Use of outdoor space for exercise • Proportion of adults who cycle for travel purposes	• The benefits of healthy environments for people are valued and maximised (P3) • People have a healthy weight and are active (P1) • Serious conditions and diseases are prevented (P1)
4. Air Quality is Improved	• In development	• Serious conditions and diseases are prevented (P1)
5. Healthy Workplaces Programme is implemented	• Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	• Environments and communities in which people live, work and learn build good mental health (P2)
6. Making Every Contact Count (MECC) training and development is rolled out	• Inequality in prevalence of obesity • Reduction in smoking in Priority Populations BAME and those with serious mental illness (plus those with COPD, in pregnancy, routine & manual workers)	• People have a healthy weight and are active (P1) • Substance misuse is low (drugs/alcohol/smoking) (P1) • Serious conditions and diseases are prevented (P1)

Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Community Safety Assembly and Implementation Plans
HWBS Priority populations:	Community Safety impacts on all Priority Populations including Key Neighbourhoods
HWBS Priority - 1, 2 and/or 3:	Priority 3 Supporting people to reach their potential by addressing the wider determinants of health
HWBS Outcomes/System Capabilities:	Outcome: People are safe and feel safe System Capability: Clear Governance
HWBS Principles for Working with Communities:	• Community capacity building: 'Building trust and relationships' • Co-designing: 'Deciding together' • Co-producing: 'Delivering together' • Community-led action: 'Communities leading, with support when they need it'
Interventions for reducing health inequalities:	Civic / System Level interventions
Author(s):	Sarah Haywood, Partnership and Community Safety Lead (Office of the Police and Crime Commissioner for Surrey); Sarah.Haywood@surrey.police.uk
Board Sponsor(s):	• Lisa Townsend - Police and Crime Commissioner for Surrey • Tim De Meyer - Chief Constable of Surrey Police • Mari Roberts-Wood - Managing Director, Reigate and Banstead Borough Council (Priority 3 Sponsor)
HWB meeting date:	21 June 2023
Related HWB papers:	Item 8 - Police and Crime Plan for Surrey 2021-2025 and Community Safety.pdf (surreycc.gov.uk) HWBS Highlight Report (item 5) HWBS Summary Implementation Plan (Item 6)
Annexes/Appendices:	**Annex A**: Draft Community Safety Assembly Terms of Reference **Annex B**: Implementation Plans **Annex C**: Draft Serious Violence Reduction Partnership Agreement **Annex D**: Draft Domestic Abuse Executive Group Terms of Reference

	Annex E: Community Harm and ASB Reduction Partnership Terms of Reference **Annex F**: Draft VAWG Partnership Terms of Reference

2. Executive summary

This short paper updates the Health and Wellbeing Board members on the developments under the Priority 3 outcome – 'People are safe and feel safe' - and in particular presents the Terms of Reference for the Community Safety Assembly and the proposed implementation plans.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Consider the Community Safety Assembly's Terms of Reference.
2. Consider and support the further development of the implementation plans for community safety under the Priority 3 outcome – 'People are safe and feel safe'.

4. Reason for Recommendations

The Health and Wellbeing Board acts as the upper tier strategic board for community safety as per the Crime and Disorder Act 1998 (as amended by the Police and Justice Act 2006) and as such has a role in considering and endorsing the implementation plans that sit under the Community Safety Agreement.

5. Detail

As the Board will recall 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 lay the foundation for the Community Safety Agreement which followed the merger, and which set the partnership's aspirations.

In March 2022 the Health and Wellbeing Board received a report that proposed through the OPCC a biannual meeting will 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 Assembly would provide the discussion space for community safety leads outside the Health and Wellbeing Board, where time and the agenda has been limited.

The first Assembly was a conference style event to listen to community safety partners and their thoughts around local delivery. The conference was especially successful in allowing partners to openly discuss the changes to the community safety landscape after several years of managing the local response to the pandemic.

The feedback from that event showed that there was an appetite for greater leadership and strategic prioritisation. The feedback lay the foundations of the Assembly's terms of reference that aims to articulate that the Assembly is to support the Surrey Health and Wellbeing Board to improve the health and wellbeing of people living in Surrey with the poorest outcomes and reduce health inequalities, closing the gap between communities that are doing well and those that are doing less well through a community safety lens.

Terms of Reference

Set out as Annex A to this report are the Terms of Reference for the Assembly. They set the background and context of the merger between the Community Safety Board and the Health and Wellbeing Board and reflect the Health and Wellbeing Board's Terms of Reference under 3.2.6 to 'Be accountable for the delivery and annual review of the Surrey Community Safety Agreement (CSA), set out in the statutory duty under Section 17 of the Crime and Disorder Act 1998 (as amended by the Police and Justice Act 2006) in which responsible authorities are required to consider crime and disorder in the delivery of all of their duties.

The objectives as set out in the Terms of Reference are the same proposed in March 2022, which are;

- Enable the development of shared priorities across community safety, criminal justice and health and social care through the Community Safety Agreement
- Meet the statutory duty to cooperate across community safety partners
- Share data and trends to enable a collective response to countywide and local threats
- 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 practice and areas of challenge
- Create a more cohesive approach to community safety

The aim of the Assembly is not to distance itself from the Health and Wellbeing Board or the 10-year strategy. The aim is to ease some of the burden on the agenda of the Board and develop the prioritisation and implementation plans, reflecting the Police and Crime Commissioners Police and Crime Plan, the 11 Community Safety Partnership Plans and the national changes to community safety policy and partnership working so as to present a clear and considered set of objectives for the Health and Wellbeing Board to endorse.

The terms of reference were presented to the Assembly in April 2023 for consideration. A number of amendments have been made to reflect the feedback from the group, including clarifying the relationship between the Health and Wellbeing Board and the Community Safety Assembly. These amendments have yet to be approved by the Assembly.

Implementation Plans

In June 2021 the Community Safety Agreement 2021-2025 was agreed by the Health and Wellbeing Board. The Agreement set out three priorities under the Health and Wellbeing Board's narrative outcome – People are safe and feel safe. These priorities are;

The Community Safety vision for Surrey currently is to ensure that we;

- Protect our most vulnerable
- Protect our communities from harm
- Empower our communities to feel safe

Review of Surrey Community Safety Agreement (including landscape and horizon scanning) is due to be developed, with an annual review thereafter.

Protect our most vulnerable

The agreement states that as a partnership we need to be able to protect those most at risk from abuse and manipulation. The first step is understanding what makes someone vulnerable and identifying those people or groups within our communities. These people and groups are often invisible or do not believe they are a victim.

The agreement focuses on our high harm areas, such as child exploitation and domestic abuse.

The focus for 2023/24 for this area is two areas.

1. Meeting our responsibilities to deliver the Serious Violence Duty

2. Refreshing and delivering the Surrey Domestic Abuse Strategy

Meeting our responsibilities to deliver the Serious Violence Duty

In the Serious Violence Strategy, the Government committed to a Serious Violence Duty and the parameters were set out in the Police Crime Sentencing and Courts Act which came into legislation in 2022. Following a period of consultation, the Duty became live on 31 January 2023.

The Duty aims to ensure that agencies focus their activity on reducing serious violence including identifying the kinds of serious violence that occur in the area, the causes of that violence (so far as it is possible to do so), and to prepare and implement a strategy for preventing, and reducing serious violence in the area. The

Duty names the specified authorities[1], the relevant authorities[2], and the related organisation[3] to collaborate

The Duty provides sufficient flexibility so that the relevant organisations will engage and work together in the most effective local partnership for any given area to produce a strategic needs assessment and a serious violence reduction strategy.

The Office of the Police and Crime Commissioner for Surrey is taking a convening role. This was suggested as they (the OPCC) occupy unique positions due to their responsibility for the totality of policing in their area, services for victims of crime, and shared objectives on prevention and reduction of serious violence.

To support the delivery of the Duty the Home Office has allocated funding from January 2023 to March 2025. This funding has been split into labour costs, costs associated with preparing and developing the needs assessment and strategy and non labour costs, intervention costs. The funding is held by the OPCC.

Highlights to date -

Programme Lead – using the labour funding a Programme Lead has been appointed for two years to support the specified and relevant partners delivery of the Duty in Surrey.

Operational Group – an Operational Group has been established with representation from all specified and relevant authorities to work together with the support of the Programme Lead to meet the requirements of the Duty in a collaborative approach.

Partnership Agreement – draft partnership agreement has been developed detailing the roles and responsibilities of the specified authorities and related organisations (See Annex C).

Crest Report – receipt of the Crest report providing a snapshot of where the partnership is in its response to the Duty. The report comes with additional tailored support for those preparing and working towards delivery of the Duty.

Delivery Plan – a draft delivery plan has been submitted to the Home Office to provide confidence in the approach and that we are collaborating with all the specified and relevant authorities.

Activities within the implementation plans approved by the Serious Violence Operational Group:

MILESTONE 1: Development of a Surrey Serious Violence Duty strategic needs assessment working under the governance of Surrey Office for Data Analytics (SODA).

[1] Specified authorities are: Police, Local Authorities, ICB, Fire and Rescue, Probation and YJS
[2] Relevant authorities are: Education, prisons and youth custody
[3] Related Organisation are: Community Safety Partnerships, VRU and Police and Crime Commissioners

MILESTON 2: Development of a Serious Violence Reduction Duty Strategy for Surrey

MILESTONE 3: Implementation of the delivery plan, ensuring prevention activity is commissioned in line with the needs assessment and Serious Violence Reduction Duty Strategy for Surrey

MILESTONE 4: Annual review of the Serious Violence Duty strategic needs assessment and Strategy completed.

7

Refreshing and delivering the Surrey Domestic Abuse Strategy

The Terms of Reference for the Domestic Abuse Executive Group can be found at Annex D. A Needs Assessment for this Strategy has been completed on behalf of the Executive Group.

The DA2024 domestic abuse recommissioning continues to move forward and remains on track for delivery in April 2024. Work is due to commence on refreshing the Domestic Abuse Strategy 2018 – 2023 with an initial planning workshop arranged for 9 June 2023. The Strategy will be informed by the findings of both the Solutions Research project and recently updated DA needs assessment. Surrey is working well with partners on the delivery of the DA support in safe accommodation strategy. The introduction of the safe accommodation grant application process has seen bids which work to address gaps identified in Surrey and the delivery of the agreed priorities.

Highlights to date -

The Youth Using Violence and Abuse (YUVA) programme has been extended until March 2024 – sustainable funding secured.

Finalised plan for a Surrey Gold Standard Coercive and Controlling Behaviours CB framework which will inform the work of practitioners across the system. The model highlights the importance of language and shifting the focus onto the perpetrator's behaviour.

Hospital Independent Domestic Violence Advocates (HIDVA) funding for 2023/2024 has been secured through the DA Support in Safe Accommodation Grant Process 2022/23 which went live to support Safe in Accommodation Strategy. Work is ongoing to secure long term, sustainable funding for HIDVA programme and fully embed the service into the Health system.

Draft version of the Domestic Abuse Needs Assessment has been shared with contributors for their review and sign off so that we can commence with the governance sign off process.

DA2024 recommissioning – The Programme is on track to be delivered by the 1st of April 2024. We are now moving into the 'Define Phase' and will build on learning we obtained from the "Discovery Phase".

Surrey wide Sanctuary Scheme has been launched doubling resources available under previous arrangements, allowing more survivors to stay in their own homes where safe to do so; and introduction of four new Housing IDVAs across Surrey.

Refuge Accommodation For All is now live providing safe accommodation for anyone not suitable for existing women only spaces i.e., men, Gypsy Roma Traveller, Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) + ; seven dispersed, self-contained properties acquired (aim to secure a further 1); two male victims of domestic abuse have already being supported – a first for Surrey. Refuge for all have received further funding through the safe accommodation grant process to expand to a total of eight units. Two of these units must be used for Surrey survivors only, and one will provide accommodation for an adult and child.

Six safe accommodation grant applications have been approved at the panel meeting and funding agreed. These include Emergency funding for essential items for those who have fled abuse 2022/23, Funding for 1 bed for survivors with no recourse to public funds 2022/23, Domestic Abuse Perpetrator Housing model (4/5 units) 2023/24 and a Surrey DA immigration project which will provide highly specialist casework required to support individuals who experience both domestic violence and complex immigration, nationality and asylum challenges.

Activities within the implementation plans approved by the Domestic Abuse Executive Group:

MILESTONE 1: Perpetrator Programme evaluated and expanded

MILESTONE 2: Coercive control Behaviour framework embedded

MILESTONE 3: Health intervention improved

MILESTONE 4: Safe accommodation ensured for survivors of DA

Protecting our communities from Harm

Our focus here is to as a partnership to listen and react to the communities that make up Surrey. Therefore, this priority is focused on those issues that cause people to feel unsafe.

The focus therefore for this area is two areas.

1. Implementing the Violence against Women and Girls (VAWG) Strategy
2. Developing and implementing the Community Harm Reduction (ASB) Strategy

Implementing the Violence against Women and Girls Strategy

Surrey's first countywide Partnership Violence Against Women and Girls has been launched (Terms of Reference at Annex E) and a Needs Assessment drafted.

Our vision is that every adult and child subjected to violence and abuse, will be seen, safe, heard, and free from harm caused by the perpetrator(s).
Ending violence against women and girls (VAWG) is everybody's business. It requires a change in our society, culture, and institutions to address the root causes. By holistically supporting survivors, focusing the accountability onto the perpetrators, and educating our communities, we will strive towards ending VAWG.

Activities within the implementation plans approved by the VAWG Partnership:

MILESTONE 1: Raised awareness of the VAWG Partnership Strategy including partner's joint commitments and objectives. Communicate Surrey's definition of VAWG, created in partnership with Surrey's survivor steering group, inclusive of girls.

MILESTONE 2: Victim Blaming challenged and changed. Surrey CC anti-victim blaming guidance will be launched early June, workshop dates to follow. This guidance will also include the UN's banning of 'parental alienation'.

MILESTONE 3: Joint VAWG Needs Assessment with OPCC. Initial data collection stage completed.

MILESTONE 4: Appointment of Internal Surrey CC Domestic Abuse, VAWG and culture change advocates. Review of policies, procedures to be VAWG appropriate completed..

Developing and implementing the Community Harm Reduction (ASB) Strategy

The Terms of Reference for the Community Harm and ASB Reduction Partnership can be found at Annex F.

Surrey's current Anti-Social Behaviour and Community Harm Strategy runs until the end of 2023. The strategy is Surrey's third and sets out how agencies across Surrey will work together to reduce the harmful effects of ASB, Serious and Organised Crime and community safety issues. Surrey has an excellent history of partnership working (HMICFRS) at both a local district/borough and county level, and ensuring that together we continue to drive down incidents of harm and develop our ways of working with residents to sustain levels of confidence and satisfaction.

The current vision is -

'We aim to continue to improve the understanding of, and our response to, incidents of anti-social behaviour/crime that cause harm in our communities. We intend to reduce instances of anti social behaviour and the numbers of people who are involved in anti social behaviour as victims and offenders. Where anti social behaviour does occur, we are committed to putting the victim first, particularly if they are vulnerable or a repeat victim. We are also committed to "getting it right at the first time of asking" and not pass the victim between agencies.'

The vision is under pinned by the four objectives.

- Improve support for victims of ASB/SOC through district and borough based Community Safety Partnerships
- Improve effective information sharing including shared IT that provides a secure joined up approach to victims at risk and case management of offenders
- Continue to improve the understanding of Anti-Social Behaviour in our local communities by the public and professionals and inform them what responses are available to tackle it
- Develop a clear communications strategy

Partners have work towards reducing ASB and community harm, framing their work within these objectives and there have been positive outcomes, but the strategy is now coming to its natural end and requires a refresh.

In March 2023 the Government announced the ASB Action Plan which set out its aspirations for tackling ASB and making communities safer. Listing the areas the Government wishes to see change;

- Make sure anti-social behaviour is treated with the urgency it deserves, increasing the use of hotspot policing and enforcement, rolling out a new Immediate Justice service so anti-social behaviour perpetrators swiftly clean up their own mess, and giving communities more of a say over, and more visibility of, reparation.

- Change laws and systems to take a zero-tolerance approach to anti-social behaviour, cracking down on the illegal drugs that blight communities and organised and harmful begging.

- Give the police and other agencies the tools they need to discourage anti-social behaviour, including higher on-the-spot fines, investment in positive activities for young people, filling empty shops and regenerating local parks.

Using this Action Plan and the Community Safety Partnership review, the focus of the Community Harm Reduction Partnership is to develop a new strategy with victims at the centre of the response in Surrey.

Activities within the implementation plans approved by the Community Harm Reduction Partnership:

- MILESTONE 1: Review of the Community Harm Reduction Strategy with a focus on meeting the aspirations in the Government's new ASB Action Plan

- MILESTONE 2: Delivery of the training programme to increase awareness and the relationship between ASB and other harmful behaviours

- MILESTONE 3: The voice of ASB Victim is captured and used to improve our partnership response (NB a Needs Assessment will be started after Victim Focus Groups in Summer 2023).

- MILESTONE 4: Development of a communications campaign and promote ASB Awareness week - 3rd - 9th July

- MILESTONE 5: Development of a Surrey data and insight portal to ensure accurate collection and interpretation of ASB information

The Implementation plans are attached as Annex B to this report.

Empower our communities to feel safe – examples

It is the aspiration through the Community safety Agreement that every individual who resides, works in or visits Surrey must have confidence in local criminal justice services and all partnership agencies. Through the programmes above the partners will continually work to prevent and reduce offending and it is crucial that we build on and effectively communicate our work to continue to improve public confidence and community cohesion.

An example of this is the Anti Social Behaviour Victims work which will gather views via an open survey and through face to face focus groups to gather first hand feedback on our response to victims of ASB.

The Serious Violence work will build a picture of placed based violence and how to build local initiatives built around the assets and experience of the local communities.

Finally, the Violence Against Women and Girls is embarking on a communication campaign to help create an anti-VAWG culture in Surrey, by focusing on addressing gender stereotypes, which can have a negative and long-term impact on children. The campaign will be strengths-based, focusing on parents/carers strengths, and highlighting positive examples.

6. Challenges

Each of the programmes has a risk register associated with the work or one will be developed as the programme progresses.

7. Timescale and delivery plan

Timescales for delivery are detailed in the attached implementation plans.

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

For each programme, the leads have engaged with their respective partnership/executive groups when developing and delivering their respective strategies and implementation plans. The Community Safety Assembly was also briefed on the development of the implementation plans in April 2023.

9. Next steps

- To return to future Health and Wellbeing Board with the quarterly /annual updates as required as part of the HWB Strategy programme management/governance (see Summary Implementation Plan agenda item).

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Surrey Community Safety Assembly

2021 to 2025

Terms of Reference

Background

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 lay 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. How as a partnership we would become better at identifying and supporting vulnerable people, making every contact count. And finally, 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 preventatives services.

Purpose

The Surrey Community Safety Assembly supports the ambitions to bring Community Safety and Health and Social Care together by providing a forum for community safety colleagues in which to provide strategic leadership and direction by co-designing the strategic objectives for Surrey which will underpin the Health and Wellbeing Board's Priority Three – Supporting people to reach their potential by addressing the wider determinants of health

The Assembly will be responsible overseeing the development on behalf of the Health and Wellbeing Board of the Surrey Community Safety Agreement that takes into account a joint needs assessment, the Police and Crime plan, the Health and Wellbeing Board's 10 year Strategy and the 11 individual plans for the Community Safety Partnerships in Surrey.

The remit of the Board also support the Health and Wellbeing Board meet its statutory duty, under the Crime and Disorder Act 1998, for a county strategy group to deliver a county Community Safety Agreement and co-ordinate county-wide activity on common themes.

Aims

To provide a forum for community safety partners to work together to use our shared capabilities and resources to enhance the response community concerns for safety and ensure we identify and support those more at risk of harm.

Objectives

The objectives of the Assembly are to –

- Enable the development of shared priorities across community safety, criminal justice and health and social care through the Community Safety Agreement
- Meet the statutory duty to cooperate across community safety partners
- Share data and trends to enable a collective response to countywide and local threats
- Create opportunities to explore co-commissioning and project delivery
- Provide a forum to respond to the Health and Wellbeing Board's forward plan and implementation plans
- Create a space for community safety partners to share best practise and areas of challenge
- Create a more cohesive approach to community safety

Membership

The following procedure will apply to membership and attendance at the Assembly:

- Taking a convening role, the Police and Crime Commissioner will be Chair of the Community Safety Assembly
- Members of the Assembly should be of sufficient seniority within their organisation/sector to make decisions and commit resources where required
- Wherever possible, there should be a continuity of representation. In exceptional circumstances organisations may send a substitute
- The minimum membership should reflect the Statutory Authorities as specified under the Crime and Disorder Act 1998 (as amended)
    - Office of the Police and Crime Commissioner
    - Surrey Police
    - Surrey Fire and Rescue
    - District and Boroughs
    - Surrey County Council
    - Integrated Care Partnerships
    - NHS Surrey
    - Surrey and Boarders Trust
    - Probation
- In addition, the membership will include
    - Housing providers
    - Community Safety Partnership representatives
    - Voluntary sector representative(s)
    - User voice representatives where required

Subject leads as well as data specialists will also be invited to provide updates on key lines of work.

Relationship with other Strategic Boards

The Assembly will make ensure there is representation from the Community Safety Partnership to ensure there is an information flow between the Health and Wellbeing Board, the Assembly and the Community Safety Partnerships.

When required the Chair will ensure there is representation from Surrey's strategic partnerships, such as the Adult's Safeguarding Board, the Criminal Justice Board or the Local Resilience Forum for the purpose of supporting the Assembly deliver against the Community Safety Agreement and the implementation plans on behalf of the Health and Wellbeing Board.

Structure of the meeting

Frequency

- the Assembly shall meet twice a year
- an annual schedule of meetings will be agreed.
- additional meetings may be convened with the agreement of the Chair.
- the Assembly may also hold additional development sessions and workshops as necessary to further develop its role and partnership arrangements

Voting

- wherever possible, decisions will be reached by consensus.
- in exceptional circumstances, and where decisions cannot be reached by a consensus of opinion, voting will take place and decisions agreed by a simple majority.
- where there are equal votes the Chair of the meeting will have the casting vote.

Quorum

- a quorum of five will apply

Declaration of Interests

- any personal or prejudicial interests held by members should be declared on any item of business at a meeting

Papers

- agenda items will be requested a month / 20 working days in advance of the meeting.
- the Chair will approve the agenda and commission reports three weeks in advance.
- meeting papers will be circulated 10 days in advance of the meeting to a widened distribution list to enable engagement with CSPs and local feedback.
- an action note will be distributed within five days of the meeting taking place

Roles and Responsibilities

The individual partner organisation roles and responsibilities in relation to the Assembly are to:

- reflect the views of the organisation or area that they represent in meetings, being sufficiently briefed and able to make decisions about future policy developments / service delivery.

- ensure that there are communication mechanisms in place within the organisation or area that they represent to enable information about the priorities and decisions of the Assembly to be disseminated.
- feed in information about issues, needs and priorities in the development of the need assessment.
- consult about the work of the assembly, where appropriate.
- act on what the Assembly has agreed.
- influence any consequent changes to policy development/service delivery in their own organisation and sector.

Priority 3: Supporting people to reach their potential by addressing the wider determinants of health

Narrative Outcome: People are safe and feel safe (community safety incl. domestic abuse; safeguarding)

Project Title: Domestic Abuse

SRO: Sonia Knight

Milestones	Activities	Accountability	Start date	End date	RAG Q3 2022/23	Milestone RAG	Comments Q3 2022/23	Risks/issues Q3 2022/23	RAG Q1 2023/24	Comments Q1 2023/24	Risks/issues Q1 2023/24	RAG Q2 2023/24	Comments Q2 2023/24	Risks/Issues Q2 2023/24
MILESTONE 1: Perpetrator Programme evaluated and expanded	YUVA - To expand the existing provision capacity to continue to support children and families. Completed Succesful bid to the HO for funding	Sonia Knight / Joe Jenkinson	01/10/22	31/03/23	On Track		Exploring multiple funding options. Evidence to date shows strong delivery	Level of demand exceeds initial expectations. This is being managed through attempts to increase capacity.	Completed	Completed Succesful bid to the HO for funding				
	YUVA programme to be evaluated and form part of the wider Domestic Abuse recommissioning 2024.	Sonia Knight / Joe Jenkinson	01/01/22	31/03/24	On Track		Ongoing collection of outcome data and performance monitoring		On Track					
	Engagement and co-production with specialist providers and survivors including from seldom heard communities Completed	Sonia Knight / Joe Jenkinson	01/12/2022	31/03/2023	On Track		Workshops have taken place with strategic partners, specialist service providers, and communities.		Completed					
MILESTONE 2: Coercive control Behaviour framework embeded	Rollout and embed the Controlling Cohersive Behaviour framework across Surrey.	Sonia Knight / Joe Jenkinson	01/10/22	31/12/23	On Track		Strategic sign off for framework. It is acknowledged that embedding will be an ongoing process beyond the end date, and require review as new staff start.		On Track	The OPCC is now leading in this area of Work				
MILESTONE 3: Health intervention improved	Evaluation of HIDVA programme to be completed to evidence impact and effectiveness of service	Sonia Knight / Joe Jenkinson	01/06/21	31/03/23	On Track		Evaluation ongoing.		On Track					
	HIDVA service - secure long term, sustainable funding from Health and fully embed into the Health system	Sonia Knight / Joe Jenkinson	01/06/21	31/03/23	On Track		Funding opportunities being explored	Long term funding not secured and service is recommissioned	Delays Possible					
	Domestic Abuse Needs assessment to be completed Draft	Sonia Knight / Joe Jenkinson	02/12/2022	01/04/2023	On Track		Work has commenced to develop performance and demographic data, and engagement findings will be fed into this.		Completed					
	Develop refreshed DA Strategy 2024	Sonia Knight / Joe Jenkinson	01/01/2023	31/12/2023	On Track		Work has commenced to develop a needs assessment and research programme which will feed into the development of the DA Strategy.		On Track					
	DA2024 Recommission of all Domestic Abuse Services	Sonia Knight / Joe Jenkinson	01/10/2022	31/03/2024	On Track		Timeline has been agreed, all other activities listed here will feed into the completion of this work.		On Track					
MILESTONE 4: Safe accommodation ensured for survivors of DA	Provision of specialist domestic abuse workers within refuges across Surrey	Sonia Knight / Joe Jenkinson	01/09/21	30/09/22	Completed		These posts are ongoing and will be included in the recommission of all DA services 2024.		Completed					
	Develop and implement grant process to support the delivery of the safe accommodation strategy	Sonia Knight / Joe Jenkinson	01/10/22	01/01/23	On Track		We will review the impact of the grant process and this may be extended for an additional financial year.		Completed					
	Delivery of 'Refuge for All' (inclusive safe accommodation provision) to support survivors of DA for whom existing refuge provision is not appropriate	Sonia Knight / Joe Jenkinson	01/02/22	31/03/24	On Track		6 x properties identified - 2 ready imminently for client accupancy.		On Track					

Highlights

Q1 2023/24	7 properties have been secured, further property currently being sourced to compose of 8 dispersed units, under the Refuge for All Scheme •YUVA service has started accepting new referrals and funding has been secured through TSU for 2023-2024. •HIDVA funding has been secured for 1 year through the safe accommodation grant process. •A perpetrator housing proposal has been accepted through the safe accommodation bid process and will be looking to mobilise in August 2023. •A Surrey DA immigration project has been accepted through the safe accommodation bid process. This project will provide highly specialist casework required to support individuals who experience both domestic violence and complex immigration, nationality and asylum challenges. •Refuge for all – a further property has now been secured, making the total of 7 units now available.
Q2 2023/24	
Q3 2023/24	
Q4 2023/24	

Top Risks

Q1 2023/24	Lack of clarity around the delivery of the safe accommodation strategy from 2025 as well as the HIDVA service
Q2 2023/24	
Q3 2023/24	
Q4 2023/24	

Milestone change requests			
No.	Change requested	Reason	Related risks/issues

Priority 3: Supporting people to reach their potential by addressing the wider determinants of health

Narrative Outcome: People are safe and feel safe (community safety incl. domestic abuse; safeguarding)

Project Title: Serious Violence

SRO: Sarah Haywood

Milestones	Activities	Accountability	Start date	End date	RAG Q3 2022/23	Milestone RAG	Comments Q1 2023/24	Risks/issues Q1 2023/24	RAG Q1 2023/24	Comments Q2 2023/24	Risks/issues Q2 2023/24	RAG Q2 2023/24	Comments Q2 2023/24	Risks/Issues Q2 2023/24
MILESTONE 1: Develop a Surrey Serious Violence Duty strategic needs assessment working under the governance of SODA	Create the govenerance structure under the Surrey Office of Data Analytics	Sarah Haywood / Uma Datta	31/01/23	31/01/24	Completed		A delivery group has been established for the completeion of the needs assessment		Completed					
	Develop a Project Implmentation Plan	Sarah Haywood / Uma Datta	31/01/23	31/01/24	On Track		Development of the PID has been achieved through the SV Needs Assessment task and finish group	Limited partnership capscity to deliver the needs assessment	On Track					
	Complete the Surrey Serious Violence Needs Assessment	Sarah Haywood / Uma Datta	31/04/2023	31/01/24	On Track									
MILESTONE 2: Develop a Serious Violence Reduction Duty Strategy for Surrey	Early scoping and research in development	Sarah Haywood	01/06/23	31/01/24	On Track	On Track	Researching the national pitcure and learning best practise	Delay in needs assessment might effect the delivery of the strategy	On Track					
MILESTONE 3: Implement the delivery plan, ensuring prevention activity is commissioned inline with the needs assessment and Serious Violence Reduction Duty Strategy for Surrey	Home Office returns for 2022/23	Sarah Haywood	01/06/21	31/04/2023	Completed				On Track					
	Complete the agreed delivery plan for Surrey - return to the Home Office		01/04/23	14/09/23	On Track				Delays Possible					

Highlights

Q1 2023/24	Programme Lead – using the labour funding a Programme Lead has been appointed for two years to support the specified and relevant partners delivery of the Duty in Surrey. Operational Group – an Operational Group has been established with representation from all specified and relevant authorities to work together with the support of the Programme Lead to meet the requirements of the Duty in a collaborative approach. Partnership Agreement – draft partnership agreement has been developed detailing the roles and responsibilities of the specified authorities and related organisations. Crest Report – receipt of the Crest report providing a snapshot of where the partnership is in its response to the Duty. The report comes with additional tailored support for those preparing and working towards delivery of the Duty. Delivery Plan – a draft delivery plan has been submitted to the Home Office to provide confidence in the approach and that we are collaborating with all the specified and relevant authorities.													
Q2 2023/24														
Q3 2023/24														
Q4 2023/24														

Top Risks

Q1 2023/24														
Q2 2023/24														
Q3 2023/24														
Q4 2023/24														

Milestone change requests														
No.	Change requested	Reason	Related risks/issues											

Priority 3: Supporting people to reach their potential by addressing the wider determinants of health

Narrative Outcome: People are safe and feel safe (community safety incl. domestic abuse; safeguarding)

Project Title: Violence Against Women and Girls

SRO:

Milestones	Activities	Accountability	Start date	End date	RAG Q3 2022/23	Milestone RAG	Comments Q1 2023/24	Risks/issues Q1 2023/24	RAG Q1 2023/24	Comments Q2 2023/24	Risks/issues Q2 2023/24	RAG Q2 2023/24	Comments Q2 2023/24	Risks/Issues Q2 2023/24
MILESTONE 1: Communicate VAWG Partnership Strategy across the county	Surrey core cross agency definiton of VAWG (now inclusive of girls) created in partnership with survivor steering group. Strategy and definition communicated to partners - ongoing.	Alice Riches	31/01/23	31/01/24	On Track	On Track			Completed					
MILESTONE 2: Victim Blaming will be challenged and changed	Internal SCC anti-victim blaming guidance and accompanying workshops written and created in partnership with specialist service provision. Circulated to survivor steering groups for comment and feedback. Launch to be wk beginning 5th June. Workshop planning dates - ongoing.	Alice Riches	01/06/23	31/01/24	On Track	On Track			On Track					
MILESTONE 3: Joint VAWG Needs Assessment	Initial data collection of VAWG from key agencies in Surrey - further meeting 21/06/23	Alice Riches SCC/Louise Andrews & Lucy Thomas OPCC	01/06/21	31/03/23	On Track				On Track					
	Mapping of exsisting VAWG serivce provisions/ work/ activity - ongoing	Alice Riches				On Track			Delays Possible					
MILESTONE 4: Internal SCC DA, VAWG and culture change advocates	Initial planning meetings with specialist DA service provision undertaken. Internal exploration with EDI teams - ongoing.	Alice Riches				On Track			Completed					

Highlights

Q1 2023/24														
Q2 2023/24														
Q3 2023/24														
Q4 2023/24														

Top Risks

Q1 2023/24														
Q2 2023/24														
Q3 2023/24														
Q4 2023/24														

Milestone change requests														
No.	Change requested	Reason	Related risks/issues											

Priority 3: Supporting people to reach their potential by addressing the wider determinants of health

Narrative Outcome: People are safe and feel safe (community safety incl. domestic abuse; safeguarding)

Project Title: Anti-Social Behaviour

SRO: Jo Grimshaw

Milestones	Activities	Accountability	Start date	End date	RAG Q3 2022/23	Milestone RAG	Comments Q1 2022/23	Risks/issues Q1 2022/23	RAG Q1 2023/24	Comments Q2 2023/24	Risks/issues Q1 2023/24	RAG Q2 2023/24	Comments Q2 2023/24	Risks/Issues Q2 2023/24
MILESTONE 1: Review the Community Harm Reduction Strategy with a focus on meeting the aspirations in the Government's new ASB Action Plan	Establish a partnership delivery plan and governance structure	Jo Grimshaw	01/04/23	01/06/23	On Track		Current goverance structure in place. Will need to be refreshed inlight of government recommenations		On Track					
	Complete a quick needs assessment on ASB in Surrey, considering data and the use of tools and powers	Jo Grimshaw	01/01/23	01/06/23	On Track			Limited partnershi capasity in system to suppor the completion of a needs assessment. Link to Serious Violence work	On Track					
	Finalise the new Stratgey and share with relevant partners	Jo Grimshaw	01/03/2023	01/09/2023	On Track	On Track			On Track					
MILESTONE 2: Deliver the training programme to increase awareness and the relationship between ASB and other harmful behaviours.	Deliver the Surrey Community Harm Training package across the pratitioners form and beyond. Sessions include training on neurodiversity, ASB and DA, the use of tools and powers and running good ASB Case Reviews	Jo Grimshaw / Louise Gibbins	01/02/23	01/04/24	On Track		Training package agreed and communications plan in development		On Track					
MILESTONE 3: Ensure the voice of ASB Victim is captured and used to improve our partnership response.	Complete a survey of Surrey communtiies on their experiences of ASB in the last 12 moonths	Sarah Haywood	01/01/23	31/03/23	Completed		Survey complete and interim report avaliable		On Track					
	ASB Help to run four focus groups to develop insight and support the development of the victim's code for Surrey	Sarah Haywood	31/03/23	31/06/23	On Track		Focus Groups developed	low nunmbers of people planning nto attend. Mitigation is to continue to promote and have online session	On Track					
	Develop the ASB Victim's Code for Surrey	Sarah Haywood	31/06/23	01/09/2023	On Track				On Track					
	Launch Code and adopt across the patnership	Sarah Haywood	01/09/2023	01/10/2023	On Track				On Track					
MILESTONE 4: Develop a communications campaign and promote ASB Awareness week - 3rd - 9th July	Develop and launch the ASB Awareness Communication Plan, focus on know your rights	Jo Grimshaw	01/03/23	09/07/23	On Track		On track and communications plan has been shared	Lack of enagement and promotion of AS	On Track					
MILESTONE 5: Develop a Surrey data and insight portal to ensure accurate collection and interpretation of ASB information	Work with partners to develop a data repository to collect meaningful and timely data to enable the delivery of victim and enforcement activtity		01/04/23	01/04/24	On Track	On Track		Capasity in system to support the devel	On Track					

Highlights

Q1 2023/24														
Q2 2023/24														
Q3 2023/24														
Q4 2023/24														

Top Risks

Q1 2023/24														
Q2 2023/24														
Q3 2023/24														
Q4 2023/24														

Milestone change requests			
No.	Change requested	Reason	Related risks/issues

Serious Violence Reduction

Surrey Partnership Agreement

Purpose of the Partnership Agreement

The aim of this Surrey Partnership Agreement to is to show a fully integrated approach to how we, the named partners below, work together to meet the requirements of the Duty and the conditions of the Serious Violence Duty funding agreement.

The Surrey Partnership Agreement sets out the roles and responsibilities of the specified authorities in relation to the Serious Violence Duty and the decision-making structure for the partnership to provide reassurance that all specified authorities and the relevant authorities are making decisions and working together in a multi-agency nature to provide a needs assessment and a Serious Violence Reduction Strategy within the scope and requirements of the allocated funding by January 2024.

Who we are

Undertaking a conveying role - Office of the Police and Crime Commissioner for Surrey

Specified Authorities –

Surrey Police	Epsom and Ewell Borough Council
Surrey County Council also acting as the education authority and the Youth Justice Service	Guildford Borough Council
Surrey Public Health	Mole Valley District Council
Surrey Fire and Rescue	Reigate and Banstead Borough Council
Surrey Heartlands ICB	Runnymede Borough Council
Frimley ICB	Spelthorne Borough Council
Elmbridge Borough Council	Surrey Health Borough Council
Tandridge District Council	Waverley Borough Council
Woking Borough Council	Surrey Probation Service

How we will work together

We are jointly committed to delivering Serious Violence Duty and the future objectives of the Surrey Reducing Serious Violence Strategy. Each partner organisation has separate respective statutory responsibilities and independence, but to achieve the best possible outcome we must work together.

The governance structure below is an attempt to recognise all the constitute partnerships that have a responsibility to the delivery of the Serious Violence Duty and to show their interoperability.

As detailed below under the roles and responsibilities the Office of the Police and Crime Commissioner for Surrey will act as the conveyer for the deliver of the Duty and meeting the requirements of the serious violence funding.

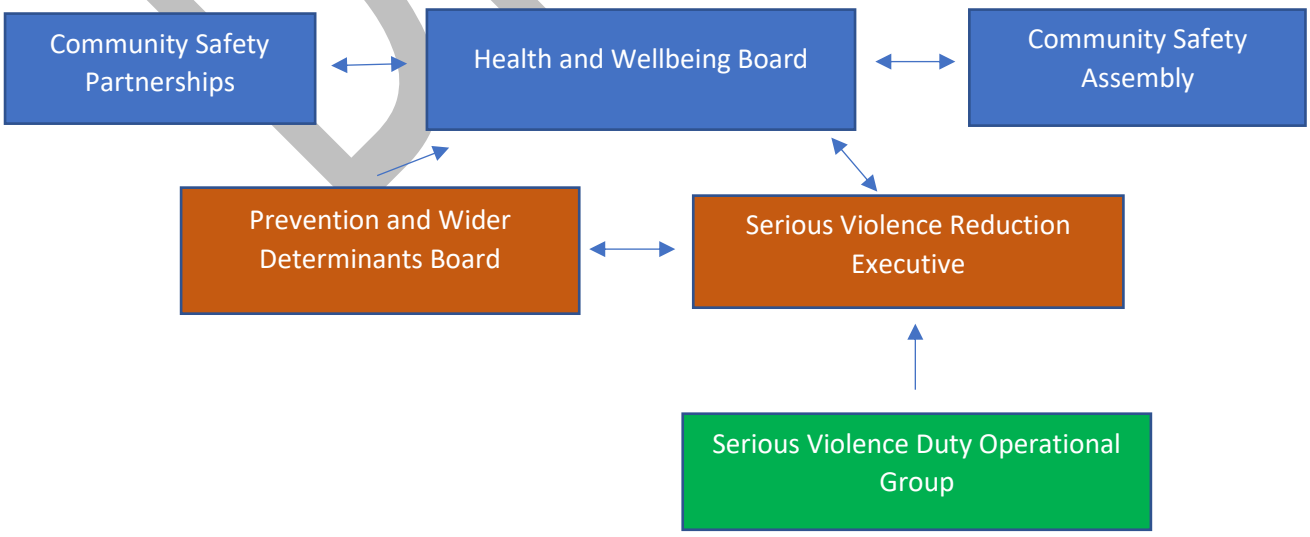
To ensure a collective delivery and clarity of ownership of the actions the Serious Violence Operational Group (terms of reference attached as appendix a) focus on the following aims;

- Oversee the successful adoption of the Serious Violence Duty for the Health and Wellbeing Board, in line with the Home Office's milestones,
- Support the wider partnership in its awareness and understanding of the Serious Violence Duty,
- Coordinate the sharing of relevant data, insights, and information to inform the problem profile/strategic needs assessment for the area,
- Support the development and implementation of a strategy to identify and mitigate the risks identified and agree an approach to preventing serious violence,
- Review the strategy and delivery plan annually to ensure it remains current and is reducing violence across Surrey.

The Operational Group will report into a Serious Violence Reduction Executive (Term of Reference attached as appendix b). Their remit will be for;

- Members provide strategic support and updates.
- To provide leadership and remove strategic challenges and barriers.
- To work as a partnership and make joint decisions to deliver the Serious Violence Duty, particularly overseeing the development of the Strategic Needs Assessment and Serious Violence Reduction Strategy and Delivery Plan.
- Support national Campaigning and awareness raising

In turn the Executive will report into the Health and Wellbeing Board, Community Safety Assembly and to the Community Safety Partners as required. There will be a supportive relationship between the Executive and the Prevention and Wider Determinant Board.



Funding

The Home Office have indicated that Surrey's funding allocation to support the development and delivery of the Duty and to support the delivery of interventions in the future Surrey Serious Violence Reduction Strategy is as follows –

22/23 - Labour Costs: £47,417.32, non-labour costs: £0

23/24 - Labour costs: £222,555.91, non-labour costs: £119,212.44

24/25 - Labour costs: £211,864.69, non-labour costs: £334,965.78

The Office of the Police and Crime Commissioner for Surrey is the grant recipient and as such will commit to meet the requirements and milestones of the funding agreement as signed by the Lead Officer and the Chief Finance and Sec 151 Officer on the 2nd February 2023.

The Office of the Police and Crime Commissioner will work with the specified authorities through the governance structure to make the specified authorities are joint decision makers in relation to the delivery plans and any spend against the grant.

The Office of the Police and Crime Commissioner for Surrey will be transparent and share all details of the quarterly returns to the Home Office.

Milestones for delivery

From 2023 to 2025 the Specified Authorities and the Office of the Police and Crime Commissioner for Surrey will work to meet the milestones as set out in the Serious Violence funding agreement.

These milestones are -

- ***March 2023****:* specified authorities will need to identify an existing partnership or establish a new partnership to deliver the Duty by March 2025.
- ***April 2023:*** the Local Policing Body is required to submit a draft delivery plan
- ***September 2023:*** the Local Policing Body is required to submit their delivery plan
- ***January 2024****:* development a local Strategic Needs Assessment (SNA) which should inform the development of a local strategy, by January 2024.
- ***January 2024****:* specified authorities will need to have prepared their local strategy, which should contain activity to prevent and reduce serious violence based on the needs of their area, by 31 January 2024.
- ***January 2025****:* the SNA and local strategy will be reviewed by the specified authorities, at a minimum, on an annual basis and updated where necessary. Updates of the mandatory products will need to be sent to the Home Office as evidence of completion.

Roles and Responsibilities

The guidance sets out specific information for the specified authorities. This information will set the parameters around how each partner will work within the Serious Violence Reduction Partnership.

Local Policing Body (Office of the Police and Crime Commissioner for Surrey)

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The Local policing bodies, being Police and Crime Commissioners (PCCs), have an important part to play as a lead convener for local partner agencies as they are responsible for the totality of policing in their area, as well as services for victims of crime.

The PCC is not subject to the Duty themselves; the local policing bodies will have a key role in supporting delivery, ensuring read across with existing functions in relation to Community Safety Partnerships.

For the purpose of this partnership agreement and for the delivery of the Serious Violence Duty the Office of the Police and Crime Commissioner for Surrey will;

- Act as the lead conveyer for the local partnership agencies.
- Co-operate with the specified authorities to ensure delivery of the Serious Violence Duty
- Monitor how the specified authorities exercise their functions under the Duty and escalate any concerns to the partnership.
- Administer the grant funding on behalf of the Home Office in partnership with the specified authorities.

Regulations conferring functions on local policing bodies have been made under section 14 of the PCSC Act70, to enable them to assist a specified authority in relation to the Duty. This includes making grants to specified authorities, convening and chairing meetings, requiring representatives of the specified authorities, relevant authorities (educational, prison or youth custody authorities) or such other persons as

Surrey Police

The Duty applies to the Chief Officer of police for all police force areas in England and Wales. Chief Officers of police are specified authorities under the PCSC Act. The Chief Officer should ensure that there is appropriate representation to all partnerships operating within their force area. This representative should be able to:

- Engage fully with local partnerships
- Share relevant police data and information to inform the strategic needs assessment for the local area (for example; data on numbers and trends in violence against the person including knife crime, gun crime, homicides and drugs as well as domestic abuse or sexual violence related incidents, information on local serious violence hotspots including people and places, information on county lines drug dealing etc.)
- Support the development and implementation of a strategy to address the risks identified
- Facilitate the use of a relevant risk assessment tool
- Support work to deliver prevention and early intervention activities and explain to partners how their data can help inform this work

Surrey County Council,

Local authorities (county councils and district and broughs) are well placed to complement the work of other agencies and contribute to the prevention and reduction of serious violence by:

- Sharing a range of relevant aggregated data sets for the development of the strategic needs assessment (for example data already collected from local schools and social care services),
- Conducting wider preventative work addressing general factors that contribute to risk and vulnerability (e.g. poverty, housing, family challenges, environment),
- Leading on wider public health commissioning to support prevention and address risk factors or impacts of trauma (e.g. substance misuse services including alcohol treatment services),
- Providing information on availability/pressures on local resources including housing, community support, children's social care, etc., and
- Effectively commissioning and supporting early intervention initiatives

Surrey Youth Justice Team

Under the Crime and Disorder Act 1998, YOTs have a duty to co-operate as a multi-agency entity to secure youth justice services appropriate to their area and drive a strategic effort to prevent offending by children and young people.

The YOT must comply with the Duty, as specified authorities under the PCSC Act, and should nominate a representative from the team who should be able to:

- Engage fully with the relevant local partnership to prevent and tackle serious violence, and where applicable, as a core member of the local Violence Reduction Unit
- Share relevant aggregated and anonymised data, where practicable, to support the development of the evidence-based problem profile/strategic assessment (for example; information on local serious violence hotspots, information on county lines drug dealing networks and wider child criminal exploitation etc.)
- Support publication and implementation of the strategy to address the risks identified, ensuring that children and their interests are fairly represented in such discussions
- Identify and act to ensure children's best interests, including safeguarding requirements and reducing vulnerability to criminal exploitation, are kept at the forefront of any strategic planning Serious Violence Duty Statutory Guidance.
- Advise on appropriate responses to increase levels of safety within the local partnership area and enable children to be able to move beyond their offending behaviour and status.
- Assist in the delivery of prevention and early intervention initiatives where possible, and explain to partners how their input can help enhance this work
- Work across local authority areas and organisational boundaries where children are not located in the partnership area (for example, when leaving custody, transitioning from youth to adult custody or in county lines drug dealing cases where children may be far from their home area)

Surrey Probation Service

The Duty applies to a provider of probation services under section 3(6) of the Offender Management Act 2007, who are specified authorities under the PCSC Act. Local Delivery Unit (LDU) heads who represent the Probation Service at Community Safety Partnerships (CSPs) should be responsible for

ensuring that there is appropriate representation to the partnership. The representative should be able to:

- Engage fully with the local partnership to prevent and reduce serious violence
- Share currently collated and/or published data and information to inform the strategic assessment for the local area (for example; Offender management quarterly statistics – key statistics relating to offenders who are in prison or under Probation Service supervision and/or Criminal court statistics – National Statistics on cases in the magistrates' courts and Crown Court)
- Use relevant aggregated Risk-Need-Responsivity Data to inform the design and commissioning of interventions aimed at reducing reoffending (The Risk-Need-Responsivity Model)
- Support the development and implementation of the local strategy to address the risks identified
- Collaborate with local partners to help reduce instances of re-offending amongst violent offenders and protect vulnerable groups (for example, victims of domestic abuse)

Surrey Integrated Care Board and Surrey Public Health

Integrated Care Systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development
- improve outcomes in population health and healthcare.

To meet the legislative requirements of the Duty, the accountable officer of an ICB should ensure that there is appropriate representation to the partnership of specified authorities. As part of the partnership, this representative will be expected to:

- Facilitate the sharing of relevant anonymous health data and information to inform the problem profile/strategic needs assessment for the area (for example, number of violent injuries treated within NHS urgent care settings),
- Support the development and implementation of a strategy to identify and mitigate the risks identified and agree an approach to preventing serious violence, managing related health problems, and improving wellbeing/resilience of the community.

Surrey Fire and Rescue

Fire and Rescue services have a tradition of engaging with local communities to promote fire safety as well as wider models of community and individual engagement to support citizenship, community cohesion and direct support to vulnerable individuals and communities. Work with children and young people, safeguarding as well as fire reduction strategies, such as the sectors work to reduce deliberate fires, should be recognised as part of the Duty.

Fire and Rescue Services should be supported to deliver trauma informed interventions, engagement activities and safety education to targeted children and young people which supports the personal development and social and emotional learning of the child to reduce their vulnerability and increase their resilience in line with current practice and evidence of what works to reduce serious violence.

Fire and Rescue Services should continue to develop partnerships to support risk reduction services to those identified as vulnerable and at risk from exploitation or abuse. Safeguarding within the fire sector is immersed in collaborative approaches with the majority of fire and rescue services represented at Local Authority Safeguarding Children and Local Authority Safeguarding Adult Boards and this should be developed as a core function of all Fire and Rescue Services.

Relevant Authorities: (applicable when requested, or request to collaborate)

Prisons

The governor or director of the prison is responsible for complying with the Duty. They may wish to identify a suitable representative, who should be able to:

- Engage with the relevant partnership to prevent and reduce serious violence.
- Share and contextualise anonymised aggregate prison data that is published or collated for business as usual purposes by the prison or HMPPS nationally.

Secure Estate

Governors of Young Offender Institutions, Governors or Directors of Secure Training Centres, Registered Managers of Secure Children's Homes and Heads of Secure Schools are responsible for complying with the Duty. Governors of Young Offender Institutions and Governors of Secure Training Centres may wish to identify a representative. The representative should be able to:

- Engage fully with the local partnership to prevent and reduce serious violence both in the community and within secure establishments
- Support the development of the evidence-based strategic needs assessment and publication and implementation of the strategy to address the drivers of serious violence within establishments and within the local partnership area
- Identify opportunities for agencies to work across local authority boundaries to tackle specific serious violence issues
- Share relevant aggregated and anonymised data, operational knowledge and experience transparently (for example; data and trends in drug dealing, resettlement needs, security issues, violence against staff and contraband, insight and experience relating to children and young people who have offended, useful information which may support crime prevention, and, where appropriate, insight and information from resident children and young people themselves)
- Review and build upon existing partnerships wherever possible (e.g. Youth Offending Teams, Children's Social Care, Secure Children's Homes, NHS and Education providers)
- Identify impacts of serious violence within the local community e.g. violence against staff and children within establishments

Education (Surrey County Council)

Educational authorities may also choose to collaborate with a specified authority, a prison or youth custody authority or another educational authority in that area of their own volition. Or, if requested by the specified authorities or another prison, youth custody or educational authority, educational authorities must collaborate with other partners in the preventing and reducing serious violence in the area (the preparation and delivery of the strategy).

Data and information sharing

To recognise the importance of effective multi-agency information sharing the guidance shows how the legislation includes specific provisions to support partners to share information, intelligence, and knowledge to prevent and reduce serious violence.

Sections 16 and 17 of the PCSC Act provides a permissive information sharing gateway to disclose information.

Section 16 – provides a permissive information sharing gateway that enables specified authorities, local policing bodies (PCCs or equivalents), educational, prison and youth custody authorities to disclose information to each other for the purposes of their functions under the Duty.

Section 17 – creates a power for local policing bodies (PCCs and equivalents) to request any specified authority and any educational, prison or youth justice authority within its police force area to supply it with such information as it may specify for the purpose of its functions relating to the Duty. The purpose of this power is to enable or assist local policing bodies (PCCs or equivalents) to assist a specified authority in the exercise of its function to collaborate and plan to prevent and reduce serious violence and monitor the local strategy and its effectiveness.

Personal information may be disclosed under section 16 and 17 by specified authorities except health and social care authorities who should be aware that there are restrictions under the powers on the disclosure of patient information and/or disclosure of personal information by a specified health or social care authority. These restrictions mean that generally they cannot be required to disclose confidential patient information. Any sharing of personal information must comply with data protection legislation (most importantly, the Data Protection Act 2018).

It is acknowledged that the 'Information Sharing to tackle Violence (ISTV)' approach taken in Serious Violence Reduction Units should be adopted as a baseline and continually improved upon where possible. The ISTVs are currently working to achieve the following three levels of information usage in order to support their work to prevent and reduce serious violence:

Level 1 – Information used to inform the strategic needs assessment in order to understand local issues;

Level 2 – Information used to better identify hotspot locations and support a targeted approach;

Level 3 – Information used to better identify individuals at risk for high-intensity support programmes. (Level 3 data would not apply for healthcare data under the Duty)

Data protection

All responsible authorities should already have arrangements in place that clearly set out the processes and principles for sharing information internally and arrangements for sharing information within the local partnerships and with external bodies, including processing personal data in order that it can be anonymised for sharing purposes. For the purpose of the Serious Violence Duty project the Surrey Community Safety Information Sharing agreement and the MASIP will cover the arrangements and the safeguarding measures to make it clear that the purpose of the data is to ensure the appropriate support and interventions for individuals can be put in place.

Terms of Reference

Domestic Abuse Executive Group

Chair	Frequency	Version	Approval date
Hayley Connor	Bi-Monthly	V.9	

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1. Purpose

The purpose of the Domestic Abuse (DA) Executive Group is to work in partnership to oversee, sign off and ensure that all members have a full commitment (on behalf of their organisation/agency) to the DA redesign and recommission programme and help support the Partnership in meeting its duty implementing the Domestic Abuse Act 2021. The group will have strategic oversight of the overall process following the recognised stages of service redesign methodology and commissioning process.

2. Aims and Objectives

- To improve outcomes for survivors of domestic abuse, including their children, through a strategic approach to identifying and addressing gaps in support within safe accommodation and specialist community-based services.
- Ensure that Surrey's partnership approach to the DA redesign and recommission process delivers on Surrey's Domestic Abuse strategy (2018-2023).
- Enable and support the programme to problem solve, remove barriers, and make decisions on how the partnership can work together to make DA survivors feel safer.
- Ensure the 'voice' of DA Survivors is central to the Programme (meetings will provide time to meet with DA providers and representatives from VCFS)
- Members provide strategic support in response to the DA Act 2021
- To provide leadership and remove strategic challenges and barriers.
- Provide an effective strategic link to the DA Management Board creating a smooth recognised pathway for operational areas of importance to inform the Executive
- Focus on Domestic Abuse and the wider direct link to Violence Against Women and Girls building a link to our responsibilities for wider change in Surrey in this key area
- To an ensure a whole system approach to perpetrator management thereby keeping survivors, children, and families safe and holding perpetrators to account

3. Meeting Membership (delegates to be sent – require decision making authority)

- Executive Director of Children, Families and Lifelong Learning
- Director of Commissioning
- Elected Member (Cabinet lead for Domestic Abuse)
- Representative from Office of the Police & Crime Commissioner (OPCC)
- Representative from Health – Clinical Commissioning Group & Integrated Care System (CCG & ICS)
- Representative from Public Health
- Representative from Surrey Police
- Representative from Adult's Social Care
- Representative from Surrey's Refuge Providers

- Representative from Surrey Community based Domestic Abuse Services
- Other Providers/Third Sector Representatives as required
- District & Borough Representative – Housing
- Registered Social Landlord Representative

4. Inputs & Responsibilities

- Provide advice and data to support the Partnership to undertake a robust local needs assessment to identify and understand the needs of domestic abuse victims within their area (including those that present from out of area).
- Provide expert advice and data to support the development of a local strategy, agreeing the appropriate steps needed to meet the needs identified.
- Help us to effectively engage with survivors of domestic abuse and expert services in understanding the range and complexity of needs.
- Support the partnership to make commissioning and decommissioning decisions (where appropriate). This can include when and how commissioning is undertaken to ensure the best and most appropriate services are made available for survivors (adult and children) and perpetrators.
- Support in ensuring join up (whole system approach) across other related areas such as housing, health, early years and childhood support, social services, criminal justice and police etc
- Advise and support in dealing with issues raised and identified from engagement through formal and informal routes.

5. Outputs

- Strategic decision making and direction
- Provide an effective strategic link to the Violence Against Women and Girls Executive Board
- Budget sign off and allocation
- Minutes/Actions

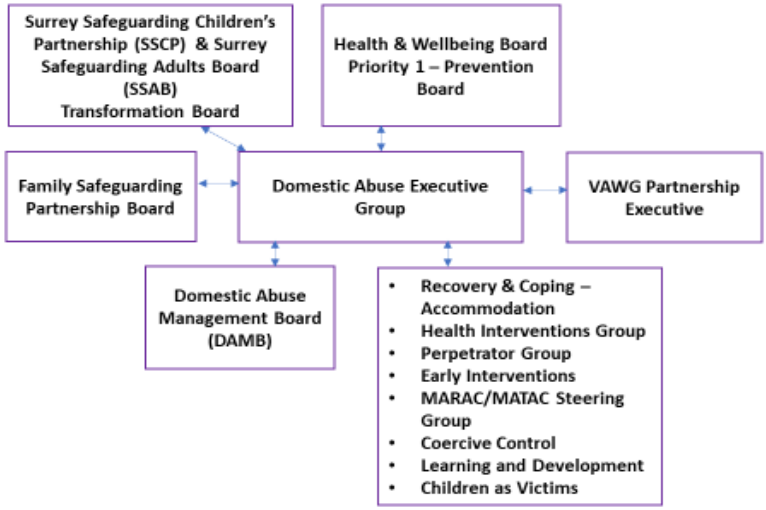
6. Behaviours

- Members who are unable to attend a meeting will take responsibility to send an alternative colleague who will be briefed.
- Individual group members will be responsible for their specific area of expertise and carry out actions as agreed at meetings within the agreed timescale.
- Members of the Board are responsible for ensuring they report back and feed into the Board on behalf of their represented groups.
- Champion the Domestic Abuse Strategy
- Make evidenced decisions in the interests of domestic abuse response in Surrey, rather than local directorate or area
- Be honest and open about what goes well and what can be improved, so that we learn lessons and do things better next time
- Raise concerns early and openly
- Act in a domestic abuse and trauma informed way
- Expect, accept, and act on challenge

7. Decision Making Protocol

- Coordinating meetings, preparing the agenda and recording action points will be carried out for each meeting by the SCC
- Action points will be issued no later than two weeks after the meeting
- SCC in liaison with the Chair will indicate optional/required attendees from meeting to meeting
- Attendees must be empowered to make/agree decisions
- All members may be contacted between meetings for advice or agreement on an issue should the need arise.
- Non-members may be invited to the meeting as and when appropriate.
- Confidential material will be marked as such and sent via protected email (in line with GDPR regulations)
- This group will be accountable to the Health and Wellbeing Board.

8. Governance



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Surrey Community Harm Reduction Group

Terms of Reference (2020)

Mission Statement

The purpose of the Surrey Community Harm Reduction Group is to bring together a range of partners and representatives from relevant agencies to identify good practice and address barriers to effective partnership delivery in response to anti-social behaviour, serious and organised crime and other emerging community safety issues.

The group will promote a proportionate and balanced response to issues of anti-social behaviour (ASB), serious and organised crime (SOC) and community safety, which reflect levels of harm caused to victims and communities whilst always putting the victim at the heart of our work.

The group will also act as a scrutiny board for community safety issues and offer peer support and advice where request along with being an influencing group in regards to changes in policy and procedure locally and nationally.

Strategic Aims

- To deliver a victim focused service to reduce the harm caused by ASB across Surrey
- Improve the understanding of the harm and impact by the public and professionals of Anti-Social Behaviour and Serious and Organised Crime in our communities which will help inform what responses are available to tackle it.
- To identify and share best practice in relation to tackling ASB and SOC
- To ensure a consistent approach across the County when tackling ASB and SOC
- To ensure connectivity between the work of the Group and other Surrey Partnership Boards where behaviours and associated vulnerabilities cut across a variety of national/local themes and agendas.

Commitment

To achieve the strategic aims the Group will develop a work programme which will be refreshed every 3 years. It is expected that all Members actively participate in the Group through contribution to task and finish groups and they will be involved in the delivery of the work programme as a whole. The task and finish groups will be identified by the Group Chair and allocated by mutual agreement. The Lead Officer(s) will provide updates to the Group at regular intervals.

The Group will produce an annual report and review the terms of reference yearly to ensure they are fit for purpose. It will give regular updates to the Serious and Organised Crime Partnership Board and the Surrey Health and Wellbeing Board reflecting the implementation of the entire work programme and the progress made.

Membership

The Group will have a core membership, however additional representatives will be invited to attend the Group in relation to specialist or specific areas of discussion and activity.

The core members of the Group will include representation from the following:

Police - ASB Manager, Problem Solving C/Inspector, SOC Partnership Manager, County Lines Manager, Victim Care and Victim Satisfaction

Office Police and Crime Commissioner – Partnership Officer

Local Authority – Community Safety Manager, Environmental Health Rep

Surrey County Council – Community Safety Manager, Fly Tipping Reduction Manager, Surrey Fire and Rescue, Targeted Support Team (Young people)

Housing Providers – Raven Housing and PA Housing

Charities/3rd Sector - Victim Service, Mediation, Catalyst and Crimestoppers

Meeting Frequency

The Group will meet every four months and will be scheduled to last for three hours.

Task and finish groups will be expected to communicate as required in accordance with the needs of the relevant work programme area.

The Group may be convened on an extra-ordinary basis in the event of an exceptional event or item requiring discussion

Standing Agenda Items

The group will discuss the following agenda items at all meetings:

1. Victim Care/Victim Satisfaction for ASB
2. Emerging threats and risks
3. Updates from Action Plan
4. ASB Week/ASB Forum/ASB Awards
5. Update from Housing Providers meeting
6. Community Trigger Activations
7. Training/Education Opportunities
8. Communications
9. Sharing of good practice

Official

Violence Against Women and Girls

VAWG Executive Group Terms of Reference

Chair	Frequency
Hayley Connor/Fiona Macpherson	Rotating on a quarterly basis (To be reviewed after third meeting)

1. Purpose

The purpose of the Violence Against Women and Girls (VAWG) Executive Group is to oversee the work of signatories to the VAWG Partnership Strategy and to ensure that the actions taken by partners are in line with the vision, objectives, and strategy set out in that document. This oversight will also cover commitment to statutory obligations as set out in the Police, Crime, Sentencing and Courts Bill and the Serious Violence Duty 2022. The executive group will also be expected to coordinate with the Domestic Abuse Executive Group to ensure there is not a duplication of efforts, and where appropriate harmonisation is maximised.

2. Aims and objectives

- Ensure that Surrey's partnership approach to preventing VAWG delivers on the Surrey VAWG partnership strategy 2022-2025.
- To improve outcomes for survivors of VAWG crimes by identifying gaps in service provision and making recommendations to improve services.
- To provide leadership for the partnership and to remove strategic challenges and barriers to support the delivery of effective services.
- Ensure that victims and survivors of VAWG crimes are supported by staff with appropriate levels of training and which recognises the intersectionality of victims and survivors.
- Ensure a whole-system approach, which is person-centred and trauma-informed, is implemented to remove barriers that may restrict access to support. This includes addressing the root causes of VAWG, namely gender inequality, misogynism, and harmful attitudes held towards women and girls, through education and prevention.
- Ensure data is used at all opportunities to ensure an evidenced-based approach is adopted and a platform is provided to survivors as the experts in their own experiences.
- To clearly communicate the principles, objectives and decisions made within the group to stakeholders.
- Improve access, support and engagement for victims and survivors with protected characteristics including but not limited to BAME victims, LGBTQ+ victims, male victims, disabled victims, GRT victims, victims with no recourse to public funds, and victims of faith-based and spiritual abuse.

3. Meeting Membership

- Surrey County Council Director of Commissioning
- Surrey County Council Assistant Director of Community Safety
- Surrey County Council VAWG Programme Officer (Secretary)*
- Assistant Chief Constable of Surrey Police
- Lead for VAWG at Surrey Police
- VAWG Force Advisor of Surrey Police
- Head of Policy and Commissioning at Office of Police and Crime Commissioner
- Elected Member of Surrey County Council – Cabinet Lead for Violence Against Women and Girls

- Representative from Public Health at Surrey County Council
- Representative of Healthy Schools at Surrey County Council
- Third Sector Representatives (Service providers)
- District and Borough Representatives from Community Safety Partnerships
- Education Safeguarding Team Lead
- *Representative from Health**

Membership of this meeting may vary depending on the specific requirements of a meeting. Survivors should also have a direct presence in this meeting (when appropriate) which can be facilitated by service providers.

4. Inputs and Responsibilities

- Approve and monitor the implementation of the VAWG Partnership Strategy for Surrey.
- Hold partners to account with regards to implementation of their action plans to prevent VAWG and the alignment of these with the vision and objectives outlined in the VAWG Partnership Strategy.
- Support the partnership to make commissioning and decommissioning decisions. This can include when and how commissioning is undertaken to ensure the best and most appropriate services are made available for survivors and perpetrators.
- Ensure services across health, housing, education, early years and childhood support, social services, criminal justice, police, and third sector specialist providers are joined-up and complementary.
- Advise and support in dealing with issues raised and identified through formal and informal routes, including feedback from the VAWG Task and Finish Group(s).

