Notice of Meeting

Health and Wellbeing Board

Date and Time	Place	Contact	Web:
Wednesday, 19 June 2024 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 @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)
Fiona Edwards	Chief Executive of the Frimley Integrated Care System
Jason Gaskell / Sue Murphy and Paul Farthing	CEO, Surrey Community Action / Chief Executive Officer, Catalyst / Chief Executive, Shooting Star Children's Hospices (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
Helen Coombes	Executive Director for Adults, Wellbeing and Health Partnerships, Surrey County Council
Rachael Wardell	Executive Director for Children, Families and Lifelong Learning
Karen McDowell	Chief Executive Officer, Surrey Heartlands Integrated Care System

Graham Wareham	Chief Executive, Surrey and Borders Partnership
Michael Coughlin	Interim Head of Paid Service, Surrey County Council
Mark Nuti	Cabinet Member for Health and Wellbeing, Public Health, Surrey County Council
Sinead Mooney	Cabinet Member for Adult Social Care, Surrey County Council
Clare Curran	Cabinet Member for Children, Families and Lifelong Learning, Surrey County Council
Sarah Cannon	Senior Probation Officer at The Probation Service
Carl Hall	Deputy Director of Community Development, Interventions Alliance
Tim De Meyer	Chief Constable of Surrey Police
Kevin Deanus	Cabinet Member for Fire and Rescue, and Resilience, Surrey County Council
Borough Councillor Ann-Marie Barker	Leader of Woking Borough Council (Surrey Leaders' Group Representative)
Steve Flanagan	North West Surrey Alliance 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
Dr Sue Tresman	Surrey's Independent Carers Lead and Co-Chair for the Carers Partnership Group, Carers System Representative
Siobhan Kennedy	Homelessness, Advice & Allocations Lead, Guildford Borough Council (Associate Member)

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

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AGENDA

1 APOLOGIES FOR ABSENCE

To receive any apologies for absence and substitutions.

2 MINUTES OF PREVIOUS MEETING: 20 MARCH 2024 (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 *(13 June 2024).*

b PUBLIC QUESTIONS

The deadline for public questions is seven days before the meeting *(12 June 2024).*

c PETITIONS

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

5 HEALTH AND WELL-BEING STRATEGY HIGHLIGHT REPORT (Pages 15 - 44)

This paper provides an overview of the progress in the delivery of the Health and Wellbeing Strategy (HWB Strategy) as of 28 May 2024.

6 HEALTH AND WELL-BEING STRATEGY INDEX SCORECARD (Pages 45 - 92)

When the Surrey Health and Wellbeing (HWB) Strategy Index was shared with the Board in 2023 it was recognised that further development was needed both in terms of indicators and the geographic levels at which the data is presented. The last iteration had the addition of Primary Care Network (PCN) level data. This latest significant update includes over 20 new indicators (61 in total), aligned to HWB Strategy's priority populations and to the priorities/outcomes to offer a more comprehensive picture.

In this paper, we summarise the additional indicators introduced (see appendix 2) and share the first iteration of the Scorecard that draws attention to areas where progress or need is particularly noteworthy.

7 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA): MULTIPLE DISADVANTAGE (Pages 93 - 100)

This paper outlines the draft recommendations of the developing multiple disadvantage JSNA chapter in recognition of the impact that the experience of multiple disadvantage has on some of the most vulnerable persons in our county. The production of this JSNA chapter has been led by our local lived experience group.

8 BETTER CARE FUND (BCF) PLAN 2023-25 (UPDATE FOR 2024/25) (Pages 101 - 172)

The Board is asked to approve the 2024/25 update to the previously submitted Surrey 2023-25 Better Care Fund (BCF) Plan.

9 INTEGRATED CARE SYSTEMS (ICS) UPDATE (Pages 173 - 184)

The Board is asked to note the update provided on the recent activity within the Surrey Heartlands Integrated Care System (ICS), and Frimley Health and Care ICS regarding the Integrated Care Partnerships and Integrated Care Boards against the Health and Wellbeing Strategy.

10 DATE OF THE NEXT MEETING

The next meeting of the Health and Wellbeing Board will be on 18 September 2024.

Michael Coughlin
Interim Head of Paid Service
Published: Tuesday, 11 June 2024

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

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Thank you for your co-operation.

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.

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MINUTES of the meeting of the **HEALTH AND WELLBEING BOARD** held at 2.00 pm on 20 March 2024 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)

* Bernie Muir (Chair)
* Dr Charlotte Canniff (Vice-Chair)
* Karen Brimacombe
* Professor Helen Rostill (Co-Sponsor)
Liz Williams (Co-Sponsor)
Kate Barker (Co-Sponsor)
* Mari Roberts-Wood
Fiona Edwards
Jason Gaskell (Co-Representative)
* Sue Murphy (Co-Representative)
* Paul Farthing
r Dr Russell Hills
* Kate Scribbins
* Ruth Hutchinson
* Helen Coombes
* Rachael Wardell
Karen McDowell
* Graham Wareham
Leigh Whitehouse
* Mark Nuti
Sinead Mooney
Clare Curran
Kevin Deanus
Sarah Cannon
Carl Hall
Tim De Meyer
* Borough Councillor Ann-Marie Barker
* Steve Flanagan
Jo Cogswell
* Dr Pramit Patel
Lisa Townsend
* Professor Monique Raats
* Dr Sue Tresman
Siobhan Kennedy (Associate Member)

Substitute Members:
* Tracey Faraday-Drake - Director for Children and Young People and All Age Learning Disabilities and Autism / Place Convenor for Surrey Heath, Frimley ICB
* Detective Superintendent Dave Bentley, Department Head Public Protection Domestic Abuse Team, Surrey Police

The Chair welcomed new Board members:

- Paul Farthing - Chief Executive, Shooting Star Children's Hospices, VCSE Alliance Co-Representative.

- Sarah Cannon - Senior Probation Officer at the Probation Service; thanked outgoing Board member: Jason Halliwell for his contributions.
- Dr Sue Tresman - Surrey's Independent Carers Lead and Co-Chair for the Carers Partnership Group, Carers System Representative.
- Leigh Whitehouse - Interim Chief Executive, Surrey County Council; thanked outgoing Board member: Joanna Killian for her contributions.

1/24 APOLOGIES FOR ABSENCE [Item 1]

Apologies were received from Karen McDowell, Leigh Whitehouse, Fiona Edwards - Tracey Faraday-Drake substituted, Tim De Meyer - Detective Superintendent Dave Bentley substituted, Lisa Townsend, Kate Barker, Jo Cogswell, Sarah Cannon, Clare Curran, Sinead Mooney, Carl Hall, Jason Gaskell, Russell Hills (remote).

2/24 MINUTES OF PREVIOUS MEETING: 14 DECEMBER 2023 [Item 2]

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

3/24 DECLARATIONS OF INTEREST [Item 3]

There were none.

4/24 QUESTIONS AND PETITIONS [Item 4]

a Members' Questions

None received.

b Public Questions

None received.

c Petitions

There were none.

5/24 HEALTH AND WELLBEING STRATEGY HIGHLIGHT REPORT [Item 5]

Witnesses:

Karen Brimacombe, Chief Executive, Mole Valley District Council (Surrey Chief Executives' Group) (Priority 1 Sponsor)
Adam Watkins, ICS Senior Programme Manager - Long Term Planning Delivery, Surrey Heartlands ICB
Ruchika Gupta, Clinical Director - Long Term Planning Delivery, Surrey Heartlands ICB
Professor Helen Rostill, Deputy Chief Executive Officer, Surrey and Borders NHS Foundation Trust and SRO Mental Health, Frimley ICS (Priority 2 Co-Sponsor)
Sara Saunders, Interim Health Integration Policy Lead, Surrey County Council
Mari Roberts-Wood, Managing Director, Reigate and Banstead Borough Council (Priority 3 Sponsor)
Nikki Roberts, CEO - Surrey Coalition of Disabled People

Key points raised in the discussion:

Priority 1

1. The Priority 1 Sponsor noted that the workshop held in November focused on partnership working in support of Looked After Children to promote healthy weight, an action plan to be developed at March's workshop. Active Surrey held the Active Schools Conference in November which explored how more positive relationships could be created with children and young people; gender equality was also discussed. The Surrey Anti-Social Behaviour and Community Harm Reduction Partnership had completed a Noxious Smells (cannabis) Framework, which helped partners to work together to stop gangs supplying drugs to neighbourhood dealers. There had also been work on improving information and resources around dementia. The Surrey Joint Carers Programme had co-designed new emotional well-being and mental health services for young carer champions. There were also some funding sources to help improve the health and wellbeing of unpaid carers.
2. The ICS Senior Programme Manager - Long Term Planning Delivery (Surrey Heartlands ICB) detailed the spotlight item: 'Surrey Heartlands Diabetes Network':
    - the vision was to improve the lives of people of all ages living with or at risk of developing diabetes across Surrey Heartlands.
    - the focus was on prevention and early identification, partnership working was key and included the all-age Diabetes Network to inform strategy and deliver improvement against identified national and local priorities.
    - topics discussed at January's Diabetes Network were: diabetes in care homes, the NHS diabetes prevention programme, improving awareness and reach, medicines optimisation.
    - the Diabetes Network's meeting later in the week has a spotlight on Learning Disability Mortality Reviews and would look at partners' work around the impact of diabetes for people with learning disabilities and or autism. Other areas of focus: the digital weight management programme, structured education with a pilot working with people from South Asian communities and work with Diabetes For South Asians (DoSA) and Active Surrey.
3. The Clinical Director - Long Term Planning Delivery (Surrey Heartlands ICB) provided further detail on the spotlight item:
    - the team was working to get a locally commissioned service for diabetes agreed for the primary care teams, to help improve identification and risk stratification of patients with diabetes, using a proactive register management tool to address the three treatment targets: controlling blood pressure, cholesterol and sugar levels.
    - working closely with children and young people (CYP), there was a pilot in East Surrey looking at the transition of CYP into adulthood.
    - the Alpha Research pilot with schools, for 3 to 13 year olds, used a finger prick test to determine their risk of developing type 1 diabetes.
    - hoped to learn from the work by colleagues in Bedford, Luton and Milton Keynes with Diabetes UK in trying to target healthy living advice for pregnant patients and those seeking advice on preconception; adapting tools in multi-languages and sharing the information more widely via the Baby Buddy app.
    - work with Surrey Minority Ethnic Forum (SMEF) via workshops in delivering the message on prevention, healthy lifestyles and blood pressure.
4. The Vice-Chair thanked officers for their work and noted that they covered other long-term conditions so could provide a similar presentation to the Board in the future if needed covering the network of services available. Noted the huge amount of work by partner organisations regarding the prevention and treatment of long-term conditions and ensuring that services are delivered consistently.
5. A Board member flagged that regarding primary prevention, there was an item on May's Informal Board agenda regarding Active Surrey and the Physical Activity

Strategy, now at the mid-point of its implementation there were positive outcomes. Noted that many colleagues would have been involved in the stakeholder events for the Food Strategy, healthy weight was key to that; noted the need to continue to work across the population, whilst targeting.

6. The Chair praised the range of initiatives across ages and demographics and asked if the pilots are successful, whether the learning would be rolled out across Surrey. The Clinical Director - Long Term Planning Delivery (Surrey Heartlands ICB) hoped that would be the case, noting that many of the pilots were in the early stages, also using best practice from other systems was crucial. Some of the pilots relied on limited funds, so creativity going forward was key to ensure that programmes would be sustainable. The Chair noted concern about the limited funding, as prevention was fundamental so there needed to be a consideration about how the initiatives are supported long-term.
7. A Board member offered support from the academic sector to help with identifying the appropriate people to undertake the research and to help identify available funding.
8. A Board member asked how people with lived experience were being involved and other than SMEF, had other organisations been involved; had CYP been involved in the co-design to ensure appropriate messaging. The Clinical Director - Long Term Planning Delivery (Surrey Heartlands ICB) explained that the Surrey young representative worked with Diabetes UK and the Surrey youth work service, listening to the voices of CYP. Currently SMEF and Active Surrey were being worked with closely, was open to working with other organisations to incorporate lived experience. The ICS Senior Programme Manager - Long Term Planning Delivery (Surrey Heartlands ICB) noted that the work in Ashford and St. Peter's Hospitals and DoSA was co-designed with the community, using lived experience about how and where to effectively deliver structured education sessions. Someone had been chosen to be part of University Hospitals of Leicester work to co-design what improved digital support for people from South Asian communities living with diabetes looks like.
9. A Board member noted that many of those people living with long-term conditions would have carers, asked how those with lived experience from a carer's perspective were being involved and supported; offered her help alongside the Joint Carers Programme team. The ICS Senior Programme Manager - Long Term Planning Delivery (Surrey Heartlands ICB) noted that needed to be developed across the long-term conditions programmes. The team had linked in with the carers programme in Surrey around opportunities such as the re-procurement of diabetes retinal screening services. He was happy to liaise with the Board member - and other colleagues - around using the work and connections developed through the carers programme to inform the next steps and building in the psychological support element further.

Priority 2

10. The Priority 2 Co-Sponsor noted that the anonymous First Steps to Support phoneline pilot launched in January in Guildford, initially targeting three Key Neighbourhoods and was now scaled across the borough. Several workshops had been held launching the Wheel of Wellbeing across Merstham and Walton South. The Workforce Wellbeing Standards programme had been soft-launched, starting with three businesses then upscaling to fifteen per quarter. The men's mental health offer delivered through Mentell had been extended to the end of August. Another one hundred mental health first aiders had been trained, with a focus on those working with the Gypsy, Roma and Traveller communities and with asylum seekers. The national Service Development Funding for suicide prevention was due to end in March, there was a business case around how to continue supporting that

programme. A bid would be submitted to the Department for Environment Food and Rural Affairs to continue the funding for green social prescribing, focusing on community-based initiatives, for primary care nature interventions to work alongside the GP Integrated Mental Health Service, supporting high intensity users and embedding nature interventions into mental health secondary care pathways. The Secretary of State would be visiting the new therapy garden at St Ebba's Hospital for children and adults with learning disabilities, developed by the community and funded through the Green Health and Wellbeing programme.

11. The Interim Health Integration Policy Lead (SCC) detailed the spotlight item 'Mental Health Investment Fund (MHIF): Round 2 awards':
    - compared to round 1, the round 2 MHIF awards had a wider geographical spread and higher average monetary value of each award at £257,000 compared to £51,000. The average duration of round 1 was 17 months compared to 29 months for round 2. It had taken around two years for most of the funding to be allocated, £5.3 million would be released this year.
    - noted the analysis regarding the Priority 2 Outcomes and Key Neighbourhoods where there was a fairly equal distribution across those, with a slight over-representation in Reigate and Banstead. Regarding the Priority Populations only one out of the twenty-four schemes focused on supporting older people in care homes. Over 60% of the funding was spent on CYP and families, 35% to adults and 4% to older adults.
    - noted that the Surrey-Wide Commissioning Committees in Common (CiC) agreed that the joint executive sponsors have the responsibility to oversee the allocation of the remaining funds to be done at pace.

Dr Pramit Patel joined the meeting at 2.37 pm.

12. A Board member queried what the consultation process would be regarding round 3 of the MHIF funding, ensuring that there is adequate time so that partnership input could be meaningful and asked what the timescale would be for its allocation. The Interim Health Integration Policy Lead (SCC) noted that the agreed recommendation at the Surrey-Wide CiC was that delegated authority be given to set the principles within which the funding would be allocated using partnership working to understand the needs of residents, not to define the specific process. Noted that there was a strong desire to allocate the remaining funding at pace so residents could benefit.
13. A Board member noted caution around pace, that to allocate the remaining funding properly for round 3, co-production takes time to ensure meaningful applications by charities. Noted that round 1 and round 2 had short lead in times, which prevented the co-production of meaningful projects and often applications were not put in. The Vice-Chair noted that it was a balance between the right speed of allocation - affecting the ability of partners to co-produce - and the effective impact on residents. The process would need to be devised and would be tested with partners, acknowledged the need to work at pace.
14. A Board member noted that the MHIF money had been centred around the voluntary sector and that should be celebrated. Noted that a lot of the MHIF money was also centred around particular areas of the county. Queried whether there would be development across the county, particularly for the First Steps to Support phoneline and sought assurance that there would be funding to continue some of the projects beyond the pilot duration. The Priority 2 Co-Sponsor could not currently provide that assurance, as it depended on the outcomes of the phoneline pilot. Regarding longer term funding, consideration was needed around the case for change and the investment request and its source. A Board member added that it was essential that the work around the phoneline is robustly evaluated, responding to the outcomes.

15. The Chair recognised the need to robustly evaluate all the initiatives yet stressed that some of those had the potential to replace business as usual programmes where there is not the same level of evaluation as to their effectiveness in outcomes across agencies, that needed to be resolved.
16. A Board member noted that the First Steps to Support phoneline had been overdue and the figures showed the need in Guildford. Noting the challenging financial situation, if not able to fund the service going forward for example the danger was setting something up and then taking it away which would increase the pressures on charities; the Board must do all it can to support that service.
17. The Chair noted the constant need for charities to fundraise and asked whether there was help for them to find alternative funding to keep them going particularly if pilots are funded for one year. A Board member noted that what would be most helpful was certainty about what the project would be, about the commitment and timescale, then that would help fundraising. Noted that setting up a pilot and service which would later be lost damaged confidence in donors and supporters.
18. A Board member welcomed the targeted funding to CYP in the MHIF round 2 and assurance given around the CYP Emotional Wellbeing and Mental Health Strategy. Noted feedback from parents and young people that the extent of emotional wellbeing and mental health problems was increasing at a faster rate than the services could meet the need. Recognised the hard work across the county through the funded programmes, but noted the need to consider what more could be done by the Board to encourage greater targeting of resources into that area. Prevention at a young age helped establish a positive lifelong trajectory of better emotional wellbeing and mental health.

Priority 3

19. The Priority 3 Sponsor referred to the outcome around community safety that ‘people are safe and feel safe’, the Office of the Police and Crime Commissioner for Surrey (OPCC) had successfully bid to the Home Office for two-year funding for a multi-agency domestic abuse perpetrator programme in Surrey. The programme’s aim was to improve victims’ safety by reducing the risk posed by stalking and domestic abuse perpetrators - as well as children and adolescents who use violence/abuse in their relationships - and to prevent reoffending. The Surrey Against Domestic Abuse Partnership launched its Steps to Change programme which was a virtual hub which would coordinate a multi-agency and trauma informed approach to end abusive behaviours. Surrey County Council and partners had set out plans to eliminate road collisions resulting in deaths or serious injury by 2050, encouraged all to take part in the consultation ending next week on the new draft Surrey RoadSafe Vision Zero Strategy being developed.
20. The CEO (Surrey Coalition of Disabled People) detailed the spotlight item ‘Access to food banks’:
    - disability comes with additional costs such as: heating, insurance, equipment; for every £100 a disabled person’s spending power is £67.
    - the report last year detailed how the cost of living situation was disproportionately affecting disabled people, views were collected via an online survey and 97% said they had been negatively impacted, 43% were no longer able to meet the needs of their impairments, disabled people were five times more likely to be at risk of food insecurity and one in four disabled people had missed a meal because they could not afford it.
    - in 2022, 45% of Coalition members polled reported that they had gone without food and the Trussell Trust reported that more than six in ten working age people referred to food banks in early 2020 were disabled.

- between July 2022 and July 2023 443 disabled households received £250 worth of food vouchers from the Coalition as part of the Government's Household Support Fund. A survey was conducted around the difficulty in accessing food support: 32% had accessed food banks, food clubs and or community cupboards, 62.5% were unable to find information about those services easily and 72% were unaware of what food support was available locally. Accessibility, the referral process, the stigma and transport were identified as barriers; 95% required home delivery.
- worked closely with Public Health to increase the amount of Household Support Fund money available for disabled people. There is now: a map of the local food banks and food sources of support, a disabled person's support coordinator and funding for people to use taxis to food banks.

21. The Priority 3 Sponsor noted that there were other food support offers such as food clubs and many charge a small annual fee to access the produce and that helped remove the stigma. There were also community fridges available.
22. A Board member referred to community fridges which helped tackle food waste and noted that different thinking was needed about the responsible use of food in the wider system, making it a collective issue.

Tracey Faraday-Drake left the meeting at 2.59 pm.

23. The Vice-Chair wondered how that could be triangulated, noting that as a GP for over twenty years in Spelthorne she did not know where the food club or community fridge was, she asked where she could find that out. The Chair added that many councillors would like to have that information mapped. The Priority 3 Sponsor noted that the information on community fridges and food clubs was searchable on Google and was available on Surrey's borough and district council websites. Acknowledged the need to consider how that information is communicated and would highlight that to the Surrey Chief Executives' Group, feeding back to the Vice-Chair who offered support in unblocking that barrier and the Chair.
24. A Board member noted that the point about where people go for information was wider than the community fridges, suggested that it would be useful to look at that more holistically and that was in line with feedback to Healthwatch Surrey about not knowing where to go to get support across the voice services. The Chair noted that the issue about not knowing where to go to access support and not knowing that certain types of support are available would be looked at; noted the need to be more proactive and to use various channels available to target across the demographics. Noted the importance of initiatives where possible to be countywide so they could be easily promoted. A Board member added that it was crucial to consider the single source of truth about what the information is as the devolution of information across places created more outlets without a control over what the quality and the use of the information is.
25. A Board member noted that it is impossible for everybody to know everything all the time, noted that the way people behave was to look for information when they need it. It was important to recognise and use the amount of social capital at place level, noting the work around towns and villages and how to coordinate at a local community level with third sector partners. Noted that at a future Board meeting it would be useful to discuss local area coordination.

RESOLVED:

1. Would use the Highlight Reports and Engagement Slides to increase awareness of delivery against the HWB Strategy and recently published / upcoming JSNA chapters through their organisations.
2. Noted the opportunities/challenges including:

- The Office for the Police and Crime Commissioner for 24/25 and 25/26 has made an allocation for the Changing Futures/Bridge the Gap programme but further sustainability funding is still required from further system partners.
- SCC funding has also been secured through Transformation & Design for a further 12 months for the fuel poverty programme co-ordination.
- Changes in funding for suicide prevention previously highlighted (including training) is creating a significant risk to continued delivery of projects by VCSE providers in the county.
- The HWB Strategy Index continues to progress work on indicators; a scorecard/annual review will come to the June HWB meeting to allow time for a comprehensive suite of indicators to be finalised and included.

Actions/further information to be provided:

1. The ICS Senior Programme Manager - Long Term Planning Delivery (Surrey Heartlands ICB) will liaise with the Board member - and other colleagues - around using the work and connections developed through the Joint Carers Programme to inform the next steps and building in the psychological support element further.
2. The Priority 3 Sponsor will highlight to the Surrey Chief Executives' Group, the need to consider how the information around community fridges and food clubs is communicated to partners including GPs and councillors, feeding that back to the Vice-Chair and Chair.
3. The Chair will liaise with the Public Health team to address the issue about people not knowing where to go to access support and not knowing that certain types of support are available.

6/24 SURREY PHARMACEUTICAL NEEDS ASSESSMENT 2025 - PROPOSED DELIVERY PLAN [Item 6]

Witnesses:

Louis Hall, Public Health Consultant, Surrey County Council
Linda Honey, Director of Pharmacy, NHS Surrey Heartlands

Key points raised in the discussion:

1. The Vice-Chair explained that the purpose of the Pharmaceutical Needs Assessment (PNA) is to describe gaps in current and future service provision related to access and need, and to describe how the community pharmacies can contribute to addressing the health needs of the local population. Every three years the full PNA must be refreshed, Surrey in the past eighteen months had experienced a significant number of pharmacy closures, sixteen. The cumulative impact of those closures on Surrey residents was a concern, particularly the Priority Populations and Key Neighbourhoods.
2. The Public Health Consultant (SCC) noted that:
    - the number of closures was unprecedented, there had been four closures in the previous cycle. Measuring the impact of the closures had been challenging, thanked the Board for their patience.
    - the decision to reopen the full PNA provided a clean slate to respond to questions around pharmaceutical need.
    - the legislation stated what must be included in the PNA in terms of current and future need, and whether the provision of services was sufficient.
    - the provision of services concerned access and availability, the location of pharmacies, how long it takes for people to walk or drive to a pharmacy, the

opening times and what services were provided. How those services were delivered and the quality of those was not in scope.

- the overall purpose of the PNA was to inform those people looking to enter the pharmaceutical market, highlighting the gaps in provision to be filled.
- regarding the measures to understand pharmaceutical needs, the report outlined the key intelligence sources, welcomed other sources being shared.
- data and intelligence was not just about figures, but also about understanding residents' perspective around access and availability, looking at the Priority Populations and mitigating against digital exclusion. Linking with Healthwatch Surrey, the VCSE Alliance and communications teams to work out how to capture that perspective through surveys and consultation.
- in line with national guidance it takes a year to complete the PNA, the team was working through a series of steps and their specified timescales.

3. The Chair noted that Europeans use their pharmacy in the first instance, which triages and provides key services. It would be useful to have comparative data about how communities in France for example are served by their pharmacy. Stressed the need to gather the right information in the PNA as pharmacies played a crucial role in channelling people to the right place and treating patients in line with the national Pharmacy First scheme. Queried how much money would need to be spent to communicate the benefit of using pharmacies in the first instance. The Director of Pharmacy (NHS Surrey Heartlands) explained that it would take time to build the public's confidence in Pharmacy First being the right approach, noted challenges to its delivery such as the abuse suffered by pharmacists and workforce issues.
4. A Board member noted that more people were accessing online pharmacy services, contrary to the Pharmacy First scheme. Queried what the impact of that increase in online use was on pharmacies, would their numbers decrease in the next few years as a result. The Director of Pharmacy (NHS Surrey Heartlands) recognised that patients had more choice around accessing their pharmaceutical services. The number of closures in Surrey mirrored the national trend, and that seemed to be slowing down. Community pharmacies were evolving quickly and were trying to work out their business model, many operated a hub and spoke service similar to the online pharmacy services.
5. The Vice-Chair noted that if the Board was going to commit to open a new PNA, it must do more than follow the rigid PNA process, noted her wish of having a strategic plan for Surrey's pharmacies that includes the national strategic direction of travel regarding their delivery of care to populations, whilst being personalised to Surrey. Noted concerns from a GP perspective that her patients cannot get their medication dosettes delivered without having to pay a delivery charge. Consideration was needed about what services - essential/additional - the pharmacies were providing. The Director of Pharmacy (NHS Surrey Heartlands) noted that the PNA's remit concerned market entry of pharmacies, to get onto the NHS pharmaceutical list they must enter a community pharmacy contractual framework and that details what essential services that pharmacy must provide such as dispensing NHS prescriptions, that did not include the delivery of prescriptions or providing Monitored Dosage Systems (MDS).
6. The Public Health Consultant (SCC) added that some elements of the above comments could be captured in the survey to community pharmacies. The challenge was that because such services were not part of the contract, they could be offered one day and ended the next day. Having a separate document alongside the PNA could be feasible detailing locally commissioned services. The Chair suggested that the Vice-Chair and report authors discuss the matter.
7. A Board member supported the Director of Pharmacy (NHS Surrey Heartlands) regarding the communications plan. Noted that last month the combined meeting of

the local committees did a deep dive on the Pharmacy First scheme, about how to communicate and build public confidence, and how to create the connections between GPs and their local community pharmacists; Surrey Heartlands was committed to develop that. It was challenging as pharmacy numbers declined in the context of the contract and the 8% reduction against the inflationary cost. The Chair noted that pharmacies have real estate which they could leverage in other ways to make money, and wondered whether they could be supported on the matter.

8. A Board member noted that there was an opportunity for a conversation across Surrey about what pharmacies mean in communities. It was important to create the atmosphere where pharmacies want to open, with communities caring about pharmacy provision; the communications strategy must reflect that. Noted that there were many organisations and charities that work with populations that are heavy pharmacy users, noted the importance of listening to them.
9. A Board member noted the importance of listening to the voice of those using pharmacies, for example noted frustrations with a busy pharmacy in Woking.
10. A Board member referred to the strategic aspect, regarding the drivers that mean that either more or less pharmacies were needed. As the Surrey Heartlands Joint Forward Plan sought to move healthcare from hospitals into community services, wondered therefore whether an explicit statement was needed on driving up the need for community pharmacies and driving down the need for the alternatives. Highlighted the need to look at that strategic planning about redevising healthcare regarding what pharmacy service was needed in three years and noted the need to analyse the interrelationships of the various measures and link to the communities work around vulnerabilities.
11. A Board member provided reassurance that Healthwatch Surrey had a huge increase in feedback for people using pharmacies, there were several surveys in areas with pharmacy closures. Noted that it might be possible to use some of those insights to inform the PNA surveys being developed, feedback included: definitions of access with people with disabilities noting that it was not the quickest route to the pharmacy that matters but the most accessible; welcomed the additional measures around access that go beyond the stipulated measures.
12. A Board member highlighted the 2021 guidance to boards about what should be included in PNAs, it was not solely about going to a pharmacy, but about the range of pharmaceutical needs including appliances and a consideration of Priority Populations. Assumed that the team would use that guidance which would help address the points raised and for it to be shared with Board members.
13. The Public Health Consultant (SCC) welcomed the comments noting that was why he flagged the scope in terms of setting expectations that the PNA is a statutory duty with strict legislation about its purpose. However, there was an opportunity with the Pharmacy First scheme to look at the strategic direction and use the broad range of intelligence from quantitative and qualitative data. It was important to understand some of that unmet need for pharmacies, who was going to A&E, their GP or calling NHS 111, before their pharmacy in the first instance. Welcomed being involved in conversations about what is happening with pharmacies to help influence the PNA being developed and sharing intelligence to support partners' work.
14. A Board member stressed the need to ensure that the PNA is not out of date when published.

RESOLVED:

1. Acknowledged the reopening of the Pharmaceutical Needs Assessment (PNA) and noted that this work will supersede the publication of an interim annual statement.
2. Agreed the proposed measures (and provided a steer on additional measures) that will be used to assess pharmaceutical need in the Surrey PNA 2025 (see section 5, table 1).

3. Agreed the timeline (see section 7, table 2) for publication for the Surrey PNA 2025.

Actions/further information to be provided:

1. The Public Health Consultant (SCC) and Director of Pharmacy (NHS Surrey Heartlands) will liaise with the Vice-Chair around the consideration needed about what services - essential/additional - the pharmacies were providing; will consider having a separate document alongside the PNA personalised to Surrey detailing locally commissioned services.
2. The Committee Manager (SCC) will circulate the 2021 national guidance regarding PNAs to Board members.
3. The Public Health Consultant (SCC) and Director of Pharmacy (NHS Surrey Heartlands) will reflect on the comments made by Board members, feeding those into the work on the PNA being developed; and sharing intelligence to support partners' work.

7/24 SURREY HEARTLANDS SYSTEM PLANNING: JOINT FORWARD PLAN UPDATE 2024 [Item 7]

Witnesses:

Dr Charlotte Canniff, HWB Vice-Chair and Joint Chief Medical Officer, Surrey Heartlands ICS
Sue Robertson, Associate Director of Strategic Planning and Integrated Assurance, Surrey Heartlands ICS

Key points raised in the discussion:

1. The Joint Chief Medical Officer (Surrey Heartlands ICS) and Vice-Chair noted that the Surrey Heartlands Joint Forward Plan (JFP) was first published in June 2023 following a broad stakeholder engagement piece, the national guidance required JFPs to be refreshed annually in March. This year, the JFP had been through a light touch refresh strengthening key areas.
2. The Associate Director of Strategic Planning and Integrated Assurance (Surrey Heartlands ICS) noted that:
    - Surrey Heartlands ICS was fortunate to have a one-to-one relationship with the Board, that made developing its Integrated Care Strategy easier.
    - the JFP was part of the delivery plan for the Integrated Care Strategy, which using the Health and Well-Being Strategy Priorities as the golden thread, had identified the three ambitions around: prevention, integration and working together differently.
    - there were many contributors across various sectors to the original JFP and refresh ensuring a comprehensive view. Additional information was condensed into fact files around specific interest areas.
    - Surrey Heartlands ICS had broadened its JFP across non-health sectors.
    - Surrey and Borders Partnership (SABP) colleagues had reviewed and provided comments on the JFP and helped to update some case studies.
    - the Board was asked to provide an updated opinion on the JFP.
    - the Chief Executive, Healthwatch Surrey helped create the summary version using helpful insights.
    - areas strengthened in the light touch refresh: a fact file on prevention had been developed, and more detail had been included on the provider collaboratives in the health service. There was a discussion underway about a broader primary care community-based collaborative.

- the aim was to get it published by the end of March.

3. A Board member queried whether the JFP linked back to the United Surrey Talent Strategy around the workforce. The Associate Director of Strategic Planning and Integrated Assurance (Surrey Heartlands ICS) confirmed that link.

RESOLVED:

1. Noted the Joint Forward Plan 2024 update and its alignment with Surrey's Health and Wellbeing Priorities and strategic approach, and the related Surrey Heartlands Integrated Care Strategy.
2. Would provide an opinion statement of the plan.
3. Noted that the next annual update of the plan will be provided in March 2025.

Actions/further information to be provided:

None.

8/24 HEALTH AND WELLBEING BOARD AND SURREY HEARTLANDS INTEGRATED CARE PARTNERSHIP/INTEGRATED CARE BOARD GOVERNANCE REVIEW [Item 8]

Witnesses:

Phill Austen-Reed, Principal Lead - Health and Wellbeing, Surrey County Council

Key points raised in the discussion:

1. The Chair explained that the proposals in the report sought to rationalise the membership and way the Health and Wellbeing Board (HWB), Surrey Heartlands Integrated Care Partnership (SHICP) and Integrated Care Board (SHICB) operate to avoid repetition. Noted that the proposals were sensible, however the representation of the organisations on the HWB needed to be addressed.
2. The Principal Lead - Health and Wellbeing (SCC) noted that:
    - the Health and Social Care Act 2012 established HWBs; ICPs and ICBs were established in 2022.
    - there had been an opportunity to align the ICP and HWB in coterminous areas however that route was not chosen due to Surrey's unique geography with two Integrated Care Systems (ICSs), Surrey Heartlands ICS had a one-to-one relationship with the HWB whilst Frimley ICS cut across five HWBs.
    - following the establishment of the ICP and ICB over the past eighteen months, it had been recognised that the agendas of those bodies and the HWB contained similar topics and memberships.
    - the Chairs of the HWB, SHICP and SHICB had discussed how to make those bodies more efficient and the proposals sought to address that through the HWB and SHICP to meet on the same day in three parts: business 'in common', HWB specific business such as community safety, and SHICP specific business; and the SHICB to meet that same day.
    - it was proposed that the HWB and SHICP membership be streamlined addressing the issue of the same organisations being represented on both bodies by different people; the level of representation would be protected.
    - officers were working more closely together to align agendas.
    - the aim of the proposals was around improving the oversight and assurance of the delivery of the Health and Well-Being Strategy and Integrated Care Strategy, and other strategies/areas, enabling more collaborative strategic

direction setting and collective decision making, better alignment around the governance, and ensuring more efficient communication.

