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	*18,309*	*5,327*	*5,327*
NHS East Surrey CCG	N		*9,397*	*9,397*
NHS Guildford & Waverley	N		*11,246*	*11,246*
NHS North West Surrey CCG	N		*19,808*	*19,808*
NHS Surrey Heath CCG	N		*5,501*	*5,501*
NHS Surrey Downs CCG	N		*16,398*	*16,398*
NHS North East Hampshire and Farnham CCG	N		*2,609*	*2,609*
Windsor, Ascot and Maidenhead CCG	N		*532*	*532*
BCF Total		**18,309**	**70,818**	**70,818**

** 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.*

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.

Rigorous procedures will be put in place to track the metrics leading to benefits and the associated spending trends. If there are signs that targets will not be achieved, reprioritisation will occur in year

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)	25	25
	Maximum support needed for other services (if targets not achieved)	25	25
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)	9	9
	Maximum support needed for other services (if targets not achieved)	9	9
Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)	10	10
	Maximum support needed for other services (if targets not achieved)	10	10
Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)	20	19
	Maximum support needed for other services (if targets not achieved)	20	19

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	2014/15 spend		2014/15 benefits*		2015/16 spend		2015/16 benefits**	
			Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
	New responsibilities under the Care Bill (Revenue)	SCC	0	0	0	0	2,563,000	0	0	0
	Capital Projects (including Disabled Facilities Grant)	SCC/Districts	0	0	0	0	5,327,378	0		
	Project Support	SCC	0	0	0	0	500,000	0	0	0
	Benefits to Health System				90,279				323,000	
	Protection for Adult Social Care				33,000	0			207,000	0
	Small Projects (up to 10% of BCF)		437,773				2,294,032			
			437,773	**0**	**123,279**	**0**	**10,684,410**	**0**	**530,000**	**0**
ES01	Optimising use of Acute Care Setting for Urgent Care through Pathway Redesign and Integrated Working		1,824,391				3,394,878			
ES02	Transforming Care and Care Settings through Pathway Redesign		410,050				612,050			
ES03	Parity of Esteem		133,212				178,712			
ES04	Promoting and Enhancing Quality of Life Through Self Management and Innovation		504,328				504,328			
ES05	Ensuring Delivery Through Appropriate Enablers		0				0			
	Benefits to Health System				1,542,281				5,518,000	
	Protection for Adult Social Care		0	0	574,000	0	0	0	3,588,000	0
ES Total			**2,871,981**	**0**	**2,116,281**	**0**	**4,689,968**	**0**	**9,106,000**	**0**
GW01	Primary Care Plus	Virgincare	700,000	0		0	1,200,000	0		0
GW02	Rapid Response	Virgincare	377,000	0		0	6,000,000	0		0
GW03	Telecare	Medivo	608,000	0		0	608,000	0		0
GW04	Virtual Wards	Virgincare	548,000	0		0	548,000	0		0
GW05	Social Care / Reablement / Carers	Surrey County Council	684,000	0		0	1,816,000	0		0
GW06	Mental Health	SABP	423,000	0		0	423,000	0		0
GW07	Other	Surrey County Council	298,000	0		0	651,000	0		0
	Benefits to Health System				1,850,570				6,621,000	
	Protection for Adult Social Care		0	0	686,000	0	0	0	4,288,000	0
GW Total			**3,638,000**	**0**	**2,536,570**	**0**	**11,246,000**	**0**	**10,909,000**	**0**
SD01	An enhanced, developed primary care service operating in networks of practices		1,000,000				3,902,000			
SD02	Ensure improved patient experience and outcomes within the continuing care assessment process through		338,000				1,446,000			
SD03	An Urgent Care and Discharge System that works to enable people to return home earlier in their recovery pathway		776,000				6,007,000			
SD04	Facilitate rapid discharge for those people with high risk of hospitalisation through a more responsive and effective Intermediate Care/Reablement teams.		2,398,000				3,570,000			
SD05	Integrated services to reduce admission (Enhanced Case Management)		508,000				1,473,000			
	Benefits to Health System				2,765,094				9,893,000	
	Protection for Adult Social Care				1,002,000				6,261,000	
SD Total			**5,020,000**	**0**	**3,767,094**	**0**	**16,398,000**	**0**	**16,154,000**	**0**
SH01	Admission Advoidance		101,000		20,000		3,260,000			
SH02	Rapid Discharge		180,000				450,000			
SH03	Nursing/residential home support		760,000				890,000			
SH04	Rehabilitation and Re- ablement		400,000				930,000			
SH05	Enabling services/structures		0							
	Benefits to Health System				913,406				3,268,000	
	Protection for Adult Social Care				336,000				2,100,000	0
SH Total			**1,441,000**	**0**	**1,269,406**	**0**	**5,530,000**	**0**	**5,368,000**	**0**
NEHF01	Carers		80,000				80,000			
NEHF02	Reablement		150,000				150,000			
NEHF03	Rehab Intergrated Pathway		100,000				100,000			
NEHF04	Mental Health		90,000				90,000			
NEHF05	Virtual Ward		50,000				50,000			
NEHF06	Frailty Integrated Pathway (including elements for CHC, equipment and social capital)		130,000				2,000,000			
	Benefits to Health System				425,679				1,523,000	
	Protection for Adult Social Care				159,000				993,000	0
NEFH Total			**600,000**	**0**	**584,679**	**0**	**2,470,000**	**0**	**2,516,000**	**0**
NW01	Integrated Frailty Pathway (incorporating end of life)		1,000,000				6,000,000			
NW02	Integrated Urgent Care Pathway		1,400,000				4,800,000			
NW03	Families, Friends and Communities (Including Carers)		1,900,000				4,000,000			
NW04	Integrated Primary Care						5,000,000			
	Benefits to Health System				3,317,945				11,871,000	
	Protection for Adult Social Care				1,210,000	0			7,563,000	
NW Total			**4,300,000**	**0**	**4,527,945**	**0**	**19,800,000**	**0**	**19,434,000**	**0**