5. Outputs

- Strategic decision making and direction
- Budget sign off and allocation
- Minutes/actions

6. Behaviours

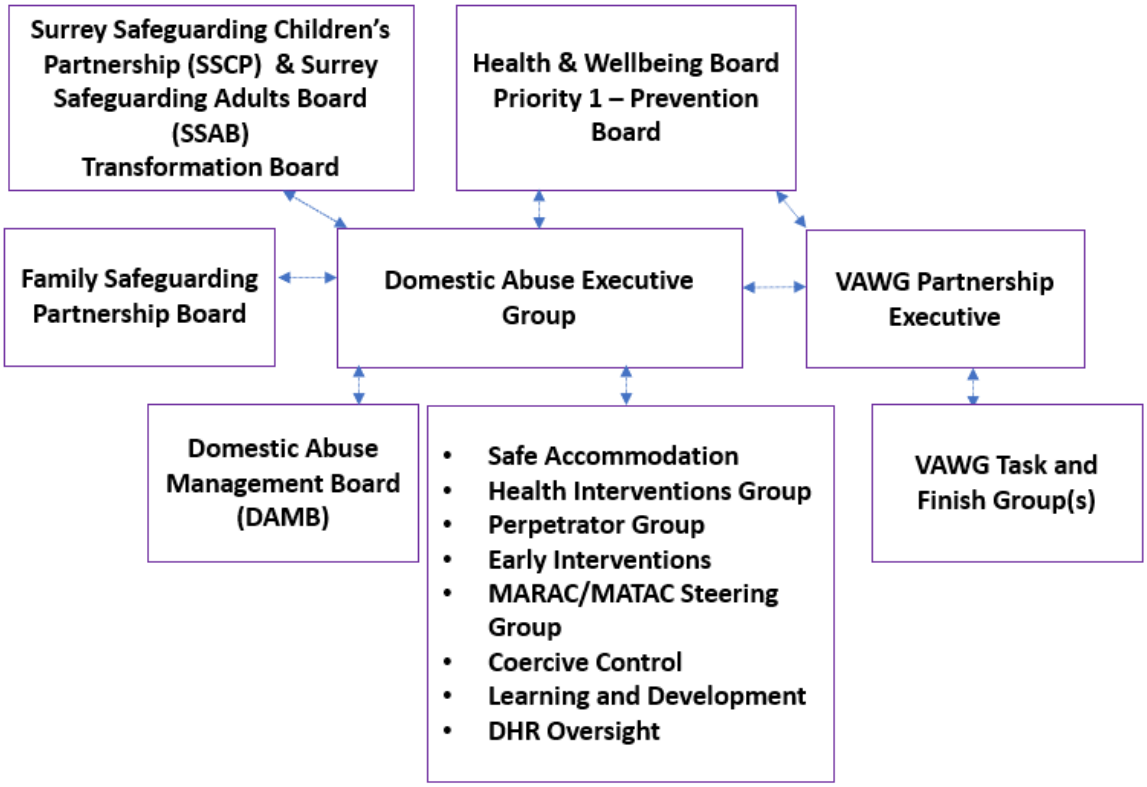
- All members of the executive group will be expected to:
    - Champion the VAWG Partnership Strategy
    - Make evidenced decisions in the interests of preventing VAWG across Surrey
    - Expect, accept, and act on challenges
    - Report back on the work of their respective organisation
    - Carry out actions as agreed at meetings within the agreed timescale
    - Attend all executive group meetings or if unable to do so send apologies and an alternative colleague who will be authorised to approve actions
    - Be open and honest about what is going well, what can be improved, and what actions should be stopped

7. Decision Making Protocol

- The VAWG Executive Group will meet once every three months
- Meeting papers will be circulated one week ahead of the meeting

- Co-ordination of the meetings, preparation of the agenda, and the recording of action points will be carried out by the Surrey County Council VAWG Programme Officer (Secretary)
- Action points will be issued no later than one week after the meeting
- The Chair(s) will indicate optional/required attendees for each meeting and communicate this to the VAWG Programme Officer
- All members may be contacted between meetings for advice or agreement on key issues should the need arise
- Confidential material will be marked as such and sent via protected email (in line with GDPR regulations)
- This group will be accountable to the Health and Wellbeing Board

8. Governance



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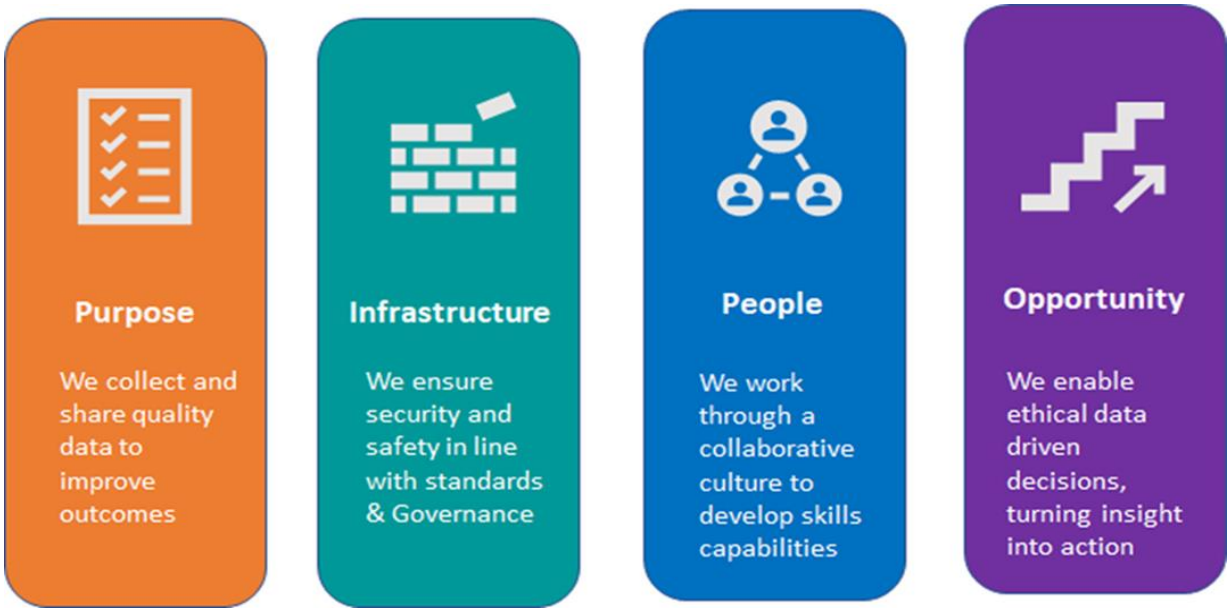
Health and Wellbeing Board (HWB) Paper

1. Reference Information

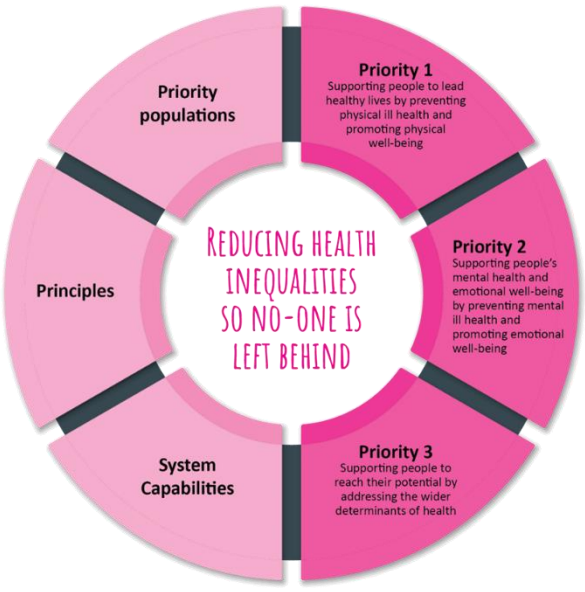
Paper tracking information	
Title:	Surrey Wide Data Strategy - Update
HWBS Priority populations:	All
HWBS Priority - 1, 2 and/or 3:	All
HWBS Outcomes/System Capabilities:	• Data, Insights and Evidence • The needs of those experiencing multiple disadvantage are met • Serious conditions and diseases are prevented • People are supported to live well independently for as long as possible
HWBS Principles for Working with Communities:	• Co-designing: 'Deciding together' • Co-producing: 'Delivering together'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions • Community Led interventions
Author(s):	David Howell, Joint Director for Strategic Insight and Analytics (Surrey Heartlands Integrated Care System); david.howell5@nhs.net
Board Sponsor(s):	Tim De Meyer - Chief Constable of Surrey Police
HWB meeting date:	21 June 2023
Related HWB papers:	Surrey Wide Data Strategy, May 2022
Annexes/Appendices:	**Appendix 1**: Surrey Wide Data Strategy

2. Executive summary

The Surrey Wide Data Strategy 2022, sets out a vision to build an interoperable data and analytics ecosystem, comprising of shared data from a range of partner organisations across Surrey to help deliver better care/services to our residents now, and in the future. This strategy was broken down into four pillars required for success:



This paper aims to provide an update to the Board on the current progress and implementation for the Surrey wide data strategy, as well as providing an insight into the challenges faced at this time. Since the purpose for the use of data across the system was extensively covered in the data strategy, this report will focus upon the latter three pillars respectively. This links to the 'Data Insights and Evidence' system Capability for the Health and Wellbeing Board priorities:



System capabilities

- Empowering and Thriving Communities
- Clear Governance
- Estate Management
- Workforce Recovery and Development
- Programme Management
- Equality, Diversity and Inclusion incl. digital
- Data, Insights and Evidence
- Integrated Care

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Note the progress that has been made to date across the system.

2. Ensure that the direction of travel and progress being made by the teams are in line with the views of the Health and Wellbeing Board membership.
3. Provide feedback and recommendations on the highlighted areas of challenge being faced at this time.

4. Progress Updates

Infrastructure

A system wide project group has been established to plan and develop a roadmap for the IT systems and platforms required to deliver the data strategy. A Strategic Outline Case (SOC) was completed in December 2022 and more recently, the next stage of the Outline Business Case (OBC) has been signed off by Surrey Heartlands ICS, and ICB. The OBC describes how we are going to implement the recommendations from the Surrey Data Strategy through the development of an Integrated Digital & Data Platform (IDDP) by the end of financial year 2024/2025. This will commence with a focus on integrated health and care across the system, but with a capability to expand to wider services in the near future. The next step and final gateway is to complete a Full Business Case (FBC), providing final costings and delivery plans for approval and onward delivery.

This IDDP will, over time, create a central and shared place to hold data about the population of Surrey. Contributions to this repository will be able to be made by a range of partners and health sources (where standards and information governance criteria is reached) to create a holistic and broad view of the population. This data can then be used by health and social care, as well as wider partners (where legal/ethical) for operational planning and reporting and has the potential to enable more advanced analytics work for complex, system wide issues. It will also provide a secure environment for research and help drive more health specific objectives related to the Surrey Care Record, Personal Health Record and Population Health Management.

This shared source of data will make it easier for authorised users across the system to find data they need to support local decision making and provide greater trust around the accuracy and timeliness of this information. It will also support greater transparency of performance and shared issues, ensuring that we can operate more effectively as one system in support of our patients, residents and communities.

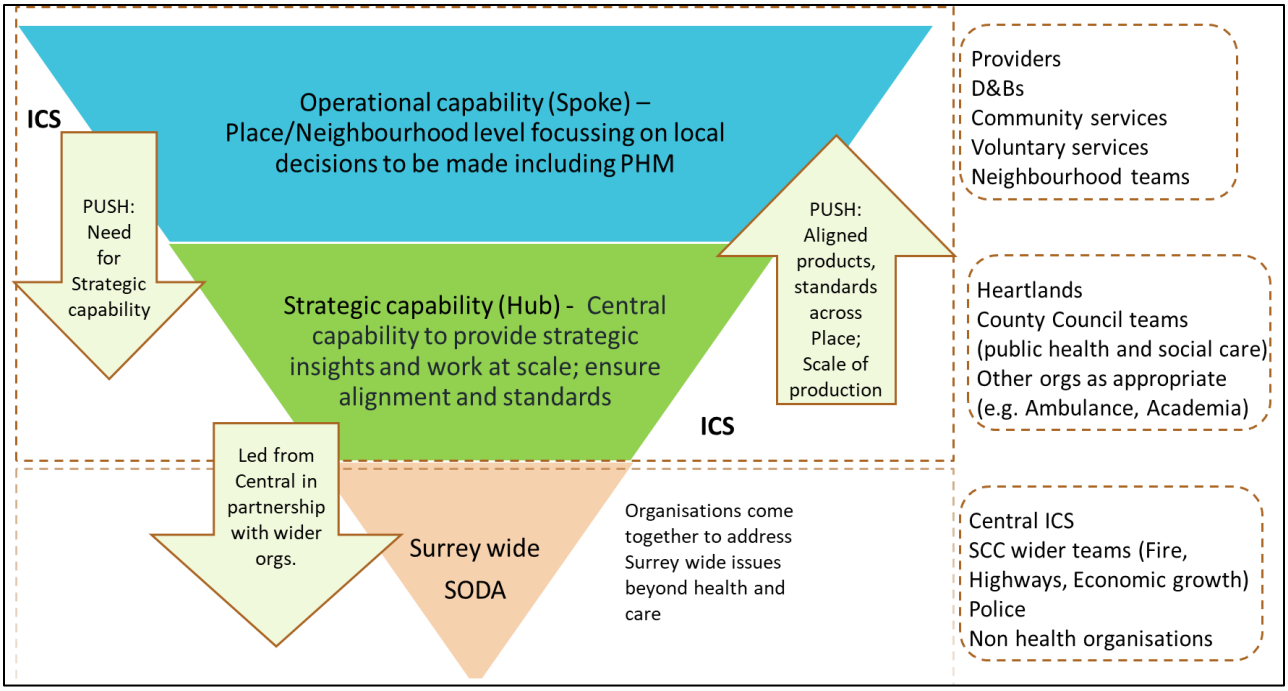
The design and implementation of the IDDP will be phased and so approval of the FBC will enable us to move to begin implementation of the initial building block for this work which will focus on expanding the capability of existing IT systems and tools already implemented within Surrey.

This programme will enable the system to realise a series of intended benefits, measuring the financial and non-financial impact of any investment. These will be described in more detail for the FBC, including a plan to realise some benefits during the initial ‘converge’ stage of the programme. The provisional benefits include:

a. More widespread use of data and population health approaches to inform and evaluate interventions by all partners to support priority population groups and reduce health inequalities.
b. Greater availability and efficient management of richer, better-linked data and increase in public understanding and support for data sharing.
c. Resources (Finance, Workforce, Estates) better targeted between reactive/proactive care and centralised/community settings.
d. Increase in staff satisfaction and retention, and wider system teams using data to drive better decision making.
e. In addition, there may be opportunities to look at greater efficiencies that could be achieved through use of the platform and its data. For example, there may be duplicated storage or reporting that can be removed by partners. The expectation is that these opportunities would be identified during the implementation period. It is not anticipated that local case management systems could be replaced by this platform.

People

Supporting our roadmap towards the vision of a shared analytics ecosystem, a significant amount of progress has also been made around integration of our shared care record platform across the Thames Valley and Surrey (TVS) partner systems.



This work, being led by Frimley partners, is being undertaken to ensure that there is closer cross collaboration between all member ICSs including with sharing of best practice, dashboards, analytical resources and expertise.

The Surrey Wide data strategy sets out the ambition for how analytical communities need to be better connected to provide the integrated insight and analytical capabilities required for the system, referred to as the data operating model. A vision

for this data operating model has now been developed and is summarised below for reference:

Progress to date:

Towns development: A plan has been developed and shared with system partners focusing upon an approach to support and develop the role of towns as distinct, recognisable places and communities around which partners can coalesce and work. This new approach proposed a 'spatial hierarchy' and phased approach over the coming year to delivering integration and partnership in towns. A proposal has been made for ten priority towns to initially focus upon in which the new approach will be developed and rolled out across the rest of the county. All of which is aimed at securing more effective and efficient delivery and better outcomes for Surrey residents and businesses. Some of these outcomes and the measures used to assess them might include:

- Improved overall life expectancy and reductions in differentials
- Levels of employment and ability of employers to recruit
- Qualitative happiness scores
- Reductions in smoking/alcohol/drug usage and dependency
- Improved quality of public realm
- Positive impacts on climate change and CO2 emissions reduction
- Community activity, social capital, and civic engagement

Central Hub Formation: A working group of analysts from across the system have recently kick started the formation of the hub and to date have held a number of initial meetings and workshops to focus upon a common approach to identification of vulnerable cohorts and population segmentation. Over the coming next couple of months, the hub have agreed to commence by working as a multi-disciplinary team on a business problem that is of strategic importance to all members of the group. This 'use case' will enable us to establish new ways of working, understand the potential barriers, how we can share information, knowledge and skills and start to establish a common hub identity.

SODA: We have begun a project with partners on undertaking a strategic needs assessment to inform a strategy on reducing serious violence. The duty on reducing violence is placed on all relevant local organisations, and so this is a good opportunity for bringing together data and analysis across all the relevant Surrey organisations. The project will help identify the opportunities and challenges in bringing the insight together, including information sharing, which we will want to use in the future remit and direction of SODA.

Once in place the IDDP will support both the centralised hub and SODA to have easier access to timely, relevant and trustworthy data. This operating model will facilitate a greater sharing of skills and knowledge across the system, build greater understanding of the datasets needed and will help shape and guide the development of the IDDP, long term, ensuring that it enables analysts (across the system) to harness the power of data for better decision making.

Opportunities

The Hewitt Report: The recent Hewitt Report has recognised that timely, relevant and transparent data is essential for integration, improvement, innovation and accountability. As high performing ICSs are already showing, high quality, integrated data collection and interoperable digital systems can initiate real change. Good data, used well, can generate actionable insights into outcomes and the drivers of inequalities, as well as productivity, quality, and safety.

Progress to date:

Through joint working and the active involvement of key stakeholders the programme team are focusing on how we can support and implement some of the recommendations that have been highlighted through the Hewitt review, all of which will strongly support the data strategy implementation for the future. These include the following:

- Focusing on enabling data sharing and digital innovation that supports real-time service improvement
- Defining standards on data taxonomy and services' interoperability, and coordinating data requests to the system
- Progressing ICS devolved autonomy for decision making and finances to enable system-wide change to promote health production and thriving communities.
- Streamline and simplify the approach to system governance and accountability. This is particularly relevant for funding initiatives which span organisations and are often dotted around the system with different bidding requirements, templates, accountability reporting, timescales, objectives and flexibilities.
- Encourage more local input and involvement in designing and delivering regulatory and accountability regimes. Streamlining the regulatory system and reducing the number of regulators would improve clarity of system assurance and enable partners to become more involved in co-developing and delivering against an accountability system for their ICS.
- The balance of national versus local targets is key to ensure that sufficient focus and priority can be given. We would like to see a smaller numbers of targets, sufficiently aligned across national and system/local priorities.
- Targets should remain static for a period of time to allow organisations to accurately monitor and review trends.
- System improvement relies on collective accountability, moving away from an organisational mindset. There is a real opportunity for stronger peer support and challenge amongst providers and system partners.

5. Challenges

The top three key risks for taking forward the Surrey Wide Data Strategy are as follows:

Resources. RED A lack of investment or availability of staff and specialist support (technical, commercial and IG) may hamper our ability to progress the Integrated Digital & Data Platform or substantially improve intelligence support to place and neighbourhood teams through the data operating model. This will however be addressed in the Full Business Case for the IDDP.

Alignment between local, regional and national plans around data and analytics. AMBER A myriad of other initiatives risk duplicating or undermining the systems own roadmap. We will work with national and regional teams to understand the future direction of travel to ensure that our own IDDP and Operating Model can align/integrate into this as required.

Public Support. AMBER Public confidence in the way their data is handled and shared is vital. We will need to develop and consult a Digital & Data Ethics Committee (as recommended in the Surrey Data Strategy) to provide assurance that our use of data will be legal, safe, and proportionate, and ensure that sufficient resource for Information Governance activities, communications and engagement is included in the forward plan.

6. Next Steps and Timescales

Infrastructure

- **IDDP Strategic Outline Case (*Completed Feb-23*).** This document lays out the strategic case for change and seeks authority to continue to develop the full business case.
- **IDDP Outline Business Case (*Completed Apr-23*).** This document will lay out a more detailed plan and identify arrangements for procurement.
- **IDDP Full Business Care (Expected Aug-23).** This will select the most economically advantageous tender and to put in place arrangements for programme delivery. **ACTION: Surrey Heartlands Integrated Care Board**

People

- **Sharing of Best practice for vulnerable cohort identification processes (*Completed Feb 23*).** Analytical hub to agree what outcomes we would be seeking to have from an aligned vulnerable cohort and segmentation approaches identification process and to share best practice from each partner with the rest of the system collaborators.

- **Develop a recommendations paper *(Completed Apr-23)*** on an aligned approach to vulnerable cohort identification for sign off by the neighbourhood board
- **Joint analytical approach to support the Prevention Spend Mapping Programme (Jun-23).** Centralised hub to jointly work together on prevention spend mapping. **ACTION: Surrey Heartlands ICS Analytical Hub Partners**
- **SODA – Serious Crime Workstream (May-23).** Establishment of working group for this use case and development of a joint multi-agency analytical product**. ACTION: Relevant systemwide partner organisations**

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Opportunities

- **Spend Analysis Recommendations Paper (Jun-23)**. Development of a spend analysis paper to be shared with ICS Stakeholders, identifying the recommendations from the Hewitt review and how these can be embedded into the system across a number of areas. **ACTION: ICS (Surrey and Frimley) Partners**

Surrey Wide Data Strategy

8

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Executive Summary

More than ever data insights are being used to improve the quality of our public services. The 2021 National data strategy, UK Industrial Strategy, Digital Strategy and Government Transformation Strategy all indicate that a better use of data can drive growth and productivity, improve the quality of our public services and position the UK as a leader of the next wave of data-enabled innovation. Data is recognised in the Government's National Data Strategy as a strategic asset and the 'great opportunity of our time, offering the possibility of a more informed and better-connected future.'

Across Surrey, and in line with the Integrated Care System (ICS) development, we recognise the potential collaborative working and data sharing brings. *Integrating care: Next steps to building strong and effective integrated care systems across England*, first published in November 2020, announced the expectation for Integrated Care Systems (ICSs) to "develop shared cross-system intelligence and analytical functions that use information to improve decision-making at every level". As a system, we have ambitions to build a truly interoperable data ecosystem to help deliver better care/services to our residents now, and in the future. With the ICS Development plan underway, we have the ideal opportunity to become truly data-enabled and build a sustainable data capability; using data to not just understand the performance and monitoring of services, but also to help plan and prepare for the future, predicting issues before they arise.

This document presents the Surrey Wide Data Strategy, its ambition to build a data ecosystem to enable partners across the system to access the information they need at the right time, in the appropriate level of detail to drive improvements and better outcomes for citizens and workforce. In this strategy we present the purpose, and the progress made to date through insights derived from system-wide stakeholder engagement, public view, our current position as a system and maturing ICS in relation to data and technical infrastructure. We present a summary of the findings to date and outline at a very high level the data architecture and operating model proposed for further development of a system wide data sharing platform and Intelligence Function.

An integrated approach to our health and care intelligence across the system, by building a collaborative analytics function, is recognised as a key enabler to transformation reform across health and social care.

The Surrey wide data strategy is forward thinking and we will harness the contribution of other public bodies, employers, voluntary sector and not just restrict the input to ICS members. The devolution context from July 2022 provides an opportunity to overcome organisational boundaries to provide Surrey the chance to bring together data and information that have traditionally been disparate and siloed in order to create a longitudinal view of the citizens' care need, utilisation and spend and also bringing in other wider determinant data.

The Surrey Wide Data Strategy closely aligns with the ICS Development Plan and other key strategies, including the Surrey County Council Data Strategy and work of the Surrey Office of Data Analytics (SODA). These initiatives are bringing partners together from across the county to look at how data sharing can be improved and what a collaborative analytics ecosystem might look like, to deliver better services to Surrey residents.

The Surrey wide data strategy team and Ethical Consulting have been working across Surrey, with a focus on the ICS for the last 6 months to identify and articulate the strengths and challenges we have

across the system in effective information and data sharing. We present recommendations, in line with regional and national NHS thinking around data sharing architecture and operating model.

We held over 15 workshops in total between December 2021 and February 2022, engaging more than 100 staff from 15 organisations across Surrey, including District and Boroughs, Surrey Heartlands, Surrey Police, Surrey County Council, and members of the third sector.

Through the feedback we were able to determine key priorities, strengths for collective focus and heard the resounding desire to work collaboratively at system-wide level. The workshops have also been useful at highlighting the some of the complexities of working at a system and place-based level and the challenges that will need to be addressed. Key challenges included Information Governance, use of common language and definitions pertaining to data and considerations for a culture and mindset shift.

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High-level principles to guide a common approach in areas such as data architecture, ways of working and information governance have received broad agreement, signalling that this work is moving in the right direction and allowing us to establish a common ambition and clear focus.

1. **Each organisation across the system will name a member of their senior leadership team to join an advisory panel -** a new way of working across partners and organisations

2. **Creating a data sharing ecosystem (a data mesh) –** a new way of working which addresses data management, data quality and IG considerations as well as the technical mechanisms for exchanging and managing data into a central data platform.

3. **Building or procuring a central data platform (a data Lakehouse)** into which data can be shared from around the data mesh and which can be accessed by appropriately authorised users and analysts across Surrey.

4. **Creating a data governance function and data management team** to support the mesh and the platform. This is a highly skilled group of data, architecture, analysts and data managers who will develop and support the solution for the ICS and across providers, partners alike.

5. **Creating a centralised IG function across the ICS** bringing in expertise from around partners and creating a responsive and open IG model to support these new ways of working with data.

6. **Undertake meaningful consultation with service users regarding how we use their data** – ensure public engagement and trust is at the core of the data strategy

Through the discovery phase of the data strategy, we have established that we do not currently have platforms capable of extension to meet our use cases as currently procured or deployed in the system.

The Surrey Care Record and PHM platform are core current data sharing assets which should remain in place to support current use cases and be incrementally enhanced as provider ability to share richer data sets is developed. However, the Graphnet platform is not technically suitable for extension to meet real time data sharing where required and operational reporting for example.

The full Ethical report contains significant detail on specific use cases for data sharing to support initial conversations in an early market engagement phase prior to inform the development of detailed specifications.

We propose an iterative approach to developing the solution, focusing initially on the work undertaken to date in the development of the ICS. We then propose moving to the wider system to onboard new providers. By so doing, we hope to demonstrate that the new data sharing solution can offer tangible benefits to partners by reducing some administrative and reporting burdens.

We propose investigating options for direct care (leveraging the SyCR/PHM and new Cerner architecture) and integrating new data sources as they develop (i.e., remote monitoring data and other forms of patient reported data) as well as external data sources such as Ds and Bs and wider determinants of health data. Over time and as we develop or procure the central data platform, we will retire duplicated solutions and reduce the number of reporting and analytical solutions we have in place.

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We have created an open dialogue with our stakeholders form across the system, this includes NHS, Local Authority, third sector, Police, District & Boroughs and other partners. This has led us to understand in great detail the strengths and challenges of working collectively and collaboratively.

Central to all the work we do, are our residents and patients. We have sought their views through the existing Surrey Citizen Panel and asked residents about their support and trust of public institutions sharing data. The survey was conducted online in January 2022 and it received a total of 987 responses. Overall, the public support data sharing and public services handling their data for improving healthcare services and products. However, their confidence in the ability of all organisations sharing data was lower.

In the concluding section of the document, we propose next steps to support the testing and development phase across partners and a roadmap to take us to the next level of detail and pave the way for the next phase of implementation. Our findings indicate that to be truly data enabled requires not only changes to our data, tools and technology, but also to our ways of working, skills, resources, people and opportunity to continually improve. Therefore, a key focus of this strategy is to advocate the right conditions for the system to become data enabled by initiating a shift in mindset, culture, behaviours, and ways of working.

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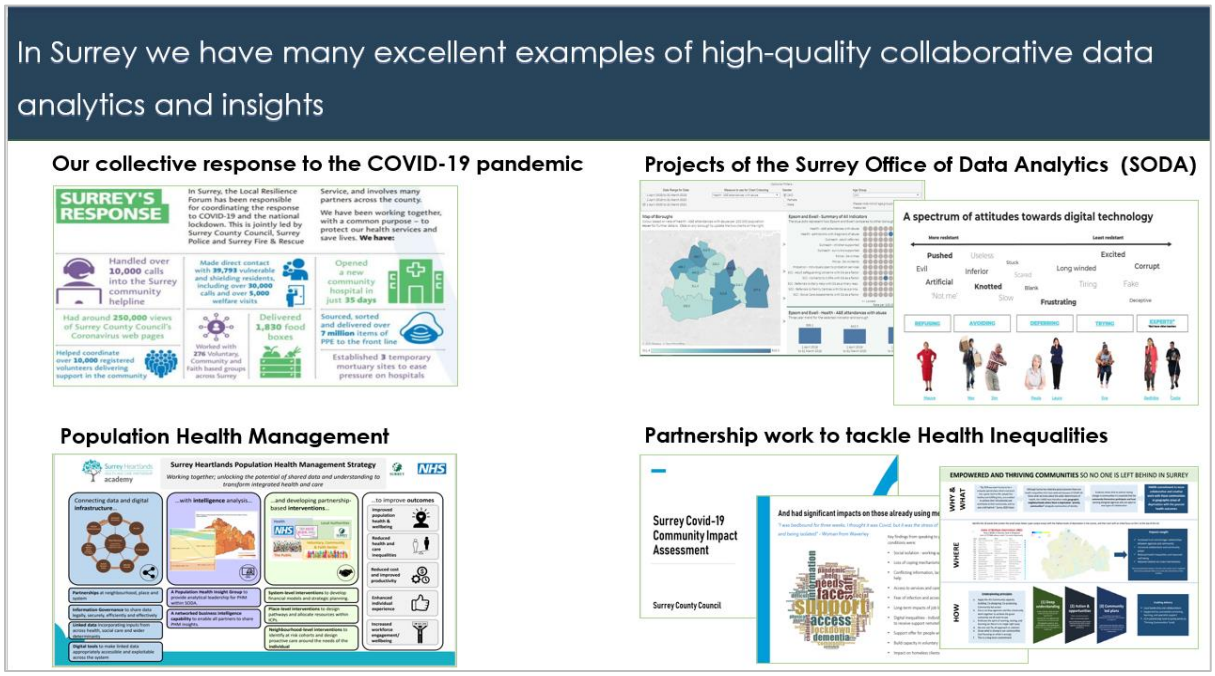
1. Introduction

One of the biggest sources of untapped potential in the public sector is data, and we are now in a position to optimise this asset across the whole system, in a joined-up way to tackle issues now and help prepare us for the future. There is now a real urgency to make demonstrable progress in the data and digital landscape – the risk of not doing so has potentially serious consequences. We have an opportunity to leverage existing strengths and harness the excellent use of data across all areas of our system to drive data and digital transformation.

Our response to the global coronavirus pandemic has demonstrated the strengths of partnership working and illustrated the benefits of information sharing, being able to draw upon the right intelligence at the right time. The way in which we have worked together and responsibly shared data across organisations to not only understand the disease, but to provide rapid response and support to the people of Surrey. This has only been possible through the analytical collaboration between the NHS, local authorities and other partners. System-wide analytical working is crucial to inform planning decisions that address cross-system priorities to deliver the best health and social care for local populations and support improved and equitable health and wellbeing. For this to happen, a multi-disciplinary approach is needed that requires analytical teams to work seamlessly with digital and IT, information governance, finance, people/workforce, service redesign, quality improvement, clinical, local authority teams and wider system partners, including Voluntary community faith sector and Police.

In Surrey we have many excellent examples of high-quality collaborative data analytics and insights, ranging from our collective response to the COVID-19 pandemic, activities led through the Surrey Office of Data Analytics (SODA), to the Population Health Management (PHM) programme, and our partnership work to tackle health inequalities. By harnessing the breadth and depth of data across our partner organisations and through the power of collaboration we have addressed issues that transcend organisational and geographical boundaries to strengthen our cross-department and system wide work.



The Health and Wellbeing Board and ICS Executive have commissioned a System wide data strategy to describe the vision and purpose for data to underpin our models of care at a Surrey level. This data strategy lays the foundations and sets the direction of travel to develop a system wide approach to how we can leverage existing strengths across the Surrey system to advance the better use of data across all of our partnerships and make recommendations for change. In this first phase of the Surrey Wide data strategy we focus on the ICS development within which effective data management is central to the requirements to become a thriving ICS.

Our vision is to build a truly interoperable data and analytics ecosystem comprising of shared data across a range of ICS partner organisations across Surrey (health, local authority, police, third sector) to help deliver better care/services to our residents now, and in the future. This will enable the aims of an ICS, strengthen collaboration, support informed decision making and evidence-based recommendations to:

- **Improve population health and health care**
- **Reduce health inequalities**
- **Enhance productivity and value for money**
- **Improve commissioning and operational decision making at a county level**
- **Support broader social and economic development**

There are four pillars which form the foundation of our data strategy.

The strategy defines our ambitions for data at a System level, with a focus at ICS level in the first phase. This is particularly opportune as we have the upcoming legislation and framework to progress rapidly to meet the new requirements and duties of an ICS. Through this we identify and catalogue our existing data assets (people, process, and technology/ environment and licenses) as well as our IG and support functions. It will identify the current barriers and blockers to effective and timely data sharing and look to the impacts on our system performance caused by those impediments.

Finally, the data strategy will set out options to create a data operating model and technical environments and an outline roadmap.

2. Case for Change

"Across the public sector, difficulties around data sharing present significant barriers to delivering more joined-up services to residents. Too often individuals are required to provide the same information to multiple agencies, risking duplication, and increased room for error. The inability to join-up different data entries about residents can also mean that vital signs of risk or vulnerability are missed, sometimes with serious consequences[1]."

Collaborative data analytics presents a unique opportunity to harness the breadth and depth of data which each organisation in Surrey holds to ensure that the work we do both individually and collaboratively is the best it can be for our residents, patients and communities.
Across Surrey we already have many examples of high-quality collaborative data analytics, ranging from activities led through the Surrey Office of Data Analytics (SODA), to the Population Health Management (PHM) programme, the Tactical Information and Analytics Cell (TIAC) work of the Local Resilience Forum during the Covid-19 response, partnership work to tackle Health Inequalities, the Surrey Care Record, our cross system Data Governance Group and much more. It is however acknowledged by partners in Surrey that siloed working, fragmented data across numerous systems, and low appetite for risk are the main barriers currently hindering a more effective use of data. Individual teams do not always have the capacity and skills to deliver new insight – and often focus on performance management rather than actionable insight.

There are a shared set of Surrey wide challenges that by their nature cross organisational boundaries, they are the reason that we need to do collaborative data analytics. These are problems that can only be tackled by sharing data, working together and developing joint solutions.
There are many issues that can only be fully understood and tackled by sharing and analysing data across partners. Some examples include frailty, mental health, domestic violence, youth crime and gangs, homelessness, substance misuse, loneliness and many more.

These problems affect our residents, patients and communities in complex and multidimensional ways and are recognised by a range of public bodies, voluntary sector organisations and businesses across

[1] KPMG – A problem shared: Sharing data across local public services.

Surrey. Within each organisation we have our own ways of framing and understanding these problems. Part of the value of collaborative analytics is to develop a joint articulation of these problems, providing the intelligence and the benefits of insights to support joint solutions to tackling them.

Across the ICS and our partners up to 70% of the time we spend on data is spent on non-value adding tasks such as working out whether we have the data and how to access it, rather than analysing it and getting the insight we need to effectively manage the system and outcomes for citizens.

Sharing of data happens, but is:

- Piecemeal – data sets much larger than required are passed around manually between partners
- Unpredictable – formats are poorly documented, inconsistent and require re-engineering to be useful
- Brittle – prone to error/failure
- Baffling – the same data is shared many times or shared, changed, and then shared again
- Unreliable – data quality issues in source systems are not fixed, but repeatedly corrected in downstream systems

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Why is collaboration important?

Collaboration can address issues that transcend organisational and geographical boundaries by strengthening cross-department and organisational sharing and collaboration with data. If partners improve the way they collaborate across the system, they can also provide better skills development opportunities for staff, and shape the technology market by speaking with a collective voice.

- Data tends to deliver most of its value when it is shared.
- Technology delivers the most value when it is scalable.
- Common standards and approaches are sometimes needed (e.g., for data sharing) that only work if all organisations take part.
- Organisations with the same requirements can save money through efficiency, economies of scale or by finding an answer once on behalf of all partners.

What are we doing about this?

Data is recognised in the Government's National Data Strategy as a strategic asset and the *'great opportunity of our time, offering the possibility of a more informed and better-connected future.'*

To meet this ambition and harness the power of data, the Health and Wellbeing Board and Integrated Care System Executive have commissioned a Surrey-wide data strategy. The steering group for this work is being chaired by Gavin Stephens, Surrey Police Chief Constable.

What will this mean for citizens?

In a system where data is collected into a single source of the truth, shared and used multiple times for primary uses, citizens will experience a number of key benefits:

- increased understanding of and confidence in the health and care system to help individuals navigate it to inform their own care journey
- improved patient experience.
- accelerated care journeys as interventions are streamlined

It will allow our health and care teams to deliver person-centric services by enabling them to:

- identify and target population cohorts that will benefit and be most impacted by interventions
- engage them and enable them to take control of their own lifestyle and care choices
- provide targeted preventative, proactive and coordinated interventions
- monitor and evaluate their compliance with goals and interventions and eventually outcomes

3. Discovery Phase

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The first phase of the data strategy is appropriately termed the Discover phase, as this is the stage in which we truly understand our current capabilities, limitations and opportunities to evolve. Four active workstreams have been driving this phase of the data strategy:

1. **Stakeholder engagement** - working with partners at a system and placed based level, to define the vision and opportunities for data sharing and collaboration.
2. **Data and technical infrastructure** - through the stakeholder engagement collating input to design high-level options/recommendations for an infrastructure that supports the vision. Examine the current technical & data landscape, engage with the technical community across the partnership organisations and identify a set of data and technical architecture models that could be implemented to meet the joint Surrey Wide data requirements.
3. **Data/analytics operating model** - mapping the analytics capability and requirements across partners to develop the operating model and make recommendations. The aim is to create a scalable solution to link and bring in any datasets, including data pertaining to population health, workforce, direct care, operational planning and reporting.
4. **Communications and engagement** - focussed on ensuring partners, workforce, patients, and residents are involved and kept up to date on progress and plans. Ensure alignment with other strategies and priorities.

There are crucial interdependencies between the different workstreams, for example the technical and data infrastructure workstream, must align with the workstream focused on the operating model and ways of working, which in turn is informed through the engagement and communications strategy.

3.1 Stakeholder engagement

Data is everybody's business and everyone's responsibility –our systems, our workforce, our communities, leaders and managers, our politicians, academic institutions, businesses and most importantly our residents. Our data strategy sets the direction of travel and provides recommendations for the next phase of our data maturity and evolution.

During the first phase of the Data Strategy development, we engaged with stakeholders across the system, focusing on system-wide needs and challenges, and those at place.

We developed different engagement mechanisms, including:

- Surrey-wide and place-based workshops
- A survey with stakeholders
- A public consultation
- Data Communities of Practice
- Showcase at existing boards and networks across the system

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3.1.1 Workshops

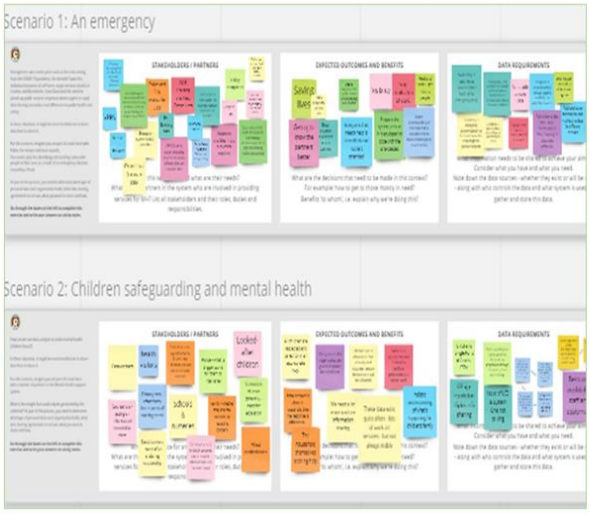
We have held over 15 workshops in total between December 2021 and February 2022, engaging more than 100 staff from 15 organisations across Surrey, including District and Boroughs, Surrey Heartlands, Surrey Police, Surrey County Council, and members of the third sector. These were online 2-hour workshops, and we used Miro Boards to collect feedback, which we have left open for ongoing feedback.

Despite the challenge of competing priorities and pressures (e.g. COVID-19, Winter pressures, workforce leave) the workshop sessions were well attended and were very productive resulting in ample insight.

Through the feedback we were able to determine key priorities, strengths for collective focus and heard the resounding desire to work collaboratively at system-wide level. The workshops have also been useful at highlighting the some of the complexities of working at a system and place-based level and the challenges that will need to be addressed. Key challenges included Information Governance, use of common language and definitions pertaining to data and considerations for a culture and mindset shift.

High-level principles to guide a common approach in areas such as data architecture, ways of working and information governance have received broad agreement, signalling that this work is moving in the right direction and allowing us to establish a common ambition and clear focus.

- **Over 15 System wide and Place Based workshops completed, further workshops scheduled** - a real desire to work together at scale.
- **Highlighted areas for collective focus**, including PHM, emergency planning, tackling problems incl. poverty and improving mental health support.
- **Emerging themes to establish a common ambition and clear focus with agreed high-level principles to guide a collective approach** - data architecture, ways of working & IG



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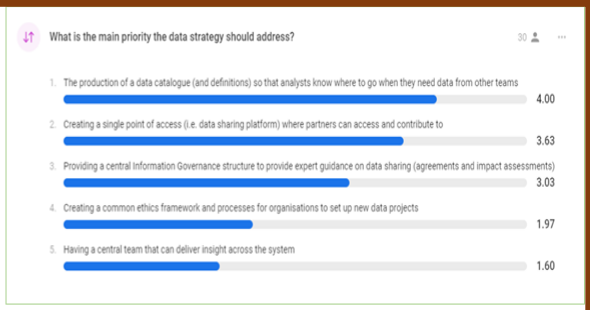
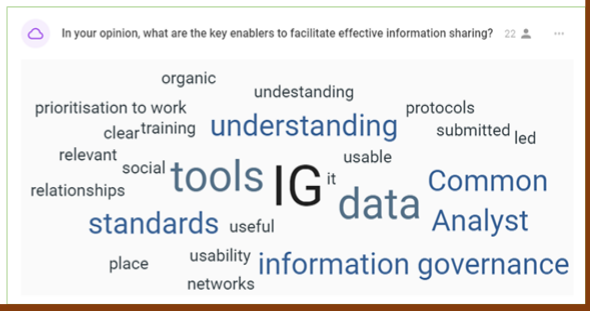
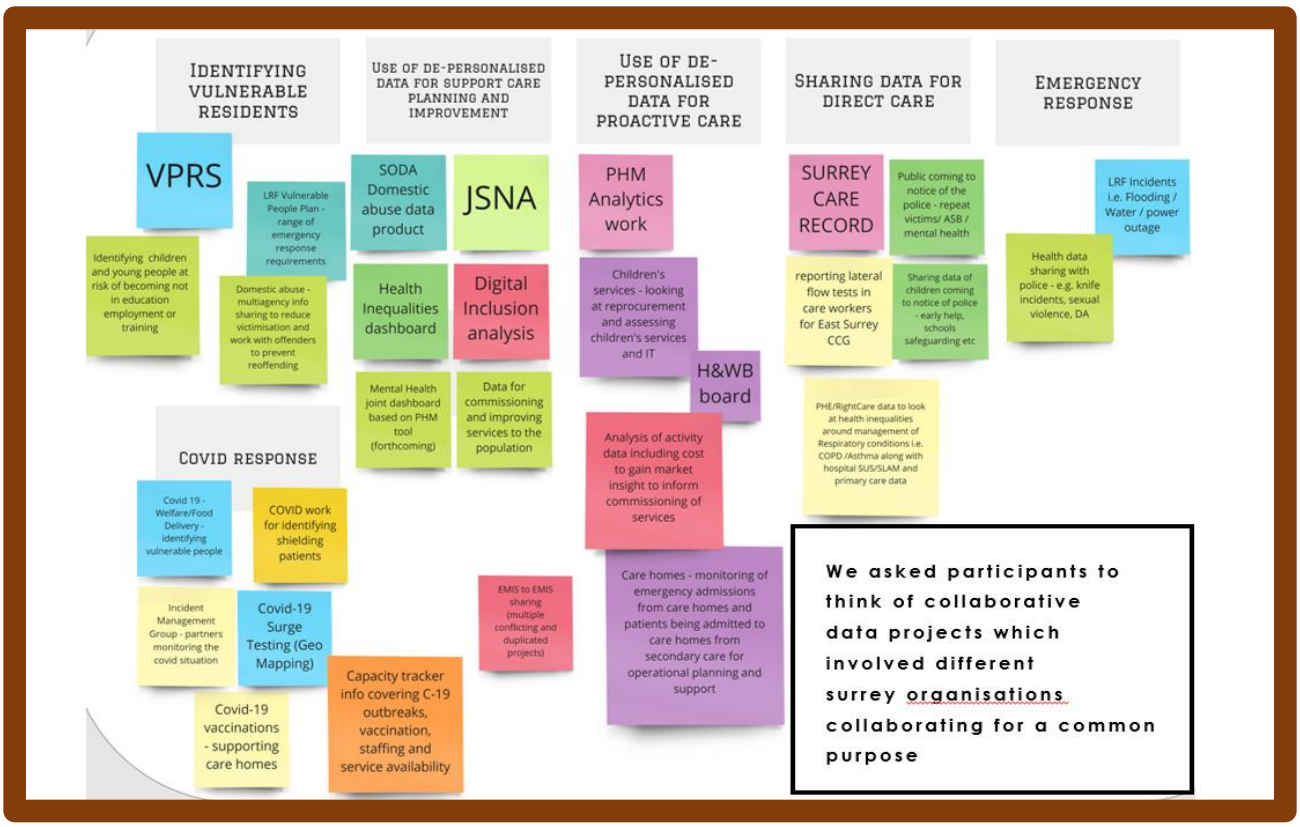
- **Deeper understanding of enablers and barriers to system wide information access and sharing**
- **Key priorities to address within the data strategy** - bottom up and top down





The workshops have highlighted many areas, including population and emergency planning, or tackling complex problems such as poverty or improving mental health support, which would benefit from a collaborative approach, and these provide an opportunity to develop solutions that could be scaled.



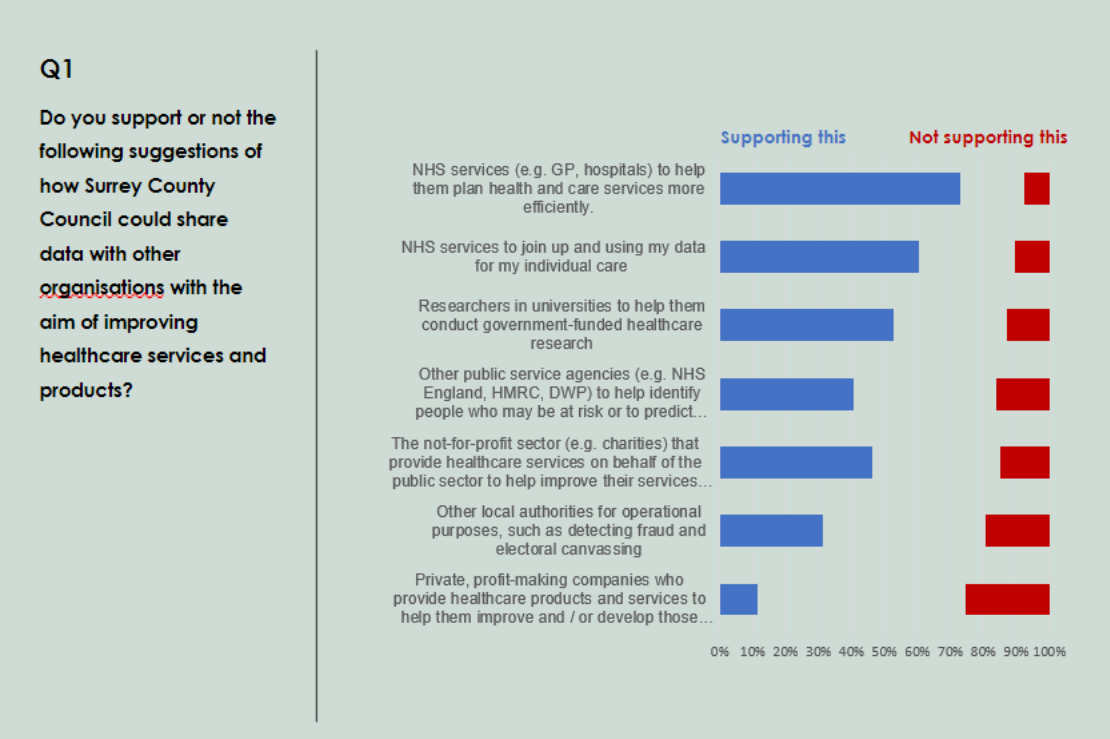
Key to the success of this work is ensuring there are agreed principles supporting the culture and mindset to work collaboratively as well as frameworks for decision making and implementation. Partners will need to focus on specific and measurable areas for improvement to create a future blueprint for ways of working, that can be scaled once established.

3.1.2 Survey

A survey was launched across the Surrey wide system to deepen our understanding of the current partner organisation data analytics, intelligence and insights functions and also to ensure our engagement reaches beyond the workshops (particularly if attendance was not possible due to competing priorities). The surveys have been cascaded to NHS, LA, Police, D&Bs, third sector through communication and engagement channels.

3.1.3 Public engagement

An initial online consultation was launched in January 2022 through the Citizen Survey platform managed by the Research team within Surrey County Council. Its purpose is to understand more about residents' attitudes to data sharing and measure their trust in organisations to look after and share their data appropriately. The consultation closed in February 2022 and received 987 responses. The findings from Surrey's public perception of data sharing survey are shown below.



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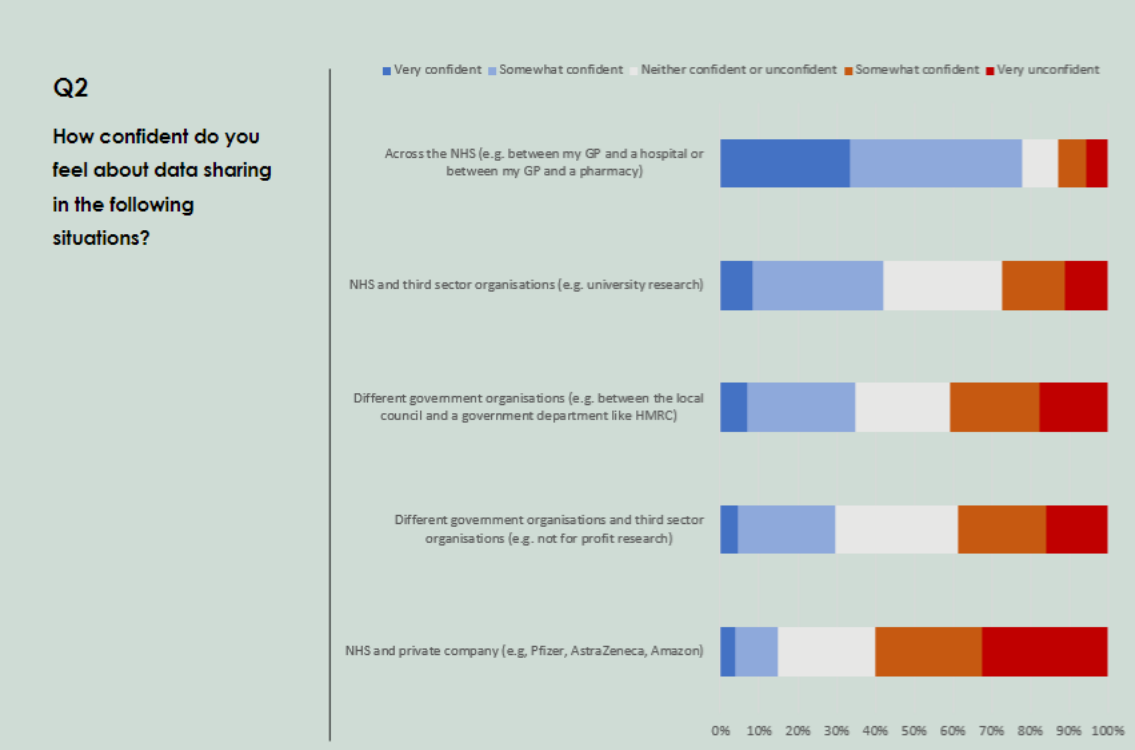
To the first question '***Do you support or not support the following suggestions of how Surrey County Council could share data with other public sector organisations with the aim of improving healthcare services and products?'*** Citizen respondents were very supportive, especially towards data sharing between NHS services for helping them plan health and care services more efficiently and for residents' individual care.

We also asked residents to tell us if *they* ***support or not support data sharing activities between the council and other private and not-for-profit sector organisations with the aim of improving healthcare services and products.***



Note: Please see appendix for raw data

In summary, despite generally the public supporting data sharing and public services handling their data for improving healthcare services and products, their confidence in the ability of all organisations to share data is lower. As part of the next phase of the Data strategy we would need to better understand the lower confidence in specific aspects of data sharing across organisations, and explore the key drivers for overall trust. We will to seek opportunities to improve citizen perception.

The second phase of this data strategy will require a more detailed consultation, this will include focus groups and a more in-depth enquiry on people's opinions and attitudes to data sharing that will inform our future practices and opportunities to improve it.

The findings will be used to inform and support work around data sharing and ethics both for the Surrey Wide Data Strategy and SCC Data Strategy.

3.1.4 Showcase at Boards and Networks

The Surrey-wide Data Strategy is being shared with colleagues across the system, including presentation at the Surrey Forum where it was endorsed by those in attendance, with enthusiasm to align this work with the collective priorities of the Forum.

The Surrey Local Resilience Forum and a number of the organisations represented on the Surrey Forum are also embedded in the data strategy workstreams.

We continue to engage with data users and analysts through the Data Communities of Practice and will be working through this mechanism as part of the next phase of data strategy implementation.

3.2 Current Data Landscape

The current landscape in Surrey for data and analytics systems is overly complex, prone to error/failure, with too many similar systems in use, and much effort spent on tasks like data management rather than higher-value functions such as data insight.

Across the ICS and our partners up to 70% of the time we spend on data is spent on non-value adding tasks such as working out whether we have the data and how to access it, rather than analysing it and getting the insight we need to effectively manage the system and outcomes for citizens.

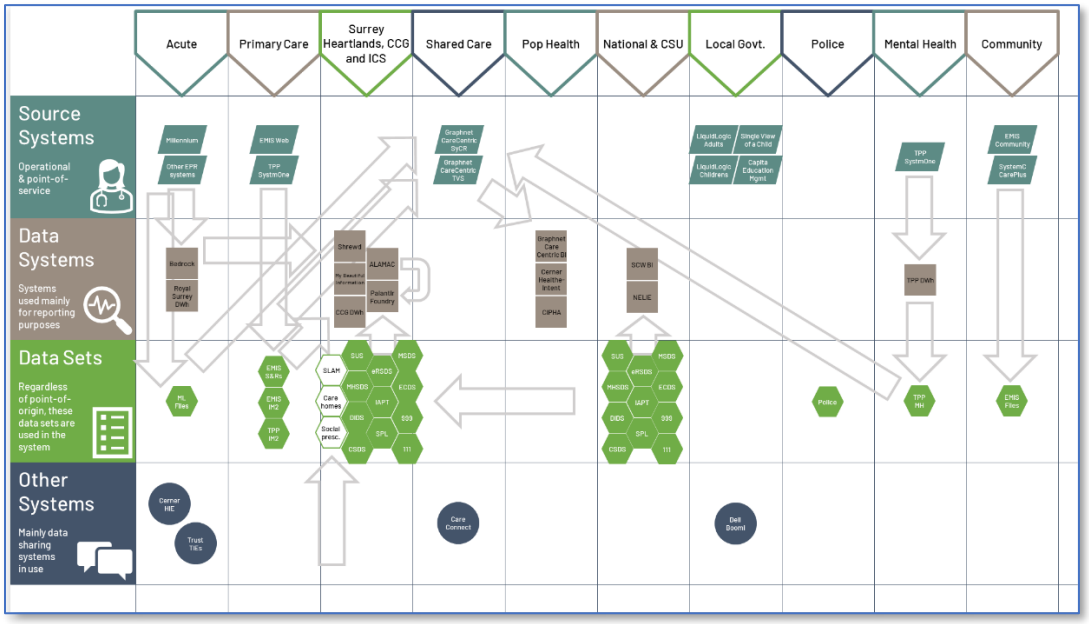


Figure 1 - Existing Data Systems

The current data landscape is fragmented, and it is becoming even more so with time.

- Multiple data partners are used for sourcing the same data, e.g. CSUs
- Data is sourced, interpreted, and then shared again, with differing outputs going to different partners
- The supply of data is at best historical (>24hrs) and at worst unreliable (primary care extracts)
- There is a large proliferation of data management solutions, i.e. over a dozen providers of analytical solutions which are duplicative and costly to manage.

3.2.1 Key Themes Arising

Some common themes emerged from over 40 interviews and multiple workshops with providers and wider stakeholders

Theme 1. **Difficulty of accessing existing data**.

- Stakeholders reported that rich data exists in their own and their partners systems, but it is difficult to access this in a usable, timely, and cost-effective way. GP, community provider data sets in particular
- Acute data is easier to access but a common Cerner data integration mechanism would be beneficial for cross trust data sharing and into the core data platform
- Shared data sets such as Surrey and TVS Shared Care Records are valuable but difficult to add to in order to enrich PHM capabilities

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Theme 2. **Making data work across functions**.

- Vocabularies, coding, and data standards do not align. Data coded in an acute setting for charging purposes may not meet the needs of PHM for example
- Difficult to match person and other data across domains. i.e. the NHS number is not universal

Theme 3. **Building trust around shared data**.

- Widespread reluctance to share data for a range of reasons from distrust as to how the data could be used, lack of resources to support data sharing externally (IG in particular) and data quality issues (in many cases, the data does not exist or cannot be physically shared)
- IG is often reactive and focused on restricting access to data

Theme 4. **Divergent approaches to data management.**

- Approaches to pseudonymisation and re-identification of data is not consistent across the system and complicates data governance
- Management of opt-outs to personal data sharing. Duplication between national and local opt out schemes

Theme 5. **Interoperability between data sources and systems**

- Open data standards such as FHIR are meaningless to non-health organisations
- Emerging health areas do not have well-developed data standards, i.e. social prescribing and online consulting

3.2.2 Data Principles

Through the work to date, the data strategy team and the wider data community have proposed a set of data sharing principles which should underpin the next stage of development of the platform

1. **Data Management**: **W*e will manage data as an asset for the Surrey partners and for the public***
   a. Data is understood and valued. It must be owned, managed, and used responsibly, whilst leveraging its value wherever possible.
   b. Data sets shall have a complete governance & ownership model (IG, business/clinical, technical) with a managed data lifecycle.

2. **Data Sharing**: ***We will ensure all data sharing shall be governed by an appropriate data-sharing agreement***
    a. We will use the Surrey Heartlands information sharing agreement for all health and social care activities where partners are joint controllers of personal data being processed
    b. We will seek to use fully anonymised personal data for non-direct care purposes wherever possible and where not possible, de-identified / pseudonymised data will be used
    c. We will have an agreed common method of managing opt outs for non-direct-care activities and pseudonymising data so this can be linked together

3. **Master Data**: ***We will collect data once and minimise duplication***
    a. A common data vocabulary across Surrey. Calling things the same name across organisations, labelling data in the same way is critical if we want to share it and all benefit from it. A common vocabulary must be used, and data definitions are available, understandable, and consistent across organisations and partners
    b. Effective governance of reference data sources shall ensure where master data exists, all partners reuse it. Master data shall be governed by the Surrey Heartlands Data Governance Group

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4. **Data Quality**: ***We will actively manage data quality across the data ecosystem***
    a. Data owners and custodians will actively monitor and measure data quality, and ensure it is fit for use, including timeliness and quality
    b. Promote reuse of data and avoid duplication. Avoid duplication of data and provide one version of the truth to support effective and efficient re use of information. Where possible, data should be re used across systems. Collect once, share many times

5. **Data Availability**: ***We will make data available to any appropriately authenticated device, application, and cloud environment***
    a. The data platform must incorporate high availability/maximum availability design, including across vendors
    b. The solution must have portability across multiple cloud vendors/platforms

6. **Data Openness**: ***We will ensure open and non-sensitive data is open by default***
    a. Users have access to the data they need to do their job. Data will be available for appropriately authorised users on demand to fulfil their services and freely collaborate and share information within that function. That function may and often will span multiple organisations.

7. **Data Standards**: ***We will make data available in open standards-based formats as far as possible***
    a. Data will be made available through open standards-based APIs
    b. Shared datasets between services are discouraged in favour of the use of APIs

8. **Data Security**: ***We will follow a 'privacy by design and default' approach when developing solutions that utilise personal data***
    a. We will ensure that all transfers of personal data between organisations and systems are appropriately secured and encrypted

b. Access to data systems shall be via strong authentication only and by a common mechanism across all partners
c. We will regularly and proactively audit access to personal data shared by partner organisations
d. Data security controls will be appropriate and not excessive

3.2.3 Principal Use Cases

Early in the project, four major use cases were identified with particular focus on the ICS landscape in line with the first phase of the data strategy. These have been consistently used in discussion with stakeholders and to shape the proposal. A detailed report contains significantly more granularity in use cases and more detailed requirements for Operational Planning. These will form the first use case for exploring the central data platform.

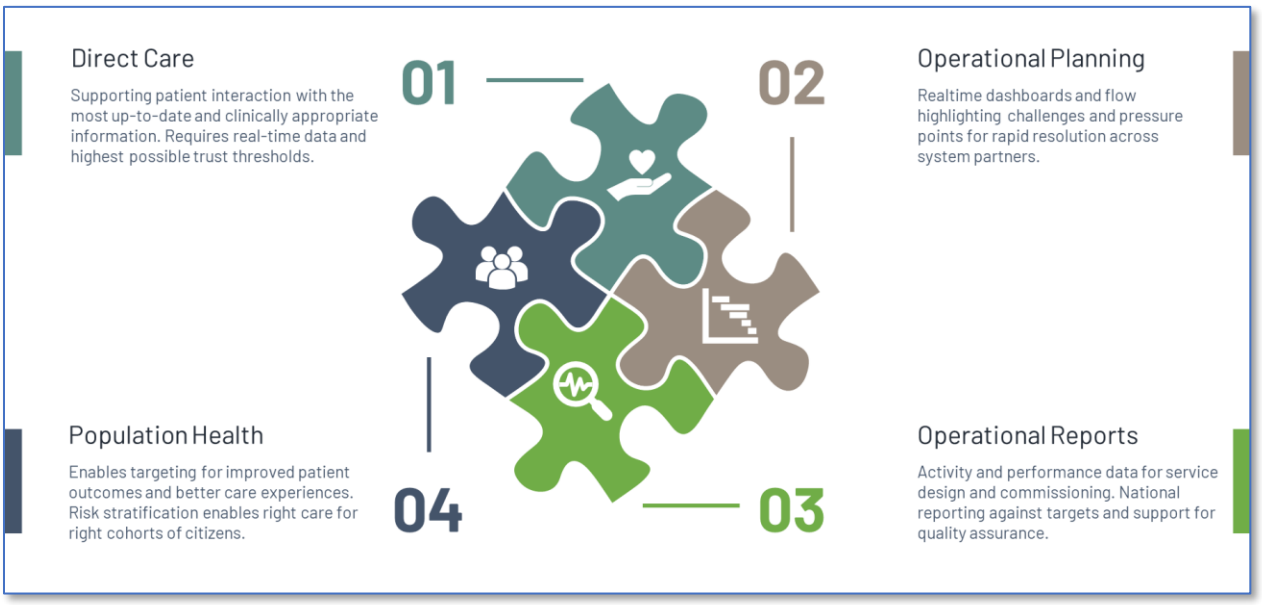

Figure 2 - Principal Use Cases

- **Type:** descriptive, diagnostic, predictive, or prescriptive
- **Identifiable:** Identifiable, or de-identified (aggregate, anonymised, pseudonymised)
- **Timeliness:** near real-time, recent, historical
- **Structure:** structured (and coded), or unstructured, e.g. image, audio
- **Access:** the end-user of this information and the use they put it to
- **Retention:** is the data discarded after use, or stored on the platform?

For further detail see Appendix 1

3.2.4. Proposed Model

To meet the needs of the use cases and providing users with the best fit of functionality, the proposal is for Surrey to develop the following four major components of a modern, flexible data sharing architecture and ecosystem. As identified during project analysis, Surrey's problem is as much effective data management as it is a technology short-fall.

Data Mesh model of operation.

A data mesh is a network of data-sharing partners governed by agreements around ways of working.

The contracts that enable participation in the mesh includes data-sharing agreements, information security, transport mechanisms and commitments around timeliness and quality of data shared into the central data platform. A core team of data professionals manage the mesh and work collaboratively with partners to ingest data into the core platform.

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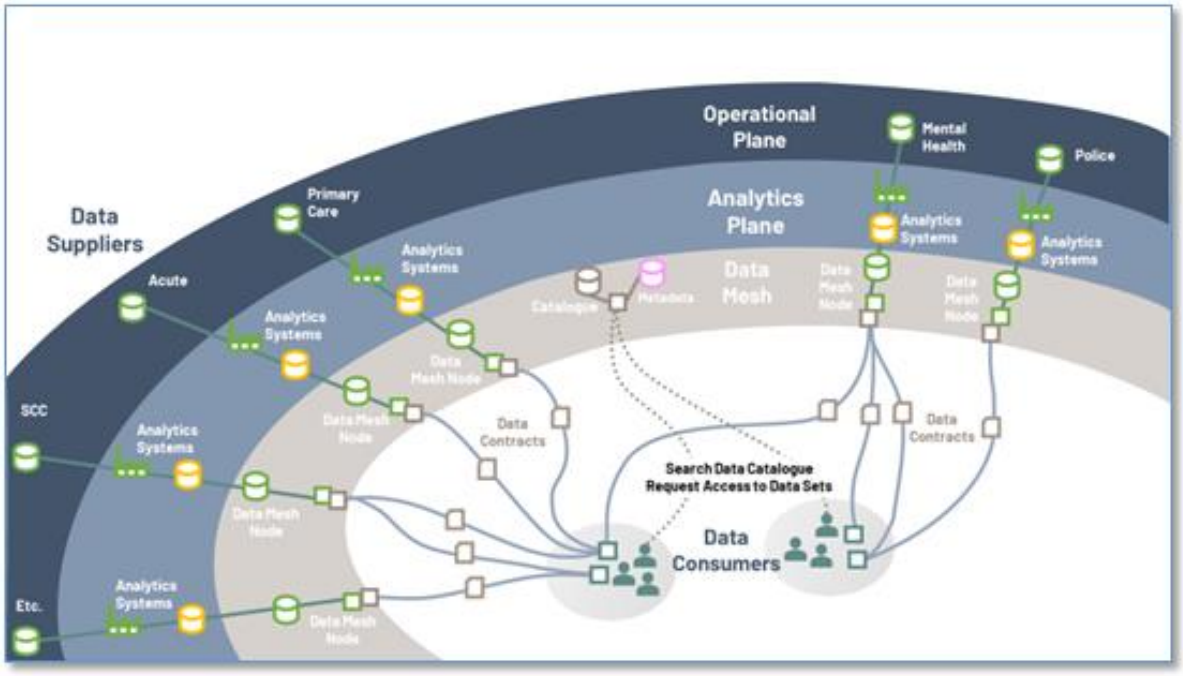

This strategy aims to put structure in place to support data sharing and make best use of each partners capabilities and improve them over time as data management and sharing matures across the system. The components of the data sharing eco-system, the mesh are as follows.