3. A Board member noted that the number of places given to the VCSE Alliance had improved partnership working, the VCSE Alliance had benefited from having that closer relationship to decision-making; the addition of a Carers System Representative had also been crucial. Stressed the need to maintain the diversity of perspectives through the membership.
4. A Board member noted the alignment between the Integrated Care Strategy's three ambitions - particular the first ambition around prevention - with the Health and Well-Being Strategy. Noted that despite the complexity of the five HWBs within Frimley ICS's geography, there was a good working relationship between those directors of public health to cross-reference. For example, Frimley ICP's membership and key themes were cross-referenced with SHICP.
5. A Board member welcomed the deduplication, however noted that it was important to have clarity in the governance arrangements of how Frimley ICS fits into the equation, offered support in understanding that.
6. A Board member welcomed the reduction in the number of meetings and aligning agendas, however noted a concern in losing certain aspects, for example the VCSE Alliance representatives. Regarding the future structure, asked whether there would still be opportunities for public questions and petitions. The Chair noted that public questions and petitions would remain for the HWB, and would ensure the right representation going forward.

Graham Wareham, Helen Coombes and Rachael Wardell left the meeting at 4.00 pm.

7. A Board member noted the need for clarity around the membership in terms of the separation of strategy (ICP) and operational delivery (ICB) in the ICS, as the ICP and the ICB were set up to have minimal overlap between them. Regarding health representatives, a consideration was needed about whether the combining of memberships would blur that separation; so as not to weaken the voice of non-health representatives. The Chair acknowledged that it was important to protect key areas of business that work in the current framework.
8. A Board member highlighted the challenge around the review of membership which might lead to less individuals participating with 'specialised knowledge or expertise in specific areas relevant to healthcare, social care and population health'. Sought additional detail to understand what specialised knowledge or expertise might be lost or not discussed in the new structure. The Principal Lead - Health and Wellbeing (SCC) noted that it was the first time the proposals have been shared with the three bodies, the concern around the balance of representation would be reflected on as the detail is developed. Emphasised that the streamlining of membership was around reducing the duplication, not about reducing the range of input. The Chair noted feedback that whilst some people were involved in sub-committees/groups, having the opportunity to raise issues directly with partners at the HWB was important.
9. A Board member noted that most HWB members were represented on the SHICP in terms of their organisation or sector. The ICP was not solely about health but the care and wellbeing of Surrey's residents, whilst some expertise might be lost; that could be addressed by bringing in representatives as needed.

Professor Helen Rostill left the meeting at 4.05 pm.

RESOLVED:

Approved that:

1. The HWB and the SHICP operates with one streamlined, membership, with agendas of business designed so they run concurrently in one meeting.
2. The respective membership of the SHICP and HWB are reviewed - to reduce any duplication of organisational representation, whilst retaining existing representation from a wide range of stakeholders, including Frimley ICS.
3. This regular meeting take place on the same day and in the same location as the SHICB to be as efficient as possible for any shared membership between HWB/SHICP and the SHICB.
4. The agendas across the combined HWB/SHICP meetings and the SHICB are planned and coordinated to eliminate duplication.
5. These updated arrangements are considered for possible implementation from May 2024 prior to steps to incorporate changes in relevant Terms of Reference and constitutions by September 2024.
6. The respective boards undertake in the interim to ensure that agenda items are clear in purpose in order to provide assurance, make decisions or seek direction/commitment on key strategic issues related to the respective strategies/plans they are responsible for.
7. Items coming to the respective boards will have been previously discussed at sub-committee level.

Actions/further information to be provided:

1. The Principal Lead - Health and Wellbeing (SCC) and Chair will reflect on the comments raised by Board members particularly around the balance of representation regarding the streamlined membership, as the detail around the proposals is developed.

9/24 INTEGRATED CARE SYSTEMS (ICS) UPDATE [Item 9]

The Chair explained that the reports from Surrey Heartlands ICS and Frimley Health and Care ICS were included for information.

RESOLVED:

Noted the update provided on the recent activity within the Surrey Heartlands Integrated Care System (ICS), and Frimley Health and Care ICS regarding the Integrated Care Partnerships and Integrated Care Boards against the Health and Wellbeing Strategy.

10/24 DATE OF THE NEXT MEETING [Item 10]

The date of the next public meeting was noted as 19 June 2024.

Meeting ended at: 4.07 pm

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Chair

Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	**Health and Well-being Strategy Highlight Report**
HWBS Priority populations:	All
Priority - 1, 2 and/or 3	All
Outcomes/System Capabilities:	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):	Phillip Austen-Reed, Principal Health and Wellbeing Lead, Health and Well-being Team, Public Health, SCC, Phillip.austenreed@surreycc.gov.uk
Board Sponsor(s):	• Karen Brimacombe, Chief Executive, Mole Valley District Council (Priority 1 Sponsor) • Professor Helen Rostill, Deputy Chief Executive Officer, 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, Managing Director, Reigate and Banstead Borough Council (Priority 3 Sponsor)
HWB meeting date:	19 June 2024
Related papers:	None
Annexes/Appendices	Appendix 1 - Highlight Report

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2. Executive summary

This paper provides an overview of the progress in the delivery of the Health and Wellbeing Strategy (HWB Strategy) as of 28 May 2024. The Highlight Report link is available in an accessible, web friendly format, and provides:

- An overview of activity against Health and Wellbeing Strategy's Summary Implementation Plan projects and programmes, describing what has been achieved with the Priority Populations and against the Priorities/Outcomes.
- Examples of collaboration by partners across the Priorities and Priority Populations.
- Identifies new data, insights and challenges that have arisen.
- The progress of the review of the Joint Strategic Needs Assessment (JSNA) chapters.
- Communication activity associated with the HWB Strategy's Priority Populations and Priorities/Outcomes.

3. Recommendations

The Board is asked to:

1. Use the Highlight Reports and Engagement Slides to increase awareness of delivery against the HWB Strategy and recently published / upcoming JSNA chapters through their organisations.

2. Note the opportunities/challenges which include the following:

    - The sharing and use of the updated HWB Strategy Index.
    - The increased focus being seen on health inequalities through Key Neighbourhoods and Priority Populations.
    - The doubling of funding for local stop smoking services for the next 5 years.
    - EOIs being requested for organisations to benefit from workplace wellbeing programme.
    - Workshops to inform topics for the Health Determinants Research Collaboration (HDRC) programme that will boost research capacity and capability within Surrey.
    - The beneficiaries being supported by Bridge the Gap are at significant risk without securing sustained funding from April 2025.
    - The funding for Serious Violence programme finishes on 31 March 2025 and there is currently no indication of a future funding settlement.

4. Detail

Highlight Report - In the Spotlight:

Priority 1
Smoking continues to be a leading cause of ill health, early death and a significant contributor to health inequalities. It is estimated that smoking costs Surrey £950m

per year. Although the proportion of people in Surrey who smoke has been on a decline, there are still about 113,000 smokers (11.9%).

In addition to the Tobacco and Vapes Bill that had been expected to go through parliament until recently, the Government has doubled the amount of funding for local stops smoking services for the next 5 years and an annual grant of £1.1m has been allocated to Surrey for 2024/25. Over the next 5 years Surrey will support an additional 15,000 quit dates to be set. We will work with key stakeholders to increase the demand for, and capacity of our stop smoking services across the county, ensuring all smokers have access to free behavioural support and resources to help them quit for good. This funding will support priority one of the recently published Surrey Tobacco Strategy

Priority 2
Dose of Nature is a mental health charity whose objective is to improve the mental health and wellbeing of individuals by increasing time outside in green spaces. With £100,000 funding from Surrey County Council's Green Social Prescribing budget, their Surrey service of a ten week Dose of Nature Prescription Programme received over 150 referrals from GPs, GPimhs and Social Prescribers attached to 23 GP surgeries across Guildford and Waverley.

This service, delivered as part of Surrey's Green Health & Wellbeing Programme, has been clearly filling a local need, often being able to reach people who might have struggled to attend traditional mental health services. Project evaluation indicates improvements in anxiety, depression and connection to nature following a Dose of Nature prescription.

Following the end of funding in October 2023, Dose of Nature has been able to maintain the successful Surrey hub at Dapdune Wharf through the ongoing success of their original hub in Richmond, as well as the various relationships they have built with Surrey primary care teams and VCSE organisations.

For more information, including on outcomes, contact Jack.Smith@surreycc.gov.uk or read the first-year report here.

Priority 3
Sexual health is critical to the overall health and wellbeing of individuals, families and the development of communities. Whilst delivery of the Surrey Health and Wellbeing Strategy (HWBS) has not previously explicitly included sexual health, its aim of reducing inequalities is highly relevant to sexual health. The drivers of sexual health are also part of all the HWBS priorities as they relate to physical well-being, mental health and emotional well-being and particularly the wider determinants of health.

Particularly, the programme targets include:

- A focus on reaching groups that do not access sexual health services, breaking down barriers and stigma, and promoting good sexual health.

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- An HIV Action Plan which aims to increase awareness around routes of transmissions, increase testing and reduce stigma and improve the lives of people living with HIV.
- The mapping of pharmacies in the 21 Key Neighbourhoods with the aim of ensuring pharmacies are providing emergency contraception, chlamydia testing and treatment, and delivering the new NHS contraception programme.
- Addressing that Surrey is below target for the chlamydia detection rate in under 25s like other counties in the Southeast of England.
- Collaboration with partners to create a whole systems approach to teenage pregnancy prevention via an action plan including a focus on leadership, communication, targeted work, and training.

5. Opportunities/Challenges

5.1 Opportunities

The further development of the HWB Strategy Index - Members should note the web link Health and Wellbeing Strategy Index | Surrey-i (surreyi.gov.uk). A scorecard/ first annual report against the Index has been produced for this meeting and is covered by a separate item. The report highlights indicators where there is a notable direction of travel positive or negative which will require further analysis. Trends across the overarching indicators for inequalities in life expectancy/ healthy life expectancy and county level indicators for the Priority Populations are also reported, creating a baseline for annual reviews.

The enhancement of HWB Strategy analysis and insights capability - Work is progressing to cross-reference all the 14 Strategy outcomes under the 3 Priorities and across the 41 programmes, in order to understand better the linkages including through the lens of the Priority Populations. It will also enable proactive analysis, such as which outcomes have more focus with regards to the number of interventions delivered against them compared with others where there might be fewer interventions.

HWB Strategy review and focus on Priority Populations - Over the next two quarters, the HWB Strategy team will lead an autumn review of the implementation plan. The aim of the review is to strengthen collective delivery towards the Strategy's outcomes and reducing health inequalities. This will focus on assessment with the programme leads of the currency of the milestones and deliverables agreed with them for the plan's refresh last summer. They will also be asked to focus more on how their programmes currently do, or could potentially impact more, on the priority populations, especially where current delivery is on a whole population basis, and including key neighbourhoods.

HWB Strategy highlight report - It is planned to move towards a revolving, six-monthly basis for programmes reporting on a more flexible basis but that can also accommodate any key updates. This would bring benefits of continuing, timely reporting to HWB and residents on a consistent basis around the agreed programme

milestones, whilst providing in each report a clearer and extended narrative around each achievement being highlighted.

Priority 1

There are opportunities through the doubling of funding for local stop smoking services for the next 5 years and an annual grant of £1.1m allocated to Surrey for 2024/25. This means that Surrey will support an additional 15,000 'quit dates'. Working with key stakeholders, Surrey will increase the demand for, and capacity of stop smoking services across the county, ensuring all smokers have access to free behavioural support and resources to help them quit for good.

The Surrey Whole System Food Strategy has been published. It was developed in partnership to focus on three key strands: addressing food insecurity, reducing climate impact of the local food system and supporting the local population to keep a healthy weight by enhancing the accessibility and affordability of nutritious food. The strategy seeks to deliver on outcomes related to Priorities One and Three of the Health and Wellbeing Strategy.

Priority 2

Now that delivery of the larger Mental Health Investment Fund (MHIF) round 2 is underway and progress is to be given oversight by the Mental Health: Prevention Board 'MHIF Oversight Sub-Group', the reporting of these projects' achievements, and any issues or risks, will in future be incorporated within the Priority 2 section of this Highlight Report, alongside the current 13 programmes in the implementation plan. Communications work across Surrey County Council and Surrey Heartlands to highlight the impact of the MHIF are now to be released monthly, to showcase the return on investment this money is having. A press release for Emerge Advocacy is ready to be published once we are out of the pre-election period, with further communications including a media release about Prospero Theatre Company and other Phase 1 projects to follow.

A networking event for the MHIF is being planned for September to celebrate the projects, improve engagement with project partners, facilitate working with wider partners in the system and support sustainability of the projects. There will be a strong focus on evaluation and impact. The MHIF team is at the final stages of agreeing an evaluation framework which will support the impact analysis of the MHIF programme, including being able to demonstrate funded projects' contribution towards the HWB Strategy Priority 2 outcomes. Planning is also underway to deliver on the remaining £1.7m of the MHIF. This follows the Surrey-Wide Commissioning Committees in Common (CiC) agreeing on 20 March that the joint executive sponsors now have the responsibility to oversee allocation of the remaining funds, going through the governance routes of iCAB and CiC.

The Public Health mental health team is seeking expressions of interest from organisations with potential to benefit from the *How are you Surrey?*, a

comprehensive intervention designed to promote mental and emotional wellbeing within any sector organisations in Surrey. The programme brings together evidence-based organisational and individual approaches, incorporating best practices in workforce engagement, mental health support, stigma reduction, and organisational culture change, to create a custom strategy tailored to individual organisational needs. A Framework for Medium and Large Businesses is now published on Healthy Surrey. Expressions of interest to be part of the programme can be made to: workforce.wellbeing@surreycc.gov.uk.

Priority 3
The National Institute of Health Research (NIHR) funding to Health Determinants Research Collaborations (HDRCs) to boost research capacity and capability within local government including Surrey is an opportunity. The funding will seek to embed a culture of research practice at the heart of Surrey County Council's policy making which is relevant to the local population and partner organisations including Districts and Boroughs. Surrey HDRC infrastructure will drive a co-produced research agenda on tackling health inequalities, especially through the wider determinants of health, across all Council directorates. It will enable the implementation of evidence-informed interventions and policy making.

5.2 Challenges

Priority 1
The Changing Futures Programme and the beneficiaries being supported by Bridge the Gap trauma informed outreach are at significant risk without securing sustained funding from April 2025 when the government grant comes to an end. Comprehensive and significant whole system engagement is being conducted to identify and pursue funding sources.

Priority 2
As cited last quarter, the Public Health Principal – Lead for Public Mental Health took an options appraisal ('SDF Suicide Bereavement Funding') to the Surrey-Wide Commissioning Committees in Common in May. This followed changes in the Government's new Suicide Prevention Strategy affecting previous funding streams. £89,514 was approved from the Surrey Heartlands' NHSE allocation to fund the bereavement service. The continuing challenge is to address the remaining £40,000 shortfall to fund the service.

Priority 3
The funding for Serious Violence programme finishes on 31 March 2025 and there is currently no indication of a future funding settlement. This would mean interventions cannot be funded past March 2025 and the staffing support will also end.

6. What communications and engagement has 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.

7. Legal Implications – Monitoring Officer:

The Chair will inform the Board of any legal implications verbally at the meeting.

8. Next steps

The most recent Highlight Report is available at this web link on the Healthy Surrey web page 24 hours after the Board meeting.

The HWB Strategy engagement slides are available on the SCC Community Engagement SharePoint site here.

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Health and Wellbeing Board Highlight Report: June 2024

These Highlight Reports are published following discussion at the quarterly, public Surrey Health & Wellbeing Board meetings.

They provide an overview of the projects and programmes which directly support the delivery of the Surrey Health and Well-being Strategy and report to the Board, plus the latest relevant insights, along with examples of collaboration and communication related to the strategy.

Please circulate more widely in your own organisation and/ or include in your own e-bulletins or newsletters as appropriate.

If there are projects or programmes you would like to connect with, please use the contact details if they are provided in the report or email: healthandwellbeing@surreycc.gov.uk.

Community Vision for Surrey:

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 Surrey system play in its delivery, the Health and Well-Being Strategy sets out Surrey's priorities for reducing health inequalities across the Priority Populations for the next 10 years. It identifies communities that experience poorer health outcomes and who need more support. It also outlines how we are collaborating to drive these improvements, with communities leading the way.

Collaborative working

The following are examples of the work happening between HWB board organisations which are adding value and contributing to the achievement of the Strategy Priorities and Outcomes:

- Following the initial launch of the Surrey HWB Strategy Index in 2023 there has been wide engagement through the HWB sub boards to add to and develop the range of indicators that show where progress is or isn't happening. This has resulted in 20+ new indicators being added into the index which will be updated in June. Alongside these is the first of what are intended to be annual "scorecards" that via the sub boards will indicate where positive changes are happening and where more attention may be appropriate.

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- Innovation for Healthcare Inequalities is leading a Health Checks Pilot that ran from January – December 2023, targeting CORE20Plus5 populations in East Surrey. The programme sought to improve access to Atrial Fibrillation and Familiar Hypercholesterolemia screening and detection for 'at risk' communities. The project's target is to increase the equity of access to cardiovascular disease (CVD) screening programmes. This pilot was delivered in partnership with Public Health, Surrey Heartlands, Health Innovation Kent Surrey and Sussex, with Alliance for Better Care and YMCA East Surrey as key delivery partners. It is focused on individuals under 40 and ethnic minority groups, delivered at over 19 different venues/events across East Surrey. Findings showed that about 267 individuals with health indicators of clinical conditions were provided health education and 183 were escalated to a GP for further care.
- The Mental Health: Prevention Board (MHPB)'s Oversight Sub Group for Mental Health Investment Fund (MHIF) projects is multi-agency and brings expertise on children's and adults' services, and with statutory and VCSE sector members. The group provided a steer in spring to strengthen the reporting processes, and better measure impact including the ability to collate the data on numbers of people being reached and who are supported.
- The Sub Group will take a collective view across the two rounds of projects currently in delivery, the wider children's and adults' commissioned services; and the element where the Council has partnered with the Community Foundation for Surrey. Four of the round one projects were reviewed at its March meeting, with a spotlight on Lucy Rayner Foundation's Counselling Service which is ending and emphasised the need for the final reports to contain clearer data for measuring impact.
- A meeting of the Chair of the Health and Wellbeing (HWB) Board, the Chair of the Surrey Safeguarding Children's Partnership and Chair of the Surrey Safeguarding Adults Board, and officers met initially to explore a better way of working between the Health and Wellbeing Board, the Safeguarding Adults Board and Safeguarding Children Partnership. This will lead to more action focused items on issues that align across the three boards where all can contribute.
- As part of a collaboration between First Community Health and Care, CSH Surrey, SCC, Surrey Heartlands and the voluntary and charity sector, over the past year the inclusion team at Children and Family Health Surrey has set up Community Kitchens, a mental health initiative to support asylum seekers in the local community. The initiative, which has been funded by SCC, and is being delivered with the help and support of local volunteers and charities, who provide kitchens and dining areas in venues including churches and village halls, brings communities together to share mealtimes, experiences and to connect, helping to build friendships and helping these individuals and families adapt to their new lives.

  The team started the Community Kitchens to support asylum seekers in Surrey, who are living in hotel accommodation, often feeling isolated and with

limited access to healthy, nutritious meals that are familiar to them and reflect their cultural heritage. Community Kitchens bring people together, giving them a place where they can prepare healthy meals of their choice using fresh ingredients. They cook and eat together in a friendly and relaxed environment, where they can socialise, share stories and enjoy time together. The project also offers a Level 2 Food Hygiene certificate for chefs who are supporting the kitchens to help them seek employment if they are applying for jobs in hospitality. Find out more at community kitchens video

- Surrey Whole System Food Strategy has been published. The strategy was developed in partnership to focus on three key strands: addressing food insecurity, reducing climate impact of the local food system and supporting the local population to keep a healthy weight by enhancing the accessibility and affordability of nutritious food. The strategy seeks to deliver on outcomes related to Priorities One and Three of the Health and Wellbeing Strategy.

Priority 1 Highlights

Priority sponsor: Karen Brimacombe. Chief Executive, Mole Valley District Council
Programme Manager: Olusegun Awolaran, Policy and Programme Manager, Surrey County Council (SCC)

In the spotlight – Surrey Tobacco Control

Smoking continues to be a leading cause of ill health, early death and a significant contributor to health inequalities. It is estimated that smoking costs Surrey £950m per year:

- £649m is attributed to productivity
- £259m is attributed to social care costs
- £35.3m relates to healthcare costs
- Also related to fires, result in annual losses of £6.9m, about 42 smoking related fires are attended by SFRS.

Although the proportion of people in Surrey who smoke has been on a decline, there are still about 113,000 smokers (11.9%).

In addition to the Tobacco and Vapes Bill that had been expected to go through parliament until recently, the Government has doubled the amount of funding for local stops smoking services for the next 5 years and an annual grant of £1.1m has been allocated to Surrey for 2024/25. Over the next 5 years Surrey will support an additional 15,000 quit dates to be set. We will work with key stakeholders to increase the demand for, and capacity of our stop smoking services across the county, ensuring all smokers have access to free behavioural support and resources to help them quit for good. This funding will support priority one of the recently published Surrey Tobacco Strategy

The Southeast Association of Directors of Public Health published an updated Position Statement on Vaping, and this document has the latest evidence, regulation, guidance and training on vaping. This has been shared with a range of networks

such as the Tobacco Alliance Network, the NHS Long-Term-Plan Tobacco programme and now the Health and Wellbeing Board.

5

Outcomes

1 People have a healthy weight and are active

- To support the implementation of a whole system approach to healthy weight in maternity, early years and education, a series of webinars are being developed by public health around food and wellbeing for pregnancy, first 100 days, primary and teen ages.
- A new contract for the 'Be Your Best' programme has been awarded to Active Surrey by Public Health for the next four years. This programme will be delivered to children within the age range of 5 -17 years inclusive, to meet a gap in support for this age group.

2 Substance misuse is low (drugs/alcohol & smoking)

- Additional post within Catch 22 to support the reduction of drug-related suspensions and exclusions is now in place
- Existing supplemental substance misuse treatment grant commissioned posts and residential rehabilitation placements to continue.

3 The needs of those experiencing multiple disadvantages are met

- Two specialist Bridge the Gap outreach workers presented their work supporting the most vulnerable individuals in Surrey at a cross-government meeting in May. Representatives from central government and communities heard about the integrative support the workers provide through the Surrey Bridge the Gap programme and how this work provides value for money and cost-effective system outcomes.
- Changing Futures presented at a national conference alongside Alliance for Better Care to promote the benefits of specialist services to support health inclusion populations including multiple disadvantage and Migrants/Refugees.
- The Changing Futures lived experience peer employment programme's efforts were acknowledged with a Silver Charter Award.

4 Serious conditions and diseases are prevented

- In a bid to develop diabetes care for children and young people, 14 schools and early years settings have signed up to the ELSA Type 1 Diabetes NIHR Screening Study. Many people whose family members already have Type 1 Diabetes are already signing up.
- Surrey Heartlands, Living Well Taking Control and Public Health are working together to target Key Neighbourhoods to address the current lower levels of referral and uptake of NHS Health Checks. Work has been initiated to strengthen connection with community and faith groups, with direct outreach to Surrey Minority Ethnic Forum and Active Surrey, for example.
- A Macmillan researcher based in SCC has begun work on a cancer inequalities research programme. A scoping and prioritisation piece of work is

currently being conducted in collaboration with Surrey Heartlands and Macmillan and will identify key inequalities along the cancer care continuum.

5 People are supported to live well independently for as long as possible

- A Hoarding training offer for members of the Surrey Multi Agency Hoarding Group was commissioned by SCC and the training has started. The goal of the training was that people's awareness around Hoarding would be raised significantly. To date about 350 people across different agencies in Surrey have attended a practice learning event. Similarly, a SharePoint site has been designed to host information and advice to assist professional staff in their role where they identify people in Surrey with hoarding behaviours.
- In March 2024, Active Surrey together with Surrey Downs, with input from Public Health developed a Falls awareness raising training package for frontline healthcare staff, and a patient checklist to enable patients to take steps to reduce their risk of falling. This training has been delivered to various PCN's in Surrey Downs place and there is potentially the option to deliver an 'on demand' version to other Places in Surrey.
- The new Carers Partnership Group was established in March 2024 with 9 unpaid carers as members, totally 75% of the membership. This is a first step to implementing the new Carers Programme Governance.

Priority 2

Priority sponsors:

Professor Helen Rostill, Deputy Chief Executive Officer, Surrey and Borders NHS Foundation Trust 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

In the spotlight – Green Health & Wellbeing Programme: Dose of Nature

Dose of Nature is a mental health charity whose objective is to improve the mental health and wellbeing of individuals by increasing time outside in green spaces and engagement with the natural world, building realistic and sustainable habits. It delivers ‘nature prescriptions’ to people referred by their GP with a wide range of mental health issues, including depression, anxiety, trauma, addiction, and bereavement.

With £100,000 funding from SCC’s Green Social Prescribing budget, their Surrey service opened on the Dapdune Wharf National Trust site at the end of 2022. Since then, they have received over 150 referrals from GPs, GPimhs and Social Prescribers attached to 23 GP surgeries across Guildford and Waverley.

The 10-week Dose of Nature Prescription Programme includes a Psychologist assessment and review, and 8, one-hour long, 1:1 weekly sessions with a Nature

Guide in nature and green spaces. In addition, clients are offered a variety of nature-based activity groups, including art, walking groups, yoga, tai-chi and bird watching.

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The service has been clearly filling a local need, often being able to reach people who might have struggled to attend traditional mental health services, or who have been through the system many times before. The engagement rate is 83% at the point of assessment, rising to 97% at the point of beginning sessions. Outcome data using empirical measures indicates improvements in anxiety, depression and connection to nature following a Dose of Nature prescription.

Following their funding ending in October 2023, Dose of Nature has been able to maintain the successful Surrey hub at Dapdune Wharf through the ongoing success of their original hub in Richmond, as well as the various relationships they have built with Surrey primary care teams and VCSE organisations.

For more information, including on outcomes, contact Jack.Smith@surreycc.gov.uk or read the first year report here.

Outcomes

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

- The Sleep Strategy Survey and interviews are complete, with a report in progress. A spring campaign led to over 200,000 website impressions.
- In the men's mental health programme, Andy's Man Club Woking continues to attract 60-70 men a week in a new venue; a new group is operating in Guilford; and Men's Pit Stops continue to be offered in Merstham.
- An extended End Stigma Survey had 232 responses (compared to 141 previously), with results now being analysed for reporting next quarter.
- Consultation on revision of The Surrey Suicide Prevention Strategy is underway, which will include reviewing the Alison Todd Suicide Prevention protocol.

2. The emotional well-being of parents and caregivers, babies and children are supported

- There is good progress on creating a universal Wellbeing Plan for Children & Young People (CYP) in Surrey, ready for Feeling Good Week activity during 7 - 11 October 2024.
- The CYP Emotional Wellbeing & Mental Health Communications and Engagement Partnership is ensuring sufficient exam communications around stress are being planned and shared across the Surrey system.
- Available support for parents and carers is being collated ready for the 2024-25 school year, around their children's physical and mental health as well as their own emotional wellbeing.

- A Self-Harm Protocol is being produced under the CYP Emotional Wellbeing & Mental Health Strategy to provide guidance for professionals, under NICE guidelines.
- 139 young people/ adults (14 - 39 years old) received counselling services by the Lucy Raynor Foundation, funded under Round 1 of the Mental Health Investment Fund, to prevent them from reaching crisis and provide them with tools and techniques to improve their emotional wellbeing and mental health.

3. Isolation is prevented and those that feel isolated are supported

- Under the Green Health & Wellbeing programme, nine young people not in work completed 9-12 weeks in the First Step Green Volunteering programme, with early outcomes of increased confidence, skills learning and interviews for traineeships.
- The programme has scheduled two 'Out In The Field' nature retreats for 40 primary care staff for June, and a Nature Health Facilitator accredited training course is planned for 8 of these staff.
- There is also project scoping to develop a green health eco-system around Horsell Common, utilising space as a health asset for the Woking community and Health and Care Partnerships for example through walks, therapeutic space, peer support groups and a community garden.

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

- First Steps to Support Pilot areas are now extended to boroughs of Waverley and Woking Broughs, and to care homes, and launch of Chatbox pilot so that the First Steps programme is made available across Surrey.
- The gambling awareness campaign ran mid-April until the end of May, resulting in 1,080,267 impressions and 2,876 clicks in its first two weeks. It will be evaluated for its impact on raising awareness of, and access to, support services, with results feeding into the needs assessment and strategic approach.
- Early enlisters (MACRO, Barratt Homes and Beard Construction) are lined up for roll out of the Workforce Wellbeing programme. The framework is now being refreshing for small organisations and an accreditation process is being developed in partnership with Bracknell Forest.
- This 'How Are You Programme' is now registered into a National Institute for Health & Care Research sponsored free network of workforce wellbeing programmes.
- In Public Health's community capacity building prototype in East Surrey, a Community Peer Researcher pilot has been developed as part of a relationship campaign, and which is targeting men's mental health.
- A Community Action Plan developed by Reigate & Banstead has also been supported, particularly around addressing gaps in housing following mapping of resident needs.

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- Three mental health training courses being delivered by the end of June are fully booked. Planning is underway to match key groups to the best evidence-based training, based on ‘Making Every Contact Count’. The training offer has included support to Woking Street Angels, Surrey Fire and Rescue, private construction companies and a parent group provider.

Priority 3

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

In the spotlight – Surrey Sexual Health Programme
Sexual health is critical to the overall health and well-being of individuals, families and the development of communities and has recently been brought into direct scope of delivery of the Surrey Health and Wellbeing Strategy (HWBS) due to its aim of reducing inequalities, which is highly relevant to sexual health and its outcome ‘Serious conditions and diseases are prevented’.

Particularly targeted elements include:

- A focus on reaching groups that do not access sexual health services, breaking down barriers and stigma, and promoting good sexual health. Public Health has developed a joint outreach action plan with the Sexual Health Service outreach team to focus on key priority populations and explore ideas and interventions for engagement.
- An HIV Action Plan which aims to increase awareness around routes of transmissions, increase testing and reduce stigma and improve the lives of people living with HIV.
- The mapping of pharmacies in the 21 Key Neighbourhoods with the aim of ensuring pharmacies are providing emergency contraception, chlamydia testing and treatment, and delivering the new NHS contraception programme.
- Addressing that Surrey is below target for the chlamydia detection rate in under 25s, rather than increasing testing in the general population, to increase our detection rate, the targeted testing approach is used to enable improvements in relevant priority populations.
- Collaboration with partners to create a whole systems approach to teenage pregnancy prevention via an action plan including a focus on leadership, communication, targeted work, and training.

Outcomes

People's basic needs are met (food security, poverty, housing strategy)

- SCC's Warm Welcome scheme launched on 1 November 2023, has closed for this year, with over 40,000 residents attending the sessions across winter, as against around 16,000 visits in 2022-2023. It distributed 1,134 fuel vouchers and almost 9,000 winter essentials to residents. Energy advice and debt support was provided to 4,699 attendees and the feedback SCC have received has been overwhelmingly positive. A review of feedback and findings from this winter will be conducted and the findings will inform planning what changes may need to be made ahead of winter 2024-25.
- Surrey Community Action have been successful in their funding bid submission to the Fuel Poverty programme and will continue to provide energy support to residents in Surrey for another 12 months through their Warmth Matters scheme. This year, they plan to do more work engaging with key demographics who are at particular risk of experiencing fuel poverty. This includes targeted projects to assist older people, the GRT community, those living in rural areas and residents with disabilities.

Children, young people and adults are empowered in their communities

- A programme of personal development courses for residents at risk of escalating care and support needs is being delivered through local libraries. Residents who are 18 years or over, at risk of requiring more formal ASC support in the future and need support to find the correct support at the correct time can be referred to for this through this link.

- In Our Own Words (young people's) peer research project is now in the implementation phase, research training being delivered to a group of recruited neuro-diverse young people who will have research questions developed and reviewed by supporters (officers/strategic leads in the system) by the end of June.

People access training and employment opportunities within a sustainable economy

- The SCC Work Wise programme is a free employment service available to any person with a mental or physical health condition, disability, or neurodivergence, who wants to work. The programme is now fully live and accepting referrals. For more information and referrals, follow this link.

People are safe and feel safe (community safety including domestic abuse; safeguarding)

- The Sanctuary Scheme offers households the choice of remaining in their homes where suitable, appropriate, and where the domestic abuse perpetrator is no longer resident in the property. As at March 2024, the

Sanctuary Scheme has fitted 277 security measures in the homes of survivors across Surrey.

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- A Violence Against Women and Girls (VAWG) Needs Assessment Working Group, jointly chaired by SCC and Surrey Police, has been created and is overseen by the VAWG Executive. This partnership is in the initial stage of identifying organizational working definitions for VAWG and initial data collection. Findings from the VAWG Needs Assessment will be incorporated to create a partnership action plan to address VAWG in Surrey.
- The Surrey Serious Violence Needs Assessment has been completed and signed off by the Surrey Serious Violence Reduction Partnership and has also been submitted to the Home Office as part of the funding agreement.

The benefits of healthy environments for people are valued and maximised (including through transport and land use planning)

- In creating the infrastructure for delivery of the Green Health and Wellbeing programme, work is ongoing to create improved search functions on ‘Connect to Support Surrey’ for professionals and the public who may be looking for nature-based activities/care & support options in localities.
- SCC has worked with residents and community groups to plant over 36,000 new trees across the county. The council remains on track to plant 1.2 million trees by 2030, marking one for every resident. Since the launch of the initiative in 2019, over 510,744 trees have now been planted across the county. This year, 1952 meters of new hedgerows have been planted during this year’s tree planting season, offering habitats for wildlife.
- Funding has been secured for the Guildford to Godalming cycling and walking corridor via bids to Active Travel England (ATE) and National Highways (NH) Designated Funds. In total circa £5M has been secured from ATE and NH plus local funding from Waverley Community Infrastructure Levy bid. The total investment in the corridor being circa £6.25M with the balance of funding underwritten by the Surrey Infrastructure Programme.

Data, insights and challenges:

Healthwatch Surrey, Giving Carers a Voice and Combating Drugs Partnership Public Involvement are all part of the wider Luminus organisation, shining a light on what matters to people.

Priority Population - Carers and young carers

Giving Carers a Voice, delivered by Luminus, ensures the voices of unpaid carers of all ages are heard across Surrey, helping services adapt to meet their needs and supporting the vital role that Surrey's unpaid carers play. In January – March 2024, they spoke to 235 carers (including young carers) across Surrey. Highlighted in their quarterly report Giving Carers a Voice: Reports - LUMINUS (luminus-cic.uk) is the difference that listening to carers can have (often relating to hospital discharge). In Healthwatch Surrey's report Carers' experiences of hospital discharge - Summer 2021 - Healthwatch Surrey, one of their recommendations was to view discharge as a handover of care. Many people are being sent home to continue their recovery and need care and support, much of which will be provided by informal, unpaid carer.

"Recently my son has had a better experience with the home treatment team… They've made proper use of me, checking in with me [as his mum and carer] to see is there anything they need to know before they go and see him, asking me what is the best way of contacting him etc. The proper human touch."

"My wife is in hospital at the moment with a broken pelvis… Yesterday there was a meeting in the hospital about her care and apparently a decision was made that carers would be popping in in the morning and afternoon. What does that mean? They haven't even visited the house to assess it, so how can they possibly know what her needs are? I wasn't present at the meeting as I wasn't told about it. I had to keep asking for the details… They don't know what a carer is and what they have to do."

"My wife has early onset dementia, Lewy body… I went in to visit her [in hospital] on Monday this week, only to be informed that she was going to be discharged to a care home on Tuesday morning... No one has discussed this with me or thought to ask if this was ok. Not one person has asked if I'm a carer or how I'm coping. I have really just been ignored..."

