Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget (for 2014/15)? (Y/N)	Spending on BCF schemes in 14/15** £'000	Minimum contribution (15/16) £'000	Actual contribution (15/16) '£000
Surrey County Council*	Y	4,000.000	5,327.378	5,327.378
NHS East Surrey CCG	N		9,397.000	9,397.000
NHS Guildford & Waverley	N		11,246.000	11,246.000
NHS North West Surrey CCG	N		19,808.000	19,808.000
NHS Surrey Heath CCG	N		5,501.000	5,501.000
NHS Surrey Downs CCG	N		16,398.000	16,398.000
NHS North East Hampshire and Farnham CCG	N		2,609.000	2,609.000
CCG	N		532.000	532.000
BCF Total		**4,000.000**	**70,818.378**	**70,818.378**

** Assumes SCC will be fundholder for all BCF projects in 2014-15. 2015-16 SCC allocation is indicative for both the PSS capital Allocations and DFG.*

*** Based on additional funding within Section 256 allocation*

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16 £m	Ongoing
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Title	Lead provider	Description	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
				Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
ES01	High Level Schemes to Transform Out of Hospital Care		Continuing Health Care -evaluation and redesign of current continuing health care programme								
			Pre A&E and A & E Front Door								
			Effective Stroke System Pathway including Stroke Community Rehabilitation								
			Sub-acute Pathway established as the "norm"								
			Frail Elderly								
			Mental Health (including adults and children, dementia pathway and Psychiatric Liaison service)								
			End of Life Care								
			Integrated Discharge Model								
			Prevention Programmes including Telehealth and Telecare.								
ES02	Projects to Support Transformation Schemes		Asset Based Community Development: Taking stock of total health and care asset base to maximise capacity. (e.g.Residential Care Bed Availability, Discharge to Assess, Discharge hotel)								
			Risk Stratification								
			Integrated Virtual Wards: Part of the local community health pathways.								
			Hospital Staffing: The 8-8 M-F and weekend working of social care staff in acute hospitals								
			Reablement Staffing: Timely discharge and increased dependency in communities.								
			Red Cross: Supports reduction in inappropriate admissions.								
			Development of Integrated Night Response Service								
			Therapy Intervention: Therapy to support bed based reablement in SCC's OP residential homes.								
			Community Equipment: Supports the virtual ward and encouraged the use of single-handed hoists.								
			Occupational Therapy: Funds the social care OTs in the reablement teams.								
			Sourcing Staffing: Funds the social care sourcing team.								
			Universal Benefit Service: Welfare benefits advice to vulnerable adults.								
			District & Borough: Funds the PPP community development services in district and boroughs.								
			Personal Health Budget Implementation: To embed and support on-going monitoring and evaluation in 2014/15								
ES03	Actions to Support and Enable Integration		Integrated Workforce Planning and Infrastructure Development (includes reviewing job descriptions, training and development, culture change, information management and communications etc)								
			Engagement and Communication Planning								
			Programme and project management support.								
ES Total											
GW01	Rapid Response										
GW02	Primary Care Plus +										
GW03	Telecare										
GW04	Virtual Ward										
GW05	Mental Health										
GW06	Other										
GW Total											
SD01	An enhanced, developed primary care service operating in networks of practices		Establish a Community Medical Network								
			Commission local General Practice to review vulnerable patients								
			Increase GP capacity								
			Commission specialist clinical networks								
			Implement risk stratification of practice lists								
SD02	Ensure improved patient experience and outcomes within the continuing care assessment process through		Joint health and social care assessments								
			Streamline the healthcare assessment tool								
			'Discharge to assess'								
			Pilot Local Authority Community Development Officers								
			Enable acute hospitals to undertake CHC placements								
			Equipment								
SD03	An Urgent Care and Discharge System that works to enable people to return home earlier in their recovery pathway		Urgent care								
			Ambulatory care								
			7 day integrated working								
			Early Discharge								
			Intermediate beds								
			Practical support services								
			Development of End of Life provision								
			Community Transport								
SD04	Facilitate rapid discharge for those people with high risk of hospitalisation through		Establish 5 Integrated Community Teams								
			Rehabilitation at home								
			Reablement								
			Working in partnership								
SD05	Integrated services to reduce admission (Enhanced Case Management)		MDT working								
			Information Sharing								
			Medicines management								
SD Total											
SH01	Admission Advoidance		Care Planning								
			Care Recording								
			Community Resilence								
			Crisis Management								
			In reach services								