Operational Plane – these are local systems in use within the partner organisations. There are hundreds of these, and these are ultimately the *generators* of data.

Data Suppliers: multiple data supplier organisations collaborating around a data exchange mechanism. Partners are responsible for managing their data and sharing it such that it can be productively consumed by the other partners.

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Data Consumers: data is supplied through the data mesh to data consumers

a. This is 'data as a service' (DaaS), managed through data contracts for access and participation
b. A data consumer can search the data catalogue and apply for access to data sets, starting an approvals workflow process that includes the data owner
c. Data consumers in this context could be any of the Surrey data partner organisations, e.g. ICS, local government, or police; or indeed other organisations and/or the public, depending on the data set and data-sharing agreement
d. Data users, from within the consumer organisations, could be analysts, professionals, managers, data scientists and data engineers

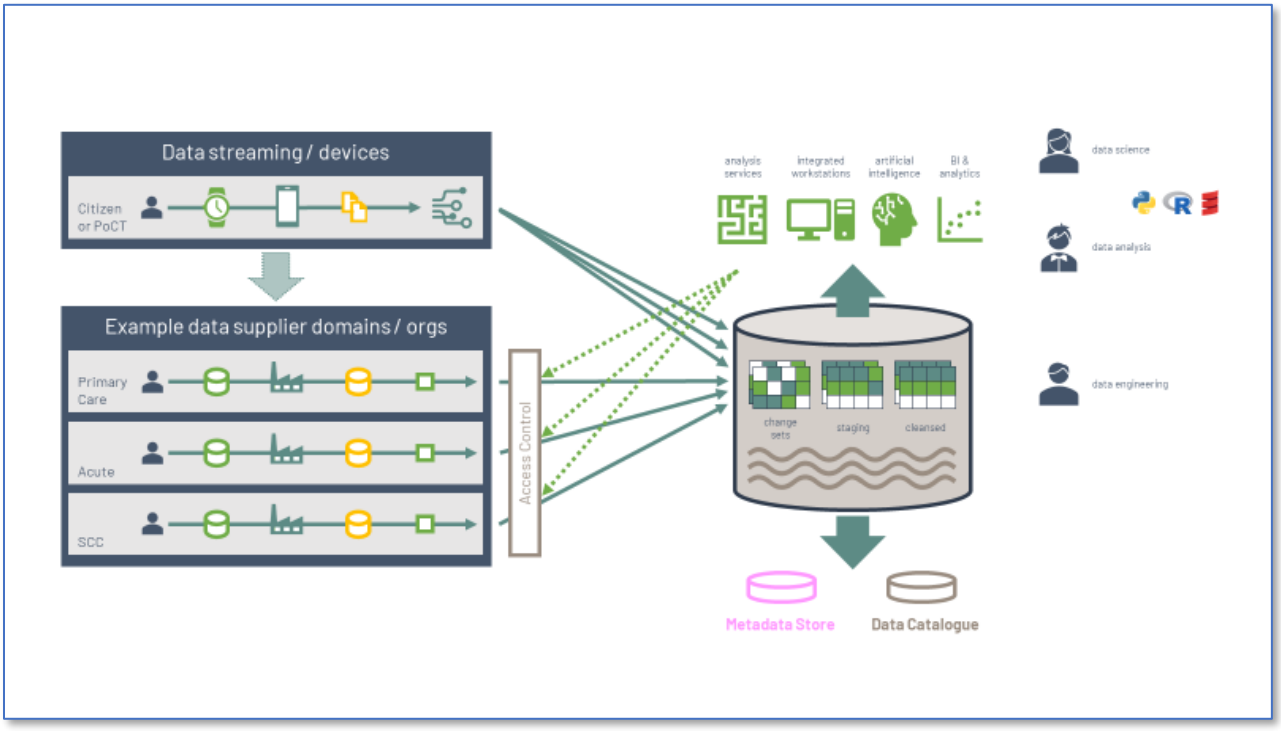
Data Contract: a data contract is a standardised agreement between data supplier and data consumer. Data contracts cover data contents, format, quality, timeliness, availability, access requirements, purpose of use/usage restrictions etc.

Data Lakehouse

A core Surrey wide data platform to support reporting and analytics across Surrey, focusing initially on the ICS and our partners. It is proposed that this platform follow a Data Lakehouse model, providing the best trade-off between tooling, efficiency, speed, and cost.
The core components of the architecture address the data issues identified through the engagement and offer solutions which meet the data principles set out and agreed between partners.

- **Catalogue:** track data sets and contracts in a data catalogue, which stores information about the data sets, and is searchable by data consumers. This allows us to identify and label the data across systems
- **Metadata:** store metadata and lineage information to support the tracking of data flows across the partnership and throughout the mesh. Lineage can also be used for system audit purposes.
- **Security Policy Engine:** operate centralised security systems that apply controls and support secure access to the data sets shared.

The core platform logical architecture is as follows:



The diagram above shows a high level structure for the central data platform and how it connects to a range of devices and data sources. The design means that we can add data sources into the eco-system as we evolve.

Data from devices (such as virtual and remote monitoring devices and personal fitness devices) can be streamed directly into the platform and used for analysis and planning.
Data from providers such as health, social care (and eventually any provider who can meet our required technical and information goverannce standards) is managed within their systems (minimising disruption to current ways of working) and imported into the central data platform through recogised data standards.

The core data platform manages the data, cleansing it, de-duplicating it, matching and compiling it. Eseentially preparing it for analysis and insight. Anonymisation will evolve to take place in the platform but we use external Data Services for Commissioners Regional Office (DSCRO) in the medium term. We wil store data catalogues and dictionaries in the central data store.

The analytics layer sits over the top and will be designed by the Surrey analytics community and support local analytics and move us from retrospective commentary to proactive and predictive analytics.

Creating a data governance function and data management team

The platform and ecosystem requires co-ordinated data governance and ongoing management . There are a number of central components to support this: The core platform and the centralised functions underpinning the mesh will require a Central Intelligence function. This core team will need to operate

Surrey-wide. In all likelihood, this means under the umbrella of the ICS, being a single incorporated body with accountability across all health partners in the system and a significant fundholder.

This core team will have a variety of responsibilities:

- Manages the metadata store and catalogue, including an audit function
- Runs the accreditation process for new joiners/data sets. This includes:
  - Central Information Governance team
  - Cyber-security (Cyber) and Secure Operations (SecOps)
- Data analyst support (to agree data content and format for the new data sets)
- Manages the core platform and roadmap development – split with platform supplier, depending on technology selection
- Engineers the data coming into the core platform, merging datasets, cleansing where appropriate

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Creating an ICS IG function and operating model

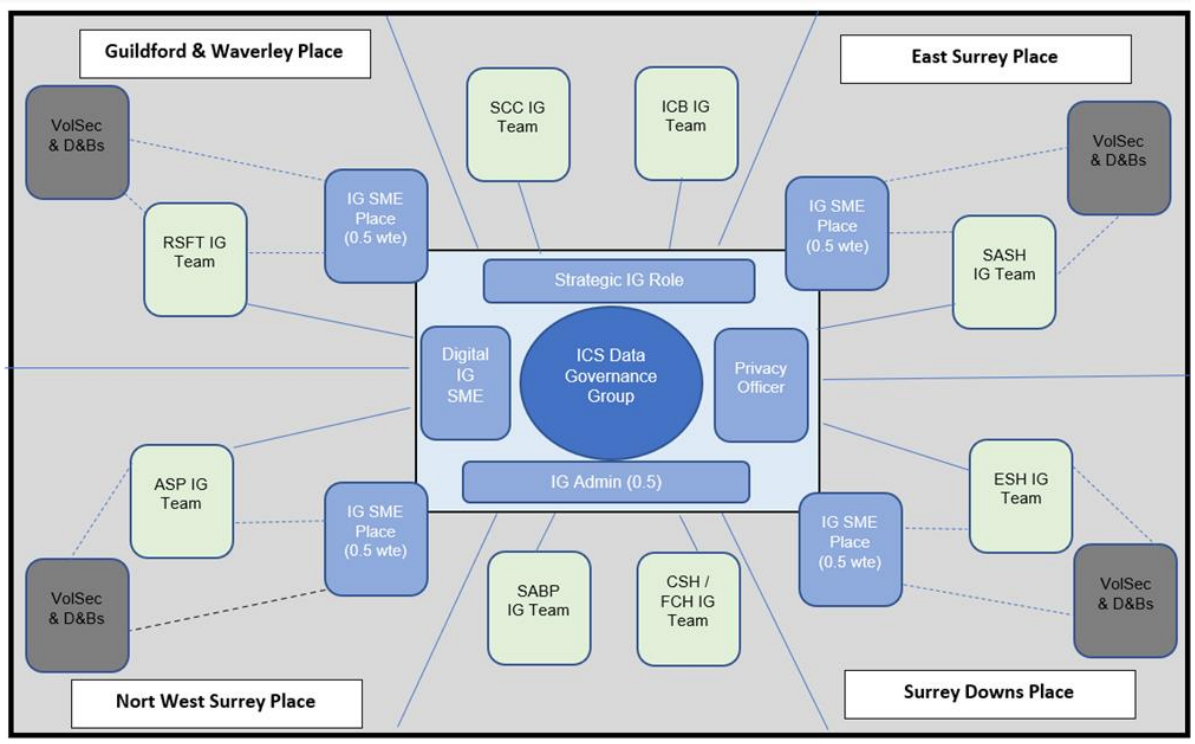
The Data Strategy and associated road map requires IG resources as follows:
A central IG function (Hub) is required to undertake the following activities on an ongoing basis on behalf of all partners involved:

- Onboarding of new partners (Data Contributors / Consumers) and local / national data-sets and data-flows;
- Management of data sharing contracts and data usage agreements;
- Initial and regular reviews of Data Contributors' compliance with the requirements specified in the Data Sharing Contracts;
- Reviews of accreditation for ICT systems utilised and the suppliers of these;
- Maintenance of central Privacy Notice explaining how data will be used and individuals' rights with respect to this sharing;
- Management of opt-outs / objections and other information rights related requests received from individuals;
- Co-ordination of proactive and reactive audits of ICT systems and usage of data accessed by partners;
- Handling / reporting of any suspected or actual data related incidents occurring.

The central function is supported by IG resources within partner organisations (Spokes) that:

- Provide assurance regarding the IG maturity of that partner and their data / systems;
- Undertake local auditing of usage of data to ensure that this complies with agreed conditions;
- Support appropriate access to data by those that require it, including de-identified data where appropriate.

This resourcing model aligns with that proposed within the Target IG Operating Model for Surrey Heartlands ICS, as detailed in the diagram below. In the following phase of the data strategy the model will require expansion, and inclusion of wider system partners including third sector, police, third sector and incorporating a trusted research environment.



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3.3 Operating Model and Ways of Working

Our vision is to have a central data and analytics ecosystem comprising of shared data across a range of partner organisations across Surrey including health, local authority, police and third sector. Within this are our aims are to improve population health and care, tackle inequalities, enhance productivity and value for money and support broader social and economic development.

It is essential that our operating model aims to support both our local and our system wide strategic goals. The Surrey 2030 Vision, The ICS Development Plan, ICB Health & Care Strategy, Population Health Management Strategy, The Joint Health and Wellbeing strategy and our JSNA (Joint Strategic Needs Assessment) goals should all align to our operating model, as well as aligning to the National Data Strategy and the NHS long term plan.

3.3.1 Partners and Partnerships

The Surrey Health and Wellbeing Board provides Surrey-wide systems leadership for integrating health and wellbeing services, promoting partnership working to secure the best possible health and wellbeing outcomes for residents. The Board agreed a new 10-year strategy in 2019 for partners to work with communities to tackle the wider determinants of health (such as the built environment) and improve wellbeing. In 2020, the Board merged with the Surrey Community Safety Board to help services

intervene early to address factors that bring people into contact with the police and criminal justice system and lead to poor health.

Surrey Heartland's Integrated Care System (ICS) is a partnership of health and care organisations working together to improve the health and wellbeing of our local population. The membership includes the clinical commissioning group and Surrey County Council (Commissioning Organisations) as well as the healthcare providers in primary care, secondary care, mental health & community care and the ambulance service (Provider Organisations)

The Integrated Care Board (ICB) is a statutory committee with executive level membership from each of the partner organisations, and responsible for producing a health and care strategy

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The organisations within the Surrey Heartlands ICS work closely together to deliver integrated care which means all the partner organisations will need to share data in order to take forward key transformation activities and achieve the planned improvements in care delivery and financial efficiency. Partner organisations will have signed data sharing agreements in line with information governance requirements to facilitate cross system analysis and support population health management. The ICB will produce a health and care strategy which align with the joint health and wellbeing strategy for Surrey.

HealthWatch Surrey is an independent champion that gives Surrey residents a voice to improve, shape and get the best from local health and care services.

Emergency services ('Blue Light') are coterminous with county boundaries.

- Surrey Police;
- Surrey Fire and Rescue (part of Surrey County Council);
- South East Coast Ambulance Service (Surrey, Kent, including Medway, West Sussex, East Sussex and north east Hampshire)
- Surrey Search and Rescue (for example missing persons, water rescue, drone imaging)

The Surrey Environment Partnership brings together Surrey County Council and the 11 district and borough councils to manage waste in the most efficient, effective, economical and sustainable manner possible. Together, they are currently updating the county's Joint Municipal Waste Strategy to introduce measures such as a deposit return scheme for cans and bottles and introducing a 'plastics tax' on packaging containing less than 30% recycled plastic.

The One Surrey Growth Board is the key strategic partnership for the economy and 'whole place'. It provides the 'Place' counterpart to the Surrey Health and Wellbeing Board. It brings together key stakeholders, such as the LEPs and University of Surrey, and has a strategic focus on Surrey's economy, homes, infrastructure and quality of life.

The Surrey Employment and Skills Board provides a collective voice for employers on skills issues that impact growth and productivity across key sectors in Surrey. It brings together knowledge, expertise and experience in the county to influence the skills agenda, and to develop solutions to the skills needs of Surrey's employers.

Other partnerships include, Universities: University of Surrey, Royal Holloway University of London, University of the Creative Arts, Businesses and Government Departments.

There are over 5,700 VCFS organisations in Surrey, supported by key infrastructure organisations.

See Appendix 2 for additional key Partnerships.

3.3.2 Context and Scope

Current intelligence outputs are a product of analyst access to data and evidence, specialist skills and knowledge, and independent software solutions. Analysts, and individuals providing analytical support, insights and outputs are dispersed across a number of agencies and organisations including:

- Surrey Heartlands Integrated Care System
- Frimley Integrated Care System
- 5 ICPs – 25 PCNs – 122 GP Practices
- 1 County Council
- 11 District and Borough Councils (different geography to the ICS)
- 1 Police Force – 3 Divisions
- 5 large acute NHS providers
- 4 community providers
- 1 mental health provider
- Multiple other wider determinant systems and third sector

Each partner organisation in Surrey will continue to require local business intelligence services for their own local reporting needs, for example to deliver contractual obligations or statutory and mandatory reporting requirements. However, as part of the Surrey wide data strategy we are focussing on our collective efforts to deliver integrated multi-agency products and as such, a whole systems intelligence approach is required. Examples of this include:

- Improvements for integrated health and care services for patients/citizens
- Better identification and targeting of hard-to-reach groups
- To develop more preventative approaches to managing population health
- Support our citizens to remain healthy and active
- To reduce inequalities within the system
- For planning, designing, and financing integrated services
- Surrey Community Vision

We have engaged with partners across the wider system, including Police, District & Boroughs and third sector. Whilst this first phase of the Surrey wide data strategy is focused on the development of an ICS Intelligence function, the following phases of the data strategy will encompass our wider system partners.

The current “As Is” analytical landscape is shown in Appendix 3.

3.3.3 The System Intelligence Function

In order to define and develop a System Intelligence Function, there are several requirements including establishing a dedicated, joint system wide analytics and insights team that is structured appropriately to respond to analytical requests from any part of the system to create coherent, logical and robust outputs for actionable insight.

The Intelligence Function supports leaders across the ICS and wider system to make better decisions through the systematic use of timely and relevant evidence. Through grounding decisions in robust analytical intelligence that draws on wide multi-disciplinary knowledge and expertise, we can respond and support targeted, more effective use of resources.

The Intelligence Function will promote innovation and inform decision-making at all levels of the system, from strategic decision-making about cross-system transformation, to planning care and managing operations at place level, to applying near-real time population-based insights at District & Borough, PCN/neighbourhood level. This function will need to be closely linked to a wide range of stakeholders, including system- and place-level leaders, operational managers, Council functions, public health, and frontline staff, who will provide steer on the types of tools and analyses required to help understand population need, set population-based budgets, and deliver proactive clinical and operational working. Moreover, the Intelligence function will be flexible and agile to work across the wider system footprint, which will include Police, District and Boroughs and the third sector. In this way, the Intelligence Function is well placed to deliver the ambitions and activities of system wide activities, including SODA.

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In addition to responding to the needs of decision-makers, the Intelligence Function will also drive cross-system priorities, producing analyses and evidence that identify areas of opportunity and ultimately enable the coordination of care across systems, place and neighbourhoods by supporting operational workflow management between different care providers.

One key purpose of the System Intelligence Function will be to support a Population Health Management (PHM) approach care, including by developing a detailed understanding of our population's health and care needs, including granular intelligence on inequalities across different population groups. This will be powered by a person-level, linked data set, which should evolve to include information about the wider determinants of health. The System Intelligence Function will support leaders at all levels to tackle health inequalities and drive down unwarranted variation in care quality.

Together with other teams across the system, beginning in the first phase with the ICS, the Intelligence Function will support staff to proactively use analysis to drive transformation. Intelligence professionals and clinicians across the ICS will have access to a Population Health Management platform that performs standard analyses, such as population segmentation and risk stratification, so that care can be targeted and personalised to the greatest effect. As population health analytics develops further, our focus will shift from condition management to the use of predictive risk factors to aid early detection and the prevention of ill health.

Another key role of the Intelligence Function will be to drive high standards of evidence-based decision-making. In any given scenario, the desired intelligence may not always be available, and as such it will be the role of the Intelligence Function to advise decision-makers when their evidence is not fully fit for the specific issue at hand, ensuring that uncertainty and other limitations of data are understood and responded to accordingly, and thus helping to maintain high standards not only in the quality of intelligence but also in its application.

3.3.4 People, Training and Development

Organisational design is a critical element of how the operating model will enable integrated, collaborative ways of working.

It is important that this analytical workforce is upskilled to understand data from parts of the system as well as exposure to different ways of working, skills and expertise.

As part of the next phase of the Surrey Wide Data strategy, we plan to undertake a skills and capability assessment from across the system to develop a skills matrix which will inform our training and development strengths and needs. We aspire to develop a training and development model that champions learning, integration and joint working across partner agencies. As part of this model we will focus on recruitment, and retention through clearer career pathways for analysts and other colleagues in health and care.

Collaboration at an ICS level to develop a fit for the future analytic workforce with effective career development structures is critical. We will develop a strategy to build the required resource capacity and skill mix for our future analytics capability.

3.3.5 Ethics

We propose the formation of a Data & Digital Ethics Committee to:

- Provide strategic oversight and scrutiny of the key Data & Digital programmes
- To ensure consistent best practice application of the ethical use of data in all programmes
- To ensure that a valid IG framework is in place to support the effective sharing of data for the benefit of the citizens of Surrey

3.3.6 Recommendations for an Operating Model

There are a range of possibilities for consideration:

- **Dispersed** - Analysts are embedded within organisational teams without a central team or formal co-ordination.

- **Functional** - Vast majority of resources remain within current organisations, but there is some central support e.g. for standards and training.

- **Centre of Excellence** - A Centre of Excellence drives creation of standards, facilitates sharing between functions, and undertakes some tasks, but the majority of work and people remain within organisationally aligned teams.

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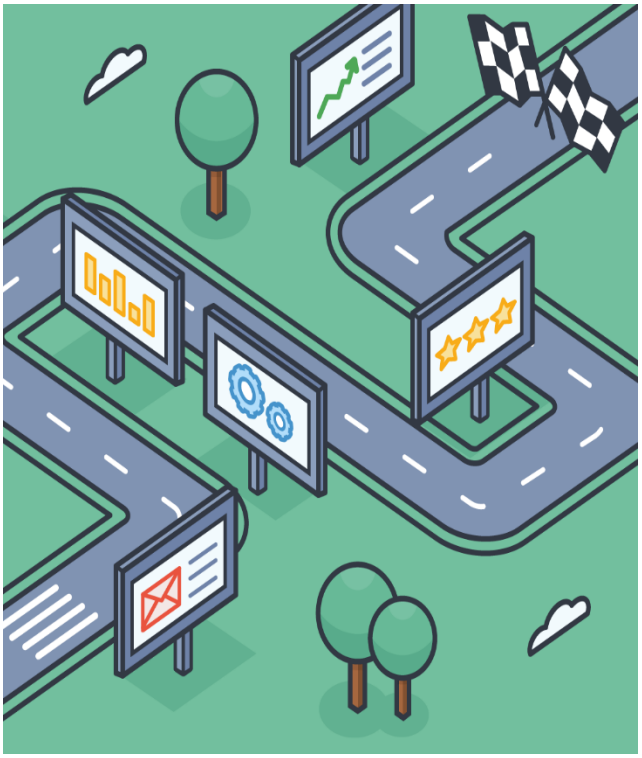
- **Hub & spoke**- A central hub provides advanced capabilities, drives priorities, aligns local activities, and facilitates sharing. Functions drive local execution, customisation, and more tactical function-specific analysis.

- **Centralised** - All analyst resources sit within a centralised team. All reporting and analytics is owned by the Centre of Excellence and undertaken through engagement with the Centre of Excellence

The second phase of the Surrey wide data strategy will explore and co-design the wider system Intelligence function.

4. Next steps



In line with the ICS development plan, the immediate next steps are to develop high level costs to support an outline business case for the ICS. This step will involve testing the proposed models and exploring key questions related to the platforms, functionality and most importantly data operating models. This work is aligned with the creation of the Surrey digital and data investment roadmap and costed investment plans.

The Surrey Wide data strategy will enter the next phase of testing, implementation and mobilisation. This will include establishing the associated workstreams with membership from across the system. These workstreams will be tasked with the next phase to provide that granular insight to define the design principles, recommendation and detail underpinning the four pillars - Purpose, Infrastructure, People and Opportunity.

We will maintain ongoing stakeholder engagement and communications throughout the next phase of the strategy. As part of the ongoing engagement we will develop a change management approach to reach the new Operating Model – including culture and mindset shift through adoption of a large scale change strategy.

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5. Appendices

Appendix 1: Use Cases

01 – Direct Care

Direct care – in the sense of face-to-face clinician/patient interaction – implies a real-time and clinically reliable data set. The best Surrey-wide *longitudinal* record (combining data from multiple sources) is the SyCR (or the TVS system), but this data is subject to time-lags – aggregated from a variety of sources in bulk overnight – and is by its nature, summary.

Partner-to-partner data-sharing in support of extended patient pathways/direct care is more commonly the preserve of integration technologies, i.e. messaging-based interoperability solutions like the Cerner HIE found in the Surrey Acute Trusts. Exploiting those capabilities and integrating that data into to Surrey wide data platform is the recommendation.

There is another example of direct care: piping intelligence data, discovered by the data platform, back into those systems. This scenario might include e.g. notifying clinicians of a high disease risk-factor for follow-up within a consultation. Or management and actioning of prioritised waiting lists across the system and across providers.

Examples of the Direct Care use case which can be explored with suppliers include:

- Referrals between health domains
- Future appointment scheduling from shared patient tracking lists
- Real-time access to mental health and housing data in support of a section 136 assessment

02 – Operational Planning

The operational planning use case – also called 'command centre' or (as currently used in Surrey), 'surge hub' – is a close to real-time view of service pinch-points across the system. With a constant feed of operational information, a picture can be built up which allows service improvement, e.g. redirection of patients to other services.

This use case is especially interesting when we think about the levels of analytics:

- **Descriptive** – a near real-time view of current service/problems
- **Diagnostic** – a system which explains why service issues are happening for human resolution
- **Predictive** – it becomes very powerful when the system can look forward to problems that will occur in the future, allowing time to put mitigation in place
- **Prescriptive** – employing AI, such a system can tell managers what to do about forthcoming problems, provide models that describe the impact of making those changes, and even reroute services accordingly/automatically

The challenges of aggregating this data are large, especially considering the number of potential data partners involved and the mobility of some of the systems, e.g. ambulance location information. The cost of narrowing the gap from, say, 15 minutes to <1 minute may well outweigh the benefits and certainly for the predictive/prescriptive levels of analytics, is largely unnecessary. Equally, a view of future appointments across Acutes does not need to be real-time.

From a service and recovery point-of-view, this is a crucial use case, but one that is very difficult to meet with the current estate. Except for a few pilots, most data are collated periodically and must then be processed through various data layers before being presented. The ultimate solution will be to proactively send these data to APIs around the core platform and/or provide query mechanisms into the supplier systems so data can be fetched on demand/frequently.

Examples of the Operational Planning use case are:

- Status dashboards indicating bed-state across Acute trusts, or awaiting discharge into the community
- Predictive dashboards for urgent care, correlating data against time periods (Friday nights in winter) and events (football matches, bank holidays)
- 111 and ambulance services activity, tracking and utilisation levels
- Significant activity in 111, Acutes, external events that will impact on GP, or *vice versa*

We propose using this use case to develop the thinking around the solution and engaging with suppliers in initial conversations.

03 – Operational Reporting

Operational reporting is the bread-and-butter of business intelligence in the region. It is the largely descriptive analytics that report what has happened for activity tracking and payment purposes. Examples of this use cases are the many statutory reports that need to be produced by the data partners, the national submissions of activity, and the commissioning reports from secondary care.

Quite what operational reporting constitutes is dependent on the organisation. Most of the individual organisations within Surrey produce their own reports and submit them to national bodies independently. In the early days of the future platform, this is not likely to change.

However, reporting that already crosses organisational boundaries, e.g. the CCG data warehouse, should be an early candidate for migration to the centre – indeed it is likely to form the backbone of that platform, as will the team managing the capability currently.

There is also a good, consistency argument for submitting all national returns via the platform as a precursor to more of the actual reporting effort being tackled on the core system. In many cases, producing the reports within partner organisations is costly and can be error prone. How and when the 'centre' takes on more responsibility for the function will be investigated , though as partner organisations are onboarded, we'll need to evaluate on a case-by-case basis. See §**Error! Reference source not found.**.

Examples of the Operational Reporting use case are:

- A&E performance against wait-time targets
- Referral to Treatment waiting times
- Commissioning returns (CDS) from Acute
- Cross-organisation outcome reporting demanded of the ICS

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04 – Population Health

A small number of use cases are supported to date by the Graphnet platform, that is available for use across the system. These focus on the real time, direct clinical care needs in the main. Separate to this however, there is a need to have much greater analytical capabilities and datasets to support a wide variety of other use cases relating to strategic level analytics for more longer-term analysis

Population health is best served by the widest possible sources of data, and it will take time to build up this capability. To date, sourcing the data, ensuring it is covered by the right sharing agreements, and that it is harmonised usefully has proved an arduous task.

As the ICS comes into being and as so much of its success will be measured against improving population outcomes, the demands on population health data systems will grow.

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As stated, the pop. health use case benefits from data from a wider-range of systems, with local government information being especially useful. Focus should be given to improving the flow of information from these other sources (social, environmental). The traditional demand of a pop. health system is that it should present an aggregate view of determinants across a health system. 'Drilling' into the record should (access controls permitting) allow a clinical/social user to identify individuals to target for intervention.

Examples of the Population Health use case are:

- Identifying cohorts of people living with Frailty at risk of deterioration
- Determining links between physical and mental health, e.g. people with a long-term condition suffering from non-treated anxiety
- Targeting patients from socially deprived backgrounds with dependency issues

Appendix 2 - Partners and Partnerships

Surrey Community Action (SCA) is a county-wide independent charity which supports voluntary and not-for-profit groups with advice and services to help them operate more effectively. In addition, there are five Councils for Voluntary Services that lead on providing infrastructure support to VCFS organisations across the county.

The Community Foundation for Surrey brings together local philanthropists with local organisations that need funding and other resources. In 2019/20, the Foundation awarded over £2 million in grant funding across over 445 grants in Surrey. It has also played a key role in Surrey's local response to coronavirus through its Coronavirus Response Fund, which has supported 100,000 people locally and awarded £1 million to charities and voluntary groups to enable them to respond to local needs.

The Surrey Association of Local Councils provides infrastructure support to 82 parish, town, village and community councils. This includes training, networking and representing their interests with agencies across the county.

Organisations supporting a strong Surrey economy

• Surrey is a member of two Local Enterprise Partnerships whose role is to bring together private, public and not-for-profit sector organisations to agree local economic priorities and deliver projects that drive economic growth and productivity.

• Enterprise M3 – covers West Surrey and most of Hampshire, serving a population of 1.52 million people and 89,700 businesses, and generates £49 billion Gross Value Added (GVA) for the UK economy.

• Coast to Capital – covering Croydon, Greater Brighton, East Surrey and West Sussex, serving a population of over 2 million people and home to major international brands, such as Body Shop and Canon, and delivers £50.7 billion GVA for the UK economy.

• The Gatwick Diamond initiative is a business led partnership covering East Surrey and West Sussex, with a goal of growing new and established companies to ensure the area thrives. It aims to grow the region's existing jobs base, attract new jobs and secure investments from companies that closely match the industry strengths of the area.

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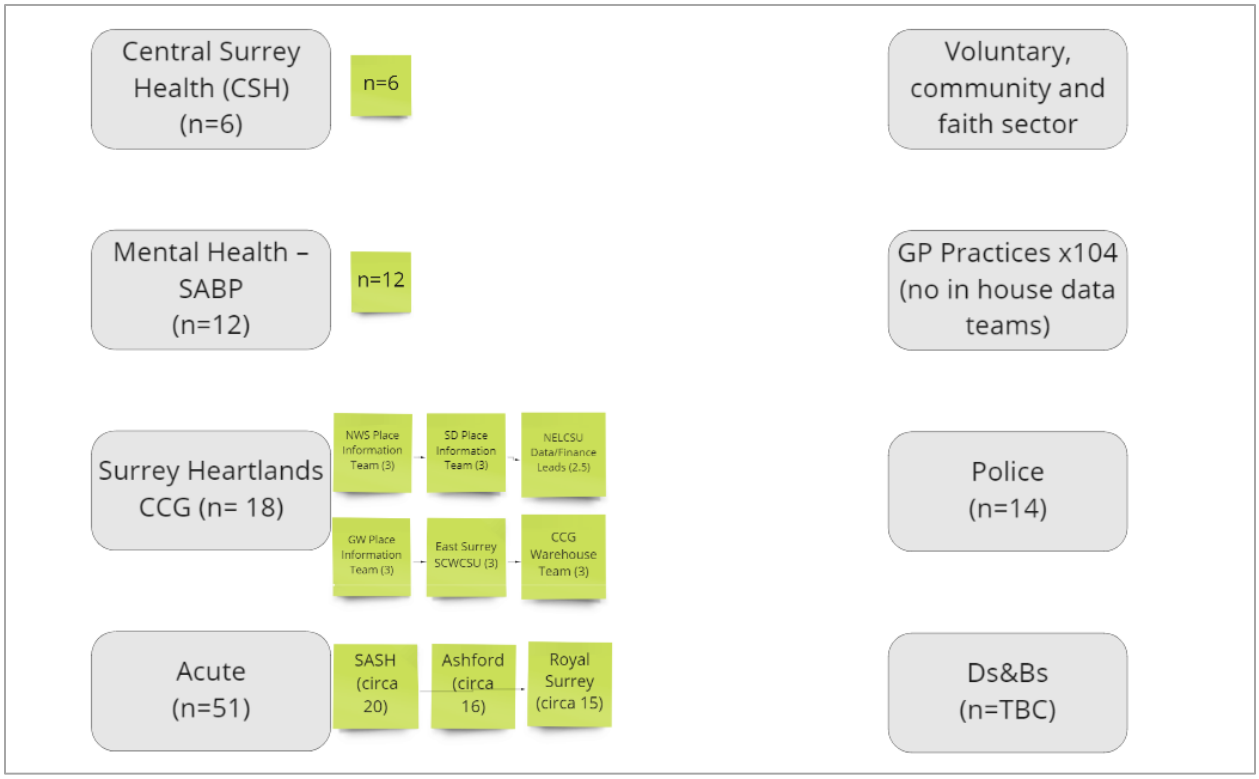
- Surrey Chambers of Commerce
- Federation of Small Businesses
- Institute of Directors (Surrey)

Appendix 3 – System Wide Analytic, Insights and intelligence teams

Appendix 3.1: Wider System Analytic Teams


Central Surrey Health (CSH) (n=6)
n=6
Voluntary, community and faith sector
Mental Health – SABP (n=12)
n=12
GP Practices x104 (no in house data teams)
Surrey Heartlands CCG (n= 18)
NWS Place Information Team (3)
SD Place Information Team (3)
NELCSU Data/Finance Leads (2.5)
GW Place Information Team (3)
East Surrey SCWCSU (3)
CCG Warehouse Team (3)
Police (n=14)
Acute (n=51)
SASH (circa 20)
Ashford (circa 16)
Royal Surrey (circa 15)
Ds&Bs (n=TBC)

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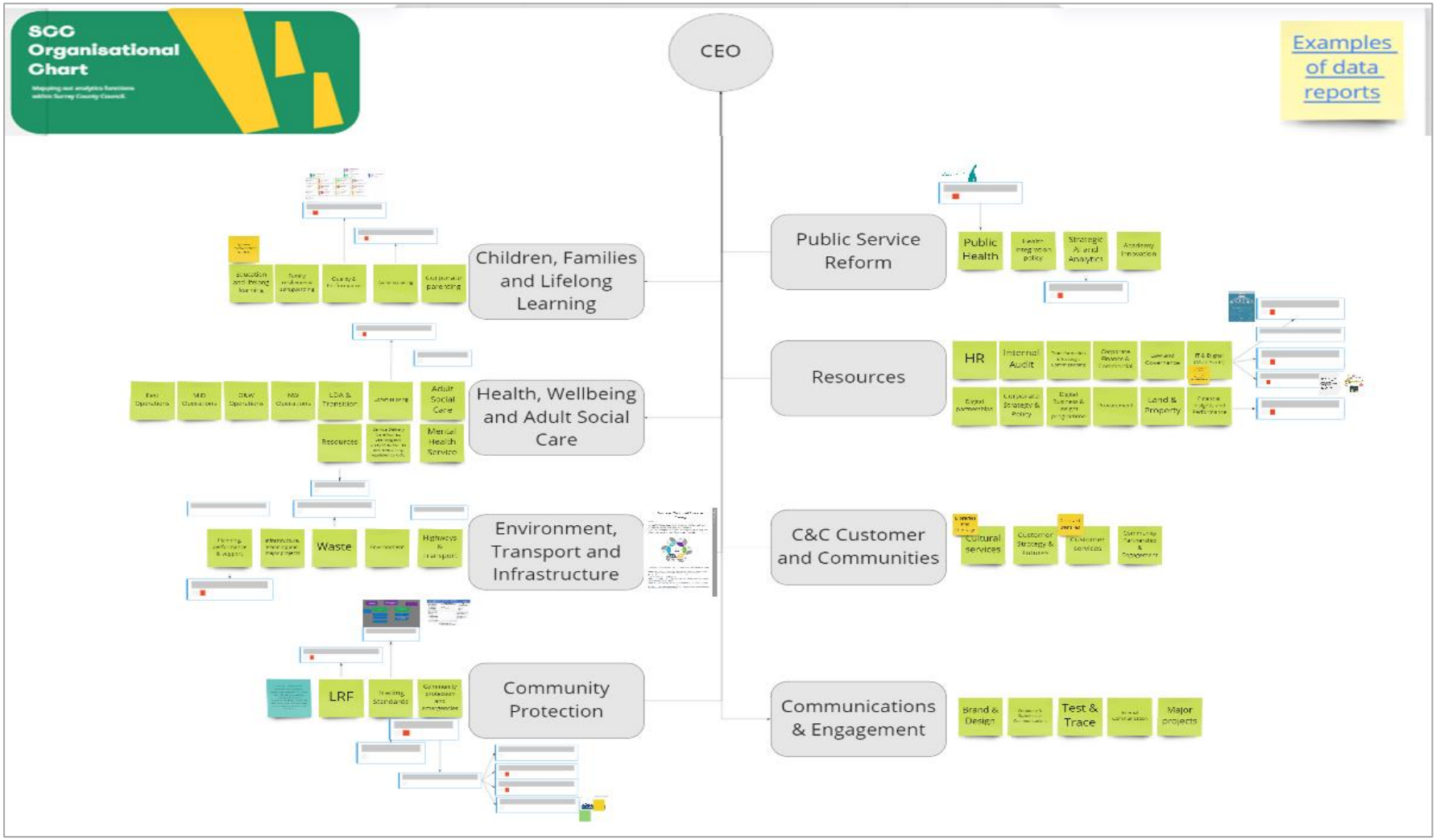
Appendix 3.2: Surrey County Council Analytic, Insights and Performance Teams.



Adult social care (ASC)

Contract Monitoring and Performance Team – 6 members

They design performance and outcome frameworks for all services externally commissioned by ASC.
They work with commissioners to build specs for performance monitoring frameworks, facilitate conversations with providers and support brokerage systems to help them with their operations.
Type of analysis include needs assessments, performance management, service evaluations, financial analysis, user engagement, data-based process audits, outcome measurement.
CCSS Tableau Server Inventory

Business Intelligence Team – 5 members

They design performance and outcome frameworks for all services by ASC in line with national statutory frameworks, statutory returns, and assurance frameworks. They work with all data from Adult Social Care except for Commissioning. Click here to access more information.
They specialise in data for decision making and use the data in their possession, as well as national and regional datasets, to provide useful insights to the Adult Social Care leadership team, to CLT (through Deep Dives), work with frontline teams build specs for performance monitoring frameworks and lead on all Tableau reporting and automation. They support business strategies and transformation programmes.
Type of analysis include service evaluations, modelling, user engagement, system mapping, data-based process audits, outcome measurement and more.
They work in the Southeast region, hosting the Tableau dashboard for their reporting (the Association of Directors of Social Services Dashboard, which holds the unvalidated data before it goes to the health department in central gov).
They maintain the VPRS system - running vulnerable adults reports and have strong links with emergency duty teams. They link with BI teams internally and in other authorities and are members of the Surrey Office of Data Analytics.

Public Service Reform

Public Health Team (PHIIT) - 11 members

PHIIT is a specialist data team sitting in Public Health. They design performance and PH outcome frameworks, including for all services externally commissioned by Public Health (e.g., on Substance Misuse, Sexual Health, Weight Management Programme, Tobacco Control Services, etc), and are responsible for the directorate's operational and statutory reporting (e.g., the Joint Strategic Needs Assessment, the National Child Measurement Programme, the Pharmaceuticals Needs Assessment, etc.). They also specialise in data for decision making, and use the data in their possession as well as national and regional datasets to provide useful insights in the following areas:

- Developing models and capabilities
- COVID-19 Surveillance and Vaccination

- Death Surveillance
- Modelling (e.g., Death modelling, predictive analytics, and projections)
- PH Systems (e.g., Hospital Episode Statistics, Primary Care Mortality Database, Births, etc)
- Performance and Public Health Agreements
- Needs Assessments and Audits
- Health Inequalities and wider determinants of health (metrics and Social Progress Index)
- Weight Management
- Better Care Fund
- Public Health intelligence (e.g., Annual Report, Ad-hoc FOI requests, etc)
- Population Health Management

More information can be found at this document, which includes an organigram.

BIA Analytics and Insight – 5 members

Structure TBC. This is a new team, that includes the Population Insight Team

IT & Digital

Data Analytics Centre for Excellence – 6 members

The Data Analytics Centre of Excellence is responsible for driving the analytics mandate across Surrey. They support the Self-Service Analytics Tools – Tableau, SQL Operations Studio, FME and Provalis.
They provide data services, analytics on-boarding and community leadership within the data analytics forum.
The services they offer are:

- Self-Service Analytics: creating, facilitating and enabling a data community within the Council
- Data expertise: unlocking data to be exploited for analytics, insight and smarter service delivery
- Solution delivery: end-to-end analytics solution design and provision
- Analytics market appraisal & evaluation: equipping Surrey to take advantage of the latest toolsets and techniques
- Next generation analytics: developing capabilities within the staff for advanced analytics
- Platform and solution support: Full technical support for analytics platforms, solutions and users

Dev Ops

Looking after the SQL server within Surrey County Council (~1000 databases, which include LCS, LAS, business apps, legal requirements, GIS etc)
They look after all MoT mechanics for all systems within the Council
Mostly use data for performance of their own team, rather than using data for business.

GIS Analytics Team – 3 members

they have some core products ESRI and create maps with different open datasets.

- Portal
- Desktop software
- AGOL

Building GIS products for teams that do not have GIS teams (e.g. culture team, History Nomination programme).
E.g potholes application using API from supplier
GIS data catalogue
Team members

Digital team

Focus of Digital 2022 / 2023

- Working with Executive Directors to articulate Digital Ambition and reflect this in roadmaps
- Focus on moving Digital to the heart of our design
- Moving the focus to delivering benefits, opposed to layering Digital on top of what we have
- Establishing and embed the Digital Operating Model
- Reviewing our programme delivery model
- Working to identify the opportunities or problems that services are trying to solve
- Joining up cross organisation opportunities
- Supporting capabilities commissioning the Data Academy courses for services that need it

Performance Team – 4 members

The Performance team is a specialist data team sitting in the Resources Directorate.

They are responsible for the collection of quantitative and qualitative data to assess corporate performance for the Resources directorate (there is no central function for this within the directorate at the moment), and for the wider corporate performance reporting (which they share with the Corporate Leadership Team, Cabinet and Scrutiny Committees).
They recently embarked on a Resource Directorate Improvement Plan, building a performance framework with all Heads of Services within the Directorate of Resources. This review serves two purposes:

- Operational: what info they need to deliver day-to-day services (including Audits, etc)
- Strategic: understanding what is needed to deliver strategic objectives (currently mostly linked in through KPIs. They currently identified 200/250 KPIs that include quantitative, qualitative indicators and future ambitions.

They will also launch a performance maturity assessment, focusing on 7 key pillars of data maturity.
Considering a review of performance frameworks (2022 - 2023) - Off the back of that they will relaunch a different performance framework

Children, Families and Lifelong learning (CFL)

Analysis and Evaluation - 5 members

Analysis and Evaluation is a specialist data team sitting in CFL Commissioning.
They design performance and outcome frameworks for all services externally commissioned by CFL and are responsible for the collection of quantitative and qualitative data to assess service performance.
They specialise in data for decision making and use the data in their possession as well as national and regional datasets to provide useful insights to commissioners, so they are empowered to develop their strategic approach and contract management activities.
They regularly participate and lead in needs assessments, performance management, service evaluations, financial forecasting, modelling, user engagement, system mapping, data-based process audits, outcome measurement and more.
They maintain strategic links with research institutions and are active members of the Surrey Office for Data Analytics.

Performance, Intelligence and Systems Team – 15 members

The Performance Intelligence and Management Information Systems (PIMIS) team sits within the Quality & Performance Service.
The purpose of the team is to ensure timely performance reports are provided to a variety of audiences and that statutory returns and collections are completed successfully.
Performance reporting is carried out both on a business as usual and an ad hoc basis. Most BAU reporting is produced via Tableau, although the team also uses Excel and other tools for analysis where required.
They work with IT systems staff and operational staff and managers to ensure electronic systems are fit for purpose and exploited to their maximum.
They develop and maintain effective working relationships with operational managers and practitioners to understand their requirements and provide information that is up to date, accurate, accessible, and understandable.

This includes working with the Analysis and Evaluation team and with finance to bring together historic reporting and analysis with forecasting and modelling and with financial data.

Environment, Transport, and Infrastructure (ETI)

Systems, Strategy, and Improvement – 3 members

This team sits within the Planning, Performance and Support service which supports the ET directorate. They are responsible for implementing the IT strategy (attached) that covers data and reporting. They work with data across a whole range of areas and will cover the collecting, extraction and visualisation of data with Tableau and FME (where needed).
They will work in many areas providing all performance reporting (Contractual, Service, DLT) as well as solutions for team to help them manage their processes or projects. Examples of this are Carbon Reduction, Street Works Permitting, Portfolio/Programme tracking and Forward Plans.
They are working to set a standard across to ensure that we are reusing/repurposing data across the directorate and moving all reporting towards being fully digital.
The ETI data strategy is looking to build up and make accessible the data we require to give people to view they need for decision making.
They will be looking to develop other areas such as Business continuity planning, bringing together data from our systems and Unit 4 to give a view of our current capacities for critical activities. This was something that came out of Covid but access to data outside of our service has been hard to get.

Business Intelligence team – 2 members

This is part of the Panning Performance and Support service.
They work provide all performance insights for the Service, directorate performance frameworks. They will analyse data to look for root causes of issues.
They work closely with the Systems, Strategy & Improvement team on dashboard development, using data they have provided for analysis.

Asset Data and Analytics Team – 4 members

This team sit within Highways and Transport but offer support across the directorate. Their main remit is to manage and maintain SCC's network asset data through GIS. They process asset data and present this back through ESRI ArcPortal and ArcOnline.
They will use survey and asset data to produce a inform annual maintenance programmes which are then digitised through maps to provide internal and external staff a view of what is going on, on the highway network.
They provide other service support with GIS where needed, bringing together spatial data into maps to help inform decisions.

FCR Flood and Climate Resilience

The FCR Team is responsible for managing local flooding issues and producing a programme of capital improvement work to reduce flood risk. We also have responsibility for managing the risk of flooding from ordinary watercourses, surface water and groundwater in partnership with other Risk Management Authorities including the Environment Agency, utility companies and Borough and District Councils.

Surrey Waste Partnership Team

This is an external team called 'Joint Waste Solutions'.
They provide reporting through a system called 'SEP' on all waste management within Surrey and work with the D&Bs.
This is funded by SCC, and they are responsible to the analysis and maintenance of waste data with the waste management contractor, Suez.

Community Protection

Emergency management and resilience team – 15 members

This team leads the Welfare groups and coordinates all directorates of the SCC to share information and data. The main use of data in this team is for the Vulnerable People Reporting System (VPRS). This is a system that collates vulnerable people data from partners across Surrey, organised into one database that the team can access and search during an incident/emergency.

Community and Resilience Team

Responsible for all Surrey prepared & other programmes through SCC
Part of this is the flood team, which uses GIS mapping to locate assets and infrastructure.
Head: Sarah Goodman

Data, Digital and Special Projects

Split into a couple of areas (some look more at technology, rather than data itself).
Data team - 2 people
Use data for:

- Scenario-based modelling (application of appliances, e.g., fire engines and vehicles to achieve the best risk coverage)
- Calculating avg response time
- KPI, performance vs Fire & rescue service benchmarking

One person undertakes data collection & quality for performance data to HMIC Police and Fire Rescue, also reporting to Home Office, CIPFA (financial info)

Community Intelligence

Developing capabilities to developing risk analysis for emergency services (e.g. buildings, regulating fire safety - getting info about number of people, height of buildings, escape routes etc) so that when a fire happens, they will know everything about buildings to help allocate resources appropriately. Getting info from Experian, etc collating, comparing it and analysing it - moving it into GIS terminals to highlight specific areas to target.
They use data feeds from ASC, and recently started receiving Children Social Care data too.
Head: Damian Watts

Local Resilience Forum Strategy and Innovation team – 2 members

This team sits underneath the Local Resilience Forum team. This is not a SCC team, but a multi-agency effort among emergency partners and local councils.

1. Currently working on a funding bid to DLUHC which aims at creating a Southeast Regional Information Hub, bringing together Thames Valley + Hampshire, Isle of Wight, London, Kent, and Sussex Local Resilience Forums. The idea is that during an incident all LRF would refer to the MAIC (Multi-Agency Information Centre) and have a regional hub to disseminate information when needed. In peace time, the hub would work on things like horizon scanning, risk assessments, etc.
2. Pending exec approval, the team is seeking to hire a MAIC manager + MAIC officer. These added resources will focus on data re: incidents and vulnerable people data that LRF holds (how it is shared, Data Sharing Agreement and processes that are currently quite bad.

Health and Safety

They have an operations team, but their work with data is prevalently performance reporting (they have a statutory duty to report incidents on an Online Reporting System, OCENS).
Peter Rice (from Fire&Rescue) runs a report a dashboard every quarter, that is presented to Cabinet and CLT against 5 KPIs:

- Total number of H&S incidents
- Number of employee incidents
- Number of 'others' injured
- Percentage of incidents reviewed
- RIDDOR Reports - number of reports.

Trading Standards – 0.6 People

They used to have a BI team but do not have that anymore because of capacity mainly.

- 0.6FTE intelligence post will help with particular investigations.
- Helped by Trading Standards Regional Intelligence Analyst Team (for all the South East) for mapping out complaints (sometimes these have breakdowns).

Coroners

Independent professionals, the service supporting sits within CPG. They don't perform analytics, only data reporting. They have a programme looking at future use of analytics sitting within a wider transformation programme with Fire Rescue.

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Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Mental Health Improvement Plan - Update
HWBS Priority populations:	• People with serious mental illness
HWBS Priority - 1, 2 and/or 3	• Priority 2 Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being
HWBS Outcomes/System Capabilities:	All Priority 2 outcomes and System Capabilities: • Empowered and Thriving Communities • Clear Governance • Workforce Recovery and Development • Programme Management • Equality, Diversity and Inclusion incl. digital • Data, Insights and Evidence • Integrated Care
HWBS Principles for Working with Communities:	• Community capacity building: 'Building trust and relationships' • Co-designing: 'Deciding together' • Co-producing: 'Delivering together' • Community-led action: 'Communities leading, with support when they need it'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions • Community Led interventions
Author(s):	• Liz Williams, Joint Strategic Commissioning Convener- Learning Disability and Autism and all age Mental Health (Surrey County Council and Surrey Heartlands) (P2 Co-Sponsor); Liz.Williams@surreycc.gov.uk • Kate Barker, Joint Strategic Commissioning Convener- Children and All Age Mental Health (Surrey County Council and Surrey Heartlands) (P2 Co-Sponsor); Kate.Barker@surreycc.gov.uk

Board Sponsor(s):	Liz Bruce, Joint Executive Director of Adult Social Care and Integrated Commissioning, Surrey County Council and Surrey Heartlands ICS
HWB meeting date:	21 June 2023
Related HWB papers:	None
Annexes/Appendices:	None

2. Executive summary

The Mental Health Improvement Plan (MHIP) is the Surrey system's 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. The plan has been reset into four programmes the detail of which, with brief updates, is included in this report.

A new approach has been agreed by system leaders and endorsed by the Mental Health System Delivery Board (MHSDB) to bring together all strands of mental health transformation work including the MHIP and work to achieve the transformation within the NHS Long Term Plan.

The Board is asked to endorse the bringing together of the transformation under 'one plan' for the purpose of delivery and resourcing.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Note the contents of this update and endorse the proposed next steps.

4. Reason for Recommendations

Further input from the Board will be requested in future updates.

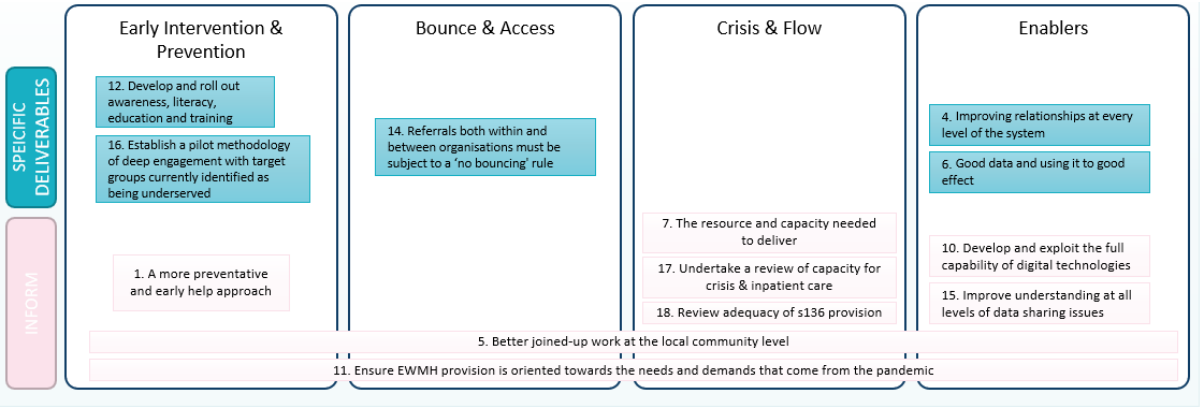
5. Detail

The executive lead for this plan is Liz Bruce and the independent chair of the Board that oversees this work (the Mental Health System Delivery Board or MHSDB) is Jonathan Perkins.

Programme Architecture

The original 19 recommendations were organised into four overarching programmes, mapped to other parts of the system or closed where they were completed.

This mapping exercise was signed off by the MHSDB in February 2023 and is detailed below:



Updates by Programme

The following is a brief update by programme.

Programme One: Early Intervention and Prevention

During 2022 it was decided that the early intervention and prevention recommendations from the MHIP be integrated with the Health and Wellbeing (HWB) Strategy's Priority 2, 'Supporting the mental health and emotional wellbeing of people'.

The Mental Health: Prevention Oversight and Delivery Board (MHPODB), in operation since September 2022, has developed a Work Plan which sets out specific priorities of work and activities operating through four work areas, focused on Surrey's Priority Populations, informed by Place and draws on public mental health evidence of preventative interventions which will have impact:

- Work Area 1 - Steer and oversee the HWB Strategy Implementation Plans for Priority Two projects and programmes, in alignment with the MHIP's early intervention and prevention deliverables.
- Work Area 2 - Identify gaps in provision or under-developed support for Surrey residents as priorities for investment, including through working with communities, based on an enhanced understanding of Place, HWB Strategy Priority Populations and Key Neighbourhoods.
- Work Area 3 - Continue to develop improved and shared approaches to measuring, monitoring and reporting impact of projects and programmes for preventing mental ill health, within and across the HWB Strategy and MHIP.

- Work Area 4 - Assess, share and use new regional, national or international research and report findings as appropriate, within the Surrey Data Strategy approach.

The MHPODB Work Plan Progress Report is described in another paper coming to this Board in June, 'Health and Wellbeing Strategy Summary Implementation Plan June 2023', which includes an appendix of highlighted proposed actions. This Progress Report will be brought to the July meeting of the MHSDB for a fuller discussion.

Programme Two: Bounce and Access

The Bounce Programme was developed from 'Recommendation 14 - Referrals both within and between organisations must be subject to a 'no bouncing' rule' and 'Recommendation 5 - better joined up work at the local and community level'.

Scoping of the programme began in detail in January 2023 including mapping other major programmes addressing 'bounce'. A series of focus groups and workshops took place which defined the problem and identified potential solutions on areas of improvements.

The initial focus group in January 2023 was led by Surrey Coalition's Independent Mental Health Network (IMHN) comprised of people with lived experience (including broader written feedback), followed up with conversations within the ICS. Place based independent mental health networks comprised of people with lived experience and front-line staff and clinicians.

Recognising that although this is a much debated and long-standing phenomenon within Surrey, that no clear definition existed a working definition was co-designed, which is:

"*Bounce occurs when a person (and their carers/ family):*

- *Has difficulty getting into services;*
- *Is passed between services; and/or*
- *Is 'dropped' by services.*

in a way which results in that person's needs not being met and an accompanying feeling of rejection."

A new 'no bouncing' principle has been drafted:

> *"If the first point of contact can't meet your needs, someone will hold responsibility for getting you to the place(s) where your needs can be met, and you and your carers/family will know who that person is and be able to contact them."*

There has been mapping of work and identifying particular places in the system where there are challenges and opportunities for focussed work.

A logic model has been developed which provides the framework on how outcomes and impact can be measured going forward. The identified areas of focus include:

- Culture shift – Services supporting person centred approach
- Increase expertise to provide care (Knowledge)
- Communication & collaboration across services
- Further service resourcing & funding.

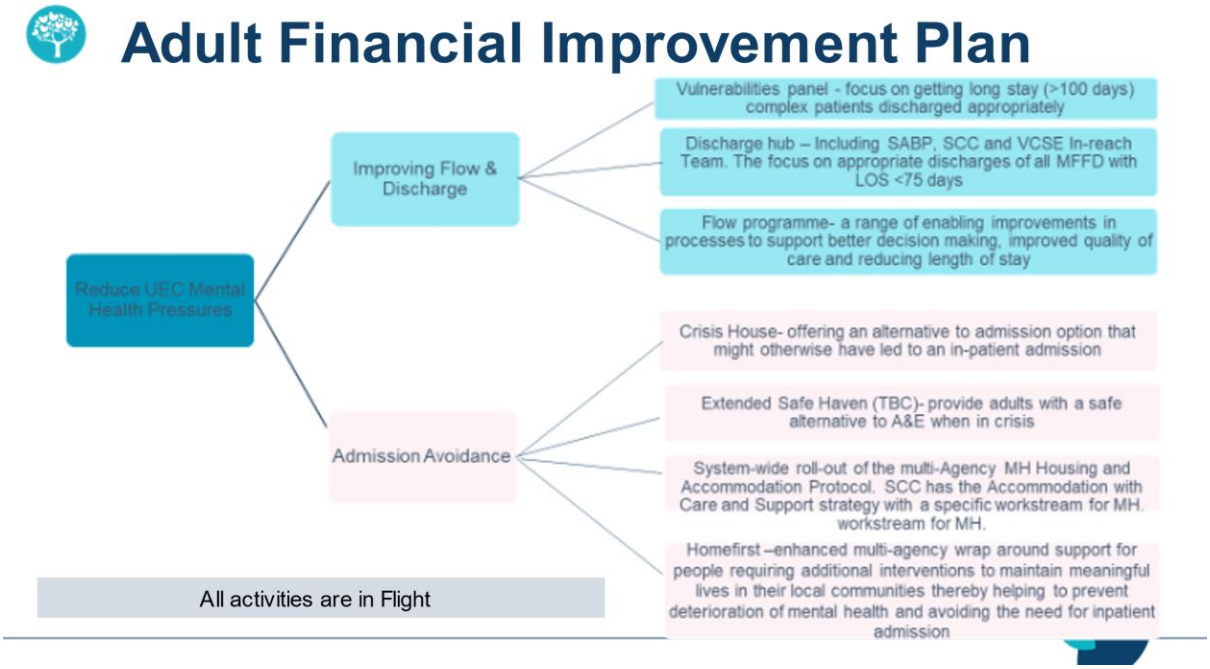
Against each of the impacts above are draft outcomes and activities.

An evaluation framework for the programme is being developed by Unity Insights to ensure current programme and projects addressing 'bounce' plus any additional areas of focussed work/projects needed to address 'bounce' have the desired impact of reducing if not eliminating 'bounce'.

Programme Three: Crisis and Flow

- The Crisis and Flow Programme was set up as a formalised programme in October 2022, led by Surrey and Borders Partnership Trust (SABP) working collaboratively with system partners e.g. Community Connections, Surrey County Council, and the Integrated Care Board.
- This addresses 'Recommendation 7 - The resource and capacity needed to deliver', 'Recommendation 17 - Undertake a review of capacity for crisis and inpatient care'; and 'Recommendation 18 - Review adequacy of s136 provision'.
- This programme also forms the basis of the adult Financial Recovery Plan and aims to:
    - Reduce demand pressure
    - Improve patient flow processes
    - Reduce Length of Stay (LOS)
    - Eliminate out of area placements
    - Reduce spend on private sector beds and agency premium
    - Development of workforce competencies to support gatekeeping/ signposting
    - Develop clear and effective discharge processes
    - Optimisation of opportunities through digital-enabled technologies/processes.

The driver diagram below sets out the programme of work:



This is a complex programme comprised of both enabling and delivery projects with bi-weekly governance wrapped around it.

Programme One: Enablers and Culture

Recommendation 4 - 'Improving relationships at every level (culture)'.

The quality of care we deliver, our openness to learning and improvement and the degree to which our workforce feels valued and supported are all underpinned by our culture and approach to leadership. As such, culture change sits at the heart of the MHIP as a key enabler. As part of the wider MHIP, the MHSDB is overseeing this workstream championing and supporting a reset of attitudes, values, goals, and ways of working.

In response to the commissioned Linguistic Landscapes independent review of culture with a focus on the fracture points in the system which impacted care delivery back in 2021/22, a series of key findings and recommendations were made relating to 3 specific areas of change needed:

1. Make relationships better: Relationships are not a 'nice to have' – they are essential to our work

2. Have honest conversations: We need to interact differently to creatively solve problems together

3. Remember we all care about the same thing: We all care about the individuals we're supporting – it's good to remember we're all in this together.

Given the resourcing constraints relating to this workstream and the ability to take the work forward, the areas of work where we have been focussing effort has been on:

1. MHIP programmes each to a identify culture priority
2. Evaluation framework (explore with Unity Insights)
3. Introduce system Schwartz rounds
4. Share findings widely with key partners
5. Scope and plan Organisational Development programme for MHSDB.

Changing culture and ways of working takes time. However, we have through the formation of the MHIP seen evidence of positive impact and greater collaboration across the system.

Workforce recruitment and retention

This remains a challenge across the Integrated Care Systems.

MHSDB has set aside a significant slot for a workforce deep dive for their June Board and requested an update inclusive of data from all system partners regarding mental health workforce including their current position in regard to recruitment and retention and work being done to address challenges. The MHSDB membership also requested that workforce wellbeing be considered.

This will build upon and add additional detail to the regular updates all partners submit to the Surrey Heartlands People's Committee and the NHS focussed workforce data submitted as part of the annual operating plan 2023/24. Commitment was made by all partners including SABP, SCC (operations and commissioning), the VCSE and providers.

Data and digital

'Recommendation 6- Good data and using it to good effect (data)' and 'Recommendation 15 - Improve understanding at all levels of data sharing issues (data) made up this key enabler.

As part of the recently published Joint Strategic Needs Aassessment (JSNA) chapter the Senior Responsible Officer noted caveats that big gaps remain in the data and the chapter and SRO recommendations include both a review of place-based data and a commitment from the Surrey Analytics hub to take a key objective to manage availability and sharing of mental health data.

To kick start this work an initial data pack was developed for the MHSDB which collated and mapped all the system data where we record on mental health activity. Given the temporary withdrawal of support from the Analytics hub, the data pack was simply there to describe what data is available rather than undertaking any analysis of data.

The data included the key performance indicators for the NHS Long Term Plan deliverables for mental health.

However, the JSNA (despite noting there are gaps) has provided a significant pack of data and progress has been made on the patient record which now includes Mental Health data. As a next step, the MHSDB has requested that a 'use case' approach is adopted to help navigate the available data when analytics capacity is identified.

System leaders are currently trying to address the data issues and have now planned a Hackathon in June 2023 including population health management colleagues to further develop the 'use case' approach.

It will be critical to follow through on the JSNA SRO recommendations to complete a review of place-based data and the commitment from the Surrey Analytics hub has taken a key objective to manage availability and sharing of mental health data.

Under 'Recommendation 10- Develop and exploit the full capabilities of digital technologies (digital)' the Adult Health Select Committee report of the October 5th 2022 detailed the offer within mental health.

The Adult Health Select Committee Report on the MHIP for June 15th 2023 committee includes a more thorough and detailed update against each of the four programmes within the plan.

Governance

As per the last report, the MHSDB has been established, and work is ongoing to continue to strengthen this Board and the Board's remit within the system governance architecture, develop to balance adults, children and young people delivery and continue to ensure the voice of people with lived experience and system stakeholders is heard via the Co-Production and Insight Group it supports.

Transformation as 'one plan'

The last report included a forward plan to phase the work of the MHIP. However, system leaders have agreed an alternative approach, bringing all transformation programmes and projects within the mental health space into one plan.

6. Challenges

Resourcing continues to be a challenge for this programme in terms of programme management and project support. However, it is hoped that the new 'one plan' approach with agreed resourcing will bring all transformation elements together to more effectively deliver.

However, current challenges to delivery are:

- Competing operational pressures

- Resourcing challenges to meet the need
- Funding position
- Scale of transformation
- Staff wellbeing
- Culture
- Digital and data insights.

7. Timescale and delivery plan

Timescales for delivery will follow the 'one plan' approach being resourced. The development of the one plan will have timescales for delivery.

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

A wide stakeholder group engaged the MHIP, in particular using members of the Co-Production and Insight Group as well as stakeholder engagement and codesign with each programme. Service users and people with lived experience are a key part of this. We continue to engage closely with the Adults and Health Select Committee.

Further assessment of our communications and engagement needs will be required as part of the 'one plan' approach and resourcing.

9. Next steps

- Resourcing decision for the 'one plan' approach is awaited.
- Governance development to be concluded.
- MHSDB meets to consider workforce and begin a round of presentations from ICS Places on their mental health plans to ensure alignment.

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Health and Wellbeing Board (HWB) Paper – Formal (public)

1. Reference Information

Paper tracking information	
Title:	Better Care Fund (BCF) Plan 2023-25 and BCF End of Year Review 2022/23
HWBS Priority populations:	All
HWBS Priority - 1, 2 and/or 3:	All
HWBS Outcomes/System Capabilities:	All outcomes
HWBS Principles for Working with Communities:	• Community capacity building: 'Building trust and relationships' • Co-designing: 'Deciding together' • Co-producing: 'Delivering together' • Community-led action: 'Communities leading, with support when they need it'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions • Community Led interventions
Author(s):	Suzi Stern, BCF Policy and Programme Manager, Surrey County Council; Susan.Stern@surreycc.gov.uk
Board Sponsor(s):	Liz Bruce, Joint Executive Director of Adult Social Care & Integrated Commissioning, SCC/Surrey Heartlands Integrated Care Board (ICB) as Executive Lead
HWB meeting date:	21 June 2023
Related HWB papers:	None
Annexes/Appendices:	**Annex 1**: BCF Planning Narrative 2023-25 **Annex 2**: BCF Planning Template 2023-25 **Annex 3**: BCF End of Year Review 2022/23 **Annex 4**: BCF Plan ICB Discharge Funding Template Frimley **Annex 5**: BCF Plan ICB Discharge Funding Template Surrey Heartlands **Annex 6**: BCF Strategy Workshop March 2023 Next Steps

2. Executive summary

The Board is asked to approve the proposed Surrey 2023-25 Better Care Fund (BCF) Plan. The BCF Plan is a two-year plan, covering 2023-25 and the two key outcomes remain the same as previous years: enabling people to stay well, safe and independent at home for longer; and providing people with the right care, at the right place, at the right time. The Adult Social Care Discharge Fund is incorporated into the BCF Plan for the first time this year.