Giving Carers a Voice also heard some positive feedback about the positive impact on carers where support is available:

"Hospital visits have become the norm in our family now, and I would be lost without the support of this Home-Start group."

“I come to the [Cameo Day Centre] Carers Cafe and sit and talk to others in the same situation. If I can help someone else going through the same thing, that's great. It's nice just to have a chat and share things. You pick up all sorts of ideas and tips about services and what helps.”

They continue to hear from young carers about the importance of having someone to listen to them:

“I enjoy coming to My Time for Young Carers because everyone is kind and I know I can talk to people if I'm worried.”

“My mum has Fibromyalgia and needs my help when she has a flare-up, as she cannot do anything when that happens, which is quite often. I do all the gardening as well as help mum with cooking and cleaning. There aren't enough youth groups for young carers. I telephoned Surrey Young Carers and was told that Action for Carers Surrey lost their funding and does not offer support once you turn 16. I'm 17 and left with no support at all. It doesn't have to be in a hall; a coffee shop would be just as good. I enjoy cycling, and it would be nice if a cycling event could be arranged for young carers to take part in.”

Priority Population - Children with additional needs and disabilities

Both Healthwatch Surrey and Giving Carers a Voice (delivered by Luminus) continue to hear from parent carers about their difficulties with EHCPs (Education, Health and Care Plans) and also long waiting times for ADHD diagnoses and the impact this wait can have:

“I’m tearing my hair out. We just had the EHCP through for my younger son and that took one day short of 42 weeks. Trying to deal with all the appointments and paperwork for everything is very challenging.”

“I'm waiting for an ADHD diagnosis [for my daughter]. The waiting list is very long and in the meantime, my daughter is self-harming.”

“My granddaughter is currently living with me and my husband… It's a nightmare, I'm caring for her but I'm exhausted and frustrated. She has lots of mental health issues and is on the waiting list to be assessed by CAMHS for ADHD. Told it will be ages and ages. She turned 18 in December and all support ceased immediately. We didn't get a transition period or handover to adult social services. I really, really need help. I called beginning of January and explained and I’ve not heard anything back. She becomes so violent and unpredictable. She spends most of the day in bed and is awake all night causing us total disruption. She has tried to engage with

services but it doesn't work for her so she leaves. I'm stressed literally all of the time."

Priority Population - People with drug and alcohol problems

The Combating Drugs Partnership Public Involvement service (delivered by Luminus), delivers a bespoke and independent public engagement service for those in Surrey who may be affected by substance use.

Between January and March 2024, they spoke to 164 people.

Their video case study highlights barriers to treatment, impacted on by people's health and wellbeing:

- Unconventional lifestyle / hard to conform to rigid processes.
- Dual diagnosis (mental health and substance use needs).
- Hierarchy of needs (food).
- Flexibility of appointments (mornings, set appointments).
- Anxiety around appointments (formality, no smoking).
- Difficulty travelling across the county (no transport, moving on foot).
- Phone difficulties (no credit/broken/borrowed phones etc.)

They also contributed insight to help in the development of the Joint Strategic Needs Assessment (JSNA) chapter on substance use.

Priority 1 (Supporting people to lead healthy lives by preventing physical ill health and promoting physical well-being).

Healthwatch Surrey contributed to the national research by Healthwatch England which was published on 1 May 2024 – Pharmacy: What people want, by contributing local insight. This research shows that community pharmacies are widely used and valued for their accessibility. It also highlighted both the benefits and barriers of the Pharmacy First service, calling for greater communication around this. The negative impact of medication shortages, prescription costs and pharmacy closures were also highlighted. Healthwatch Surrey have also undertaken a survey in 3 areas of Surrey where pharmacy closures have taken place to understand the impact on local people. This survey has just closed and findings will be published later this month.

Priority 2 (Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being)

From what Healthwatch Surrey hear when talking to the public, one of the biggest challenges regarding prevention of ill health and promoting wellbeing is that people are not aware of the range of supportive services that are available. As part of their work, provide information and guidance on accessing services through the NHS App and other digital related services. One example of this, highlighted in their Quarterly impact report - Quarter 4 (January to March 2024) - Healthwatch Surrey occurred when they attended a community breakfast at a church in Camberley and spoke to a person who had concerns about the challenges around digital access to services

alongside caring for her husband. In talking it transpired that her caring responsibilities had changed over time but, not identifying as a carer, she hadn't accessed any support services. Healthwatch Surrey were able to provide information about different ways to book appointments with her GP practice and also signpost to support in her caring role.

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Priority 3 (Supporting people to reach their potential by addressing the wider determinants of health)
In 2022, SCC took a decisive step by introducing Local Area Coordination to fulfil the system-wide commitment of supporting independence, promoting prevention, and addressing health inequalities within Surrey. Two years on, an independent evaluation outlines the successful implementation and positive impact of Local Area Coordination in Surrey. In a relatively short time, Surrey have achieved several successes across the following domains: people, community, and systems. The findings of the evaluation are based on the data from resident interviews and stakeholder interviews. The results show as follows:

In the people domain, residents highlighted the positive and wide-ranging impact local area coordinators (LAC) have had on them as they have walked alongside in Surrey. The achieved outcomes reported by residents, following their interaction with LAC are diverse, but primarily centred around community integration and practical assistance.

In the community domain, stakeholders highlighted that the overarching aims and objectives of LAC were clearly defined from the beginning, and coordinators spoke positively about their induction process. Stakeholders seem to have embraced the model, which has resulted in changes to management practices and increased collaborative efforts.

In the systems domain, the findings obtained from stakeholders who were from the LAC leadership group provided an understanding of the growth of LAC and its broader impact at a systems level. Respondents noted that there is a seamless integration of LAC into the wider system in Surrey and the successes realised were through purposeful engagements with senior partners, carefully planned implementation process, and the establishment of permanent roles (see full report here).

JSNA update

Chapters published: One chapter has been published in the last quarter.

Priority 1:

A new Joint Strategic Needs Assessment (JSNA) chapter on **Substance Misuse** in Surrey has been published. This chapter was developed with Surrey's Combating Drugs Partnership, which includes health, local authority, criminal justice, and community partners with Luminus capturing the lived experience of people affected by alcohol and drugs. The chapter is accompanied by an interactive Tableau

dashboard. The chapter highlights that alcohol and drug use causes harm not only to individuals but to families and communities and costs millions of pounds every year in dealing with the associated heath problems, loss of productivity, children and adult social care costs and drug related crime and disorder, with problematic alcohol and drug use being a pathway to poverty, leading to family breakdown, crime, debt, homelessness and child neglect. The chapter looks at the data and lived experience stories to look at the best ways to prevent and reduce substance misuse, provide hep to those in need and create a healthier, safer environment for everyone.

Chapters to be published:

Priority 1

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). Phase 1 will focus on adults experiencing multiple disadvantage – this will be published in early 2024. Phase 2 will focus on children and young people and families experiencing multiple disadvantage and the transition between children and adults. This chapter is being co-produced with Experts by Experience. Phase 1 is nearing completion and is going through internal sign-off processes.

Tobacco Control – development has started, a first draft of the chapter has been completed using much of the insight gathered for the Tobacco Control Strategy.

Food and Health – development has started, chapter is being scoped and data sources identified.

Priority 2

Loneliness and social isolation **– chapter is being written, with much of the research and data analysis conducted.**

Priority 3

Economy – development has started, the final draft is now being produced alongside the Tableau dashboard.

Community Safety – development has started, chapter is being scoped.

Air quality – development planned to start in 2024/25.

Priority Populations: see Multiple Disadvantage above for People experiencing domestic abuse; People with serious mental illness; People with drug and alcohol problems; People experiencing homelessness

Other

Armed Forces and Military Veterans – Development has started, chapter is being scoped and data sources identified.

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HWB Board Communications Group update

Priority population - People with learning disabilities & their carers

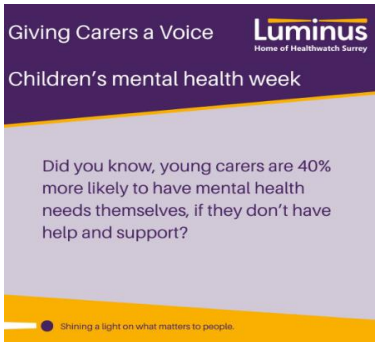
Families set to benefit from new short breaks accommodation being built in Woking helped mark the official start of work at a milestone groundbreaking ceremony. The purpose-built £5.7m facility will enable autistic people and those with learning disabilities to enjoy new experiences while their families take a break from caring. It's part of SCC's drive to create the right homes with the right support for people who need it and represents a major investment in specialist accommodation to help people achieve greater independence. The new accommodation on the site of the old Lakers Youth Centre will provide eight ensuite bedrooms as well as a sensory room, a communal lounge/dining room and landscaped gardens. It will provide the first such service in that part of the county and will ultimately add almost 2,500 nights of additional short breaks capacity per year for adults with additional and complex needs.

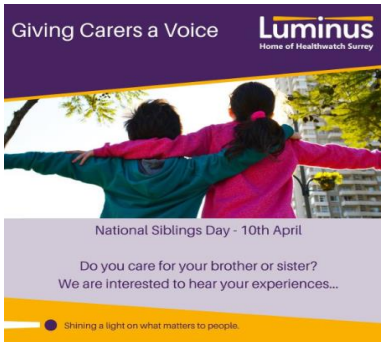
The event marked the first "spade in the ground" for an ambitious county council strategy which aims to deliver more than 1,400 units of specialist accommodation for adults with support needs across Surrey. Communication about the planned new accommodation and wider strategy included videos and a media release leading to coverage across a range of outlets and channels.

Each month 'Giving Carers a Voice' (Healthwatch Surrey/Luminus) calls for evidence via social media, which when relevant, also provides information and signposting to services.

The last 3 months covered:

- In February, in line with children's mental health week, where the theme was My Voice Matters, 'Giving Carers a Voice' asked young carers to share their experiences if they had accessed a service and how they would look after their wellbeing.
- In March, the focus was on #YoungCarersActionDay.
- In April, as it was National Siblings Day, and Giving Carers a Voice asked people if they cared for their brother and sister and invited them to share their experiences with us.





Giving Carers a Voice also shared the opportunity to join the Direct Payments Committee and the Carers Partnership Group who were looking for carer representatives, as well as the Surrey Carers Partnership group Co-Chair opportunity.

Priority Population - Children with additional needs and disabilities/Adults with learning disabilities and/or autism

Healthwatch Surrey are working in partnership with local organisations and community groups to gather neurodivergent people's experiences of hospital care. They are visiting local groups and attending community engagement sessions and have also created a survey to ask neurodivergent people (or their parents or carers) for their experiences of local hospitals as an outpatient.

Priority Population - People with long term health conditions, disabilities or sensory impairments.

Healthwatch Surrey were commended in the National Healthwatch Impact Awards. This followed their work with a local resident, Chantelle, who has a learning disability and is a wheelchair user. She shared with Healthwatch Surrey that she was unable to access cancer screening. Healthwatch Surrey's video tells Chantelle's experience.

Priority Population - Older people 80+ and those in care homes

To support SCC's communications awareness campaign to ensure people who are thinking about their future care needs have the right information, Healthwatch Surrey ran a survey to ask what people currently consider when they are planning future care and where they might go for information.

Priority Population - People with drug and alcohol use - As part of our wider Luminus team, the Combating Drugs Partnership Public Involvement continued to promote their survey asking if people are worried about their or someone else's alcohol or drug intake. The idea behind the survey is to understand more about people's barriers to information and treatment.

Priority 1

Measles: Together with partners SCC are working to encourage people to take up the offer of the Measles, Mumps, Rubella (MMR) vaccine, particularly in children and those aged 19-25 years. SCC have been running a digital advertising campaign targeted at parents, carers and under vaccinated communities. Posters were delivered to community and health settings. As well as amplifying messages through the media, social media and schools, GP practices in areas of lower uptake are also working to increase vaccination rates, all of which is being supported by the national catch-up campaign. Easy read leaflets were designed and delivered by outreach teams to specific communities. Targeted communications work is also planned, where we will be working with communities to co-design localised materials.

Promotion of Covid-19 spring booster vaccinations to eligible cohorts: This has continued and included digital and social media content to promote the offer across social media platforms, targeted to communities and areas of lower uptake, which are often linked to areas of health inequalities and our key neighbourhoods. This campaign is aimed at people in eligible groups and included activity aimed at people aged 75 years and over, those in care homes, and those aged 6 months and over with a weakened immune system.

Pharmacy First: Following the launch of the national Pharmacy First service at the end of January 2024, the Surrey Heartlands launched a local campaign to raise awareness of the new service and the seven conditions that pharmacies can now treat under the new service specification. The campaign included internal and external communications activity including social media, a media release and radio work to raise awareness and increase use of the service. The audience for campaign activity has been broad and will include a number of our Priority Populations. This campaign links to Priority 1 and disease prevention, with more support available in a community setting to aid earlier diagnosis and treatment.

Dental health: As Healthwatch Surrey continue to hear from people regarding problems with finding NHS dentists, they highlighted the launch of the government's NHS Dental Recovery Plan, as well as highlighting the NHS website link regarding dentists and also reminding people of their Helpdesk service.

Specsavers Surrey Youth Games: Target audience is Children and Young People in Lower Super Output Areas (LSOAs) in either the 1st, 2nd, 3rd or 4th deciles on the Income Deprivation Affecting Children Index (IDACI) domain. We conducted a promotion to drive registrations to the free offer of 6-8 weeks of activity training in Spring 2024 for Boccia, Swimming, Tennis, Girls Touch Rugby, Street Basketball, Judo, Dance, and the Run, Bike Row Challenge. All participants are beginners aged between 7-16. Sessions are running from April – June 2024 in 9 Boroughs and Districts in Surrey. To end of April 2024, we have received over 1000 registrations.

Friday Night Project: Target audience is young people aged 11 – 16 who haven't been able to access mainstream sport and physical activity settings before. The project is promoted via Email, Instagram, Facebook, Active Surrey Website and the Activating Your Community Newsletter. Each project also has their own FNP flyer that they promote across their networks and social media channels.

Step OUT to Step IN: Target audience is young people aged 11 – 16 who are at risk of offending or engaging in antisocial behaviour. Communications include email, Instagram, Facebook, Active Surrey Website, Activating Your Community Newsletter.

'Club 4' – School Holidays and Food: Target audience is children in school years Reception in receipt of benefits related free school meals (FSMs). The DFE has funded local authorities to run fully funded Holiday Activity & Food camps for children who receive FSMs. These camps – known as 'Club4' in Surrey – run in the Easter, summer and Christmas holidays and offer healthy food and fun activities for eligible children aged 4-16. Active Surrey are working with trusted and vetted activity providers to run the Club4 programme on behalf of Surrey County Council. The programme is communicated to service users via a voucher (email or text) through the Holiday Activities platform (via their school). This is received by the eligible parent/carer who can then access the booking system.

Surrey School Games / Sports Crew / Physifun / Active Play / First Steps to Leadership. Target audience is Surrey Schools KS1, KS2, KS3 and KS4. Aims to ensure people have a healthy weight and are active and serious conditions and diseases are prevented. These programmes are regularly promoted through social channels and school newsletters.

Health Resource Hub Refresh: Target audiences (primary/secondary) are – Health and Care Professionals and Volunteers; any professional in a resident facing role. Web content and navigation have been updated to enhance user experience. The aim of the hub is to firstly, upskill health and care professionals to understand the benefits and importance of physical activity to enable them to incorporate physical activity into more conversations with patients and clients, and secondly, provide resources and signposting to physical activities to help prevent and manage long-term health conditions. See Professionals Resource Hub | Health | Active Surrey

Female Activity Champions / Train to Gain: Target audience is females from minority ethnic groups plus other females that have barriers to participation. Flyers promoting sessions and opportunities were distributed, along with Whatsapp messages, attendance at community events, meetings with partners.

Hoarding Awareness Week: In recognition of May 13-17 being designated as national Hoarding Awareness Week, the May edition of the Surrey Matters resident newsletter featured a case study from a former hoarder, and promoted the support available to Surrey residents, including help with their mental health and the availability of Safe and Well visits from Surrey Fire and Rescue Service, acknowledging the increased fire risk. Awareness-raising was also through channels including social media and Surrey partners. It's estimated that more than 2% of the population exhibit some signs of hoarding, which at the extreme is recognised as a standalone mental health condition. Often arising as a response to stress,

depression or anxiety, hoarding can lead to greater ill health with rooms unable to be cleaned adequately - or even used for their intended function - and mental wellbeing impacted further.

5

Priority 2

First Steps to Support Phoneline: The First Steps pilot in Guildford, Waverley and Woking has been promoted with new 'chatbot' technology to engage people with the phoneline and highlight ways in which people can support their mental being. The phoneline has also been promoted in community settings, through posters and outdoor stickers.

Right Care, Right Person: Right Care, Right Person (RCRP) was implemented by Surrey Police and with the involvement from local health and social care partners on Monday 22 April. RCRP is a national model being rolled out across the UK aimed at ensuring people with health-related concerns get the help they need from the right expert or agency and is used to triage incoming 999 calls to decide on an appropriate course of action, including whether to deploy police officers. RCRP considerations will only be applied to calls for service relating to adults and will not be applied to calls concerning a child (under 18 years old), or where a child is present. Surrey Police worked closely with local NHS Trusts, the ambulance service, and social care teams over the last few months to plan, test and implement this model, and will continue to collaborate as success is evaluated.

To support the implementation, communications were sent to partner organisations for internal cascade, external stakeholders were engaged with and informed of the process, and the news was shared proactively on Surrey Police channels through a media release, social media and website updates. Further communications will be considered with partners as required.

Baby Loss Support: Healthwatch Surrey presented an article on their website and on social media regarding the introduction of baby loss certificates for parents who lose a baby before 24 weeks. The article provided information on how to apply for these certificates. A series of papers in The Lancet -(https://www.thelancet.com/series/miscarriage) in April 2021 called for reforms around the care of those who'd had a miscarriage and in Healthwatch Surrey's Treatment of Pregnancy Loss report (https://www.healthwatchsurrey.co.uk/.../Treatment-of...) one of their suggestions was that all hospitals should offer commemorative certification for those who lose a baby before 24 weeks.

Coffee and Chat Events: With thanks to the Mental Health Investment Fund, Surrey Youth Focus continue to deliver their popular and highly valued Coffee and Chat sessions – training, learning and networking for practitioners, with topic-based sessions that offer input, practical strategies and signposting. Coffee and Chats are open to all professionals and volunteers supporting children, young people and families in Surrey, providing a multi-agency network that creates a diverse and dynamic learning forum as colleagues from Charities and Community Groups, Health, Local Authority, Education and Police come together. Sof far in 2024 there have been 2 events, one focused on self-harm underpinned by the lived experience of a young person who attended. The second was around emotionally based school non-attendance (EBSNA). The session was shaped to include understanding what EBSNA is and its causes, best practice, strategies and tools that help, signposting to further info and support, and opportunities to connect with others working in this space. Positive was received on the session "So, so useful. Always love these sessions and find them so informative."

Students: On University Mental Health Day Healthwatch Surrey shared details about the day, some statistics, details of their signposting page with links to support and an ask for people to share their experiences.

Priority 3

Healthwatch Surrey highlighted the launch of the new Cranleigh Hospital Hoppa service, which offers door-to-door transport to and from a number of healthcare facilities, including Royal Surrey County Hospital. When Healthwatch Surrey had visited Cranleigh in October 2022, they heard about the difficulties some people were having getting to Royal Surrey County Hospital. Lack of affordable public transport options and the cost and accessibility of parking were proving to be very real barriers which Healthwatch Surrey shared with the Guildford and Waverley Alliance, so it was good to be able to let local people to know that this service was now available.

HWB Board Communications Group forward planning:

- **Summer Health – vaccinations, ticks, heat health**
- **Winter health**
- **Domestic Abuse**
- **Men's mental health**

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Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	**Health and Wellbeing Strategy Index and Scorecard**
HWBS priority populations:	People with a serious mental illness Adults with learning disabilities and/or autism Children with additional needs and disabilities Adult Carers People with long-term conditions, disabilities or sensory impairments People with drug and/or alcohol problems Young people out of work People experiencing domestic abuse People experiencing homelessness Key Neighbourhoods
Assessed Need including link to HWBS priority - 1, 2 and/or 3:	Measuring Surrey's progress against the HWB Strategy
HWBS outcomes:	All outcomes (except 'The needs of those with Multiple Disadvantage are met')
HWBS system capability:	Data, Insights and Evidence
HWBS principles for working with communities:	• Community capacity building: 'Building trust and relationships'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions
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Board Sponsor(s):	Ruth Hutchinson, Director of Public Health, SCC
HWB meeting date:	19 June 2024
Related HWB papers:	Item 5 - Highlight Report - cover report.pdf (surreycc.gov.uk) – December 2023 – Further development of HWBS Index Item 7 - Health and Well-being Strategy Index.pdf (surreycc.gov.uk) - September 2023
Annexes/Appendices:	Appendix 1 - Scorecard Pack (in PowerPoint) Appendix 2 - Indicator list

2. Executive summary

When the Surrey Health and Wellbeing (HWB) Strategy Index was shared with the Board in 2023 it was recognised that further development was needed both in terms of indicators and the geographic levels at which the data is presented. The last iteration had the addition of Primary Care Network (PCN) level data. This latest significant update includes over 20 new indicators (61 in total), aligned to HWB Strategy's priority populations and to the priorities/outcomes to offer a more comprehensive picture. The only outcome still without indicators relates to meeting the needs of those experiencing Multiple Disadvantage and the reason is related to the way that it covers a range of intersecting issues and therefore data. This gap, however, emphasises the prioritisation of the Joint Strategic Needs Assessment (JSNA) chapter being developed on Multiple Disadvantage after which it is hoped more specific indicators can be introduced in future iterations of the Index.

At the same time as this significant update, an annual summary (Scorecard) of progress to help gauge system-wide success (or otherwise) is also being presented to the Board, to help inform understanding and influence action across the HWB Strategy and identify where momentum needs to be maintained, where need persists and improvement may be required. In this paper, we summarise the additional indicators introduced (see appendix 2) and share the first iteration of the Scorecard that draws attention to areas where progress or need is particularly noteworthy. This uses published data available as of March 2024 however every effort has been made to include indicator data that has been published following this[1].

The Scorecard now provided includes actual values for the overarching Life Expectancy, Healthy Life Expectancy and Inequality in Life Expectancy indicators and HWB Strategy priority populations at county level, and the outcome indicators at each geographic level where it is available. It will be possible to show the change in these scores and ranks over time with each annual refresh of the HWBS Index from 2025. The Scorecard will be presented to the Board annually, with any significant in-year updates included in the Highlight Report. The online Index will be updated after this meeting at the end of June and will be available at this link Health and Wellbeing Strategy Index | Surrey-i (surreyi.gov.uk).

3. Recommendations

The Board is asked to:

1. Review and provide feedback to healthandwellbeing@surreycc.gov.uk on the annual HWBS Index and Scorecard and the progress/needs it highlights.
2. Promote the HWB Strategy Index and Scorecard to inform organisational and partnership plans where relevant.
3. Raise awareness of the HWB Strategy Index and Scorecard at related boards and networks.

[1] Some data published in since March may not have been included in the static scorecard but will be updated in the online strategy Index

4. Reason for Recommendations

The HWB Strategy Index and Scorecard are intended to demonstrate progress on the delivery of the Strategy and suggest areas of further action through certain key indicators where data is available.

The aim is to enable a common view on a cross section of publicly available indicators that relate to the HWB Strategy's priority populations, priorities and outcomes. It assists with highlighting populations of identity and geography where residents experience poorer outcomes, to prompt more detailed exploration about what action might be needed to address this. It is for this reason that Board members are asked to note the progress highlighted in the Scorecard and share this and the Index within their organisations, relevant boards and networks.

5. Detail

a. Overarching Indicators

The first section of the Scorecard shows the progress on the Strategy's overarching indicators of life expectancy and healthy life expectancy at birth, and inequality in life expectancy at birth, across the county.

There is some fluctuation across these measures over the periods highlighted, notably for healthy life expectancy at birth, but Surrey performs better than the regional average for both life expectancy and healthy life expectancy at birth. **It is notable that the recent trend for life expectancy at birth in Surrey is downwards, with a reduction of 0.62 years life expectancy for females and 0.82 years for males.** This is a reversal of the longer-term upward trend but mirrors the regional picture.

Inequality in life expectancy is lower in Surrey for males (6.2 years) and females (5.2 years) than for the region. **The longer-term trend however is an increase in inequality for females in Surrey with no change for males.** We know there are also significantly greater inequalities in life expectancy within borough/districts and wards in Surrey, between the most and least deprived areas, that are not reported here at this overarching level. See The Surrey Context: People and Place | Surrey-i (surreyi.gov.uk) for more information. The Health Foundation, based on available Office for National Statistics data, has stated that nationally 'inequalities in life expectancy remain wide and have been entrenched and exacerbated by the pandemic'.

b. Priority populations

The second section of the Scorecard shows the indicators for the HWB Strategy's priority populations and are currently only largely available at county level due to the

geographical level at which the data is available or published. As with the overarching indicators, there is some fluctuation across these measures over the periods highlighted.

Surrey is performing better than the regional and national average on the employment gap for adults with a learning disability registered with adult social care and is in line with the regional and national average on adult carers with enough social contact, which reverses a recent downward trend for the latter measure.

Surrey is performing significantly worse than the national average on adults with a learning disability registered with adult social care who are in stable and appropriate accommodation, but the percentage is increasing and the gap with the national and regional average is getting smaller.

Surrey is also performing significantly worse for adults in contact with secondary mental health services in terms of the employment gap between them and the general population *and* in terms of the numbers in stable and appropriate accommodation.

c. Priorities and outcomes

The third section of the Scorecard details the progress across the indicators included for each outcome within the three HWB Strategy's priorities where indicators are available at a county level and/or the lower geographic areas in the Index.

Of the 61 indicators currently indexed in this section, there has been improvement at a county level in 24 of the indicators and a decline in 17. There was no change in one of the indicators, one indicator is neutral and there is currently no trend data for the remaining indicators.

It should be noted that changes look small for most indicators that reference percentage changes, whether increases or decreases, but these shifts are meaningful in numeric terms. For example, youth unemployment fell across Surrey from 2.87% to 1.81% (good to be low); this represents a drop of nearly a third in the number of young people claiming unemployment benefit (from 3,414 in 2021-22 to 2,157 in 2022-23).

6. Opportunities/Challenges against the outcomes

Opportunities

This Scorecard provides the opportunity for us to have a shared understanding of how we are progressing in the longer term for life expectancy / healthy life expectancy and inequalities in life expectancy (in 5a, 5b above) and in the shorter term for our priority populations and against our HWB Strategy's priorities and outcomes.

Positive progress is being seen within some of the indicators for the priority populations (in 5b above) and for the following outcome indicators and these offer the opportunity to further build upon the positive work in these areas:

- Adults who are physically active (doing at least 150 minutes of moderate intensity activity in the past week) has improved in the county from 66.8% to 69.9% in 12 months (good to be high).
- Chlamydia detection rates in females 16-24 years have risen by 420 cases, from 933 to 1,361 to 1,781 (good to be high).
- The proportion of people with serious mental illness having had a complete range of physical health checks has improved by 11.9% from 51.5% to 63.4% (good to be high).
- The number of unemployment benefit claimants has fallen by 0.8% from 2.8% to 2% (good to be low).
- Rates of anti-social behaviour incidents per 1,000 of the population have fallen by 3.1 from 16.2 incidents to 13.1 incidents (good to be low).
- Rates of domestic abuse have also fallen by 1.5 from 9.8 incidents per 1,000 of the population to 8.3 (good to be low).

Challenges

As well as the poor progress for overarching indicators (in 5a above) and against the priority populations indicators (in 5b above), poor progress against the below outcome indicators in the Index is also noteworthy; these results identify need and present challenges to examine what we are doing and improve:

- **Children who are physically active (60+ minutes of moderate physical activity per day) has fallen by 2.8% from 48.9% to 46.1% (good to be high).**
- **Diabetes prevalence in Surrey increased from 5.8% to 6.02% (good to be low)**
- **Smoking prevalence in adults with routine and manual occupations has risen by 10.4% from 19.6% to 30% (good to be low)**
- **Averages of anxiety scores have increased in Surrey from 2.94 (out of 10) to 3.36 (good to be low)**
- **The proportion of households in fuel poverty has risen by from 7% to 8%; this equates to a rise in 12 months of 4,983 households to a total of 40,987 households.**
- **Levels of travel to work by active transport (walking and riding a bicycle) and public transport (rail and bus) have fallen by 3.4% and 11.2% respectively (good to be high) since the 2011 Census.**

Additionally, Spelthorne is consistently identified through the outcome indicators as having higher levels of need across all priorities. SASSE Network 3 area, operating in Spelthorne, also clearly has higher levels of need.

However, the indicators available continue to be limited by the data that is collected, with some indicators relevant to assessing progress only being available at a higher Surrey footprint which limits the full benefit of use at a more local level. A number of indicators have been, or will be, identified (for example, through new or revised JSNA chapters) and this will enable improvements to the Index over the next 12 months.

Ward level data shows considerable variation across all the indicators where this level of data is available, demonstrating the importance of local place-based review of the Index to understand needs and trends in particular geographic areas.

7. Timescale and delivery plan

The Scorecard will continue to be updated with additional indicators / levels of geography as the Index develops and will be maintained as an annual product (available each June).

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

The HWB Strategy Index has had input and prior circulation with the Prevention and Wider Determinants of Health Board (PWDHDB) and Mental Health: Prevention Board (MH: PB) members. Opportunities to engage communities with this Scorecard will be explored to seek their input and leadership in developing appropriate interventions to meet identified needs once the Scorecard is online.

9. Legal Implications

The Chair will inform the Board of any legal implications verbally at the meeting.

10. Next steps

Having engaged with partner organisations to incorporate what is believed to be all currently available publicly published indicators, the Sub Boards (PWDHB and MH: PB) will work with local data related workstreams to develop additional indicators and lower levels of geography and insight where gaps remain for introduction into the Index. Indicators currently in scope for this work are included in Appendix 2.

Questions to guide Board discussion

- Do the Board members feel the HWB Strategy Index and Scorecard provides a useful overview of progress against the priority populations, priorities and outcomes of the HWB Strategy?
- Are there any additional workstreams that the sub boards need to be linked into to continue to develop a fuller picture of progress for 2025?
- What should we be doing as a system to address the challenges, where need is identified and progress is poor?

Appendix 1

Surrey Health and Wellbeing Board

HWB Strategy Scorecard June 2024

Rich Carpenter, Senior Analyst, Analytics and Insight, SCC

19 June 2024

The Health and Wellbeing Strategy

The Surrey Health and Wellbeing Strategy was refreshed in early 2022 in response to COVID-19, to ensure it had a greater focus on reducing health inequalities, so no-one is left behind. In the refreshed Strategy there was also a commitment to community capacity building, co-designing and co-producing responses to problems, and community led action; these principles for working with communities are crucial to our success.

Delivering the Strategy continues to play a crucial role in achieving the 'Community Vision for Surrey in 2030'.The strategy is published on the Healthy Surrey website.

Partners in Surrey are measuring the long-term impact of the Health and Wellbeing Strategy on reducing health inequalities in Surrey using the Health and Wellbeing Strategy Index. The purpose of the Index is to measure progress against the Health and Wellbeing Strategy's Priorities, Outcomes, and meeting the needs of our Priority Populations (including the Key Neighbourhoods), where the data is available.

The Index combines appropriate physical, mental and wider determinants of health indicators into baskets at different geographic levels. These allow us to see improvements that come from working together in partnership. The Index is calculated on an annual basis but not all data is from the same year; the most recent data available is used for each indicator.

Alongside the Index are overarching indicators around life expectancy, healthy life expectancy and inequality in life expectancy, and indicators currently available for some of the Priority Populations at a Surrey-wide level.

These indicators and the Index are presented in an interactive dashboard available on the surrey-i website.

The Health and Wellbeing Strategy Scorecard

This Scorecard presents a simple to read summary of the findings in the HWB Strategy Index, outlining overall progress against the HWB Strategy to help gauge system-wide success (or otherwise) and support the direction of appropriate interventions related to the Priority Populations and Outcomes in the HWB Strategy where improvement is required.

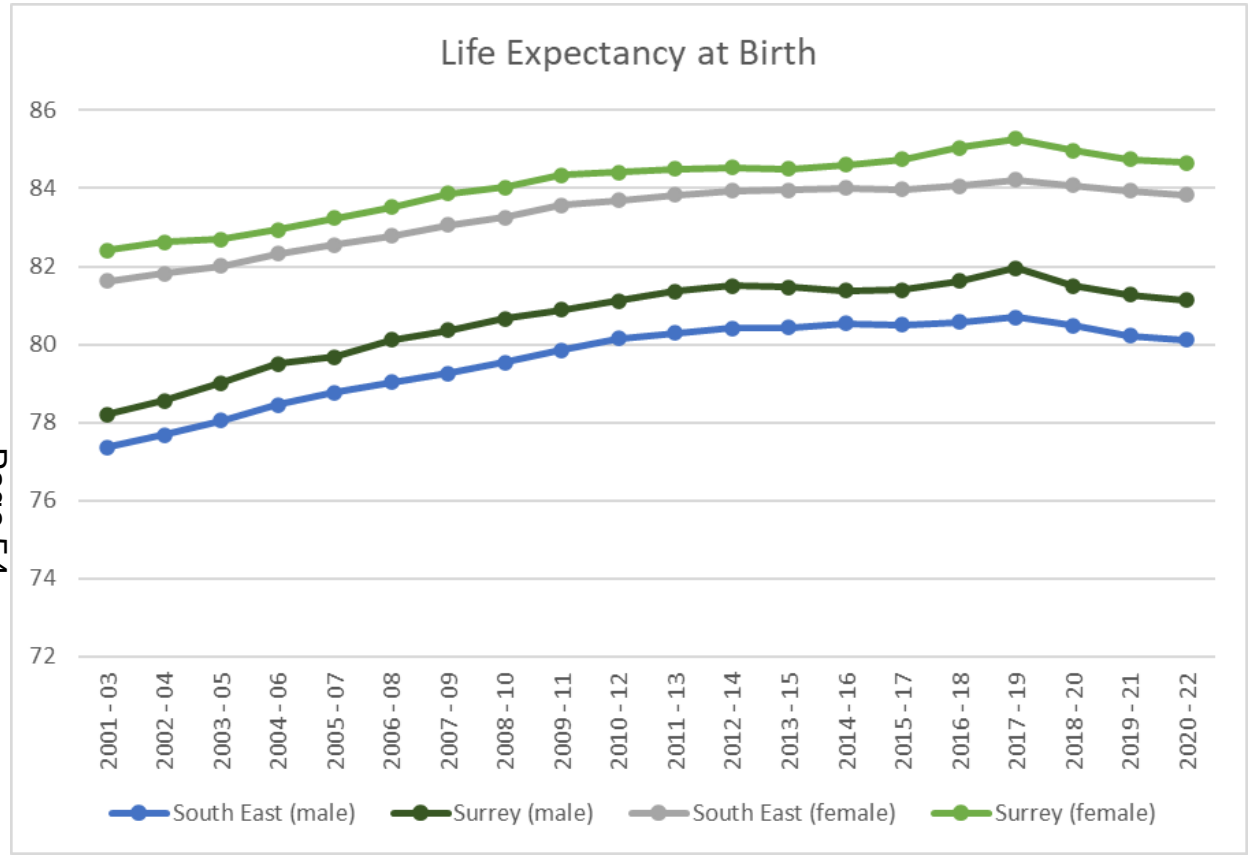
The Index section helps us understand needs at a place level and is currently published at a borough and district, Primary Care Network and ward level geographies, but this Scorecard also includes indicators for the whole county to present a Surrey-wide picture of progress.