SH02	Rapid Discharge		Discharge Planning								
			Early Supported discharge								
			CHC (community health care) assessment & placement								
SH03	Nursing/residential home support		Care planning								
			Nursing leadership, skills and competencies								
			Transfer to and from homes and other care providers								
SH04	Rehabilitation and Re-ablement		Rehabilitative services								
			Re-ablement services								
SH05	Enabling services/structures		Information sharing/IG								
			Tele-care								
			Tele-health								
			Risk stratification								
			Strategic workforce planning								
SH Total											
NEHF01	A significantly greater investment in prevention and in earlier intervention for those at risk of		Systematically identify those at higher risk, intervene earlier to manage that risk.								
			Provide more support for patients and their carers, by harnessing the potential of the third sector								
			Test how we offer Personal Health Budgets (PHB) to patients who are eligible for Continuing Health Care (CHC).								
NEHF02	A new model of integrated primary and community care		Design local integrated Care Teams to include GP Practices, Community Services, Mental Health Service, Social Care and the Voluntary Sector.								
			Trial the production of Personal Care Plans in the Integrated Care Teams Pilot.								
			Redesign services for frail elderly people who require support to remain at home.								
			Provide step up and step down beds in Farnham to integrate reablement and intermediate care								
			New integrated services to support patients at the end of life and their families and carers								
NEHF03	A comprehensive range of community based services offering safe, excellent		Deliver greater levels of community based rehabilitation and reablement in order to break the vicious circle of admission, discharge and readmission.								
			Improvements for residents to ensure they receive the correct nutrition and hydration to prevent ill health.								
NEHF04	Excellent hospital care focussed on delivering the very best care to those individuals with the most acute		Work in partnership with all agencies to achieve access to services across 7 working days								
			Transformation of community services and through greater integration of services in A&E, that only those patients whose needs cannot be safely met in the community, are admitted to hospital								
NEFH Total											
NW01	Integrated Frailty Pathway (incorporating end of life)		Ensuring older and more vulnerable people receive (i) proactive support to keep them independent and well in their own place of residence and (ii) responsive care that delivers timely interventions when required to avoid the need for urgent or emergency care. We will deliver an integrated pathway through								
			Implementing a lead professional role for those people who are over 75 or most at risk of a hospital admission								
			Providing a single patient centred care plan, which is electronically accessible to all relevant health and care professionals								
			boroughs/districts								
			Continued focus on developing more integrated support for people with dementia and their carers								
			Joint delivery of reablement services for those recently discharged from hospital (including post-stroke)								
			Review of the rehabilitation pathway, including effective utilisation of rehabilitation beds								
			A joint approach to the support and development of nursing/care homes								
			Optimisation of technology where appropriate								
			An integrated approach to the procurement of continuing healthcare								
NW02	Integrated Urgent Care Pathway		Ensuring an effective and timely response when people need an urgent or emergency service, that flow through the whole system is optimised at all times, and that people are returned to their normal place of residence, with appropriate support where required, as quickly as effective care allows. We will streamline urgent and emergency services by investing								
			A 'telephone first' approach through creation of a single telephone hub with direct co-ordination and booking access to all urgent care services including same-day primary care.								
			An urgent home assessment and treatment service (in partnership with the ambulance service)								
			A review of walk-in clinics and out of hours services with potential development of a co-located urgent care centre at St Peters Hospital								
			Access to short stay beds and respite services to prevent unnecessary hospital admission								
			Delivery of Keogh clinical standards for urgent and emergency care								
NW03	Integrated Locality Hubs		Focused on delivering equivalence in the out of hospital environment and ensuring both care practitioners and the public have as much confidence in out of hospital services as in hospital care. Over the next five years our ambition is to invert care provision so that significantly more of our resources are invested proportionately in the out of hospital environment as opposed to on hospital care, for example through developing								
			Aligned services in three locality hubs (primary care, community services, social care, ambulance services, third sector care etc.), led by GPs								
			Systematic medical leadership 7 days a week, provided by primary care (including a review of out of hours services)								
			Enhanced social care and specialist health services								
			Named care co-ordinators for the elderly and vulnerable, ensuring continuinty of care for those who need it most								
			7 day, 24 hour services where needed to enable the urgent care pathway								
			Extended access to planned care services including better integrated pathways that optimise outcomes for patients								
NW Total											
Grand Total											

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

A joint metrics group has been established. The group will undertake the analysis needed to define the expected outcomes and benefits by end of February 2014.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Surrey has agreed to use the national metric which is currently under development.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

A Joint metrics group has been established and will develop a response by end of February 2014.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Surrey is planning with the Surrey Health and Wellbeing Board only and will thus submit a single Surrey-wide version of the metric template.

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	Comments
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	567.7	N/A		Data extracted from HSC IC (2010/11-2012/13) This is not available in the Operational Planning Atlas as stated in the Guidance
	Numerator	1,155			
	Denominator	203,275			
		(April 2012 - March 2013)		(April 2014 - March 2015)	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	72	N/A		Data extracted from HSC IC (2010/11-2012/13) This is not available in the Operational Planning Atlas as stated in the Guidance
	Numerator	225			
	Denominator	315			
		(April 2012 - March 2013)		(April 2014 - March 2015)	
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	198.8			Data extracted from NHS England published statistics, Delayed Transfer of Care
	Numerator	27,668			
	Denominator	139			
		(Dec 2012 - Nov 2013)	(April - December 2014)	(January - June 2015)	
Avoidable emergency admissions (composite measure)	*Metric Value*				**See Comments data sheet** Data is available at CCG level (2009/10- 2012/13) One of the 4 indicators which maske up this composite is available at LA level (2003/04 - 2012/13 This data is available on the Ambitions Atlas
	Numerator				
	Denominator				
		(TBC)	(April - September 2014)	(October 2014 - March 2015)	
Patient / service user experience [National metric (under development) is to be used]			N/A		Await National Metric
Estimated diagnosis rate for people with dementia (NHS OF 2.6i)	*Metric Value*	43.90%			Based on Dementia Calculator Check indicator and also may be able to update to 2012/13 data?
	Numerator	6872			
	Denominator	15669			
		(April 2011 - Mar 2012)	*(insert time period)*	*(insert time period)*	

Details of how the £65.5m will be invested, and the stretch targets and financial outcomes associated with the investments, are the subject of ongoing joint planning between the County Council and Surrey's CCGs. Those plans will be reflected in the April submission