The BCF Plan has been developed in collaboration with partners across the system and represents the Surrey plan for resource allocation and outcome delivery.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Approve the proposed 2023-25 BCF Plan (including Planning Narrative and Planning Template)
2. The Board note:
   i. 2022/23 BCF Review which was submitted to NHSE on 23 May following delegated authority by HWB Board Chair.
   ii. Integrated Care Board (ICB) Additional Discharge Templates for Surrey Heartlands and Frimley Health and Care – both submitted to NHS England on 19 May 2023.
   iii. BCF Strategy Workshop next steps actions (from 3 March 2023)
3. The Board recommend that a Section 75 agreement* between Surrey County Council and Surrey Heartlands ICB should be developed, based on the BCF Plan, for approval by the Surrey-Wide Commissioning Committees in Common (CIC).
4. Recommend that a Section 75 agreement* between Surrey County Council and Frimley ICB should be developed, based on the BCF Plan, for approval by CIC.

**Section 75 agreements are made between local authorities and NHS bodies and can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner/s.*

4. Reason for Recommendations

These plans have been developed in collaboration with partners across the system and have been approved through both local and system governance routes. They represent a robust plan for how Surrey BCF money should be spent and what outcomes we will achieve over the next two years.

5. Detail

The BCF Narrative and BCF Planning Template (included documents) describe the key features of the BCF Plan. A summary of the BCF Plan is as follows:

Surrey's Joint Strategic Needs Assessment (JSNA) and local health profiles tell us that Surrey has an ageing and growing population. This will inevitably result in an increase in the number of people living with complex needs such as long-term conditions, dementia, falls, depression and loneliness. The Surrey system continues to experience increasing pressure on mental health services with the nationally predicted plateauing in demand expected to occur in 2023/24 yet to materialise in Surrey. Many of the schemes for 2023-25 will therefore be prioritised towards supporting Surrey's aging population. Whilst delivering against the national conditions, we will also be shifting the focus more toward prevention and earlier intervention, to ensure HWB Board priorities around reducing health inequalities are delivered.

Surrey's BCF continues to drive organisations to work across boundaries to deliver outcomes for Surrey residents. With the introduction of Joint Executive roles and the establishment of a partnership agreement between Surrey Heartlands ICB and SCC for Integrated Commissioning, a key focus for 2023-25 is to build on the learning from the 2022/23 BCF review work, prevention spend mapping, and the recent BCF strategy workshop with partners in March 2023. This can be translated into a strategic programme of work that identifies opportunities to commission to system wide strategic priorities in a consistent and cost-effective way that supports the tailoring of delivery at place, town and neighbourhood level, making sure we deliver against Surrey's Community Vision for 2030 to ensure that 'No-one is Left Behind'.

A key priority is transforming Surrey's reablement offer to support all people, from the community and following hospital discharge and to have a stronger focus on prevention. Our future approach to reablement services is being developed and the recommissioning of a transformed collaborative reablement offer will take place later in 2023 that ensures a greater emphasis on working with community referrals as well as continuing to support discharge.

We will continue to strengthen our approach to supporting patients to be discharged from hospital successfully. We will also be seeking to establish a longer-term Discharge to Assess (D2A) offer; segment our market provision to flex capacity and meet fluctuating demand to support hospital pressures whilst also focusing on prevention; and ensure pathways for individuals to return or remain at home are clear and robust. In Surrey, approx. 40% of patients needing discharge are self-funders and we will be working with the national team to understand how NHS England and the Department of Health and Social Care can support systems to improve the flow of patients who are self-funded.

2023-25 will see the introduction of a new HWB Board Index for Surrey to enable a broader focus across health, wellbeing and the wider determinants of health and the HWB Strategy's Priority Populations of identity and geography. This will improve our understanding of outcomes that have many contributing factors. Our capacity and demand approach is still under development in Surrey, and we also intend to progress towards a more comprehensive approach to capacity and demand planning at place level during 2023-25.

Surrey has an ambitious programme of work to deliver its strategic ambition to ensure No-One is Left Behind. This is supported by the Integrated Care Strategies for both Surrey Heartlands and Frimley Health and Care. We know that none of this can be delivered without system and partnership working and the BCF is a core component of how this can happen and brings together partners across Surrey to focus on the key priorities for our residents.

6. Challenges

- Ensuring NHS England reporting requirements are met within the agreed timeframes.
- Ensuring data from across the system is available to continue to improve upon the Capacity and Demand plan included within the documentation.

7. Timescale and delivery plan

BCF Plan 2023-2025 is to be submitted to NHSE by 28 June 2023.

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

This plan has been reviewed and approved by the following committees in 2023:

- Local engagement with Surrey-wide Local Joint Commissioning Forums - May
- Surrey Heartlands Contracts & Commissioning Committee – 24 May
- Surrey Wide Commissioning Collaborative – 26 May
- Surrey Heartlands ICS Execs – 30 May
- Surrey County Council Chief Executive Officer – 1 June
- Frimley Health and Care ICB representative – 1 June
- Surrey Heartlands ICB – 7 June

9. Next steps

Submit BCF Plan 2023-2025 to NHS England by 28 June 2023.

Surrey Better Care Fund (BCF) Plan 2023-25

Narrative Template

Contents

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SECTION 1: BCF Plan Development & Governance

Bodies involved strategically and operationally 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 representatives from Surrey County Council, integrated care systems (ICSs), 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
- Surrey Strategic Health and Care Commissioning Collaborative
- Surrey Health and Wellbeing (HWB) Board, which includes representatives from: the Surrey voluntary, community, social enterprise sector (VCSE); and social care providers.
- Surrey Heartlands ICS executive team

How have you gone about involving these stakeholders?

Local Partnerships are the key element to ensuring involvement and on-going stakeholder engagement in the development of Surrey's Better Care Fund (BCF) approach. District and borough council representatives regularly attend Local Joint Commissioning Group meetings throughout the year and are actively engaged 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, the voluntary and community sector, and other social care providers and additional local service providers.

In March 2023 we held a BCF strategy workshop for HWB Board members, where Local Joint Commissioning Groups presented their proposed approach for 2023-25 which followed on from previous BCF programme review work carried out during 2022/23 This enabled feedback from a broad range of stakeholders, including NHS, public health, social care, local councillors and user representatives. We plan to repeat this workshop in autumn 2023 in order for system and local leaders to collectively review progress against key outcomes.

In May 2023, the Surrey Strategic Health and Care Commissioning Collaborative acted on behalf of the HWB Board and Integrated Care Partnership (ICP) to oversee preparation of the BCF plan. This forum brings together strategic commissioners and decision makers from Surrey County Council, Surrey Heartlands ICS and Frimley ICS to identify the opportunities for integration and collaboration and agree how best to implement them to ensure consistency of approach. It also provides a system

leadership role ensuring, on behalf of the HWB board, that BCF funding is used to best effect to deliver on key strategic priorities.

The draft BCF plan was then refined in response to feedback, agreed by Integrated Care Boards (ICBs) and Surrey CC's CEO, and signed off by Surrey's HWBB in line with national policy guidance. Finally, through integrated commissioning arrangements and the provision of Discharge to Assess in particular, many strategic groups and meetings established during this period are now able to contribute to the development of BCF funded services and initiatives that align with strategic and Place-based requirements.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The BCF in Surrey has local commissioning arrangements. Seven Local Joint Commissioning Groups 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 Local Joint Commissioning Groups that are updated on a regular basis to ensure strategic overview is maintained across the whole system and that robust budget management is in place.

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Each Local Joint Commissioning Group funds a programme of local initiatives. The remit of Local Joint Commissioning Groups includes overseeing the performance of these initiatives, with commissioning leads and/or representatives invited to present progress, outcomes and future plans. Representatives from district and borough councils regularly attend Local Joint Commissioning Groups which helps provide essential local knowledge. The Local Joint Commissioning Groups also oversee the delivery of Surrey-wide initiatives such as the Handyperson Scheme, Community Equipment, Community Connections and Carers' services to ensure that they are tailored appropriately for their Place.

The Surrey-wide Strategic Health and Care Commissioning Collaborative maintains oversight of the quarterly reporting submissions and BCF plans to NHS England and can request deep dives into BCF performance as required, particularly with regard to countywide commissioned schemes.

The Surrey-wide Commissioning Committees in Common (which includes necessary delegated authority) oversees the development of the Surrey-wide integrated commissioning governance between Surrey County Council, Surrey Heartlands ICS and Frimley ICS.

Additional audits are undertaken through Surrey County Council's internal audit team with recommendations complementing the above. Previous audits have looked at governance, performance reporting and monitoring arrangements.

Surrey's HWB Board signs off the final BCF Plan and ensures it is aligned with Surrey's HWB Strategy. This is a ten-year strategy (first published in 2019 and refreshed in 2022) 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. The Health and Wellbeing Strategy now sets out the need for different partners across Surrey work to together with local communities to commission services.

Please note that Surrey's governance arrangements are currently under review and BCF governance arrangements may adapt during 2023-25 in response to any broader changes in Surrey's overall governance structures. In 2023, Surrey invested in a dedicated BCF Programme and Policy lead whose role is to co-ordinate the overall approach and ensure transparency across the system. This post has been instrumental in the work being undertaken to streamline the governance arrangements and ensure decisions are made at the appropriate level.

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SECTION 2: Executive Summary

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Surrey's Joint Strategic Needs Assessment (JSNA) and local health profiles tell us that Surrey has an ageing and growing population. This will inevitably result in an increase in the number of people living with complex needs such as long-term conditions, dementia, falls, depression and loneliness. The Surrey system continues to experience increasing pressure on mental health services with the nationally predicted plateauing in demand expected to occur in 2023/24 yet to materialise in Surrey. Many of the schemes for 2023-25 will therefore be prioritised towards supporting Surrey's aging population. Whilst delivering against the national conditions, we will also be shifting the focus more toward prevention and earlier intervention, to ensure HWB Board priorities around tackling health inequalities are delivered.

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Surrey's Better Care Fund (BCF) continues to drive organisations to work across boundaries to deliver outcomes for Surrey residents. With the introduction of joint executive roles and the establishment of a partnership agreement between Surrey Heartlands and Surrey County Council for integrated commissioning, a key focus for 2023-25 is to build on the learning from the 2022/23 BCF review work, prevention spend mapping, and the recent BCF strategy workshop with partners in March 2023. This can be translated into a strategic programme of work that identifies opportunities to commission to system wide strategic priorities in a consistent and cost-effective way that supports the tailoring of delivery at Place, town and neighbourhood level, making sure we deliver against Surrey Community Vision 2030 ambition that 'No-one is Left Behind'.

A key priority is transforming Surrey's reablement offer to support all people, from the community and following hospital discharge and to have a stronger focus on prevention. Our future approach to reablement services is being developed and the recommissioning of a transformed collaborative reablement offer will take place later in 2023 that ensures a greater emphasis on working with community referrals as well as continuing to support discharge.

We will continue to strengthen our approach to supporting patients to be discharged from hospital successfully. We will also be seeking to: establish a longer-term Discharge to Assess offer; segment our market provision to flex capacity and meet fluctuating demand to support hospital pressures whilst also focusing on prevention; and ensure pathways for individuals to return or remain at home are clear and robust. In Surrey, approximately 40% of patients needing discharge are self-funders and we will be working with the national team to understand how NHS England and the Department of Health and Social Care can support systems to improve the flow of patients who are self-funders.

2023-25 will see the introduction of a new HWB Strategy Index for Surrey to enable a broader focus across health, wellbeing and the wider determinants of health and the Priority Populations of identity and geography. This will improve our understanding of outcomes that have many contributing factors. Our capacity and demand approach is still under development in Surrey, and we intend to progress

towards a more comprehensive approach to capacity and demand planning at Place level during 2023-25.

Surrey has an ambitious programme of work to deliver its strategic ambition to ensure No-One is Left Behind. This is supported by the ICS strategies for both Surrey Heartlands and Frimley Health and Care. We know that none of this can be delivered without system and partnership working and the BCF is a core component of how this can happen and brings together partners across Surrey to focus on the key priorities for our residents.

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SECTION 3: National Condition 1: Overall BCF Plan and Approach to Integrating Health, Social Care and Housing

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

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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 for 2023-25 will be prioritised towards supporting Surrey's aging population. The Surrey system continues to experience increasing pressure on mental health services with the nationally predicted plateauing in demand expected to occur in 2023/24 yet to materialise in Surrey. Shifting the focus more toward prevention and earlier intervention, building on prevention spend mapping work undertaken in 2022/23, will remain a key focus for the BCF programme in 2023/24 and 2024/25 to ensure HWB Strategy priorities around reducing health inequalities are delivered.

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 Integrated Care Partnership in both Surrey Heartlands and Frimley Health and Care have developed and delivered their strategies for the ICS:

- Surrey Heartlands: Our strategy - ICS (surreyheartlands.org)
- Frimley Health and Care: Our Strategy | Frimley Health and Care

These strategies detail the ambitions and vision each system has in delivering joined up health and care which put people and communities at the centre. The strategies were developed in partnership and demonstrate how organisations and services must be integrated in order to achieve our strategic ambitions.

The role of the Surrey Heartlands Integrated Care Partnership in delivering system ambitions is to:

- Coordinate a system approach to support delivery.

- Maintain a system focus on health inequalities (priority groups including the NHS Core20PLUS5).
- Align with system strategic objectives via the HWB Board & Surrey Forum.

The role of the Frimley Health and Care Integrated Care Partnership is to:

- 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.

The ambition of Surrey's Community Vision in supporting its people is that No-One is Left Behind and:

- Children and young people are safe and feel safe and confident.
- Everyone benefits from education, skills and employment opportunities that help them succeed in life.
- Everyone lives healthy, active and fulfilling lives, and makes good choices about their wellbeing.
- Everyone gets the health and social care support and information they need at the right time and place.
- Communities are welcoming and supportive, especially of those most in need, and people feel able to contribute to community life.
- We want our county's economy to be strong, vibrant and successful and Surrey to 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.

Surrey's ambition to create a truly integrated system has been operationalised within Surrey Heartlands by the creation of joint roles which span both Surrey County Council and the 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 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 have director roles that work across NHS and local government, supporting and enabling integration:

- Director of Integration 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.

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Overall Plan

Surrey's BCF 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 Group and reflected within local plans, including local and regional HWB 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 Home First 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 possibly 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 multi-disciplinary teams 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.

With the introduction of joint executive roles and the establishment of a partnership agreement between Surrey Heartlands and Surrey County Council for integrated commissioning the focus for 2023-25 is to build on the learning from the 2022/23 BCF review work, prevention spend mapping, and the recent BCF strategy workshop with partners in March 2023, and to translate this into a strategic programme of work that identifies opportunities to commission to system wide strategic priorities in a consistent and cost effective way that supports the tailoring of delivery at Place, town and neighbourhood level to drive improvements in health inequalities and place more focus on prevention and early intervention.

SECTION 4: National Condition 2: Enabling People to Stay Well, Safe and Independent at Home for Longer

SECTION 4.1: Overall Approach

(Enabling People to Stay Safe, Well and Independent at Home for Longer)

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

The evolving structure of the health and care partnership alongside the continued incorporation of population health data through Graphnet technology assists Local Joint Commissioning Groups 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.

Across the county, BCF funding has been used for prevention and self-management using a strengths-based approach which recognises the assets of the individual:

- 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 locally commissioned service, playing a central role in the development of primary care network wide multidisciplinary teams, 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 and social care, and the voluntary sector.
- The BCF has also seen considerable investment in Reablement. Reablement services, delivered countywide but implemented to meet specific Place based requirements include the use of

domiciliary care services (home based care) who focus specifically on collaborative reablement supported by in house reablement teams.

Care within the home services are already jointly commissioned between Surrey County Council and NHS Continuing Healthcare (CHC) and as such are well placed to respond to fluctuating demand and different models of service delivery. In order to strengthen our ability to keep people safe, well and independent at home for longer much of the BCF funded services at Place need to align to strategic service development; we have commissioned hospital admission avoidance hours, bridging services and block care hours from the domiciliary care market that compliment reablement already in place.

BCF continues to address inequalities through its strategic alignment to Surrey Heartlands and Frimley Health and Care's ICS strategies, 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. BCF funding continues to be allocated to projects/services directly addressing health inequalities, for example:

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- 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 heathy 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 primary care networks, 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 develop 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 development programmes (Growing Health Together and personal development services such as Wellbeing Prescription) enable individuals to engage in community networks thus creating a sense of resilience. Partners within the Local Joint Commissioning Group 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.

In 22/23 Surrey Downs supported more than 20 organisations with seed funding benchmarked against BCF metrics for new projects that we anticipate will lead to sustained benefits through 2023-25. Key priorities being to encourage connectivity and reduce isolation (particularly following Covid), to

develop skills among young people; and to provide bereavement support (given the greater demand as a result of covid-related deaths).

North East Hampshire and Farnham are planning targeted work on fallers this year by looking at increasing activity levels and reviewing what services are available. They are considering expanding the service that currently runs throughout the rest of Surrey into Farnham (as Farnham is not covered at present). They are planning to use population health data to identify where higher incidences of fallers occur and encourage ideas from the local community on how they can invest in services to help.

SECTION 4.2: Capacity & Demand Approach for Intermediate Care in the Community

(Enabling People to Stay Safe, Well and Independent at Home for Longer)

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
  - where number of referrals did and did not meet expectations
  - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
  - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

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Our overall approach to capacity and demand planning within Surrey is continuing to develop and our aim to have a Capacity and Demand Plan which is live and actively used by operational teams across the county. The first step has been developing the Capacity and Demand Assessment submitted as part of this plan and we intend to progress towards a more comprehensive approach at Place level during 2023-25. For this submission, we have based our assessment on Surrey Heartlands data and added an additional 15% to estimate Surrey wide figures which has been agreed with system colleagues. As numbers for the voluntary sector are not collected, we have made an assumption that these are 3% of total capacity based on local knowledge and available evidence.

We have used this initial Capacity and Demand Assessment to inform what services we plan to invest in over the coming years, and as we amend and continue to improve its outputs, we will ensure our BCF investments meet the needs of our local populations. Our plan shows a predicted increase in Pathway 1 and Urgent Community Response demand. The schemes we are investing in at Local Joint Commissioning Group level will attempt to meet that predicted demand, for example some of the investment into assistive technologies or Pathway 1 Discharge to Assess investment.

Most referrals for local authority funded services comes from community referrals. However, reablement sees demand for services generated from acute hospital discharges at around 80% of current capacity. Coupled with this, additional bed based, and home care capacity was established (under Discharge to Assess) to also meet the demands of hospital flow.

Learning from this demonstrated three main areas of challenge:

- Self-funders, out of county placements and complex needs placements cause delays and bed blocking in hospitals.
- Focus on prevention would be more beneficial than continuing focus on 'back door' discharge approaches and capacity.
- Intermediate and primary care (including clinical services) need to be available to manage effective access to, and utilisation of, existing and new capacity.

In Surrey, approximately 65% of patients needing discharge are self-funders and we support them through a number of ways:

- Adult Social Care fund six weeks of home-based reablement support to all patients (regardless of funding status) preventing the need for care home/escalation of care which could delay discharge.
- Three of the Surrey acute NHS Trusts (Royal Surrey Foundation Trust, Surrey and Sussex Healthcare Trust, and Epsom and St Helier University Hospital Trust) run the Care Home Select (CHS) programme. Once patients are identified as self-funders and having capacity, the hospital engage CHS to identify a suitable care home on behalf of the families and arrange the placement. The hospitals fund this directly with CHS (£600/pt).

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Self-funders create challenges to effective discharge due to the fact Adult Social Care have no legal duty to fund ongoing care and support arrangements for self-funding patients once they have been identified as medically fit for discharge. In addition to this, acute trusts and the ICS invest a significant amount of time and resources into supporting self-funders as the Choice Policy is difficult to enforce (and has been for years) for patients who are medically fit for discharge. There needs to be a solution which ensures the safety and best outcomes for the patient but supported by statutory levers. The high level of self-funders in Surrey makes this a particularly challenging problem locally.

We are working with the national team to understand how NHS England and the Department of Health and Social Care can support systems to improve the flow of patients who are self-funders out of acute trusts and into an appropriate place of residence.

SECTION 4.3: How BCF is Adapting to Support Delivery & Expected Impact on Metrics

(Enabling People to Stay Safe, Well and Independent at Home for Longer)

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

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A key priority for Surrey County Council adult social care is transforming Surrey's reablement offer to support all people, from the community and following hospital discharge, who would benefit from personalised support to achieve their goals and to gain or re-gain skills, confidence and independence.

To deliver this ambition the future approach to reablement services is being developed and the recommissioning of a transformed collaborative reablement offer will take place later in 2023 that ensures a greater emphasis on working with community referrals as well as continuing to support discharge.

BCF funded services, such as home from hospital services and TEC, currently, and in the future, will continue to compliment reablement and home-based care hospital avoidance schemes and the delivery of core intermediate and primary care services to ensure a clear pathway for patients / residents wishing to return home. This will also be essential in developing better pathways back to someone's residential and nursing care home as appropriate.

There are a number of ways the BCF is continuing to support this national ambition, including:

- The BCF funds reactive services through integrated community services. One of which is the integrated @home service that support people to remain at home as an alternative to an admission or extended hospital stay.
- BCF funding helps support the integrated team that deliver wrap around care for over 65 residents with staff made up of health and social care.
- Evidencing a measurable impact for residents, with reduced emergency department attendances non-elective admissions for Surrey Downs residents to local acutes.

The future focus for BCF funding and integrated commissioning will be to focus on delivering against this objective in the following ways:

- Establishing a longer-term Discharge to Assess offer.
- Focusing on a new model of reablement targeted at prevention.
- Segmenting market provision to flex service capacity at Place and meet fluctuating demand driven predominantly by hospital pressures, but also focusing on prevention.

- Ensure pathways for individuals to return / remain at home are clear and robust, considering care within the home services, transport, discharge planning, medication, intermediate care integration with models of social care delivery and use of technology enabled care as examples.

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SECTION 5: National Condition 3: Provide the Right Care, in the Right Place, at the Right Time

SECTION 5.1: Overall Approach

(Provide the Right Care, in the Right Place, at the Right Time)

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

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From 2023 Surrey County Council will be undertaking work as part of a regional Assistant Directors of Adult Social Services (ADASS) commitment to NHS England South East Regional Delivery Unit. This will explore a more strategic approach to discharge across the region. There are 4 workstreams (as below) and Surrey County Council will be involved in the Models of Care work. Outputs of this regional work will feed into our system approach to discharge in the future.

1. **Metrics** - Identify 10 metrics across the health and care sector used to measure flow and discharge.
2. **Strategic Surge Response** - Strategic multi-agency surge plan taking account of commissioning, workforce, funding, and pathway challenges that is preventative in nature, responding to peaks in demand in a co-ordinated, cost-effective manner.
3. **Workforce** - A workforce strategy across the region that resolves challenges to rates, ways of working and deployment.
4. **Models of Care** - Develop and test new models of care that are joined up and seamless.

The metrics referred to have not yet been developed. Surrey County Council are directly involved in the models of care workstream, and we will be kept abreast of the work through the ADASS network and await the outputs from the metrics workstream with interest.

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 BCF. 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 both at Place and System level. We continue to emphasise personalised care across the system. We have an ICS Personalised Care Steering Group, a Personalised Care Lead (at associate director level) and hospital discharge personal health budgets are organised and managed at Place level.

Surrey is continuing to operate a Discharge to Assess model across the whole of Surrey covering both the Surrey Heartlands ICB and Frimley ICB footprints. It is currently estimated that approximately £16m will be required on Discharge to Assess services commissioned to facilitate discharge of people from acute hospitals into support arrangements in their own homes or step-down services in care homes.

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The £7.6m of Adult Social Care Discharge Fund (ASC DF) grant monies being received by ICBs and allocated to the Surrey area combined with Surrey County Council's ASC DF grant that are being pooled in the 2023/24 Better Care Fund will fund a proportion of the total £16m (approximate) expected expenditure on D2A services in 2023/24. The remaining £8.4m (approximate) of estimated Discharge to Assess expenditure in 2023/24 will be funded out a combination of some core BCF monies and funding held outside of the BCF including some non-recurrent funds. The Discharge to Assess costs funded by the ASC DF are all additional in terms of representing services that have been purchased to support discharge utilising the grant funding outside of base budget expenditure across ICBs and the Council.

Surrey's ASC DF grant funding in 2023/24 represents a reduction of £1m from the £8.6m received in 2022/23 due to changes in the way funding for local authorities was allocated between authorities which resulted in Surrey County Council receiving a lower allocation.

The 2023/24 ASC DF grant funding pooled in Surrey's BCF in 2023/24 will be funding additional Discharge to Assess capacity that we would otherwise be unable to fund through our broader recurrent funding. Similarly, the expected increase of up to £12.2m of ASC DF grant monies to be pooled in Surrey's BCF in 2024/25 will fund additional capacity that we would currently be unable to fund through recurrent funding sources.

Within this year's BCF there are a number of programmes and schemes in place which have the aim of reducing delays and supporting timely discharge, without increasing admissions:

- The implementation and 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 additional reablement and therapy provision. There has been significant investment into our community nursing teams, including into In-Reach

community nursing roles within the acute hospital. These roles have helped to ensure that more patients, and 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 service is available for pathway 1 and pathway 0 hospital patients. Volunteers contact all discharged patients 3 days post discharge and provide assistance 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 pool capacity and reduce delays. For example, the co-location of reablement and rapid response colleagues in East Surrey is firmly established.
- BCF has agreed to support a new Discharge to Assess and Recover pilot which is a rapid response 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 a multi-disciplinary 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.

Planning to support this demand and the complex discharges is ongoing. The BCF has dedicated investment in the Discharge to Assess and Recover model, 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.

There is now a daily Surrey System oversight call with all NHS providers reporting current positions within a collaborative support and problem-solving ethos. Mutual support can be provided, and patient-level solutions can be identified with call upon BCF funded services as necessary.

SECTION 5.2: Capacity & Demand Approach for Intermediate Care to Support Discharge from Hospital

(Provide the Right Care, in the Right Place, at the Right Time)

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
  - where number of referrals did and did not meet expectations
  - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
  - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
  - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

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As outlined previously, our overall approach to capacity and demand planning within Surrey is continuing to develop and our aim is to have a Capacity and Demand Plan which is live and actively used by operational teams across the county. The first step has been developing the Capacity and Demand Assessment submitted as part of the BCF Plan and we intend to progress towards a more comprehensive approach at Place level during 2023-25. For this submission, we have based our Capacity and Demand Assessment on Surrey Heartlands data and added an additional 15% to estimate Surrey wide figures which has been agreed with system colleagues. As numbers for the voluntary sector are not collected, we have made an assumption that these are 3% of total capacity based on local knowledge and available evidence.

Learning from commissioning and operational practice of the 2022/23 ASC DF has been incorporated into Discharge to Assess planning to ensure funding is deployed to maximum effect. This includes ensuring block purchased services are commissioned as closely in line with actual discharge volumes to facilitate timely discharge and limit any under-usage of blocks.

We anticipated a mixture of need, including both care at home and in care homes. We accordingly commissioned a variety of care offers based upon meeting the full spectrum of people's needs. The situation has been very fluid and influenced by a number of factors including availability of care, acuity of patient, declared operational pressures escalation level (OPEL) of hospitals etc. There have been some challenges in securing timely, safe and appropriate discharge for arrangements for adults and older people with challenging behaviour. We have also recognised, as a system, that we need to take forward a joint approach to managing the discharge (from general acute hospitals) of people with poor mental health who are under 65. In addition to this, we have recognised a need to take discrete

actions regarding training and practice for anyone who is eligible for Mental Health Act s117 aftercare and is awaiting discharge from general acute hospital.

We have adjusted our commissioning arrangements accordingly and plan to have more robust arrangements in place during 2023 to be able to swiftly flex up and down the service required based upon need. We will be using commissioning activity to minimise potential voids in discharge services, making the BCF money go further. Recently, we are getting clear communications from the domiciliary care market that they have more availability of staff. Therefore, we will be going to market to seek relevant cost efficiencies and additional capacity to continue to expand our Home First default position.

We are also taking learning around patients who have delirium or are non-weight bearing and awaiting rehabilitation.

Integrated care will be viewed at Place to ensure greater alignment with market management activity and capacity modelling / delivery, which is well underway for adult social care commissioned provision, most significantly, Discharge to Assess. This will see opportunities to align existing BCF contributions to support demographic need at Place and develop a more robust integrated care offer where the system requires this. Governance is being strengthened to ensure system alignment and clarity of decision making.

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SECTION 5.3: How BCF is Adapting to Support Delivery & Expected Impact on Metrics

(Provide the Right Care, in the Right Place, at the Right Time)

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

We have recently worked closely as Surrey County Council and ICB Partnership to undertake evaluations of all ICB Place systems in Surrey to consider:

- How we have approached discharge to usual place of residence
- Variation
- Recommendations to ICB Executive going forward.

In 2022-23 there were a variety of options available to patients being discharged from hospital. Broadly, people could either be discharged to a bed-based care facility or back to their own home with care and support provided.

As far as the bed-based offer was concerned, people could:

- Return to the care home that they were admitted from, subject to the care home still being able to meet their needs.
- Move to a different care home (with a different registration category) if their usual care home residence could no longer meet their needs.

- Move temporarily to a step-down facility (community hospital or care home) whilst further health and social care assessments were undertaken.

The return to one's own home offer consisted of the full spectrum of services listed in 5.1 and involved additional BCF investments into primary care, home-based care including reablement.

Our ambitions around discharge for 2023-25 include:

- Delivering a consistent hospital discharge offer across all Places which is focused on Home First with the patient, carer, and family at the centre of the pathway which can flex up and down as appropriate, with surge.
- Agreeing a shared Discharge to Assess system metrics.
- Improving whole system commissioning processes which support Surrey County Council adult social care commissioners to lead on system wide market engagement and market shaping, with closer working at Place, to deliver tailored support in the right place at the right time with the right system balance.
- Ensuring that BCF budget supports System and recognises Place.
- Developing Place delivery models aligned to demand modelling and have these agreed by the Urgent and Emergency Care Board.
- Ensuring complex care pathways are reviewed by Place with Discharge Cell oversight, aligned to mental health transformation.
- Ensuring education and understanding of Discharge to Assess across the system is available for patients, Carers, and staff.
- Improving engagement and risk management with community, medicines management, Health Watch, the voluntary, community & social enterprise sector, Surrey Care Association, and primary care.
- Ensuring integration and wrap around with Virtual Care and Virtual Wards which is resourced and scaled up.
- Ensuring a community data set that includes hospital discharge is approved by Place and owned by System.
- Ensuring governance at Place and System are aligned.

In line with the ambitions set out in NHS England Delivery Plan for recovering Urgent and Emergency Care Services, we have established (for 2023 and beyond) a dedicated Improving Discharge Workstream as part of the Surrey Urgent and Emergency Care Board's work. This has system leadership from across the ICS.

In addition to this, we will ensure that people with delirium or who are non- weight bearing do not get delayed in hospital. Use of BCF assists as a funding mechanism to secure timely discharge for these cohorts of people. We have committed to use our existing learning to consider jointly developing a wider Delirium or non-weight bearing pathway that is consistent across the ICB area. This work will be progressed via the Urgent & Emergency Care "Expanding Care Outside of Hospital" workstream.

We know that 93% of non-elective admissions in Surrey return to their usual place of residence following discharge from hospital. We will undertake a comparative review to consider this statistic against other systems and to identify and understand any significant variation within the Surrey system.

SECTION 5.4: Progress in Implementing the High Impact Change Model

(Provide the Right Care, in the Right Place, at the Right Time)

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

The Surrey system has used the High Impact Change Model as a driver for some time. The key focus now is the Urgent and Emergency Care Recovery plan that incorporates all of this. There is a specific workstream we are leading on under the Urgent and Emergency Care Collaborative which incorporates the High Impact Change Model. The key to this is to expand and enrich our discharge data to understand both demand but also the impact of any discharge improvement. We have a discharge dashboard within the SHREWD IT platform that is in development.

In summary, the Emergency Care Recovery Plan aims are about:

- Improving joint discharge processes via roll out of Transfer of Care Hubs with improved assessment and planning processes.
- Promoting principles that underpin the Discharge to Assess model.
- Highlighting where capacity does not match demand levels across all the pathways and taking any remedial action.
- 80/20 Discharge split at weekend.
- Embedding, where possible, the work completed by Impower consultants regarding Discharge and Flow across Surrey.
- Developing a care home/domiciliary care dashboard.
- Scaling up intermediate care – utilising the evaluation of the Frontrunner national standard for rapid discharge into intermediate care.
- Scaling up social care services by working with local government and social care providers to optimise access to social care.
- Undertaking further work with Continuing Health Care to ensure patients with the most complex needs have similar experiences and outcomes to the general inpatient population when they are ready for discharge.

What we expect:

- Improvement in Criteria to Reside performance.
- To continue to embed the 10 best practice interventions in 100-day challenge.
- Increased flow into intermediate care.
- Increased access through Adult Social Care.
- To reduce bed base Length of Stay for medically fit.
- Robust discharge data to evidence.
- Improve 80/20 performance.
- Reduced variation in performance.
- Established process for Personal Health Budgets in Integrated Care System.

93% of Surrey residents return to their usual place of residence. There is still some variation at Place and we are committed to exploring this variation further in the future. We have made additional

investments into health & social care community teams for D2A from BCF. We have also invested in ring-fenced domiciliary care to achieve this objective. We do not complete continuing healthcare assessments in hospital. The implementation of Criteria to Reside has had been widely adopted by consultants & this is also having an effect. We are rolling out of Transfer of Care Hubs with improved assessment and planning processes. This workstream will also highlight where capacity doesn't match demand levels across all the pathways.

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SECTION 6: BCF Support to Unpaid Carers and Care Act Duties

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

BCF funding is utilised to support advocacy services (instructed and non-instructed) throughout Surrey and investment in the Safeguarding Board operation. A contribution is also made towards the operation of domiciliary care, known as Care within the Home, which is a joint arrangement between Surrey County Council and NHS Heartlands continuing health care which also operates on behalf of Frimley.

This investment supports the overall ambition for people living in Surrey to be supported to remain independent, stay at home, strength gain and reable where possible. These contributions facilitate, in part, Surreys' ambition to ensure people have access to the support they need from providers of good quality operating under contractual arrangements within the integrated system.

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BCF funding is also spent on information and advice services, provided through Age UK Surrey, which ensures people can access support for their health and wellbeing, including realising any entitlement to benefits, and can make informed decisions about their short and / or long-term health and care needs.

Surreys' Stroke Recovery service is also funded through BCF and is commissioned from Surrey adult social care on behalf of both Surrey Heartlands and Frimley systems.

All of these programmes funded by the BCF enable the duties of the Care Act to be delivered.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

A ringfenced budget has been created within the BCF specifically to address the support needs of Carers, implementing the co-produced Surrey-wide strategies for adult Carers and for young Carers. The budget supports the long-standing and well-established Integrated Carers team. This comprises Surrey County Council and Surrey Heartlands ICB employed staff and is hosted within Surrey County Council under the Partnership agreement between the two organisations. It also works in partnership with Frimley ICB. The team work on a range of projects and programmes to improve outcomes from unpaid Carers. One theme from the strategy was around supporting working Carers and to progress this a staff Carers' survey will be launched in Carers' week in June 2023 across the System; Carers' champions have been appointed in Surrey Heartlands ICB; staff sessions on managing carer burnout have been set up and there are plans for a Surrey employers event to focus on supporting working Carers.

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

A review of the specific support needed by Carers of someone with mental health needs has led to service specifications being co-produced with Carers and an approach to the provider market is planned this summer.

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There is also an innovation fund to address issues that arise and that are not otherwise addressed in the specifications for the system wide commissioned services, allowing smaller scale, Place, town or neighbourhood specific initiatives to be developed or for new approaches to supporting Carers to be developed and tested out to inform future strategies.

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.

SECTION 7: BCF Support to Housing, including the Disabled Facilities Grant (DFG)

SECTION 7.1: Strategic Approach to Housing to Support Independence at Home

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Surrey County Council works strategically with its 11 district and borough councils and has a clear commitment to the importance that housing and housing support plays in promoting and supporting independence. This commitment is set out in the recently published Housing Strategy (DRAFT Strategy for Housing Accommodation and Homes - Cabinet Report - Oct22 MC.pdf (surreycc.gov.uk)) and through a range of specialist housing strategy documents that form part of Surrey County Council's Accommodation with Care and Support Strategy and transformation programme. This programme includes three strategic areas of focus with clear and ambitious targets to fundamentally change the range of accommodation with support available to Surrey residents as follows:

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- Extra Care Housing – to delivery 725 units of Extra Care Housing by 2030
- Supported Independent Living for people with Learning Disabilities and Autism
- Supported Independent Living for people with mental health support needs.

- **ECH 2019 Strategy** - 16. Accommodation with Care support Cabinet report July 2019.pdf (surreycc.gov.uk)
- **SIL LD 2020 Strategy** - Supported Independent Living Report- Cabinet.pdf (surreycc.gov.uk)
- **SIL MH 2023 Strategy** - PART 1 CABINET REPORT - DELIVERY STRATEGY FOR MODERNISING AND TRANSFORMING ACCOMMODATION WITH SUPPOR.pdf (surreycc.gov.uk)

The Disabled Facilities Grant (DFG) is paid to district and borough 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 occupational therapists being involved in ensuring provision is reasonable and appropriate (Guildford and Waverley). District and boroughs 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 Local Joint Commissioning Groups 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 district and borough councils attend every other meeting (six each year) to provide essential local knowledge.

In addition, Integrated Care Partnerships (ICPs) will be a delivery forum for issues which require a co-ordinated approach. In attendance will be district and borough councils, health and VCSE representatives. This enables 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.

SECTION 7.2: Regulatory Reform Order 2002

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

No

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SECTION 8: Equality and Health Inequalities

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

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System Priorities and Operational Guidelines Regarding Health Inequalities in Surrey

The BCF in Surrey is aligned with both BCF national policy guidance and the HWB Strategy. In Surrey, as nationally, we continue to focus on the health and wider inequalities that persist in our populations and this is driven by the focus of our local health and wellbeing strategy which explicitly states an ambition to reduce health inequalities across Surrey. Building on the rapid needs assessment done during the COVID-19 pandemic, and the Joint Strategic Needs Assessment more broadly, this focuses on a number of Priority Populations of identity and geography including the 21 Key Neighbourhoods that relate to the Index of Multiple Deprivation.

These have been adopted as Priority Populations in the refreshed Health and Wellbeing Strategy and are increasingly being used to focus activity around health ine qualities across organisations, including within the BCF programme. For example, Carers and Young Carers (one of the Priority Populations of Identity) are supported through the BCF Carer's Budget as outlined in section 6. BCF support to one of the Key Neighbourhoods in Farnham is outlined as a case study below. Our local Integrated Care Systems (ICS) have both adopted a further focus on inclusively supporting those in greatest need through working with communities and across the NHS, local authorities, and other partners through programmes that are delivering a focus on CORE20 plus 5.

In Surrey Heartlands, the Equality and Health Inequality Workstream consider the Priority Populations as set out in the HWB Strategy. They also consider the issue of equality and health inequalities for our citizens, patients, and also the workforce that supports their care. The role of the Equality and Health Inequalities Board is to focus on our response to the NHS Operational Planning Guidance which outlines five priority areas for tackling health inequalities.

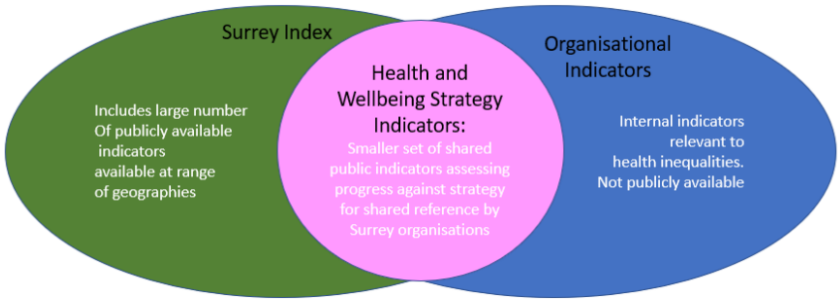
In Frimley, the Local Plan ambitions include reducing inequalities. A range of insights have been gathered to identify specific cohort groups across communities where further action is needed. This work cuts across all areas of the ICS plans including elective recovery, mental health transformation and community redesign. Locally, population health management approaches, data segmentation and risk stratification have also been used to provide insight into those facing the greatest health

inequalities and/or with the most complex needs that would benefit from local, targeted, personalised and multidisciplinary support.

Key to all of this work on health inequalities is our need for continued and greater engagement with communities which is represented through the Key Principles of working with communities in our Health and Wellbeing Strategy. The VCSE sector has 3 members on the HWB Board.

Key Changes for 2023-25

A key change during 2023-25 will be the introduction of a new HWB Strategy Index for Surrey to enable a broader focus across health, wellbeing and the wider determinants of health. It is intended that the new metrics will 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 a common set of publicly available indicators will 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. Wherever data is available, the indicators will be available to be interrogated at the lowest possible geographical level. This will enable the BCF to take a more targeted approach to reducing health inequalities across Surrey.

How Equality Impacts of the Local BCF Plan have been Considered in Surrey

When developing BCF plans, Local Joint Commissioning Groups take into consideration strategic commitments to reduce health inequalities in relevant Place-based plans, ICS operational plans, district and borough and Surrey County Council strategies.

Rather than an overarching equalities impact assessment being in place for the high-level BCF plan, all commissioned programmes locally (including those in the BCF) include specific equality impact assessments to not only ensure compliance with the Equality Act 2010 but more importantly ensure all opportunities for access for those with protected characteristics are maximised.

How Inequalities are Being Addressed by the BCF

In line with our overall HWB Strategy, our approach for 2023-25 will include projects that are designed to reduce inequalities. We have an included a case study of healthy eating courses from Farnham as an example:

Case Study: Healthy Eating Courses in Farnham, Surrey

We recently identified a specific area of deprivation in Farnham and invested in healthy eating courses to improve diet, reduce food wastage, improve life skills, promote physical activity, reduce loneliness, and address cost of living crisis by teaching cost effective use of energy and food. The community centre also acts as a warm space within the winter months. The aim is to use this initiative to bring those who might not usually use the community centre into the space to see the range of broader offers including mental health support and citizen's advice bureau.

The project is centred on the population of Sandy Hill estate in Farnham. Sandy Hill has been identified as being within one of the Key Neighbourhoods in Surrey by the HWB Strategy. The Farnham Health Inequalities Group are working to promote and develop the existing work of Hale Community Centre based on the estate, and recently have linked with The Health Creation Alliance in this aim. The area is poorly served by transport links and lies on the outskirts of the town with poor facilities apart from some large green spaces, and an active community centre. Work to date has identified a lower level of physical activity for Sandy Hill residents than in surrounding areas, a desire to eat more healthily and concerns regarding financial stressors.

More broadly, any new funding requests for North East Hampshire and Farnham Local Joint Commissioning Group, will now have to show how the population health needs of the local population will be addressed.

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BCF Planning Template 2023-25

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

2. Cover

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).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, 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'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

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 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. 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.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, 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 Condition 4 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 6b.
- 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. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. 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 eligible expenditure on social care under National Condition 4.
- 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.

7. 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 on NHS commissioned out of hospital services under National Condition 4. 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.

8. 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.

9. 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.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.
12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

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 2023-25. 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 2023-24.

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 2023-24. 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 (2021)
- Actual performance for each quarter of 2022-23 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.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- 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. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. 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 2022-23, 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 2023-24 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 2022-23 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.

4. Residential Admissions:
- 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 2022-23. 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.

5. Reablement:
- 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 2022-23. 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.

8. Planning Requirements

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 Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 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 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Complete:
Health and Wellbeing Board:	Surrey	Yes
Completed by:	Suzi Stern	Yes
E-mail:	susan.stern@surreycc.gov.uk	Yes
Contact number:	susan.stern@surreycc.gov.uk	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	<Please Select>	No
If no please indicate when the HWB is expected to sign off the plan:		No

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Tim	Oliver	tim.oliver@surreycc.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Dr	Claire	Fuller	clairefuller1@nhs.net	Yes
	Additional ICB(s) contacts if relevant	Mr	Jonathan	Sly	jonathan.sly@nhs.net	Yes
	Local Authority Chief Executive	Ms	Joanna	Killian	joanna.killian@surreycc.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Jon	Lillistone	jonathan.lillistone@surreycc.gov.uk	Yes
	Better Care Fund Lead Official	Ms	Suzi	Stern	susan.stern@surreycc.gov.uk	Yes
	LA Section 151 Officer	Mr	Leigh	Whitehouse	leigh.whitehouse@surreycc.gov.uk	Yes
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	Health Integration Policy Lead	Ms	Lucy	Clements	lucy.clements4@nhs.net	

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Surrey

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£10,155,847	£10,155,847	£10,155,847	£10,155,847	£0
Minimum NHS Contribution	£90,012,843	£95,107,570	£90,012,843	£95,107,570	£0
iBCF	£11,408,352	£11,408,352	£11,408,352	£11,408,352	£0
Additional LA Contribution	£1,008,564	£1,008,562	£1,008,564	£1,008,562	£0
Additional ICB Contribution	£11,343,869	£11,343,869	£11,343,869	£11,343,869	£0
Local Authority Discharge Funding	£1,599,433	£2,665,722	£1,599,433	£2,665,722	£0
ICB Discharge Funding	£5,509,223	£9,579,424	£5,509,223	£9,579,424	£0
Total	**£131,038,131**	**£141,269,346**	**£131,038,131**	**£141,269,346**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£25,582,047	£27,029,991
Planned spend	£37,523,959	£39,555,627

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£53,028,113	£56,029,504
Planned spend	£53,787,698	£56,920,735

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	130.0	140.0	155.0	143.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,124.5	2,124.5
	Count	5380	5380
	Population	228579	228579

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 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)	93.6%	86.8%	91.3%	93.6%

Residential Admissions

		2021-22 Actual	2023-24 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	555	698

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	69.4%

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 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Surrey

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	
	All data is from CSDS. Urgent includes all those with waiting times under 2hrs and Reablement includes all those that were more than 2hrs. This includes only Surrey Heartlands. 15% uplifted added to emulate Surrey-wide. As numbers for the voluntary sector are not collected, an assumed 3% of total capacity has been used. This includes referral numbers, not care contacts Includes/excludes referrals from acute setting [Acute Hospital Inpatient/Outpatient Department], where appropriate. Where [SourceOfReferralForCommunityDescription] is BLANK or UNKNOWN this is counted as a community source The following formula was used to get the total monthly capacity: The highest number of cases in a given day since 2018/19 * days in the month. This calculation assumes the average length of stay per patient is 1 day.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	Demand - Hospital Discharge												
OTHER	Social support (including VCS) (pathway 0)	13	13	12	13	12	13	14	13	13	11	9	6
OTHER	Reablement at home (pathway 1)	51	83	56	70	74	125	127	143	143	94	75	61
OTHER	Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
OTHER	Short term domiciliary care (pathway 1)	61	48	49	72	50	47	55	52	48	48	44	24
OTHER	Reablement in a bedded setting (pathway 2)	313	293	267	288	264	241	263	213	223	196	176	96
OTHER	Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
OTHER	Short-term residential/nursing care for someone likely to require a longer-	0	0	0	0	0	0	0	0	0	0	0	0

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	11	16	18	20	20	26	29	25	27	24	15	17
Urgent Community Response	136	308	367	448	407	581	614	519	617	431	247	345
Reablement at home	43	61	71	81	136	163	205	169	202	208	178	139
Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	2	3	5	7	1	5	5	0	4	6	3	2
Other short-term social care	156	150	132	122	112	113	111	125	76	140	68	60

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	118	122	118	122	122	118	122	118	122	122	111	122
Reablement at Home	Monthly capacity. Number of new clients.	600	620	600	620	620	600	620	600	620	620	560	620
Rehabilitation at home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care	Monthly capacity. Number of new clients.	210	217	210	217	217	210	217	210	217	217	196	217
Reablement in a bedded setting	Monthly capacity. Number of new clients.	3120	3224	3120	3224	3224	3120	3224	3120	3224	3224	2912	3224
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
		100%
		100%
		100%
		100%

3.4 Capacity - Community

	Capacity - Community												Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	88	91	88	91	91	88	91	88	91	91	82	91			100%
Urgent Community Response	Monthly capacity. Number of new clients.	1440	1488	1440	1488	1488	1440	1488	1440	1488	1488	1344	1488			100%
Reablement at Home	Monthly capacity. Number of new clients.	780	806	780	806	806	780	806	780	806	806	728	806			100%
Rehabilitation at home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	270	279	270	279	279	270	279	270	279	279	252	279			100%
Other short-term social care	Monthly capacity. Number of new clients.	420	434	420	434	434	420	434	420	434	434	392	434			100%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Surrey

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Surrey	£10,155,847	£10,155,847
DFG breakdown for two-tier areas only (where applicable)		
Elmbridge	£976,997	£976,997
Epsom and Ewell	£785,282	£785,282
Guildford	£805,901	£805,901
Mole Valley	£886,819	£886,819
Reigate and Banstead	£1,286,692	£1,286,692
Runnymede	£874,205	£874,205
Spelthorne	£943,241	£943,241
Surrey Heath	£884,021	£884,021
Tandridge	£522,380	£522,380
Waverley	£852,606	£852,606
Woking	£1,337,703	£1,337,703
Total Minimum LA Contribution (exc iBCF)	**£10,155,847**	**£10,155,847**

Complete:

Yes

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Surrey	£1,599,433	£2,665,722

Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Frimley ICB	£506,521	£1,238,157
NHS Surrey Heartlands ICB	5002701.86	£8,341,267
Total ICB Discharge Fund Contribution	£5,509,223	£9,579,424

Yes

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Surrey	£11,408,352	£11,408,352
Total iBCF Contribution	**£11,408,352**	**£11,408,352**

Yes

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Surrey	£492,744	£492,742	Surrey contribution to BCF
Surrey	£515,820	£515,820	Carry Forward - Frimley side of council
Total Additional Local Authority Contribution	**£1,008,564**	**£1,008,562**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Frimley ICB	£11,562,727	£12,217,178
NHS Surrey Heartlands ICB	£78,450,116	£82,890,393
Total NHS Minimum Contribution	**£90,012,843**	**£95,107,570**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Surrey Heartlands ICB	£9,300,000	£9,300,000	Carry forward of Additional Contribution
NHS Frimley ICB	£1,300,000	£1,300,000	Carry forward of Additional Contribution
NHS Frimley ICB	£743,869	£743,869	Carry forward from 22/23
Total Additional NHS Contribution	**£11,343,869**	**£11,343,869**	
Total NHS Contribution	**£101,356,712**	**£106,451,439**	

Yes

	2023-24	2024-25
Total BCF Pooled Budget	**£131,038,131**	**£141,269,346**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Surrey

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£10,155,847	£10,155,847	£0	£10,155,847	£10,155,847	£0
Minimum NHS Contribution	£90,012,843	£90,012,843	£0	£95,107,570	£95,107,570	£0
iBCF	£11,408,352	£11,408,352	£0	£11,408,352	£11,408,352	£0
Additional LA Contribution	£1,008,564	£1,008,564	£0	£1,008,562	£1,008,562	£0
Additional NHS Contribution	£11,343,869	£11,343,869	£0	£11,343,869	£11,343,869	£0
Local Authority Discharge Funding	£1,599,433	£1,599,433	£0	£2,665,722	£2,665,722	£0
ICB Discharge Funding	£5,509,223	£5,509,223		£9,579,424	£9,579,424	£0
Total	**£131,038,131**	**£131,038,131**	**£0**	**£141,269,346**	**£141,269,346**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£25,582,047	£37,523,959	£0	£27,029,991	£39,555,627	£0
Adult Social Care services spend from the minimum ICB allocations	£53,028,113	£53,787,698	£0	£56,029,504	£56,920,735	£0

Checklist

Column complete:																		
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

36, 55,
60, 61,
62, 63,
64, 65,
66, 67,
68, 69,
70, 71,
72, 73,
74, 75,
76, 77,
78, 79,
80, 81,
82, 83,
84, 85,
86, 87,
88, 89,
90, 91,
92, 93,
94, 95,
96, 97,
98, 99,
100, 101,
102, 103,
104, 105,
106, 107,
108, 109,
110, 111,
112, 113,
114, 115,
116, 117,
118, 119,
120, 121,

						Planned Expenditure											
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	ES 1a - Responsibilities under the Care Act	Homecare Service Provision	Care Act Implementation Related Duties	Other	Carer advice and support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£373,670	£373,670	14%
2	ES 1b - Responsibilities under the Care Act	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£4,551	£4,551	0%
3	ES 1c - Responsibilities under the Care Act	Safeguarding	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£17,778	£17,778	1%
4	ES 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		502	502	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£380,000	£380,000	4%
5	ES 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£4,660,776	£4,924,576	4%
6	ES 4 - Prescription Schemes	Social Prescription	Prevention / Early Intervention	Social Prescribing					Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£518,004	£547,323	1%
7	ES 5 - Community Grants	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£168,650	£178,196	0%
8	ES 6 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment support for mental health				Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£120,341	£127,152	0%
9	ES 7 - Tech to Connect	Training to residents to enable social inclusion through the use of technology	Assistive Technologies and Equipment	Digital participation services		508	537	Number of beneficiaries	Other	Wellbeing Services	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£67,479	£71,298	1%
10	ES 8 - Growing Health Together	Co-creating conditions for peoples health and wellbeing to thrive	Prevention / Early Intervention	Other	Local PCN led scheme to promote wellbeing				Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£147,658	£156,015	0%
11	ES 9 - Home from Hospital	Home First	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£149,183	£157,627	1%
12	ES 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	Existing	£19,408	£20,507	1%
13	ES 11 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		70	74	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£120,000	£126,792	1%
14	ES 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	Existing	£41,073	£43,397	2%
15	ES 13a - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£257,410	£276,264	0%
16	ES 13b - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£75,709	£75,709	0%
17	ES 14 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£44,683	£47,212	12%
18	ES 15 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		1942	1954	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£570,610	£602,907	6%
19	ES - 16 Autism Friendly Communities	Providing support to communities in Surrey to be inclusive of people with Autism	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,500	£3,698	0%
20	ES - 17 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	Existing	£68,241	£72,104	4%
21	ES 18 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		224	224	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	Existing	£1,268,237	£1,268,237	12%
22	ES 19 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Other	Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3)	38	38	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£1,729,975	£1,729,975	1%
23	Discharge Fund - Surrey Heartlands Pathway 1	Pathway 1	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		31711	52874	Hours of care	Social Care		NHS			Private Sector	ICB Discharge Funding	New	£760,755	£1,268,446	1%
24	ES 21 - ICB Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry Forward				Community Health		NHS			NHS	Additional NHS Contribution	Existing	£4,800,000	£4,800,000	4%
25	ES 22 - D2A contribution	D2A Funding	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		19685	19540	Hours of care	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£472,253	£468,758	0%

26	GW 1a - Responsibilities under the Care Act	Homecare Service Provision	Care Act Implementation Related Duties	Other	Carer advice and support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£427,399	£427,399	16%
27	GW 1b - Responsibilities under the Care Act	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£5,207	£5,207	0%
28	GW 1c - Responsibilities under the Care Act	Safeguarding	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£20,394	£20,394	1%
29	GW 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		575	575	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£435,000	£435,000	4%
30	GW 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£4,369,690	£4,617,014	3%
31	GW 4 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Support for Mental Health				Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£141,927	£149,960	0%
32	GW 5 - End of Life Care - Contract	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£185,586	£196,090	11%
33	GW 6 - Psychiatric Liaison Services	Mental Health Support	Prevention / Early Intervention	Other	Psychiatric Liaison				Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£190,976	£201,785	0%
34	GW 7 - Mental Health wards	Mental Health Support	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		LA			Local Authority	Minimum NHS Contribution	Existing	£177,614	£187,667	2%
35	GW 8 - Funding for Non Elective Admissions in acute	Contributions to Acute contracts	Other						Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£200,000	£211,320	0%
36	GW 9 - Care Home Matrons	Discharge to Care Homes	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£138,431	£146,266	1%
37	GW 10 - Let's get steady, Fall prevention	Falls Prevention	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£26,000	£27,472	0%
38	GW 11 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		8095	9823	Hours of care	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£194,190	£235,661	0%
39	GW 12 - Falls Prevention Packs	Falls Prevention	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£9,343	£9,872	0%
40	GW 13 - Social Prescribing Administrator	Social Prescription	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£33,000	£34,868	0%
41	GW 14 - Outline Grant	Outline Grant	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£276	£292	0%
42	GW 15 - Red Bag	Red Bag Scheme	High Impact Change Model for Managing Transfer of Care	Red Bag scheme					Community Health		NHS			Private Sector	Minimum NHS Contribution	New	£1,794	£1,896	0%
43	GW 16 - Home from Hospital	Home First	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£23,010	£24,312	0%
44	GW 17 - 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	Existing	£22,833	£24,126	1%
45	GW 18 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		63	66	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£107,000	£113,056	1%
46	GW 19 - 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	Existing	£48,088	£50,809	3%
47	GW 20a - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£293,492	£314,990	0%
48	GW 20b - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£86,319	£86,319	0%
49	GW 21 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£51,917	£54,855	14%
50	GW 22 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		2299	2314	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£675,568	£713,806	7%

51	GW 23 - Social Prescribing	Social Prescription	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£69,687	£73,632	0%
52	GW 24- 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	Existing	£73,346	£77,498	4%
53	GW 25 - ASC Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£35,960	£37,995	0%
54	GW 26 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		222	222	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	Existing	£1,253,448	£1,253,448	12%
55	GW 27 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Other	Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3)	43	43	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£1,981,153	£1,981,153	1%
56	Discharge Fund - Surrey Heartlands Pathway 2	Pathway 2	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support discharge)		614	1024	Number of Placements	Social Care		NHS			Private Sector	ICB Discharge Funding	New	£3,686,198	£6,146,191	74%
57	GW 29 - ICB Carry Forward 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry forward				Community Health		NHS			NHS	Additional NHS Contribution	Existing	£1,500,000	£1,500,000	1%
58	SD 1a - New responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Other	Carer advice and support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£610,436	£610,436	23%
59	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	Existing	£7,437	£7,437	0%
60	SD 1c - New responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£29,127	£29,127	1%
61	SD 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		821	821	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£621,000	£621,000	6%
62	SD 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£6,333,486	£6,691,961	5%
63	SD 4 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Support for Mental Health				Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£173,715	£183,547	0%
64	SD 5 - End of Life Care Contract	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£371,934	£392,985	22%
65	SD 6 - Integrated Teams	Integrated Community Health Team	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£528,787	£558,716	5%
66	SD 7 - Care Home support post	Support to Care Homes	Integrated Care Planning and Navigation	Care navigation and planning					Continuing Care		NHS			NHS	Minimum NHS Contribution	Existing	£38,776	£40,971	2%
67	SD 8 - Mental Health - Psychiatric Liaison	Mental Health Support	Prevention / Early Intervention	Other	Psychiatric Liaison				Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£469,101	£495,652	1%
68	SD 9 - Local CCG Schemes mapped to BCF projects	Various small contracts	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£73,699	£77,870	0%
69	SD 10 - Funding for Non Elective Admissions in	Contributions to Acute contracts	Other						Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£334,000	£352,904	0%
70	SD 11 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		32952	34942	Hours of care	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£790,512	£838,265	1%
71	SD 12 - Tech to Connect	Training to residents to enable social inclusion through the use of	Assistive Technologies and Equipment	Digital participation services		470	497	Number of beneficiaries	Other	Wellbeing services	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£62,443	£65,977	1%
72	SD 13 - Care Home Improvement and	Care Home improvement including workforce training	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Other	Workforce Development	NHS			NHS	Minimum NHS Contribution	Existing	£38,776	£40,971	0%
73	SD 14 - Falls Prevention Packs	Falls Prevention	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£10,782	£11,392	0%
74	SD 15 - Hospital to Home Support Service	Home First	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£89,103	£94,146	1%
75	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	Existing	£35,392	£37,395	2%

76	SD 17 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		132	140	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£225,000	£237,735	2%
77	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	Existing	£70,558	£74,551	4%
78	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	Existing	£400,063	£429,366	0%
79	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	Existing	£117,666	£117,666	0%
80	SD 20 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£80,610	£85,172	22%
81	SD 21 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		3295	3316	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£968,268	£1,023,072	10%
82	SD 22 - Social Precribing	Social Prescription	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£119,223	£125,971	0%
83	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	Existing	£133,308	£140,853	8%
84	SD 25 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		489	489	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£2,763,648	£2,763,648	27%
85	SD 26 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Other	Discharge from hospital (with reablement) to	62	62	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£2,827,262	£2,827,262	2%
87	SD 28 - ICB Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry forward				Community Health		NHS			NHS	Additional NHS Contribution	Existing	£1,500,000	£1,500,000	1%
88	NW 1a - Responsibilities under the Care Act	Homecare Service Provision	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£734,033	£734,033	28%
89	NW 1b - Responsibilities under the Care Act	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£8,943	£8,943	0%
90	NW 1c - Responsibilities under the Care Act	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£35,025	£35,025	1%
91	NW 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		988	988	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£747,000	£747,000	7%
92	NW 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£7,753,243	£8,192,077	6%
93	NW 4 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Support for Mental Health				Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£237,148	£250,571	0%
94	NW 5 - Mental Health Virtual Wards	Mental Health Support	Personalised Care at Home	Mental health /wellbeing					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£451,981	£477,563	96%
95	NW 6 - Acute Contributions	Contributions to Acute contracts	Other						Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£1,687,000	£1,782,484	0%
96	NW 7 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		43175	45512	Hours of care	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,035,761	£1,091,825	1%
97	NW 8 - Outline	Support to people with their sexuality and gender identity	Prevention / Early Intervention	Choice Policy					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	New	£481	£508	0%
98	NW 9 - Bright Lights	Support to individuals with Learning Disabilities and Autism	Prevention / Early Intervention	Other	Social Interaction				Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	New	£13,224	£13,972	0%
99	NW 10 - Home from Hospital	Home First	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£97,410	£102,923	1%
100	NW 11 - 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	Existing	£37,575	£39,702	2%

101	NW 12 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		123	130	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£210,000	£221,886	2%
102	NW 13 - 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	Existing	£79,185	£83,666	5%
103	NW 14a - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£501,720	£538,465	1%
104	NW 14b - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£147,440	£147,438	0%
105	NW 15 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£106,094	£112,099	29%
106	NW 16 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		3179	3199	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£934,082	£986,951	10%
107	NW 17 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	Existing	£154,879	£163,645	9%
108	NW 18 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		641	641	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	Existing	£3,622,770	£3,622,770	36%
109	NW 19 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Other	Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3)	74	74	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£3,400,298	£3,400,298	2%
110	Discharge Fund - Surrey Heartlands Staffing	Staffing	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		NHS			Private Sector	ICB Discharge Funding	New	£318,340	£530,785	0%
111	NW 21 - ICB Carry forward from 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry forward				Community Health		NHS			NHS	Additional NHS Contribution	Existing	£1,500,000	£1,500,000	1%
112	Discharge Fund - Heartlands SCC	Pathway 1	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		8947	14912	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge Funding	New	£214,643	£357,737	0%
113	Discharge Fund - Heartlands SCC	Pathway 2	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support discharge)		173	289	Number of Placements	Social Care		LA			Private Sector	Local Authority Discharge Funding	new	£1,040,035	£1,733,392	21%
114	Discharge Fund - Heartlands SCC	Pathway 3	Residential Placements	Short-term residential/nursing care for someone likely to require a longer-term care home replacement					Social Care		LA			Private Sector	Local Authority Discharge Funding	New	£66,983	£111,639	0%
115	Discharge Fund - Heartlands SCC	Staffing	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Private Sector	Local Authority Discharge Funding	New	£89,817	£149,696	0%
116	Discharge Fund - Frimley ICB	Pathway 1	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		13966	34140	Hours of care	Community Health		NHS			Private Sector	ICB Discharge Funding	New	£335,050	£819,007	0%
117	Discharge Fund - Frimley ICB	Pathway 2	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support discharge)		29	70	Number of Placements	Community Health		NHS			Private Sector	ICB Discharge Funding	New	£171,471	£419,150	3%
118	Discharge Fund - Frimley SCC	Pathway 1	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		5182	8637	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge Funding	New	£124,327	£207,212	0%
119	Discharge Fund - Frimley SCC	Pathway 2	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support discharge)		11	18	Number of Placements	Social Care		LA			Private Sector	Local Authority Discharge Funding	new	£63,628	£106,046	1%
120	GW 30 - Community Schemes / D2A	D2A Funding	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		30349	30349	Hours of care	Community Health		NHS			NHS	Minimum NHS Contribution	New	£728,068	£728,068	1%
121	SH 1a - New responsibilities under the Care Act	Homecare Service Provision	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£200,019	£200,019	8%
122	SH 1b - New responsibilities under the Care Act	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,437	£2,437	0%
123	SH 1c - New responsibilities under the Care Act	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£9,544	£9,544	0%
124	SH 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		270	270	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£204,000	£204,000	2%
125	SH 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,630,108	£1,722,372	1%

126	SH 4 - End of Life Care Contract	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£82,262	£86,918	5%
127	SH 5 - End of Life Care Clinical Lead	Staffing costs	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£11,870	£12,542	1%
128	SH 6 - Mental Health - Psychiatric Liaison - Contract	Mental Health Support	Prevention / Early Intervention	Other	Psychiatric Liaison				Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£218,885	£231,274	0%
129	SH 7 - Integrated Care Team	Staffing costs	Enablers for Integration	Integrated models of provision					Social Care		NHS			NHS	Minimum NHS Contribution	Existing	£430,529	£454,897	68%
130	SH 8 - Out of Hospital	D2A	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		NHS			NHS	Minimum NHS Contribution	Existing	£221,148	£233,665	2%
131	SH 9 - Occupational Therapist (SHBC)	Occupational Therapist (SHBC)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£72,940	£77,068	0%
132	SH 10 - VSNS Asset Development post	Social Prescribing	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£40,638	£42,938	0%
133	SH11 - Social prescribing post Federation (CAB)	Social Prescription	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£34,172	£36,106	0%
134	SH 12 - Social prescribing post SHBC	Social Prescription	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£41,680	£44,039	0%
135	SH 13 - Elemental Subscription for Social Subscribers	Social Prescription	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,800	£1,902	0%
136	SH 14 - Time to Talk	Mental Health Support	Personalised Care at Home	Mental health /wellbeing					Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£20,840	£22,020	4%
137	SH 15 - Locality Director	Staffing costs	Enablers for Integration	Integrated models of provision					Social Care		NHS			NHS	Minimum NHS Contribution	Existing	£64,451	£68,099	10%
138	SH 16 - MH Case Worker (Homelessness)	Homelessness	Housing Related Schemes						Social Care		NHS			NHS	Minimum NHS Contribution	Existing	£27,175	£28,713	7%
139	SH 17 - Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£112,226	£69,918	0%
140	SH 18 - Community Schemes - Tech Post	Technology Enabled Schemes	Assistive Technologies and Equipment	Assistive technologies including telecare		345	365	Number of beneficiaries	Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£45,833	£48,427	0%
141	SH 19 - Health Integration Development Officer	Development Officer to progress Health Integration	Workforce recruitment and retention						Primary Care		NHS			NHS	Minimum NHS Contribution	New	£43,012	£45,446	0%
142	SH 20 - Home from Hospital ICB	Home First	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£41,924	£44,297	0%
143	SH 21 - Home from Hospital SCC	Home First	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£10,920	£11,538	0%
144	SH 22 - 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	Existing	£10,752	£11,361	1%
145	SH 23 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		32	34	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£55,000	£58,113	1%
146	SH 24 - 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	Existing	£22,962	£24,261	1%
147	SH 25a - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£136,930	£147,073	0%
148	SH 25b - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£42,275	£42,275	0%
149	SH 26 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£37,509	£39,632	10%
150	SH 27 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		1234	1242	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£362,636	£383,161	4%

151	SH 28 - 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	Existing	£51,763	£54,693	3%
152	SH 29 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		156	156	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	Existing	£882,488	£882,488	9%
153	SH 30 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Other	Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3)	20	20	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£927,309	£927,309	1%
154	SH 31 - CCG Carry forward from 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry forward				Community Health		NHS			NHS	Additional NHS Contribution	Existing	£1,212,658	£1,212,658	1%
155	SH 32 - SCC Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry forward				Social Care		LA			Local Authority	Additional LA Contribution	Existing	£106,129	£106,129	0%
156	NEHF 1a - Responsibilities under the Care Act	Homecare Service Provision	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£92,462	£92,462	4%
157	NEHF 1b - Responsibilities under the Care Act	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,126	£1,126	0%
158	NEHF 1c - Responsibilities under the Care Act	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£4,412	£4,412	0%
159	NEHF 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		124	124	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£94,000	£94,000	1%
160	NEHF 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,186,435	£1,253,587	1%
161	NEHF 4 - Supported Employment	Mental Health Employment Support	Prevention / Early Intervention	Other	Employment Support for Mental Health				Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£46,712	£49,356	0%
162	NEHF 5 - End of Life Care - Contract	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£39,075	£41,287	2%
163	NEHF 6 - Discharge to Assess	D2A	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£95,719	£97,601	1%
164	NEHF 7 - Home from Hospital	Home First	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£144,781	£152,976	1%
165	NEHF 8 - Home from Hospital	Home First	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£5,070	£5,357	0%
166	NEHF 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	Existing	£5,708	£6,031	0%
167	NEHF 10 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		14	15	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£24,000	£25,358	0%
168	NEHF 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	Existing	£10,653	£11,256	1%
169	NEHF 12a - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£59,801	£64,181	0%
170	NEHF 12b - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£17,588	£17,588	0%
171	NEHF 13 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£11,971	£12,649	3%
172	NEHF 14 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		738	743	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£216,817	£229,089	2%
173	NEHF 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	Existing	£14,694	£15,526	1%
174	NEHF 16 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		50	50	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	Existing	£282,969	£282,969	3%
175	NEHF 17 - Improve BCF 22/23	Support to D2A process through Care Home packages	Residential Placements	Short-term residential/nursing care for someone likely to require a longer-term care home replacement					Social Care		LA			Local Authority	iBCF	Existing	£428,574	£428,574	0%

176	NEHF 18 - CCG Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry forward				Community Health		NHS			NHS	Additional NHS Contribution	Existing	£519,578	£519,578	0%
177	NEHF 19 - SCC Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry forward				Social Care		LA			Local Authority	Additional LA Contribution	Existing	£182,982	£182,982	0%
178	EB 1a - New Responsibilities under the Care Act	Homecare Service Provision	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£24,531	£24,531	1%
179	EB 1b - New Responsibilities under the Care Act	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£299	£299	0%
180	EB 1c - New Responsibilities under the Care Act	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,170	£1,170	0%
181	EB 2 - Carers Funding	Carers Contracts	Carers Services	Respite services		33	33	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£25,000	£25,000	0%
182	EB 3 - Health Commissioned Services	Community Health Contracts	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£264,027	£278,971	0%
183	EB 4 - Podiatry - Frimley NHS	Podiatry Service	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£25,233	£26,661	0%
184	EB 5 - D2A Risk Contingency Pool	D2A	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£28,169	£29,763	0%
185	EB 6 - End Of Life - TVHC	End of Life Contract	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£30,000	£31,698	2%
186	EB 7 - Commissioning Reserve	Support to Commissioning	Enablers for Integration	Joint commissioning infrastructure					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£24,425	£25,807	4%
187	EB 8 - Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£0	£513	0%
188	EB 9 - Reablement	Reablement in East Berkshire place	Other						Community Health		NHS			NHS	Minimum NHS Contribution	New	£49,419	£52,216	0%
189	EB 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	Existing	£1,142	£1,206	0%
190	EB 11 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		5	5	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£8,000	£8,453	0%
191	EB 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	Existing	£2,328	£2,459	0%
192	EB 13a - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£19,545	£20,976	0%
193	EB 13b - Mental Health Community Connections	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support contracts				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£5,747	£5,747	0%
194	EB 14 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,079	£3,253	1%
195	EB 15 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		178	179	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£52,378	£55,343	1%
196	EB 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	Existing	£3,768	£3,982	0%
197	EB 17 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		15	15	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	Existing	£82,287	£82,287	1%
198	EB 18 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Short-term residential/nursing care for someone likely to require a longer-term care home replacement					Social Care		LA			Local Authority	iBCF	Existing	£113,781	£113,781	0%
199	EB 19 - CCG Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry forward				Community Health		NHS			NHS	Additional NHS Contribution	Existing	£311,633	£311,633	0%
200	EB 20 - SCC Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this through the year	Community Based Schemes	Other	Carry forward				Social Care		LA			Local Authority	Additional LA Contribution	Existing	£226,709	£226,709	0%

201	CW 1 - Integrated Multi Disciplinary Teams - Social Care	Hospital, Reablement and Occupational Therapy Staffing	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,849,480	£4,067,361	37%
202	CW 2 - Integrated Multi Disciplinary Teams - Mental Health	Integrated Mental Health Teams	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		LA			Local Authority	Minimum NHS Contribution	Existing	£269,621	£284,882	3%
203	CW 3 - Protection of Carers Service	Contribution to Carers Contracts	Carers Services	Respite services		10302	10302	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£7,791,119	£8,232,096	76%
204	CW 4 - Protection of Community Equipment	Contribution to ASC Community Equipment Costs	Assistive Technologies and Equipment	Community based equipment		7147	7192	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,100,000	£2,218,860	22%
205	CW 5 - Protection of Reablement Staffing	Contribution to ASC reablement costs	Other						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£7,867,281	£8,312,569	1%
206	CW 6 - Protection of Hospital ASC Teams	Contribution to ASC Hospital Staffing	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,352,652	£3,542,412	33%
207	CW 7 - Protection of OP HBC	Contribution to Homecare Service Provision	Home Care or Domiciliary Care	Domiciliary care packages		463598	504588	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£11,121,707	£12,105,061	8%
208	CW 8 - Protection of Collaborative Reablement	Reablement partnerships	Other						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,330,535	£1,405,843	0%
209	CW 9 - D2A Staffing	Contribution to ASC D2A Staffing costs	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,025,350	£1,083,385	10%
210	CW 10 - BCF Administration	Staffing costs	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£111,800	£118,128	18%

Further guidance for completing Expenditure sheet

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'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. 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	1. Independent Mental Health Advocacy 2. Safeguarding 3. 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	1. Respite Services 2. Carer advice and support related to Care Act duties 3. 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	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social 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	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 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	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. 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	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	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. 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	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	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. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams 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.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. 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.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	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.
16	Prevention / Early Intervention	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.