The first results presented on the Scorecard are the published overarching indicators, which are a measure of the long-term impact of the Strategy. This is followed by results published for indicators for some of our Priority Populations of identity, where data is available. Both these sets of indicators are published at a county level to present a Surrey-wide picture.

The results published at a borough and district, Primary Care Network and ward level geographies* then follow and present progress against the HWB Strategy's Outcomes, grouped by the three Priorities. These help us understand progress and compare need at a more local level.

Note: A borough/district or PCN which is ranked in the bottom three on the overall Index is highlighted in orange text.
HWB Strategy Key Neighbourhoods are highlighted in pink text.

Overarching Indicators: Life Expectancy at Birth



Life expectancy at birth is a measure of how long a person will live in years. For males and females in Surrey life expectancy is better than the regional average.

The recent trend is downwards however, with a reduction of 0.62 years life expectancy for females between 2017-19 and 2020-22, and 0.82 years for males over the same period. This is a reversal of the longer-term upward trend and mirrors the regional picture.

	2014-16	2015-17	2016-18	2017-19	2018-20	2019-21	2020-22
South East (female)	84	83.98	84.06	84.21	84.07	83.94	83.84
Surrey (female)	84.61	84.75	85.05	85.27	84.97	84.74	84.65
South East (male)	80.54	80.51	80.57	80.7	80.48	80.22	80.12
Surrey (male)	81.38	81.4	81.63	81.96	81.5	81.28	81.14

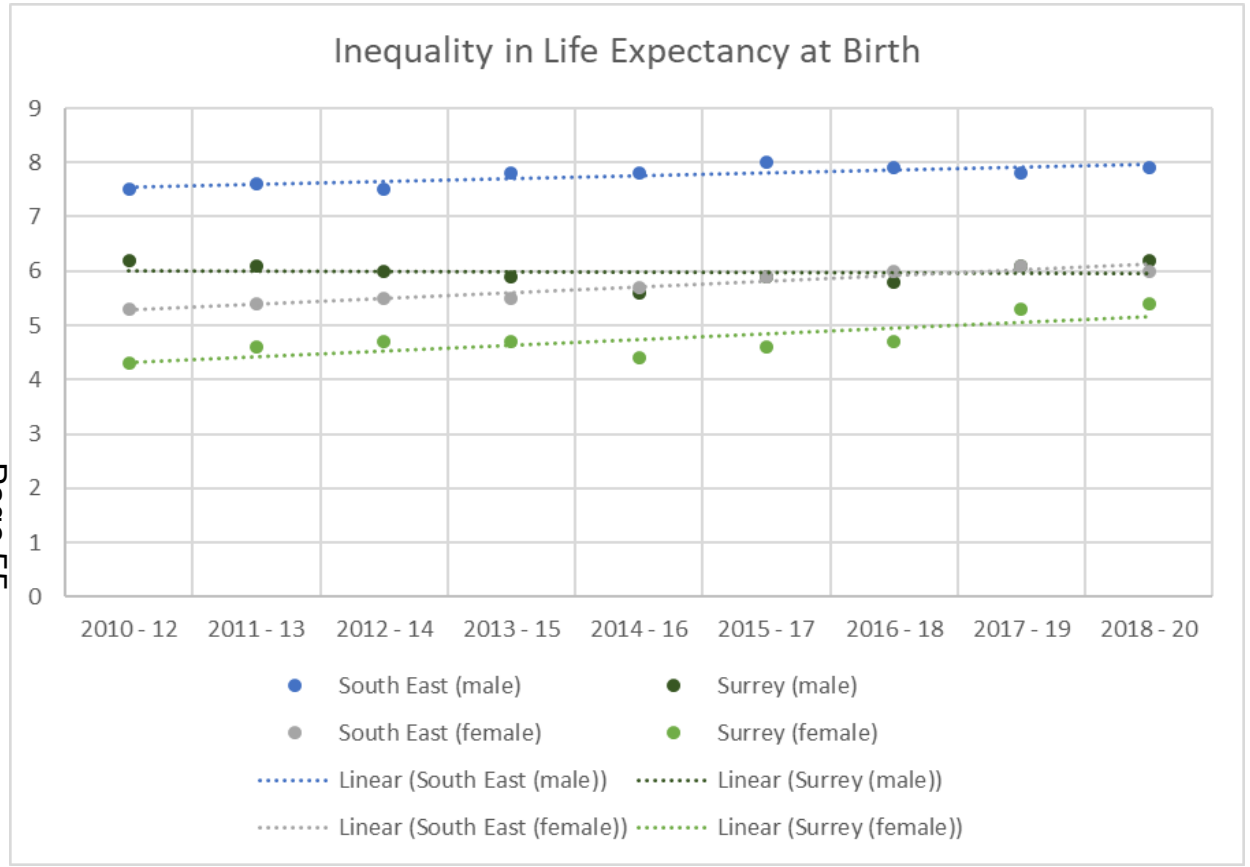
Change from previous reporting period

Increase

Decrease

Good to be high

Overarching Indicators: Inequality in Life Expectancy at Birth



Inequality in life expectancy at birth is a measure of the difference in life expectancy in years between someone living in the most deprived decile in the county and someone living in the least deprived decile.

This inequality is lower in Surrey for both males and females compared to the region and has fluctuated up and down by small margins over the past few years. There has been a 1-year increase in inequality since 2014-16 for females and 0.8-year increase for males over the same period. The longer-term trend in Surrey is an increase in inequality for females but no change for males.

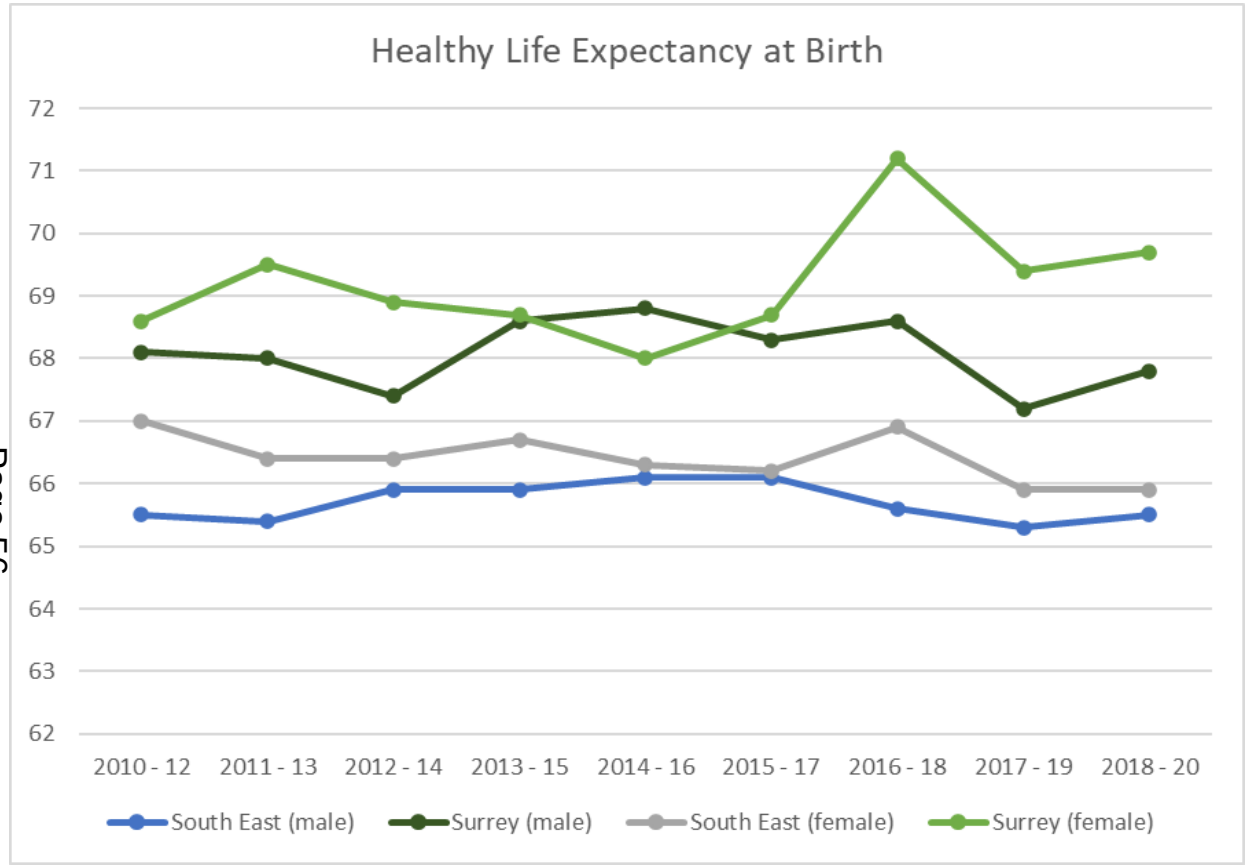
	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19	2018-20
South East (male)	7.5	7.6	7.5	7.8	7.8	8	7.9	7.8	7.9
Surrey (male)	6.2	6.1	6	5.9	5.6	5.9	5.8	6.1	6.2
South East (female)	5.3	5.4	5.5	5.5	5.7	5.9	6	6.1	6
Surrey (female)	4.3	4.6	4.7	4.7	4.4	4.6	4.7	5.3	5.4

Change from previous reporting period

- Increase
- Decrease
- No Change

Good to be low

Overarching Indicators: Healthy Life Expectancy at Birth



Healthy life expectancy at birth is a measure of the average number of years a person would expect to live from birth in good health. This is better for males and females in Surrey than the regional average.

There has been some notable fluctuation in the past few years, with some strong increases followed by reductions. There was a spike in healthy life expectancy for females between 2014-16 and 2017-19, where it increased by 3.2 years from 2014-16 to 2016-18 before falling again. Conversely, males experienced a gentle decline in this period, with healthy life expectancy falling 1.6 years between 2014-16 and 2017-19.

The most recent trend in the available data is upwards, with an increase of 0.6 years healthy life expectancy for males and 0.3 years for females in Surrey between 2017-19 and 2018-20.

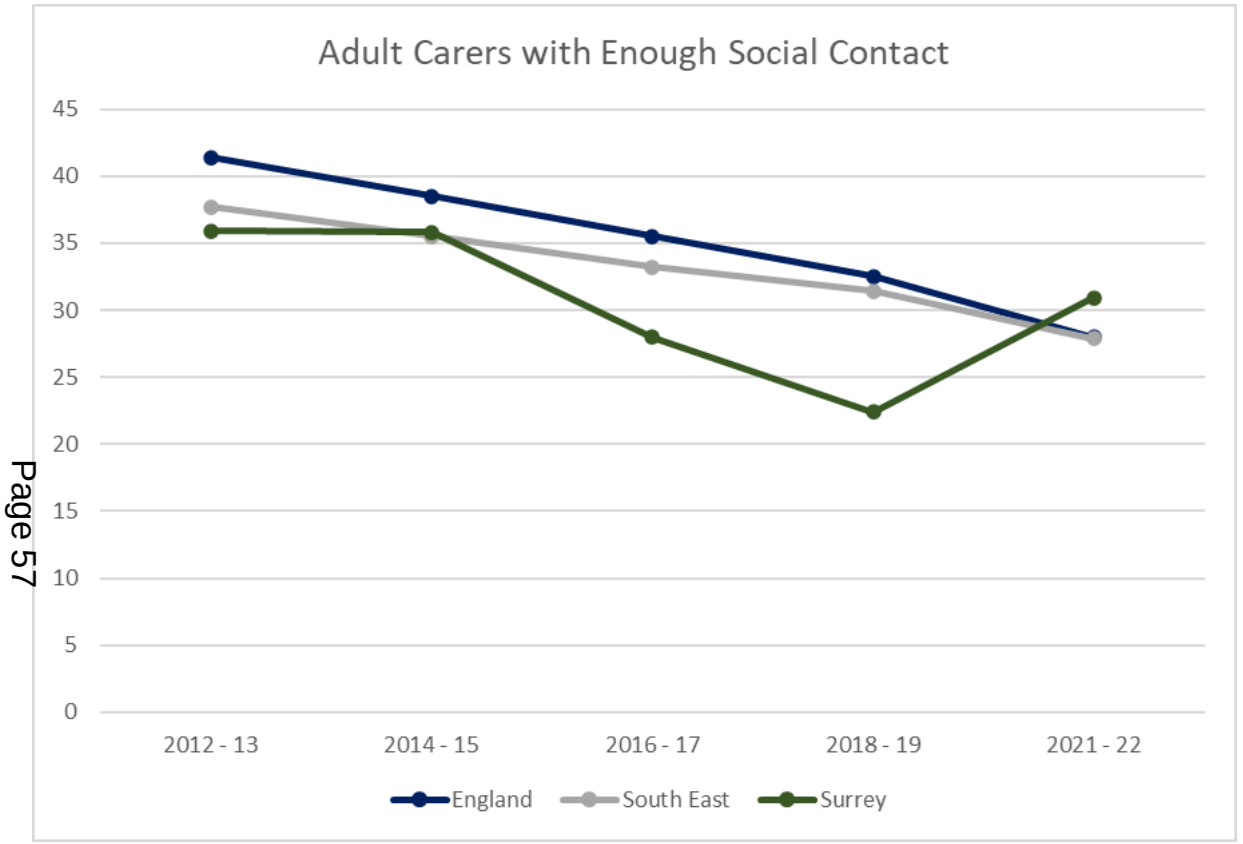
	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19	2018-20
South East (male)	65.5	65.4	65.9	65.9	66.1	66.1	65.6	65.3	65.5
Surrey (male)	68.1	68	67.4	68.6	68.8	68.3	68.6	67.2	67.8
South East (female)	67	66.4	66.4	66.7	66.3	66.2	66.9	65.9	65.9
Surrey (female)	68.6	69.5	68.9	68.7	68	68.7	71.2	69.4	69.7

Change from previous reporting period

- Increase
- Decrease
- No Change

Good to be high

Priority Populations: Adult Carers with Enough Social Contact



This is a measure of the percentage of adult carers (aged 18+) who have as much social contact as they would like.

Surrey has generally performed below the national average on this survey-based measure, although Surrey has gone against the continued downward trend seen regionally and nationally to be slightly above the national average in 2021-22 (this difference is reported as being not statistically significant).

	2012-13	2014-15	2016-17	2018-19	2021-22
England	41.4	38.5	35.5	32.5	28
South East	37.7	35.5	33.2	31.4	27.9
Surrey	35.9	35.8	28	22.4	30.9

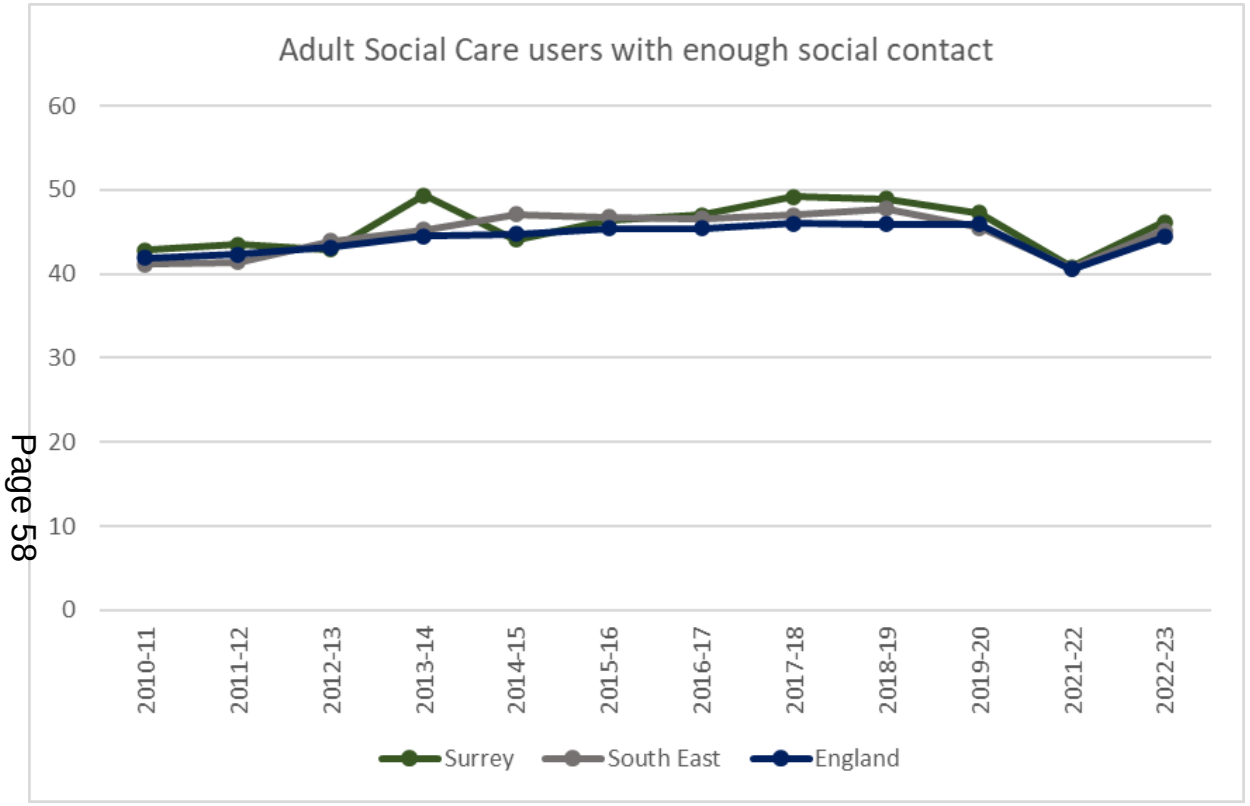
Change from previous reporting period

Increase

Decrease

Good to be high

Priority Populations: Adult Social Care Users with Enough Social Contact



This is a measure of the percentage of adult social care service users (aged 18+) who have as much social contact as they would like.

Surrey has generally performed above the national average on this survey-based measure, although the difference is not statistically significant, and has followed the trend seen regionally and nationally. This has included a gradual increase in the percentage of Adult Social Care users who have as much social contact as they would like since 2010, but is marked by a recent decline, particularly during the Covid-19 pandemic. The performance shows signs of recovery in 2022-23 however.

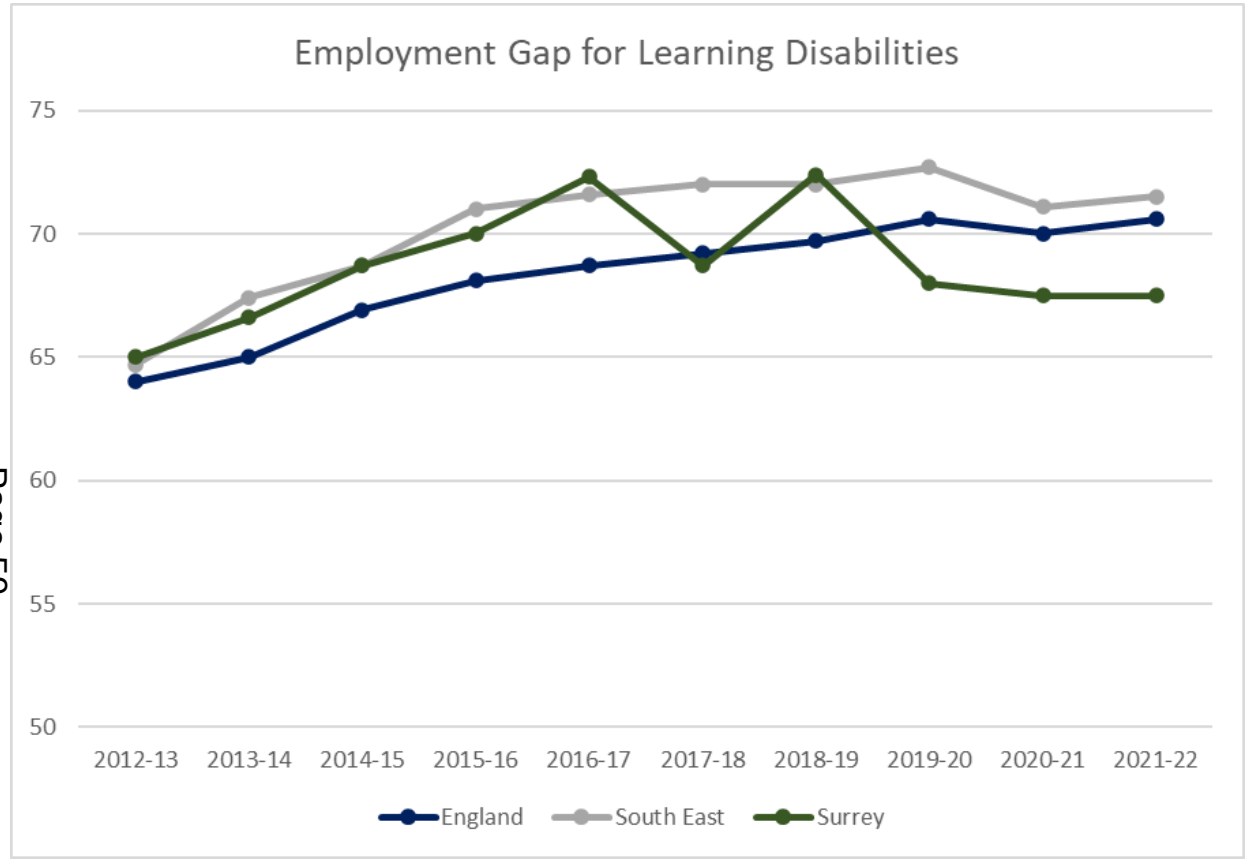
	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2020-21	2021-22	2022-23
England	41.9	42.3	43.2	44.5	44.8	45.4	45.4	46.0	45.9	45.9	40.6	44.4
South East	41.2	41.4	43.9	45.3	47.1	46.8	46.6	47.0	47.8	45.5	40.7	45.2
Surrey	42.8	43.5	42.9	49.4	44.1	46.4	47.0	49.2	48.9	47.3	40.8	46.2

Change from previous reporting period

- Increase
- Decrease
- No change

Good to be high

Priority Populations: Employment Gap for Adults with a Learning Disability



This is a measure of the percentage gap in the employment rate between those who are in receipt of long-term support for people with a learning disability (aged 18 to 64) registered with adult social care and the overall employment rate. For example, if 80% of the wider population is employed compared to 10% of adults with a learning disability, the gap is 70%.

Surrey has moved from performing roughly in line with or worse than the national average on this measure, to performing better than the national and regional average (and a statistically significant difference). The current employment gap of 67.5% is bigger than the lowest point seen in the trend (65% in 2012-13) but has narrowed since 2018-19 (when it was 72.4%) by almost 5%.

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
England	64	65	66.9	68.1	68.7	69.2	69.7	70.6	70	70.6
South East	64.7	67.4	68.7	71	71.6	72	72	72.7	71.1	71.5
Surrey	65	66.6	68.7	70	72.3	68.7	72.4	68	67.5	67.5

Change from previous reporting period

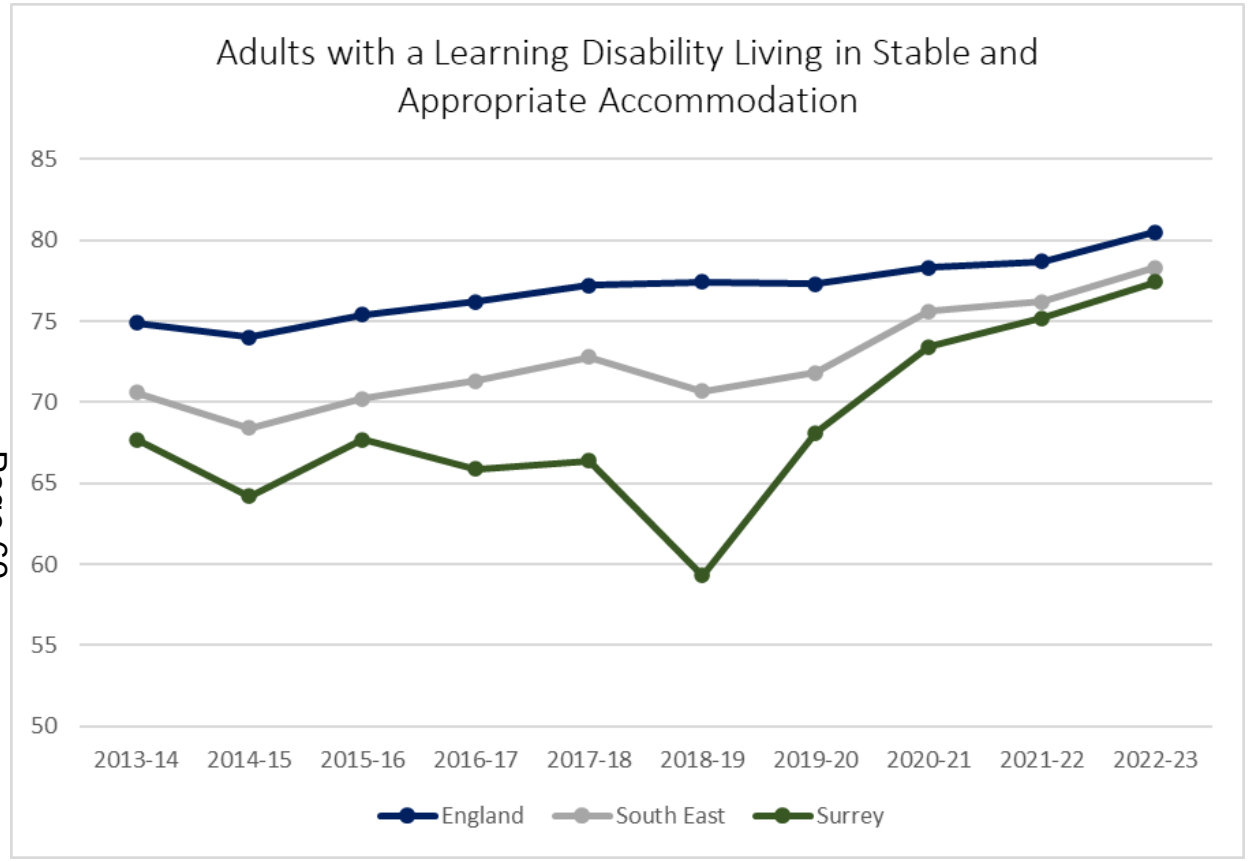
Increase

Decrease

No Change

Good to be low

Priority Populations: Adults with a Learning Disability Living in Stable and Appropriate Accommodation



This is a measure of the percentage of adults (aged 18 to 64) with a learning disability registered with adult social care who are living in stable and appropriate accommodation as a percentage of adults with a learning disability.

Surrey is performing 3% worse than the national average, .9% worse that the regional on this measure, despite the percentage increase of 18.1% since 2018-19.

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
England	74.9	74	75.4	76.2	77.2	77.4	77.3	78.3	78.7	80.5
South East	70.6	68.4	70.2	71.3	72.8	70.7	71.8	75.6	76.2	78.3
Surrey	67.7	64.2	67.7	65.9	66.4	59.3	68.1	73.4	75.2	77.4

Change from previous reporting period

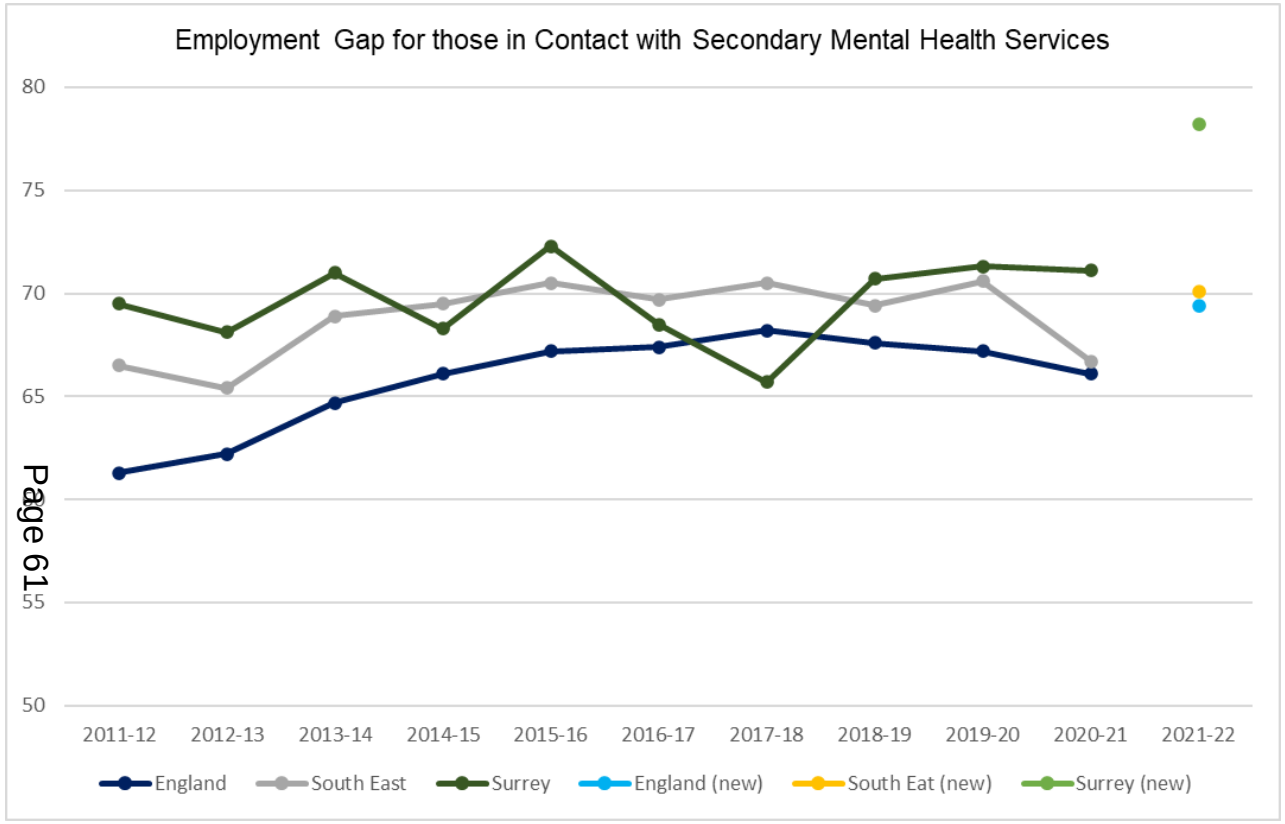
Increase

Decrease

No Change

Good to be high

Priority Populations: Employment Gap for Adults in Contact with Secondary Mental Health Services



This is a measure of the percentage gap in the employment rate between those who are in contact with secondary mental health services (aged 18 to 69) and the overall employment rate (aged 16-64). For example, if 80% of the wider population is employed compared to 10% of adults in contact with secondary mental health services, the gap is 70%.

This indicator was previously the employment gap for adults in contact with secondary mental health services **and** on the Care Programme Approach (CPA) but changed in 2021-22 to be **all** those contact with secondary mental health services because the CPA was superseded by the Community Mental Health Framework. Since 2018-2019, Surrey's progress has been significantly worse compared to nationally and regionally and is over 8% worse compared to both on the new indicator.

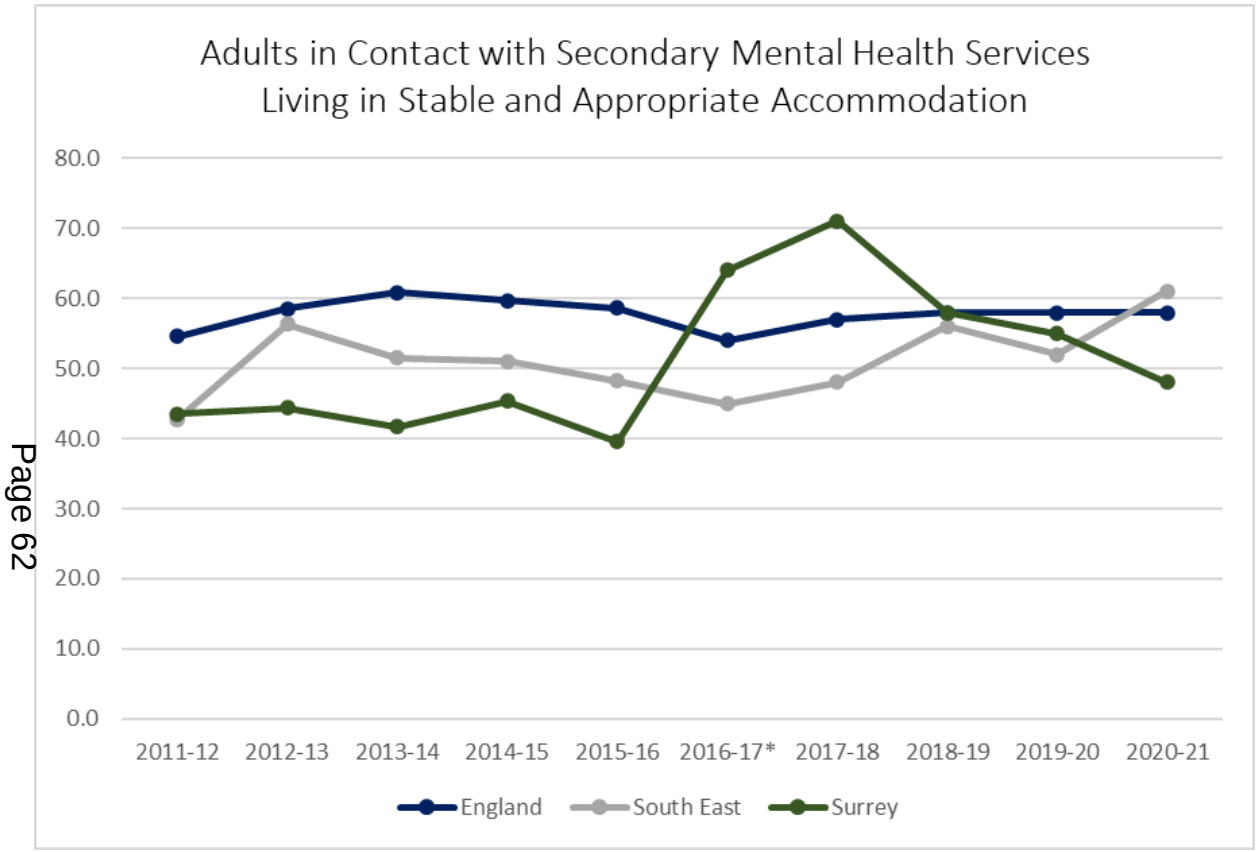
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
England	61.3	62.2	64.7	66.1	67.2	67.4	68.2	67.6	67.2	66.1	69.4
South East	66.5	65.4	68.9	69.5	70.5	69.7	70.5	69.4	70.6	66.7	70.1
Surrey	69.5	68.1	71	68.3	72.3	68.5	65.7	70.7	71.3	71.1	78.2

Change from previous reporting period

- Increase
- Decrease
- No Change
- New Definition

Good to be low

Priority Populations: Adults in Contact with Secondary Mental Health Services in Stable and Appropriate Accommodation



This is a measure of the percentage of adults who are receiving secondary mental health services on the Care Programme Approach (CPA) recorded as living independently, with or without support, out of all adults who are receiving secondary mental health services and are on the CPA (aged 18 to 69).