Grand Total			**18,308,754**	**0**	**14,925,252**	**0**	**70,818,378**	**0**	**64,017,000**	**0**
	* Plans for 2014/15 incorporate ongoing projects from 2013/14: it is expected that these will generate benefits for health and for social care, but the detail behind that is yet to be finalised.									
	** 'Work is ongoing to generate the analysis of scheme-by-scheme benefits which will deliver the overall aspiration. This may lead to some adjustment to the investment proposals, including the possibility of setting aside some funding as necessary in order to ensure the £25m of additional benefit to protect social care spending									

18308754
0

70818378
0

Health Benefit	**10,905,252**	**39,017,000**
ASC Protection	**4,000,000**	**25,000,000**
		64,017,000
		64,017,000
		0.609478732

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 with membership from Surrey County Council and each Surrey CCG. The group will provide the necessary metric support to the local BCF coordination groups and report to the Surrey BCF Board.

Metric 1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000. This metric will enable us to measure our success at identifying those at risk of incurring high health care costs, providing coordinated care to prevent people reaching crisis and our ability to provide 7 day coordinated care to enabled people to stay supported in their own homes for as long as possible, including timely discharge from hospital. Achieving success in this objective will have financial benefits as overall costs to health and social care will be lower. Current performance for this indicator in Surrey is good. Surrey in the 2nd best quintile nationally and ranked 38th lowest out of 152 local authorities for performance against this metric. Due to the uncertainty around effects of the Care Bill and to the increasing proportion of the ageing population, Surrey is seeking to maintain its current position. Currently for 2013/14, the figure is projected to be 1,177. This metric is measured using social care data sets.

Outcome: Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home.

Metric 2: Proportion of older people who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services. This metric will enable us to measure our success at providing timely, high quality reablement services that are integrated with wider support services for people who have been admitted to hospital thus enabling people to stay at home for as long as possible. Surrey is in the lowest performing quintile nationally for this metric. This may be partly explained by under-reporting. In 2012/13 figures were under reported by approx 55%, which was due to recording issues around the first year submission of this data set.

Outcome: Ongoing sustained level of independence and recovery for people with long term health and care needs.

Metric 3: Delayed transfers of care from hospital

This metric will enable us to track progress on improving the interface between acute and community health and social care organisations. Surrey is currently a poor performer and is in the 4th quintile nationally (quintile 5 is the poorest performer).The Surrey BC board agreed that the statistically significant target of a 3.2% reduction of delayed transfers of care by June 2015 was not stretching enougth so are aiming for a 14% in the current value which will place Surrey in quintile 3.

Outcome: More individuals have their health and social care needs met in the most appropriate setting.

Metric 4: Avoidable emergency admissions
Emergency admissions can be clinically unnecessary, destabilising for the patient and costly to the system. By providing coordinated care in the community we hope to reduce the likelihood of conditions escalating so patients require admission and improve our capacity to provide appropriate care out of the hospital setting. Surrey currently has a low rate of avoidable emergency admissions and is aiming for a statisticaly significant improvement of 4.4% reduction by March 2015. We are aware that the data needs to be seasonally adjusted. The initial baseline (Oct 2012-Sept 2013) is based on 12 months of data, whereas the targets are based on 2 6 month data periods: April 2014-September 2014 and Oct 2014- March 2014.
Outcome: Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home.

Metric 5: Patient / service user experience
We are awaiting national guidance for this metric, however we anticipate being able to quantify the parts of the health and social care system where satisfaction is not high and requires improvement.
Outcome: Improved satisfaction with health and social care services

Metric 6: Estimated diagnosis rate for people with dementia.
This local measure has been chosen as it has a clear demonstrable link to the Health and Wellbeing strategy. Earlier diagnosis can mean appropriate treatment can be established for the patient and plans can be made with carers before the condition escalates. The Surrey BCF Board is aiming for the national target of a 66.7% diagnosis rate by 2015/16. Data is available from the dementia prevalance calculator which gives the expected number of patients who have dementia. The calculator requires the QOF data for the actual count of dementia registered patients.
Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place.

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

The assurance process is the same for all the metrics. We are using five nationaly defined metrics and one locally defined metric (metric 6: dementia). The performance has been calculated by ananlyisng: historic trends, performance against comparator local authorities and nationally. This work is coordinated by a BCF metrics and finance group which reports to the Surrey BCF Board. It has representation from Surrey County Council and each CCG in Surrey.

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
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	568.2	N/A	568.2
	Numerator	1,155		1,221
	Denominator	203,275		214,918

		(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	77.1
	Numerator	225		243
	Denominator	315		315
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	258.0	240	222
	Numerator	21,054	19,782	23,323
	Denominator	906,631	915,816	925,149
		(Apr 2013 - Dec 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	123.4	121.0	118.0
	Numerator	17,178	8,513	8,393
	Denominator	1,159,940	1,172,608	1,185,259
		(Oct 2012 - Sep 2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [National metric (under development) is to be used]			N/A	
Estimated diagnosis rate for people with dementia (NHS OF 2.6i)	*Metric Value*	43.9%	49.0%	55.0%
	Numerator	6,872	8,020	9,186
	Denominator	15,669	16,368	16,702
		(April 2011 - Mar 2012)	*(Apr 2014 - Sep 2014)*	*(Apr 2014 - Mar 2015)*