17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 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	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	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.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Surrey

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	158.0	134.8	138.7	127.6	We looked at the average indicator value for last year and overlayed this with known seasonal and other trends and variatons. Due to national trends in increased attendances and admissions to acute Trusts, our plan is to maintain our postion. This is a challenging target given the rising demand and more complex	We will deliver this through an enhanced front door offer and implementation of preventative programmes through the BCF. Many of the schemes invested in support the developmend of neighbourhood teams and same-day urgent care which we anticiapte reducing the rate of admissions	Yes
	Number of Admissions	2,147	1,831	1,884	-			
	Population	1,196,236	1,196,236	1,196,236	1,196,236			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	130	140	155	143			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,124.5	2,124.5	2,124.5	Our overall performance has been stable over the last few years, and we aim to maintain current performance. Again, this is a challenging target given the expected increase in the number of people living with complex needs and inflationary cost pressures on services.	We continue to invest in a falls prevention programme and this is linked to wider frailty programmes through regular MDTs. We are also planning targeted work underpinned by population health data in North East Hampshire and Farnham.	Yes
	Count	5,380	5380	5380			Yes
	Population	228,579	228579	228579			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
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 (%)	90.2%	91.6%	91.3%	90.4%	We looked at the average indicator value for last year and overlayed this with known seasonal and other trends and variatons. Due to national trends in increased attendances and admissions to acute Trusts, our plan is to maintain our postion. This is a challenging target given the rising demand and more complex needs of Surrey's ageing population, and	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.	Yes
	Numerator	20,182	18,881	18,816	21,700			
	Denominator	22,380	20,621	20,608	24,000			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	93.6%	86.8%	91.3%	93.6%			
	Numerator	20,500	19,000	20,000	20,500			Yes
	Denominator	21,900	21,900	21,900	21,900			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
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	555.5	508.9	623.8	697.8	Projection of 2021 census data. Local data showing increase of patient acuity and increase in placement being made. We have published our Market Position Statement for long term planning for older people's care. This includes	We have inserted an incrreased figure but this is a worst case scenario. We will take actions to minimise admissions to care homes as referenced in the narrative document of this return - particulay in relatrion to our Urgent and	Yes
	Numerator	1,277	1,200	1,471	1,670			Yes
	Denominator	229,900	235,815	235,815	239,307			

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

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
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%	70.3%	69.8%	69.4%	We have a strong reablement team who work across the system in partnership with other providers. The operational teams have assessed the trends and data from last year and developed a plan based on this. Our proposed targets are	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	Yes
	Numerator	434	460	398	431			Yes
	Denominator	639	654	570	621			Yes

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Surrey

	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	Complete:
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* 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? *Paragraph 11* 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? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes	Section 1			Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • 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 - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* 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. *Paragraph 15*	Narrative plan	Yes	Section 3, Section 8			Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - 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? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes	Section 7			Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	Section 4			Yes
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes	Section 5			Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes	Section 5			Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**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 to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes	Expenditure Plan - 10.05 update from NHSE to say PR7 should read '....maintain spending on social care services to the fund and investment in NHS commissioned out of hospital services from the NHS minimum....'			Yes
Agreed expenditure plan for all elements of the BCF	**PR8**	**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? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* 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? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	Section 6			Yes
Metrics	**PR9**	**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 based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes	Metrics tab			Yes

Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.

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 grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally 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 tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

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

ASC Discharge Fund-due 2nd May

This is the last tab in the workbook and must be submitted by 2nd May 2023 as this will flow to DHSC. It can be submitted with the rest of workbook empty as long as all the details are complete within this tab, as well as the cover sheet although we are not expecting this to be signed off by HWB at this point. The rest of the template can then be later resubmitted with the remaining sections completed.

After selecting a HWB from the dropdown please check that the planned expenditure for each scheme type submitted in your ASC Discharge Fund plan are populated.
Please then enter the actual packages of care that matches the unit of measure pre-specified where applicable.
If there are any new scheme types not previously entered, please enter these in the bottom section indicated by a new header. At the very bottom there is a totals summary for expenditure which we'd like you to add a breakdown by LA and ICB.

Please also include summary narrative on:
1. Scheme impact
2. Narrative describing any changes to planned spending – e.g. did plans get changed in response to pressures or demand? Please also detail any underspend.
3. Assessment of the impact the funding delivered and any learning. Where relevant to this assessment, please include details such as: number of packages purchased, number of hours of care, number of weeks (duration of support), number of individuals supported, unit costs, staff hours purchased and increase in pay etc
4. Any shared learning

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF 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

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. 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:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2022-23 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2022-23/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to NHS Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Dischaege to usual place of residence and avoidable admissions at a local authority level to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes and the unavailability of published metric data for one/two of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Income and Expenditure

The Better Care Fund 2022-23 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Adult Social Care discharge fund.

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2022-23 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ASC discharge fund via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2022-23 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2022-23 in the yellow boxes provided, **NOT** the difference between the planned and actual income.
- Please provide any comments that may be useful for local context for the reported actual income in 2022-23.

Expenditure section:
- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2022-23 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please include actual expenditure from the ASC discharge fund.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2022-23.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2022-23 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:
- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2022-23
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist
Health and Wellbeing Board:	Surrey	Complete:
Completed by:	Susan Stern, BCF Policy and Programme Manager for Surrey	Yes
E-mail:	susan.stern@surreycc.gov.uk	Yes
Contact number:	n/a	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Surrey

Confirmation of Nation Conditions			
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	**Checklist** Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Surrey

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	545.9	On track to meet target	Admission avoidance schemes have challenges including workforce recruitment, seasonal impacts such as covid and variance in service provision such as care availability.	Avoidable admissions were supported by BCF programmes including Growing Health Together, Anticipatory Care Community Matrons, Phyllis Tuckwell Integrated Community Model and Falls Prevention.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	90.5%	On track to meet target	Surrey has a strong focus on D2A and support models. Key challenges include workforce in rural areas, night care models and support for long term needs.	Discharge to normal place of residence is a strong focus of BCF supported schemes, notably our Community Discharge Nursing Team.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	509	Not on track to meet target	Cost of care due to market availability and recruitment within care home sector, and a gap in the provider market of appropriately skilled staff to support complexity of needs post pandemic.	Locally the BCF supports our nursing and residential homes via the Care Home Matrons & Advice and Guidance to Care Homes.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	70.3%	On track to meet target	Workforce remains a key challenge.	This has been supported through the BCF by D2A, reablement funding and our community equipment service. In Surrey Heath, a BCF role supported integration of intermediate care and reablement.	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Surrey

Income

	2022-23	
Disabled Facilities Grant	£10,155,847	
Improved Better Care Fund	£11,408,352	
NHS Minimum Fund	£85,191,031	
Minimum Sub Total		£106,755,230

	Planned		Actual			
NHS Additional Funding	£23,271,880		Do you wish to change your additional actual NHS funding?	No		
LA Additional Funding	£3,164,726		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£26,436,606				£26,436,606

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£133,191,836	£133,191,836

ASC Discharge Fund

	Planned		Actual			
LA Plan Spend	£3,328,864		Do you wish to change your additional actual LA funding?	No		
ICB Plan Spend	£5,222,966		Do you wish to change your additional actual ICB funding?	No		
ASC Discharge Fund Total		£8,551,830				£8,551,830

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£141,743,666	£141,743,666

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	

Expenditure

	2022-23
Plan	£133,191,835

Do you wish to change your actual BCF expenditure?	Yes
Actual	£121,332,147

	ASC Discharge Fund
Plan	£8,551,830

Do you wish to change your actual BCF expenditure?	No
Actual	£8,551,830

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	BCF planned vs Actual differences relate to Additonal Investment from prior years that has not been spent. This will be carried forward to 2023-24 and allocated in the next plan.

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Surrey

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	Local Joint Commissioning Groups have continued to improve joint working between Surrey CC, Surrey Heartlands ICB and Frimley ICB. Joint posts across health and social care have supported joint working across the local system, delivering impactful schemes for our local population.	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Agree	The majority of BCF schemes have been implemented as planned, and where adaptations have been needed they have been managed jointly.	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Agree	BCF schemes have continued to drive integration locally and have had a positive impact for residents in the community. The delivery of the BCF plan has also supported an integrated response to system pressures throughout the year, for example around continued provision for hospital discharge and system flow.	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production	BCF funding supported the wider development of our Growing Health Together programme in East Surrey Place. The programme has supported a myriad of ways people in our local communities, and our beautiful local environment, are supporting health and wellbeing across East Surrey, including compiling a resource page bringing together the support offered by a variety of organisations around the cost of living, for those living in East Surrey.	Yes
Success 2	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	The impact of the increase in the cost of living has been significant and was highlighted as particularly affecting our more vulnerable residents. Through joint discussions we agreed that this was resulting in some residents being unable to continue to fund the available paid for prevention services delivered by the borough. Through the BCF we were able to quickly respond and provide a small amount of funding to ensure residents were supported over the winter and continue to receive these services such as meals at home and community alarms.	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	6. Good quality and sustainable provider market that can meet demand	The provider market has been and continues to be severely challenged making it difficult to fully deliver some of the initiatives in a timely way.	Yes
Challenge 2	3. Integrated electronic records and sharing across the system with service users	Data governance issues have been a huge challenge and delayed transfer of information.	Yes

Footnotes:
Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care
Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Surrey

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.

The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.

1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).
2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.
3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.
4) For 'improvement retention of existing workforce', please state the number of staff this relates to.
5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.
6) For 'Assistive Techonologies and Equipment' , please state the number of unique beneficiaries through the fund.
7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible	Do you have any learning from this scheme?
ASC discharges into long term care home placements outside of D2A	Residential Placements	Care home	£533,677	£630,074	67	Number of beds	No		Yes	Supported the funding of people discharged into ASC pathway 3 long term care home placements commissioned by Surrey County Council	Helped to inform ongoing planning of discharge arrangements in Surrey
ASC discharges into long term care home placements outside of D2A	Residential Placements	Nursing home	£1,349,287	£1,252,891	148	Number of beds	No			Supported the funding of people discharged into ASC pathway 3 long term care home placements commissioned by Surrey County Council	Helped to inform ongoing planning of discharge arrangements in Surrey
Frimley Discharge to Assess	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£56,239	£123,367	24	Number of beds	No			Funded part of the cost of the Discharge to Assess system that operated in the period in Surrey's Frimley footprint.	Helped to inform ongoing planning of discharge arrangements in Surrey
Frimley Discharge to Assess	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£130,265	£63,137	24	Hours of care	No	Please note that in line with the submitted plan, the number of care packages commissioned has been provided here instead of the hours of care which is not readily available for the		Funded part of the cost of the Discharge to Assess system that operated in the period in Surrey's Frimley footprint.	Helped to inform ongoing planning of discharge arrangements in Surrey
Mental Health discharge	Bed Based Intermediate Care Services	(blank)	£200,000	£200,000	15	N/A	No			Supported discharge from Mental Health in-patient settings	Helped to inform ongoing planning of discharge arrangements in Surrey
Mental Health discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£90,852	£90,852	1,890	Hours of care	No			Supported discharge from Mental Health in-patient settings	Helped to inform ongoing planning of discharge arrangements in Surrey
Supporting discharge for self-funders	Other	(blank)	£63,290	£0		N/A	Yes	This scheme was not taken forwards. The funding was instead spent on Surrey Heartlands Discharge to Assess packages (noting total expenditure on Discharge to Assess in the period		This scheme was not progressed due to pressures as arrangements already in place to support discharge for self-funders were considered to be sufficient in the context of the	The Surrey system continues to consider how self-funder discharge can
Surrey Heartlands Discharge to Assess	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£4,187,536	£4,647,721	449	Number of beds	No			Funded part of the cost of the Discharge to Assess system that operated in the period in Surrey's Surrey Heartlands footprint.	Helped to inform ongoing planning of discharge arrangements in Surrey
Surrey Heartlands Discharge to Assess	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£1,225,214	£1,045,059	566	Hours of care	No	Please note that in line with the submitted plan, the number of care packages commissioned has been provided here instead of the hours of care which is not readily available for the		Funded part of the cost of the Discharge to Assess system that operated in the period in Surrey's Surrey Heartlands footprint.	Helped to inform ongoing planning of discharge arrangements in Surrey
Surrey Heartlands Discharge to Assess	Residential Placements	Care home	£37,663	£26,253	3	Number of beds	No			Funded part of the cost of the Discharge to Assess system that operated in the period in Surrey's Surrey Heartlands footprint.	Helped to inform ongoing planning of discharge arrangements in Surrey
Surrey Heartlands Discharge to Assess	Residential Placements	Nursing home	£677,806	£472,476	49	Number of beds	No			Funded part of the cost of the Discharge to Assess system that operated in the period in Surrey's Surrey Heartlands footprint.	Helped to inform ongoing planning of discharge arrangements in Surrey

Schemes added since Plan											
	Local recruitment initiatives										
	<Please Select>										

Planned Expenditure	£8,551,829
Actual Expenditure	£8,551,830
Actual Expenditure ICB	£5,222,966
Actual Expenditure LA	£3,328,864

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Additional ICB Discharge Funding 2023-24 and 2024-25: ICB to HWB allocation template

Guidance

Additional Funding for activity to support discharge from hospital has been provided via ICBs and LAs. This funding must be pooled into local Better Care Fund plans and used in line with the conditions set out in the BCF Planning Requirements.

Half of the Discharge funding has been distributed via ICB allocations. The funding must be pooled into HWB level BCF plans. Allocations to HWB (LA) level have not been set centrally and it is for systems to agree how to distribute this funding at HWB level. The distribution to HWB level should be agreed between the ICB and local authorities.

Agreed contributions from the ICB element of the discharge funding should be included in individual BCF Planning Templates. These HWB allocations will need to be agreed in sufficient time for local BCF plans to be finalised and agreed in time for the 28 June deadline. This template is for ICBs to confirm the distribution of ICB allocated funding across all HWBs within their footprint. ICB finance leads are responsible for ensuring that a completed version of this template is returned for each ICB to england.bettercarefundteam@nhs.net (copied to the Better Care Manager) on 28 June, separately from HWB level plans.

You should ensure that the total sum distributed to HWBs for 2023-24 and 2024-25 from your ICB is equal to the total allocation from the ASC DIscharge Fund.

As with all BCF templates, the information from this template will be shared with national partners, including finance colleagues. ICBs may be asked to report further on the use of this funding during the year.

Yellow sections indicate required input

ICB name	NHS Frimley ICB

	2023-24	2024-25
Total allocation	£2,408,780.70	£5,888,324.55

Name of person completing this form	Suzi Stern, susan.stern@surreycc.gov.uk

HWB	2023-24 Funding	2024-25 Funding
Bracknell Forest	£357,138.63	£873,080.80
Hampshire	£566,133.69	£1,383,688.04
Slough	£508,760.89	£1,243,744.94
Surrey	£506,475.11	£1,238,156.97
Windsor and Maidenhead	£470,272.38	£1,149,653.80
Total (Must equal allocation)	£2,408,780.70	£5,888,324.55

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Additional ICB Discharge Funding 2023-24 and 2024-25: ICB to HWB allocation template

Guidance

Additional Funding for activity to support discharge from hospital has been provided via ICBs and LAs. This funding must be pooled into local Better Care Fund plans and used in line with the conditions set out in the BCF Planning Requirements.

Half of the Discharge funding has been distributed via ICB allocations. The funding must be pooled into HWB level BCF plans. Allocations to HWB (LA) level have not been set centrally and it is for systems to agree how to distribute this funding at HWB level. The distribution to HWB level should be agreed between the ICB and local authorities.

Agreed contributions from the ICB element of the discharge funding should be included in individual BCF Planning Templates. These HWB allocations will need to be agreed in sufficient time for local BCF plans to be finalised and agreed in time for the 28 June deadline. This template is for ICBs to confirm the distribution of ICB allocated funding across all HWBs within their footprint. ICB finance leads are responsible for ensuring that a completed version of this template is returned for each ICB to england.bettercarefundteam@nhs.net (copied to the Better Care Manager) on 28 June, separately from HWB level plans.

You should ensure that the total sum distributed to HWBs for 2023-24 and 2024-25 from your ICB is equal to the total allocation from the ASC DIscharge Fund.

As with all BCF templates, the information from this template will be shared with national partners, including finance colleagues. ICBs may be asked to report further on the use of this funding during the year.

Yellow sections indicate required input

ICB name	NHS Surrey Heartlands ICB

	2023-24	2024-25
Total allocation	£5,002,701.86	£8,341,267.25

Name of person completing this form	Suzi Stern, susan.stern@surreycc.gov.uk

HWB	2023-24 Funding	2024-25 Funding
Surrey	£5,002,701.86	£8,341,267.25
West Sussex		
Total (Must equal allocation)	£5,002,701.86	£8,341,267.25

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BCF Strategy Workshop 3 March 2023: Key Conclusions & Proposed Next Steps FINAL 24.04.23

Area of Discussion	Next Steps	Leads	Timelines	Priority
LJCG Plans Content with the overall LJCG approach to BCF spend in 23/25.	We will convene another BCF strategy workshop for HWB members/ICS execs to continue strategic discussions on the BCF. Commissioning Collaborative will oversee the development of the BCF 23/25 plan and approve LJCG allocations. The plan will then be agreed by ICBs and Surrey CC CEO, prior to seeking final approval from the June HWBB.	Jon & Suzi	Strategy workshop – September 2023 (TBC) Submission of BCF plan to NHSE - 28 June	High
Strategic Alignment It would be useful to compare how preventative spend is spread across the system.	PSM team will develop a paper for ICS execs on potential options to progress towards this requirement and the commitments required across the system to progress further.	PSM team	PSM paper for ICS execs – May 2023 (TBC)	Medium
System Wide Priorities, Local Flexibility and Allocations Mixed views over potential changes to allocation methodologies. Whilst there could be benefits in using population health data to set allocations, any potential changes need to be considered carefully given potential impact on core services.	LJCGs to consider use of population health data to inform the profile of spend within each place, rather than changing overall allocations methodology at this stage. LJCGs to provide an update on their approach at the next BCF strategy workshop. We may consider future potential allocation methodologies/impact of any proposed changes for future programme years (timeline TBC depending on programme capacity)	LJCGs & Popn health team Jon, Suzi & Popn health team	LJCGs to update at next BCF strategy workshop – September 2023 (TBC) TBC	Medium
Impact of Year-on Year Planning There are potential benefits to muti-year models if we can ensure they retain sufficient flexibility to adapt to BCF national policy conditions and/or broader funding streams	National policy guidance for 2023-25 has now been published. BCF will be developing its first multi-year approach with a two-year plan.	Jon & Suzi	Submission of BCF plan to NHSE - 28 June	Medium

Strategic coordination and governance It is important to be able to share experience and expand successful models across the system	We will test and refine existing governance arrangements over the next twelve months to ensure they are effective. We will set up informal coordination mechanisms across LJCG and county wide commissioners to support best practice and experience sharing.	Jon & Suzi	Update to next BCF strategy workshop – September 2023 (TBC) May 2023	High

Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	System Planning: Surrey Heartlands Draft Joint Forward Plan (JFP) 2023 - 2028
HWBS Priority Populations:	All
HWBS Priority - 1, 2 and/or 3:	All
HWBS Outcomes/System Capabilities:	The Joint Forward Plan supports outcomes across the 3 priorities and draws on system capabilities to deliver the ambitions of the Integrated Care Strategy.
HWBS Principles for Working with Communities:	• Community capacity building: 'Building trust and relationships' • Co-designing: 'Deciding together' • Co-producing: 'Delivering together' • Community-led action: 'Communities leading, with support when they need it'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions • Community Led interventions
Author(s):	• Sue Robertson, Associate Director of Strategic Planning and Integrated Assurance, Surrey Heartlands ICS • Kathryn Croudace, Head of Strategic Planning, Surrey Heartlands ICS
Board Sponsor(s):	Professor Claire Fuller, CEO NHS Surrey Heartlands ICS
HWB meeting date:	21 June 2023
Related HWB papers:	None
Annexes/Appendices:	**Annex 1**: Executive Summary from the full draft JFP **Annex 2**: Summary plan (draft) **Annex 3**: Full draft JFP

2. Executive summary

Surrey Heartlands Integrated Care System (ICS) Strategy, which draws on the Surrey Health and Wellbeing strategic priorities, was agreed by the Integrated Care Partnership in December 2022. The Joint Forward Plan is the five-year strategic delivery plan for the ambitions set out in the ICS strategy. The plan also covers key deliverables in the NHS Long Term Plan and other planning guidance. The initial plan is to be published by 30 June 2023 and will be refreshed annually in March thereafter.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Note the near-final draft Joint Forward Plan and its alignment with Surrey's Health and Wellbeing priorities and strategic approach.
2. Provide an opinion of the plan.
3. Note that the annual update of the plan will be provided in March 2024.

4. Reason for Recommendations

The Board is asked to review the Joint Forward Plan as part of the development process and provide an opinion, which will be included in the plan.

5. Detail

Three annexes are provided:

- Annex 1: Executive Summary from the full document, including a Plan on a Page
- Annex 2: Draft Summary Plan – co-designed for a public audience. Note that this is a plain text document, which will be designed-up with photos and other images for publication.
- Annex 3: Full draft plan, with more detail. Additional information will be available in the final published version through linked 'fact files' on website.

6. Challenges

The Joint Forward Plan has been developed iteratively to create a plan which is representative of the ambitions of the system and our partners. Challenges are set out in the Executive Summary as the 'wicked problems' jointly faced by the system.

7. Timescale and delivery plan

The plan will be published by 30 June 2023. Drafts have been widely shared with system partners during the development plan, from January 2023 onwards, including regular updates and discussion at the Integrated Care Partnership meetings.

Further development of prevention plans will continue, commissioning VCSE organisations where possible, locally or at system level, such as through the mental health investment fund.

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

The ICS Strategy and Joint Forward Plan have drawn on extensive system engagement carried out by Surrey's team in late 2022. Seven discovery sessions were held: informal conversations with 188 people, across several locations: hospitals, shopping centres, supermarkets. Thematic analysis identified broad themes which were developed into a survey for Surrey's Citizens' Panel of 2,000 people.

A report of the findings will be included as an Appendix to the published JFP. Key points are included in the Summary plan attached.

Following approval of the ICS Strategy, an initial draft of the Joint Forward Plan was discussed at a series of 'Reading Panels' in January and February 2023. A second draft was circulated widely to partners and stakeholders in early April 2023 for further comment. It was discussed at Healthwatch Surrey VCSE Voice group 18 Apr 23. The Voice group suggested a number of improvements and shared views and suggestions for development of the public-facing version, which have been followed.

There have been regular updates and discussion at the Integrated Care Partnership meetings during the iterative development of the plan and discussion at a system partners' review meeting on 17 May, resulting in further updates to the plan.

Engagement is also undertaken through relevant individual programme areas and our Places.

9. Next steps

- Joint Forward Plan being formally approved through Surrey Heartlands NHS Trust and NHS Foundation Trust Boards, and the Integrated Care Board during June 2023.
- Summary and full versions of the plan published on the Surrey Heartlands ICS website by 30 June 2023, also with accessible versions.
- The Joint Forward Plan will be refreshed annually in March. The updated plan be presented to the Health and Wellbeing Board in March 2024.

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Joint Forward Plan

2023 - 2028

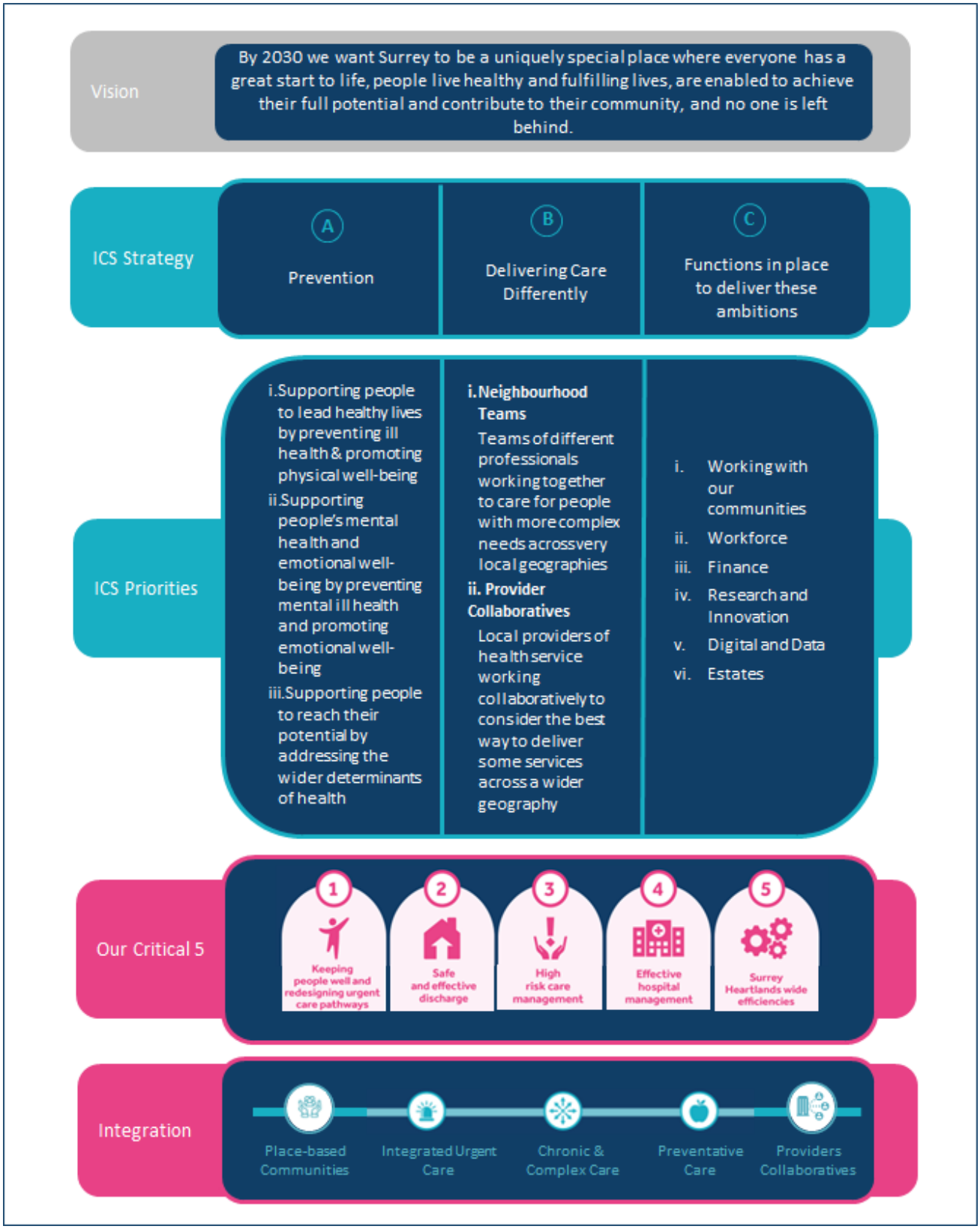
11

FINAL DRAFT – EXECUTIVE SUMMARY

V4.2

12 June 2023

One System, One Plan – On A Page



Executive Summary

Only by taking a collective responsibility across our partnership will we be able to achieve the step-change in outcomes, for all our communities, that we want to see.

Our Integrated Care Strategy describes how we intend to meet the health and wellbeing needs of local people; building on existing collaboration. This is about promoting the right partnerships – at System, Place and Neighbourhood level – that will lead to improvements in health and wellbeing and the socioeconomic conditions of local people. Our strategy reinforces the importance of prevention and keeping people well, as the major catalyst for change.

The strategy is based on **three ambitions** that reflect where we are and what our populations have told us, so that 'no-one is left behind'. These set out our key areas of focus with significant emphasis on reducing inequalities.

A. Prevention
B. Delivering Care Differently
C. What we need to deliver these ambitions

This our first Joint Forward Plan. We describe how we will move towards realising our vision for people's health and wellbeing and start delivering our strategy. It builds on work already underway through the 'Community Vision Surrey in 2030' and the 'Surrey Health and Wellbeing Strategy', focusing on the prevention of ill health and the greater integration of health and care services including the wider public and voluntary sectors, reflecting the NHS Mandate and what local people are telling us. It sets out how we will deliver local health and care services alongside broader care delivery, focusing on **Years One and Two** of our strategy.

We know that **clinical care alone** only makes around a 20% contribution to health and wellbeing with a 30% contribution from **individual health behaviours**; the rest (the **wider determinants of health**, excluding genetic and hereditary factors) is influenced by things such as education, housing, employment, and the environment.

This plan describes our strategic delivery plans through our wider partnerships and the work we are doing across our four Places and local neighbourhood teams, shifting the focus from treating sickness to collectively using our resource to focus on prevention and keep people healthier. Positive intervention in a child's life represents prevention in their life as an adult, interventions which should be made at the earliest opportunity from pregnancy onwards.

We will put greater focus on prevention and targeting support where it's most needed:

- Working proactively with our communities to support people to lead healthy lives,
- Providing more personalised care,
- Working together to offer a wider range of support closer to people's homes.

In doing so, we will achieve the ICS four purposes:

- Improve outcomes in population health and healthcare,
- Tackle inequalities in outcomes, experience and access,
- Enhance productivity and value for money,
- Help the NHS support broader social and economic development.

Overall our health and care needs are changing, our lifestyles are increasing risk of preventable disease and affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease and the health inequality gap is increasing. Population Health Management helps us understand – at system, 'Place' and neighbourhood - current health and care needs, creating informed predictions of what people need to help prevent ill health. We will increase personalised care, designing more joined-up services and incorporating our working with

communities principles, to make best use of our collective resources and improve people's overall health and wellbeing.

Through social research and local insight, we know our combined efforts are making a difference. For example, improved access and communication to and from primary care, greater experience of personalised care and improved experience of integrated adult social care. Local people have highlighted common themes to inform our ambitions, including the need for more health and care integration, better access to services and the importance of supporting our valued workforce.

These strategic ambitions are a key part of our One System, One Plan framework – a single view of transformation and recovery which is reflected in the plans and strategies of all partners. Embedded within these is the vision from the Fuller stocktake to:

- streamline access to care and advice for people and ensuring care is always available in their community when they need it
- provide more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs
- help people to stay well for longer as part of a more joined-up approach to prevention.

To achieve our ambitions, we need to create **the right conditions for success**. This includes how we work with communities enabling them to lead locally driven change, involving and listening to what people are telling us, progressing digital ambitions and use of data, and developing a workforce with the right culture, skills, training and leadership.

Our Trust Provider Collaborative, to be formally established in summer 2023, will work together, as experts in service delivery, to address immediate challenges and deliver longer-term service transformation to ensure future quality, workforce and financial sustainability.

In 2028, when we have delivered this plan, our population will benefit from the priority outcomes detailed in our strategy and experience:

- Increased services **focusing on prevention**, providing communities with the right access to preventative support.
- **Integrated Neighbourhood Teams** shaped and designed by partners from across the health and care spectrum – statutory, voluntary, community and social enterprise organisations.
- **Improved access to same-day urgent care and general practice,** enabling Neighbourhood Teams to take an active role in **creating healthy communities** by working with local people, and developing closer relationships with local authorities, voluntary and community sectors.
- **Streamlined access to integrated urgent, same-day care and advice** from expanded multi-disciplinary team, using data/digital technology to find patients the right support.
- Our 'Team of Teams' will **have the physical space to work together** in their neighbourhoods
- Multidisciplinary teams with **new skills and capabilities**, through successful recruitment, retention and learning to support the communities they serve.
- **Digital technology and data** underpinning how our teams work, how our communities interact with us and how we analyse and use data to continuously improve services.
- **Health on the high street** driving town centre reimagination through our health diagnostic offer and positive economic impacts driven by the ICS supply chain helping to deliver sustained socio-economic outcomes.

Over **the next two years**, we will also deliver against the national NHS priorities:

Recovering services & productivity	Urgent and emergency care
	Community adult and children's health services
	Primary care
	Elective Care, Diagnostics, Cancer
	Maternity, neonatal & children's services
	Mental health

Delivering transformation & LTP ambitions	Learning disabilities & Autism
	Improve health and reduce inequalities
	Invest in our workforce
	Use of collective resources; Continuing Health Care, Medicines Optimisation, ICS running costs, Workforce and Agency Spend

Across these priorities we will be considering what we do at an individual level to provide more preventative and personalised care, how we work within our neighbourhood teams, across our larger Place partnerships and the wider health and care system.

We will focus on prevention and tackle what will make the most difference to people's lives **over the next three to five years** by continuing to **integrate primary care services**; bringing together general practice, community pharmacy, dentistry and optometry, alongside other health services and personalised care for people and families, where they live.

Above all, we need to be bold in our approach, leveraging our collective efforts as partners to transform what, where and how we provide care and work with local communities so they can take more control of their own health and wellbeing.

The deliverables set out in this plan are based on what needs immediate attention, and for which funding in the coming year has been identified. Year one of the plan therefore contains the most detail. Other schemes may require business cases to be developed, to seek additional funding, before they can be delivered. We describe longer term aspirations (3-5 years) as ambitions. These will be reviewed each year when this plan is updated and future funding allocations are confirmed.

Our wicked problems

We are operating in a financial landscape that is challenged and is not likely to get easier in the near future. We consider the most effective way to address these financial constraints and improve outcomes is the closer integration of health and social care, with less reliance over time on large hospitals and traditional care models, to sustainably address health inequalities.

- **How we focus activity and funding on prevention and tackling health inequalities** in a challenged operational and financial landscape.
- **Social care demand and complexity has overtaken funding levels,** resulting in higher acuity for those admitted and greater difficulty in discharging from acute settings.
- **An older population** – Surrey has 20% more people aged 80+ than the rest of England meaning a large frail population with greater needs and complexity.
- **Recovery from the Covid19 pandemic** – high volumes of planned and emergency care following the pandemic, including delays in care and presentation.
- **Fragmented acute landscape** – high number of hospitals resulting in duplication and smaller scale operations, plus multiple middle- and back-office functions and non-consolidated estate.
- **Over reliance on private sector** – high number of non-NHS independent providers undertaking high margin cost activity, removing private revenues from the ICS.
- **Lack of specialised care, compounded by proximity to London** – due to lack of highly specialised care in the ICS, alongside ease of access to London and other areas, a large proportion of activity occurs outside the ICS (£247m London spend 2021).
- **Funding for increased mental health conditions prevalent locally** – we receive less funding from national allocations, based on assessment of low complexity and need in our population, due to focus on psychosis, and less consideration for other conditions (like eating disorders) where we have higher prevalence.
- **Supporting other areas** – providers serve multiple ICSs including Frimley, Kent and Sussex.
- **Our workforce capacity is concentrated in acute settings, with more scarcity in community, primary care and social care partners**, meaning we don't have the right people in the right place to deliver the models of care we aspire to.
- **Surrey cost of living, access to affordable accommodation, variable education provision within the county and inflexible working options** add further hurdles to building an effective workforce supply.
- **Running cost reductions** – achieving success while streamlining workforce and other costs.

- **System Flow** – high levels of demand and reduced capacity in care settings and effective discharge result in longer patient journeys through our system and challenging environments for our workforce.
- **System maturity** – whilst we have good relationships across our partners, and bold ambitions, we have variable maturity in how we work together to transform, integrate and manage our services day to day.
- **Addressing access and continuity of care** – we continue to see service users experiencing challenges and delays in accessing some services and fragmented care.

Building On Our Successes

We have seen many achievements despite the challenges of the pandemic (**Error! Not a valid ookmark self-reference.**). Using our collective strengths and assets, we will measure success through our 2028 achievements, performance measures, plus patient and user experience.

- **Prevention** - Growing Health Together in East Surrey invites people living and working in communities across East Surrey to collaborate and co-create conditions in which everyone's health and wellbeing can flourish.
- **Equality, Diversity & Inclusion** – Supporting ethnically diverse women in Maybury and Sheerwater to gain activity qualifications, empowering them to become role models for physical activity in their community. We are also actively using Black and Minority Ethnic experiences to improve workplace, service standards and culture development.
- **Maternity** - Perinatal mental health service now in place, alongside a 'Baby Buddy' app providing daily tips/advice on lots of topics for families with children up to 1 year old.
- **Technology** – With Mole Valley Life, First Community's Responsive Services have supported the installation of emergency lifeline alarms and key safe boxes for residents, helping them feel safer when the team or their family aren't around.
- **Supporting Surrey's Carers** - Five new carer support hubs located within communities including improved tailored support for young carers (HSJ awards finalists).
- **Pioneering Cancer Treatment** - Artificial intelligence-led project at Royal Surrey hospital improving cancer care - 'Ethos' targets radiotherapy with precision avoiding damage, limiting side effects and tailoring to changes in patient's bodies.
- **Clinical Research** – Surrey and Sussex Healthcare NHS Trust awarded best Clinical Site Team in the Pharma Times International Clinical Researcher of the Year Awards, June 2022, for their demonstration of excellence in setting up and conducting research trials.
- **Improving Emergency Care** - The Emerge Project at Ashford and St Peter's Hospitals, with the East to West charity, has supported hundreds of vulnerable young people coming to the Emergency Department in a mental health crisis, with wider care in the community.
- **Personalised Care** - Surrey Heartlands published a joint Palliative and End of Life Care Strategy where everyone is seen as an individual, with care tailored to meet their needs.
- **Social Care** – 94.1% of adults receiving adult social care feel safer, enjoy better quality of life, with greater control over their daily lives (above the national and Southeast average).

Figure 1 – highlights from Surrey Heartlands

This Joint Forward Plan (JFP) sets out how we will deliver our strategic ambitions over the next five years:

- Introduction — About Surrey Heartlands
- Chapter One — Ambition 1: Prevention and Keeping People Well
- Chapter Two — Ambition 2: Delivering Care Differently
- Chapter Three — Ambition 3: What we need to deliver these ambitions

FRONT PAGE

Surrey Heartlands

Joint Forward Plan

Summary

DRAFT v1.7

12 June 2023

Please note, this is a plain text version of the summary plan, which will be designed-up for publication, with photos, maps and other images added.

The document is designed to be read across two pages, like a book or magazine. If read on screen, it will work best if viewed across two pages.

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Inside front cover

ACKNOWLEDGEMENTS

This document has been created by Surrey Heartlands Integrated Care System in partnership and with collaboration from:

- The **citizens of Surrey and their families**, Surrey Carers Partnership Board

- **NHS and social enterprise partners:** Ashford & St Peter's Hospitals NHS Foundation Trust; CSH Surrey; Epsom & St Helier University Hospital NHS Trust; First Community Health & Care; Royal Surrey NHS Foundation Trust; South East Coast Ambulance Service NHS Foundation Trust; Surrey & Borders Partnership NHS Foundation Trust; Surrey and Sussex Hospitals NHS Trust, NHS Surrey Heartlands Integrated Care Board, our 104 GP practices who work as part of 25 primary care networks; six GP Federations

- **Local authority partners:** Surrey County Council, Elmbridge Borough Council; Epsom & Ewell Borough Council; Guildford Borough Council; Mole Valley District Council; Reigate & Banstead Borough Council; Runnymede Borough Council; Spelthorne Borough Council; Tandridge District Council; Waverley Borough Council; Woking Borough Council

- **Voluntary and Community Partners,** Healthwatch Surrey; Surrey Voluntary, Community and Social Enterprise (VCSE) Alliance

- Our **Independent Providers**

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ABOUT SURREY HEARTLANDS

The Surrey Heartlands Health and Care Partnership is a partnership of organisations that have come together to plan and deliver joined up health and care services, and to improve the lives of people who live in Surrey. Having a clear strategy in place is vital and allows us to focus on how best to meet the health and wellbeing needs of people in Surrey and reduce the inequalities we know currently exist.

We know that clinical care alone only makes around a 20% contribution to health and wellbeing, with a further 30% from individual health behaviours; the rest is influenced by factors such as education, housing, employment and the environment.

As a health and care partnership we want to work with our communities to harness local innovation, so residents can access the right support that's developed from the ground-up, with joined up health and care services that make the most of digital technology.

With a focus on prevention and support that is targeted where it's most needed, we will reduce the unfairness some people experience in accessing care, so nobody is left behind.

Our health and care partnership (also known as an Integrated Care System) is made up of an Integrated Care Board, Integrated Care Partnership, four Place-based Partnerships and local neighbourhoods – more detail is on our website.

www.surreyheartlands.org

MAP

Place-based partnerships

Partnerships of health, local government, the voluntary, community and charity sector with wider partners across local populations of around 250,000 – 300,000.

Neighbourhood teams

Teams of different professionals working together to care for people with more complex needs across very local geographies.

The Fuller Stocktake

Our Chief Executive, Professor Claire Fuller, led a national review looking at primary care - general practice, community pharmacy, dentistry and optometry - to identify what was working well and why.

The resulting 'Next steps for integrating primary care: the Fuller Stocktake' sets out a vision to improve access, experience and outcomes for people and communities.

Reflecting our vision for greater integration of local services, the recommendations centre around three essential areas:

- Streamlining access to care and advice
- Providing more proactive, personalised care
- Helping people to stay well for longer

Our Vision

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Our vision is to work collaboratively with people and partners across Surrey Heartlands to improve long-term health and care.

The recommendations in the Fuller Stocktake reflect our vision for greater integration of local services and to act on what matters most to our communities, namely:

- making it easier to access the care that they need when they need it and;
- creating the space and time for our clinicians to provide the continuity of care that is so important to our patients.

WHAT YOU TOLD US

During Autumn 2022, we held several social research and public engagement sessions around Surrey to ask you, our residents, about your priorities and thoughts about the NHS and health and care services. We heard about the challenges experience, what is working well as well as your expectations and opportunities for improvement.

Accessing healthcare

You told us that you continue to struggle with making contact with or accessing services. Being directed to online services with long waiting times can be confusing and act as a barrier. We also heard that more frequent and proactive communications from service providers would help you to feel more confident and in charge over your health and care journey.

> "*Your referral is in a cloud and you don't know what's happening. No communications, no transparency on where you're at. You need to be proactive and chase constantly because there's nothing coming from them. It's the same with the GP. But the thing is, you know there's an issue with waiting times. All you need is communication and transparency about this."*

> *"Our expectations and way of life is not suitable for the NHS. We want everything immediately… has to be instant. We expect much more. But as it is, the NHS can't meet these expectations, because this is not a functional NHS. The system can't cope with this."*

Continuity of care

You told us that lack of staff and investment in the health and care workforce negatively impacts the experience received and too often care is fragmented and has to be repeated or delayed.

Patient L told us that community care following her hospital discharge was insufficient.

She couldn't access support from district nurses as frequently as indicated upon discharge. She felt there was a lack of communication between the hospital and community services. Her husband spent a long-time making calls to different providers to follow up on their requests and questions about things such as equipment and home visits, as no single agency seemed to have overview and ownership of her care.

> *"Can't fault the care…current problems are about the system, not the quality of care."*

> *"It is not the consultant's fault. The management and processes are broken."*

> *"The hospital is short on staff, there aren't enough people to look after patients. That's why I come here every day to look after my mother. There are not enough mature nurses. A lot of the staff are temporary and inexperienced and burdened".*

Proactive approach to care

You agreed that proactive, personalised care supports your longer-term health and care needs.

> *"It's prevention rather than cure... this is how things should work. And that's what I received."*

> *"I felt people really listened to me. They supported me when I decided to give birth that way. The doctors and nurses listened to me, and made it happen. It was a very personalised experience".*

The voice of our population has been strong and clear; our strategy reflects what we have heard.

OUR STRATEGY

Our Integrated Care Strategy is based on population insights and knowledge gained through our Joint Strategic Needs Assessment, Surrey's Health and Wellbeing Strategy and listening to our residents directly; the voice of our population has been clear and strong, and our strategy reflects this.

Our strategy describes our shift in focus - from treating sickness to focusing on prevention using our collective resources to keep people healthier. We know that positive intervention in a child's life represents prevention in their adult life - interventions which should be made at the earliest opportunity from pregnancy onwards.

To deliver this, our strategy is based on three underpinning ambitions:

1. Prevention
2. Delivering care differently
3. What needs to be in place to deliver these ambitions

Through our wider partnerships and the work we are doing across our four Places and local neighbourhood teams, we are seeking to decrease the pressure on health and care services, reduce waiting times and increase person-centred care.

We are not going to fix every problem overnight. The shift in approach needed – moving to a model where organisations work together as a system to design and deliver care – is significant and will not be without its challenges.

It's not just about transforming how services are delivered on the front line, it's also about realigning all our functions and re-imagining how they can enable our neighbourhood and place teams.

Image/ continuation of Our strategy info

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OUR AMBITIONS

We have developed three ambitions that reflect where we are strategically and what our populations have told us. These set out the key areas of focus we need to take and how we will measure our success against them.

Prevention

Reflecting the three key priorities within Surrey's Health and Wellbeing Strategy we will reduce health inequalities and support our priority populations to:

- lead healthy lives by preventing physical ill health and promoting physical well-being
- prevent mental ill health and promote mental health and emotional well-being
- reach their potential by addressing the wider determinants of health (so things like education, housing, employment).

Delivering Care Differently

Local people have told us they want services that are responsive to their needs and that they are at the centre of decision-making by:

- making it easier for people to access the care that they need when they need it.
- creating the space and time for our workforce to provide the continuity of care that is so important to our populations.

What needs to be in place to deliver these ambitions

So we can be effective and deliver our first two ambitions, there are a number of other functions we need to be working well. This includes how we:

- work with our communities and enable them to lead locally driven change
- progress our ambitions around digital services and how we use data;
- develop a workforce with the right culture, values, behaviour, skills, training, and leadership to face the demands of the future.

We know that if we align our approach through these shared ambitions, we can accelerate the pace of change.

OUR JOINT FORWARD PLAN

Our Joint Forward Plan sets out how our Integrated Care System will work together over the next five years to deliver on:

- **Local strategies**, including the Surrey Heartlands integrated care strategy and Surrey health and wellbeing strategy
- **The NHS long-term plan**, national priorities and constitutional standards
- **Organising and developing** the system
- **Achieving financial sustainability**, transformation and to integrate our delivery model.

Engaging and working with our communities

Our plan aims to address what we have heard from our communities - to improve access, navigation, continuity of care and keep people well across all aspects of our health and care system.

Transforming services in our neighbourhoods and towns

Care and support available in your local area

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- Your local integrated health and care team care team will 'know' who you are
- We will carry out health checks and provide care plans tailored to the individual along with vaccinations and immunisations
- Complex care management will be proactive to prevent further complications
- Support will be given for vulnerable and 'at risk' groups
- We will work together to provide treatment and care closer to people's homes

Transforming services in our four areas (Places)

Care and support in your local district and borough

- Services will be in place that meet the demands of the local area
- There will be multi-professional, multi-agency teams in local communities
- Community urgent care hubs will be available where they are needed

Transforming services across Surrey Heartlands

Organising health and care for the whole of our population.

- We will transform how we use technology and share information across the system
- We will work towards recruiting and retaining more staff
- Our premises will be fit for purpose
- NHS 111 will be main way to access the services needed
- We will improve urgent and same day care with clear alternatives to accident and emergency departments
- There will be a modern and responsive ambulance service

DELIVERING OUR AMBITIONS

Prevention: Supporting people to lead healthy lives by preventing physical ill health and promoting physical wellbeing

We will know that we have succeeded in our ambition when our population can say:

"*I have access to all the information and support I need to remain as independent as possible*."

You have told us that keeping well and living your own healthier life is important. Highlights of our response for **prevention and keeping people well** priority include:

Outcomes for this priority	We are doing
People have a healthy weight and are active.	We will continue to develop the range of support such as **nutrition, physical activities and children's healthy weight** on our Healthy Surrey website.
Substance misuse is low (drugs/alcohol/smoking).	We will be funding Tobacco Dependency Advisors to deliver 'in-house' smoking cessation services across all the acute and maternity services
The needs of those experiencing multiple disadvantages are met.	Surrey's Changing Futures Programme is introducing the Bridge the Gap Trauma Informed Assertive Outreach alliance - joining together to provide a specialist, relational model of **trauma-informed outreach for adults** by helping people to become more self-reliant over time.
Serious conditions and diseases are prevented.	We are developing **Community diagnostic hubs** in communities increase access and early diagnosis for our population. This includes outreach models such as working with the homeless communities who can now access mobile Hepatitis C screening and liver testing as well as Covid vaccinations from an outreach community team.
People are supported to live well independently for as long as possible.	We are increasing accessing **day services and activities** within their local communities helping people stay independent for longer.

Prevention: Supporting people's mental health and emotional wellbeing by preventing mental ill health and promoting emotional wellbeing

Outcomes for this priority	We are doing
Adults, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources.	For children and young people, we will support them through our **Anxiety & Suicide Prevention programme** and tailored services. We will continue our strong partnership working such as HOPE service to **provide help and support, closer to home** through commitment to the iTHRIVE approach. We will have a much stronger focus on early intervention, with mental health support embedded in all our schools and colleges. We will ensure 24/7 adult psychiatric liaison in all emergency departments.
The emotional wellbeing of parents and caregivers, babies and children is supported.	We are extending our **specialist perinatal mental health services** from preconception to 24 months after birth with additional access to psychological therapies in services and addressing the equity of our services for our population.
Isolation is prevented and those that feel isolated are supported.	We know that people may not see themselves as **Carers** or know about support and services to help them. We are focusing on including Carers as part of the patient's assessments so that the entire family – young people and adults, will have ready access to appropriate information and be able to access appropriate support services.
Environments and communities in which people live, work and learn build good mental health.	We will continue to expand green health and wellbeing and social prescribing initiatives that connect people to activities, groups, and services in their community to meet the practical, social and emotional needs that affects their health and wellbeing.

Prevention: supporting people to reach their potential by addressing the wider determinants of health

Outcomes for this priority	We are doing (JFP Delivery example)
People's basic needs are met (food security, poverty, housing strategy etc).	Each of our district and borough councils have an active **homelessness and housing** strategy. Health and care partners are working together to arrange support for those that need it; including older, disabled and more vulnerable residents to live, safe, healthy and independent lives.
Children, young people and adults are empowered in their communities.	Surrey's **Early Support Service for young children with disabilities** will give information about support that is available. We will ensure public and voluntary services work together to support families at the earliest opportunity to become more confident and resilient in the future.
People access training and employment opportunities within a sustainable economy.	We are developing through our **workforce** strategy - United Surrey Talent - a core offer for our people, where everyone on the team has access to the same or equivalent support and reward.
People are safe and feel safe (community safety including domestic abuse, safeguarding).	Reduce the long-term harm and cost of **domestic abuse** in Surrey, with targeted support in our Neighbourhood Teams for our priority populations - Surrey Against Domestic Abuse.
People benefit from healthier environments (including through greener transport/land use planning).	We are working to move to low carbon inhalers for asthma and COPD where appropriate, as part of care quality improvements for **respiratory care**. We will continue preventative support to reduce the prevalence of smoking and increase in electric vehicles in the NHS fleet.

Delivering Care Differently: Improving access, navigation and continuity of care

We will know that we have succeeded in our ambition when our population can say:

"*I have care and support that is coordinated, and everyone works well together and with me.*"

You have told us that improving access, navigation and continuity of care will be most impactful to your experience and health and care outcomes. Our second priority then, is to **deliver care differently**.

Outcomes for this priority	We are doing
When every person can **access** care easily, efficiently and receive the help and support of their choosing.	Roll out of **advanced telephony systems in general practice** to increase ease of access and effective use of online consultations. This will enable seamless service flow and re-direction by offering 'call-back' functions to enhance people's experience and aid clinical decision making – in and out of hours.
When people who want **personalised care,** receive it through multi-disciplinary teams and care coordination.	We will continue to work with individuals, health care professionals and referrers to ensure they have the relevant information to **support choices about care and treatment**. In primary care, we will seek to implement delivering care from a named health or care professional.
People should experience a reduction in unplanned attendances to emergency/urgent care services, the number of times they need to contact their GP practice and visits to other health services.	Our **diabetes** programme will empower our citizens to manage their diabetes or reduce their risk by raising awareness, providing quality education programmes and reduce variation in care provision and clinical outcomes. This will increase people taking an active role in managing their condition and aims to reduce hospital admissions particularly for cardiovascular and renal disease.

What needs to be in place to deliver our ambition: Functions that need to work well

We will know that we have succeeded in our ambition when our population can say:

"*I am able to access care in an environment which is appropriate to my needs with the right facilities and supporting information both I, and my care professional, need*."

So we can be a mature, productive and effective system and deliver our ambitions, there are a number of other **functions we need to be working well**. This is our third ambition.

Outcomes for this priority	We are doing
Working with our communities to create more opportunities for collaboration with partners at neighbourhood level.	We will continue developing and our local community engagement groups for citizens and staff, using learning from existing multi agency, neighbourhood assemblies to co-design healthier communities and supporting communities to lead the way and supporting people to take more control of their health and wellbeing.
A **workforce** with the right values, behaviours, skills, training and culture across all partners organisations.	We are creating a new Health & Social Care Academy for **learning and education** across our 40,000 staff and students in our local colleges and higher education.
Our workforce benefits from systems **leadership**/skills, educational and development opportunities.	Our leaders will need to work across organisational boundaries at both local and county levels and through our pioneering a new "**Growing System Leaders**" programme, will help key people develop their stewardship skills.
Health and social care services are delivered in the right, **fit for purpose space and conditions** to support communities.	Our **Integrated Estates Strategy** will bring flexible integrated health and care estate that enables the right services to be delivered; relieve pressure on acute settings, provide a more agile way of working for staff, and help to reduce inequalities and improve access to the right settings.
A highly **digitally** skilled workforce, using digital technologies with a digitally empowered population able to manage their own care.	We will continue to use and scale the use of **remote monitoring tools** and applications such as blood pressure monitoring service 'BP@Home', urine tests, Children's e-Red book, My COPD. We will support the digitisation of 600 local health and care settings – social care and care homes - to improve citizens outcomes through coordinated and connected professional teams.

Outcomes for this priority	We are doing
Data sharing across systems and partner organisations to improve health and care outcomes	Our **Integrated Digital and Data Platform** (IDDP) will provide an integrated central data system to drive Population Health Management goals, support the Surrey Care Record and Personal Health Record through state-of-the-art business intelligence and advanced analytics.
Innovation and research is used to maximise outcomes and faster recovery to our population.	With the support of the Allied Health Science Network (AHSN) and wider system partners, we will make Surrey Heartlands the destination of choice to trial and scale research and innovation. And develop a strategy that will attract industry investment to support delivery and development of novel solutions for the benefit of our population.
Finance	We will agree a system wide single procurement approach to maximise value for money and best use of collective resources within Surrey Heartlands and associated wider partners.

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NEXT STEPS

Only by taking a collective responsibility across our partnership will we be able to achieve the step-change in outcomes - for all our communities - that we want to see. We believe we have a strong plan to deliver this change.

We will know we are succeeding when we can see that:

- **Access –** every patient is able to access primary care easily, efficiently and receive the appointment type of their choice.

- **Continuity** – there is an increase in personalised care being provided by multi-agency, multi-disciplinary teams with care co-ordinators, enabling patients to see the same clinicians or teams.

  We will see a reduction in the number of emergency department attendances for defined groups of patients, an overall reduction in the number of GP contacts and outpatient contacts.

- **Approach to care –** groups of patients identified with clear inequalities in terms of life expectancy, immunisation and screening, diabetes and cardiovascular prevention get the right care and support to meet their needs.

  We should also see populations who aren't routine health seekers receive early cancer diagnosis**.**

The Joint Forward Plan will be reviewed and published annually by 1 April up to 2028 as required by the Health and Care Act 2022.

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Inside back cover

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BACK COVER

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Joint Forward Plan

2023 - 2028

FINAL DRAFT

11

V4.2

12 June 2023

Purpose

The Joint Forward Plan sets out how our local NHS, partner local authorities, voluntary, community and social enterprise (VCSE) sector, our Places and Neighbourhoods will deliver the **ICS strategy** and **NHS Long Term Plan** commitments for our local population over the next five years.

The Joint Forward Plan describes how we will:

- **Deliver on local strategies**, including the Surrey Heartlands Integrated Care Strategy and Surrey Health and Wellbeing Strategy
- **Deliver NHS specific ambitions**, including the NHS long-term plan, planning guidance priorities and constitutional standards
- **Organise and develop** the system to deliver on these ambitions
- **Work together to achieve financial sustainability**, transformation and to integrate our delivery model.

We face significant **financial challenges**. Surrey Heartlands Health and Care Partnership is working together to achieve financial sustainability for our system, as we integrate and transform our ways of working.

The creation of this document reflects the legislative requirements of the Health and Care Act 2022 in relation to system Joint Forward Plans.

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Acknowledgments

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- **Voluntary and Community Partners,** Healthwatch Surrey; Surrey Voluntary, Community and Social Enterprise (VCSE) Alliance
- Our **Independent Providers**

Review Date: January 2024

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Foreword

We all want people in Surrey to live in good health for as long as possible and that they are supported to get the right help, when and where they need it.

Surrey is already one of the healthiest places to live in England, with better cancer survival rates and people less likely to have a stroke or heart attack than many other areas. Our services also perform well, with most health and care providers rated good or outstanding.

However, there are big differences between what most of us experience and what some of us can expect, with up to a 12-year gap in life expectancy depending on where you live. Because most people in Surrey are living longer that also means more people living with ill health and conditions such as dementia, with social isolation and loneliness increasing. We also know that clinical care alone will only ever impact about 20% of someone's health and wellbeing; the rest is influenced by factors such as education, housing, employment, the environment and hereditary factors. Which is why it's so important for organisations to come together to tackle these wider issues collectively.

Surrey Heartlands is a formal partnership of health and care organisations working together to do just that. This means health organisations, the local authorities and others taking collective responsibility for improving the health of the local population, managing resources (including money) and delivering high quality health and social care. Doing this in partnership gives us much greater scope to have real influence on people's health and wellbeing in ways we couldn't if we simply focused on fixing symptoms rather than the wider causes of poor health.

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In Surrey Heartlands we want to create a health and care system that builds on the amazing community spirit we witnessed during the pandemic. One that values the role of the local community and organisations, focused particularly at the most local, neighbourhood level, enabling people and families to take more control of their health and wellbeing, with easy access to high-quality care when it's needed.

By 2028, we will have put greater focus on prevention and targeting support where it's most needed, so no-one is left behind.

At the same time, we want to take advantage of what we have in Surrey to pursue innovation with business, public sector partners and communities, joining up services for residents and developing digital technologies to create smarter ways of managing health and accessing support.