There has been some notable fluctuation in the past few years, with a 31.4% increase from 2015-16 to 2017-18, followed by a 23.0% reduction to the current reporting period of 2020-21.

Surrey's current progress is 13% worse than the regional average and 10% worse than the national average.

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17*	2017-18	2018-19	2019-20	2020-21
England	54.6	58.5	60.8	59.7	58.6	54.0	57.0	58.0	58.0	58.0
South East	42.7	56.3	51.5	51.0	48.2	45.0	48.0	56.0	52.0	61.0
Surrey	43.5	44.4	41.7	45.3	39.6	64.0	71.0	58.0	55.0	48.0

Change from previous reporting period

- Increase
- Decrease
- No Change

Good to be high

* There is a reported data quality issue with this value

Priority 1: Supporting People to Lead Healthy Lives by Preventing Physical Ill Health and Promoting Physical Wellbeing
Outcome 1: People Have a Healthy Weight and are Active

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Adults who are physically active (doing at least 150 minutes of moderate intensity activity in the past week)	High	**69.9% (Nov 2021-22)**	+3.1 66.8% (Nov 2020-21)	Best: Elmbridge 74.9% Worst: Epsom and Ewell 62.3%	Data not available at this geography	Best: Godalming Charterhouse (Waverley) 12.0% Worst: Stanwell North (Spelthorne) 30.7%*
Adults who are physically inactive (doing less than 30 minutes of moderate intensity activity in the past week)	Low	**19.5% (Nov 2021-22)**	- 1.6 21.1% (Nov 2020-21)	Best: Tandridge 16.3% Worst: Epsom and Ewell 22.8%	Data not available at this geography	Best: Holy Trinity (Guildford) 77.4% Worst: Stanwell North (Spelthorne) 55.2%*
Children who are physically active (doing an average of 60+ minutes of moderate intensity activity per day)	High	**46.1% (Academic Year 2022-23)**	-2.8 48.9% (Academic Year 2021-22)	Best: Mole Valley 55.0% Worst: Surrey Heath 36.0%	Data not available at this geography	Data not available at this geography
Proportion of residents who reported eating five or more portions of fruit and/or vegetables yesterday**	High	**39.5% (April - December 2023)**	Trend data not currently available	Best: Epsom and Ewell 47.8% Worst: Spelthorne 26.8%	Data not available at this geography	Data not available at this geography

*These are modelled estimates
** Responses to the Joint Neighbourhood Survey

Change from previous reporting period
- Decline
- Improvement
- No Change

Priority 1: Supporting People to Lead Healthy Lives by Preventing Physical Ill Health and Promoting Physical Wellbeing
Outcome 2: Substance Misuse is Low (page 1 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Admission episodes for alcohol-related conditions (standardised rate per 100,000)	Low	**1,511 (2021-22)**	+251 1,260 (2020-21)	Best: Epsom and Ewell 1,287 Worst: Spelthorne 1,888	Data not available at this geography	Data not available at this geography
Hospital admissions for alcohol attributable harm (standardised emergency admission ratio - SAR)*	Low	**83.83 (2016 to 19)**	Only one reporting period is available for this indicator	Best: Elmbridge 71.51 Worst: Guildford 96.98	Best: East Elmbridge 70.43** Worst: GRIPC 111.65**	Best: Hinchley Wood and Weston Green (Elmbridge) 51.54** Worst: Stoke (Guildford) 146.30**
Deaths from drug misuse (standardised rate per 100,000)	Low	**2.5 (April 2018-March 20)**	No change 2.5 (April 17- March 19)	Best: Guildford 1.3 Worst: Woking 3.3	Data not available at this geography	Data not available at this geography

* This is an old indicator which has been replaced by a new reporting method. The SAR is a ratio of the actual number of emergency admissions in the area to the number expected if the area had the same age specific admission rates as England, multiplied by 100. An SAR of 100 indicates that the area has average emergency admission rate, higher than 100 indicates that the area has higher than average emergency admission rate, lower than 100 indicates lower than average emergency admission rate.
** These are custom area rates aggregated from MSOA averages.

Change from previous reporting period

- Decline
- Improvement
- No Change

Priority 1: Supporting People to Lead Healthy Lives by Preventing Physical Ill Health and Promoting Physical Wellbeing
Outcome 2: Substance Misuse is Low (page 2 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Smoking status at the time of delivery*	Low	**5.7% (2022-23)**	-0.1 5.8% (2021-22)	Best: Reigate and Banstead 5.6% Worst: Surrey Heath 6.6%	Data not available at this geography	Data not available at this geography
Smoking prevalence in adults (18+) with long term mental health conditions	Low	**22.0% (2022-23)**	+2.0 20.0% (2021-22)	Best: Mole Valley 11.2% Worst: Runnymede 35.4%	Data not available at this geography	Data not available at this geography
Smoking prevalence in adults (18-64) in routine and manual occupations	Low	**30.0% (2022)**	+10.4 19.6% (2021)	Data not available for all areas at this geography	Data not available at this geography	Data not available at this geography

* The number of mothers known to be smokers at the time of delivery as a percentage of all maternities with known smoking status. A maternity is defined as a pregnant woman who gives birth to one or more live or stillborn babies of at least 24 weeks gestation, where the baby is delivered by either a midwife or doctor at home or in an NHS hospital

Change from previous reporting period

- Decline
- Improvement
- No Change

Priority 1: Supporting People to Lead Healthy Lives by Preventing Physical Ill Health and Promoting Physical Wellbeing
Outcome 4: Serious conditions and diseases are prevented (page 1 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Proportion of people with learning disabilities (aged 14+) having complete range of physical health checks in the 12 last months	High	**80.2% (February 2024)**	Trend data not currently available	Best: Surrey Heath 86.7% Worst: Elmbridge 56.8%	Data not currently available at this geography	Data not available at this geography
Under 75 mortality rate from colorectal cancer (all persons)*	Low	**10.4 (2020-22)**	-0.1 10.5 (2019-21)	Best: Elmbridge 7.4 Worst: Woking 14.2	Best: South Tandridge 82.1 Worst: SASSE Network 3 122.9	Best: Farnham Bourne (Waverley) 45.5 Worst: Walton North (Elmbridge) 154.5
Under 75 mortality rate from breast cancer (females)*	Low	**17.5 (2020-22)**	-0.9 18.6 (2019-21)	Best: Guildford 13.6 Worst: Woking 25.6	Best: Banstead Healthcare 81.2 Worst: SASSE Network 2 125.1	Best: Beare Green (Mole Valley) 50.7 Worst: Lovelace (Guildford) 205.4
Under 75 mortality rate from cancer (all persons)**	Low	**101.9 (2020-22)**	-0.1 102.0 (2019-21)	Best: Elmbridge 92.9 Worst: Woking 112.7	Best: East Elmbridge 94.8 Worst: COCO 138.9	Best: Ewhurst (Waverley) 25.2 Worst: Okewood (Mole Valley) 137.9

* Results for PCNs and Wards show the number of new cases of cancer, not deaths under 75. Figures are presented as indirectly age-sex standardised registration ratios (number of new cases as a percentage of expected new cases), calculated relative to England, for 2012-15.
** Results presented for PCNs and Wards are the age standardised estimates of deaths from all cancers for people aged under 75 (standardised mortality ratio) for 2016-19. The ratio is calculated by dividing the observed total deaths in the area by the expected deaths (applying age-specific death rates for England) and multiplying by 100. A score of 100 means the observed deaths are as expected.

Priority 1: Supporting People to Lead Healthy Lives by Preventing Physical Ill Health and Promoting Physical Wellbeing
Outcome 4: Serious conditions and diseases are prevented (page 2 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Diabetes prevalence	Low	**6.02% (April 2022 - March 23)**	+0.4 5.8% (April 2021 – March 22)	Best: Elmbridge 4.84% Worst: Spelthorne 7.52%	Best: East Elmbridge 4.52% Worst: SASSE Network 1 7.5%	Best: Oxshott and Stoke D'Abernon (Elmbridge) 3.82% Worst: Stanwell North (Spelthorne) 8.83%
Chlamydia detection rate (per 100,000 females aged 15 to 24)*	High	**1,781 (2023)**	+420 1,361 (2022)	Best: Epsom and Ewell 2,562 Worst: Mole Valley 745	Data not available at this geography	Data not available at this geography
Hypertension prevalence (all ages)	Low	**13.6% (April 2022 - March 23)**	+0.5 13.1% (April 2021 – March 22)	Best: Guildford 11.8% Worst: Mole Valley 15.8%	Best: GRIPC 10.5% Worst: Banstead Healthcare 16.1%	Data not available at this geography
MMR vaccination (proportion of children receiving two doses aged 5)**	High	**83.5% (April 2022 - March 23)**	-0.4 83.9% (April 2021 – March 22)	Data to follow in future update	Best: West Byfleet 85.9% Worst: Woking Wise 75.9%	Data not available at this geography

Change from previous reporting period

- Decline
- Improvement
- No Change

* The chlamydia detection rate among under 25-year-olds is a measure of chlamydia control activity, aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting transmission. An increased detection rate is indicative of increased control activity; the detection rate is not a measure of morbidity

** PCN level data is for January to December 2023

Priority 1: Supporting People to Lead Healthy Lives by Preventing Physical Ill Health and Promoting Physical Wellbeing
Outcome 5: People are supported to live well independently for as long as possible

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Emergency hospital admission rates of people with dementia	Low	**5.2% (April 2022 - March 23)**	+0.2 5.0% (April 2021 - March 22)	Best: Surrey Heath 1.3% Worst: Elmbridge 9.7%	Data not available at this geography	Data not available at this geography

Change from previous reporting period

- Decline
- Improvement
- No Change

Priority 2: Supporting People's Mental Health and Emotional Wellbeing by Preventing Mental Ill Health and Promoting Emotional Wellbeing
Outcome 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 (page 1 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Average anxiety score (out of 10)*	Low	**3.36 (April 2022 - March 23)**	+0.42 2.94 (April 2021 – March 22)	Best: Woking 2.76 Worst: Spelthorne 5.16	Data not available at this geography	Data not available at this geography
Average feeling worthwhile score (out of 10)*	High	**7.75 (April 2022 - March 23)**	-0.10 7.85 (April 2021 – March 22)	Best: Mole Valley 8.46 Worst: Spelthorne 6.61	Data not available at this geography	Data not available at this geography
Average life satisfaction score (out of 10)*	High	**7.62 (April 2022 - March 23)**	+0.04 7.58 (April 2021 – March 22)	Best: Woking 8.21 Worst: Spelthorne 7.2	Data not available at this geography	Data not available at this geography
Average happiness (out of 10)*	High	**7.48 (April 2022 - March 23)**	+0.09 7.39 (April 2021 – March 22)	Best: Surrey Heath 7.89 Worst: Reigate and Banstead 7.07	Data not available at this geography	Data not available at this geography
Suicides (standardised rate per 100,000 persons aged 10+)**	Low	**9.5 (2020-22)**	-0.5 10.0 (2019-21)	Best: Spelthorne 5.6 Worst: Mole Valley 13.7	Data not available at this geography	Data not available at this geography

Change from previous reporting period

- Decline
- Improvement
- No Change

* Some of the data at borough level for this indicator is considered unreliable

**Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population. Data source is Office for National Statistics Annual Mortality Extract (produced for OHID) and accessed via Public Health Fingertips

Priority 2: Supporting People's Mental Health and Emotional Wellbeing by Preventing Mental Ill Health and Promoting Emotional Wellbeing
Outcome 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 (page 2 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Access to Community Mental Health Services for adults and older adults with serious mental illness	High	**21,885 (March 2023 - February 2024)**	+2,920 18,965 (May 2022 – April 2023)	Data to follow in future update	Data to follow in future update	Data not available at this geography
Number of young people aged under 18 supported through NHS funded mental health with at least one contact	High	**23,135 (March 2023 - February 2024)**	+560 22,570 (May 2022 – April 2023)	Data to follow in future update	Data to follow in future update	Data not available at this geography
Patients who felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment	High	**84.7% (2023)**	Data to follow in future update	Data to follow in future update	Best: West of Waverley 91.7% Worst: SASSE Network 3 75.6%	Data not available at this geography
Proportion of people with serious mental illness having complete range of physical health checks in the 12 last months	High	**63.4% (April 2022-March 2023)**	+11.9 51.5% (April 2021– March 2022)	Data to follow in future update	Data to follow in future update	Data not available at this geography
Proportion of patients on the GP register with mental health issues (all ages)*	Neutral	**0.77% (April 2022-March 2023)**	+0.03 0.74% (April 2021– March 2022)	Data to follow in future update	Best: Woking Wise 0.56% Worst: Care Collaborative (Redhill) 0.95%	Data not available at this geography

Change from previous reporting period

- Decline
- Improvement
- No Change

* The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers. Quality and Outcomes Framework (QOF), NHS England

Priority 2: Supporting People's Mental Health and Emotional Wellbeing by Preventing Mental Ill Health and Promoting Emotional Wellbeing
Outcome 2: The emotional well-being of parents and caregivers, babies and children is supported

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
The proportion of school pupils receiving special educational needs support whose primary need is social, emotional and mental health		**22.5% (June 2024)**	Trend data not currently available	Data not currently available at this geography	Data not currently available at this geography	Data not currently available at this geography
The proportion of school pupils with an EHCP whose primary need is social, emotional and mental health		**16.9% (June 2024)**	Trend data not currently available	Data not currently available at this geography	Data not currently available at this geography	Data not currently available at this geography
Proportion of children receiving a 12-month review with their Health Visitor	High	**69.4% (March 2024)**	+7.9 61.5% (December 2023)	Data not currently available at this geography	Data not currently available at this geography	Data not currently available at this geography
Proportion of children receiving 2-and-a-half-year check with their Health Visitor	High	**64.2% (January-March 2024)**	-6.3 70.5% (October-December 2023)	Data not currently available at this geography	Data not currently available at this geography	Data not currently available at this geography

Change from previous reporting period

- Decline
- Improvement
- No Change

Priority 2: Supporting People's Mental Health and Emotional Wellbeing by Preventing Mental Ill Health and Promoting Emotional Wellbeing
Outcomes 3: Isolation is prevented and those that feel isolated are supported

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
In my local area there are place people can meet up and socialise*	High	**76.7% (April - December 2023)**	Trend data not currently available	Best: Epsom and Ewell 85.1% Worst: Spelthorne 64.5%	Data not available at this geography	Data not available at this geography
If I needed help, there are people in the local area who would be there for me*	High	**79.2% (April - December 2023)**	Trend data not currently available	Best: Surrey Heath 86.5% Worst: Woking 72.5%	Data not available at this geography	Data not available at this geography

* Responses to new Joint Neighbourhood Survey

Change from previous reporting period

- Decline
- Improvement
- No Change

Priority 2: Supporting People's Mental Health and Emotional Wellbeing by Preventing Mental Ill Health and Promoting Emotional Wellbeing
Outcomes 4: Environments and communities in which people live, work and learn build good mental health

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
I feel like I belong to my local area*	High	**81.1% (April - December 2023)**	Trend data not currently available	Best: Mole Valley 89.1% Worst: Spelthorne 72.2%	Data not available at this geography	Data not available at this geography
Proportion of residents doing any unpaid work to help their community or the people who live in it in the last year*	High	**37.8% (April - December 2023)**	Trend data not currently available	Best: Waverley 46.2% Worst: Spelthorne 33.0%	Data not available at this geography	Data not available at this geography

* Responses to new Joint Neighbourhood Survey

Change from previous reporting period

- Decline
- Improvement
- No Change

Priority 3: Supporting People to Reach Their Potential by Addressing the Wider Determinants of Health
Outcome 1: People's basic needs (food security, poverty, housing) are met (page 1 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Proportion of children (aged 0-19) in relative low-income families	Low	**9.5% (April 2021 - March 22)**	+0.1 9.4% (April 2020 – March 21)	Best: Elmbridge 6.9% Worst: Woking 12.6%	Best: Guildford East 5.57% Worst: Woking Wise 2 14.47%	Best: Woldingham (Tandridge) 0.9% Worst: Canalside (Woking) 28.4%
Proportion of households in fuel poverty	Low	**8.3% (2022)**	+1 7.3% (2021)	Best: Surrey Heath 6.8% Worst: Waverley 9.3%	Best: Five areas* report 7% Worst: Four areas** report 10%	Best: Four areas# report 5% Worst: Westborough (Guildford) 15%
Proportion of households owed a homelessness duty	Low	**7.0% (April 2022 - March 23)**	+0.2 6.8% (April 2021 – March 22)	Best: Surrey Heath 3.9% Worst: Spelthorne 9.2%	Data not available at this geography	Data not available at this geography

* COCO, Surrey Heath, West Byfleet, Woking Wise 1 and Woking Wise 3 PCNs
** Central and North Guildford, Dorking, South Tandridge and West of Waverley PCNs
# Burpham (Guildford), Horley East and Salfords (Reigate and Banstead), Heatherside (Surrey Heath) and St. Paul's (Surrey Heath)

Change from previous reporting period

- Decline
- Improvement
- No Change

Priority 3: Supporting People to Reach Their Potential by Addressing the Wider Determinants of Health
Outcome 1: People's basic needs (food security, poverty, housing) are met (page 2 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Proportion of residents who have struggled to pay any essential bills in the last 6 months?*	Low	**16.4% (April - December 2023)**	Trend data not currently available	Best: Woking 13.4% Worst: Reigate and Banstead 21.9%	Data not available at this geography	Data not available at this geography
Proportion of residents who have had to access a food bank or community food provision in the last 6 months?*	Low	**14.4% (April - December 2023)**	Trend data not currently available	Best: Tandridge 5.1% Worst: Spelthorne 23.8%	Data not available at this geography	Data not available at this geography
Proportion of residents who have had to access additional borrowing (e.g. loans or credit cards) in the last 6 months?*	Low	**30.4% (April - December 2023)**	Trend data not currently available	Best: Waverley 20.5% Worst: Spelthorne 38.1%	Data not available at this geography	Data not available at this geography

* Responses to new Joint Neighbourhood Survey

Change from previous reporting period

- Decline
- Improvement
- No Change

Priority 3: Supporting People to Reach Their Potential by Addressing the Wider Determinants of Health
Outcome 2: Children, young people and adults are empowered in their communities

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Attainment gap between non-/disadvantaged pupils: Early years foundation stage good level of development*	Low	**27.3% (2023)**	Trend data not currently available	Best: Tandridge 16.4% Worst: Mole Valley 33.7%	Data not available at this geography	Data not available at this geography
Attainment gap between non-/disadvantaged pupils: Key stage 2 reading, writing and maths*	Low	**31.8% (2023)**	Trend data not currently available	Best: Reigate and Banstead 24.7% Worst: Waverley 38.4%	Data not available at this geography	Data not available at this geography
Attainment gap between non-/disadvantaged pupils: Key stage 4 (attainment 8 score)*	Low	**20.3% (2023)**	Trend data not currently available	Best: Tandridge 14.0% Worst: Surrey Heath 25.4%	Data not available at this geography	Data not available at this geography
Proportion of residents who would be willing to work with others to improve their local area**	High	**79.5% (April - December 2023)**	Trend data not currently available	Best: Elmbridge 85.4% Worst: Woking 76.6%	Data not available at this geography	Data not available at this geography

Change from previous reporting period

- Decline
- Improvement
- No Change

* For example, if 76% of non-disadvantaged pupils attain a good level of early years development, compared to 49% of disadvantaged pupils, the gap is 27%. Disadvantage includes looked after children, adopted children and children eligible for Free School Meals in the last 6 years. Children with an EHCP are not included unless they meet the above criteria.
** Responses to new Joint Neighbourhood Survey

Priority 3: Supporting People to Reach Their Potential by Addressing the Wider Determinants of Health
Outcome 3: People access training and employment opportunities within a sustainable economy

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Job seekers claimants claiming for over 12 months*	Low	**0.0% (April 2022 - March 23)**	-0.1 0.1% (April 2021 – March 22)	All boroughs are either 0.0 or 0.1%	Best: numerous PCNs at 0.0% Worst: GRIPC 0.04%	Best: numerous Wards at 0.0% Worst: Longcross, Lyne and Chertsey South (Runnymede) 1.8%
Unemployment benefit (Jobseekers Allowance and out of work Universal Credit claimants)*	Low	**2.0% (April 2022 - March 23)**	-0.8 2.8% (April 2021 – March 22)	Best: Waverley 1.7% Worst: Spelthorne 2.9%	Best: Guildford East 1.4% Worst: SASSE Network 3 3.7%	Best: Englefield Green East (Runnymede) 0.4% Worst: Stanwell North (Spelthorne) 4.9%
Youth unemployment (young people aged 18-24 receiving Jobseekers Allowance or Universal Credit)**	Low	**1.81% (April 2022 - March 23)**	-1.6 2.87% (April 2021 – March 22)	Best: Guildford 1.4% Worst: Spelthorne 4.1%	Best: Guildford East 1.2% Worst: SASSE Network 3 5.4%	Best: 12 Wards at 0.0% Worst: Egham Hythe (Runnymede) 7.0%
Rate of young people aged 16-18 participating in training, education or employment	High	**75.4% (June 2024)**	Trend data not currently available	Data to follow in future update	Data not available at this geography	Data not currently available at this geography

Change from previous reporting period
- Decline
- Improvement
- No Change

* Proportion of the resident population aged 16+
** Proportion of the resident population aged 18-24

Priority 3: Supporting People to Reach Their Potential by Addressing the Wider Determinants of Health
Outcome 4: People are safe and feel safe

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Domestic abuse*	Low	**8.3 (April 2022 - March 23)**	-1.5 9.8 (April 2021 - March 22)	Best: Waverley 5.3 Worst: Runnymede 9.1	Data not currently available at this geography	Data not currently available at this geography
Anti-social behaviour*	Low	**13.1 (April 2022 - March 23)**	-3.1 16.2 (April 2021 - March 22)	Best: Waverley 8.8 Worst: Spelthorne 18.6	Best: West of Waverley 6.4 Worst: SASSE Network 3 32.7	Best: Black Heath and Wonersh (Waverley) 0.6 Worst: Holy Trinity (Guildford) 37.1
Violent and sexual offences*	Low	**23.6 (April 2022 - March 23)**	-0.7 24.3 (April 2021 - March 22)	Best: Waverley 17.3 Worst: Spelthorne 27.9	Best: West of Waverley 12.8 Worst: SASSE Network 3 23.4	Best: Shamley Green and Cranleigh North (Waverley) 1.6 Worst: Friary and St. Nicolas (Guildford) 66.8
Proportion of residents who would feel safe walking alone after dark in their neighbourhood**	High	**81.1% (April - December 2023)**	Trend data not currently available	Best: Guildford 89.3% Worst: Epsom and Ewell 70.4%	Data not available at this geography	Data not available at this geography

* Rate of incidents and crimes per 1000 people in the population
** Responses to new Joint Neighbourhood Survey

Change from previous reporting period
- Decline
- Improvement
- No Change

Priority 3: Supporting People to Reach Their Potential by Addressing the Wider Determinants of Health
Outcome 5: The benefits of healthy environments for people are valued and maximised (page 1 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Cycling at least once per month for travel*	High	**8.1% (Nov 2022)**	+2.0 6.1% (Nov 2021)	Best: Elmbridge 15.3% Worst: Four areas** report 0%	Data not available at this geography	Data not available at this geography
Walking at least once per month for travel**	High	**44.2% (Nov 2022)**	+8.4 35.8% (Nov 2021)	Best: Epsom and Ewell 49.5% Worst: Surrey Heath 35.4%	Data not available at this geography	Data not available at this geography
Travel to work by bicycle or on foot***	High	**7.4% (Census 2021)**	-3.4 10.8% (Census 2011)	Best: Guildford 10.1% Worst: Tandridge 5.0%	Best: GRIPC 15.2% Worst: Banstead Healthcare 4.3%	Best: Westborough (Guildford) 22.3% Worst: Normandy (Guildford) 2.1%
Travel to work by rail or bus***	High	**5.6% (Census 2021)**	-11.2 16.8% (Census 2011)	Best: Epsom and Ewell 8.4% Worst: Waverley 2.9%	Best: Integrated Care Partnership 8.6% Worst: Farnham 2.5%	Best: Whyteleafe (Tandridge) 13.1% Worst: Alfold, Cranleigh Rural and Ellens Green (Waverley) 1.4%

Change from previous reporting period

- Decline
- Improvement
- No Change

* Active Lives Survey by Sport England
** Reigate and Banstead, Runnymede, Surrey Heath and Tandridge
*** Proportion of people travelling to work as a percentage of the usual resident population aged 16+

Priority 3: Supporting People to Reach Their Potential by Addressing the Wider Determinants of Health
Outcome 5: The benefits of healthy environments for people are valued and maximised (page 2 of 2)

Indicator	Good to be	Latest Surrey result	Change from previous Surrey result	Latest Borough and District result	Latest Primary Care Network result	Latest Ward result
Proportion of residents who report having avoided/minimised throwing away food in the last 6 months*	High	**91.8% (April - December 2023)**	Trend data not currently available	Best: Elmbridge 94.1% Worst: Spelthorne 90.1%	Data not available at this geography	Data not available at this geography
Proportion of residents who report having minimised the amount of energy used at home in the last 6 months*	High	**87.9% (April - December 2023)**	Trend data not currently available	Best: Mole Valley 89.8% Worst: Epsom and Ewell 85.4%	Data not available at this geography	Data not available at this geography

* Responses to new Joint Neighbourhood Survey

Change from previous reporting period

- Decline
- Improvement
- No Change

Appendix 2: Summary of indicators in index previously published and added June 24 along with examples of those currently in scope for addition over the next 12 months

Priority One HWBS Indicators

1. Previously published indicators

	Indicator	Relevant Priority Populations	Geographical levels available	Notes
Outcome 1. People have a healthy weight and are active				
	Proportion of physically inactive adults		Borough and district, Ward	Proposed ICS Core Purpose indicator (IOPHHC)
	Proportion of physically active adults		Borough and district, Ward	
	Proportion of physically active Children		Borough and district	
Outcome 2. Substance misuse is low (drugs, alcohol, smoking)				
	Deaths from drug misuse		Borough and district	
	Alcohol related hospital admissions		Borough and district	
Outcome 4. Serious conditions and diseases are prevented				
	Proportion of children aged 5 with 2 doses of MMR		PCN	Also within Health Protection Dashboard.
	New cases of colorectal cancer		PCN, Borough and District, Ward	
	New cases of female breast cancer		PCN, Borough and District, Ward	
	Deaths under 75 from all cancers		PCN, Borough and District, Ward	
	Hypertension prevalence		PCN, Borough and District	Quality Outcomes Framework

	Diabetes prevalence		PCN, Borough and District, Ward	Proposed ICS Core Purpose Indicator (IOPHHC) Quality Outcomes Framework
Outcome 5. People are supported to live well independently for as long as possible				
	Emergency admission rates of people with dementia		Borough and district	

2. New Indicators added June 24

	Indicator	Relevant Priority Populations	Geographical levels available	Notes
Outcome 1. People have a healthy weight and are active				
	Proportion of residents who reported eating five or more portions of fruit and/or vegetables yesterday		Borough and district	Joint Neighbourhood Survey
Outcome 2. Substance misuse is low (drugs, alcohol, smoking)				
	Smoking status at the time of delivery		Borough and district	
	Smoking prevalence in adults (18-64) in routine and manual occupations		Borough and district (data not available for all due to reporting issues)	SH Core Purpose Indicator
	Smoking prevalence in adults (18+) with long term mental health conditions		Borough and district	
Outcome 4. Serious conditions and diseases are prevented				
	Rate of GP health checks for people aged 14+ with learning disabilities		Borough and district	PCN data to follow.
	Chlamydia detection rate		Borough and district	

	Current indicators for incidence of Breast Cancer and Colorectal cancer have changed to u75 mortality		PCN, Borough and District, Ward	

3. Possible Indicators to be included in next update to Index following development work

	Indicator	Relevant Priority Populations	Geographical levels available	Notes (why not currently able to be included)
Outcome 5. People are supported to live well independently for as long as possible				
	Proportion of deaths in usual place of residence			Not currently possible to extract from the Palliative and End of Life Care dashboard. Requires more work to understand recording issues.
	Effectiveness of reablement services		County (to be included)	Priority populations

Priority Two HWBS Indicators

1. Previously published indicators

R	Indicator	Relevant Priority Populations	Geographical levels available	Notes
Outcome 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 - anxiety		Borough and district	
	Self reported wellbeing - low satisfaction		Borough and district	
	Self reported wellbeing - Worthwhile		Borough and district	
	Self reported wellbeing - happiness		Borough and district	
Outcome 3. Isolation is prevented and those that feel isolated are supported				
	Proportion of adult carers who have as much social contact as they would like (18+ yrs.) **(Priority Population Indicator)**	Adult Carers	County	Priority populations
	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (also P3) **(Priority Population Indicator)**	People with serious mental illness	County	Priority populations
Outcome 4. Environments and communities in which people live, work and learn build good mental health				
	Adults with mental health issues in stable and appropriate accommodation (also P3) **(Priority Population Indicator)**	People with serious mental illness	County	Priority populations

2. New indicators added June 24

	Indicator	Relevant Priority Populations	Geographical levels available	Notes
Outcome 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				
	Premature mortality in adults with severe mental illness	People with serious mental illness	County only	Priority populations
	Proportion of patients on the GP register with mental health issues (all ages)		PCNs	Quality Outcomes Framework
	Access to Community Mental Health Services for adults and older adults with severe mental health issues			SH ICS Core Purpose Indicator
	Number of young people aged under 18 supported through NHS funded mental health with at least one contact			SH ICS Core Purpose Indicator
	Proportion of people with serious mental illness having complete range of physical health checks in the 12 last months		Borough and district, PCNs (to follow)	SH ICS Core Purpose Indicator.
	Patients who felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment		Borough and district, PCNs (both to follow)	GP Patient Survey
	Suicides (standardised rate per 100,000 persons aged 10+)**		Borough and district	
Outcome 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		Borough and district	
	Proportion of children receiving 2 1/2 year check		Borough and district	

	The proportion of school pupils receiving special educational needs support whose primary need is social, emotional and mental health		Surrey	
	The proportion of school pupils with an EHCP whose primary need is social, emotional and mental health		Surrey	
Outcome 3. Isolation is prevented and those that feel isolated are supported				
	In my local area there are places where people can meet up and socialise		Borough and district	Joint Neighbourhood Survey
	Adult social care users with as much contact as they would like (percentage of adult social care users who have as much social contact as they would like (18+ yrs.))	People with long-term conditions, disabilities and sensory impairments	County	Priority populations
	If I needed help, there are people in the local area who would be there for me*		Borough and district	Joint Neighbourhood Survey
Outcome 4. Environments and communities in which people live, work and learn build good mental health				
	I feel like I belong to my local area		Borough and district	Joint Neighbourhood Survey
	Proportion of residents doing any unpaid work to help their community or the people who live in it in the last year		Borough and district	Joint Neighbourhood Survey

3. Possible Indicators to be included in next update to Index following development work

	Indicator	Relevant Priority Populations	Geographical levels available	Notes
	Loneliness and isolation indicators potentially highlighted following publishing of JSNA chapter			To be added following completion of JSNA chapter
Outcome 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				
	Reduction in the number of referrals being rejected by adult secondary MH care (due to GPimhs)			
	Increase in referral to CBTI / decrease in medications			
Outcome 3. Isolation is prevented and those that feel isolated are supported				
	UK Measures of National Well-being data - includes measures on Loneliness / Risk of Loneliness Age 65+ (Age UK Surrey Heat Maps based on 'relative risk of loneliness by neighbourhood' based on the 2011 Census) / Loneliness Index (based on Local Insights – PHIT has access via national database)			

Priority Three HWBS Indicators

1. Previously published indicators

	Indicator	Relevant Priority Populations	Geographical levels available	Notes
Outcome 1. People's basic needs are met (food security, poverty, housing strategy etc.)				
	Homelessness Duty		Borough and district	
	Children 0-15 or 19 in absolute /relative low-income/ couple/lone families (8) Annual		Borough and district, Ward	
	Households in Fuel Poverty		Borough and district, Ward	ICS Core Purpose indicator (NHSS&E)
	Adults with learning disabilities in stable and appropriate accommodation **(Priority Population Indicator)**		County	Priority populations
Outcome 2. Children, young people and adults are empowered in their communities				
	Key stage 2 attainment gap for disadvantaged / non-disadvantaged pupils		Borough and district	
	Key stage 4 attainment gap for disadvantaged / non-disadvantaged pupils		Borough and district	

	Early years foundation stage attainment gap for disadvantaged / non-disadvantaged pupils		Borough and district	
Outcome 3. People access training and employment opportunities within a sustainable economy				
	Unemployment rate		Borough and district, PCN, Ward	
	Employment and Support Allowance claimants aged 16-24		Borough and district, PCN, Ward	
	Job seekers over 12 months		Borough and district, PCN, Ward	
	Gap in the employment rate between those with a learning disability and the overall employment rate **(Priority Population Indicator)**		County	Priority populations
	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate **(Priority Population Indicator)**		County	Priority populations
Outcome 4. People are safe and feel safe (community safety including domestic abuse, safeguarding)				
	Rate of domestic abuse incidents		Borough and district	
	Public feeling safe in community after dark		Borough and district	Joint Neighbourhood Survey

	Violent crime		Borough and district, PCN, Ward	
	Antisocial behaviour		Borough and district, PCN, Ward	
Outcome 5. The benefits of healthy environments for people are valued and maximised (including through transport/land use planning)				
	Active Travel Walking		Borough and district	
	Active Travel Cycling		Borough and district	
	Travel to work on foot		Borough and district, Ward	
	Travel to work on by cycle		Borough and district, Ward	
	Travel to work by bus, minibus or coach		Borough and district, Ward	
	Travel to work by train		Borough and district, Ward	
	Travel to work by underground, metro, light rail, tram		Borough and district, Ward	

2. New indicators added June 24

	Indicator	**Relevant Priority Populations**	**Geographical levels available**	**Notes**
Outcome 1. People's basic needs are met (food security, poverty, housing strategy etc.)				

	Have you had to access any of the following in the last 6 months? (food bank, additional borrowing) (2 indicators)		Borough and district	Joint Neighbourhood Survey
	Have you struggled to pay the following bills in the last 6 months?		Borough and district	Joint Neighbourhood Survey
Outcome 2. Children, young people and adults are empowered in their communities				
	Proportion of residents who would be willing to work with others to improve their local area		Borough and district	
Outcome 3. People access training and employment opportunities within a sustainable economy				
	Participation rate training/education 16-18		Borough and district	
Outcome 5. The benefits of healthy environments for people are valued and maximised (including through transport/land use planning)				
	Food waste reduction in the last 6 months		Borough and district	Joint Neighbourhood Survey
	Energy saving in the last 6 months		Borough and district	Joint Neighbourhood Survey

3. Possible Indicators to be included in next update to Index following development work

	Indicator	Relevant Priority Populations	Geographical levels available	Notes (why not currently able to be included)
Outcome 4. People are safe and feel safe (community safety including domestic abuse, safeguarding)				
	Children's Safeguarding. The number of appropriate and detailed referrals due to better identification of neglect and its impact on families			
	Adult Safeguarding. The percentage of enquiries where individuals or individual's representatives outcome were partially or fully met			
	Adult Safeguarding. The percentage of enquiries where the individual or individual's representative were asked what their desired outcomes were?			