The creation of statutory partnerships – known as Integrated Care Systems - via the Health and Care Act 2022 - has given us the right framework to make this step-change and the opportunity to make genuine long-lasting change through delivery of our new Integrated Care Strategy. At a critical time of rising demand for services, the need to reduce waiting lists, improve access and continuity of services, we have the mandate to work differently and create the transformation that's needed to improve people's health and wellbeing and provide sustainable, high-quality services into the future.

This document sets out how we plan to do this over the coming years, working in partnership with both our workforce and local people, to continue to support the people of Surrey Heartlands to live healthier lives. We face significant financial challenges as our partnership works together to achieve financial sustainability, transformation and to integrate our delivery model across our four Places.

This is our first Joint Forward Plan. It will be refreshed by the end of March each year reflecting the evolution and maturity of our plans.

Health and Wellbeing Board Statement

ADD OPINION OF PLAN – Board 21 JUNE 2023

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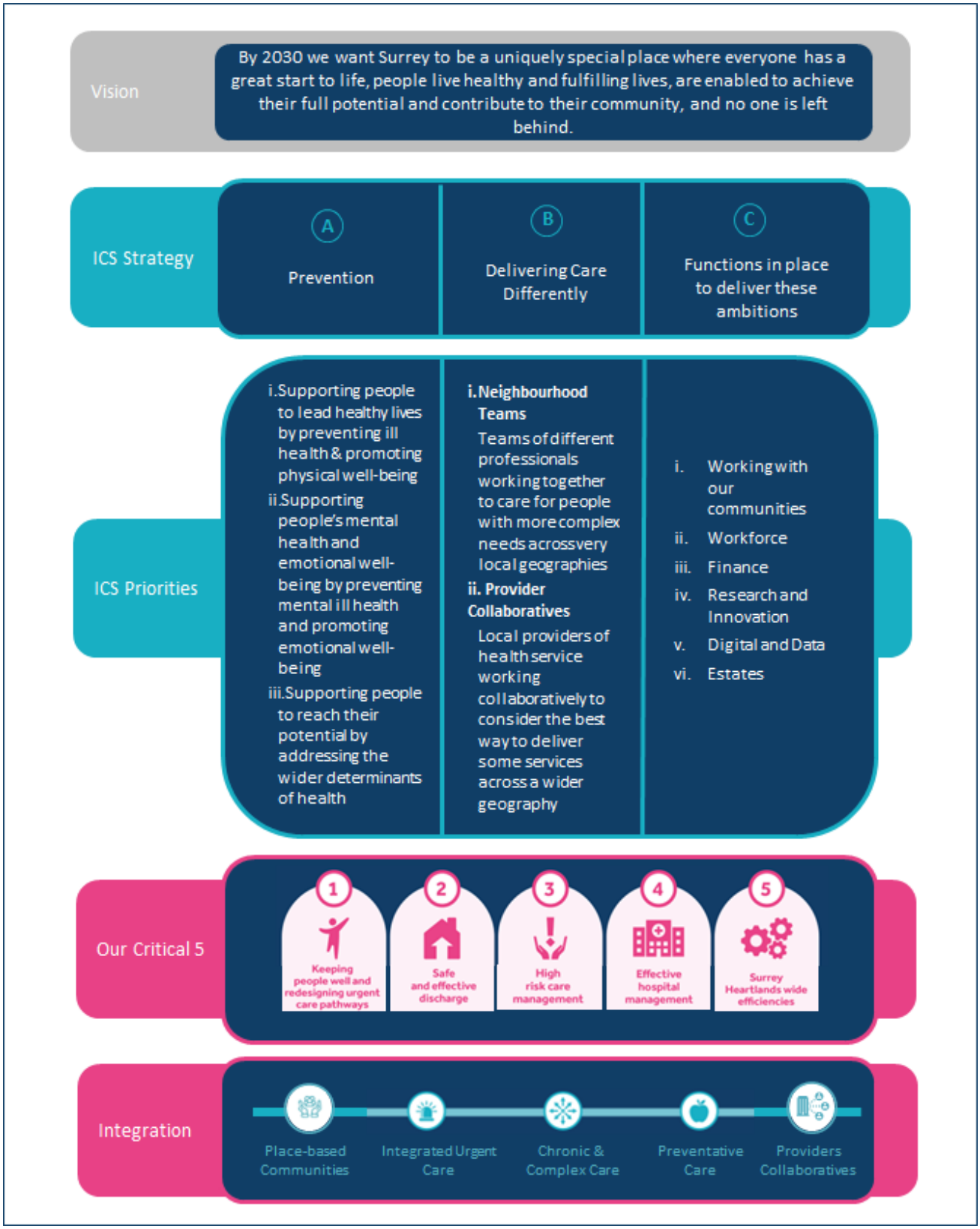
One System, One Plan – On A Page



Executive Summary

Only by taking a collective responsibility across our partnership will we be able to achieve the step-change in outcomes, for all our communities, that we want to see.

Our Integrated Care Strategy describes how we intend to meet the health and wellbeing needs of local people; building on existing collaboration. This is about promoting the right partnerships – at System, Place and Neighbourhood level – that will lead to improvements in health and wellbeing and the socioeconomic conditions of local people. Our strategy reinforces the importance of prevention and keeping people well, as the major catalyst for change.

The strategy is based on **three ambitions** that reflect where we are and what our populations have told us, so that 'no-one is left behind'. These set out our key areas of focus with significant emphasis on reducing inequalities.

A. Prevention
B. Delivering Care Differently
C. What we need to deliver these ambitions

This our first Joint Forward Plan. We describe how we will move towards realising our vision for people's health and wellbeing and start delivering our strategy. It builds on work already underway through the 'Community Vision Surrey in 2030' and the 'Surrey Health and Wellbeing Strategy', focusing on the prevention of ill health and the greater integration of health and care services including the wider public and voluntary sectors, reflecting the NHS Mandate and what local people are telling us. It sets out how we will deliver local health and care services alongside broader care delivery, focusing on **Years One and Two** of our strategy.

We know that **clinical care alone** only makes around a 20% contribution to health and wellbeing with a 30% contribution from **individual health behaviours**; the rest (the **wider determinants of health**, excluding genetic and hereditary factors) is influenced by things such as education, housing, employment, and the environment.

This plan describes our strategic delivery plans through our wider partnerships and the work we are doing across our four Places and local neighbourhood teams, shifting the focus from treating sickness to collectively using our resource to focus on prevention and keep people healthier. Positive intervention in a child's life represents prevention in their life as an adult, interventions which should be made at the earliest opportunity from pregnancy onwards.

We will put greater focus on prevention and targeting support where it's most needed:

- Working proactively with our communities to support people to lead healthy lives,
- Providing more personalised care,
- Working together to offer a wider range of support closer to people's homes.

In doing so, we will achieve the ICS four purposes:

- Improve outcomes in population health and healthcare,
- Tackle inequalities in outcomes, experience and access,
- Enhance productivity and value for money,
- Help the NHS support broader social and economic development.

Overall our health and care needs are changing, our lifestyles are increasing risk of preventable disease and affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease and the health inequality gap is increasing. Population Health Management helps us understand – at system, 'Place' and neighbourhood - current health and care needs, creating informed predictions of what people need to help prevent ill health. We will increase personalised care, designing more joined-up services and incorporating our working with

communities principles, to make best use of our collective resources and improve people's overall health and wellbeing.

Through social research and local insight, we know our combined efforts are making a difference. For example, improved access and communication to and from primary care, greater experience of personalised care and improved experience of integrated adult social care. Local people have highlighted common themes to inform our ambitions, including the need for more health and care integration, better access to services and the importance of supporting our valued workforce.

These strategic ambitions are a key part of our One System, One Plan framework – a single view of transformation and recovery which is reflected in the plans and strategies of all partners. Embedded within these is the vision from the Fuller stocktake to:

- streamline access to care and advice for people and ensuring care is always available in their community when they need it
- provide more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs
- help people to stay well for longer as part of a more joined-up approach to prevention.

To achieve our ambitions, we need to create **the right conditions for success**. This includes how we work with communities enabling them to lead locally driven change, involving and listening to what people are telling us, progressing digital ambitions and use of data, and developing a workforce with the right culture, skills, training and leadership.

Our Trust Provider Collaborative, to be formally established in summer 2023, will work together, as experts in service delivery, to address immediate challenges and deliver longer-term service transformation to ensure future quality, workforce and financial sustainability.

11

In 2028, when we have delivered this plan, our population will benefit from the priority outcomes detailed in our strategy and experience:

- Increased services **focusing on prevention**, providing communities with the right access to preventative support.
- **Integrated Neighbourhood Teams** shaped and designed by partners from across the health and care spectrum – statutory, voluntary, community and social enterprise organisations.
- **Improved access to same-day urgent care and general practice,** enabling Neighbourhood Teams to take an active role in **creating healthy communities** by working with local people, and developing closer relationships with local authorities, voluntary and community sectors.
- **Streamlined access to integrated urgent, same-day care and advice** from expanded multi-disciplinary team, using data/digital technology to find patients the right support.
- Our 'Team of Teams' will **have the physical space to work together** in their neighbourhoods
- Multidisciplinary teams with **new skills and capabilities**, through successful recruitment, retention and learning to support the communities they serve.
- **Digital technology and data** underpinning how our teams work, how our communities interact with us and how we analyse and use data to continuously improve services.
- **Health on the high street** driving town centre reimagination through our health diagnostic offer and positive economic impacts driven by the ICS supply chain helping to deliver sustained socio-economic outcomes.

Over **the next two years**, we will also deliver against the national NHS priorities:

Recovering services & productivity	Urgent and emergency care
	Community adult and children's health services
	Primary care
	Elective Care, Diagnostics, Cancer
	Maternity, neonatal & children's services
	Mental health

Delivering transformation & LTP ambitions	Learning disabilities & Autism
	Improve health and reduce inequalities
	Invest in our workforce
	Use of collective resources; Continuing Health Care, Medicines Optimisation, ICS running costs, Workforce and Agency Spend

Across these priorities we will be considering what we do at an individual level to provide more preventative and personalised care, how we work within our neighbourhood teams, across our larger Place partnerships and the wider health and care system.

We will focus on prevention and tackle what will make the most difference to people's lives **over the next three to five years** by continuing to **integrate primary care services**; bringing together general practice, community pharmacy, dentistry and optometry, alongside other health services and personalised care for people and families, where they live.

Above all, we need to be bold in our approach, leveraging our collective efforts as partners to transform what, where and how we provide care and work with local communities so they can take more control of their own health and wellbeing.

The deliverables set out in this plan are based on what needs immediate attention, and for which funding in the coming year has been identified. Year one of the plan therefore contains the most detail. Other schemes may require business cases to be developed, to seek additional funding, before they can be delivered. We describe longer term aspirations (3-5 years) as ambitions. These will be reviewed each year when this plan is updated and future funding allocations are confirmed.

Our wicked problems

We are operating in a financial landscape that is challenged and is not likely to get easier in the near future. We consider the most effective way to address these financial constraints and improve outcomes is the closer integration of health and social care, with less reliance over time on large hospitals and traditional care models, to sustainably address health inequalities.

- **How we focus activity and funding on prevention and tackling health inequalities** in a challenged operational and financial landscape.
- **Social care demand and complexity has overtaken funding levels,** resulting in higher acuity for those admitted and greater difficulty in discharging from acute settings.
- **An older population** – Surrey has 20% more people aged 80+ than the rest of England meaning a large frail population with greater needs and complexity.
- **Recovery from the Covid19 pandemic** – high volumes of planned and emergency care following the pandemic, including delays in care and presentation.
- **Fragmented acute landscape** – high number of hospitals resulting in duplication and smaller scale operations, plus multiple middle- and back-office functions and non-consolidated estate.
- **Over reliance on private sector** – high number of non-NHS independent providers undertaking high margin cost activity, removing private revenues from the ICS.
- **Lack of specialised care, compounded by proximity to London** – due to lack of highly specialised care in the ICS, alongside ease of access to London and other areas, a large proportion of activity occurs outside the ICS (£247m London spend 2021).
- **Funding for increased mental health conditions prevalent locally** – we receive less funding from national allocations, based on assessment of low complexity and need in our population, due to focus on psychosis, and less consideration for other conditions (like eating disorders) where we have higher prevalence.
- **Supporting other areas** – providers serve multiple ICSs including Frimley, Kent and Sussex.
- **Our workforce capacity is concentrated in acute settings, with more scarcity in community, primary care and social care partners**, meaning we don't have the right people in the right place to deliver the models of care we aspire to.
- **Surrey cost of living, access to affordable accommodation, variable education provision within the county and inflexible working options** add further hurdles to building an effective workforce supply.
- **Running cost reductions** – achieving success while streamlining workforce and other costs.

- **System Flow** – high levels of demand and reduced capacity in care settings and effective discharge result in longer patient journeys through our system and challenging environments for our workforce.
- **System maturity** – whilst we have good relationships across our partners, and bold ambitions, we have variable maturity in how we work together to transform, integrate and manage our services day to day.
- **Addressing access and continuity of care** – we continue to see service users experiencing challenges and delays in accessing some services and fragmented care.

Building On Our Successes

We have seen many achievements despite the challenges of the pandemic (**Error! Not a valid bookmark self-reference.**). Using our collective strengths and assets, we will measure success through our 2028 achievements, performance measures, plus patient and user experience.

- **Prevention** - Growing Health Together in East Surrey invites people living and working in communities across East Surrey to collaborate and co-create conditions in which everyone's health and wellbeing can flourish.
- **Equality, Diversity & Inclusion** – Supporting ethnically diverse women in Maybury and Sheerwater to gain activity qualifications, empowering them to become role models for physical activity in their community. We are also actively using Black and Minority Ethnic experiences to improve workplace, service standards and culture development.
- **Maternity** - Perinatal mental health service now in place, alongside a 'Baby Buddy' app providing daily tips/advice on lots of topics for families with children up to 1 year old.
- **Technology** – With Mole Valley Life, First Community's Responsive Services have supported the installation of emergency lifeline alarms and key safe boxes for residents, helping them feel safer when the team or their family aren't around.
- **Supporting Surrey's Carers** - Five new carer support hubs located within communities including improved tailored support for young carers (HSJ awards finalists).
- **Pioneering Cancer Treatment** - Artificial intelligence-led project at Royal Surrey hospital improving cancer care - 'Ethos' targets radiotherapy with precision avoiding damage, limiting side effects and tailoring to changes in patient's bodies.
- **Clinical Research** – Surrey and Sussex Healthcare NHS Trust awarded best Clinical Site Team in the Pharma Times International Clinical Researcher of the Year Awards, June 2022, for their demonstration of excellence in setting up and conducting research trials.
- **Improving Emergency Care** - The Emerge Project at Ashford and St Peter's Hospitals, with the East to West charity, has supported hundreds of vulnerable young people coming to the Emergency Department in a mental health crisis, with wider care in the community.
- **Personalised Care** - Surrey Heartlands published a joint Palliative and End of Life Care Strategy where everyone is seen as an individual, with care tailored to meet their needs.
- **Social Care** – 94.1% of adults receiving adult social care feel safer, enjoy better quality of life, with greater control over their daily lives (above the national and Southeast average).

Figure 1 – highlights from Surrey Heartlands

This Joint Forward Plan (JFP) sets out how we will deliver our strategic ambitions over the next five years:

- Introduction — About Surrey Heartlands
- Chapter One — Ambition 1: Prevention and Keeping People Well
- Chapter Two — Ambition 2: Delivering Care Differently
- Chapter Three — Ambition 3: What we need to deliver these ambitions

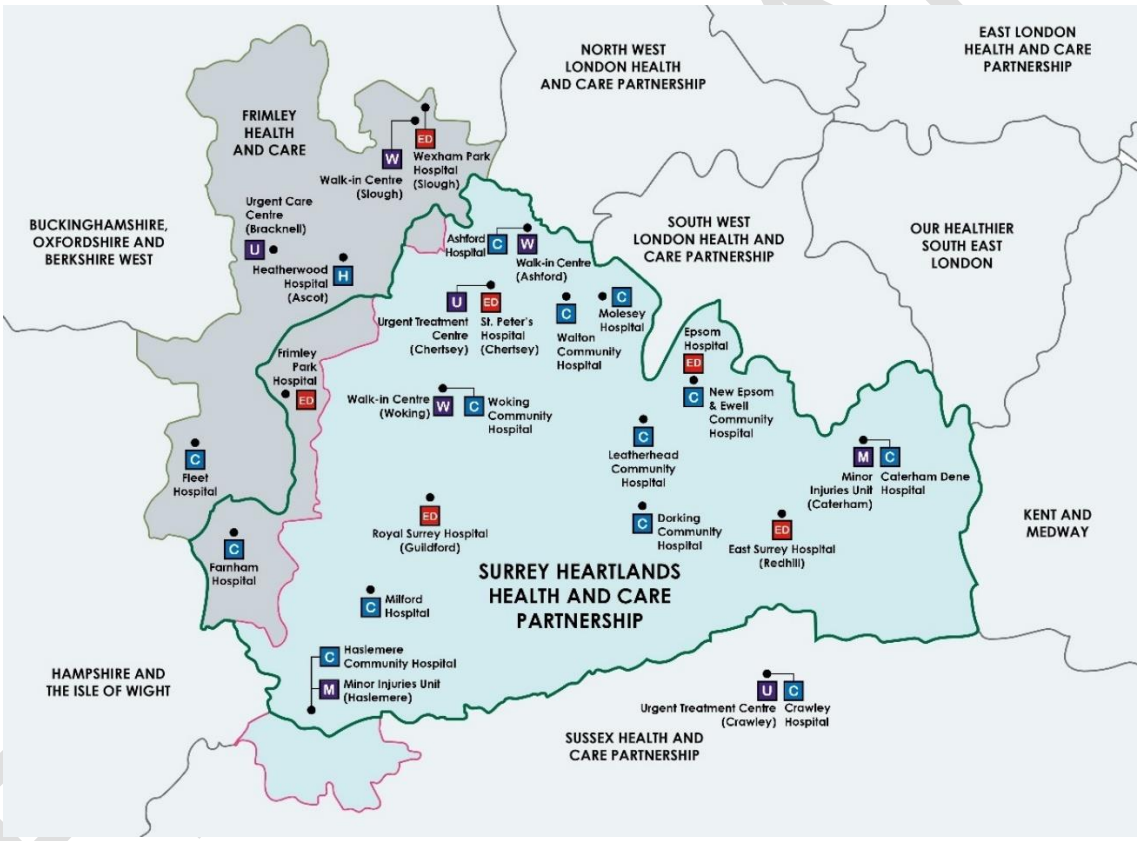
Introduction: About Surrey Heartlands

Surrey Heartlands Health and Care Partnership is an 'Integrated Care System' (or ICS for short). That means we take collective responsibility for improving the health of the local population, managing resources (including money) and making sure services are high quality.

Our partnership covers most of Surrey, a population of around 1.2 million, as shown in the map below. The rest of Surrey (including the borough of Surrey Heath and parts of Farnham) are covered by the Frimley Health and Care system. We have long standing partnerships and collaboration with neighbouring health and care systems, from Southwest London to Hampshire.

As a partnership we want to create a health and care system that builds on the amazing community spirit we've witnessed during the pandemic. One that builds trust and relationships with communities and supports people to take more control in their lives and in their communities, with easy access to high-quality care when it's needed.

You can read more about how we developed leadership and accountability across our system partners in the Surrey Heartlands' Development Plan (2022) and governance in appendix 1.



The Population We Serve

The health of people in Surrey is generally better than the England average. Surrey is one of the 20% least deprived counties in England, however about 9.1% (18,310) of children live in low-income families. Life expectancy for both men and women is higher than the England average.

We know that in our community we still face challenges:

- Implications of covid has impacted on **school readiness** including speech, language and communication and increased anxiety.

- There is a **12-year gap in life expectancy for females and 10 year gap for males** depending on where you live in Surrey Heartlands. Access to care is not always the same for our communities.
- Surrey is rural place with limited transport links therefore access to care is not always the same across our communities.
- We have an **aging population**. 2018 predictions estimate the population in Surrey will increase from 1,189,934 in 2018 to 1,227,467 in 2043. This prediction suggests the older population will increase. The increase in the population groups aged 45 and over in Surrey is likely to impact more on health and social care services due to increased risks of developing long term conditions and other needs.
- We have more people than we have seen before **living with ill health and conditions** such as dementia, and loneliness **together with higher acuity**.
- Our populations have told us that the **Cost of Living Crisis** is a significant cause of concern which has the potential to lead to poor health outcomes for them, such as the impact of social isolation on mental health or not having a warm place of residence impacting on long-term condition management. Just over a quarter (26.4%) of the population are economically inactive, of which 2% **are long term sick or disabled** and 12.9% are retired.

Drawing on our Joint Strategic Needs Assessment (JSNA) and population health management approach, we will focus in prevention and support where it's most needed. The Pandemic highlighted the urgent need to prevent and manage ill health in groups that experience **health inequalities – differences in health that are avoidable** - and the unsustainable increase in demand on public services. We know that delays in presentation, postponement of elective care and screening will have led to later presentation of non-Covid illness because of the Covid19 pandemic. The Surrey Community Impact Assessment in 2020 found:

- health impacts were greatest for people aged over 80 and those in care homes,
- those that are not used to needing support have started to struggle,
- there are significant impacts on those already using mental health services,
- more people are participating in unhealthy behaviours such as smoking and alcohol consumption,
- more people felt more isolated.

We will deliver these ambitions through our Surrey Health and Wellbeing Strategy implementation plans and the CORE20Plus5 adults and children programmes, which are described later.

Population Insights

We have backed up these insights by engaging with Healthwatch Surrey, our local providers and the wider community, voluntary and faith sector to understand what local people are telling them directly. Alongside these conversations, we have engaged with local people directly through "on the street" events and Place-specific engagement activities during the development of our plans. People told us about challenges experienced and opportunities to make a difference to the health and care support received:

Access: People continue to struggle with contacting or accessing services. It can be confusing or a barrier when directed to online services with long waiting times.

Continuity: Lack of staff negatively impacts their experience and too often care is fragmented and has to be repeated or delayed.

Approach: People agree that proactive, personalised care supports their longer term health and care needs.

Working with People and Communities

As we work together to deliver our priorities, we are focusing our approach on the strengths of individuals, community networks and other assets to focus on outcomes rather than a focus on services. Local people have told us they want services that are responsive to their needs and out them at the centre of decision making. Our new model of care can only work if our communities and our staff are able to be equal partners in how services are shaped, designed and delivered.

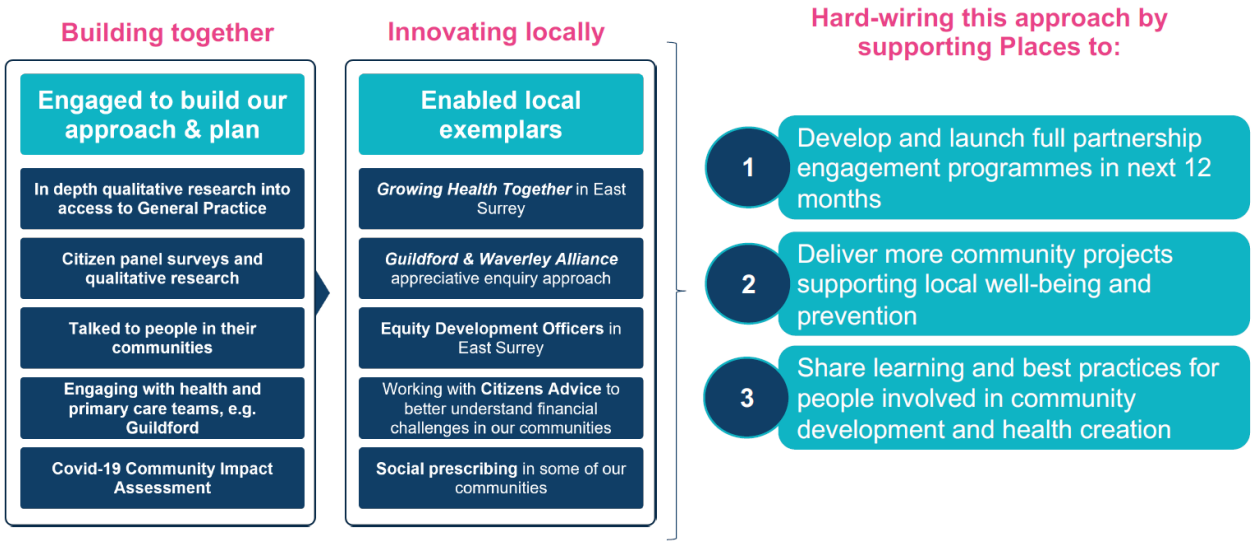
We will continue to identify specific cohorts who would benefit from proactive care in the community and working with Primary Care Networks (PCN) to refer them to social prescribing or multidisciplinary teams. Our response to the needs of our populations is primarily through these local places; supporting people to become expert patients, developing confidence and responsibility for their own care.

The national programme **CORE20PLUS5** is aimed at reducing healthcare inequalities for adults and children and young people. We have aligned our response to Surrey's Health and Wellbeing Strategy to meet local needs. Our **CORE20** population is made up of four Key Neighbourhoods - the four electoral wards that include areas of deprivation in the national top 20 percent, while our **PLUS** population is composed of two groups; the Key Neighbourhoods and our communities of identity with the poorest health outcomes.

Underpinning this work, we will focus on specific population groups, including the most deprived 20 percent of our population and those people, families and communities experiencing poorer-than-average health access, experience or outcomes, alongside five national clinical areas - **pregnancy, severe mental illness, chronic respiratory disease (COPD), early cancer diagnosis and hypertension** - which we know significantly contribute to life expectancy gaps in more deprived populations.

We are clear that what might work in one neighbourhood may not work in another and we will be guided by clinicians, professionals, voluntary, community and faith partners and the wider community in shaping what each neighbourhood offer looks like. Our Involvement and Participation Framework sets out our strategy for working with people and communities. The implementation of the **Fuller Stocktake Report** and the subsequent development of Place and Neighbourhood teams will drive how care is delivered for populations across Surrey Heartlands.

Shaping our approach with our communities



Communication & Engagement

Involving, listening to, and supporting the ongoing participation of local people and staff in the work of the ICB – and our wider health and care partnership - is critical in meeting the health and care needs of our population and tackling the healthcare gaps and inequalities we know exist.

In our **Working with People and Communities** strategy we set out our commitment to this, describing how we will consistently listen and collectively act on the experience and aspirations of local people, communities and staff. This includes supporting people to sustain their health and wellbeing, as well as involving people and communities in developing plans and priorities and continually improving services.

As a system, we have a solid foundation of involving and engaging local people; from strong community relationships, positive stakeholder relationships – with the community, voluntary and faith sector, local borough partners, Patient Participation Groups and elected representatives – and involvement in service redesign, to our citizen engagement programme, cited nationally as good practice in developing our citizen's panel. Our system-wide Involvement and Participation Group, which includes VCSE partners, Healthwatch Surrey, Place representation, members of Surrey County Council's Adults & Health Scrutiny Committee, and other patient and partner representation, provides independent support and oversight for our involvement work and the sharing of best practice.

Figure 2 – involving people and communities across our system

We are moving our overall approach away from the more traditional model of engagement to enable genuine co-production and personalised care – tailored to local needs and preferences – as well as a strong reliance on social research and insight to inform decision-making. Working within our Place-based Partnerships and local Neighbourhoods, we are supporting local people to develop a ground-up approach to healthier communities, empowering people to take more control of their health and wellbeing.

CASE STUDY

In Surrey Downs a strong thriving communities programme is focused on redefining how the local partnership works with communities to support people living healthy, fulfilling lives and addressing health inequalities. The local 'Pulling Together' programme has brought together staff and citizens from across the local area to explore the importance of citizen involvement in service design and the opportunities for developing local communities in partnership. Via a series of workshops the programme has looked at the practical steps of how staff and citizens can work together to deliver change and has embedded citizens as part of the programme governance.

We have common involvement principles that we work to across the whole of Surrey Heartlands, actively enacted at local levels through our Place Based Partnerships and local Neighbourhoods.

Key involvement principles

- Putting the voices of people and communities at the centre of health and care decision-making
- Developing trusted relationships to understand people's experiences and aspirations, particularly those most affected by health inequalities
- Building a culture of co-production, insight and involvement – that is meaningful and demonstrating clearly where actions have been taken
- Involving people and communities at an early stage when developing strategies and plans
- Avoiding duplication by understanding and building on insights we already have
- Working in partnership with local communities and going to where people are
- Providing clear, accessible communication/public information

In developing our plans we have listened to what local people are telling us; through ongoing engagement and conversation, targeted engagement programmes which have supported the development of service-specific strategies and through a wider engagement programme during the autumn of 2022 which included a total of 188 in-depth qualitative conversations to understand more about what matters to local people, followed up by a survey of our citizen's panel which generated over 1,000 responses for analysis. Over the next five years we will continue to involve local people as we develop our health and care plans, ensuring their voices are heard and that services are developed around the needs of local people, particularly those experiencing inequalities in care and access.

You can find out more about our engagement programmes and how to get involved on our website.

The way we will work

Since 2017, Surrey Heartlands ICS has been strengthening relationships, promoting equality, diversity, and inclusion and consolidating partner organisation ambitions so we can focus on the wider causes of poor and ill health.

We are taking an increasingly **Place-based approach** to commissioning, partnerships, and service design in order to reflect the unique qualities of Surrey's different towns and villages. These are not statutory organisations, but a way of working with increased collaboration through shared goals.

Our Place-based partnerships cover most of Surrey (Figure 3) and involve the NHS, local government and other local organisations such as voluntary, community and social enterprise sector organisations and social care providers.

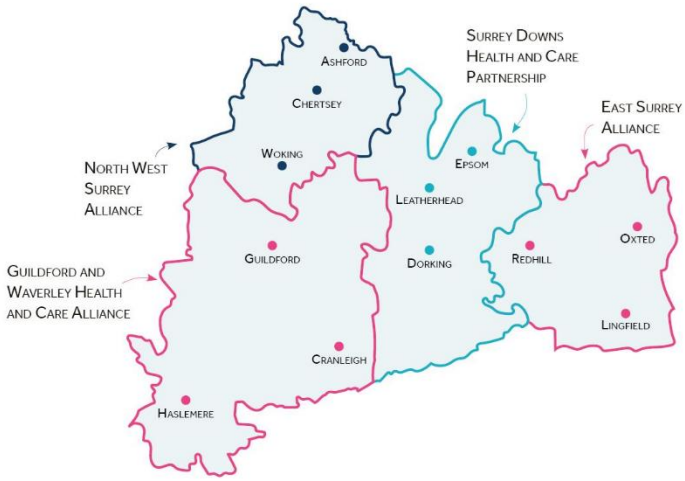


Figure 3 – Surrey Heartlands Place-Based Partnerships and Alliances

We have an ambitious programme to drive improved health outcomes for people through the development of strong local partnerships and working with people where they live. We have four Place-based partnerships or Alliances – Guildford and Waverley, East Surrey, North West Surrey, and Surrey Downs bringing together health, local government, the voluntary, community and charity

sector with wider partners across local populations. Using their local knowledge and relationships, they aim to reduce health inequalities and support delivery of local services across smaller geographical footprints.

Working at a Place level, we use opportunities for our residents, their families, and their communities to be at the centre of our integrated working. Our Place-based partnerships are an invaluable generator of ideas and considerations. In addition to our 'working with communities' commitment, we are committed to developing community assets – using the skills, knowledge, facilities and social networks - to build positive, trusted and enduring relationships with communities.

CASE STUDY

North West Surrey Health and Care Alliance are developing a new health campus in Weybridge, which will return health and community services to Weybridge. Our vision is for a state-of-the-art community hub that incorporates a modern, purpose-built health facility, fit for the 21st century, providing a range of high quality health and wellbeing services for the local community by the end of 2025.

This is a partnership between Surrey County Council, NHS Surrey Heartlands and Elmbridge Borough Council, with the development of the health campus as phase 1. We anticipate the facility to include:

- Doctors, nurses and therapists working together to provide a one-stop shop for local health services
- Flexible space and room for expansion so we can respond to population growth and meet future needs
- Access to 'on-the-day' urgent care provided by nurses, GPs and a range of health professionals
- Ultrasound and blood testing services on site
- A range of children's services including 0-19 Health Visiting and School Nursing Hub, as well as Speech & Language/Physical Therapy

Each of our four Places has identified its local priorities to deliver the ICS ambitions. These reflect the diverse needs of their specific populations and thinking about how they will work differently in the future to achieve. Figure 4 shows our Places' the combined key delivery focus and outcomes. You can read more about how we will locally deliver the One System, One Plan in each Place on our website.

Key delivery focus	Outcomes
Establishment and embedding of Neighbourhood Teams where multi-agency teams come together, building on the work of primary care networks	Increased joined-up, proactive and personalised care
Implementing viable community based urgent care response as an alternative to Emergency Departments	Reduced demand in Emergency Departments
Simplifying navigation services to ensure people receive and enabling continuation of care thereby improving access and patient experience	Reduced waiting times in Emergency Departments
	Expedient community based resolution to urgent care need
	Care will be delivered closer to home
	Care will be received in the right care, at the right time and not 'bounce around' the care system

Figure 4 - Key Place-Based focus over the next two years

Neighbourhood Teams

We will make neighbourhoods 'real' for residents. This is critical to the establishment of all neighbourhoods. It is where communities will come together at a local level to shape and integrate services which address both the wider determinants of health and health delivery. These include community organisations and primary care services which work together in a small local area with Primary Care Networks to form Integrated Neighbourhood Teams (INT). Each of these INTs are best equipped to understand and drive the changes that our communities want and need by bringing together professionals across Health & Social Care and Voluntary, Community and Social Enterprise.

Partner Strategies

Surrey Heartlands Provider Partners each have strategies which support delivery of their organisational, NHS and ICS objectives to meet the physical and mental health needs of our populations. You can read more about these on our providers' websites.

NHS Ashford and St. Peter's Hospitals NHS Foundation Trust Our Strategy (2022 - 2025)	CSH Surrey CSH Surrey
NHS Epsom and St Helier University Hospitals NHS Trust St George's, Epsom and St Helier University Hospitals & Health Group Strategy 2023-2028	First Community Health and Care Strategic Approach 2020 - 2024
NHS Royal Surrey NHS Foundation Trust Strategy 2022-2025	NHS Surrey and Borders Partnership NHS Foundation Trust Strategies
NHS South East Coast Ambulance Service NHS Foundation Trust Improvement Journey Autumn 2022 (5 Year Strategy due December 2023)	NHS Surrey and Sussex Healthcare NHS Trust Strategy

Provider Collaboratives

The Surrey Heartlands Trust Provider Collaborative (TPC) is where the three acute trusts and the mental health trust work collaboratively as the experts in service delivery, to address immediate challenges and deliver longer-term service transformation to ensure future quality, workforce and financial sustainability. Each Trust will retain its own identity, support development and delivery of Place strategies, and within the collaborative lead on specific clinical services to optimise patient outcomes through delivery of operational excellence and value for money.

The TPC is expected to be formally in place from August 2023, and will focus on agreed priorities which need to be addressed as a provider system rather than at organisational level. The agreed priorities for 2023/24 are the elective centre, stroke, cancer, maternity and neonatal, and paediatric services; as well as a focus on mental health and acute partnership to ensure that people who present with acute mental illness receive the appropriate clinical input in a timely way and in an appropriate environment. The TPC will continue to focus on elective recovery and addressing unwarranted clinical variation.

The TPC will focus on transformation that needs to be undertaken across the providers at scale, while continuing to play a key role in working with colleagues at Place to deliver the agreed local priorities that recognise that neighbourhood needs are unique and varied.

Programmes will be structured with Multi-Professional Clinical Leads to ensure there is coproduction of the underpinning principles to innovate, and to optimise opportunities to deliver at scale where this provides clear benefits. We have already seen the Virtual Ward Programme benefitting from the collective design and agreed underpinning principles to minimise inequalities emerging from the

Programme. This approach extends across Community services and Primary Care and Patient Carers for future Virtual Care.

Social Care

Social Care in Surrey is delivered through a number of different routes. There are statutory services provided directly by Local Authorities, provision supplied by the VCSE, independent Care Providers and of course, the vast amount of care provided by unpaid carers which is often unseen and unrecognised. Social care, unlike health care, is means tested and this creates an additional layer of complexity in Surrey given that approximately two thirds of Surrey residents fund their own care. In many instances, those who self-fund their care will need to arrange it for themselves, often navigating a complex system at a point of crisis.

People at the Heart of Care set out the 10 year vision for adult social care. From this we have shaped three point vision for Surrey, so that our people:

1. Are informed and able, or have the support, to make decisions about their lives
2. Are enabled to be active, independent and have good wellbeing
3. Are connected to their communities

Our social care strategic priorities reflect our commitment to a modern service promoting people's independence, wellbeing and fulfilling lives.

- Developing an innovative, high-quality prevention approach, underpinned by an accessible digital offer for those residents who are able to self-serve to access information and advice on demand and personalised support for those who need it.
- Transforming Surrey's reablement offer to support all people, from the community and following hospital discharge, who would benefit from personalised support to achieve their goals and to gain or re-gain skills, confidence and independence.
- Improving mental health outcomes to maximise independence for Surrey's people through better early intervention, prevention, targeted and long-term support.
- Delivering with partners modern, technology-enabled homes and accommodation models with the right care and support to enable people to live as independently as possible.
- Working together as an effective and financially sustainable system, with place-based partners and residents to co-produce services, to deliver good outcomes for people, support them to access health and social care at the right time and in the right place.
- Working in partnership to improve outcomes for young people in transition to adulthood to maximise their independence and live their best life.
- Enhancing our commitment to consistent strengths-based approaches to prevent, reduce and delay reliance on, and demand for, long-term care.
- Creating the environment for staff to develop, progress their careers and thrive in a respectful, inclusive workplace with a supportive culture.

You can read more about our social care delivery plans in the 'Fact File' on our website.

Carers

A carer is anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or addiction and cannot cope without their support. The care they give is unpaid.

Surrey Heartlands will be a place where carers are recognised, valued and supported as pivotal to the ambition of the system, both in their caring role and as an individual. We want to do everything we can to enable carers to live well. It is crucially important that carers are identified at the earliest opportunity. Carers will be respected as partners in care, will have a strong voice that influences improvement, and will be able to access responsive support they need, when they need it, and in the way that works best for them. This support will be available equally to all carers.

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 know ledge to increase identification of young carers, enable young carers to self-identify and provide the right support to young carers and their families. We will develop an 'All-Age Carers Strategy' aiming for publication by the end of 2024/25.

Our work includes the following priorities for **young people**:

- 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 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

Our work includes the following priorities for **adults**:

- Place based carer action groups
- Personalisation (Social Prescribing and Carers Personal Health Budgets), Carer Passports
- Hospital Discharge and Community Support Guidance Hospital discharge and community support guidance
- Inclusion of carers in the co-design of virtual wards in Heartlands and the implementation of the wards at Place. Surrey Independent Carers Lead appointed to the Virtual Ward Programme Board.

You can read more about our delivery plans in our adult carers and young carers strategies and find out helpful information on our Carers page on the Surrey Heartlands website.

The following chapters describe how our strategic priorities will be delivered by the Integrated Care Board (ICB) and its partners.

1. Prevention and Keeping People Well

'I have access to all the information and support I need to remain as independent as possible.'

Our Health and Wellbeing Strategy based on our JSNA focuses on three linked priorities:

- Supporting people to lead healthy lives by preventing physical ill health and promoting physical well-being
- Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being
- Supporting people to reach their potential by addressing the wider determinants of health

Most people in Surrey lead healthier lives than the average UK citizen. However, this strong average performance often masks areas of underperformance, inequality or where additional focus is required. We will focus on delivering reduced **health inequalities** for our priority populations – those with the poorest health outcomes - through the CORE20PLUS5 programmes for adults and children.

You can access quarterly highlight reports which provide an overview of the progress of local shared projects supporting the delivery of the Health and Well-being Strategy on the Healthy Surrey website.

1.1. Supporting people to lead healthy by preventing physical ill health and promoting physical well-being

We are participating as one of only fifteen areas in the country operating a National Changing Futures Programme to support the most vulnerable individuals in our communities with **multiple disadvantage** and help them achieve their goals. The Changing Futures Programme in Surrey explores gaps in care, unwarranted variation and disparities in health and care outcomes for this population and challenges opportunities where the system could be effective in improving the outcomes.

Surrey's Changing Futures Programme has introduced Bridge the Gap Trauma Informed Assertive Outreach alliance of homeless, mental health and domestic abuse providers to support optimal outcomes for people with multiple disadvantages. The alliance is a group of third-sector providers delivering a specialist, relational model of trauma-informed outreach for adults with multiple disadvantage, supported by clinical psychologists who are trauma specialists. A full evaluation of the Changing Futures programme has been commissioned for 2023/24. Resolution of these issues offer not only the prospect of reducing offending and reoffending rates, but significant societal benefits and a reduction in costs for the health service, social care, police, and criminal justice systems.

Another example, is our system approach to physical activity, including improving use of green spaces, transport initiatives, and healthy planning to enhance the preventative aspects of wellbeing. Since the development of our Long Term Plan, the number of adults classed as inactive in Surrey is the lowest ever, at 19.5%[1] however over 50% of young people are still not meeting Chief Medical

[1] people who do less than 30 minutes of activity a week (www.activesurrey.com). England average 21.4% (18/19).

Officers' physical activity guidelines. We will continue to develop the range of support such as nutrition, physical activities and children's healthy weight on our Healthy Surrey website.

Prevention of ill health includes screening and **Health Protection** activities, which encompass a set of public health activities protecting individuals, groups and populations from infectious disease such as childhood vaccines for preventable diseases and seasonal influenza, incidents and outbreaks - managed by our system Emergency Preparedness processes, all help people to stay well for longer.

Our ambition is that everyone in later life can experience good physical health and emotional wellbeing, have a sense of meaning and purpose, social connectedness and better resilience. We will achieve healthy aging and care through improving our integrated health and care services to provide seamless treatment and support when needed, promoting good health and wellbeing, early intervention and prevention, in a way patients can control and plan in our towns and through neighbourhood teams.

Over the next 10 years, the number of people aged 65+ living in Surrey is expected to rise by 19.6%. As this population grows, there is will be a rise in the number of people with multimorbidity, such as dementia and diabetes alongside frailty which is associated with increasing age. We know that being active can increase the amount of time that people can stay independent and healthy.

As we age, it is common to have a growing number of health issues. Over time, this can affect our ability to bounce back after an illness or other stressful events, as well as our ability to live independently or keep in touch with family and friends.

Our Living Well in Later Life Strategy sets out the support for people in Surrey. It is shaped from the views of hundreds of residents, carers, staff and care providers. This is our plan for how we will help residents to have more choice and control over the care and support they need, when and where they need it. We will change how we design and buy services and work with partners to make these changes.

CASE STUDY

Live Longer Better pilot through Active Surrey in Elmbridge is focused on helping people stay healthy, happy and independent for as long as possible. It's mission is to change the culture surrounding ageing, replacing the concept of care with the concept of enablement. It includes improving physical ability and resilience, preventing and coping with disease and understanding and changing how people think about ageing.

By 2028 our population will benefit from:

- 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.

1.2. Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being

This priority is about enabling the emotional wellbeing of our citizens by focusing on preventing poor mental health and supporting those with mental health needs, so people have access to early, appropriate support to prevent further escalation of need, including parents and care givers.

We have a strong and growing **social prescribing** network and expanded **green social prescribing** initiatives across our Places which are a collaboration between health, social care, district & borough councils and a range of voluntary sector organisations in our Neighbourhood Teams. These provide proactive, personalised support such as healthy lifestyles and physical activity, debt and benefits services and mental health & emotional wellbeing.

CASE STUDY

Social Prescribing in Guildford & Waverley Neighbourhoods

Mark is a veteran with Post Traumatic Stress Disorder (PTSD), depression, anxiety and chronic pain from a back injury. Mark receives some practical support from adult social care. Mark wanted to have more interaction with other people as he was limited to small amounts of employment due to his injury. Through social prescribing Mark was put in touch with Welcome Buddies and Welcome to Volunteering (supported access to a volunteer placement). Although Mark was referred as a client, he was more interested in becoming a volunteer buddy to support others. He is now working towards becoming a buddy and mentor for people with mental health issues as part of the Welcome Buddies project.

By 2028 our population will benefit from:

- Adult, 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 wellbeing 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.

Our NHS delivery priorities to achieve these successes are described in chapter 2 - Delivering Care Differently. You can read more about our work to improve health and wellbeing through social prescribing on the Surrey County Council website.

1.3. Supporting people to reach their potential by addressing the wider determinants of health

We will support our citizens to reach their potential by helping them to develop the skills needed to succeed in life and flourish in a safe community. This is not only about making sure people's basic needs are met but also about skills development, training and employment, involvement in life-long learning and in their own communities and considering the impact of community safety and the built/natural environment on health.

We aim to improve the perception of disability and increase expectations for everyone. Our Physical Disability and Sensory Impairment Strategy aims to remove barriers and support people with disabilities to become well informed and expert in their own needs and better able to exercise their rights, choices and life opportunities.

By 2028 our population will benefit from:

- People's basic needs are met (including food security, poverty, housing strategy).
- 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 including domestic abuse, safeguarding)
- The benefits of healthy environments for people are valued and maximised (including through transport/land use planning).

2. Delivering Care Differently

'I have care and support that is coordinated, and everyone works well together and with me.'

Our populations have told us they want a model of care which is responsive to their needs and puts them at the centre of decision making. To enable this, we have determined two main aims as we transform how we deliver care:

- making it easier for people to access the care that they need when they need it
- creating the space and time for our workforce to provide the continuity of care that is so important to our populations.

We are putting delivery of joined up health and care services at the heart of our approach – integrated care - enabling 'Making Every Contact Count' to provide proactive and personalised care through our developing Place and Neighbourhood teams.

We will enable people to easily access high quality care and focus on support where it's most needed to access care through our commitment to improving the navigation and information relating to health and care services ensuring:

- Proactive access, joined up health and care support
- Digitally advanced services
- Nobody is left behind

We need to manage rising demand, on behalf of patients and staff, at the same time as recovering our system post-pandemic, reducing waiting times and transforming how we provide care and support people in their communities. We are moving away from reactive treatment of illness to proactive and preventative care promoting health and wellness. We aim to ensure every person can access care easily, efficiently and receive the help and support of their choosing and when people want personalised care, receive it through multi-disciplinary teams and care coordination.

2.1. Making it easier for people to access the care that they need

We will move patients safely and efficiently through our clinical pathways, delivering high quality care based on the 'Get it Right First Time' principles.

This chapter focuses on improved access - including service navigation - and integrated care pathway developments, ensuring healthcare works effectively when needed and movement through health and care services known as 'system flow' improves.

We are proud to have showcased how we are enhancing access to primary care and joining up services for patients to Amanda Pritchard, Chief Executive of the NHS in March 2023.

"The team here are showing the benefits that can come through embracing the power of technology, making best use of the skills of a wide group of clinicians and other professionals, and forging strong links with communities and other services – and it is exactly these benefits which the NHS is working to ensure people across the country can enjoy."

We will deliver this integrated system working through our collaborative organisation partnerships focusing around the needs of the patient. This is not just about transforming how services are delivered on the front line, it's also about realigning our functions and re-imagining how they can enable our teams to work together.

Primary Care

Good primary care is the foundation of an effective health system for patients. When working well, it supports the early identification of serious illnesses and the management of chronic conditions, while also helping people to live healthier lives. To achieve this, two defined areas aligned to the Fuller Stocktake and the delivery plan for recovering access to primary care, have been identified:

- **Personalised Care for the who need it**: delivering care from a named health or care professional (using all disciplines in Health & Care)
- **Streamlined Access:** Expanding MDTs and providing flexibility to tailor services to local demands. Optimising data and technology to integrate siloed same day urgent care services.

Access challenges are being caused by an increased demand for services - both volume and complexity - combined with ongoing workforce pressures and reduced numbers of GP.

Our system has a clear support offer to general practice which aims to provide insight in addition to radically transforming general practice and wider Primary Care services (Figure 5). We strongly believe that patients should always be able to receive the same, or an equivalent service, however they access their GP practice - be that digitally, by telephone or by walking into the surgery.

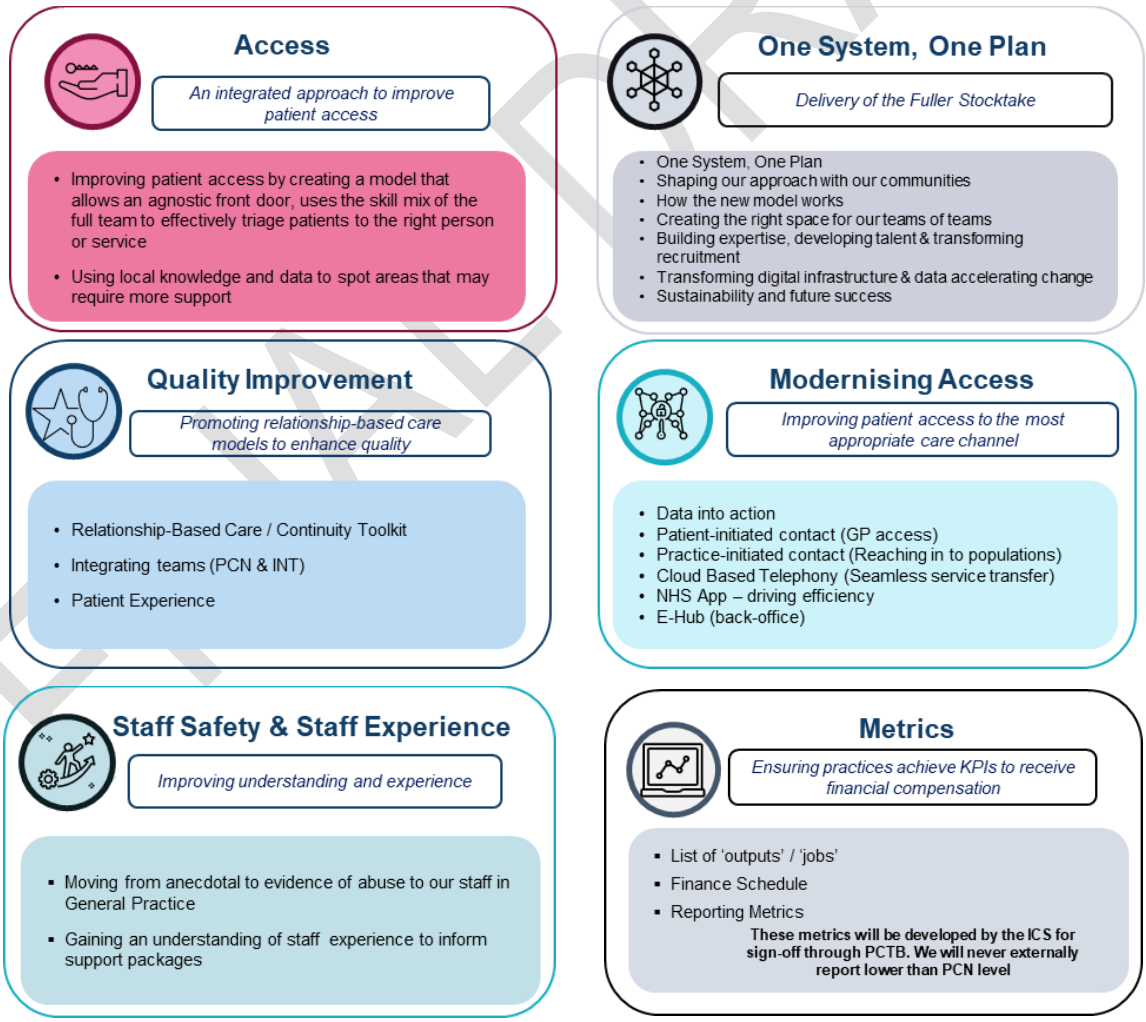


Figure 5 – General Practice Development Toolkit key components to transform the models of care and streamline the patient journey

Improving Patient Access

We have designed our patient-initiated and practice-initiated models to find the most efficient and effective way for patients to access and be contacted by General Practice (Figure 6). The models will incorporate technologies such as advanced telephony - cloud based systems with clinical system integration – and the NHS APP to ensure our population is able to access a wide range of services and support when they need.

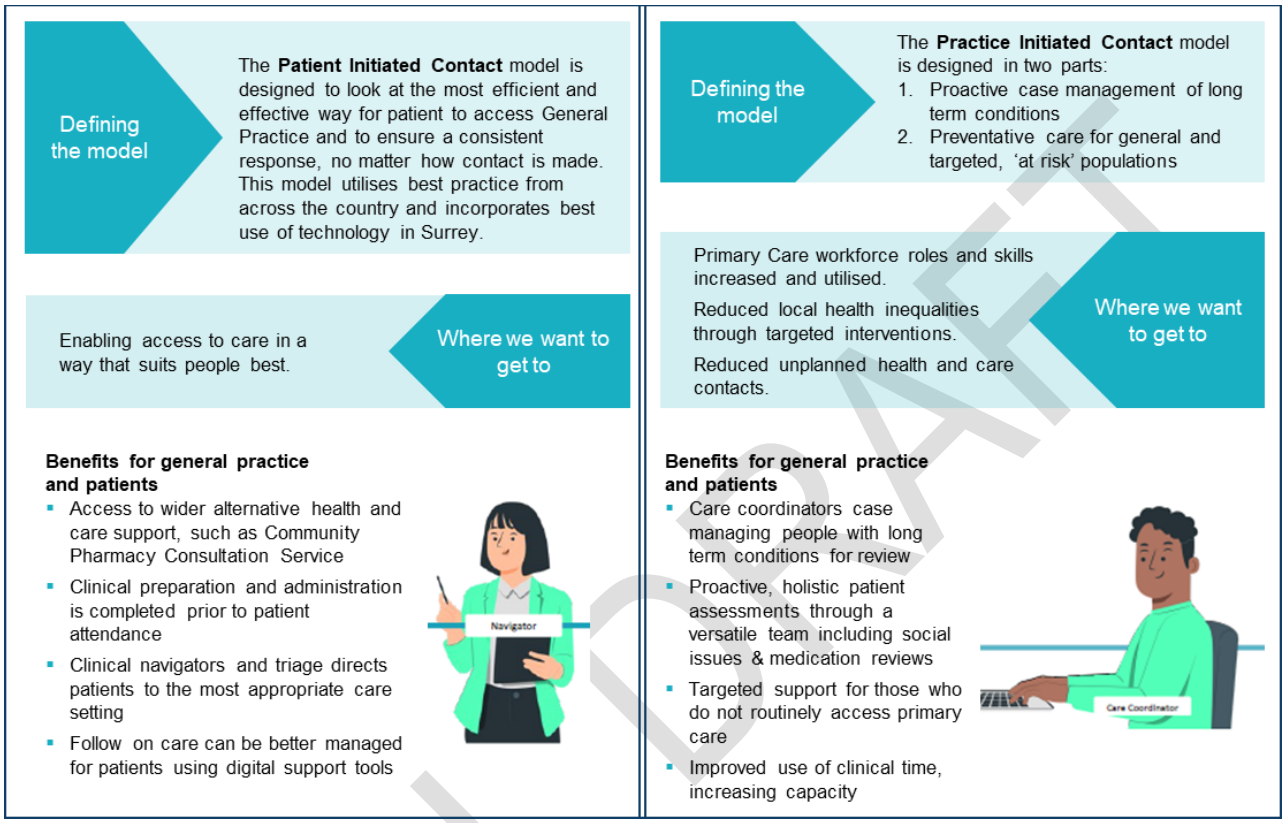


Figure 6 – patient and practice initiated contact models

CASE STUDY

Primary Care Networks – Growing Health Together works across East Surrey has seen primary and community health care workers, social prescribers, the county council, borough and district councils, VCSE groups and others collaborate - getting alongside communities to support, enable and promote citizen-led action and projects that create social connections and improve health and wellbeing - this includes, for example, community gardens, arts and music events and peer support groups.

Through the Community and Mental Health Transformation (CMHT) programme we are implementing **General Practice Integrated Mental Health Services** (GPIMHS). We are embedding teams into primary care networks through the NHS England early implementer CMHT funding, with full coverage achieved by 202023/24, across Surrey Heartlands.

Within each primary care network an integrated multi-agency GPIMHS team is deployed, including representation from health, social care, the third sector and people with lived experience of mental health needs. As well as supporting people to stay well and out of hospital, the programme supports people currently in secondary care mental health services who are stable and would be well placed to alternatively receive recovery focused and integrated mental health care services in primary care, with seamless 'easy in' and 'easy out' as required, and with a potential shared care arrangement.

Our key delivery priorities to achieve our aims include:

- **Continuity of Care** – Reducing fragmentation and promoting joint up pathways including expanding MDTs in community pathways
- **Patient Experience** – Gathering regular feedback to promote a proactive approach to the improvement in the ease of access to general practice
- **Professional Integration** - aligning teams between PCNs and INTs

Community Pharmacy, Optometry & Dentistry

Giving ICSs responsibility for direct commissioning is a key enabler for integrating care and improving population health in line with the NHS Long Term Plan. It provides the flexibility to join up key pathways of care, leading to better outcomes and experience for patients, and less bureaucracy and duplication for clinicians and other staff. Therefore, as part of empowering local decision making, NHS England (NHSE) set out the intention to delegate commissioning functions of Community Pharmacy, Optometry and Dentistry (POD) to all ICSs by April 2023; Surrey Heartlands became an early adopter and transitioned the services in July 2022.

By co-designing additional support and services we will better deliver the national contract, expedite recovery and aid retention issues in our dental practices and professionals (Figure 7).

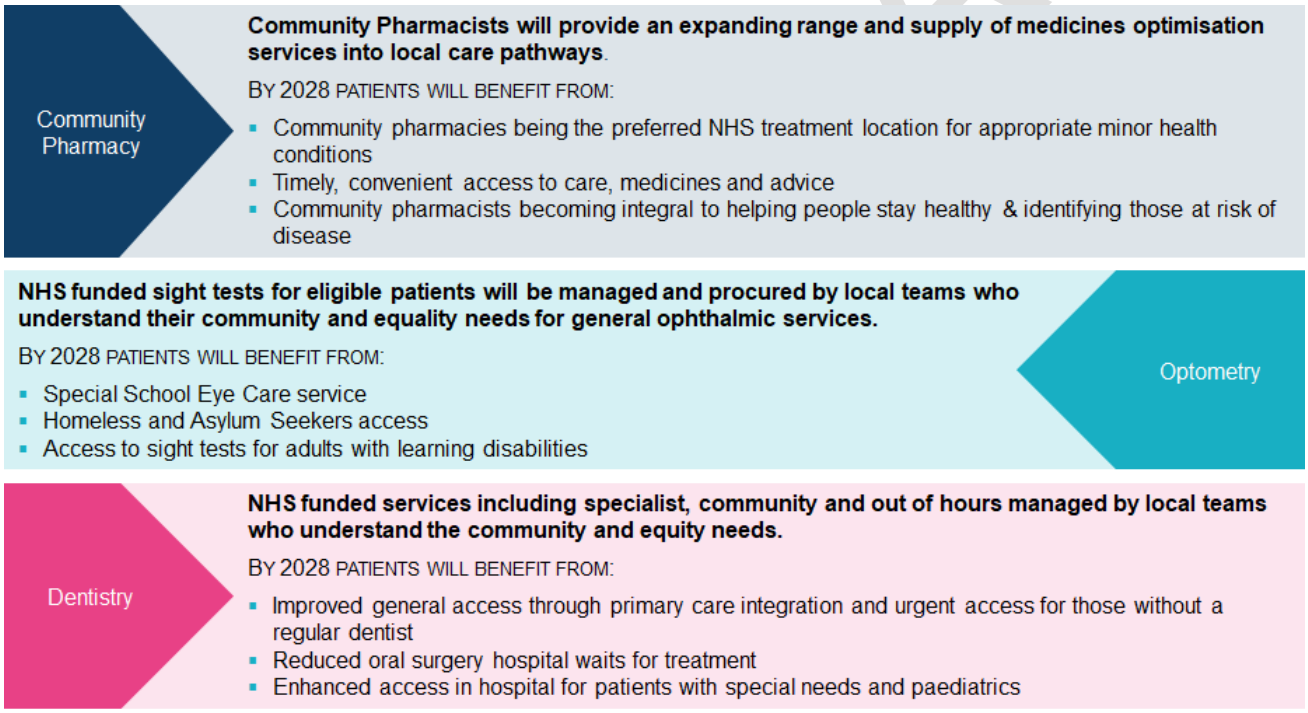


Figure 7- Community Pharmacy, Optometry and Dentistry transformation focus

The Surrey Training Hub exists to develop, support, retain, and attract the primary care workforce through education and training opportunities.

By 2028 our population will benefit from:

- Improved telephony and triage to helping practices manage demand;
- Enhanced booking and triage capabilities to local walk-in sites;
- Local service provision to meet identified challenges in our neighbourhoods;
- Expanded primary care offer at our walk-in sites, including same day emergency care pathways;
- Freeing up GP appointments so that people who need to receive GP advice are able to see their GP more quickly.
- Integrated urgent care pathways such as virtual wards as part of care pathways.

Community Care

We know that integrated care teams in the community reduce the likelihood of emergency care needs, enabling people to live in as good health and where appropriate, as independent as possible. Our Community Transformation comprises of 5 workstreams:

1. **Urgent community Response** (UCR) aims to expand and improve the Reablement, Intermediate, Virtual Ward capacity and ensure a two hour urgent community response service is available 7 days a week.
2. **Community Health Services** workstream focuses on pathway redesign and improvement for community based services and initiatives including Long Covid, Population Health Management, Carers and Children and Young People community services.
3. **Integrated Community Pathways** focusses more on safe and effective discharge using 'discharge to assess' models, trusted assessors, Personal Health Budgets (PHB) and expanding multidisciplinary teams in the community.
4. **Care homes & Domiciliary Care** aims to further integrated Health and Social care, linking PCNs, Care homes and the Enhanced Health in Care Homes model.
5. **Prevention and independent living** includes the vaccination programmes, further digital tools and services such as virtual wards and 'Making Every Contact Count'.

Our proactive and preventative care is delivered in many ways across our communities, such as offering **blood pressure and atrial fibrillation** screening to eligible patients following Covid19 vaccination. Clinicians with a special interest, such as in frail elderly people, lead our **complex care** function, acting as the link between the integrated neighbourhood team and complex care function in each Place to co-ordinate integrated decision making and care. INTs will identify patients through clinical judgement, conversations with patients, and risk stratification enabled by population data. We will continue support those through NHS Continuing Healthcare or **Continuing Care** Packages for children (where eligible) to enable people with long term complex health needs, receive care outside of hospital such as their home or care home to aid improvement in the quality of life.

We will better support people by having in place a community-based **falls response** service in all systems for people who have fallen at home including care homes and providing **additional support for care homes** through reducing unwarranted variation in ambulance conveyance rates.

We will **maximise the use of virtual wards** as an alternative to admission or earlier safe and supported discharge seven days a week, 8am to 8 pm. By supporting acute capacity management, virtual wards add value in making our services more sustainable and provide care closer to home. Our model brings together primary care, secondary care, and community services to support patients who would otherwise be in hospital. We are expanding our step-down capacity and we've developed a step-up model that will operate at place level and evaluating the establishment of an Acute Respiratory Infection (ARI) hub to support same-day assessment.

Our Better Care Fund (BCF) supports people to live healthy, independent and dignified lives by joining up health, social care and housing services. Surrey County Council, Surrey Heartlands Integrated Care Board and Frimley Integrated Care Board agree a joint BCF plan for Surrey which is owned by the Surrey Health and Wellbeing Board (HWB). It is aligned with the Surrey HWB strategy delivery and governed to tackle pressures faced across the health and social care system and drive better outcomes for people.

The BCF programme underpins key priorities in the NHS Long Term Plan, joining up services in the community - such as support for unpaid carers, housing support and public health and supporting 'Next steps to put People at the Heart of Care'. Our BCF programmes will begin to support prevention programmes and continue to facilitate the smooth transition of people out of hospital, reduce the chances of re-admission and support people to avoid long term residential care by acting on the plan to recover urgent and emergency services.

We are working closely with colleagues across other parts of Surrey, including the Frimley Integrated Care System and Southwest London Integrated Care System, to ensure our ambitions for high quality, compassionate, person centred, co-ordinated **palliative and end of life care** to meet people's wishes and choices (dying well), are aligned across the whole county. Our Palliative and End of Life Care strategy is being led at a local level by our Place partnerships. You can read more about the improvement ambitions and support information on the Surrey Heartlands website.

By 2028 our population will benefit from:

- A workforce that works around the child from buildings local to families and within communities
- An increase in personalised care provided by multi-agency, multidisciplinary teams with care coordinators, enabling patients to see the same clinicians or teams
- Targeted support where there is clear inequality in terms of life expectancy, immunisation, screening in populations who aren't routine health seekers
- Relevant services are part of Surrey Family Hubs and Frailty Hubs support adults and children close to home
- Digitally shared care records to support individuals get the care and support they need
- Support for all care home residents requiring frailty and enhanced health care
- Seamless urgent community response and virtual wards provision for people with escalating health and care needs, ensuring access to timely support and early interventions in their place of residence
- Increased opportunities to access immunisations and vaccinations for adults and children

11

Urgent Care

Our **urgent and emergency care** system is challenged across both our local practices and the wider care system. Unless we work across the traditional boundaries of primary and urgent care as one system using one plan, the relentless pressures on our health and care system that have become commonplace will not go away.

Central to our approach, we are developing effective, resilient, neighbourhood-based same-day access to urgent care that can serve as an easily accessible first point of contact for patients with routine issues. This sits as part of our integrated urgent care pathway, which ensures clarity for patients and referring clinicians (Figure 8).

Our ambition is to improve access to same day urgent care for those who need it, free up capacity to enable continuity of care and test and learn to shape new approaches that work locally. There will be separate emergency and urgent care services, which are clearly defined purpose, appropriate access and care provided for adults and children.