Health and Wellbeing Board (HWB) Paper – Formal (public)

1. Reference Information

Paper tracking information	
Title:	**Joint Strategic Needs Assessment (JSNA): Multiple Disadvantage**
HWBS Priority populations:	State priority population/s inc. key neighbourhood/s: • Looked after children and adults with care experience • Adults with learning disabilities and/or autism • People experiencing domestic abuse • People with serious mental illness • People with drug and alcohol problems • People experiencing homelessness • Those in key neighbourhoods
Assessed Need including link to HWBS Priority - 1, 2 and/or 3:	Supporting people experiencing multiple disadvantage – where people face overlapping issues such as mental health needs, substance use, homelessness, domestic abuse, and contact with the criminal justice system.
HWBS Outcome:	**Links to Priority 1 outcomes:** • The needs of those experiencing multiple disadvantage are met • Substance misuse is low (drugs/alcohol/smoking) • People are supported to live well independently for as long as possible **Links to 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 **Links to Priority 3 outcomes:** • People's basic needs are met (food security, poverty, housing strategy etc) • People are safe and feel safe (community safety incl. domestic abuse; safeguarding) • The benefits of healthy environments for people are valued and maximised (inc. through transport/land use planning)
HWBS System Capability:	• Empowered and Thriving Communities • Equality, Diversity and Inclusion • 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):	• Lisa Byrne, Changing Futures Programme Manager, Surrey County Council: Project Supervisor • Ella Turner, Research Officer, Surrey County Council: Lead Author
Board Sponsor(s):	• Vicky Stobbart, Director of Long Term Planning Delivery, Surrey Heartlands ICS: Chapter sponsor • Ruth Hutchinson, Director of Public Health, Surrey County Council: Board sponsor
HWB meeting date:	19 June 2024
Related HWB papers:	N/A
Annexes/Appendices:	Appendix 1 - Multiple Disadvantage JSNA chapter primary research participants

2. Executive summary

This paper outlines the draft recommendations of the developing multiple disadvantage JSNA chapter in recognition of the impact that the experience of multiple disadvantage has on some of the most vulnerable persons in our county. The production of this JSNA chapter has been led by our local lived experience group.

Multiple disadvantage is used to describe persons experience of overlapping issues such as mental health needs, substance use, homelessness, domestic abuse, and contact with the criminal justice system and therefore requires a progressive and integrated system response.

The chapter represents a comprehensive effort to understand the breadth and depth of the challenges faced by those affected by multiple disadvantage in Surrey. It is the result of extensive stakeholder engagement, data analysis, and collaboration across sectors. By bringing together insights from health, social care, housing, criminal justice, and the voluntary and community sector, we aim to provide a detailed picture of the needs and gaps in service provision for this vulnerable population.

As a result of large-scale system engagement, this JSNA chapter presents eleven recommendations that are both cross cutting, long term in nature, and have relevance across the partners represented on the Health and Well-Being Board. The intention is that by providing early insight into the draft recommendations board members will be able to disseminate and support actions within their own organisations and wider partners once it is published in full in summer 2024.

3. Recommendations

The Board is asked to:

1. Consider how the headline draft recommendations are relevant to their own organisations and what actions can be taken to support progress to be made.
2. Once the final chapter is published support dissemination of the chapter's findings and recommendations within their own organisations and networks.

4. Reason for Recommendations

The experience of multiple disadvantage is a reality for far too many. It is estimated that approximately 336,000 adults in England are experiencing multiple disadvantage, with at least 3,000 of these individuals living in Surrey (Lankelly Chase, 2015). For many, their current circumstances are shaped by long-term experiences of poverty, trauma, abuse, and neglect. Multiple disadvantage also puts them at an increased risk of chronic and premature mortality and morbidity, resulting in poorer physical and mental health, higher social care needs, and a poorer life expectancy.

The recommendations set out in this JSNA chapter will not be an endpoint but a beginning, and a call to action for all of partners in Surrey. An underlying theme is that the change that we have started to see in Surrey needs to be amplified and accelerated at individual, service, and system levels to ensure people experiencing multiple disadvantage feel safer and healthier as this will be important in achieving our ambition of reducing health inequalities so that 'no one is left behind'.

5. Detail

The engagement that has been carried out in the development of this JSNA chapter identifies that in addition to the exciting and innovative developments that we have seen in Surrey over recent years, there are clear opportunities for Surrey to improve both the type of support available, and the way support is delivered, to residents experiencing multiple disadvantage.

The findings suggest an urgent need for coordinated and sustained action that builds on the range of work from partners to date to better support those experiencing multiple disadvantage. The complexity of multiple disadvantage means that no single organisation can address these issues in isolation and the need to work effectively as a 'whole system' to enable better outcomes for persons in this situation is highlighted in the chapter. The findings identify the opportunity to improve joint working, break down siloed working, and meet the needs of those experiencing multiple disadvantage with dignity, respect, and comprehensive support.

Whilst this shift in culture and approach is happening, systems transformation takes time to achieve and requires collaboration and partnership working across the 'whole system'. This is the first time in Surrey that a JSNA chapter focusing on multiple disadvantage has been produced, and this is one of the few multiple disadvantage JSNA chapters in the country.

This JSNA chapter will be published in two phases and this paper covers the first phase:

- Phase 1: Adults experiencing multiple disadvantage
- Phase 2: Children, Young People, and Families experiencing multiple disadvantage

Multiple disadvantage has clear links to Surrey's whole system Health and Wellbeing Strategy (HWBS) and applies across its priority populations, strategic priorities, and system capabilities. Elements of multiple disadvantage are identified under the HWBS narrative outcomes and specifically the outcome: 'The needs of those experiencing multiple disadvantage are met'.

This chapter has been co-produced with a group of experts by experience that are part of Surrey's Changing Futures Lived Experience Recovery Organisation (LERO). The LERO was set up in early 2023, with the group meeting with the JSNA Chapter Delivery Group an average of 2-3 times per month through a combination of online and in-person meetings. The JSNA Chapter's governance process also includes a Multiple Disadvantage Multi-Agency Group and the JSNA Oversight Group.

The current **headline draft recommendations** that have been informed from the primary research findings are:

1. Strengthen governance structures by establishing a Multiple Disadvantage Partnership Board.
2. Develop a 5-year strategy for multiple disadvantage.
3. Improve system-wide data collection and sharing protocols.
4. Ensure people experiencing multiple disadvantage are placed at the centre of strategic decision-making processes and involved in the design, commissioning, co-production, and evaluation of services.
5. Invest in early intervention and prevention solutions to reduce the prevalence, duration, and impact of multiple disadvantage.
6. Prioritise embedding a cross-cutting Trauma Informed Approach at individual, service, and system levels.
7. Ensure that key health and care services are commissioned in a way that promotes partnership and integration through the adoption of commissioning best practices for people experiencing multiple disadvantage.
8. Redistribute existing funding to provide a range of integrated, accessible, relational, and person-centred services for people facing multiple disadvantage.
9. Ensure that people experiencing multiple disadvantage are offered a diverse range of mental health services with improved ease of access, flexibility and better outcomes.
10. Conduct a comprehensive review of commissioned substance use services in Surrey to ensure people affected by multiple disadvantage have access to high quality, effective, person-centred alcohol, drug and recovery services.
11. Improve ease of access to housing and accommodation support and ensure sufficient housing options for people experiencing multiple disadvantage.

6. Opportunities/Challenges

Opportunities:

- Ownership and co-production of the JSNA chapter by the Lived Experience Recovery Organisation.
- Extensive levels of engagement and networking through primary research with stakeholders across the system.
- Further building stronger cross-sector partnerships at a strategic and operational level.
- Ability to embed innovative best practice into local commissioning processes.

Challenges:

- Current external challenges impacting on system and services ability to change in line with national direction on work relating to multiple disadvantage and health inclusion.
- Adapting and responding to the level of wider change occurring in the system.

7. Timescale and delivery plan

Following a period of further final engagement, the final chapter including findings and more detailed recommendations will be published in the summer. A range of engagement events is planned to support partners engagement in delivery against the recommendations.

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

A range of stakeholders across Surrey took part in the primary research, including representatives from Surrey County Council, local District and Borough Councils, System leaders, County Councillors, Health and Care Partners (Frimley and Surrey Heartlands ICSs), Voluntary and Community organisations, prison and probation services, Surrey Police, Surrey Fire and Rescue, community pharmacies, and the Office for Health Improvement and Disparities. For a full summary of participants, please see Appendix 1.

The Chapter has been co-produced with people with lived experience of multiple disadvantage through the Lived Experience Recovery Organisation (LERO). The LERO have been involved throughout each stage of this JSNA chapter writing process, from setting out the scope and contents, to designing interview guides and surveys, to receiving training as peer researchers, supporting with stakeholder engagement, identifying key themes, and conducting coding analysis (‘co-designing’ and ‘co-producing’).

At the start of the chapter delivery process, a research skills training session was delivered to experts by experience. This session covered the purpose of research, different methods for conducting research (e.g., qualitative, and quantitative), interview types and techniques, how to prepare for an interview and interview role play. Experts by experience were then supported to lead in-depth just under 30 interviews with stakeholders working in services or roles of particular interest to them.

The LERO are also taking part in presentation skills training to empower them to support dissemination of the chapter with stakeholders once published.

Once the JSNA chapter is published, a communications plan will be used to ensure the chapter is shared with all participants that took part in the chapter research, in addition to relevant stakeholders including Surrey residents, Surrey County Council, Surrey Health and Care Partners, relevant local providers, Health and Well-Being Strategy Governance Structures, Voluntary and Community sector and District and Boroughs.

9. Legal Implications – Monitoring Officer:

The Chair will inform the Board of any legal implications verbally at the meeting.

10. Next steps

Following a further period of further final engagement with partners on the final findings and draft recommendations a series of Multiple Disadvantage JSNA chapter dissemination and discussion events will be held with key stakeholders, providers, and partners across Surrey.

Questions to guide Board discussion:

- What collaborative actions can we take across the system to carry forward the draft recommendations that are currently being developed through this JSNA chapter and provide comprehensive support for those facing multiple disadvantage?
- In what ways can we involve individuals with lived experience of multiple disadvantage in the planning and implementation of our strategies and decision-making to ensure their voices are heard and their needs are met?

Appendix 1: Multiple Disadvantage JSNA chapter primary research participants

- **Surrey County Council (SCC):** including roles relating to the changing futures programme, Bridge the Gap alliance, and Surrey Adults Matter services. Other roles across SCC included: system convenors, programme managers, coroner, assistant directors, heads of department, and those working to support equality, diversity and inclusion, adult social care, care leavers, needle and syringe provision, GRT communities, and rough sleepers. This also includes community link officers and local area coordinators.
- **Surrey and Borders Partnership (SABP) and Surrey Heartlands:** including roles relating to neurodiversity, substance use (i-access), adult mental health, clinical psychologists, medical officers, service managers, therapies, service liaison and diversion, GPIMHS, clinical leads and long-term planning.
- **Voluntary, Community and Faith sector (VCFS):** In total, 22 stakeholders from voluntary and community organisations across Surrey took part in an in-depth interview. VCFS stakeholders had varying remits to support people experiencing multiple disadvantage. Some VCFS organisations focused on supporting specific cohorts e.g., children and young people, others focused on supporting one specific challenge e.g., domestic abuse, housing and supported accommodation, night shelters, food banks. Through the interviews the team spoke to people in a range of roles from CEOs to Service Mangers, to a faith leader, community leads and frontline staff).
- **Outreach providers** (both statutory and non-statutory)
- **Local district and borough councils:** including commissioners and directors
- **County Councillors and Local Authority Leads**
- **Surrey Heartlands Integrated Care System (ICS):** health and care providers including primary care such as GPs, consultants, pharmacists, practitioners, and secondary care such as hospitals.
- **Prison and Probation Services:** including Probation Officers and Domestic Abuse Officers
- **Office for Police and Crime Commissioning (OPCC)**
- **Surrey Police:** including County Lines, policies and commissioning, mental health and suicide prevention
- **Surrey Fire and Rescue Service (SFRS)**
- **Community Pharmacies**
- **Office for Health Improvement and Disparities (OHID)**
- **National Health Service England (NHSE)**
- **Children, young people, and families support providers:** including professionals supporting Early Help, Family Centres, PSHE, Wellbeing, Healthy Schools, Team around the School, Targeted Youth Support, commissioning for adolescence and youth offending, youth homelessness, Children, Family and Lifelong Learning (CFLL), Early Years, SEND, education and the virtual school. Primary research relating to children, young and families will be analysed and presented in the Multiple Disadvantage JSNA Chapter: Phase 2. Phase 2 will focus of children, young and families experiencing multiple disadvantage in Surrey.

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Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	**Better Care Fund (BCF) Plan 2023-25 (update for 2024/25)**
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):	• Jonathan Lillistone, Director of Integrated Commissioning, SCC; jonathan.lillistone@surreycc.gov.uk • Paul Morgan, Head of Continuing Care, SCC; paul.morgan@surreycc.gov.uk
Board Sponsor(s):	Helen Coombes, Executive Director of Adults Wellbeing and Health Partnerships, Surrey County Council
HWB meeting date:	19 June 2024
Related HWB papers:	None
Annexes/Appendices:	Annex 1 - BCF Planning Narrative 2023-25 Annex 2 - BCF Planning return 2024-25 Annex 3 - BCF End of Year Return 2023/24

2. Executive summary

The Board is asked to approve the 2024/25 update to the previously submitted Surrey 2023-25 Better Care Fund (BCF) Plan. The BCF Plan is a two-year plan, covering 2023-25 and this paper provides an update to this with the two key outcomes remaining the same: 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 was incorporated into the BCF Plan for the first time in 2023/24.

The BCF Plan was 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. Note and agree the 2024/25 update to the previously approved 2023-25 BCF Plan.
2 Note the 2023/24 BCF Return which was submitted to NHSE on 23 May.
3 Note the update following the BCF Strategy Workshop in February 2024.

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 at Annexes 1 and 2) 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 of demand that was expected to occur in 2023/24 failing to materialise in Surrey. Many of the schemes for 2023-25 continue to be prioritised towards supporting Surrey's aging population. Whilst delivering against the national conditions, we are still keen to shift the focus more toward prevention and earlier intervention to ensure that 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. The key intentions for 2023-25 are to build upon the learning from the 2022/23 BCF review work, prevention spend mapping, and to take forward the suggestions made at the recent BCF strategy workshop with partners in February 2024. This can be translated into a strategic programme of work that identifies opportunities to commission 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 approach to reablement services continues to be developed and we aim to place a greater emphasis on working with community referrals as well as continuing to support discharge - thus working hard to avoid people's needs increasing and reducing the likelihood of hospital admission.

We will continue to strengthen our approach to supporting patients to be discharged from hospital successfully. Our ambitions are to have 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.

We have now introduced a 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. Although our capacity and demand approach is still in development in Surrey, we intend to progress towards more comprehensive modelling of capacity and demand planning during 2024-25.

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.

A strategy workshop was held in February 2024 and considered "How we can make the most of our BCF in Surrey". The workshop considered our ambition and appetite for longer term BCF planning including consideration of:

- How we determine future priorities for BCF funding
- Developing jointly agreed criteria to inform BCF funding.
- Decision-making timelines & process for BCF funding
- Our approach to capacity and demand management

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

The 2024/25 Update to BCF Plan 2023-2025 was submitted to NHSE on 10 June 2024.

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

Engagement regarding the BCF Plan has taken place with:

- Local engagement with Surrey-wide Local Joint Commissioning Forums
- Surrey Heartlands ICS Execs – Karen McDowell
- Surrey County Council Chief Executive Officer (former) – Leigh Whitehouse
- Frimley Health and Care ICB representative – Tracey Faraday-Drake
- Surrey Heartlands ICB – Ian Smith

9. Legal Implications

There are already NHS Act 2006 s75 arrangements in place for the Surrey HWB BCF.

10. Next steps

The updated BCF Plan 2024-2025 was submitted to NHS England on 10 June 2024.

Ongoing quarterly BCF updates to be submitted to NHSE during 2024/25.

Capacity is coming into place over the summer to provide some dedicated Surrey system leadership for BCF. A Senior Business Manager and a Senior Programme Manager will take forward the work from the February 2024 Strategy Workshop event and provide ongoing robust oversight of BCF in Surrey.

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.

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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.

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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.

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- 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.

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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.

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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.

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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:

- 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)

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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.

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.

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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.

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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.

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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.

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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.

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In summary, the Emergency Care Recovery Plan aims are about:

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- 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.

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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.

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?

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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:

- 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)

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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.

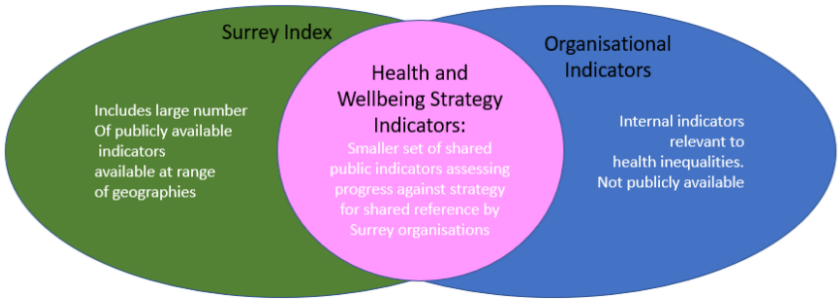
In Frimley, the Local Plan ambitions include reducing inequalities. A range of insights have been gathered to identify specific cohort groups across communities where further action is needed. This work cuts across all areas of the ICS plans including elective recovery, mental health transformation and 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.

8

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BCF Planning Template 2024-25

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. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

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 in this table 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 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'.

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

6. Please ensure that all boxes on the checklist are green before submission.

7. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

4. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

4.2 Hospital Discharge

A new text field has been added this year, asking for a description of the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation. Please answer this briefly, in a couple of sentences.

The capacity section of this template remains largely the same as in previous years, asking for estimates of available capacity for each month of the year for each pathway. An additional ask has now also been included, for the estimated average time between referral and commencement of service. Further information about this is available in the capacity and demand guidance and q&a documents.

The demand section of this sheet is unchanged from last year, requesting expected discharges per pathway for each month, broken down by referral source.

To the right of the summary table, there is another new requirement for areas to include estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways. Please estimate this as an average across the whole year.

4.3 Community

Please enter estimated capacity and demand per month for each service type.

The community sheet also requires areas to enter estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

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 2024-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations, DFG allocations and allocations of ASC Discharge Fund grant to local authorities for 2024-25. The iBCF grant in 2024-25 remains at the same value nationally as in 2023-24.

2. The sheet will be largely auto-populated from either 2023-25 plans or confirmed allocations. You will be able to update the value of the following income types locally:

- ICB element of Additional Discharge Funding
- Additional Contributions (LA and ICB)

If you need to make an update to any of the funding streams, select ‘yes’ in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

3. The sheet will pre populate the amount from the ICB allocation of Additional Discharge Funding that was entered in your original BCF plan. Areas will need to confirm and enter the final agreed amount that will be allocated to the HWB's BCF pool in 2024-25. As set out in the Addendum to the Policy Framework and Planning Requirements; the amount of funding allocated locally to HWBs should be agreed between the ICB and councils. These will be checked against a separate ICB return to ensure they reconcile.

4. The additional contributions from ICBs and councils that were entered in original plans will pre-populate. Please confirm the contributions for 2024-25. If there is a change to these figures agreed in the final plan for 2024-25, please select ‘Yes’ in answer to the Question ‘Do you wish to update your Additional (LA/ICB) Contributions for 2024-25?’. You will then be able to enter the revised amount. These new figures will appear as funding sources in sheet 6a when you are reviewing planned 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 2023-24 (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 at the bottom of the sheet 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 has been auto-populated with spending plans for 2024-25 from your original 2023-25 BCF plans. You should update any 2024-25 schemes that have changed from the original plan. The default expectation is that plans agreed in the original plan will be taken forward, but where changes to schemes have been made (or where a lower level of discharge fund allocation was assumed in your original plan), the amount of expenditure and expected outputs can be amended. There is also space to add new schemes, where applicable.

If you need to make changes to a scheme, you should select yes from the drop down in column X. When 'yes' is selected in this column, the 'updated outputs for 2024-25' and 'updated spend for 2024-25' cells turn yellow and become editable for this scheme. If you would like to remove a scheme type please select yes in column X and enter zeros in the editable columns. The columns with yellow headings will become editable once yes is selected in column X - if you wish to make further changes to a scheme, please enter zeros into the editable boxes and use the process outlined below to re-enter the scheme.

If you need to add any new schemes, you can click the link at the top of the sheet that reads 'to add new schemes' to travel quickly to this section of the table.

For new schemes, as with 2023-25 plans, 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 dropdown list that best describes the scheme being planned.

- Please note that the dropdown 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 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.

- A change has been made to the standard units for residential placements. The units will now read as 'Beds' only, rather than 'Beds/placements'

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.

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 (£)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 was 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 2024-25. 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 2024-25.

Some changes have been made to the metrics since 2023-25 planning; further detail about this is available in the Addendum to the BCF Policy Framework and Planning Requirements 2023-25. The avoidable admissions, discharge to usual place of residence and falls metrics remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics.

The effectiveness of reablement metric will no longer be included in the BCF as there is no direct replacement for the previous measure.

The metric for rate of admissions to Areas should set their ambitions for these metrics based on previous SALT data.

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 2024-25. 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
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2023-24 are pre-populated in the template and will display once the local authority has been selected in the dropdown 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 metric for the BCF requires areas to 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 the indicator value as well as the expected count of admissions and population for 2023-24 and 2024-25 plan.
- We have pre-populated the previously entered planned figures for your information and further more recent data will be available on the BCX in the data pack here: https://future.nhs.uk/bettercareexchange/view?objectID=116035109

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 usual 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. Areas should agree ambitions for a rate for each quarter of the year.
- 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 where available else we will use the previously entered plan data.

4. Residential Admissions:

- This section requires inputting the expected and plan 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 2023-24. 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.
- Although this data collection will be discontinued it is anticipated this will map across to the new CLD extract once this becomes available.

Better Care Fund 2024-25 Update Template

2. Cover

Version 1.3.0

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:	Paul Morgan		Yes
E-mail:	paul.morgan@surreycc.gov.uk		Yes
Contact number:	07805 690402		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Wed 19/06/2024	<< Please enter using the format, DD/MM/YYYY	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Bernie	Muir	bernie.muir@surreycc.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Karen	McDowell	karen.mcdowell2@nhs.net	Yes
	Additional ICB(s) contacts if relevant	xxx	xxx	xxx	xxx	No
	Local Authority Chief Executive		Leigh	Whitehouse	Leigh.whitehouse@surreycc.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Helen	Coombes	helen.coombes@surreycc.gov.uk	Yes
	Better Care Fund Lead Official		Paul	Morgan	paul.morgan@surreycc.gov.uk	Yes
	LA Section 151 Officer		Anna	D'Alesssandro	Anna.DAlessandro@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 -->						

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.

Template Completed

	Complete:
2. Cover	Yes
4.2 C&D Hospital Discharge	Yes
4.3 C&D Community	Yes
5. Income	Yes
6a. Expenditure	Yes
7. Narrative updates	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2024-25 Update Template

3. Summary

Selected Health and Wellbeing Board: Surrey

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£11,077,494	£11,077,494	£0
Minimum NHS Contribution	£95,107,570	£95,107,570	£0
iBCF	£11,408,352	£11,408,352	£0
Additional LA Contribution	£1,639,109	£1,639,109	£0
Additional ICB Contribution	£1,374,416	£1,374,416	£0
Local Authority Discharge Funding	£2,665,722	£2,665,722	£0
ICB Discharge Funding	£9,579,424	£9,579,424	£0
Total	**£132,852,087**	**£132,852,087**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	2024-25
Minimum required spend	£27,029,991
Planned spend	£39,718,220

Adult Social Care services spend from the minimum ICB allocations

	2024-25
Minimum required spend	£56,029,504
Planned spend	£57,022,887

Metrics >>

Avoidable admissions

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	137.8	130.9	155.0	143.0

Falls

		2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,433.0	2,433.0
	Count	6176	6176
	Population	228579	228579

Discharge to normal place of residence

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 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)	91.7%	91.7%	91.3%	93.6%

Residential Admissions

		2022-23 Actual	2024-25 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	643	617

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	0
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	0
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 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: Surrey

Hospital Discharge

Capacity - Demand (positive is Surplus)	Capacity surplus. Not including spot purchasing												Capacity surplus (including spot puchasing)											
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	-54	-51	-54	-40	-52	-36	-52	-45	-45	-53	-47	-49	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	-27	-29	-29	-20	-26	-13	-18	-19	-27	-23	-16	-21	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 (pathway 3)	-44	-43	-53	-47	-56	-63	-50	-57	-64	-57	-72	-53	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
19	Contact Hours per package
15	Contact Hours per package
0	Average LoS (days)
47.7	Average LoS (days)
0	Average LoS (days)

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes

Please briefly describe the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation – e.g. social support from the voluntary sector, blitz cleans. You should also include an estimate of the number of people who will receive this type of service during the year.

We routinely offer advice and information to people being discharged from hospital regarding what support may be avaliable from the voluntary sector. We do not record this in a reportable way. SCC has updated its public facing website to include a section on "Preparing for and leaving hospital services" https://www.connecttosupportsurrey.org.uk/health-and-wellbeing/ .We commission very little in the way of lower level, one off, type of services as described, via our D2A offer.

Capacity - Hospital Discharge

Service Area	Metric	Refreshed planned capacity (not including spot purchased capacity												Capacity that you expect to secure through spot purchasing											
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	221	222	221	203	194	191	209	211	209	234	223	215	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	1.2	1.2	1.2	1.3	1.3	1.1	1.2	1.3	1.3	1.2	1.2	1.1												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	76	65	62	75	73	91	74	87	88	104	107	113	54	51	54	40	52	36	52	45	45	53	47	49
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	8	8	8	8	8	8	8	8	8	8	8	8												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	32	46	39	38	37	42	42	50	44	49	48	44	27	29	29	20	26	13	18	19	27	23	16	21
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	8	8	8	8	8	8	8	8	8	8	8	8												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	44	43	53	47	56	63	50	57	64	57	72	53
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	8	8	8	8	8	8	8	8	8	8	8	8												

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Demand - Hospital Discharge

Please enter refreshed expected no. of referrals:

Pathway	Trust Referral Source	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Total Expected Discharges:	Total Discharges	454	456	458	423	438	436	445	469	477	520	513	495	Yes
Reablement & Rehabilitation at home (pathway 1)	Total	221	222	221	203	194	191	209	211	209	234	223	215	Yes
	OTHER	221	222	221	203	194	191	209	211	209	234	223	215	Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
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	(blank)													Yes
	(blank)													Yes
Short term domiciliary care (pathway 1)	Total	130	116	116	115	125	127	126	132	133	157	154	162	Yes
	OTHER	130	116	116	115	125	127	126	132	133	157	154	162	Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
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	(blank)													Yes
	(blank)													Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	(blank)													Yes
	(blank)													Yes
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Other short term bedded care (pathway 2)	Total	**59**	**75**	**68**	**58**	**63**	**55**	**60**	**69**	**71**	**72**	**64**	**65**	Yes
	OTHER	59	75	68	58	63	55	60	69	71	72	64	65	Yes
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	(blank)													Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**44**	**43**	**53**	**47**	**56**	**63**	**50**	**57**	**64**	**57**	**72**	**53**	Yes
	OTHER	44	43	53	47	56	63	50	57	64	57	72	53	Yes
	(blank)													Yes
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	(blank)													Yes

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: Surrey

Community **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours	
Full Year	Units
0	Contact Hours
0	Contact Hours
0	Contact Hours
0	Average LoS
0	Contact Hours

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes

Capacity - Community

Please enter refreshed expected capacity:

Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Social support (including VCS)	Monthly capacity. Number of new clients.	24	29	38	35	30	30	28	29	31	62	53	50	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	517	605	860	807	587	600	581	633	587	1396	1114	1125	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	141	152	145	122	123	104	92	83	152	172	148	128	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	1	1	6	3	0	7	1	5	3	10	6	3	Yes
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Demand - Community

Please enter refreshed expected no. of referrals:

Service Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Social support (including VCS)	24	29	38	35	30	30	28	29	31	62	53	50	Yes
Urgent Community Response	517	605	860	807	587	600	581	633	587	1396	1114	1125	Yes
Reablement & Rehabilitation at home	141	152	145	122	123	104	92	83	152	172	148	128	Yes
Reablement & Rehabilitation in a bedded setting	1	1	6	3	0	7	1	5	3	10	6	3	Yes
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Better Care Fund 2024-25 Update Template

5. Income

Selected Health and Wellbeing Board: Surrey

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Surrey	£11,077,494
DFG breakdown for two-tier areas only (where applicable)	
Elmbridge	£1,065,660
Epsom and Ewell	£856,547
Guildford	£879,037
Mole Valley	£967,298
Reigate and Banstead	£1,403,460
Runnymede	£953,540
Spelthorne	£1,028,840
Surrey Heath	£964,246
Tandridge	£569,786
Waverley	£929,980
Woking	£1,459,100
Total Minimum LA Contribution (exc iBCF)	**£11,077,494**

Complete:

Yes

8

Local Authority Discharge Funding	Contribution
Surrey	£2,665,722

Yes

ICB Discharge Funding	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
NHS Frimley ICB	£1,238,157	£1,238,157	
NHS Surrey Heartlands ICB	£8,341,267	£8,341,267	
Total ICB Discharge Fund Contribution	£9,579,424	£9,579,424	

Yes

iBCF Contribution	Contribution
Surrey	£11,408,352
Total iBCF Contribution	**£11,408,352**

Yes

Local Authority Additional Contribution	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
Surrey	£492,742	£492,742	
Surrey	£515,820	£1,146,367	
Total Additional Local Authority Contribution	**£1,008,562**	**£1,639,109**	

Yes

NHS Minimum Contribution	Contribution
NHS Frimley ICB	£12,217,178
NHS Surrey Heartlands ICB	£82,890,393
Total NHS Minimum Contribution	**£95,107,570**

Additional ICB Contribution	Previously entered	Updated	Comments - Please use this box clarify any specific uses or sources of funding
NHS Surrey Heartlands ICB	£9,300,000	£437,758	
NHS Frimley ICB	£1,300,000	£0	Additional contribution returned to ICB 23/24
NHS Frimley ICB	£743,869	£936,658	
Total Additional NHS Contribution	**£11,343,869**	**£1,374,416**	
Total NHS Contribution	**£106,451,439**	**£96,481,986**	

Yes

	2024-25
Total BCF Pooled Budget	**£132,852,087**

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 2024-25 Update Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Surrey

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure	Balance
DFG	£11,077,494	£11,077,494	£0
Minimum NHS Contribution	£95,107,570	£95,107,570	£0
iBCF	£11,408,352	£11,408,352	£0
Additional LA Contribution	£1,639,109	£1,639,109	£0
Additional NHS Contribution	£1,374,416	£1,374,416	£0
Local Authority Discharge Funding	£2,665,722	£2,665,722	£0
ICB Discharge Funding	£9,579,424	£9,579,424	£0
Total	**£132,852,087**	**£132,852,087**	**£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).

	2024-25 Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£27,029,991	£39,718,220	£0
Adult Social Care services spend from the minimum ICB allocations	£56,029,504	£57,022,887	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes		Yes	Yes	Yes		Yes		Yes	Yes

Sheet complete

									Planned Expenditure												
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Previously entered Outputs for 2024-25	Updated Outputs for 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	Previously entered Expenditure for 2024-25	Updated Expenditure for 2024-25 (£)	% of Overall Spend (Average)	Do you wish to update?	Comments if updated e.g. reason for the changes made
1	ES 1a - 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	£373,670		14%	No	
2	ES 1b - Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£4,551		0%	No	
3	ES 1c - Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£17,778		1%	No	
4	ES 2 - Carers Funding	Carers Contracts -respite care/carers breaks, information, assessment,	Carers Services	Respite services		502		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£380,000		4%	No	
5	ES 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	£4,924,576		4%	No	
6	ES 4 - Prescription Schemes	Social Prescription	Prevention / Early Intervention	Social Prescribing					Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£547,323		1%	No	
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	£178,196		0%	No	
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	£127,152		0%	No	
9	ES 7 - Tech to Connect	Training to residents to enable social inclusion through the use of	Assistive Technologies and Equipment	Digital participation services		537		Number of beneficiaries	Other	Wellbeing Services	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£71,298		1%	No	
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				Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£156,015		0%	No	
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	£157,627		1%	No	
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	£20,507		1%	No	
13	ES 11 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		74	0	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£126,792	£120,000	1%	Yes	Reduced to last years budget as not fully spend within year.
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			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£43,397	£42,800	2%	Yes	Small reduction from previous plan
15	ES 13a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support		0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£276,264	£274,843	0%	Yes	Small reduction from previous plan
16	ES 13b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£75,709		0%	No	
17	ES 14 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£47,212	£44,683	12%	Yes	Reduced to match 23/24 budget
18	ES 15 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		1954	2110	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£602,907	£651,991	6%	Yes	Small increase to previous budget
19	ES - 16 Autism Friendly Communities	Providing support to communities in Surrey to be inclusive of people with	Community Based Schemes	Integrated neighbourhood services			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,698	£0	0%	Yes	Small reduction from previous plan
20	ES - 17 All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£72,104	£68,241	4%	Yes	Reduced to 23/24 budget

21	ES 18 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		224	245	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£1,268,237	£1,383,330	12%	Yes	Increase to DFG allocation grant
22	ES 19 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Other	Discharge from hospital (with reablement) to	38		Number of beds	Social Care		LA			Local Authority	iBCF	Existing	£1,729,975		1%	No	
23	Discharge Fund - Surrey Heartlands Pathway 1	Pathway 1	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		52874		Hours of care (Unless short-term in which	Social Care		NHS			Private Sector	ICB Discharge Funding	New	£1,268,446		1%	No	
24	ES 21 - ICB Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry Forward		0		Community Health		NHS			NHS	Additional NHS Contribution	Existing	£4,800,000	£0	0%	Yes	Additional investment in BCF from previous years was returned and spend on Health schemes during 23/24
25	ES 22 - D2A contribution	D2A Funding	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		19540		Hours of care (Unless short-term in which	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£468,758		0%	No	
26	GW 1a - 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	£427,399		16%	No	
27	GW 1b - Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£5,207		0%	No	
28	GW 1c - Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£20,394		1%	No	
29	GW 2 - Carers Funding	Carers Contracts -respite care/carers breaks, information, assessment,	Carers Services	Respite services		575		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£435,000		4%	No	
30	GW 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	£4,617,014		3%	No	
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	£149,960		0%	No	
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	£196,090		11%	No	
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	£201,785		0%	No	
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	£187,667		2%	No	
35	GW 8 - Funding for Non Elective Admissions in	Contributions to Acute contracts	Other						Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£211,320		0%	No	
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	£146,266		1%	No	
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	£27,472		0%	No	
38	GW 11 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		9823		Hours of care (Unless short-term in which	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£235,661		0%	No	
39	GW 12 - Falls Prevention Packs	Falls Prevention	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£9,872		0%	No	
40	GW 13 - Social Prescribing Administrator	Social Prescription	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£34,868		0%	No	
41	GW 14 - Outline Grant	Outline Grant	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£292		0%	No	
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	£1,896		0%	No	
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	£24,312		0%	No	
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	£24,126		1%	No	
45	GW 18 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		66	0	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£113,056	£107,000	1%	Yes	Reduced to last years budget as not fully spend within year.
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			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£50,809	£50,110	3%	Yes	Small reduction from previous plan
47	GW 20a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support		0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£314,990	£313,367	0%	Yes	Small reduction from previous plan
48	GW 20b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£86,319		0%	No	
49	GW 21 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£54,855	£51,917	14%	Yes	Reduced to match 23/24 budget
50	GW 22 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		2314	2499	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£713,806	£771,918	7%	Yes	Small increase to previous budget

51	GW 23 - Social Prescribing	Social Prescription	Prevention / Early Intervention	Social Prescribing			0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£73,632	£71,253	0%	Yes	Small reduction to match contract in place
52	GW 24- All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£77,498	£73,346	4%	Yes	Reduced to 23/24 budget
53	GW 25 - ASC Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services			0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£37,995	£0	0%	Yes	Reduced as not spend last year
54	GW 26 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		222	242	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£1,253,448	£1,367,198	12%	Yes	Increase to DFG allocation grant
55	GW 27 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Other	Discharge from hospital (with reablement) to	43		Number of beds	Social Care		LA			Local Authority	iBCF	Existing	£1,981,153		1%	No	
56	Discharge Fund - Surrey Heartlands Pathway 2	Pathway 2	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		1024		Number of placements	Social Care		NHS			Private Sector	ICB Discharge Funding	New	£6,146,191		74%	No	
57	GW 29 - ICB Carry Forward 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry forward		0		Community Health		NHS			NHS	Additional NHS Contribution	Existing	£1,500,000	£0	0%	Yes	Additional investment in BCF from previous years was returned and spend on Health schemes during 23/24
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		23%	No	
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		0%	No	
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		1%	No	
61	SD 2 - Carers Funding	Carers Contracts -respite care/carers breaks, information, assessment,	Carers Services	Respite services		821		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£621,000		6%	No	
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	£6,691,961		5%	No	
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	£183,547		0%	No	
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	£392,985		22%	No	
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	£558,716		5%	No	
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	£40,971		2%	No	
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	£495,652		1%	No	
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	£77,870		0%	No	
69	SD 10 - Funding for Non Elective Admissions in	Contributions to Acute contracts	Other						Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£352,904		0%	No	
70	SD 11 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		34942		Hours of care (Unless short-term in which	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£838,265		1%	No	
71	SD 12 - Tech to Connect	Training to residents to enable social inclusion through the use of	Assistive Technologies and Equipment	Digital participation services		497		Number of beneficiaries	Other	Wellbeing services	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£65,977		1%	No	
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	£40,971		0%	No	
73	SD 14 - Falls Prevention Packs	Falls Prevention	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£11,392		0%	No	
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	£94,146		1%	No	
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	£37,395		2%	No	
76	SD 17 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		140	0	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£237,735	£225,000	2%	Yes	Reduced to last years budget as not fully spend within year.
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			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£74,551	£73,525	4%	Yes	Small reduction from previous plan
78	SD 19a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support		0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£429,366	£427,159	0%	Yes	Small reduction from previous plan
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		0%	No	
80	SD 20 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£85,172	£80,610	22%	Yes	Reduced to match 23/24 budget

81	SD 21 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		3316	3581	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£1,023,072	£1,106,362	10%	Yes	Small increase to previous budget
82	SD 22 - Social Precribing	Social Prescription	Prevention / Early Intervention	Social Prescribing			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£125,971	£119,223	0%	Yes	Reduced to 23/24 budget
83	SD 23 - All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£140,853	£133,309	8%	Yes	Reduced to 23/24 budget
84	SD 25 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		489	533	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£2,763,648	£3,014,451	27%	Yes	Increase to DFG allocation grant
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		Number of beds	Social Care		LA			Local Authority	iBCF	Existing	£2,827,262		2%	No	
86	Discharge Fund - Surrey Heartlands Pathway 3	Pathway 3	Residential Placements	Short-term residential/nursing care for someone likely to require a				Number of beds	Social Care		NHS			Private Sector	ICB Discharge Funding	New	£395,845		0%	No	
87	SD 28 - ICB Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry forward		0		Community Health		NHS			NHS	Additional NHS Contribution	Existing	£1,500,000	£0	0%	Yes	Additional investment in BCF from previous years was returned and spend on Health schemes during 23/24
88	NW 1a - Responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£734,033		28%	No	
89	NW 1b - Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£8,943		0%	No	
90	NW 1c - Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£35,025		1%	No	
91	NW 2 - Carers Funding	Carers Contracts -respite care/carers breaks, information, assessment,	Carers Services	Respite services		988		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£747,000		7%	No	
92	NW 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	£8,192,077		6%	No	
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	£250,571		0%	No	
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	£477,563		96%	No	
95	NW 6 - Acute Contributions	Contributions to Acute contracts	Other						Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£1,782,484		0%	No	
96	NW 7 - D2A funding	Funding for D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		45512		Hours of care (Unless short-term in which	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,091,825		1%	No	
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	£508		0%	No	
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	£13,972		0%	No	
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	£102,923		1%	No	
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	£39,702		2%	No	
101	NW 12 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		130	0	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£221,886	£210,000	2%	Yes	Reduced to last years budget as not fully spend within year.
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			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£83,666	£82,514	5%	Yes	Small reduction from previous plan
103	NW 14a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support		0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£538,465	£535,596	1%	Yes	Small reduction from previous plan
104	NW 14b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£147,438		0%	No	
105	NW 15 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£112,099	£106,094	29%	Yes	Reduced to match 23/24 budget
106	NW 16 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		3199	3454	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£986,951	£1,067,301	10%	Yes	Small increase to previous budget
107	NW 17 All age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£163,645	£154,879	9%	Yes	Reduced to 23/24 budget
108	NW 18 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		641	699	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£3,622,770	£3,951,538	36%	Yes	Increase to DFG allocation grant
109	NW 19 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Other	Discharge from hospital (with reablement) to	74		Number of beds	Social Care		LA			Local Authority	iBCF	Existing	£3,400,298		2%	No	
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	£530,785		0%	No	

111	NW 21 - ICB Carry forward from 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry forward		0		Community Health		NHS			NHS	Additional NHS Contribution	Existing	£1,500,000	£0	0%	Yes	Additional investment in BCF from previous years was returned and spend on Health schemes during 23/24
112	Discharge Fund - Heartlands SCC	Pathway 1	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		14912		Hours of care (Unless short-term in which	Social Care		LA			Private Sector	Local Authority Discharge	New	£357,737		0%	No	
113	Discharge Fund - Heartlands SCC	Pathway 2	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		289		Number of placements	Social Care		LA			Private Sector	Local Authority Discharge	new	£1,733,392		21%	No	
114	Discharge Fund - Heartlands SCC	Pathway 3	Residential Placements	Short-term residential/nursing care for someone likely to require a				Number of beds	Social Care		LA			Private Sector	Local Authority Discharge	New	£111,639		0%	No	
115	Discharge Fund - Heartlands SCC	Staffing	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Private Sector	Local Authority Discharge	New	£149,696		0%	No	
116	Discharge Fund - Frimley ICB	Pathway 1	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		34140		Hours of care (Unless short-term in which	Community Health		NHS			Private Sector	ICB Discharge Funding	New	£819,007		0%	No	
117	Discharge Fund - Frimley ICB	Pathway 2	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		70		Number of placements	Community Health		NHS			Private Sector	ICB Discharge Funding	New	£419,150		3%	No	
118	Discharge Fund - Frimley SCC	Pathway 1	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		8637		Hours of care (Unless short-term in which	Social Care		LA			Private Sector	Local Authority Discharge	New	£207,212		0%	No	
119	Discharge Fund - Frimley SCC	Pathway 2	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		18		Number of placements	Social Care		LA			Private Sector	Local Authority Discharge	new	£106,046		1%	No	
120	GW 30 - Community Schemes / D2A	D2A Funding	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		30349		Hours of care (Unless short-term in which	Community Health		NHS			NHS	Minimum NHS Contribution	New	£728,068		1%	No	
121	SH 1a - New responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£200,019		8%	No	
122	SH 1b - New responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,437		0%	No	
123	SH 1c - New responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£9,544		0%	No	
124	SH 2 - Carers Funding	Carers Contracts -respite care/carers breaks, information, assessment,	Carers Services	Respite services		270		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£204,000		2%	No	
125	SH 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	£1,722,372		1%	No	
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	£86,918		5%	No	
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	£12,542		1%	No	
128	SH 6 - Mental Health - Psychiatric Liaison	Mental Health Support	Prevention / Early Intervention	Other	Psychiatric Liaison				Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£231,274		0%	No	
129	SH 7 - Integrated Care Team	Staffing costs	Enablers for Integration	Integrated models of provision					Social Care		NHS			NHS	Minimum NHS Contribution	Existing	£454,897		68%	No	
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	£233,665		2%	No	
131	SH 9 - Occupational Therapist (SHBC)	Occupational Therapist (SHBC)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£77,068		0%	No	
132	SH 10 - VSNS Asset Development	Social Prescribing	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£42,938		0%	No	
133	SH11 - Social prescribing post Federation (CAB)	Social Prescription	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£36,106		0%	No	
134	SH 12 - Social prescribing post SHBC	Social Prescription	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£44,039		0%	No	
135	SH 13 - Elemental Subscription for Social Subscribers	Social Prescription	Prevention / Early Intervention	Social Prescribing					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,902		0%	No	
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	£22,020		4%	No	
137	SH 15 - Locality Director	Staffing costs	Enablers for Integration	Integrated models of provision					Social Care		NHS			NHS	Minimum NHS Contribution	Existing	£68,099		10%	No	
138	SH 16 - MH Case Worker (Homelessness)	Homelessness	Housing Related Schemes						Social Care		NHS			NHS	Minimum NHS Contribution	Existing	£28,713		7%	No	
139	SH 17 - Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£69,918		0%	No	
140	SH 18 - Community Schemes - Tech	Technology Enabled Schemes	Assistive Technologies and Equipment	Assistive technologies including telecare		365		Number of beneficiaries	Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£48,427		0%	No	

141	SH 19 - Health Integration Development	Development Officer to progress Health Integration	Workforce recruitment and retention					WTE's gained	Primary Care		NHS			NHS	Minimum NHS Contribution	New	£45,446		0%	No	
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	£44,297		0%	No	
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	£11,538		0%	No	
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	£11,361		1%	No	
145	SH 23 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		34	0	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£58,113	£55,000	1%	Yes	Reduced to last years budget as not fully spend within year.
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			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£24,261	£23,354	1%	Yes	Small reduction from previous plan
147	SH 25a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support		0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£147,073	£147,855	0%	Yes	Small reduction from previous plan
148	SH 25b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£42,275		0%	No	
149	SH 26 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£39,632	£37,509	10%	Yes	Reduced to match 23/24 budget
150	SH 27 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		1242	1341	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£383,161	£414,355	4%	Yes	Small increase to previous budget
151	SH 28 - All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£54,693	£51,763	3%	Yes	Reduced to 23/24 budget
152	SH 29 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		156	170	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£882,488	£962,574	9%	Yes	Increase to DFG allocation grant
153	SH 30 - Improve BCF 23/24	Support to D2A process through Care Home packages	Residential Placements	Other	Discharge from hospital (with reablement) to	20		Number of beds	Social Care		LA			Local Authority	iBCF	Existing	£927,309		1%	No	
154	SH 31 - CCG Carry forward from 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry forward		0		Community Health		NHS			NHS	Additional NHS Contribution	Existing	£1,212,658	£476,327	1%	Yes	Carry Forward from 23/24 - additional investment in BCF from previous years was returned and spend on Health schmes during 23/24
155	SH 32 - SCC Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry forward		0		Social Care		LA			Local Authority	Additional LA Contribution	Existing	£106,129	£309,798	0%	Yes	Additional underspend from 23/24 to be carried forward to 24/25
156	NEHF 1a - Responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£92,462		4%	No	
157	NEHF 1b - Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,126		0%	No	
158	NEHF 1c - Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£4,412		0%	No	
159	NEHF 2 - Carers Funding	Carers Contracts -respite care/carers breaks, information, assessment,	Carers Services	Respite services		124		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£94,000		1%	No	
160	NEHF 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	£1,253,587		1%	No	
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	£49,356		0%	No	
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	£41,287		2%	No	
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	£97,601		1%	No	
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	£152,976		1%	No	
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	£5,357		0%	No	
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	£6,031		0%	No	
167	NEHF 10 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		15	0	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£25,358	£24,000	0%	Yes	Reduced to last years budget as not fully spend within year.
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			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£11,256	£11,100	1%	Yes	Small reduction from previous plan
169	NEHF 12a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support		0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£64,181	£63,851	0%	Yes	Small reduction from previous plan
170	NEHF 12b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£17,588		0%	No	

171	NEHF 13 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£12,649	£11,971	3%	Yes	Reduced to match 23/24 budget
172	NEHF 14 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		743	802	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£229,089	£247,740	2%	Yes	Small increase to previous budget
173	NEHF 15 - All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£15,526	£14,694	1%	Yes	Reduced to 23/24 budget
174	NEHF 16 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		50	55	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£282,969	£308,648	3%	Yes	Increase to DFG allocation grant
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				Number of beds	Social Care		LA			Local Authority	iBCF	Existing	£428,574		0%	No	
176	NEHF 18 - CCG Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry forward		0		Community Health		NHS			NHS	Additional NHS Contribution	Existing	£519,578	£229,485	0%	Yes	Carry Forward from 23/24 - additional investment in BCF from previous years was returned and spend on Health schmes during 23/24
177	NEHF 19 - SCC Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry forward		0		Social Care		LA			Local Authority	Additional LA Contribution	Existing	£182,982	£172,889	0%	Yes	Additional underspend from 23/24 to be carried forward to 24/25
178	EB 1a - New Responsibilities under the Care	Homecare Service Provision	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£24,531		1%	No	
179	EB 1b - New Responsibilities under the Care	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£299		0%	No	
180	EB 1c - New Responsibilities under the Care	Safeguarding	Care Act Implementation Related Duties	Other	Safeguarding Board				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,170		0%	No	
181	EB 2 - Carers Funding	Carers Contracts -respite care/carers breaks, information, assessment,	Carers Services	Respite services		33		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£25,000		0%	No	
182	EB 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	£278,971		0%	No	
183	EB 4 - Podiatry - Frimley NHS	Podiatry Service	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£26,661		0%	No	
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	£29,763		0%	No	
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	£31,698		2%	No	
186	EB 7 - Commissioning Reserve	Support to Commissioning	Enablers for Integration	Joint commissioning infrastructure					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£25,807		4%	No	
187	EB 8 - Community Schemes	Grants to Community Organisations	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£513		0%	No	
188	EB 9 - Reablement	Reablement in East Berkshire place	Other						Community Health		NHS			NHS	Minimum NHS Contribution	New	£52,216		0%	No	
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	£1,206		0%	No	
190	EB 11 - TECS	Technology Enabled Care Services	Assistive Technologies and Equipment	Assistive technologies including telecare		5	0	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£8,453	£8,000	0%	Yes	Reduced to last years budget as not fully spend within year.
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			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,459	£2,425	0%	Yes	Small reduction from previous plan
192	EB 13a - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support		0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£20,976	£20,867	0%	Yes	Small reduction from previous plan
193	EB 13b - Mental Health Community	Mental Health Support	Prevention / Early Intervention	Other	Mental Health community support				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£5,747		0%	No	
194	EB 14 - Handy Persons	Handy Persons - not DFG funded	Housing Related Schemes				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,253	£3,079	1%	Yes	Reduced to match 23/24 budget
195	EB 15 - Community Equipment	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		179	193	Number of beneficiaries	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	Existing	£55,343	£59,849	1%	Yes	Small increase to previous budget
196	EB 16 - All Age Autism Strategy	Providing support to people with Autism in Surrey	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,982	£3,768	0%	Yes	Reduced to 23/24 budget
197	EB 17 - Disabled Facilities Grant	Funding passported to Borough and District Councils	DFG Related Schemes	Adaptations, including statutory DFG grants		15	16	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£82,287	£89,755	1%	Yes	Increase to DFG allocation grant
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				Number of beds	Social Care		LA			Local Authority	iBCF	Existing	£113,781		0%	No	
199	EB 19 - CCG Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry forward		0		Community Health		NHS			NHS	Additional NHS Contribution	Existing	£311,633	£230,846	0%	Yes	Carry Forward from 23/24 - additional investment in BCF from previous years was returned and spend on Health schmes during 23/24
200	EB 20 - SCC Carry Forward from 22/23	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry forward		0		Social Care		LA			Local Authority	Additional LA Contribution	Existing	£226,709	£225,922	0%	Yes	Additional underspend from 23/24 to be carried forward to 24/25

201	CW 1 - Integrated Multi Disciplinary Teams - Social	Hospital, Reablement and Occupational Therapy Staffing	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£4,067,361	£3,936,372	37%	Yes	Small reduction from previous plan
202	CW 2 - Integrated Multi Disciplinary Teams - Mental	Integrated Mental Health Teams	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			0		Mental Health		LA			Local Authority	Minimum NHS Contribution	Existing	£284,882	£182,730	3%	Yes	Small reduction from previous plan
203	CW 3 - Protection of Carers Service	Contribution to Carers Contracts - respite care/carers breaks,	Carers Services	Respite services		10302		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£8,232,096		76%	No	
204	CW 4 - Protection of Community Equipment	Contribution to ASC Community Equipment Costs	Assistive Technologies and Equipment	Community based equipment		7192	7192	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,218,860	£2,100,000	22%	Yes	Contract contribution in place has stayed at £2.1M level
205	CW 5 - Protection of Reablement Staffing	Contribution to ASC reablement costs	Other				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£8,312,569	£8,390,952	1%	Yes	Some staff posts have been moved
	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			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,542,412	£3,369,031	33%	Yes	Some staff posts have been moved
207	CW 7 - Protection of OP HBC	Contribution to Homecare Service Provision	Home Care or Domiciliary Care	Domiciliary care packages		504588	532000	Hours of care (Unless short-term in which	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£12,105,061	£12,572,020	8%	Yes	Overestimated expediture for CRS and CES has meant increase to contribution to HBC.
208	CW 8 - Protection of Collaborative Reablement	Reablement partnerships	Other				0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,405,843	£1,064,939	0%	Yes	Block contracts have been reduced
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	Existing	£1,083,385		10%	No	
210	CW 10 - BCF Administration	Staffing costs	Enablers for Integration	Joint commissioning infrastructure			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£118,128	£266,757	18%	Yes	Further posts supporting the management of BCF is now funded from the pooled fund.

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Adding New Schemes:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'		Outputs for 2024-25	Units (auto-populate)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	New/ Existing Scheme		Expenditure for 2024-25 (£)	% of Overall Spend
211	ES 23 - ICB Carry Forward from 23/24	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry Forward				Community Health		NHS			NHS	Additional NHS Contribution	New		£84,866	3%
212	ES 24 - SCC Carry Forward from 23/24	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry Forward				Social Care		LA			Local Authority	Additional LA Contribution	New		£84,866	3%
213	GW 31 - ICB Carry Forward from 23/24	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry Forward				Community Health		NHS			NHS	Additional NHS Contribution	New		£79,764	3%
214	GW 32 - SCC Carry Forward from 23/24	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry Forward				Social Care		LA			Local Authority	Additional LA Contribution	New		£79,764	3%
215	SD 29 - ICB Carry Forward from 23/24	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry Forward				Community Health		NHS			NHS	Additional NHS Contribution	New		£185,128	7%
216	SD 30 - SCC Carry Forward from 23/24	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry Forward				Social Care		LA			Local Authority	Additional LA Contribution	New		£185,128	7%
217	NW 22 - ICB Carry Forward from 23/24	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry Forward				Community Health		NHS			NHS	Additional NHS Contribution	New		£88,000	3%
218	NW 23 - SCC Carry Forward from 23/24	This is the carryforward from the previous year, bids are made against this	Community Based Schemes	Other	Carry Forward				Social Care		LA			Local Authority	Additional LA Contribution	New		£88,000	3%

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 or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2024-25 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: Surrey

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

Across the Integrated Care System, Surrey Heartlands has seen 8% rise in population growth since 19/20 and a 7% decrease in unplanned admissions. Overall, the average time a person spends in hospital has decreased by 4%. We are seeking similar data for the Frimley part of the HWB. Each of the Surrey Places undertake an end of year review that considers demand across all services. We look at demands in different areas. We look at activity, pathways, the type of care provision and length of stay within the services. Each Place has a Local Joint Commisioning Group (LJCG) and a Discharge to Assess Oversight Group that examines LoS in hospital and identifies what the delay points are in hospital discharge. This helps us identify where we need to invest in key services. Another development has been the creation of Local Integrated Neighbourhood Teams. We look at the levels of demand for these teams and make sure that they are fully resourced through BCF funding , then look to other NHS funding sources if required.
Actuals have transferred into a need to invest additional funding and capacity into community equipment for 2024-25. Again, we have monitored the in-year demand for equipment in each of our Places and this has read across into additional use of BCF for investment for 2024-25. SCC has a JSNA and a suite of Commissioning Strategies, as well as a Market Sustainability Plan that considers capacity and demand for residential and nursing care, as well as home based care.

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?

Ongoing development of services is happening at Place in Surrey. The existing intermediate care services include Urgent Community Response (with a 2 hr response designed to prevent hospital admission) and Virtual Wards (that both support dischrge and avoid admission). Surrey has used BCF to developed a service offer that can be proactive and reactive and includes Integrated Neighbourhood support, Carers support , Falls prevention, Care Home support , Proactive planning and support , Virtual Wards, Anticipatory Care, Ageing Well, High Intensity Users. There is in-year evaluation and monitoring of capacity and demand via LCJGs and D2A Oversight Groups. There are daily System Oversight Calls, which along with use of SHREWD, provide a real time system view of pressure points. SCC have real-time brokerage activity reporting ability. This means that we know at any one time which care homes and home care providers have vacancies, how many hospital discharges are planned for that day, how many referrals have been received and how many care providers are assessing potential patients/residents.

What impacts do you anticipate as a result of these changes for:

i. Preventing admissions to hospital or long term residential care?

One impact has been around workforce. Within the HWB we know about care sector challenges in staffing across heath and care. Within the ICB we undertook a detailed gap analysis for our workforce model . We recruited a new Recovery at Home service, which provided a new type of worker (rather than taking up exsiting workforce capacity). This provided additional capacity equating to around 800 weekly additional care calls. All of these calls were committed to keeping people out of hospital. We have also been monitoring the outcomes of our D2A cohort that go temporarily to a care home. Our data shows that 18% of people in this cohort have a hospital episode within the first 6 weeks. This compares with 13% of all new admissions to care homes having a hospital episode within the same timeframe. We will be doing some work to understand this and to consider whether we need to provide greater support to people and care providers during that time of transition. This is related to reducing admissions.

ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

As we move into year 2 of this plan, we continue to monitor our commisioned services and the contribution that they make to improving Hospital Discharge, as outlined above. Commissioners have spent a lot of time trying to re-purpose and support Places with maximising occupancy of block contracts, but,more importantly, improving the service to benefit residents/patients and system flow. This has been done at pace, where necessary, based upon positive and long-standing relationships with residential and domicilary care providers. Change can be achieved quickly in this arena. Currently, we are looking at varying residential care block bed provision in North West Surrey so that long term residential beds are reduced. This will be replaced with bed provision that has more flexibility in terms of short term, step-up/step down provision. This change will assist with admission avoidance and discharge flow. We have historically dedicated some of our BCF allocation to staff whose roles directly influence hospital discharge. Although this is badged against Acutes in lines 35,69 and 95 on tab 6a, we will refine this to give it a more accurate description in 2024/25.

Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.

We have not made as much progress as we would have wished regarding this at the end of year one of the Plan. Capacity and demand work is going on in a wide variety of settings - in Places, in Acutes, in SCC, as well as each individual BCF funded service having intelligence and insights about what needs are and are likely to be. Care home & domicilary providers and the voluntary sector will also have such intelligence (some of it adding extra richness, as it will qualitative). So there is enough evidence & D&C data within Surrey HWB but it is clunky in the way that it shared. Our HWB ambition is for D&C to be rephrased and reframed beyond just data and include insights and intelligence. Additionally, in year 2, we aim to to develop some initial thinking on an easily accessible, cross-system D&C data sharing platform. Such a platform would explain the Surrey HWB narrative, link our HWB ambitions with other plans - BCF, MSIF, SCC commissioning strategies, etc - and give service provider D&C real time data, where we can collect it. This would give additional assurance around commissioning decisions being soundly based upon local evidence and relating to these plans. We would be interested in learning from NHSE whether there any other local systems that have got progressed this approach already and considering the learning from that.

Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?	**Yes**

Linked KLOEs (For information)

Checklist Complete:	
Yes	Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?
Yes	Does the plan describe any changes to commissioned intermediate care to address gaps and issues? 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 capacity needed for additional services?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?
Yes	

Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.		
Data is shared across the HWB to assist in our understanding of the needs of our population, using this to influence the types and volumes of care that we need to avoid admission to hospital and to facilitate timely hospital discharge. HWB ICBs have access to SUS on Better Care Exchange and have produced a Community Dashboard during 2023-24. The LA produce data through Public Health and via the Adults, Well Being and Health Partnerships Business intelligence Team. Below this, activity data is held at Place level and by Place service. For example, one Surrey Place has a Home First, Transfer of Care Hub. This Hub is able to report on activity and unmet demand that will be fed back to the LJCG. Long term demand for OP residential care has been modelled up to 2030 using multiple variable linear regressions, considering factors such as population growth, dementia diagnosis, and the availability of alternative care services such as Extra Care Housing and Direct Payments. The models suggest the demand for general residential beds will fall by approximately 250 to 300 beds by 2030. Conversely, the demand for enhanced residential (dementia and complex needs) and nursing beds will both increase, with approximately 50 to 100 additional beds required in Nursing, and 125 to 175 beds for enhanced residential care (based on March 2024 service user data). We have a Care Home Operational Group which aims to implement the Enhanced Health in Care Home Framework, linking with all the care home place leads. We are currently putting together the programme plan for next year and have included work on hospital discharge (not just discharge to assess which comes with its own unique challenges). We have done work to promote personalised care, as well as UCR, with care homes. Every care home is aligned to a primary care network (PCN), has a named clinical lead, has a weekly 'home round' supported by the care home multidisciplinary team (MDT)	Yes	Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care?

Approach to using Additional Discharge Funding to improve

Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.		
We have been providing monthly reports to NHSE re ADF. Surrey has used ADF, as well as BCF, to contribute to our wider Discharge To Assess offer. Each Surrey Place and Acute has a locally agreed approach to D2A that focuses upon timely discharge and appropriate interim support whilst ongoing health and care assessments are undertaken. The ADF has been crucial in funding this D2A capacity, which would have not been available through our broader recurrent funding. Without investing the ADF into D2A schemes, we would have had a much reduced D2A offer, resulting in fewer timely discharges and an increased LoS. We have a Surrey Wide Discharge To Assess Task Force which has the function of taking an overarching view of D2A across Surrey, The Task Force considers the monthly D2A Activity and Performance Report and identifies areas of strength and areas for improvement. Comparisons are made between Places to consider varation and share learning.	Yes	Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Is the plan for spending the additional discharge grant in line with grant conditions?

Please describe any changes to your Additional discharge fund plans, as a result from o **Local learning from 23-24** o **the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)**		
Local learning from 23-24 has influenced our ADF plans in the following ways via our D2A approach - we have reduced reliance on block contracts, we have increasingly shifted to home first approach, we have used ADF as an enabler for collaborative working at Place - thus creating shared imperatives for Acutes and community health and social care services. Commissioners have worked proactively with care providers to ensure that varying levels of patient needs can be met. This has involved securing complex care and care for people who have delirium or are non weight bearing. In addition to this each Place has used its own exeriential learnining from 23-24 to make local changes for 2024-25 (within the same D2A envelope). For example, one Place will recruit in 2024-5 a practioner dedicated to moving people on from their interim D2A arrangement in a tmely way. This is seen as more efficient than various different practitoners working with a different number of patients. Another Place has chosen to ringfence ADF to make service developments - working with secondary care to align D2A strategic and operational goals. Another area has reduced its amount of block contracted care home beds in 2024-5 as it seeks to continue the Home First approach. The ADF national evaluation 22-23 has been useful in learning what other systems have done and in hearing about the similar challenges faced. It has not particulary influenced any changes in 2024-25 in Surrey as we have largely adopted a "steady-state" approach over the 2 year plan. However, we intend to updat eand revose this approach during this year on the basis of a HWB event held in February 2024.	Yes	Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"

Ensuring that BCF funding achieves impact

What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics?		
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 sets out the need for different partners across Surrey work to together with local communities to commission services. All services that are funded by BCF have to meet the criteria set out in the BCF requirements.	Yes	Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?

Better Care Fund 2024-25 Update Template

7. Metrics for 2024-25

Selected Health and Wellbeing Board: Surrey

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	137.8	130.9	155.0	143.0	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 the inflationary cost pressures on services.	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	1,872	1,778	-	-			
	Population	1,205,616	1,205,616	-	-			
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan			
	Indicator value	137.8	130.9	155	143			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,124.5	2,433.0	2,433.0	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	6176	6176			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

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	91.7%	91.7%	91.3%	93.6%	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 needs of Surrey's ageing population, and the reduction in the ASC DF funding this year. Understanding the schemes and impact which have been invested in through the BCF in 22/23 has helped us understand the expected impact of them in 23/24.	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	21,180	21,571	20,000	20,500			
	Denominator	23,108	23,511	21,900	21,900			
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan			
	Quarter (%)	91.7%	91.7%	91.3%	93.6%			
	Numerator	21,604	22,002	20,400	20,910			Yes
	Denominator	23,570	23,981	22,338	22,338			Yes

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
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	643.1	697.8	616.4	616.7	We are reflecting the % increase in population for 2024-5. We have not considered additional pressures such as increasing complexity and acuity. Collectively, our various Plans contain ambitions to keep people at home, and, if people should go into hospital, have Home First as a default offer.	As detailed in tab 6a, BCF supports a wide range of health and social care services that are aimed at keeping people in their own homes and out of hospital and residential care homes.	Yes
	Numerator	1,470	1,670	1,475	1,497			Yes
	Denominator	228,579	239,307	239,307	242,739			

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

Please note, actuals for Cumberland and Westmorland and Furness are using the Cumbria combined figure for the Residential Admissions metrics since a split was not available; Please use comments box to advise.

Better Care Fund 2024-25 Update Template

8. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Surrey

	Code	2023-25 Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) to be confirmed for 2024-25 plan updates	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 (in line with the Health and Wellbeing Board's formal governance arrangements) approval? **Paragraph 11 as stated in BCF Planning Requirements 2023-25* Have local partners, including providers, VCS representatives and local authority service	Cover sheet Cover sheet Cover sheet Cover sheet	Yes				Yes
	Not covered in plan update - please do not use	**A clear narrative for the integration of health, social care and housing**	Not covered in plan update						
	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? 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?	Cover sheet Planning Requirements	Yes	We have asked for reports on DFG from the D&Bs within our HWB. We will also be suggesting to D&Bs that further scrutiny is undertaken in the			Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4 & PR6**	**A demonstration of how the services the area commissions will support the BCF policy objectives to:** **- Support people to remain independent for longer, and where possible support them to remain in their own home** **- Deliver the right care in the right place at the right time?**	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service? Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care? Have gaps and issues in current provision been identified? Does the plan describe any changes to commissioned intermediate care to address these gaps and issues? Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC demand, capacity and flow estimates in NHS activity operational plans and BCF capacity and demand plans? Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?		Yes				Yes
Additional discharge funding	**PR5**	**A strategic, joined up plan for use of the Additional Discharge Fund**	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? Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?		Yes				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**	PR 4 and PR6 are dealt with together (see above)						
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 and NHS commissioned out of hospital 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? Does the total spend from the NHS minimum contribution on NHS commissioned out of hospital services match or exceed the minimum required contribution?		Yes	In both areas the total spend exceeds the minimum required contribution			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? Where there have been significant changes to planned expenditure, does the plan continue to support the BCF objectives? Has the area included estimated amounts of activity that will be delivered/funded through BCF funded schemes? (where applicable) Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? Is there confirmation that the use of grant funding is in line with the relevant grant conditions? Has the Integrated Care Board confirmed distribution of its allocation of Additional Discharge Fund to individual HWBs in its area? 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		Yes	Plan supports the BCF objectives. Some % is still to be worked out after draft submission. Some work is still to be done around grant conditions, where the grant is paid to D&Bs and not managed by SCC. HWB is sighted on plans and will sign off at next meeting. We acknowledge the use of "Other" which is the same as last year and cannot be changed. We commit to reducing the use of "Other" and to providie narrative in the future regarding this. HWB ICBS and SCC intend to spend all			Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric setting out: - supporting rationales that describes how these ambitions are stretching in the context of current performance? - plans for achieving these ambitions, and - how BCF funded services will support this?		Yes		The narrative does provide rationale in tab 8. However the HWB does not have any stretch plans or targets in place		Yes

Better Care Fund 2023-24 Year End Reporting Template

1. Guidance for Year-End

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), working with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). An addendum to the Policy Framework and Planning Requirements has also been published, which provides some further detail on the end of year and reporting requirements for this period.

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, including performance metrics

4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting can be used by local areas, including ICBs, local authorities/HWBs and service providers, to further understand and progress the integration of health, social care and housing on their patch. BCF national partners will also use the information submitted in these reports to aid with a bigger-picture understanding of these issues.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

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 and those that are not for completion are in grey, as below:

Data needs inputting in the cell
Pre-populated cells
Not applicable - cells where data cannot be added

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 to 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.

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 submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and spend from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.

2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.

3. 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 HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (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/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB 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: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer

National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The latest BCF plans required areas to set stretching ambitions against the following metrics for 2023-24:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions 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 in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

No actual performance is available for the ASCOF metrics - Residential Admissions and Reablement - so the 2022-23 outcome has been included to aid with understanding. These outcomes are not available for Westmorland and Cumbria (due to a change in footprint).

5. Income and Expenditure

The Better Care Fund 2023-24 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 Additional Discharge Fund.

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2023-24 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 ADF via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2023-24 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 2023-24 in the yellow boxes provided, **NOT** the difference between the planned and actual income. Please also do the same for the ASC Discharge Fund.

- Please provide any comments that may be useful for local context for the reported actual income in 2023-24.

6. Spend and activity

The spend and activity worksheet will collect cumulative spend and outputs in the year to date for schemes in your BCF plan for 2023-24 where the scheme type entered required you to include the number of output/deliverables that would be delivered.

Once a Health and Wellbeing Board is selected in the cover sheet, the spend and activity sheet in the template will prepopulate data from the expenditure tab of the 23-25 BCF plans for all 2023-24 schemes that required an output estimate.

You should complete the remaining fields (highlighted yellow) with incurred expenditure and actual numbers of outputs delivered to year-end.