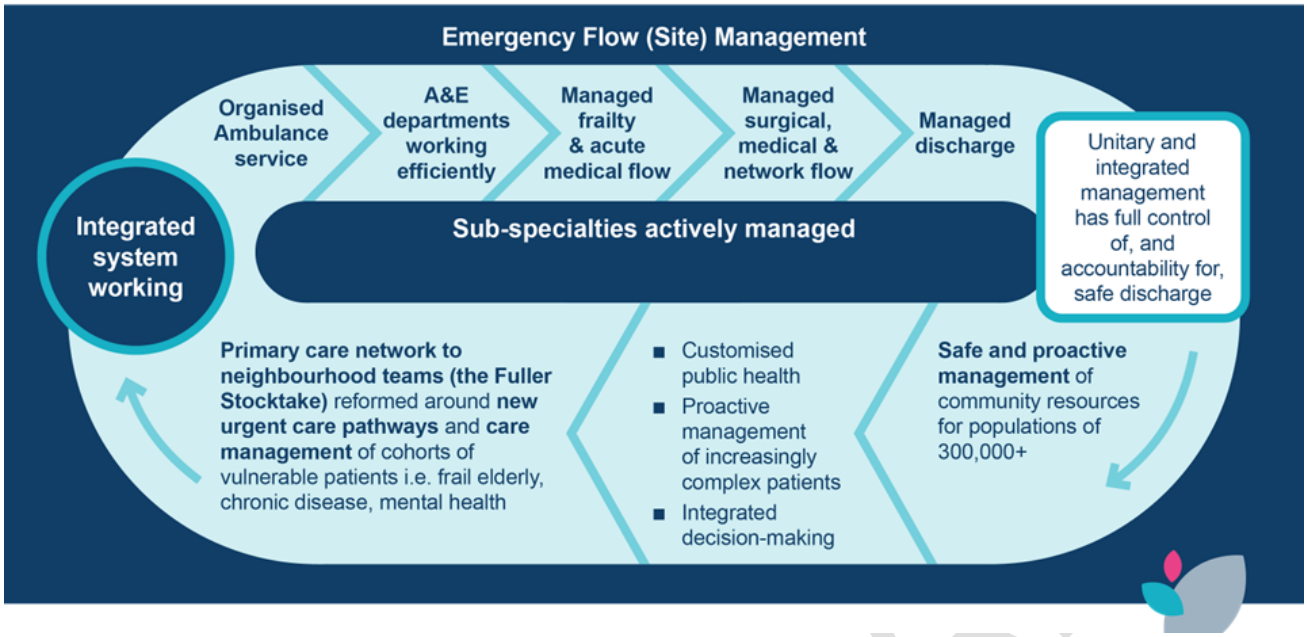


Figure 8 – Integrated system working

We are developing new proactive models that work to allow same day urgent care access directly to our local communities across digital, innovation and hub models. These include:

- **Enhanced access hubs** – same day urgent appointments that can be accessed digitally and include multidisciplinary teams that work until 8pm weekly and across the weekends
- **Urgent community response** - for our more complex and frail patients we will provide a multidisciplinary rapid response approach to help patients avoid the need to be transported away from their home and into an acute hospital
- **Urgent children and young people response** - many children and young people attend A&E with minor complaints that could have been treated in the community. We are exploring ways in which children will be treated closer to home in a more appropriate settings such as virtual wards. This includes some elements of care that have historically been given in hospital
- **Community diagnostic hubs** – working across Place we have developed models of diagnostics that are placed within local communities, including outreach models such as working with the homeless communities who can now access mobile Hepatitis C screening and liver testing as well as Covid vaccinations from an outreach community team
- **Care homes** – we have implemented a multidisciplinary approach to the management of care for these residents, particularly those who are more complex requiring extra support to avoid hospital admission
- **Frailty models of care** - we have developed key ambitions for frailty services that work with our local communities and carers to deliver urgent care in frailty that allow people to stay at home for longer safely
- Anticipatory care models – using our new digital risk stratification we can better target those most at risk of admission and attendance into the urgent care system
- **Triage improvements in referral processes** are proving effective in enabling the 'right care, in the right place' and we are now looking to extend these models across practices.

CASE STUDY

Surrey Downs Urgent Care Coordination Centre - is a single point of access for all referrals (including from health and social care colleagues, 111 and self-referral). The single point of access will allocate referrals to the appropriate team within the place-based urgent care pathway - whether

it is urgent community response, virtual ward, Homefirst+ or primary care network hubs. It aims to streamline and support greater clarity in navigating the system for all and can provide care coordination as patients move through the pathway ensuring continuity of care.

Same Day Emergency Care (SDEC) is a service that provides emergency care to people without the need for an admission to hospital and can provide direct referral into mental health services, dentistry, community pharmacy and services such as ophthalmology. We will ensure:

- SDEC operates 7 days a week for 12 hours daily.
- Enhanced diagnostic access and referral routes with an increase in the number of Advanced Practitioners.
- Surrey Heartlands meets the core service provision as per Long Term Plan, including community child and adolescent mental health services and 24 hour a day crisis teams.

Our **NHS 111 service** supports people who need urgent not a life-threatening emergency care. It provides advice and treatment if your GP practice is closed or if people are injured or ill and are unsure what to do. Surrey Heartlands in line with national ambitions, is continuing to develop this service to make it easier for people to access the care that they need and support emergency departments to work more effectively. This includes dedicated paediatric advice and guidance for families to support decision making around care options. You can find out more about how our service works on our website.

Ambulance

11

Our ambulance services are under extreme pressure resulting in slower call response times and fewer resources available. We know that handover delays – the time from arrival to transfer to a clinician at hospital – are not the only cause of slower ambulance response times. Our ambulance trust South East Coast Ambulance (SECAmb), like many across the country, has experienced increases in sickness and other staff absence, along with the complexity of ambulance crews' work increase meaning each incident is taking longer.

Surrey Heartlands ICS and SECAmb are committed to getting ambulances to patients quicker and in turn support recovery of patient flow. During 202023/24 we will improve ambulance response times for Category 2 incidents to 30 minutes on average, with further improvement in 2024/25 towards pre-pandemic levels.

SECAmb has established specific strategic objectives to achieve our collective aims; Quality Improvement, Responsive Care, People & Culture, and Sustainability & Partnerships. These will provide safe, effective, and timely response times for patients through the implementation of smarter and safer approaches to patient care and to become a sustainable provider by optimising referral pathways and avoiding inappropriate conveyance to emergency departments.

The Trust Board priorities and aspirations align with the Integrated Care System's Joint Forward Plan and demonstrate the Trust's commitment to improving patient outcomes, delivering high-quality and responsive care, developing sustainable healthcare provision, building a culture of continuous improvement, and promoting a positive and inclusive culture. The Trust aims to become a leader in the UEC arena, providing exceptional care to its patients and supporting its staff in delivering this, working as a key partner is each the four integrated care systems to which it relates.

Emergency Care

Surrey Heartlands ICS has experienced exceptional pressures throughout 2022 and into 2023. Unlike previous years, this has not been wholly created by increases in demand, increased ambulance conveyances and NHS 111, but exacerbated by high number of patients who no longer need to reside in hospital severely constricting patient flow into and out of hospital.

Our primary focus is delivering the NHS recovering urgent and emergency services two year plan to regain improved waiting times and patient experience. The integrated system working described earlier will enable us to support people access the care they need and alleviate continuation of care delays to recover patient flow . We are committed to the ambition to improve the percentage of

patients being admitted, transferred or discharged within four hours by March 2024 to the national 76% target, with further improvement in 2024/25.

Managed Discharge

We know that long stays in hospital through delayed discharges, are not good for patients and significantly impacts how hospitals are able to provide services. We will focus on improving discharge processes – sometimes known as 'flow'- between hospitals, community services, local authorities and social care to improve health and care outcomes plus patient experience.

Surrey Heartlands will deliver health and care discharge services seven days a week for people ready to leave an acute hospital bed. Surrey Heartlands will continue to build on personalised health and care initiatives that focus on people leaving the hospital, including interim care support packages coordinated across health, social care and voluntary sector partners. Getting discharge planning right is a crucial component of our process for managing surges in demand.

The NHS Delivery plan for recovering urgent and emergency care services encourages us to centre our improvement work on joint discharge processes, intermediate care and social care services. We will focus our efforts on embedding discharge planning at the point of admission with an estimated discharge date and identifying those with complex discharge needs by working with families and carers. We will use our 'Discharge to (Recover and) Assess' (D2A) to facilitate care closer to people's homes, with increased health and care agency coordination for intermediate care and domiciliary care, and supported by the Better Care Fund.

CASE STUDY

A pilot for in-reach community nursing within the **Royal Surrey County Hospital** was launched in January 2022. The adult community discharge senior nurses work to review all Guildford and Waverley community nursing caseload admissions to the hospital prior to their discharge home. The nurses are made aware of any patients on the district nursing caseload attending A&E and assist with preventing unnecessary admissions.

In the first six weeks community nurses received 165 referrals, promoting self-care in 21 patients, facilitating four early discharges and referring five frequent attenders who were previously unknown to the community matrons, in the hope of preventing avoidable admissions. The self-care instruction to insulin dependent patients alone avoided costs of estimated £93,447 per year. Feedback from staff within the hospital Trust was extremely positive and the decision was taken to provide Better Care Funding to expand and extend these roles.

By 2028 our population will benefit from:

- Providing clear relevant information to ensure patients can access alternative services for urgent same day care.
- Providing access to online resources 24/7, in a variety of formats, so that support can be given more quickly for many conditions.
- Neighbouring partners working together for walk-in sites booked appointments and Same Day Emergency Care (SDEC) pathways.
- Providing greater opportunity for care and support to be tailored to the individual's own support network and community.
- Urgent and emergency care services are consistently rated as good or outstanding.
- Our urgent and emergency care system is attractive to staff to work in.
- Linking care records, with consent, so that the person is able to 'tell their story once'.
- Providing more direct appointments with many local services, considerably reducing wait times.
- Ensuring that the Emergency Departments are better able to meet the needs of people who require emergency care due to suffering a life-threatening health event.
- Reducing wait times within the Emergency Departments; and increasing timely discharge from hospital.

Maternity and Neonatal Care

The best start in life begins well before birth. The NHS Long Term Plan national set the ambition to halve the rates of stillbirths, neonatal mortality, maternal mortality and brain injury by 2025. Within Surrey Heartlands we aim to ensure patient safety and to go further to achieve sustainable, high-quality physical and mental health care for women, birthing people and babies that meets the wide range of needs in our communities.

This means increasing choice, personalisation and continuity of carer, listening to women and birthing people, improving access to maternity and perinatal mental health services and improving uptake of prevention activities. Our local maternity and neonatal system seeks to provide women, birthing people and their partners with a positive, supportive experience from conception through to caring for their baby after the birth.

We know from the Independent Reviews of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (Ockenden, 2020 and 2022) and Maternity and Neonatal Services in East Kent: 'Reading the signals' we need to develop multi-professional training, recruitment and retention. We are proactively focusing on safety, positive cultures, and future workforce concerns within our Maternity Services. We will align our work with NHS England's three year delivery plan for maternity and neonatal services, including achieving the national ambitions by 2025.

We will prioritise improving and co-designing maternity and neonatal services in collaboration with pregnant women and birthing people through our local Maternity Voice Partnership (MVP), to ensure maternity equity and meet the needs of communities. Our key provision priorities include personalised care, continuity of carer and establishment of community hubs, improved postnatal care and appropriate bereavement care services for women who suffer pregnancy loss.

To improve outcomes for women, birthing people and babies, we have a number of priorities including:

- To halve the rates of stillbirths, neonatal mortality, maternal mortality and brain injury by 2025. Our collaborative Maternal Medicine Network with Southwest London LMNS will improve outcomes for women and consequently babies and referral criteria will reflect the increased vulnerability of women from ethnic minorities and those who are socially deprived.
- Addressing health inequalities - Our 5-year perinatal equity strategy.
- Physical health - to work with Southwest London Maternal Medicine Network to develop pathways for maternal medicine and we will scope services for pelvic health following birth.
- Emotional wellbeing: Perinatal Mental Health - ensuring that every woman:
    - Has access to services to during the antenatal period for 2 years after birth.
    - Is able to access quality perinatal mental health care and treatment at the right time, at the right level and at the right location
- Public health – We are working on pathways for smoking cessation during pregnancy in collaboration with Public Health. We also have public Health campaigns such as Ready for Pregnancy and Ready for Parenthood.

CASE STUDY

The Maternity and Neonatal Voices Partnership (MVP) is a national initiative that brings women, birthing people and families together with NHS staff and other stakeholders in an equal partnership to coproduce improvements to local maternity services. NHS Surrey Heartlands has four MVPs; one for each of our maternity provider trusts. The MVPs are chaired by a team of local mums with lived experiences within each trust. Our MVPs will continue to lead on gathering feedback from women and families in a variety of ways (from 'Walking the Patch' at the maternity unit, to visiting toddler and community groups), and work with staff to keep women and families' voices at the heart of maternity and neonatal improvements and developments.

MVP activity includes building relationships with local faith groups, food banks and charities, attending and presenting at Trust quality & safety meetings, co-producing bereavement pathways and literature, social media engagement with the public, contributing to strategies, and co-producing information and communications literature.

By 2028 our population will benefit from:

- Services co- designed with pregnant women and birthing people.
- A reduced rate of still births, neonatal and maternal mortality and morbidity.
- Feedback from women and birthing people demonstrating that they are listened to, have a choice and are the key decision maker for their care.
- Pregnant women and birthing people offered continuity of carer.
- Whenever possible, care closer to home.

Children and Young People

High quality services for children and young people are essential to improving whole of life health outcomes and reducing health inequalities. Poor health outcomes can become embedded early in childhood, so children and young people access a wide range of services during this life phase affords many opportunities to tackle this and make improvements. We are focusing on managing children effectively in primary care or community settings to improve the quality of care for acute and longer term illness.

The NHS Long term plan sets out key aspirations which consider the diverse and complex needs of children. The focus includes improving the quality of care for children with long term conditions such as asthma, epilepsy, diabetes and, more recently, long covid; right sizing paediatric critical care and surgical services to meet the changing needs of patients, ensuring that children and young people access high quality care as close to home as possible and selectively moving to a '0-25 years' service which will improve children's experience of care, outcomes and continuity of care.

The Best Start for Surrey Strategy has set the transformation ambitions for pregnancy and early childhood (up to age 5) over five years (2022 – 2027), with a focus on our collaborative transformation plans as an ICS. The delivery of this strategy will ensure that every child and family in Surrey has the best start in life.

CASE STUDY

Surrey and Borders Partnership NHS Foundation Trust and Elysium Healthcare have come together in partnership to build and manage a brand-new, dedicated mental health inpatient unit for young people.

The unit offers 12 inpatient beds for young people and a therapeutic, safe, and nurturing environment to support and aid recovery. There will be a variety of communal living and outdoor spaces to give young people the opportunity to socialise with their peers and be as independent as possible. There will also be an Ofsted registered school set up on-site to enable young people to continue with their schooling whilst receiving treatment.

Joy Chamberlain, Chief Executive Officer of Elysium Healthcare said, "Partnership working to deliver services in this way will create a new benchmark for the future, and we look forward to continuing to work with Surrey and Borders Partnership on this exciting journey."

Supporting this ambition, our Joint Commissioning Strategy outlines how our system architecture, will commission services for children and young people – for Surrey services, neighbourhood and individual level. Our vision is to support children and families holistically to live healthy and fulfilling lives', using improved understanding of needs across health and care services, hearing children and families' voices and managing our resources together.

The strategy focuses on three main theme areas:

1. promoting and facilitating good health, emotional wellbeing, and healthy relationships;
2. recognising and promoting the importance of development and early learning; enabling partnership working and collaboration; and
3. recognising the benefit of fully inclusive services, communities, and neighbourhoods.

We will continue to use our learning from the development of current services such as iTHRIVE, HOPE service and care closer to home, to continue strong partnership working to achieve our ambition. The Helping Families Early Strategy, Children's Community Health Services re-commissioning, maternity transformation, the Fuller Stocktake and the Children's Digital Programme are significant enablers of this strategy.

Our vision for **Children's Community Health Services** is to meet the needs of children, young people and their families at the earliest opportunity, through providing timely support, advice and specialist delivery at home, within local communities and across the county's geographies. We aim to ensure healthy lives and a brighter future supports children to grow up safe and resilient by prioritising prevention, early intervention and addressing health inequalities, enabled by designing and delivering services across Surrey and at Place.

As a partnership, our improvement priorities include:

- Children with Disabilities - Social Care alignment to health services, including continuing care, speech and language therapy, occupational therapy, physiotherapy, community paediatrics, and child and adolescent mental health services (CAMHS)
- Personalisation - including increasing take-up of and streamlining personal budgets, direct payments and personal health budgets
- Health of Looked After Children and Care Leavers - better use of health assessments, and understanding of the mental and emotional health of these children and young people
- Ordinarily Available Provision - services to support children with additional needs in schools enabling those that work in universal services to know what is available in their communities
- Community Health Services - making sure waiting times are reduced, workforce issues are addressed, and services are more impactful on shared outcomes
- Children and Young People (CYP) with a diagnosable eating disorder receive timely access to treatment, irrespective of severity and maintain the delivery of the 95% achieving the national waiting times standards of 4 weeks for routine care and 1 week for urgent care.
- Vulnerable Adolescents - Anxiety & Suicide Prevention to address the rising numbers of young people who are experiencing mental health crises, heightened through the pandemic, particularly through our Targeted Youth Offer
- Neurodevelopmental Pathway ensuring practitioners and services come together around a family at every stage of their journey
- Post Adoption and Special Guardianship Order (SGO) support ensuring therapeutic provision to prevent adoption or SGO family breakdown

To ensure that children with additional needs and disabilities can access the right support at the right time, from local, high quality health services, we will deliver an integrated system across Health, Social Care and Education. As well as providing appropriate and easy transitions for young people into adult services, we are committed to developing a transition to adult services that is seamless. We will increase use of digital technologies and multidisciplinary teams within clinical pathways as the normal way of working to ensure we make the best use of our resources.

CASE STUDY

North West Surrey Alliance are using an innovative community platform to focus on supporting children and young people to achieve their potential, from birth through adolescence, education is a key to support health and wellbeing for all. Through a comprehensive approach we aim to support families with practical and emotional support, provision of opportunities for work placements and work experience to increase aspirations and develop children for a future Surrey workforce.

The Alliance has partnered with Coram Life Education and Home Start Elmbridge, who are raising funds to give children and young people in North West Surrey the best start in life, supporting their welfare, mental health and education.

For children and young people with complex needs and special educational needs and disability (SEND), our ambition is that Surrey children and young people aged 0 to 25 years will lead the best possible life. They will be able to access health information and will understand the services available when they transition into adult healthcare provision as part of 'Preparing for Adulthood' in higher education or employment, independent living, participating in society, and being as healthy as possible.

By 2028 our population will benefit from:

- Better managed long-term conditions with reduced unplanned hospital attendances and admissions plus reduced co-morbidities later in life.
- Improved health and wellbeing including improved school attendance for children and young people, breastfeeding rates, healthy relationships with secure attachment and early learning.
- Children will be seen in a more appropriate community setting instead of an emergency department whenever possible.
- Children's critical care will be provided closer to home whenever possible.
- Each child or young person with an Education, Health and Care plan will have high quality health provision to ensure their health needs are met in alignment with their educational outcomes within statutory timescales.
- Under school age children with Special Educational Needs, will have their health needs identified early.
- Children and young people, parents and carers will be able to access clear health information.
- Young People in Surrey will have access to the Health Services they need as part of Preparing for Adulthood.
- Health interventions in Non-Maintained Independent Educational Provision will meet standards in line with National guidance and expectations.
- Medical needs of Children and young people in Educational Provision will be met.
- All Young People with Learning disabilities and or autism in Surrey who are aged over 14 and over will have an annual health check.

You can read more about our children's services, strategy for looked after children and children's social care priorities in the Corporate Parenting Strategy on our websites.

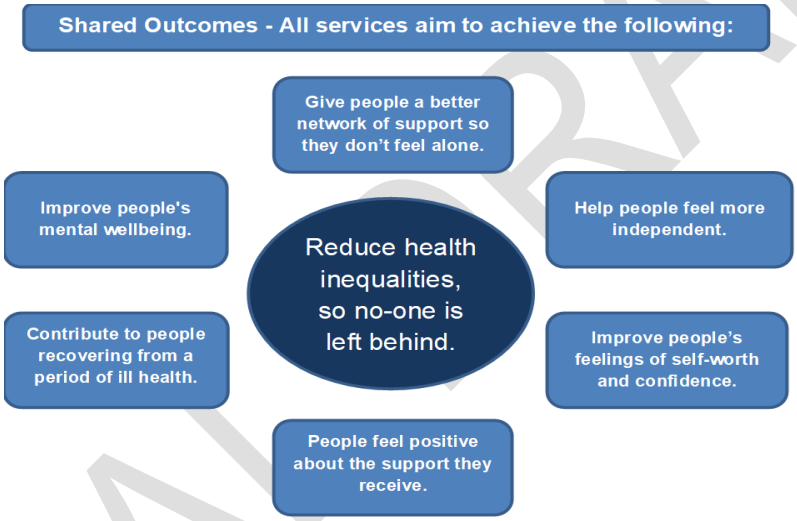
Mental Health

We know that self-reported wellbeing has decreased significantly over the last 3 years; the combination of the impact of the Covid19 pandemic and cost of living has affected many people in Surrey and across the country. There is around a 20 year gap in life expectancy for people with

Serious Mental Illness (SMI)[2] and notably excess mortality[3] for those under 75 years is significantly higher in Surrey for SMI than the England average. In Surrey the percentage of citizens reporting high anxiety[4] is 22.5%, which while better than the England average (24.2%), is higher than the reported best (15.9%). This correlates with the increase in demand and use of all age mental health services in Surrey Heartlands.

Our ambition is that we will achieve the national mental health deliverables informed by the NHS Long-Term Plan and deliver the recommendations from the local Surrey Mental Health Improvement Plan. Through the Surrey Heartlands Provider Collaborative, we will develop an integrated approach to manage the interrelationship between physical and mental health, especially for those experiencing a mental health crisis.

Mental health is a priority in Surrey. Priority Two of the Health and Wellbeing Strategy is focused on prevention, removing barriers, and supporting people to become proactive in improving their emotional health and wellbeing. Using this and the national drivers for change such as the Adult Social Care's Accommodation with Care and Support Strategy for people with mental health needs, the Mental Health Partnership board report and improvement plan outline areas for improvement in mental health services, with a focus on a more preventative and early help approach, improving access and preventing services gaps.



We are refreshing the Children and Young People's Emotional Wellbeing and Mental Health (EWMH) Strategy to support the development a culture of emotional wellbeing and mental health support for children and families based on prevention, strengthening early intervention, and building resilience. This work is closely interconnected with the delivery of our Best Start Strategy[5].

By 2028 our population will benefit from:

- Increased access to evidence-based care to an additional 24,000 women with moderate to severe perinatal mental health difficulties and personality diagnosis each year until March 2024. Care provided by specialist services will be extended from preconception to 24 months after birth and access will also be expanded to psychological therapies in services. A key priority was the development of a Maternal Mental Health Service, which was launched in December 2022.
- 24/7 psychiatric liaison in all emergency departments.

[2] Health and life expectancies - Office for National Statistics (ons.gov.uk)
[3] the number of deaths above the five-year average
[4] Public Health Outcomes Framework - Data - OHID (phe.org.uk) indicator C28d 2020/21
[5] Publication expected summer 2023.

- 60% of people with a diagnosed severe mental illness receive an annual physical health check in a primary care setting.
- Increased access to psychological therapies
- Implementation of actions from the Suicide and Prevention Strategy 2022.
- A tailored service to young people between 18 and 25 years old who are experiencing mental health challenges.
- Working towards eliminating all inappropriate out of area placements.
- Supported the creation of an Adult Mental Health Alliance, which will help facilitate voluntary sector engagement with the health and social care system in a more strategic manner.
- Implementation of actions from the EWMH strategy, which provides the strategic framework for all partners in Surrey to improve EWMH of CYP and ensures commitment to the implementation of the I-Thrive framework.
- A much stronger focus on early intervention, with mental health support for children and young people embedded in all our schools and colleges.
- Implementation of Community Transformation and One Team approach for adult community services.
- Improving accommodation and employment support for people with poor mental health lead by SCC with ICS partners.
- CYP experiencing a mental health crisis able to access the support they need. This will be achieved by 100% coverage of 24/7 age-appropriate crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment function as well as being supported to prevent a crisis occurring again by being connected to support from early intervention offers.

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You can read more about our mental health programme on the Surrey Heartlands website.

Dementia

In Surrey, people with dementia have a higher number of hospital admissions with longer lengths of stay and higher emergency admissions compared to people the same age without dementia. Whilst Surrey performs similar to or better than the England average[6] on the majority of the dementia care indicators, to meet the health and wellbeing strategy target of reducing emergency admission rates of people with dementia from 3,272 to 2,496 per 100,000 we must do things differently.

Our Joint Health and Care Dementia Strategy for Surrey sets out the collective ambitions we want to achieve across Surrey to improve the dementia care pathway in five parts:

1. Stopping people from getting dementia
2. Helping people who have just been told they have dementia
3. Helping people with dementia to live well
4. Supporting the care of people with dementia
5. Supporting people with dementia to live for as long as possible

[6] Joint Health and Social Care Dementia Strategy for Surrey 2022 – 2027, p10

By 2028 our population will benefit from :

- People can make good decisions about when to consider care and how to find the best choice for them, shown through improved outcomes.
- Information, advice and guidance offered ensures everyone accessing care and support for themselves or for someone else, can have the right information at the right time.
- People to know about the different options available to them locally in the community and how to get support to live independently.
- Increase in Surrey residents accessing day services and activities within their local communities to stay independent for longer.
- Enhanced services such as Advocacy and Stroke recovery, to continue people being enabled.
- Understanding that technology is not a preference for all residents and ensuring that other options are available to support, ensuring no one is digitally excluded.
- Continued research and development of initiatives to provide access to trials of new medications and treatments.
- Progressing actions from the Joint Health and Care Dementia Strategy for Surrey 2022 to 2027.
- Using new and existing technology to improve people's care choices and independence.

You can read more about the work to support these improvements in our Dementia Strategy.

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Learning Disabilities and Autism

We are using the national policy drivers to optimise outcomes for those with Learning Disabilities and Autism (LDA), including Building the Right Support Action Plan.

Our ambition is to make sure no one person is left behind for those with Learning Disabilities and/or Autism. We are using our local drivers including the Surrey All Age Autism Strategy, LDA Three year delivery plan, Joint Commissioning Strategy for Children and Young People, Children and Young People with Additional Needs & Disabilities: 2022 -2030 Sufficiency Plan and Surrey Accommodation Care and Support Strategy which outline the local response and actions to meet the national drivers and Surrey 2023 community vision.

People with a learning disability tend to have worse physical and mental health than the general population. We know that **women with a learning disability live 22 years and men 11 years less than their counterparts**. We will focus on specific and measurable actions that reduce the health gap between people with a learning disability and autistic people and the wider population, with the aim of achieving equivalence of care.

Good quality healthcare and effective access to Primary Care services are key to how we are tackling such inequalities. As some health problems experienced by people with a learning disability are simple to treat once diagnosed, a GP can often prevent a serious health condition with early identification. To this effect, an Annual Health Check is offered to anyone aged 14 or over who is on their GP's learning disability register.

By 2028 our population will benefit from:

- Delivering the workstreams in the All-Age Autism Strategy 2021 to 2026.
- Increase the number of people with learning disabilities on general practice register, receiving an Annual Health Check and effective Health Action Plan to prevent physical ill health and promote physical well-being.
- Numbers of individuals in inpatient settings reduces and stays below national targets – no more than 3 at any one time (adults, young people and children). Children and young people will be supported by key working service, with a digital dynamic support register and intensive support service.

- Increase in Supported Independent Living (SIL) options, meaningful activities in the community and numbers of people in employment.
- We will have a workforce trained in learning disability and autism in line with the Health and Care Act 2022.
- Proactive Public Health targeted interventions to reduce health inequalities to decrease disease burden and prevent premature mortality.

You can read more about our Learning Disabilities and Autism work on the Surrey Heartlands website.

Elective Care

Our ambition following a significant reduction in elective services during the emergency phases of the pandemic, is that elective services recover to pre-pandemic levels. National data shows that the recovery rate for children's elective care has been at a slower rate than for adults and Surrey Heartlands replicates this.

Our aim is to reduce the volume of patients waiting long periods for admitted care and that they 'wait well' with the following objectives: no patient waiting over 52 weeks for elective care by March 2025; 95% of patient waiting six weeks or less for a diagnostic; and 75% of patients referred for a suspected cancer be diagnosed or have cancer ruled out with 28 days by March 2024.

We understand the impact longer waits have on our patients and their families. The safety of our patients is our top priority, and we will prioritise the most clinically urgent patients. We will continue to share information on a range of conditions to enable a better understanding of supporting your own health while on the waiting list – known as 'waiting well'. It is a key system priority to progressively reduce the volume and length of elective care waiting lists.

Delivering such a high volume of activity is costly and puts significant strain on an already pressured workforce. Surrey Heartlands will implement robust pathway changes that improve efficiency to deliver the same patient care across fewer episodes and with less cost.

We have successfully reduced our longest waits over the last 18 months, whereby now no one is waiting longer than 18 months and are now working to achieve no waits over 65 weeks (15 months) by March 2024. However, our plans will need us to do things differently, creating additional capacity within our system and changing for the better the way services are delivered, while giving patients more choice and control over their experience in the NHS.

Delivery of our elective recovery plan includes several initiatives:

- Significant investment in and reconfiguration of our diagnostic services, including standardisation of referral pathways and clinical criteria
- Collaborative systemwide working to reduce variation and standardise referral pathways into Single Points of Access (SPOA) models where appropriate.
- To identify opportunities to consolidate services in order to improve clinical outcomes, reduce variation and improve efficiency.
- Develop digital technology to support operational delivery of elective care, including integration of patient-facing digital technology with the NHS app.
- Development of care models to consolidate attendances, provide flexibility to arrange own follow-up appointments and expand capacity to deliver high-quality care

Services for people with a range of rare and complex conditions, often involving treatments for those with rare cancers, genetic disorders or complex medical or surgical conditions known as Specialised Services, has a large Clinical Transformation Programme in line with national Long-Term Plan and strategic priorities. As part of the development of a 3 year Forward View and Strategic Plan for specialised services during 2023/24, a strategic review of our Clinical Networks

will be incorporated to establish and manage the Specialised Services Operational Delivery Networks (ODNs) across South East England.

From 1st April 2024, NHSE aims to delegate some specialised services commissioning responsibility to ICBs such as critical care, neonatal care, cardiac care, renal dialysis, and some cancer care. This will enable a real opportunity in Surrey Heartlands to join up specialised and non-specialised patient pathways to truly improve the health of local populations and integrate care pathways – from prevention to primary care, through to secondary and highly specialised care.

Our **outpatient services** see by far the great volume of NHS. Demand for these services continues to increase with improved care treatments reducing the need for admission and waiting lists created because of the pandemic. We will improve demand management to reduce the volume of patients being seen in an acute setting unnecessarily and redesign care pathways to include opportunities for patients to seek support and guidance from appropriate alternative health and care professionals, such as optometrists with more effective and timely advice and guidance (A&G) to primary and community care services.

Surrey Heartlands has already made significant progress improving **cancer services**. We have met the cancer 28 day Faster Diagnostic Standard (FDS) during 2022/23 and are committed to deliver the core cancer waiting time standards: 28 days to diagnosis; 31 days from referral to decision to treat; and 62 days from referral to first definitive treatment. Maintaining excellent cancer pathways is one of our key aims, supported by the Cancer Centre at Royal Surrey Foundation NHS Trust and the Surrey and Sussex Cancer Alliance.

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Through our Cancer Centre and Surrey University, we aim to deliver research and innovation in cancer, offering patient trials and new technologies where available. By implementing new technologies, changes to screening protocols and best practice timed pathways will all enable Surrey Heartlands to continue to deliver one of the best cancer performances in the country.

We are increasing **diagnostic provision** to meet the needs of the population and transform services to ensure patients are diagnosed faster, earlier, more efficiently and are able to be prescribed the most appropriate course of treatment, thereby improving patient experience and outcomes.

We will develop our Diagnostics Strategy during 2023, with the expectation to publish at the end of September 2023. This will see the implementation of the recommendations from the Diagnostics: Recovery and Renewal, meaning we will expand existing Community Diagnostic Centres to ensure patients can access a range of diagnostics closer to home, ensure effective collaboration between different workstreams such as cancer diagnostics and NHS@home; and develop a sustainable and resilient workforce.

By 2028 our population will benefit from:

- Improved access to specialist advice – providing greater flexibility in how advice from clinicians is accessed by patients, enabling more timely, convenient and appropriate care and avoiding the need for unnecessary appointments.
- Improved patient pathways - reducing avoidable delays by ensuring we are making the best use of the latest technology, clinical time and expertise.
- Expanding community diagnostic centres - focusing on ease of access and convenience for patients.
- Care is more personalised – more choice and options to reflect patient preferences and needs.
- Targeted support for patients – patients are informed, supported to wait well and co-develop personalised plans to prepare for treatment.

You can read more about the planned care delivery plans in our Fact Files on our website.

2.2. Delivering NHS Long Term Plan Priorities

"When I need it, I get the right care, in the right place, and I am empowered to self-manage my condition."

We know that life expectancy has increased over the years since the NHS was founded, and different types of diseases are becoming more common. Mortality from heart and circulatory diseases has declined by more than three quarters over the last 40 years. But we have seen an increase in the number of long term conditions – illnesses which last longer than a year, often worsening with time – which are responsible for a substantial amount of poor health and demand on health and care services.

There have been slower improvements in the number of years of life lost particularly for **cardiovascular, stroke, respiratory conditions and diabetes**. The NHS Long Term Plan (LTP) set out a number of improvement priorities which we have been working on and achieving over the last five years. There are still improvement ambitions we want to achieve for our population; some going beyond what is required, to ensure no-one is left behind.

Our Medical Directors and professional clinical body are developing an ICS Clinical Strategy, which we expect to publish in Summer 2023. This will align with organisation clinical strategies and support the delivery ambitions of the Provider Collaboratives through the coordination of care into a single or coherent process forming clinical integration. As part of this focus, we are leading specific work to reduce clinical unwarranted variation - variation that cannot be explained by illness, medical need, or the dictates of evidence-based medicine – to realise optimal health outcomes.

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In this chapter we describe our delivery and outcome ambitions for these LTP priorities.

Cardiovascular

The NHS Long Term Plan's national ambition is to prevent 150,000 strokes, heart attacks and dementia cases over the next 10 years and has agreed a set of ambitions which seek to improve the detection and treatment of the high-risk conditions including **Atrial Fibrillation (AF), Blood Pressure (BP) and Cardiovascular Disease (CVD)**.

Our ambition for the Cardiovascular programme is to support the NHS Long Term Plan objective through our local priorities:

- Heart Failure Management
- Atrial Fibrillation detection and management
- Hypertension detection and management
- Cholesterol management
- Cardiac Rehabilitation
- Improving efficiencies and embracing patient initiated follow-ups (PIFU), Advice & Guidance and Virtual consultations

CASE STUDY

Heart Failure patient placed on the transplant waiting list following successful rehabilitation with First Community's cardiac rehab physiotherapists.

Mr George was treated at Harefield Hospital, Uxbridge to undergo surgery to attach a Left Ventricular Assist Device (LVAD) to his heart. He was referred to **First Community's Cardiac Rehabilitation Service** as he was not deemed well enough to be on the heart transplant waiting list. The team of physiotherapists conducted routine fitness assessments and medical checks early on, to enable them to plan a comprehensive rehabilitation programme for Mr George.

Mr George has been accepted and is well enough, to go onto the heart transplant waiting list and said, "The First Community team has left an indelible mark on me; the experience has been ecstatic and the support the team has given me has been amazing."

By 2028 our population will benefit from:

- Identification of a minimum of 85% of patients at risk of AF and of those patients:
- 80% of patients with high blood pressure to be identified and of those, 80% to be treated
- 75% of people aged 40-74 to have received a formal validated CVD risk assessment and cholesterol reading recorded.
- 25% of people with Familial Hypercholesterolaemia (FH) are to be diagnosed and treated optimally.
- Increase identification of Heart Failure diagnosis

You can read more about our cardiovascular delivery plan in our Fact File on our website.

Stroke

The NHS Long Term Plan's ambition for stroke care includes developing improved post-hospital stroke rehabilitation models, delivering a ten-fold increase in the proportion of patients who receive a thrombectomy after stroke and delivering improved thrombolysis performance with access to all patients who could benefit.

Integrated Stroke Delivery Networks (ISDN) are an integral part of delivering the LTP commitments for stroke. The Frimley and Surrey Heartlands ISDN aims to improve the quality of stroke care, through improving clinical outcomes, addressing areas of unwarranted clinical variation, excellent patient experience and patient safety. The ISDN brings together key stakeholders and partners to collectively agree a strategic plan of work to facilitate service improvements across the whole stroke pathway, ensuring a patient centred, evidence-based approach to delivering transformational change. Stroke, alongside paediatrics and maternity, are being reviewed across Surrey Heartlands as part of the provider collaborative discussions. The Frimley and Surrey Heartlands ISDN will support and inform any end to end stroke pathway transformation discussions providing subject matter knowledge and expertise.

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The ISDN has developed 3 key workstreams:

1. **Prevention** - The development of a stroke prevention strategy is linked with the cardiovascular disease programme.
2. **Acute and Urgent Care** - This workstream brings together clinicians (including Stroke Consultants, nursing and therapy staff) and service managers working across the acute hospitals within the ISDN, representatives from SCAS and SECAmb, nursing staff within the Early Supported Discharge Teams, GP leads and the Stroke Association. Key priorities include **SSNAP Performance, Transient Ischaemic Attack Pathways, Pre-hospital pathway and Thrombectomy Pathway.**
3. **Rehabilitation and Life after Stroke** - delivering the Integrated Community Stroke Service Model (ICSS), improving the intensity and access to rehabilitation across their geographies and ensuring the integration of social care in the delivery of stroke rehabilitation.

By 2028 our population will benefit from:

- As part of the joint CVD / stroke prevention strategy, significant and sustained improvements will have been made in the identification and treatment of hypertension and atrial fibrillation within the population
- Thrombolysis and thrombectomy rates will have increased significantly and the LTP ambitions for thrombectomy achieved
- Pre-hospital video triage will be 'business as usual' within the Stroke pathway

- CT Perfusion will be available across all Acute Stroke Centres within the ICS and the NOSIP fully implemented
- Routinely admitting stroke sites will consistently achieve SSNAP 'A' ratings
- Agreed rehabilitation data sets will ensure that quality and quality measurement is at the heart of the stroke rehabilitation model. They will enable ongoing service evaluation, performance review and outcome measurement, thereby supporting continuous service improvement and development
- Quality equitable care will be delivered across the Stroke pathway, including sustainable stroke specific rehabilitation with opportunities for mutual aid in times of need
- Patient and carer experience will be embedded as an integral element informing and developing ongoing pathway development and quality improvement

You can read more about our stroke delivery plan in our Fact File on our website.

Respiratory

The NHS Long Term Plan's ambition is to improve treatment options and reduce the impact on those with the condition through prevention and self-management developments. Our ambitions for those with respiratory conditions are for:

- Appropriate treatment and support, enabling self-management and access to services when needed. Through this, we will transform our outcomes so that they are to equal, or better than, our international counterparts.
- People admitted to an acute or mental health hospital who smoke will be offered NHS-funded tobacco treatment services. The model will be adapted for expectant mothers and their partners.
- Transform Pulmonary Rehabilitation services by increasing capacity, improving accessibility, and to enable patients to be empowered to self-manage their condition by working with system health and care partners and voluntary organisations.
- Achieve economy of scale with ensuring developments are made jointly with cardiovascular disease and cardiac rehabilitation, prehabilitation and moving from reactive treatment post event to prevention.

Around a third of people with a first hospital admission for chronic obstructive pulmonary disease exacerbation have not had a previous diagnosis. Surrey Heartlands has commenced a programme of reducing variation in quality of spirometry. We are re-introducing access to training and reviewing locally commissioned services to enable consistent provision.

Asthma is the most common long-term medical condition in the UK, with around 1 in 11 children and young people living with asthma, with outcomes exacerbated when living in the most deprived areas. We know that the UK has one of the highest prevalence, emergency admissions and death rates for childhood asthma in Europe. Surrey Heartlands is acting to improve early diagnosis such as improving access to diagnostics, implementing breathlessness pathways, using medicines optimisation and improving the asthma pathway for children, young people and adults through implementing the national bundle of care objectives.

Smoking rates in Surrey are below the national average and are continuing to fall. But we know that smoking rates are much higher among our more deprived communities, having a significant impact on increasing health inequalities by reducing life expectancy by up to 20 years and that smokers are 36% more likely to be admitted to hospital. Research from Action on Smoking and Health (ASH) estimates there are about 87,000 households in Surrey with at least one smoker; 21% of households with a smoker fall below the poverty line. If these smokers were to quit, around 6,000 households in Surrey would be elevated out of poverty. Surrey Heartlands will implement the

tobacco prevention model for inpatients (acute and mental health patients), adapted for expectant mothers and their partners.

By 2028 our population will benefit from:

- More patients will have access to testing, such as spirometry testing, so that respiratory problems are diagnosed and treated earlier
- Patients with respiratory disease receive and use the right medication, including educating patients on the correct use of inhalers
- Expanded rehabilitation services, including pulmonary rehabilitation and digital tools so that more patients have access to them and have the support they need to best self-manage their condition and live as independently as possible
- Improved treatment and care of people with pneumonia
- Lowest smoking prevalence rate in England

You can read more about our respiratory delivery plan in our Fact File on our website.

Diabetes

Our ambition is to improve the lives of people with or at risk of developing diabetes across Surrey Heartlands. Identifying people earlier and providing equitable access to education and services. We will empower our citizens to manage their diabetes or reduce their risk by raising awareness, providing quality education programmes and by reducing variation in care provision and clinical outcomes.

We will achieve this by working together across healthcare, social care, and voluntary sector ensuring the care we provide meets the needs of our population and is of the highest quality. The Diabetes Strategy was derived from these ambitions and together with drivers such as the NHS Long Term Plan we aim to ensure local diabetes services are equitable and accessible by all.

Around 50,000 people in Surrey Heartlands are diagnosed with diabetes. In addition, there are approximately a further 66,118 people at a higher risk of developing type 2 diabetes[7].

The Surrey Heartlands Diabetes Strategy sets key ambitions to drive an improvement:

- Improve performance in the annual National Diabetes Audit for people with diabetes receiving all eight NICE Care Processes (8NCP) and achieving the three Treatment Targets (3TT) across our lowest 50% of practices.
- Reduce hospital admissions for cardiovascular and renal disease.
- Ensure inpatients with diabetes in our hospitals, admitted for any condition, receive effective care of their diabetes. Wherever possible they will be actively involved in decisions concerning management of their diabetes.
- Develop diabetic foot care services, increase capacity to reduce waiting times and reduce rates of lower limb amputations.
- Ensure people newly diagnosed with diabetes attend structured education within one year of diagnosis.
- Early identification of non-diabetic hyperglycaemia (NDH) and referral to prevention and weight loss programmes such as the NHS Diabetes Prevention Programme (NDPP).
- Support people with diabetes to use existing and emerging technology to support their diabetes care and self-management.

[7] https://fingertips.phe.org.uk/profile/diabetes-ft/data#page/3/gid/1938133138/pat/44/par/E40000005/ati/154/are/E38000177/iid/92952/age/164/sex/4/cat/-1/ctp/-1/cid/4/tbm/1

By 2028 our population will benefit from:

- Reduction in unwarranted variation including access to services and achievement of treatment targets across the ICS.
- An increase in people taking an active role in managing their condition.
- Reduction in development of diabetes related complications such as number of major and minor lower limb amputations.

You can read more our diabetes delivery plan in our Fact File on our website.

By reducing pressure on our health and care services over time, we create the space for our workforce to provide care quality with continuity of care and do much more on preventative care to support people to stay well for longer. The following chapter focuses on care quality, safety, personalised care plus equality, diversity and inclusion.

2.3. Providing Quality, Safety and Continuation of Care

"I am able to access care in an environment which is appropriate to my needs with the right facilities and supporting information both I, and my clinician or care professional, need."

Core to our ICS strategy are the principles of **quality and equitable care, patient safety and tailored care that supports patient choice**, whenever possible in line with the National Quality Board principles. Quality threads through everything we do an ICS. This section summaries our approach.

Our ambition is to improve quality by creating a culture that is focused on continuous improvement and learning, ensuring that our health and care services provide people with safe, effective, responsive, caring, well led, and compassionate services, where innovation is encouraged and is safe.

In Surrey Heartlands, we are strengthening partnerships with staff, local communities and people using services to deliver higher-quality care and tackle health inequalities and ensuring that decisions are taken closer to the communities they affect, so that they are more likely to lead to better outcomes. We strive to provide people with an improved experience of health and care, as services are more coordinated, focused on addressing health inequalities and based on the latest evidence, learning and best practice.

11

All of Surrey Heartlands NHS provider trusts are rated 'good' or 'outstanding' overall. 85% of adult social care services are rated 'good' or 'outstanding and 93% of GP Practices are rated 'good' or 'outstanding'.

We are committed to continuous care quality improvement at every level of our system and have established the Quality Improvement Collaborative (QIC) to drive our quality governance model across Place-based areas and the ICS. Surrey Heartlands' Quality Management System Framework has been developed with partnership organisations building on existing quality governance principles, delivery mechanisms and the joint commitment to the delivery of care that is effective, safe and provides as positive an experience as possible.

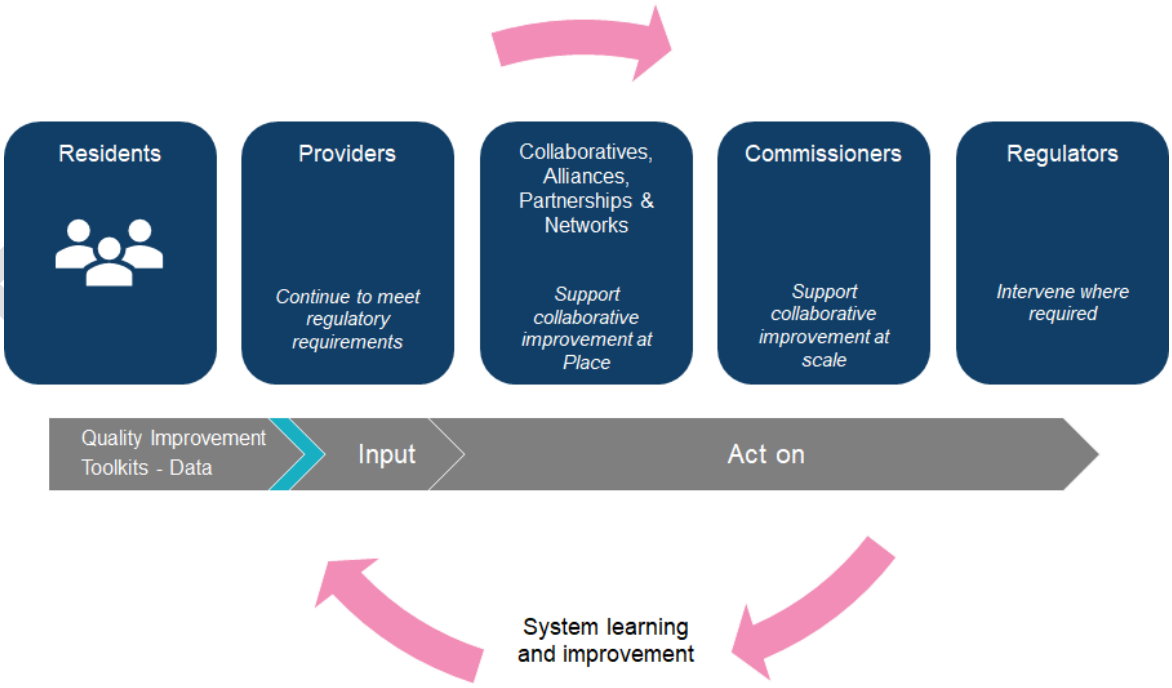


Figure 9 - System by Default, ICS Quality Management System

We will continue to use our System Quality Group (SQG), formed from ICB, Trusts, Public Health and Regulators, to provide a strategic, integrated forum to inform decision making and risk management to improve quality of care for those who use our services. You can read more about our care quality improvement monitoring and management in our website Fact File.

The Surrey Heartlands Quality Improvement team support the system to use improvements approaches where quality improvement is required either from across the system - trusts, place or neighbourhood level. By learning from patients, staff, and partners we aim to ensure high-quality governance, patient safety, and risk mitigation. We will continue to utilise the national Commissioning for Quality and Innovation (CQUIN) approach to embed sustainable care quality and patient safety improvements in Surrey Heartlands.

CASE STUDY

Royal Surrey's Maternity Services Team undertook an innovative project to look at how the team received feedback about their service from women using it, particularly hard-to-reach groups. The team recognised that the existing channels they were using did not represent their target audience fairly.

As the team was involved in developing new maternity hubs in local communities and setting up assigned small teams of midwives to see women through pregnancy and birth, it was keen to gather feedback to further develop its services.

Led by Clare Cardu, Transformation Lead Midwife, the team explored how women's voices could be better heard. The solution they came up with was to use a patient experience service (PEP Health) to automate collection of online feedback from social media platforms.

Amy Stubbs, Deputy Director of Midwifery and Head of Nursing, Women and Children's, said: "The ability to collect feedback from a broad range of online platforms has been invaluable, giving us a rich resource for understanding patients' experience of our maternity services. The feedback is then shared regularly among all areas of the service and helps us to keep learning and improving".

This project won the **HSJ Patient Safety 2022** award for **Maternity and Midwifery Initiative of the Year** for a patient-led service development project entitled 'Hearing the True Voice of Women'.

Patient Safety

We will build into our care quality, **a patient safety culture** and **a patient safety system** with three strategic aims:

1. **Insight** - improving understanding of safety by drawing intelligence from multiple sources of patient safety information
2. **Involvement** - equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system
3. **Improvement** - designing and supporting programmes that deliver effective and sustainable change in the most important areas.

Nationally there are over 700 Patient Safety Specialists including at Executive level. Within our NHS trusts and through the ICS, we are providing leadership and support to patient safety activities across their organisation. We will provide mandatory patient safety training for all staff in conjunction with Health Education England in collaboration with Academy of Medical Royal Colleges (AoMRC).

We will continue involving patients, families and carers in their own safety through our Patient Safety Specialists. Our Patient Safety Specialist Network will continue to provide the opportunity to share concerns and sharing learning across the whole health and care system to work more collaboratively through regular workshops.

Infection and Prevention Control

Our overarching aim is to continually improve quality of care by reducing the risk of avoidable harm from Health Care Associated Infections (HCAI) and other communicable diseases.

To achieve this, we will have in place governance oversight processes to monitor and receive assurance on the following strategic objectives:

- Being person centred- listening to all our service users
- To build ICS specialist IPC workforce capacity to collaborate and support provider services to deliver safe care
- To support health and social care providers to maintain compliance with the code of practice on the prevention and control of infections and related guidance, to deliver safe and effective and reduce risk associated with HCAI
- To capture and share meaningful system wide learning from incidents and outbreaks, to drive IPC quality improvements across all health & care settings
- Maximising financial capacity

Medicines Optimisation

Medicines optimisation looks at the value which medicines deliver, making sure they are clinically effective and cost-effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team.

Our medicines optimisation goal is to help patients to improve their outcomes, take their medicines correctly, avoid taking unnecessary medicines, reduce wastage of medicines and improve medicines safety.

We have identified key priority areas of work from a pharmacy and medicines optimisation perspective to support the organisation in delivering its strategy and overarching key ambitions including the Critical Five, implementation of the recommendations from the Fuller Stocktake report next steps for integrating primary care and include:

- **Workforce** - The overarching ambition is to develop a collaborative pharmacy workforce with the ability to provide integrated pharmacy services to patients across Surrey Heartlands. This will ensure that we provide high quality medicines related care for those who need it, in the right place, at the right time, by the right person; working innovatively and in partnerships across our services to better serve the population and make Surrey Heartlands the best place to work (for the pharmacy workforce) in line with the NHS people plan.
- **Medicines Safety**- Developing an open, learning, and safer culture locally is a high priority across Surrey Heartlands. This aligns with the aims of the Medicines Safety Improvement Programme (MedSIP), one of the workstreams within the wider National Patient Safety Improvement Programme, which is to reduce severe avoidable medication-related harm by 50% by 2024 and the third WHO Global Patient Safety Challenge: Medication Without Harm
- **Antimicrobial Medicines Optimisation** - with a focus on reducing unwarranted variation in prescribing, improving prescribing standards and reducing harm from inappropriate antimicrobial use aligned to the UK five-year national action plan. Priority areas of work include management of UTIs, review of co-amoxiclav prescribing and alignment of secondary care clinical guidelines.
- **Community Pharmacy** - to fully embed all services included in the national Community Pharmacy Contractual Framework. The ambition is for community pharmacies to be:
  - the preferred NHS location for treating and where appropriate testing for minor health conditions, promoting patient self-care
  - taking pressure off our local urgent care, out of hours services and GPs, reducing waiting times and offering convenient care for patients (including CPCS)
  - become established as healthy living centres, helping local people and communities to stay healthy, identifying those at risk of disease and reducing health inequalities.

- support key local and national NHS targets and quality improvement initiatives such as tackling antimicrobial resistance, improving vaccination uptake rates.
- continue to ensure patients can safely and conveniently access the medicines they need as well as doing more to improve patient and medicines safety.

Dispensing doctors and dispensing appliance contractors form part of our delegated responsibility for Primary Dental Services and Prescribed Dental Services, Primary Ophthalmic Services and Pharmaceutical Services. Work will be undertaken with Pharmaceutical Services providers to support integrated, collaborative working in order to deliver a more joined up preventative and personalised care for the population of Surrey Heartlands.

Supportive Learning Culture

We are working together in complementary ways through our joint commitment to the delivery of care so that it is effective, safe and provides as positive an experience as possible. This will demonstrate improvements in both population and clinical outcomes and provide clarity on roles, responsibility and accountability.

Key to this approach is ensuring subject matter experts from all sector partners are given the platform to collaborate to work together, agree quality outcomes, intelligence requirements, support innovation and standardise good practice (Figure 10).

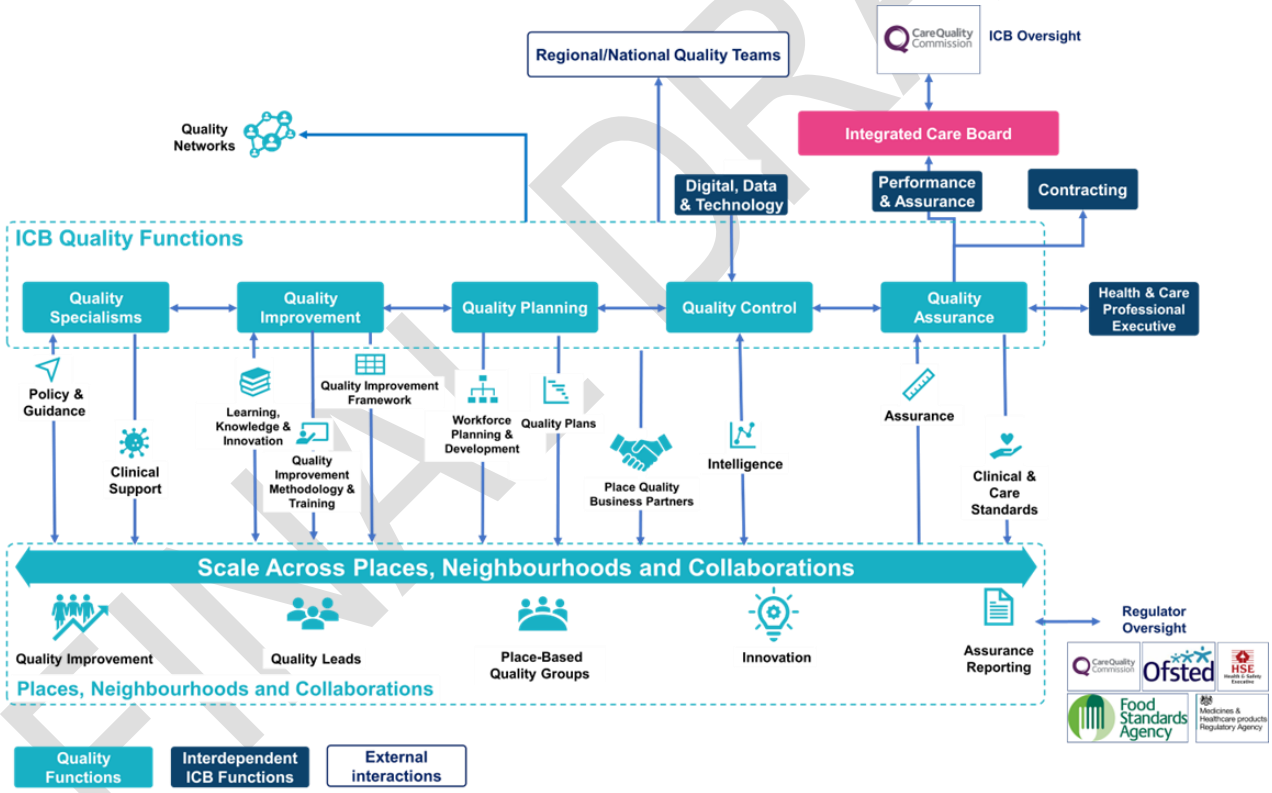


Figure 10 - Surrey Heartlands integration and governance

You can read more about the metrics and monitoring used to assure our delivery in appendix 3.

Safeguarding and Domestic Abuse

The safety and welfare of children and adults, alongside the protection of those with care and support needs from abuse and neglect is of paramount importance to NHS Surrey Heartlands.

Our safeguarding team provides strategic leadership, expert advice to our partner organisations and ensures all services provide high quality, safe and effective care. Using the NHS Safeguarding Accountability and Assurance Framework ensures improvements in health outcomes for those with support needs.

A significant proportion of adults who need safeguarding support may be experiencing domestic abuse (DA). Our vision is for every adult and child experiencing domestic abuse to be seen, safe and heard, and free from the harm caused by perpetrator behaviour. As a partnership, we will focus on preventing domestic abuse and ensuring all children, young people and adults affected across their lifespan:

- Can access the right information, services and support, at the right time in the right place.
- Are empowered to live lives free from domestic violence or abuse.
- Gain the personal confidence to build healthy relationships for themselves and their dependants.
- Perpetrators are held to account and change their behaviour.

Our priorities are threefold:

- **Community** - To break the silence about domestic abuse within our local communities and remove the barriers that make it hard for survivors and perpetrators to reach support.
- **Professionals** - To maximise every opportunity to identify and respond to domestic abuse for survivors and perpetrators.
- **Expert support** - To empower specialist expert support to work with survivors, children and perpetrators in a way that achieves safety, with minimum reliance on external resources.

You can find out more information about domestic abuse on Surrey County Council, our joined-up approach to tackle Violence Against Women and Girls in Surrey and support on Health Surrey websites. To find out more about our safeguarding work, visit the Surrey Heartlands' Safeguarding webpages.

11

Equality, Diversity and Inclusion

Surrey Heartlands aims to be a leader in promoting equality, diversity, and inclusion (EDI). We believe that our organisation must reflect the full diversity of the communities and people it serves, both in employment and service delivery.

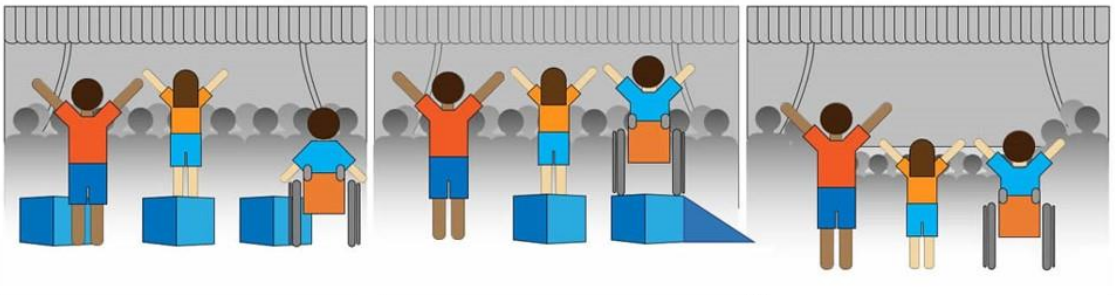
Public sector organisations have specific duties that need to be fulfilled. The general duty has three aims:

- Eliminate unlawful discrimination, harassment and victimisation.
- Advance equality of opportunity between people from different groups; and
- Foster good relations between people from different groups.

Our particular duties relate to:

- **Equality -** we want everyone to have equally good health and care. However, the term 'equality' is sometimes used to describe equal treatment, care or access for everyone regardless of need or outcome.
- **Equity -** we want fair outcomes for everyone. What is important is addressing avoidable or remediable differences in health between groups of people.

Figure 11 -demonstrates that to achieve equity, some groups may need more or different support or resources in order to achieve the same outcomes. Ideally, the barriers would be removed for everyone, so adjustments wouldn't be required. However, this is not always possible.



Equality – everyone gets the same resources	**Equity** – everyone gets the same outcomes, with resources distributed according to need	**Equal outcomes** – through the removal of structural barriers

Figure 11 - Characteristics of people or places associated with differences in health outcomes (Health disparities and health inequalities: applying All Our Health - GOV.UK (www.gov.uk))

We are seeking to gain insight and research from local communities and support in developing culturally appropriate interventions through the use of Equity Development Officers and programme leads, which is being piloted in East Surrey Partnership, with the potential for use across the system. We will enact the targeted actions to address prejudice and discrimination as set out in the NHS equality, diversity, and inclusion improvement plan.

11

CASE STUDY

Perinatal Equity Project is being led by Surrey Minority Equality Forum in Woking, Spelthorne, Reigate and Banstead focusing on pregnancy and the first two years of a child's life to provide information and support to families, pregnant people and new parents to improve their experience of pregnancy and parenthood in Surrey.

Community Activity Champions are working to remove barriers preventing women from being active. Through trusted community leaders, women are taking up activities benefiting their wellbeing, families and community.

Our ambition for our **Contingency, Asylum, Refugee, Evacuee and Migrant Service** that it is equitable, agile, and coordinated for all the different schemes to enable the most effective support for these vulnerable people across the health and care system. This starts with GP registration and initial health care check to assess the level of health needs following entry into the country, with appropriate follow up and support.

You can read more about our Equality, Diversity and Inclusion workforce approach in chapter 3 and more about our Equality, Diversity and Inclusion work on our website.

Personalisation and Patient Choice

Surrey Heartlands believes that personalised care and patient choice are fundamental to helping people to stay well for longer as part of a joined-up approach to health and care support. This gives people the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life.

Our ambition is to ensure our citizens have choice and control in the way their care is planned and delivered, building skills, knowledge and confidence to support them to live independent lives and improve outcomes. That they can access outstanding quality and tailored care and support and find adult social care fair and accessible with a workforce that is enabled to deliver these commitments.

Our work will continue to assure and enforce patient choice principles across all our partners and through our professionals by ensuring:

- Patients are aware of their choices, including their legal rights, and actively seek and take up the choices available to them.
- GPs and referrers are aware of and want to support patients in exercising the choices available to them.
- Patients, GPs and referrers have the relevant information to help patients make choices about their care and treatment.
- Choice is built into service development plans, contracting arrangements and provision.
- Choice is embedded in referral models, protocols and clinical pathways.

By 2028 our population will benefit from:

- Our providers retain CQC ratings of either 'good' or 'outstanding' across our system
- An integrated population outcomes and clinical outcomes dashboard
- Delivery of our ambitions against the Patient Safety Strategy and Infection Prevention and Control Strategy
- Improvements in Quality Improvement methodologies are equitable and embedded across the system
- Social prescribing link workers are part of admission & discharge pathway to enable post discharge support
- Being connected to non-medical, community- based activities and support to build networks and resilience, tackling loneliness and isolation
- Supported referral into services offering help on social determinants of health e.g. housing, homelessness, energy, debt, welfare
- Being safe and feel safe (community safety including domestic abuse, safeguarding)
- Greater choice and control of the care and treatment

11

You can read more about Personalised Care on NHS England's website.

3. What We Need To Deliver These Ambitions

"I am able to access care in an environment which is appropriate to my needs with the right facilities and supporting information both I, and my clinician or care professional, need."

So we can be a mature, productive and effective system and deliver our ambitions, we need a number of other functions to be working well. This chapter presents our priorities to enable achievement of our ambitions.

People and Culture

We know that building a sustainable workforce is one of the greatest challenges facing our organisations and the integrated systems we are developing with partners today. There are well documented challenges – high waiting times from stretched capacity, falling retention and staff satisfaction, a difficult labour market, declining public satisfaction and a worsening financial environment. We must address these problems in ways which also enable the improvements and developments in care described in this plan.

The Fuller Stocktake calls for new ways of bringing our people together – through integrated neighbourhood teams that organise themselves around local population health needs – so we can provide more holistic care for the most vulnerable members of our community. Meanwhile, developments in elective care will require a more mobile and shared workforce.

At the heart of our vison is a 'united team', aiming to share ways of working (a shared system culture), which connects us more and better and drives better connected resourcing, sharing talent and expertise across partners and sectors. Our United Surrey Talent strategy describes how we will utilise six change levers (Figure 12) to transform ways of working and career development in Surrey Heartlands through a series of process and collaboration changes (Figure 13).

Figure 12 – Six levers for change, (ICS Strategy United Talent, 2022)

Figure 13 – Areas of change (ICS Strategy United Talent, 2022)

The scale and pace required of these changes will only be possible through a connecting culture that speaks to the 'how' and 'why' and not just the 'what' we do together, to drive innovation, shared learning and spread across our partner organisations and local people. We have launched a workforce innovation fund to stimulate change and test ideas for scaling across our system, with over 30 pioneer projects in place.

Fundamental to the integrated neighbourhood teams is 'how' they connect. We are helping to shift the focus from services, systems and diseases to local population health needs and human connection through our cultural development work, 'Connecting Surrey Heartlands'. Working at

neighbourhood, Place and ICS levels, we are focusing our attention on those things that are already working and using a systematic and science-based methodology, social research, to understand what and why people connect well and the conditions that enables and breeds success for effective change.

Developing our future workforce and Team of Teams

With over 40,000 jobs in the county, we can offer local talent a whole range of opportunities, including across career pathways, different settings and flexible work to suit.

We should not over-rely on overseas recruitment and as living in Surrey is expensive, we need to grow our own talent. This includes offering more opportunities to students at local education providers and reaching out to wider talent pools such as helping people with disabilities, armed forces backgrounds and those from care to support them find new careers in our services.

With Surrey County Council, we are establishing the Surrey Heartlands Health & Social Care Academy to help build, develop, share, and nurture talent across all settings incorporating social care sector staff. As an example, the Academy will help equip staff better to look after residents and patients at home. This is a win-win; helping people stay well at home whilst professionalising this important staff group with skills and better reward. With changes in care models, there will also be significant increase in academy types of support, such as diagnostics and frailty, where coordinated and focused support will be created for these priority pathways.

Such is the scale and breadth of opportunities across our organisations, we will trial a career guarantee by offering two jobs at the same time in some career pathways – your first role and a conditional offer for your next move.

11

CASE STUDY

Inspiring students to take up NHS careers

150 students and parents from local secondary schools and colleges were given behind the scenes access and expert demonstrations from teams at East Surrey Hospital in an inspiring careers event.