The collection only relates to scheme types that require a plan to include estimated outputs. These are shown below:

Scheme Type	Units
Assistive technologies and equipment	Number of beneficiaries
Home care and domiciliary care	Hours of care (unless short-term in which case packages)
Bed based intermediate care services	Number of placements
Home based intermediate care services	Packages
DFG related schemes	Number of adaptations funded/people supported
Residential Placements	Number of beds/placements
Workforce recruitment and retention	Whole Time Equivalents gained/retained
Carers services	Number of Beneficiaries

The sheet will pre-populate data from relevant schemes from final 2023-24 spending plans, including planned spend and outputs. You should enter the following information:
- **Actual expenditure to date in column K.** Enter the amount of spend to date on the scheme.
- **Outputs delivered to date in column N**. Enter the number of outputs delivered to date. For example, for a reablement and/or rehabilitation service, the number of packages commenced. The template will pre-populate the expected outputs for the year and the standard units for that service type. For long term services (e.g. long term residential care placements) you should count the number of placements that have either commenced this year or were being funded at the start of the year.
- **Implementation issues in columns P and Q.** If there have been challenges in delivering or starting a particular service (for instance staff shortages, or procurement delays) please answer yes in column P and briefly describe the issue and planned actions to address the issue in column Q. If you answer no in column P, you do not need to enter a narrative in column Q.

7.1 C&D Hospital Discharge and 7.2 C&D Community

When submitting actual demand/activity data on short and intermediate care services, consideration should be given to the equivalent data for long-term care services for 2023-24 that have been submitted as part of the Market Sustainability and Improvement Fund (MSIF) Capacity Plans, as well as confirming that BCF planning and wider NHS planning are aligned locally. We strongly encourage co-ordination between local authorities and the relevant Integrated Care Boards to ensure the information provided across both returns is consistent.

These tabs are for reporting actual commisioned activity, for the period April 2023 to March 2024. Once your Health and Wellbeing Board has been selected in the cover sheet, the planned demand data from April 2023 to October 2023 will be auto-populated into the sheet from 2023-25 BCF plans, and planned data from November 2023 to March 2024 will be auto-populated from 2024-25 plan updates.

In the 7.1 C&D Hospital Discharge tab, the first half of the template is for actual activity without including spot purchasing - buying individual packages of care on an 'as and when' basis. Please input the actual number of new clients received, per pathway, into capacity that had been block purchased. For further detail on the definition of spot purchasing, please see the 2024-25 Capacity and Demand Guidance document, which can be found on the Better Care Exchange here: https://future.nhs.uk/bettercareexchange/view?objectID=202784293

The second half is for actual numbers of new clients received into spot-purchased capacity only. Collection of spot-purchased capacity was stood up for the 2023-24 plan update process, but some areas did not input any additional capacity in this area, so zeros will pre-populate here for them.

Please note that Pathway 0 has been removed from the template for this report. This is because actuals information for these services would likely prove difficult for areas to provide in this format. However, areas are still expected to continue tracking their P0 capacity and demand throughout the year to inform future planning.

8. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2023-24 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 2023-24
3. The delivery of our BCF plan in 2023-24 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 2023-24.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2023-24

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. The 9 points of the SCIE logic model are listed at the bottom of tab 8 and at the link below.
SCIE - Integrated care Logic Model

HM Government

NHS England

Better Care Fund 2023-24 Year End Reporting Template

2. Cover

Version 2.0

Please Note:

- The BCF quarterly 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 Better Care Exchange) 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

Health and Wellbeing Board:	Surrey	
Completed by:	Paul Morgan	
E-mail:	paul.morgan@surreycc.gov.uk	
Contact number:	07805 690402	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Wed 19/06/2024	<< Please enter using the format, DD/MM/YYYY

When all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. I&E actual	Yes
6. Spend and activity	Yes
7.1 C&D Hospital Discharge	Yes
7.2 C&D Community	No
8. Year End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2023-24 Year End Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Surrey

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off		Yes

Confirmation of National Conditions			
National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the year:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-24 Year End Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Surrey

National data may be unavailable at the time of reporting. As such, please use 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 2023-24 planning Q1	Q2	Q3	Q4	Assessment of progress against the metric plan for	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	130.0	140.0	155.0	143.0	On track to meet target	Actuals by quarter for 23/24 in Surrey are 137.8 130.8 136.3 135 Average of 142 predicted for 23/24 Average of Actuals ofr 2023/4 is 135 Still issues related to volumes of	BCF investments are making a difference in this metric as 5% reduction in our forecast v actual for unplanned admissions. Strong partnerships at Place and a service	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.6%	86.8%	91.3%	93.6%	On track to meet target	Planned for 2023/24 was 91.3 Actual for 2023/24 was 91.6 This is broadly in line with plans and slightly exceeds them. We continue to have good availability of domicilary	We work hard as a system to get people back to their usual place of residence. We will continue to work on this, both as a system and at Place. We will continue to embed our Home	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,124.5	On track to meet target	1914 is the SUS end of year figure. This does not appear to be a complete year as Q4 data seems to be incomplete.	A range of BCF investments contribute to performance relating to falls. These include community equipment, use of technology enabled care, supporting carers and	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				698	On track to meet target	Actual figure is 616. We are seeing an improving picture on res admissions but we have also heard that we make more res admissions compared to other comparator LAs which we are	BCF has contributed to this due to investments in both community services and hospital discharge care. There is an overarching joint ethos of admission avoidance to both hospital	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				69.4%	On track to meet target	This metric is being withdrawn. We would like to understand how we measure against other comparator systems for this metric.	Reablement remains a key service offer in Surrey that assists with both admission avoidance and hospital discharge.	Yes

Better Care Fund 2023-24 Year End Reporting Template

5. Income actual

Selected Health and Wellbeing Board: Surrey

Income

	2023-24
Disabled Facilities Grant	£11,042,043
Improved Better Care Fund	£11,408,352
NHS Minimum Fund	£90,012,843
Minimum Sub Total	£112,463,238

	Planned	Actual		
NHS Additional Funding	£11,343,869	Do you wish to change your additional actual NHS funding?	No	
LA Additional Funding	£1,008,564	Do you wish to change your additional actual LA funding?	No	
Additional Sub Total	£12,352,433			£12,352,433

	Planned 23-24	Actual 23-24
Total BCF Pooled Fund	£124,815,671	£124,815,671

Additional Discharge Fund

	Planned	Actual		
LA Plan Spend	£1,599,433	Do you wish to change your additional actual LA funding?	No	
ICB Plan Spend	£5,509,223	Do you wish to change your additional actual ICB funding?	No	
Additional Discharge Fund Total	£7,108,656			£7,108,656

	Planned 23-24	Actual 23-24
BCF + Discharge Fund	£131,924,327	£131,924,327

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2023-24	

Expenditure

	2023-24
Plan	£131,038,131

Do you wish to change your actual BCF expenditure?	Yes

Actual	£129,403,545

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2023-24	The BCF funding not used in 2023/24 has been carried forward to 2024/25 to be spend on local community schemes as agreed at Local Joint Commission Groups.

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2023-24 Year End Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Surrey

Checkli Yes Yes Yes Yes

Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Q3 Actual expenditure to date	Actual Expenditure to date	Planned outputs	Q3 Actual delivered outputs to date	Outputs delivered to date (estimate if unsure)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
4	ES 2 - Carers Funding	Carers Services	Respite services	Minimum NHS Contribution	£380,000	£285,000	£380,000	502	377	502	Beneficiaries	No	
9	ES 7 - Tech to Connect	Assistive Technologies and Equipment	Digital participation services	Minimum NHS Contribution	£67,479	£50,609	£67,479	508	381	508	Number of beneficiaries	No	
13	ES 11 - TECS	Assistive Technologies and Equipment	Assistive technologies including	Minimum NHS Contribution	£120,000	£32,833	£53,791	70	19	£31	Number of beneficiaries	Yes	Should not be £31 in N12 - should be 31. Not implementation issues as such. There was a delay in getting projects started.
18	ES 15 - Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£570,610	£427,958	£473,167	1,342	1,457	1610	Number of beneficiaries	No	
21	ES 18 - Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG	DFG	£1,268,237	£1,378,303	£1,378,303	224	112	112	Number of adaptations funded/people	Yes	Planned output was calculated at start of year based on feedback from some D&Bs, this has been adjusted at year end. No implementation issue as such, more output from start was overly optimistic.
22	ES 19 - Improve BCF 23/24	Residential Placements	Other	iBCF	£1,729,375	£1,297,481	£1,729,375	38	29	38	Number of beds/placements	No	
23	Discharge Fund - Surrey Heartlands Pathway 1	Home Care or Domiciliary Care	Domiciliary care to support hospital	ICB Discharge Funding	£760,755	£570,566	£760,755	31,711	23,783	31711	Hours of care (Unless short-term in which case it is packages)	No	
25	ES 22 - D2A contribution	Home Care or Domiciliary Care	Domiciliary care to support hospital	Minimum NHS Contribution	£472,253	£354,190	£472,253	19,685	14,764	19685	Hours of care (Unless short-term in which case it is packages)	No	
29	GW 2 - Carers Funding	Carers Services	Respite services	Minimum NHS Contribution	£435,000	£326,250	£435,000	575	431	575	Beneficiaries	No	
38	GW 11 - D2A funding	Home Care or Domiciliary Care	Domiciliary care to support hospital	Minimum NHS Contribution	£194,190	£145,643	£194,190	8,095	6,020	8095	Hours of care (Unless short-term in which case it is packages)	No	
45	GW 18 - TECS	Assistive Technologies and Equipment	Assistive technologies including	Minimum NHS Contribution	£107,000	£64,397	£84,808	63	38	50	Number of beneficiaries	Yes	Not implementation issues as such. There was a delay in getting projects started.
50	GW 22 - Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£675,568	£506,676	£560,201	2,299	1,724	1906	Number of beneficiaries	No	
54	GW 26 - Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG	DFG	£1,253,448	£1,362,823	£1,362,823	222	149	111	Number of adaptations funded/people	Yes	Planned output was calculated at start of year based on feedback from some D&Bs, this has been adjusted at year end. No implementation issue as such, more output from start was overly optimistic.
55	GW 27 - Improve BCF 23/24	Residential Placements	Other	iBCF	£1,381,153	£1,485,865	£1,381,153	43	32	43	Number of beds/placements	No	
56	Discharge Fund - Surrey Heartlands Pathway 2	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with	ICB Discharge Funding	£3,686,198	£2,764,649	£3,686,198	614	460	614	Number of placements	No	

Better Care Fund 2023-24 Year End Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Surrey

Checkli							Yes			Yes		Yes	Yes
Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Q3 Actual expenditure to date	Actual Expenditure to date	Planned outputs	Q3 Actual delivered outputs to date	Outputs delivered to date (estimate if unsure)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
61	SD 2 - Carers Funding	Carers Services	Respite services	Minimum NHS Contribution	£621,000	£465,750	£621,000	821	616	821	Beneficiaries	No	
70	SD 11 - D2A funding	Home Care or Domiciliary Care	Domiciliary care to support hospital	Minimum NHS Contribution	£730,512	£532,884	£730,512	32,352	24,714	32952	Hours of care (Unless short-term in which case it is packages)	No	
71	SD 12 - Tech to Connect	Assistive Technologies and Equipment	Digital participation services	Minimum NHS Contribution	£62,443	£46,832	£62,443	470	353	470	Number of beneficiaries	No	
76	SD 17 - TECS	Assistive Technologies and Equipment	Assistive technologies including	Minimum NHS Contribution	£225,000	£61,943	£102,154	132	36	60	Number of beneficiaries	Yes	Not implementation issues as such. There was a delay in getting projects started.
81	SD 21 - Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£368,268	£726,201	£802,316	3,295	2,471	2732	Number of beneficiaries	No	
84	SD 25 - Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG	DFG	£2,763,648	£3,004,803	£3,004,803	489	328	245	Number of adaptations funded/people	Yes	Planned output was calculated at start of year based on feedback from some D&Bs, this has been adjusted at year end. No implementation issue as such, more output from start was overly optimistic.
85	SD 26 - Improve BCF 23/24	Residential Placements	Other	iBCF	£2,827,262	£2,120,447	£2,827,262	62	47	62	Number of beds/placements	No	
86	Discharge Fund - Surrey Heartlands Pathway 3	Residential Placements	Short-term residential/nursing care for	ICB Discharge Funding	£237,409	£178,057	£237,409		30	40	Number of beds/placements	No	
91	NW 2 - Carers Funding	Carers Services	Respite services	Minimum NHS Contribution	£747,000	£560,250	£747,000	988	741	988	Beneficiaries	No	
96	NW 7 - D2A funding	Home Care or Domiciliary Care	Domiciliary care to support hospital	Minimum NHS Contribution	£1,035,761	£776,821	£1,155,761	43,175	32,381	48177	Hours of care (Unless short-term in which case it is packages)	No	
101	NW 12 - TECS	Assistive Technologies and Equipment	Assistive technologies including	Minimum NHS Contribution	£210,000	£55,741	£96,608	123	33	57	Number of beneficiaries	Yes	Not implementation issues as such. There was a delay in getting projects started.
106	NW 16 - Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£934,082	£700,562	£774,567	3,179	2,384	2636	Number of beneficiaries	No	
108	NW 18 - Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG	DFG	£3,622,770	£3,938,893	£3,938,893	641	321	321	Number of adaptations funded/people	Yes	Planned output was calculated at start of year based on feedback from some D&Bs, this has been adjusted at year end. No implementation issue as such, more output from start was overly optimistic.
109	NW 19 - Improve BCF 23/24	Residential Placements	Other	iBCF	£3,400,298	£2,550,224	£3,400,298	74	56	74	Number of beds/placements	No	
112	Discharge Fund - Heartlands SCC	Home Care or Domiciliary Care	Domiciliary care to support hospital	Local Authority Discharge Funding	£214,643	£160,982	£214,643	8,947	6,710	8947	Hours of care (Unless short-term in which case it is packages)	No	

Better Care Fund 2023-24 Year End Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Surrey

Checkli | Yes | Yes | Yes | Yes

Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Q3 Actual expenditure to date	Actual Expenditure to date	Planned outputs	Q3 Actual delivered outputs to date	Outputs delivered to date (estimate if unsure)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
113	Discharge Fund - Heartlands SCC	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with	Local Authority Discharge Funding	£1,040,035	£780,026	£1,040,035	173	130	173	Number of placements	No	
114	Discharge Fund - Heartlands SCC	Residential Placements	Short-term residential/nursing care for	Local Authority Discharge Funding	£66,383	£50,237	£66,383		8	11	Number of beds/placements	No	
116	Discharge Fund - Frimley ICB	Home Care or Domiciliary Care	Domiciliary care to support hospital	ICB Discharge Funding	£335,050	£251,288	£335,050	13,366	10,475	13366	Hours of care (Unless short-term in which case it is packages)	No	
117	Discharge Fund - Frimley ICB	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with	ICB Discharge Funding	£171,471	£128,603	£171,471	29	22	29	Number of placements	No	
118	Discharge Fund - Frimley SCC	Home Care or Domiciliary Care	Domiciliary care to support hospital	Local Authority Discharge Funding	£124,327	£93,245	£124,327	5,182	3,887	5182	Hours of care (Unless short-term in which case it is packages)	No	
119	Discharge Fund - Frimley SCC	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with	Local Authority Discharge Funding	£63,628	£47,721	£63,628	11	8	11	Number of placements	No	
120	GW 30 - Community Schemes / D2A	Home Care or Domiciliary Care	Domiciliary care to support hospital	Minimum NHS Contribution	£728,068	£427,700	£439,813	30,349	17,828	20834	Hours of care (Unless short-term in which case it is packages)	No	
124	SH 2 - Carers Funding	Carers Services	Respite services	Minimum NHS Contribution	£204,000	£153,000	£204,000	270	203	270	Beneficiaries	No	
140	SH 18 - Community Schemes - Tech Post	Assistive Technologies and Equipment	Assistive technologies including	Minimum NHS Contribution	£45,833	£27,347	£34,296	345	206	258	Number of beneficiaries	No	
141	SH 19 - Health Integration Development Officer	Workforce recruitment and retention		Minimum NHS Contribution	£43,012	£23,739	£31,652		1	1	WTE's gained	No	
145	SH 23 - TECS	Assistive Technologies and Equipment	Assistive technologies including	Minimum NHS Contribution	£55,000	£19,127	£31,849	32	11	£19	Number of beneficiaries	Yes	Should not be £19 in N50, should be 19. Not implementation issues as such. There was a delay in getting projects started.
150	SH 27 - Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£362,636	£271,977	£300,708	1,234	926	1023	Number of beneficiaries	No	
152	SH 29 - Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG	DFG	£882,488	£353,494	£353,494	156	78	78	Number of adaptations funded/people	Yes	Planned output was calculated at start of year based on feedback from some D&Bs, this has been adjusted at year end. No implementation issue as such, more output from start was overly optimistic..
153	SH 30 - Improve BCF 23/24	Residential Placements	Other	iBCF	£327,309	£695,482	£327,309	20	15	20	Number of beds/placements	No	
159	NEHF 2 - Carers Funding	Carers Services	Respite services	Minimum NHS Contribution	£94,000	£70,500	£94,000	124	91	124	Beneficiaries	No	

Better Care Fund 2023-24 Year End Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Surrey

Checkli							Yes			Yes			Yes	Yes
Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Q3 Actual expenditure to date	Actual Expenditure to date	Planned outputs	Q3 Actual delivered outputs to date	Outputs delivered to date (estimate if unsure)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
167	NEHF 10 - TECS	Assistive Technologies and Equipment	Assistive technologies including	Minimum NHS Contribution	£24,000	£8,044	£13,695	14	5	8	Number of beneficiaries	Yes	Not implementation issues as such. There was a delay in getting projects started.
172	NEHF 14 - Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£216,817	£162,613	£179,731	738	554	612	Number of beneficiaries	No	
174	NEHF 16 - Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG	DFG	£282,369	£307,660	£307,660	50	34	25	Number of adaptations funded/people	Yes	Planned output was calculated at start of year based on feedback from some D&Bs, this has been adjusted at year end. No implementation issue as such, more output from start was overly optimistic.
175	NEHF 17 - Improve BCF 22/23	Residential Placements	Short-term residential/nursing care for	iBCF	£428,574	£321,431	£428,574		7	9	Number of beds/placements	No	
181	EB 2 - Carers Funding	Carers Services	Respite services	Minimum NHS Contribution	£25,000	£18,750	£25,000	33	25	33	Beneficiaries	No	
190	EB 11 - TECS	Assistive Technologies and Equipment	Assistive technologies including	Minimum NHS Contribution	£8,000	£1,267	£2,219	5	1	1	Number of beneficiaries	Yes	Not implementation issues as such. There was a delay in getting projects started.
195	EB 15 - Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£52,378	£39,284	£43,433	178	134	148	Number of beneficiaries	No	
197	EB 17 - Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG	DFG	£82,287	£89,467	£89,467	15	16	7	Number of adaptations funded/people	Yes	Planned output was calculated at start of year based on feedback from some D&Bs, this has been adjusted at year end. No implementation issue as such, more output from start was overly optimistic.
198	EB 18 - Improve BCF 23/24	Residential Placements	Short-term residential/nursing care for	iBCF	£113,781	£85,336	£113,781		2	3	Number of beds/placements	No	
203	CW 3 - Protection of Carers Service	Carers Services	Respite services	Minimum NHS Contribution	£7,791,119	£4,393,424	£6,260,474	10,302	6,603	8278	Beneficiaries	No	
204	CW 4 - Protection of Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£2,100,000	£1,575,000	£2,100,000	7,147	5,360	7147	Number of beneficiaries	No	
207	CW 7 - Protection of OP HBC	Home Care or Domiciliary Care	Domiciliary care packages	Minimum NHS Contribution	£11,121,707	£10,669,453	£13,895,081	463,598	444,748	579203	Hours of care (Unless short-term in which case it is packages)	No	

Better Care Fund 2023-24 Capacity & Demand EOY Report

7.1. Capacity & Demand

Selected Health and Wellbeing Board: Surrey

Estimated demand - Hospital Discharge

Service Area	Metric	Prepopulated from plan: Apr-23	####	Jun-23	Jul-23	####	####	Oct-23	Q2 Refreshed planned demand: ####	####	Jan-24	Feb-24	Mar-24
Reablement & Rehabilitation at home (pathway 1)	Planned demand. Number of referrals.	51	83	56	70	74	125	127	144	144	99	78	75
Short term domiciliary care (pathway 1)	Planned demand. Number of referrals.	61	48	49	72	50	47	55	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Planned demand. Number of referrals.	313	293	267	288	264	241	263	328	320	301	289	305
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Planned demand. Number of referrals.	0	0	0	0	0	0	0	0	0	0	0	0

Actual activity - Hospital Discharge

Service Area	Metric	Actual activity (not spot purchase): Apr-23	####	Jun-23	Jul-23	####	####	Oct-23	####	####	Jan-24	Feb-24	Mar-24
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients.	218	219	218	200	191	188	206	208	206	231	220	212
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients.	75	64	61	74	72	90	73	86	87	102	105	111
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients.	32	45	38	37	36	41	41	49	43	48	47	43
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Actual activity - Hospital Discharge

Service Area	Metric	Actual activity in spot purchasing: Apr-23	####	Jun-23	Jul-23	####	####	Oct-23	####	####	Jan-24	Feb-24	Mar-24
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients.	53	50	53	39	51	35	51	44	44	52	46	48
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients.	27	29	29	20	26	13	18	19	27	23	16	21
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients.	43	42	52	46	55	62	49	56	63	56	71	52

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

7.2 Capacity & Demand

Selected Health and Wellbeing Board: Surrey

Demand - Community		Prepopulated from plan:							Q2 refreshed expected demand				
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)	Planned demand. Number of referrals.	11	16	18	20	20	26	29	0	0	0	0	0
Urgent Community Response	Planned demand. Number of referrals.	136	308	367	448	407	581	614	519	613	432	250	591
Reablement & Rehabilitation at home	Planned demand. Number of referrals.	43	61	71	81	136	163	205	169	203	210	185	181
Reablement & Rehabilitation in a bedded setting	Planned demand. Number of referrals.	2	3	5	7	1	5	5	150	100	187	104	120
Other short-term social care	Planned demand. Number of referrals.	156	150	132	122	112	113	111	0	0	0	0	0

Actual activity - Community		Actual activity:											
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 activity. Number of new clients.												
Urgent Community Response	Monthly activity. Number of new clients.												
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.												
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.												
Other short-term social care	Monthly activity. Number of new clients.												

Checklist Complete:
No
No
No
No
No

Better Care Fund 2023-24 Year End Reporting Template

8. 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	Strongly Agree	The BCF remains a key enabler in joint working arrangements between health and social care in Surrey.	Yes
2. Our BCF schemes were implemented as planned in 2023-24	Strongly Agree	All schemes were implemented as planned in 2023-24	Yes
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality	Strongly Agree	The BCF has been an effective driver in this regard.	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 2023-24	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	9. Joint commissioning of health and social care	We have achieved much by the ICB and LA taking a joint approach to this. The ICB and LA have a joint Dynamic Purchasing System (DPS) for Home Based Care and Residential and Nursing Home Care for Older People. This enables shared provider arrangements, with similar expectations within the contract specification. Commissioners engage in market shaping activity and by monitoring placements can respond to gaps in capacity and identify quality issues. A Joint Enhanced Care Protocol has been established to ensure that a consistent approach is taken in supporting care	Yes
Success 2	8. Pooled or aligned resources	We have aligned and pooled resources via our BCF and ADF commitments. MISF investments have also had system-wide impact as they have been used to invest in workorce and reduce social care waiting times. Since 2019/20 SH ICS has seen an 8% rise in population and a 7% decrease in unplanned admissions. Over the same period, the length of time that people stay in Acute hospital has reduced by 4%. Shared approaches have been highlighted by North West Surrey Alliance being shortlisted for HSJ 2023 "Best Place-base partnership and integrated care award ". East Surrey was a	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2023-24	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	We face challenges that are broadly similar to other systems. These include demography, greater acuity and complexity in presenting needs, financial health of ICBs and LAs. We are also challenged by the Place v Scale issue in that the ICB and LA want to see a broadly consistent offer to our residents/patients. Places, however, are more concerned with their local populations. and there is danger of variation in the type and availabity of support across Surrey. We would also like to see long term financial commitments being made by BCF to provide clarity and certainty for the local system (and	Yes
Challenge 2	9. Joint commissioning of health and social care	This is not a challenge as such, given that we have already recorded it above as a success area. However, it is worth reporting that this is an arena where there is potential for further development, and that there are ongoing joint discussions taking place regarding this.	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

Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	**ICS Update: Surrey Heartlands ICS**
HWBS Priority populations:	Applicable across Priority Populations
Assessed Need including link to HWBS Priority - 1, 2 and/or 3:	Priorities 1, 2 and 3
HWBS Outcome:	Supports HWB S outcomes across the Priorities
HWBS System Capability:	Empowered and thriving communities Data, insights and evidence Equality, Diversity and Inclusion 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):	• Rian Hoskins, NHS Surrey Heartlands Governance Manager; rian.hoskins@nhs.net 07500606793 • Sue Robertson, Associate Director of Strategic Planning; sue.robertson@nhs.net • Sarah Wimblett, Health Policy Advisor, SCC; sarah.wimblett@surreycc.gov.uk
Board Sponsor(s):	Dr Charlotte Canniff, Surrey Heartlands Joint Chief Medical Officer; Health and Wellbeing Board Vice-Chair
HWB meeting date:	19 June 2024
Related HWB papers:	None
Annexes/Appendices:	Annex 1 - Surrey Heartlands Integrated Care System Report to Surrey Health and Wellbeing Board, June 2024

2. Executive summary

This ICS report includes key updates from the Integrated Care Partnership and recent reports to the Integrated Care Board (ICB), highlighting those which support the achievement of the Surrey Health and Wellbeing Strategy's outcomes for the Priority Populations and Key Neighbourhoods.

3. Recommendations

The Board is asked to note the contents of the report.

4. Reason for Recommendations

9

Content of the report includes information which supports the Board's priorities. There no approvals required from the Board.

5. Detail

Annex 1 highlights key recent activities of Surrey Heartlands ICS in relation to:

- Civic / System Level interventions
- Service Based interventions
- Community Led interventions

6. Opportunities/Challenges

The report describes opportunities to learn from and replicate approaches taken.

7. Timescale and delivery plan

The report describes activities already delivered and plans for future events, such as the Surrey Heartlands Expo.

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

The report describes engagement and involvement in activities, including the Voluntary Community and Social Enterprise (VCSE) sector. The Expo will provide an opportunity for extending partner engagement, supporting further community capacity building, building trust and relationships, codesign and co-production. Planning for the Expo is being jointly led by Surrey Heartlands ICB, Surrey County Council (Member and officer), with VCSE representatives.

9. Legal Implications – Monitoring Officer:

No issues identified.

10. Next steps

As set out in the report.

Questions to guide Board discussion

The report expected to be for noting only, as a summary of the activities of Surrey Heartlands ICS which support delivery of Surrey's Health and Wellbeing priorities.

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Surrey Heartlands Integrated Care System: Report to Surrey Health and Wellbeing Board, June 2024

This combined report includes key updates from the Integrated Care Partnership and recent reports to the Integrated Care Board (ICB), highlighting those which support the achievement of the Surrey Health and Wellbeing Strategy's outcomes for the Priority Populations and Key Neighbourhoods.

1. Reducing health inequalities

1.1 System/civic-level interventions

At the ICB meeting on 8 May, the Board received a presentation led by Ruth Hutchinson, Director of Public Health, on Addressing Health Inequalities in Surrey Heartlands. The paper presented an overview of health and healthcare inequalities in Surrey, what is required of Integrated Care Boards in relation to tackling health inequalities and the economic case for a focus on health inequalities. The Board noted the progress report and the continued oversight of delivery by the joint *Healthcare Inequalities (Core20+5) and NHS Long Term Plan Prevention (LTP) Group*, which provides:

- assurance of ongoing coordinated delivery at system, Place, town, and neighbourhood levels
- alignment with the Surrey Heartlands Population Health Management Programme.

https://www.surreyheartlands.org/download.cfm?doc=docm93jijm4n2236.pdf&ver=2669

The ICS has begun planning its second system Expo, likely to be held in the autumn, providing an opportunity to bring together wider partners from the Integrated Care Partnership, boroughs and districts, wider health partners, the community and voluntary sectors and other local partners. The focus of the event will be to reflect how we are starting to deliver our integrated care strategy, launched 18 months ago at the previous Expo and, importantly, to think about the role we each play in supporting further delivery, now and in the future. There will be a strong focus on collaboration and how our organisations, towns, villages, and places work together with and in support of our residents and communities. The event will include a lively marketplace and interactive break-out sessions to strengthen engagement in key areas of development.

1.2 Service based interventions

People with a learning disability (LD) can experience poorer physical and mental health than the general population but good access to health and care help tackle these disparities. A project led by Surrey Heartlands ICS and 'The PSC' (Public Service Consultants), established in 2022, has won a Silver *Health Service Journal* Partnership Award. Looking at data from annual health checks and LeDeR (learning from lives and death reviews) and the impact of living circumstances and deprivation on people with LD, we improved our understanding of these specific inequalities and identified key recommendations. The project provides a strong foundation for addressing health inequalities for other under-served or vulnerable populations. It was also an opportunity to empower people with LD and give them a voice to influence healthcare policies and ultimately improve lives.

1.3 Community-led interventions and engagement

The Integrated Care Partnership on 17 April was in the form of a walkabout in Horley, East Surrey Place. The visit showcased a Community of Practice initiative bringing together local leaders and professionals to learn from best practices in health creation, prevention and community development. They learnt about the community 'cook along' initiative addressing childhood obesity and food poverty, the Growing Health Together programme, 'Men in Sheds' and a presentation about the charity Warren Clark Golfing Dreams, which aim to enhance lives through golf activities for disabled and disadvantaged individuals and groups.

The May ICP meeting included an update by Jack Wagstaff from February's Walton visit and highlighted the prospective development of a community hub including a GP practice, space for VCSE and a meeting spot for the community to spend time in. Members were particularly interested in the process with the aim to replicate elsewhere. There was also an update on the mental health programme presented by Non-Executive Director, Lynette Nusbacher that will seek the voice of service users and carers to support plans to develop services for all ages and all of Surrey.

2 Enablers

Equality, Diversity and Inclusion

The ICB Board received the Public Sector Equality Duty (PSED) Report, which is published annually. The report set out information to demonstrate compliance with

the PSED in relation to the ICB workforce, and those impacted by its policies and practices. The report included a summary of relevant data and the high impact actions. The report noted that a key element of our plans is a focus on reducing health inequalities, so no one is left behind, focusing on the people who experience the poorest health outcomes – our priority populations.

https://www.surreyheartlands.org/download.cfm?doc=docm93jijm4n2236.pdf&ver=2669

3 Other updates

Chief Executive's Report:

The Chief Executive Officer's report to the ICB in May included updates on:

- Delivering statutory responsibilities:
    - System performance
    - NHS operational planning guidance for 24/25
    - ICB operating model
    - Spring Covid-19 vaccination programme
    - EPRR team winning a regional award
- Continuing to deliver the ICS strategy:
    - Right care, right person
    - Project to reduce health inequalities for those with a learning disability
    - 'Let's get you home' discharge project
    - Women's health strategy event
    - The Prime Minister's visit to Woking Community Hospital
    - Non-Executive Director/Partner workshop
- Looking after our people
    - The NHS staff survey

Other papers noted by the Board included the Assurance, Finance and Risk reports, various committee reports from recent meetings and updates from partner members.

For CEO's report and other ICB papers: NHS Surrey Heartlands Integrated Care Board Meetings - ICS

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Health and Wellbeing Board (HWB) Paper

1. Reference Information

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HWBS System Capability:	All
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
Board Sponsor(s):	Fiona Edwards, Chief Executive, Frimley Health and Care ICS (substitute member: Nicola Airey - Director of Places and Communities, Frimley ICS)
HWB meeting date:	19 June 2024
Related HWB papers:	None
Annexes/Appendices:	None

2. Executive summary

A summary of the areas of focus of the Frimley ICP and Frimley ICB.

3. Recommendations

The Board is asked to note the contents of the report.

4. Reason for Recommendations

The content of the report includes information which supports the Board's priorities.

There no approvals required from the Board.

5. Detail

ICS Strategy Refresh & Integrated Care Partnership

Working continues in preparation for the next meeting of the Integrated Care Partnership in June 2024. Our work is continuing on a refresh to the design and operation of the Integrated Care Partnership in the Frimley system. The design group is working closely with the current ICP Co-Chairs and Directors of Public Health from across the geography, including Surrey, to determine how best the ICP can operate during 2024/25. The ICP will continue to focus the on the effective discharge of its core three functions:

(1) To provide oversight and approval of the ICS Strategy creation process and the impact of its delivery

(2) To provide a formal environment for the consideration of the wider determinants of our residents health outcomes

(3) To help nurture and evolve our shared vision and values as partner organisations and local leaders

We are committed to working with the Health and Wellbeing Boards to ensure that there is a stronger connection between the ICP and the Health and Wellbeing Boards, as well as the Joint Strategic Needs Assessments which are led by the Public Health teams.

The March 2024 ICP took singular focus on Obesity, the wider causes of Obesity and the role that the whole public and third sector partnership can take in addressing the wider determinants of this condition. A productive session was held between the partners in the room, taking a particular focus on the actions each organisation

represented could take in order to create an aggregated response to improving obesity rates for the 800,000 Frimley residents.

The June 2024 ICP is likely to be focused on Children and Young People, with an ask of partners to consider how the wider determinants of a young person's lived experience in our geography could be examined and improved in order to contribute to greater happiness and health.

Joint Forward Plan & Annual Operational Plan 2024/25

We have now completed the first refresh of the Frimley NHS Joint Forward Plan for the period of 2024 – 2029, for which we are required by legislation to publish by 31 March 2024. The NHS organisations in Frimley which oversee the production of this document have worked together on reassessing our priorities for the year ahead and how these interventions will deliver the improvements required under our overarching strategy. The refreshed Joint Forward Plan has been approved by the Board of the ICB but will not made publicly available until the conclusion of the Pre Election Period.

The Frimley Integrated Care System published its first Joint Forward Plan on 30 June 2023. This plan, which covers the period 2023 – 2028, is the first document which brings together the totality of the NHS transformation focus for the forthcoming five year period. The plan is a statutory requirement of the Health and Care Act (2022) which came into lawful effect on 1 July 2022.

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.

Alongside this, we have recently concluded the production of our Operational Plan for 2024/25 which sets out the detailed plans for how the partnership will achieve its priorities in the next year of implementation. It includes specific actions, targets and milestones for each of the priority areas identified by our local partnership. It represents many of the "year ahead" 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. We have committed to an ambitious but achievable plan for 2024/25 which commits to deliver all of the national asks set out in the 24/25 planning guidance set by NHS England.

Work Well – DWP & Frimley Pilot Programme

We are delighted to have been selected by the DWP to act as a pilot site for the national "Work Well" programme.

Frimley ICS has been chosen as one of 15 pilot sites which will receive significant funding over the next two years to support local residents get back into employment, where poor health has been an inhibitor to doing so.

The purpose of the programme is to connect people from October to local support services including physiotherapy and counselling so they can get the tailored help they need to stay in or return to work. Participants do not need to be claiming any Government benefits and will receive personalised support from a Work and Health Coach to understand their current health and social barriers to work and draw up a plan to help them overcome them.

Frimley ICS will want to work with partners in statutory bodies and the VCSE to establish a programme which recognises the central role of the community and the importance of sustainable employment as a wider determinant of health outcomes.

6. Opportunities/Challenges

N/A.

7. Timescale and delivery plan

N/A.

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

N/A.

9. Legal Implications – Monitoring Officer:

No issues identified.

10. Next steps

Note future ICS updates.

Questions to guide Board discussion

The report expected to be for noting only, as a summary of the activities of Frimley Health and Care ICS which support delivery of Surrey's Health and Wellbeing priorities.