Local students in year nine or above were invited to our 'meet the practitioner' careers event. They were able to watch demonstrations from doctors, nurses and therapists in the simulation suite, learn life-saving CPR techniques in 're-start a heart' style workshops and attend a range of presentations about different careers in healthcare.

The event was delivered together with Surrey Heartlands Health and Care Partnership, and First Community Health and Care with support from London Southbank University and University of Surrey. Students from 29 schools and colleges attended.

Both provider and Neighbourhood Teams will be enabled to form teams of teams so they can work across settings. Digitisation and data will be key; we will draw on the National digital staff passporting developments to help easy mobility of teams between organisations, we will increase access to shared care data and implement the required deployment systems, such as rostering and temporary staffing solutions.

We will build on our collaborative with Frimley and Buckinghamshire, Oxfordshire and Berkshire ICS to unite temporary staffing across Surrey, with fair pay and access to work, whilst incentivising the take up of permanent careers with our partners.

Access to our one public estate and related digital infrastructure will continue to augment – helping staff with more flexible working, getting the job done wherever they are and increasing opportunities for our teams of teams to come together physically.

Examples where increased mobility will be prioritised include elective and diagnostic activity across our provider collaborative, integrated neighbourhood teams and temporary staffing across all providers. We will develop our ambitions for workforce transformation in community and acute settings as the ICS clinical strategy emerges during 2023/24.

Looking after our people

Health and care is about teamwork. We want to see Surrey develop a core offer for our people, where everyone on the team has access to the same or equivalent support and reward. We have established a mental health support hub and are finding innovative ways to ensure this can be accessible to the many small VCSE organisations as well as the larger NHS Trusts.

CASE STUDY

Working with NHS Practitioner Health & Doctors in distress, Surrey Heartlands offers a supervision programme to support for GPs who are having mental health issues. General Practitioners who often work on their own for long hours need to be able to share issues that they are dealing with in a safe and blame free environment, so they are not reliant on family members or colleagues who may have burdens themselves and might be conflicted.

The programme is designed to improve GPs wellbeing, offer confidential safe place to help prevent escalation of mental problems and reduce the risk or suicidal thoughts. Over time the programme could be rolled out to wider groups of staff across primary care and beyond.

Cost of living has hit staff hard. We struggle to attract and retain staff in a county which is beautiful but expensive. We are working with Surrey County Council on its housing strategy for more affordable accommodation and on ways to improve the pay for social care workers. Meanwhile, the NHS continues to rely on recruiting international workforce and Surrey Heartlands ICS has invested significant amounts on recruiting world-wide.

The benefits of a diverse workforce cannot be overstated especially as it provides opportunities to recruit from a wider pool of candidates and projects a positive image of an inclusive organisation.

A corresponding investment in training, resources and awareness on Equality, Diversity and Inclusion to support its diverse workforce will contribute to additional recruitment, support the retention strategy and lead to increased productivity.

Leadership and Health and Care Professional Development

Surrey Heartlands' ambition is to create a diverse range of multi-professional leaders and representative professional leadership model that reflects our clinical and care professionals, and the diversity of our population across the full range of partnerships, health and caser services through the commitment to improvement on behalf of residents and partner organisations. This is central to designing and delivering integrated care and meeting the complex needs of people, not conditions.

CASE STUDY

The University of Surrey is partnering with the University of Exeter, to support the development of this new and innovative curriculum for a **new medical school**. It will offer a 4 year, graduate-entry bachelor's degree medical programme and expects to welcome the first cohort of 40 students in 2024.

We will provide improved and integrated services to Surrey residents by having effective and integrated system leadership that enhances capabilities of all partners. This will be achieved by bringing together quality and safety, system leadership and improvement focusing on Improving Health and Care Quality and Safety through Multi-Professional Involvement and engagement (Figure 14).

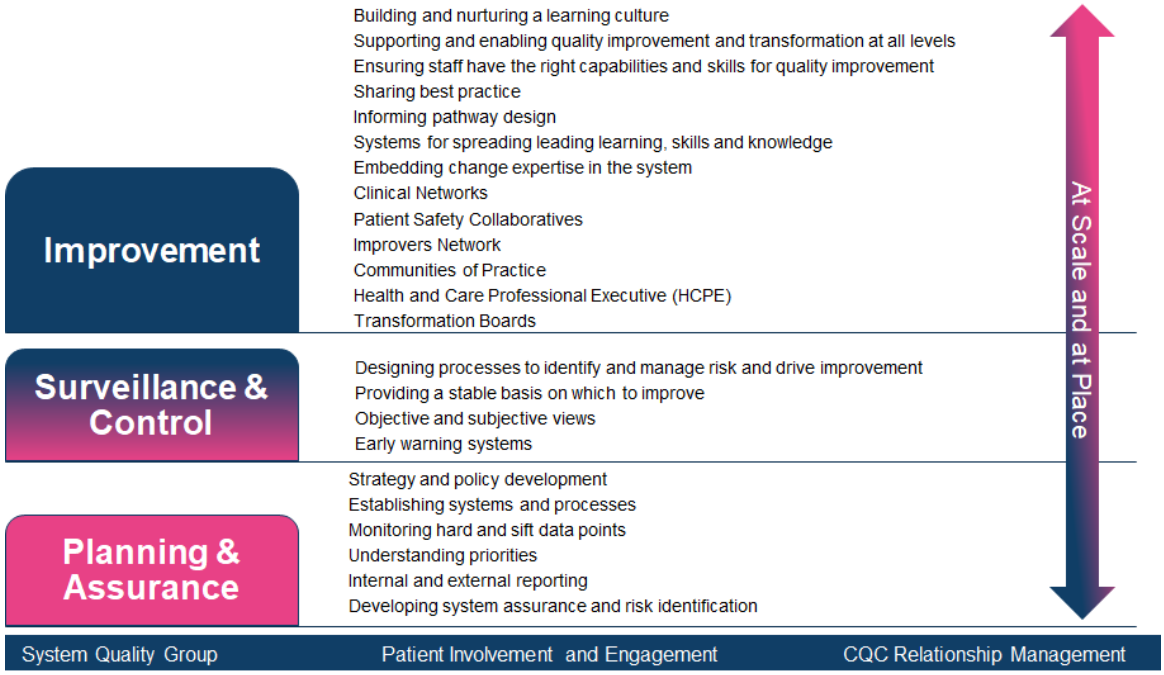


Figure 14 – transparent, continuous cyclical shared learning with work examples

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To drive the changes described in this plan, our leaders need to work across organisational boundaries at both local and county levels. Starting in East Surrey, we are pioneering a new "Growing System Leaders" programme to help key people develop their stewardship skills. We are also building maturity in how organisations shape and deliver transformation as a system, recognising the needs for more effective change capability, capacity and governance.

By 2028 our population will benefit from:

- More staff looking after people in out of hospital settings, either at or near home
- A professionalised care workforce, with accredited skills, qualifications and better pay, terms and conditions
- More "home-grown talent", with disadvantaged job seekers provided better access to employment and more degree education provision in Surrey for professional roles.
- A corresponding investment in training, resources and awareness on Equality, Diversity and Inclusion to support and attract a diverse workforce.
- Targeted increases in roles in non-medical primary care, community nursing, diagnostics and social care
- A more mobile workforce, able to share data and work across settings.
- A "go to" digital academy for access to diverse opportunities to earn and learn across health, social care and VCSE sectors.
- Clear and accessible career structures enabling staff to have greater control over their future.
- More clinical apprenticeship and degree courses running at Surrey institutions.
- Supporting staff with better access to affordable housing and equitable, universal provision of physical and mental health services
- Many more multi-professional teams in place who are supported to collaborate, learn and improve together to consistent standards.
- United temporary staffing services across partners

- A leadership more representative of the people it serves and with the skills and tools to lead effectively across traditional boundaries.
- Trialled, researched and evaluated methods for securing the best culture to thrive.

Estates

Estates can be a catalyst for integration, particularly when approaching the delivery of neighbourhood teams and same-day urgent care. As a system, we can develop spaces and establish the conditions for communities to improve their wellbeing, on their own terms, in non-clinical ways.

The developing Surrey Heartlands and Surrey County Council Integrated Estates Strategy represents the partnership between Surrey County Council (SCC) and Surrey Heartlands Integrated Care System to re-set and re-commit to the delivery of a more efficient and effective public sector estate.

Our ambition is to make it easier to provide and support great health and social care, in the appropriate property, in the right place, fit for purpose, available at the right time and support communities and partners to deliver more effective ways of tackling health inequalities and the wider determinants of health.

CASE STUDY

WeyBetter Weybridge is a partnership Alliance - NHS Surrey Heartlands, Surrey County Council and Elmbridge Borough Council - to redevelop the healthcare and community facilities in Weybridge. The immediate priority is to build the health campus.

Future plans for the site include the redevelopment of the library and other facilities such as a community centre. The site holds many opportunities, but it is important that the plans consider all users and have the support of the site's neighbours.

Alongside the plans for community facilities, Surrey County Council is planning improvements to the town centre. The aim is to create a better town centre environment by improving pedestrian crossings and street furniture, encouraging active travel such as walking and cycling and improving traffic flow and associated air quality. The community will be involved in developing these designs.

11

Our population will benefit from:

By 2022/23

- A clear understanding of the health and wider public estate and opportunities.
- Developing models of delivery and a detailed programme to deliver priority schemes and pilot new ways of working.

By 2026

- Close work with community and social care services, teams, and others to identify and support delivery of priority schemes which help reduce health inequalities including supporting the creation of community diagnostic and maternity hubs.
- Delivery models for new health delivery pathways, for example, 'health on the high street'.

By 2030

- Flexible integrated health and care estate that enables the right services to be delivered and empowers communities to support each other in the places that need them.
- Estate supporting the changes in the way services are provided relieving pressure on acute settings, provide a new more agile way of working for staff, and help to reduce inequalities and improve access to the right settings across the system.

Net Zero

Surrey Heartlands' ambition is to align ICB, Acute, Mental Health and Ambulance trusts' ambitions with the wider NHS goal of becoming Net Zero Organisations. During the life of this plan, NHS England aims to reduce the emissions we control directly (the NHS Carbon Footprint) by 2040, with an **ambition to reach an 80% reduction by 2028 to 2032**.

We are looking across our estates, housing and transport programmes to progress our net zero policies across our System and Place geographies.

In our ICS Green Plan we identify the four local priorities for the NHS in Surrey Heartlands:

1. **Inhaler Project** aimed at achieving a transition of prescribing to dry powder inhalers within Acute and Primary Care resulting in reduction in emissions as well as better health outcomes (medicines optimisation).
2. **Innovation Programme** aimed at supporting innovators with implementing sustainability within their own developing programmes (innovation & research).
3. **Engagement Strategy** within the ICS and public to cultivate sentiment towards sustainability and increase understanding (working with communities).
4. **Funding support for Providers** to bid for funding for sustainability projects within their organisations.

You can read more about our sustainability work including Green Plan actions on our website and each of the NHS Trusts and Foundation Trusts have published Green Plans on their websites.

11

CASE STUDY

Greener NHS - Since the launch of Ashford and St Peter's Green Plan in 2021, 80% of the vehicles in the van fleet are now electric. Food delivery miles have reduced by 20% (438 truck-miles per week). The Trust no longer uses desflurane anaesthetic, a carbon-creating gas.

Digitally Enabled Care

Our ambition is to improve how teams use and share data to create better and healthier lives empowered by digital and data. We have a vision to increase staff capacity by removing cumbersome manual administrative tasks and eliminating costs through use of automation and artificial intelligence. In this section we cover the **Digital Strategy, Data Strategy, Personal Health Record, Digital First Primary Care, Information Governance and Data Protection.**

Our **Surrey Digital and Data Strategy** is being developed by bringing together existing separate Data and Digital strategies to provide a single integrated Surrey wide strategy to help deliver better care and services to our residents now, and in the future. We have categorised 3 key categories and 7 strategic capabilities that are being delivered (Figure 15), following the NHSE design principles for the development of the digital strategy:

- Put people at the heart of everything you do
- Design for the outcome and be inclusive
- Design for context and Trust
- Test the problem and clarify assumptions
- Make, learn and iterate
- Do the hard work at the beginning to make it simple
- Make things open. It makes things better

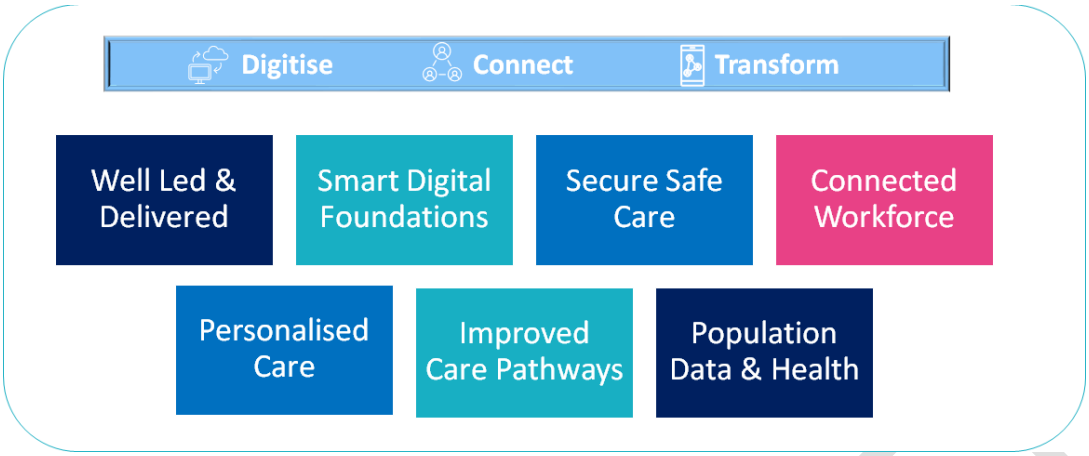

Figure 15 – Digital strategy key categories and strategic capabilities

Category 1: Digitise our services
An aligned digital and data infrastructure to create a consistent secure agile foundation for future digital transformation and tools:

- **Cyber** – A single cross organisational strategy and plan to manage cyber risk across Surrey.
- A single system wide **Data Architecture** - A shared data ecosystem (a data MESH) used for public services across health, social care and voluntary care.
- The **Integrated Digital and Data Platform** (IDDP) will meet this system integration need by providing an integrated central system, to drive Population Health Management (PHM) goals, deliver the Surrey Care Record (SCR) and Personal Health Record (PHR), a **Secure Data Environment** (SDE), Operational Planning and Reporting, including workforce, and state of the art business intelligence and advanced analytics. We expect the IDDP to go live from January 2024.
- **Surrey Care Record** - By connecting data from our many providers we can understand current and future health care needs and trends. We will also need to ensure our hard to reach populations are not digitally excluded.
- **Electronic Patient Records** - Implementation and optimisation of new EPR solutions e.g. Oracle Cerner and System 1.
- **Digitising Social Care and Care Homes** -Supporting the digitisation of 600 local health and care settings to improve citizens outcomes.

Category 2: Connect our different services and organisations
We undertook a listening project to look at ways in which digital technologies might better support patients. We spoke to patients, clinicians and the wider public to truly understand how digital technologies might support people's health needs. We particularly wanted to hear from under-represented groups and from people who do not normally use digital technologies.

- **Personalised Care** e.g. Patient Portals. Using these insights and acknowledging concerns raised during engagement sessions with citizens and staff, we are building safe and secure online access to your health records, whenever you need them and to help better manage care. Using the NHS App and healthcare provider systems people will have 24 hour access to their health care information and records to make, change or cancel appointments, check test results, contact their health and care professionals and submit test results.
- **Connecting our Workforce** - Digital Passport: Improve retention through Surrey Professional Development platform and Resilience Hub; improve recruitment through Surrey-wide temporary staffing and recruitment platforms; embed digital literacy into Core Training and focus on digital passporting.

Category 3: Transform our current service and clinical pathways to deliver better care and outcomes

- **Elective Care** Working with colleagues to transform the Diagnostics digital capability using new technology and AI to support demand and capacity management. The creation of a single cross provider patient treatment list, implementation of improvements in theatre utilisation and prioritisation of out-patient cohorts and lists.
- **Urgent and Emergency Care** Optimisation of system control centres and further embedding the use of SHREWD - real-time operational management tools - to provide a system wide view of capacity and demand.
- **Virtual Care** Working with colleagues to support the procurement and implementation of a system wide platform to support monitoring of patients outside of hospital.
- **Digital First Primary Care** The development of digital tools to help patients easily access the care they need, such as receiving advice, booking and cancelling appointments, consulting with a healthcare professional, receiving a referral and obtaining a prescription. Expanding the capabilities most GP surgeries, hospitals, mental health services and community care services offer with video consultations, enabling contact with patients via a video call to their smartphone, tablet or computer, to talk to and see the patient.
- **Mobile first health and care applications** We will continue to use and scale the use of remote monitoring tools and applications such as blood pressure monitoring service 'BP@Home', urine tests, Children's e-Red book, My COPD. This means that patients no longer need to visit their GP surgery or health care facility to have their readings taken. Patients will be able to submit their results via digital App, text, email or even by phone.

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Not everyone wants to or can use digital technologies. However, we want everyone to have freedom of choice in accessing their care and that digital technologies complement rather than replace existing ways of working. Our **Digital Inclusion** project ensures that no one is left behind for example, we deliver digital skills training to people who have experienced domestic abuse in refugees across Surrey Heartlands and the Surrey Coalition for Disabled People project Tech to Community Connect, provides people with access to technology and advice.

We estimate that around 30% of the Surrey population do not have access to digital technologies or choose not to use them if they do. We also know that this is broadly linked to deprivation, which in turn is broadly related to poorer health outcomes.

We have created a targeted programme of action to identify those most at risk of exclusion from digital NHS services and ensure they have the support they need to access healthcare services. That means individuals being able to use computers and the internet (digital skills), being able to access to the internet (connectivity) and services designed to meet all users' needs, including those dependent on assistive technology to access digital services (accessibility).

Information governance (IG) and data protection is all about how to manage and share information safely and securely. It provides a consistent way to deal with the many different standards and legal rules that apply to information handling.

Our ambition is to create an integrated information governance function for the ICS, ensuring the safe and appropriate use of personal data on behalf of our citizens and supporting information sharing arrangements between our organisations.

Organisations within the Surrey Heartlands are now working more closely together as part of the Integrated Care System, within our Places and Primary Care Networks.

ICS, Places and PCN partner organisations need to share and use personal confidential data in order to take forward key transformational activities and achieve planned improvements in care delivery and financial efficiency. To ensure there is a protocol for these activities, the Surrey Heartlands Health and Social Care Information Sharing Agreement has been established.

Our aim is to:

- Provide a clear framework for the secure sharing of personal confidential data for the delivery of care and for the management of the health and social care system,
- Accelerate the pace with which regional and local sharing requirements can be agreed, and
- Reduce the costs of developing and agreeing individual sharing requirements.

By 2028 our population will benefit from:

- Aligned data and digital platform to create a consistent foundation for future digital tools - simplifying access to the right information at the right time and by standardising the quality of data we will improve the available intelligence and insights for care pathway redesign, workforce prioritisation, and targeted treatment for those at high risk
- A data governance function and data management team to support the new data platform and the delivery of further integration of additional information sources, to support health and care partners deliver improved services.
- An integrated Information Governance function.
- An increase in digital capability maturity through delivery of key digital roadmap initiatives such as the Children's eRedbook (personal child health record), the Collaborative Bank (staff), Virtual Wards, Population Health Management and the Digital Social Care record.
- Access to health and care information from more partner organisations through the Surrey Care Record including Hospices and the Voluntary sector, supporting efficiencies of workflow and improvements in care transfer and delivery for better outcomes for our citizens. Implementing single-sign-on from Acute Trust electronic record systems to improve access, experience and efficiencies for health and care professionals.
- Improved quality of information held by care providers to support better care planning, decision support, improved outcomes for those in care. This will also support efficiencies in transfer of care, by assisting community and local authority partners to implement electronic records (Care homes and domiciliary) with a target of achieving 80% of providers having an electronic record by March 2024.
- Partners attaining Healthcare Information and Management Systems Society (HIMSS) level 5 Digital Maturity for comprehensive, secure electronic information available to support health and care professionals decision making, for improved patient outcomes. Acute hospitals and mental health trust by 2024(funded) with ambition of supporting Community providers to do so by 2026.
- Provision of an integrated personal health and care record, providing people of Surrey with easy access to a combined view of their health and care information held across all partner organisations from one place (NHS app). People will be able to view and change appointments, communicate with their health and care professionals and engage with their health and care plans.
- The new national Electronic Staff Record solution will be available; including increased self-service availability for managers and staff – reducing waste and improving data quality. The solution will improve our ability to ensure the right skills are built and deployed as care models improve.

You can read more about our work on the Surrey Heartlands website.

Finance

We are operating in a financial landscape that is challenged and we consider the most effective way to address these financial constraints is closer integration of health and social care as described in

this strategy, with less reliance over time on large hospitals and traditional care models, to sustainably address health inequalities and the likely needs of our population in the future.

Surrey Heartlands ICS faces a significant financial challenge. In the 2022/23, the ICS reported a deficit of (£33.6m) which represents (1.5%) of the total allocation it received for healthcare services of £2.213bn. Achievement of the deficit (£33.6m) was in part achieved using non-recurrent means - on an 'underlying' basis (excluding the impact of the non-recurrent benefits), the ICS deficit position is closer to £100m.

Recognising the extent of the underlying financial deficit in 2022, the ICS developed a five-year 'sustainability plan' which sought to both improve patient outcomes as well as place the system on a more sustainable financial footing. This work identified that without intervention and transformative re-design of services (a 'do nothing' scenario), the deficit position would deteriorate as demand for services increased a greater rate than likely available funding. Framed round the 'Critical Five' strategic objectives, a series of interventions and transformational programmes of work were developed which identified almost £100m of financial benefits over a 5 year period and which would support a balanced ICS system over time.

Work identified in the five year sustainability plan is underway. Examples include a common approach to the management of agency staff across the secondary acute system, which is starting to realise benefits and the Surrey Heartlands Elective Centre, where additional capital funding was received via a successful bid to streamline the delivery of lower complexity, higher volume surgical activity. Building on the early success of the sustainability plan work, the ICS is currently refreshing and refining its work on financial sustainability notably:

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1. Extending the strategic scope of the financial plan to include SCC, recognising that the integration of services means using the aggregate available resource across all partners to the maximum benefit of the taxpayer and Surrey patients and citizens.
2. A programme of work that focusses on the interventions and service re-design that will have a short term (12-24 months) impact to try and address the immediate challenges of delivering financial balance and sustainability.

The scope of the financial plan is under development. Immediate interventions are being managed through a Delivery Oversight Group with CEO and ICS executive representation reporting to the ICS executive. Examples of programmes include:

- Leveraging the benefits of the new 'Elective Centre' at ASPH more widely across the ICS through pathway redesign which should ensure clinical interventions are delivered at the right place and at the right time;
- Continuing the commonality of approach to the management of agency and back-office resource across the system to ensure consistency and best value for money;
- Driving efficiencies on drugs procurement in both primary and secondary care designed to both improve health outcomes and reduce the overall medicines bill for the ICS; and
- Mental Health, Paediatric, Maternity and Stroke pathway optimisation across Provider organisations.

The ICS continues to work on the detail of Acute Provider Collaborative arrangements and delegations to Place, in order to support the principles of subsidiarity.

The **Better Care Fund programme** is enabling Surrey Heartlands to pool money to address the strategic ambitions of the fund. This is one financial approach we're taking to better integrate health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

The ICS submitted a breakeven income and expenditure plan for 2023/24 in line with its statutory obligation and is planning to manage its capital spend within the operating capital envelope allowable by NHSE. On an underlying basis, the ICS is a 'deficit' healthcare system – that is where

planned expenditure is greater than planned income. Several system partners recorded deficits in 2022/23 and have submitted deficit plans for 2023/24.

It is acknowledged all partners have areas where clinical outcomes can be improved, staffing may be fragile or there is provision duplication that could be delivered collaboratively to contribute to system efficiency. Appendix 2 details productivity contributions from services featured in this Joint Forward Plan.

Like all parts of the NHS, Surrey Heartlands' procurement is subject to a number of key legislative requirements when determining the provider of a contract including the principles of transparency, equal treatment and non-discrimination. When awarding public contracts we are expected to achieve Government objectives, including value for money, maximising public benefit such as tackling climate change and integrity. The introduction of the Provider Selection Regime (PSR) requires public sector buyers to take a broad view and take account of the national strategic priorities set out in the National Procurement Policy Statement (NPPS).

Integrated Commissioning

In 2019, Surrey Heartlands made the decision to integrate commissioning across health and care; beginning with Children's services and Learning Disability & Autism, Continuing Health Care, Carers and moving to adult mental health.

Together we will continue to work in more integrated and collaborative ways for the good of the families living in Surrey. Across our system, there are several partners involved - including the local authority, health, education, the police and third sector organisations - ensuring that in Surrey people are safe, healthy and can live up to their potential.

Our programme of work aims to:

- **Re-affirm the vision and ambition for integrated commissioning** – re-committing to and further defining integrated commissioning in Surrey as essential to ensuring good outcomes for residents/patients and value for money.
- **Re-affirm a target operating model for integrated commissioning** – understanding the gap between the ambition and the current situation to develop, design and implement improvements. This will include around governance, working practices, culture, infrastructure such as IT and building space etc.
- **Improve joint-planning** – ensuring a better understanding of existing organisation plans and planning cycles and enable greater joint-planning both in the short and long term.
- **Identify initial areas of commissioning/contracts where we can improve our integrated working** – understanding what opportunities we have coming up within our commissioning forward plan to improve our integrated commissioning practice (using the target operating model) and improve outcomes and value for money for residents and patients.
- **Ensure commissioners are supported to do good integrated commissioning** – through a learning, development and networking programme.

CASE STUDY

Our Joint Commissioning Strategy for Children and Young People highlights good areas of effective joint commissioning including – the HOPE and crisis intensive support services, Mindworks and community health contracts.

Governance and System Working

As a mature ICS, Surrey Heartlands is already achieving aspects of thriving system working. At the same time, it's clear the scale of the challenges we face, alongside our wider ambitions, mean we will need to work very differently over the next few years if we are going to get services back to where our communities want and need them to be, and create the step-change we want to see for our population.

Working as a system we can accelerate improvement and innovation to ensure investment and support is targeted where it will have the greatest impact. Developing the principle of subsidiarity is our ambition through the delivery of our ICS strategy. Strengthening local leadership, supported by continuous quality improvement and a commitment to sustainable primary care provision is at the heart of our approach to governance.

We will continue to develop informed decision making through the incorporation of expert advice such as the Primary Care Advisory Forum and Health Care Professional Executive - and broader engagement including people and communities.

You can find our more information about our board meetings, board members, committees and governance on the Surrey Heartlands website and appendix 1.

System Led Assurance

Assurance and performance monitoring is enacted through a wide range of tools and assurance reports, underpinned by the NHS Oversight Framework (OF) – a national framework with local flexibility encompassing NHS priorities and operational planning and NHS Long Term Plan delivery commitments. Assurance arrangements are set out within a Memorandum of Understanding (MoU) at ICS, Place, and organisational performance delivery level. To support this, review meetings are undertaken as follows:

- ICS Review Meetings: led by NHSE regional team with the ICS Leadership Team, system partner CEOs and AO and commissioners on a quarterly basis.
- Place Review Meetings: obtained through existing local governance arrangements for the four place-based partnerships, which continue to evolve. Led by the ICS with provider and commissioner leadership team and Place Based Leaders as appropriate. The frequency of meetings to be determined in discussion between NHSE regional team and the ICS.
- Individual organisations/collaboratives: led by NHSE, ICS and organisational teams as relevant for cross ICS, provider collaborative and exceptional meetings. This includes the bi-monthly SECAmb System Assurance Meetings jointly held by the ICS and NHSE.

The Assurance, Performance and Quality Teams work together to ensure the inter-dependencies with Quality Assurance are integral to the ICS-led assurance processes. You can read more about the metrics and monitoring used to assure our delivery in appendix 3.

Innovation and Research

Through our Innovation strategy, Surrey Heartlands aims to establish itself as a dynamic health and care ecosystem and the destination of choice to trial and scale the latest local, national, and international health and care research and innovations. Through collaborations and partnerships that leverage knowledge and expertise across Industry, Academia and Health and Care, we can look to drive exploratory innovation to address unmet needs whilst identifying and implementing those that will deliver the most impact at scale.

With the support of the Allied Health Science Network (AHSN) and wider system partners, our Innovation Strategy aims to establish us as a dynamic health & care system and the destination of choice to trial and scale research and innovation. It has four objectives aligned to the NHS Long Term Plan to drive future outcomes improvement through enabling prevention of ill-health, earlier diagnosis, better outcomes, and faster recovery and increasing the number of people participating in health research and accelerating development of innovations:

1. Create, manage, and deliver an effective innovation pipeline prioritised to the needs of the citizens of Surrey Heartlands
2. Create an internal operating model and methodology to deliver maximum benefits to Surrey ICS

3. Develop a strategy to attract industry investment and leverage additional capabilities to support delivery and development of novel solutions
4. Develop a Research Strategy to advocate & establish a mechanism for Research to be scaled at a system level and embedded into "care as usual"

This will be achieved through the adoption of an influencing model that enables the ICS innovation function to offer services across neighbourhood, place & system. We will cultivate a culture that allows people within and across multiple organisations to co-create, develop, and test new ideas and facilitate turning those ideas into business value. Our focus will be on guiding the Innovation Strategy at a system level and with the support of the AHSN and wider system partners, we will:

- Convene and support providers to implement innovation aligned with Core20Plus5, the Health and Wellbeing Strategy, the 'Critical 5' and the Fuller Stocktake
- Promote innovation, from the development of new ideas to spread through all areas of the system
- Develop a workforce culture, supporting entrepreneurs and embedding innovation into practice
- Enable economic growth through the development and adoption of innovation across Surrey Heartlands

By 2028 our population will benefit from:

- Greater use of innovation – for example, to support self-management for citizens
- Reductions in unwarranted variation in the provision of care when this is needed
- Greater economic growth – jobs and investment measurably leveraged into the local system

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Glossary

Acronym	Description	Acronym	Description	Acronym	Description
3TT	Three Treatment Targets	FH	Familial Hypercholesterolaemia	PCN	Primary Care Network
8NCP	Eight NICE Care Processes	GP	General Practitioner	PHB	Personal Health Budget
A&E	Accident & Emergency	GPIMHS	General Practice Integrated Mental Health Services	PHM	Population Health Management
A&G	Advice and Guidance	HCAI	Healthcare Associated Infections	PHR	Personal Health Record
AF	Atrial Fibrillation	HIMSS	Healthcare Information and Management Systems Society	PIFU	Patient Initiated Follow Up
AO	Accountable Officer	HSJ	Health Serviced Journal	POD	Point Of Delivery
AOMRC	Academy of Medical Royal Colleges	ICB	Integrated Care Board	PSR	Provider Selection Regime
ARI	Acute Respiratory Infection	ICP	Integrated Care Partnership	PTSD	Post Traumatic Stress Disorder
ASH	Action on Smoking and Health	ICS	Integrated Care System	QIC	Quality Improvement Collaborative
ASHN	Allied Science Health Network	ICSS	Integrated Community Stroke Service	RSFT	Royal Surrey Hospital
BAME	Black and Minority Ethnic	IDDP	Integrated Digital and Data Platform	SABP	Surrey and Borders Partnership NHS Trust
BSI	Blood Stream Infections	IG	Information Governance	SASH	Surrey and Sussex Healthcare NHS Trust
CAMHS	Child And Adolescent Mental Health Services	INT	Integrated Neighbourhood Teams	SCAS	South Central Ambulance Service
CEO	Chief Executive Officer	ISDN	Integrated Stroke Delivery Networks	SCC	Surrey County Council
CHC	Continuing Health Care	JFP	Joint Forward Plan	SCR	Surrey Care Record
CMHT	Community and Mental Health Transformation	LDA	Learning Disabilities and Autism	SDE	Secure Data Environment
COPD	Chronic obstructive pulmonary disease	LHRP	Local Health Resilience Partnerships	SDEC	Same Day Emergency Care
CPCS	Community Pharmacy Consultation Service	LTP	Long Term Plan	SECAMB	South East Coast Ambulance
CPR	Cardiopulmonary Resuscitation	LVAD	Left Ventricular Assist Device	SEND	Special Educational Needs And Disability
CQUIN	Commissioning For Quality And Innovation	MEDSIP	Medicines Safety Improvement Programme	SGO	Special Guardian Order
CVD	Cardio Vascular Disease	MOU	Memorandum Of Understanding	SQP	System Quality Group
CYP	Children And Young People	MVP	Medicines Value Programme	SSNAP	Sentinel Stroke National Audit Programme
DA	Domestic Abuse	NDH	Non-Diabetic Hyperglycaemia	UCR	Urgent Community Response
EDI	Equality, Diversity and Inclusion	NDPP	National Diabetes Prevention Programme	UK	United Kingdom
EPR	Electronic Patient Record	NHSE	NHS England	VCSE	Voluntary, Community and Social Enterprise
ERF	Elective Recovery Fund	NNPS	National Procurement Policy Statement	WDES	Workforce Disability Equality Standards
EWMH	Emotional Wellbeing And Mental Health	NOSIP	National Optimal Stroke Imaging Pathway	WHO	World Health Organisation
FDS	Faster Diagnosis Standard	OF	Oversight Framework	WRES	Workforce Race Equality Standards

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Integrated Health and Social Care for people experiencing homelessness
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Joint Health and Social Care Dementia Strategy for Surrey 2022-2027 (PDF)
Joint local health and wellbeing strategies
Joint strategic needs assessments
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Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	System Planning: Frimley Draft Joint Forward Plan (JFP) 2023 - 2028
HWBS Priority Populations:	All
HWBS Priority - 1, 2 and/or 3:	All
HWBS Outcomes/System Capabilities:	The Joint Forward Plan supports outcomes across the 3 priorities and draws on system capabilities to deliver the ambitions of the Integrated Care Strategy.
HWBS Principles for Working with Communities:	• Community capacity building: 'Building trust and relationships' • Co-designing: 'Deciding together' • Co-producing: 'Delivering together' • Community-led action: 'Communities leading, with support when they need it'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions • Community Led interventions
Author(s):	• Sam Burrows - ICS Programme Director at Frimley Health and Care ICS • Tracey Faraday-Drake - Director for Children and Young People and All Age Learning Disabilities and Autism, Place Convenor for Surrey Heath
Board Sponsor(s):	Fiona Edwards, Chief Executive of the Frimley Health and Care Integrated Care System (ICS)
HWB meeting date:	21 June 2023
Related HWB papers:	None
Annexes/Appendices:	**Annex 1**: Summary presentation of the draft JFP

2. Executive summary

The Frimley Integrated Care System (ICS) Strategy, which aligns with the Surrey Health and Wellbeing strategic priorities, was agreed by the Integrated Care Partnership in May 2023. The Joint Forward Plan is the five-year strategic delivery plan as agreed between the NHS organisations within the Frimley ICS geography. The plan also covers key deliverables in the NHS Long Term Plan and other planning guidance. The initial plan is to be published by 30 June 2023, subject to Board approval of the NHS organisations which have jointly produced it. It will be refreshed annually in March thereafter using a rolling five year period.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Note the near-final summary presentation of the draft Joint Forward Plan and its alignment with Surrey's Health and Wellbeing priorities and strategic approach, and provide informal feedback.
2. Note that the annual update of the plan will be provided in March 2024.

4. Reason for Recommendations

The Board is asked to review the Joint Forward Plan and provide informal feedback for consideration by the NHS organisations which are responsible for its production.

The Frimley ICS is not seeking a formal opinion at this time. This is a deliberate divergence from the national guidance and the current position of the Surrey ICS position. The rationale for this divergence is our desire to treat all five upper-tier Local Authorities in the Frimley ICS equitably. The three Unitary Local Authorities in East Berkshire are yet to establish new Health and Wellbeing Boards following the pre-election period and subsequent Local Elections in May 2023. In with our commitment to equity, we will be seeking an opinion on the Joint Forward Plan from all five Health and Wellbeing Boards when they are in a position to provide one.

5. Detail

Our recently published ICS Strategy - Creating Healthier Communities - provides the overarching vision for how the Integrated Care System will work together to improve health and wellbeing across the Frimley geography. It sets out the key priorities and ambitions for the next decade and provides a framework for decision-making across the partnership.

This Joint Forward Plan is fully aligned with the ICS Strategy and it outlines how the local NHS will contribute to achieving our shared goals and priorities. In particular, the Joint Forward Plan describes how the NHS will work in partnership together to meet our headline strategic objectives of reducing health inequalities and increasing healthy life expectancy.

The Frimley ICS 2023/24 Operational Plan sets out the detailed plans for how the partnership will achieve its priorities in the first year of implementation. It includes specific actions, targets and milestones for each of the priority areas identified in the Planning Guidance released in December 2022. It represents many of the year one actions of the Joint Forward Plan, although it should be noted that the latter is more ambitious and expansive than the national minimum planning requirements for the year ahead. The Joint Forward Plan also provides a longer-term perspective on how the NHS will evolve its services and workforce over the next five years, to support the achievement of the ICS priorities in the longer term.

Overall, the Joint Forward Plan is an essential document for the implementation of both the longer term ICS Strategy and the year ahead requirements of the 2023/24 Operational Plan. It maps out the NHS contribution to the partnership's goals and provides a clear framework for decision-making and resource allocation over the next five years. By aligning with the ICS Strategy and the Frimley ICS 2023/24 Operational Plan, the Joint Forward Plan ensures that the NHS is working in a coordinated and integrated way with other organisations across the partnership. This document, refreshed on an annual basis, will help to maximise the impact of our collective efforts to improve health and wellbeing across the geography.

In summary, this Joint Forward Plan is an important document that provides a clear roadmap for the evolution of NHS services and its workforce over the next five years. By working in partnership with other organisations across the Integrated Care System, we can ensure that we are delivering the best possible outcomes for patients, while making the most efficient use of our resources.

6. Challenges

N/A

7. Timescale and delivery plan

N/A

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

N/A

9. Next steps

- The final JFP will be submitted and published in full on the 30th of June 2023 on the websites of Frimley ICB, Frimley Health Foundation Trust, Surrey and Borders Partnership Foundation Trust and Berkshire Healthcare Foundation Trust.
- The Joint Forward Plan will be refreshed annually in March.

Frimley ICS - NHS Joint Forward Plan

Summary Presentation for Boards

2023/24 – 2027/28

About the Joint Forward Plan and how it relates to other system strategies and plans

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Creating Healthier Communities – Our 2023 ICS Strategy

The Frimley ICS Strategy

Creating Healthier Communities was published in 2019 as the first Frimley Health and Care ICS Strategy. This was designed following significant co-production between partner organisations, the third sector, our workforce, patients, and the public. The ICS Strategy was heavily informed by the data and insight available from the Connected Care platform and led to the formation of six Strategic Ambitions which have comprised the programme architecture for delivery between 2019 and 2022. We have recently completed a new partnership-led refresh of the ICS Strategy which sets out our aspiration for long term improvement to the health and care of the population.

Our Integrated Care Partnership

The Frimley Integrated Care Partnership (ICP), established in July 2022, is a joint committee between Local Authorities in the Frimley ICS geography and the NHS Frimley Integrated Care Board. At its core is an ICP Assembly, bringing together clinical and professional leaders of public sector, voluntary sector, and charitable organisations, which have an interest in improving the health and wellbeing of over 800,000 people who reside in the Frimley ICS geography. The ICP provides a platform for a broad range of stakeholders who are committed to making this ambition a reality. Building on our engagement with our partners, the Frimley ICP was established to have a strategic role, considering what arrangements work best in our local area by creating a dedicated forum to enhance relationships between leaders across the health and care system. The agreed remit for the ICP is to:

- 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 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.

The ICP is not an NHS construct and is, therefore, out of scope for this Joint Forward Plan. It will, however, continue to develop and evolve under the direction of a cross system partnership comprised of NHS, Local Government and VCSE expertise.

Our Resident facing services – Strategic Focus Areas for the Next Five Years

Introduction

As we progress our work together, it is essential that our services are equipped to meet the ever-evolving needs of our population. In this chapter of the Joint Forward Plan, we set out a roadmap for how we will develop and adapt our services to best serve the people who live in this geography.

Looking to 2023/24 and the four years beyond we examine a range of services from healthcare to social support, and identify what needs to happen to ensure that they are fit for purpose. We recognize that a one-size-fits-all approach is not sufficient when it comes to meeting the diverse needs of our population, and, therefore, we will take a tailored approach to service development.

To support reducing the disparity in healthy life expectancies and optimise how services are used, we will encourage the integration of services across acute and rehabilitation, and physical and mental health needs.

The key success factors, risks, and dependencies of our service development strategy are explored in this section. We understand that the success of our plan depends on a range of internal and external factors, from securing funding and building partnerships to ensuring that we have the right staff with the right skills in place. We will work collaboratively with stakeholders, including the public, to ensure that we are meeting their needs in a way that is both effective and efficient.

We recognize that there will be challenges and risks associated with service development, particularly in the wake of the Covid-19 pandemic and the recovery of services. However, we are committed to taking a proactive and adaptive approach to ensure that we are able to navigate these challenges successfully.

Ultimately, our goal is to ensure that our services are accessible, inclusive, person-centred and responsive to the needs of our population. By taking a comprehensive and strategic approach to service development, we are confident that we can achieve this goal and make a positive impact on the lives of those who live in our geography. Using this Joint Forward Plan as a base, the Frimley Clinical Reference Group will steward the production of a fully refreshed Service Strategy during the Summer of 2023.

Core20 PLUS 5

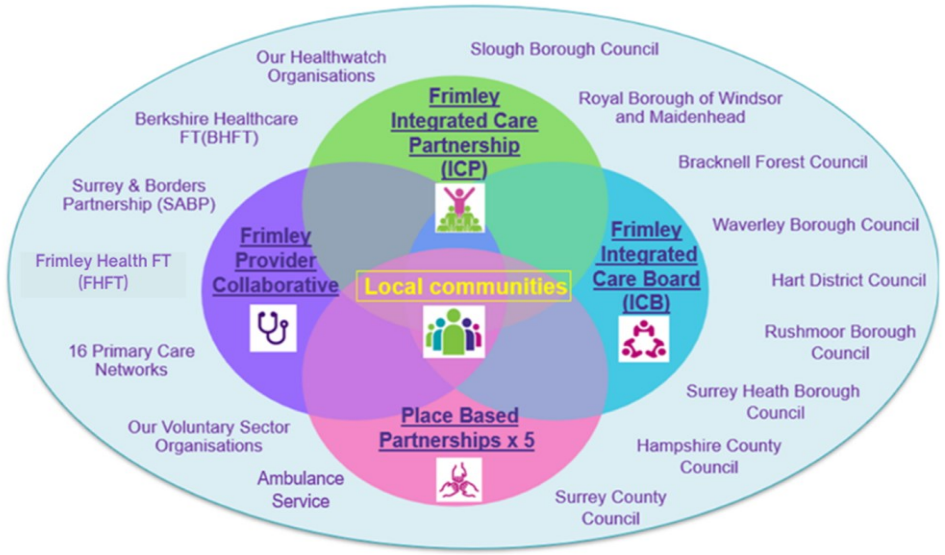
We are committed to implementing the Core20PLUS5 methodology to help us achieve our primary objective of reducing health inequalities. We will continue to work with our clinical and professional leaders at Place to identify PLUS groups who would benefit from additional focus on improving health outcomes, as well as accelerating our work to improve the healthcare offer for those in deprivation deciles one and two (the most deprived 20% of the population) and, where appropriate, those in deciles three and four. Further information about this methodology is set out on the following page.

Governance, Leadership and Culture – Strategic Context

Strategic Context

As our system architecture continues to evolve and mature we will continue to develop our approach to governance ('the way we do things') across our system footprint that builds on the core principles of partnership working and distributed leadership. By making decisions together with others and enabling distributed leadership we will be able to mobilise our leaders at all levels of the system, and across our partner organisations, to build capacity for improvement and change in a timely and effective way. We will ensure that our governance reflects a system perspective that:

- Recognises the importance of leadership by expertise (rather than years)
- Builds on high levels of trust, transparency and mutual respect
- Seeks more equitable distribution of decision making and delivery
- Focuses on consultation, engagement and consensus seeking
- Enables change and improvement from the bottom up to flourish



Our approach

Over the next five years we will ensure that the four key constructs of our system architecture (Integrated Care Partnership, Integrated Care Board, Provider Collaboratives and Place Based Partnerships) are working together to ensure we deliver our six system ambitions as set out in our system strategy, our joint five year priorities and annual plans.

Our governance will be underpinned by arrangements that support:

- Clear and transparent decision making
- Fully informed consideration of the balance of risks across safety, quality, performance, finance, workforce and service sustainability
- Decision making at the most appropriate level and made by consensus whenever possible
- Appropriate assurance on deliver of strategy and plans, use of resources and quality of services

We will have a reflective and flexible approach to the governance framework within which we operate that enables our building blocks to flourish so the right decisions are made by the right people in the right places. AS with all new and emerging complex systems the arrangements for today may need to change for tomorrow but the principles of subsidiarity and distributed leadership underpin our approach.

Provider Collaborative Development – Strategic Context

Provider collaboratives will be a key component of system working, being one way in which providers work together to plan, deliver and transform services.

By working effectively at scale, provider collaboratives provide opportunities to tackle unwarranted variation, making improvements and delivering the best care for patients and communities.

Significant scope to deliver these benefits already exists within current legislation and, subject to its passage through Parliament, we expect the Health and Care Bill will provide new options for trusts to make joint decisions.

Provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- reduce unwarranted variation and inequality in health outcomes, access to services and experience
- improve resilience by, for example, providing mutual aid
- ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Provider collaboratives work across a range of programmes and represent just one way that providers collaborate to plan, deliver and transform services. Collaboratives may support the work of other collaborations including clinical networks, Cancer Alliances and clinical support service networks.

Providers may also work with other organisations within place-based partnerships, which are distinct from provider collaboratives. Place-based partnerships co-ordinate the planning and delivery of integrated services within localities and alongside communities, while provider collaboratives focus on scale and mutual aid across multiple places or systems.

System partners will need to agree the areas of focus and delivery for each type of collaboration and decide how these arrangements can work most efficiently and coherently in a local context to achieve benefits for people and communities.

Provider Collaborative Development – Next Steps

As a committed partner of the Frimley NHS partnership, the Frimley Provider Collaborative continues to be ambitious about the role provider collaboration can play in the delivery of this Joint Forward Plan. We believe that working together is the key to achieving better outcomes for our patients and our communities and recognise that although there are still challenges to be overcome, we are committed to working together to find solutions.

Our focus remains on meaningful service transformation rather than structures and governance. We believe that by working together, we can identify the most effective solutions for our patients and our communities. We will continue to collaborate with our partners in the Frimley NHS partnership to ensure that we deliver high-quality care that meets the needs of our patients.

For the 23/24 year, we have refreshed our Provider Collaborative Board. This new Board has greater Place and Primary Care representation, recognising the importance of oversight and direction from a broad array of provider voices. We believe that this will help to ensure that our services are better integrated, more patient-centred, and more effective.

One of our key priorities for the coming year is to increase our focus on elective care transformation and the recovery of long waiting times. We recognise that this is a significant challenge, but we are committed to working with our partners to find new and innovative solutions that will help us to deliver high-quality care to all our patients.

In addition to this, we will also be looking to identify new pathways that could focus on a more collaborative approach to redesign and integration. We recognise that there are often many different organisations and pathways that patients must navigate to use our services, and we believe that by working together, we can identify more effective ways to support our patients and their families.

Ultimately, the success of provider collaboratives depends on effective clinical and executive leadership. By working together in a collaborative and transparent manner, our leaders will create a culture of trust and cooperation that supports the delivery of high-quality care. This is essential for ensuring that patients receive the best possible outcomes and that providers are able to deliver care that is both efficient and effective.

Place Development – Strategic Context

Context for Place-based development

Our five places within the Frimley system have a well-established history.

Each has a relationship with a different upper tier local authority, and some with additional lower tier local authorities, without clearly defined and aligned boundaries in some cases.

CCGs were originally established across the five geographies of North East Hampshire and Farnham, Surrey Heath, Bracknell and Ascot, Windsor Ascot and Maidenhead and Slough before the Frimley system was formed.

We now have a single Frimley ICB following the implementation of the Health and Care Act (2022) and have five Places which align more closely with our local authority boundaries, and with an opportunity to redefine the ways of working within those Places and the partnerships they embody.

We see Place as an opportunity for our residents and their families, their communities and the unique characteristics they have to be at the heart of our integrated working at place, with and for those residents, families, communities and our public services.

Process for Place-based development

- Since 2021/22, we have held place development workshops together and continued to have a range of conversations within places and across places.
- Those workshops focused on discussing and shaping:
- Principles of place-based working, their strengths and alignment with heath and well-being boards
- Role and purpose of place, relationships and ways of working for success
- Enabling elements to support places: people and capabilities, joint decision-making approaches, benefits and opportunities of pooled budgets

The **Integration White Paper** continues to be considered and offers a further framing for our ongoing development of our five places, in the context of the more mature shaping we have agreed across our ICP, ICB, and Provider Collaborative structures.

Place Development – Next Steps

Our aspiration for the development of Place based working

Our aspiration for the development of place-based working in our health and care system is to create a model of care that is truly person-centred and responsive to the needs of our local communities. We believe that by working together, we can create a system that is more integrated, efficient, and effective.

Our vision for place-based working is centred around five key principles:

- **Collaboration**: We believe that effective place-based working requires a collaborative approach that brings together stakeholders from across different sectors. This includes healthcare providers, local authorities, third-sector organisations, and patients and their families.
- **Co-design**: We believe that place-based working requires a co-design approach, where stakeholders work together to develop solutions that meet the specific needs of each community. This means involving patients and their families in the design of services and empowering them to take an active role in their own care.
- **Local leadership**: We believe that effective place-based working requires local leadership that understands the unique challenges facing each community. This means working with local leaders to develop solutions that are tailored to the needs of each place.
- **Innovation**: We believe that effective place-based working requires an innovative approach that is open to new ideas and new ways of working. This means exploring new technologies and new models of care delivery that can help to improve outcomes for patients.
- **Data-driven**: We believe that effective place-based working requires a data-driven approach that is informed by the latest evidence and best practices. This means using data to identify areas for improvement and to measure the impact of interventions.

Our aspiration is to create a place-based working model that is grounded in these principles. This will require a collaborative approach that brings together stakeholders from across different sectors to co-design solutions that are tailored to the unique needs of each community. We will work with local leaders to develop innovative models of care delivery that are informed by the latest evidence and best practices.

In order to achieve our aspiration, we will need to build strong partnerships with stakeholders across different sectors. This will require a commitment to open communication, trust-building, and a willingness to work together towards the implementation of our *People, Places and Communities* strategic ambition as defined in the ICS Strategy, *Creating Healthier Communities*.

Workforce – Our Priorities for 2023/24

Ambition one
Creating a joint workforce model for health and care

- Create a joint health and social care career model and enabling structure to support greater agility in the system.
- Enabling the workforce to be in the right place at the right time and to support them to live well

First steps:
1. Develop new roles which meet demand gaps and strengthen health and care career alignment
2. Research options available to enhance collaboration on pay, terms and conditions

Ambition two
Widening access to employment and keeping the people we have

- Identifying what works well to retain our people and support them to be their best
- Engage with our communities through an anchor institution approach to widen pathways into satisfying, valuable work.

First steps:
1. To pilot the introduction of community 'employment brokers' and spread this approach
2. To deliver our system programmes in EDI, Retention, Health and Wellbeing, Nurse/AHP transformation, Housing, Reservists and Widening participation

Ambition three
Strengthening partnership working and new models of care

- Develop new and digitised workforce models to increase collaboration, productivity and align these to new models of care

First steps:
1. Strengthen alignment with the system digital transformation programme
2. Extending our Temporary staffing and CLEAR programmes
3. Develop a logic model approach to prioritisation and development

Using QI methodology we are collaboratively designing our outcomes, action plans and evaluation for each ambition, to be validated at our system People Board in May 2023

23/24 NHS System Financial Plan

May 2023 submission

£'m		% Cost Base	% Allocation
Gross Deficit	**(146.6)**	**7.6%**	**10.1%**
Profit on disposal	16.7		
Non-Recurrent efficiencies - Surge	11.0		
Other Balance sheet/NR benefits	19.8		
Revised deficit after NR / technical adjs	**(99.1)**	**5.1%**	**6.8%**
FHFT Led	25.2		
ICB Led	11.4		
Low & Medium Risk schemes	**36.6**	**1.9%**	**2.5%**
FHFT	22.8		
ICB	6.0		
High risk efficiency	**28.8**	**1.5%**	**2.0%**
System Stretch	**33.8**	**1.8%**	**2.3%**

- The 23/24 gross deficit is £147m, 10% of the system allocation. The profit on disposal and the benefit of 22/23 non recurrent items has reduced this deficit to £99m, 6.8%. It is assumed that the change in accounting treatment for disposals will continue to apply in 23/24 allowing the profit to be recognised in year.
- Efficiency plans for FHFT and the ICB have been identified totalling £65.4m, of which £36.6m are considered to be low to medium risk. The remaining £38.8m is higher risk schemes in terms of delivery.
- In order to achieve a balanced plan a further system stretch of £33.8m has been included.
- Note that a 1.1% efficiency is assumed across all portfolios through the national tariff efficiency assumptions.
- The May submission was a balanced plan for 23/24

Financial Sustainability Plan on a Page

Strategic Context

As an NHS Partnership, we have agreed a collective approach to how we are going to work together to deliver a financially sustainable NHS for the Frimley population. Our Financial Sustainability Plan sets out a proposed “blueprint” for the development as a system team of a programme that will deliver financial control and alignment with cost efficiency programmes for each Statutory NHS Organisation within the Frimley system.

2023/24 represents year one of a multi-year system financial sustainability plan, to support delivery of the strategic objectives of the Frimley Integrated Care System. The intention is that the blueprint aligns with and complements the developing system governance architecture, such that the objective of delivering a financial “sustainability”, as opposed to “recovery” programme can be delivered. The programme is not intended to be a one-off recovery intervention, but a sustainable solution which enables the system to maintain recurrent financial grip and optimise value-based decision making on an ongoing basis.

The choice of terminology in describing the programme as system sustainability rather than “turnaround” or “recovery” is deliberate. The intention is to develop a programme which can sit within the system’s business as usual governance structures in order to establish and to retain a financial sustainability mechanism to place the system on a secure footing to deliver future strategy.

The sustainability programme must focus on the clear understanding and effective control of the system cost base as a single system entity, rather than an aggregation of organisational positions; such that the system is able clearly to consider and to account for inter-dependencies between different options for the deployment of financial resource to meet health need, in order to inform optimal decision making.

High level financial modelling identifies a material underlying gap in resource availability. The system will adopt an approach to planning on the basis of demand, and capacity to meet that demand, which will enable that financial resource gap to be described alongside a capacity resource gap, with a clear relationship between the two gaps.

Our Financial Sustainability Principles

1. Prioritisation of NHS resource allocation, based on clinical and cost effectiveness – focusing on those which are the most effective

2. The development of New Care Models – developing new ways of working across the health, social care and voluntary sectors.

3. Optimising Value for Money - continue to review all services to optimise value for money, reduce duplication and free up resources to respond to population growth and increasing demand

4. Maximisation of Technical Efficiencies

5. Reduction in Unwarranted clinical variation

6. All efficiency schemes must include a clear route to monetisation for the Frimley system. Plans will:
    a. Include schemes which create capacity being utilised to repatriate or to facilitate reductions in escalation capacity and will take account of stranded costs and consequent time to monetisation.
    b. Allow for cases which need to be combined to release fixed or semi-fixed cost to be progressed together, without which monetisation cannot be delivered.

7. System development and maintenance of a clear understanding of its cost base in order to:
    a. Allow comparative analysis of alternative options to meet demand. For example, new community services vs. meeting the same need in an acute setting, avoiding step costs for new facilities or the opening of escalation capacity if the same need can be met in an alternative setting).
    b. Give visibility of fixed and semi-fixed costs in order, for example, to realise estates opportunities, and to allow the development of benchmarking internally and with others.

Other areas covered by the Joint Forward Plan

This document is a brief summary of the material elements of the Frimley NHS Joint Forward Plan for 2023 – 2028. The full document contains additional detail on:

- Service development priorities for each of our major clinical and resident facing services
- How we will promote integration and partnership working across the NHS to provide a better offer to our residents
- The ambition around leadership and cultural development which will enable our teams to work better, together
- Granularity on our proposed use of capital allocations and how we will take decisions on estates improvement opportunities
- How the changing nature of procurement and supply chain will enable us to achieve greater value for money and lower overheads for NHS organisations
- The use of digital, technology and innovation as an enabler to higher quality care and new services for patients which provide greater sustainability for the NHS as a whole
- Our delivery priorities in 2023/24, which represents year one of this five year plan.

The full version of the Joint Forward Plan will be published on the websites of all four NHS organisations which have created this Joint Forward Plan together, from 1st July 2023. We will engage with our population and their elected representatives over the summer and consider their views in the production of this plan's next iteration, which is required to be published by 1st April 2024.

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Update to Surrey Health and Wellbeing Board from Surrey Heartlands Integrated Care System – 21 June 2023

Surrey Heartlands Integrated Care Partnership (ICP)

Agenda items and brief summary from the latest meeting (May):

Hewitt Review

- Discussion at the Integrated Care Partnership (ICP) focused on the ICP's response to the Hewitt Review and how Surrey Heartlands are performing against and can implement the recommendations. Focused on these specific recommendations:
  - The share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years.
  - Government leads and convenes a national mission for health improvement.
  - That a national Integrated Care Partnership Forum is established.
  - Government establishes a Health, Wellbeing and Care Assembly
  - NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers.
  - NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Data Alliance and Partnership Board
  - An appropriate group of ICS leaders should work together with DHSC, DHLUC and NHS England to create new 'High Accountability and Responsibility Partnerships'.
  - Each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These priorities should be treated with equal weight to national targets and should span across health and social care.
  - Government should produce a strategy for the social care workforce.
  - NHS England should work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer.
  - The implementation groups for the Messenger review should include individuals with significant experience of leading sustained cultural and organisational change in local government and the voluntary sector as well as the NHS
  - NHS England and ICBs need to agree a common approach to co-production working with organisations like the NHS Confederation, NHS Providers and the LGA.
- Full report can be read here: https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems

Towns Footprint

- ICP in February agreed that a towns programme would be a key component of wider public service reform. This would enable partners across the county to achieve their strategic intentions.

- Based on the previous report, this report outlined headline recommendations, including the order in which town footprints should be implemented, governance, roles, and responsibilities, as well as the role of the ICP in overseeing and steering the process.
- While there will always be different spatial layers for different purposes, towns can act as crucial focal points for enhanced partnerships by acting as distinct and recognisable places for residents and businesses.
- To reduce health inequalities, improve equal opportunity and access to services, and develop effective approaches to prevent and invest upstream.

Estates

Agenda focused on key updates relating to the ICS Estates portfolio:

- Change in Executive leadership to CFO.
- Requirement to deliver ICS Infrastructure (Estates) Strategy by December 2023
- Ongoing work to complete the PCN Toolkit (June 2023)
- High-level updates on Acute and Mental Health Partner programmes and major Primary Care related schemes

It set out the strategic vision and ambition for the way in which the ICS will work and how estate will be used as a catalyst to drive integration, collaboration, and patient activation.

Place Leaders described the local Place based developments and discussed operational delivery plans across the various towns, villages, and PCNs/Integrated Neighbourhood Teams within Surrey Heartlands

The ICP was asked to note the breadth of work in delivery and the key milestones in 2023/2024 and support delivery of some practical next steps:

- Review NHS Infrastructure (Estate) Strategy Toolkit and associated guidance
- Confirm ICS resource requirements.
- Establish Task and Finish Group for Strategy development.
- Re-establish ICS Governance Structures for Estates planning and coordination.
- Establish or identify and join - ICS wide Local Planning forum(s) to coordinate responses to Local Authority Local Plans.
- Prepare for the potential of short notice NHSE capital funding being made available by shortlisting and prioritising options across Surrey Heartlands.

Joint Forward Plan Update

- Provided an update on the development of the Surrey Heartlands five-year Joint Forward Plan (JFP). The plan draws on the ICS Strategy, Surrey Health and Wellbeing priorities, Surrey Vision 2030, and other local and national priorities. Insights from local engagement are informing the development of the Joint Forward Plan.

- ICSs are required to publish their Joint Forward Plan by the end of June 2023 and refresh it by the end of March each year thereafter.
- Integrated Care Partnership were asked to note the development update for the Joint Forward Plan.
- The Integrated Care Partnership will receive the final Joint Forward Plan at the next Committee.

Forward plan items

June ICP

- The Integrated Care Partnership meeting in June will be a private/informal meeting held in a hybrid format - both virtually and in person at Woodhatch.
- This meeting marks the first time we'll use our revised approach to running the Integrated Care Partnership focused on towns and key neighbourhoods. Guildford will be the focus of this ICP, which will provide a holistic view of the work underway there in light of our Integrated Care Strategy.

Surrey Heartlands Integrated Care Board (ICB)

Summary below of the Surrey Heartlands ICB Part One meeting held on Wednesday 3 May 2023:

- Written responses would be given to the questions on weekend access, IVF BMI thresholds and the use of the NHS App. The last of these had been very successful and was being used particularly well for repeat prescriptions.
- There was a deep dive on Surrey Downs place with a particular focus on neighbourhood teams that had a shared ambition and values with an infrastructure as shown by the example of the Banstead Integrated Community Service being a “team of teams” with the conditions of building delivery with relationships.
- There were further verbal updates from the remaining places of North West Surrey, East Surrey as well as Guildford and Waverley.
- The Chief Executive Officer’s report highlighted updates such as delivering statutory responsibilities, continuing to delivery the ICS strategy and looking after people through ongoing staff engagement as well as the BAME Forum event while the Armed Forces Covenant was signed on behalf of the organization.
- There was a planning update with one target where the ICS was non-compliant according to NHS England but this was being addressed.
- The 2022/2023 Month 12 Assurance Report highlighted key risks and next steps within the 6 Oversight Framework themes including:
    - Leadership and Capability
    - Quality of Care, Access and Outcomes
    - Preventing Ill Health and Reducing Inequalities
    - People
    - Finance and Use of Resources

- There was an update from the most recent Quality and Performance Assurance Committee with a focus on concerns with the children's wheelchair services as well as maternity services while the role of Healthwatch in addition to the consistency of approach using guidance regarding Nitrous Oxide was discussed.
- The 2022/2023 Month 12 System Finance Report was a summary as the reporting cycle for M12 was extended for yearend so the supporting financial information was not available for a complete report yet the system M12 position was a deficit of £33.6m which was as per forecast and this wass the net of the deficit position agreed with NHSE in Q3 of £39.0m less £5.4m of incremental funding for prescribing cost pressures received in Q4 while operating capital expenditure was £105.1m versus an envelope of £104.3m with a +£0.8m overspend.
- There was an update from the most recent Strategic Finance and Assurance Committee with a detailed review of estates as well as recognizing that inflation pressures were volatile.
- There was an update from the most recent Audit Committee with a recognition that a change from individual organization to a system approach would be significant.
- A summary of items discussed at the Integrated Care Partnership and the Health and Well-being Board forward plan items were presented.
- There were updates from the respective Partner Members concerning Mental Health, NHS Foundation Trusts, Primary Care Medical Services and Local Authority.
- The April 2023 Risk Report highlighted that the Board Assurance Framework (BAF) had been updated for the May 2023 meeting cycle so the Surrey Heartlands Board Assurance Framework Report (BAF) showed risks split into ICB-specific risks as well as risks held in common with partners both with a score of 12 or above while Risks in Common are aligned to the Surrey Heartlands "One System Plan" health and care priorities; which meant that the ICB risks are aligned to both the OPPs in addition to the "One System Plan".
- The extension to the existing Pharmacy, Optometry and Dentistry Committee Terms of Reference to 30 June 2023 was approved.

Update to Surrey Health and Wellbeing Board from Frimley Integrated Care System - 21 June 2023

Frimley Integrated Care Partnership (ICP) and Frimley Integrated Care Board (ICB)

ICS Strategy Refresh & Integrated Care Partnership

The ICS strategy was considered at the last meeting of the Integrated Care Partnership when it came together as an assembly on 11 May (rearranged from March due to Industrial Action). The ICS strategy has now been through multiple statutory boards and committees, as well as several informal engagement events with chairs of Health and Wellbeing boards and other Partner Organisations. Feedback has been captured, themed and addressed into a final draft version of the ICS strategy, which was circulated to ICP members at the beginning of March. The focus of the Assembly was on prioritisation for each Strategic Ambition, to help form the foundation of a delivery plan for the year ahead.

Next steps for the strategy include the finalisation of this delivery plan for each of their strategic ambitions, working with Partner Organisations to understand what can be delivered this year and in future years to achieve the objectives set out in the document. An update on this delivery plan can be produced for a future meeting and the final version of the refreshed ICS Strategy is on the Frimley ICS website.

Joint Forward Plan (See item 12, Annex 1: Summary Presentation for Boards)

The first draft of the Joint Forward Plan was submitted in draft to NHS England in the first week of April following consideration (twice) by the ICB Board and other partner organisations.

Significant work has gone into the creation of this new document which sets out our five year aspiration for the development of NHS services as a system partnership.

The plan was further iterated during the months of April and May as this coincided with the pre-election period and the most recent formal feedback received from the ICB Board. After local elections were held on 4 May 2023, further engagement has commenced with health and wellbeing boards, including this meeting, both formally and informally. Following changes to the political administrations of the majority of Local Authorities in the Frimley geography, formal engagement with their health and wellbeing boards will not take place until the Summer of 2023 onwards. The final JFP will be submitted and published in full on 30 June 2023 on the websites of Frimley ICB, Frimley Health Foundation Trust, Surrey and Borders Partnership Foundation Trust and Berkshire Healthcare Foundation Trust. Further work is now planned to create a shorter, more consistent plan that is digestible for partners, staff and the public.

2023/24 NHS Annual Plan

The ICS submitted its final plan for the financial year 2023/24 at the end of April 2023. The plan sets out how the ICS will deliver thirty new national priorities and work in partnership with the whole public sector to progress our local priorities for the year ahead. The plan includes stretching efficiency gains and improvements to patient and

resident facing services which were set out nationally in December for all NHS systems to deliver.

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Delegated Commissioning

Frimley ICB has submitted an Expression of Interest to act as the hosting "hub" for delegated commissioning activities for the whole South East Region of the NHS. These services include Community Pharmacy, Optometry, Dentistry and, at a later date, Specialised Services. Due diligence is currently being undertaken prior to the Frimley ICB Board taking a final decision on the proposed transfer in June. Further detail can be provided at a later date to set out the scope and scale of the transformation opportunities which may be available as a result of these changes.