BCF REVIEW 2021-22 – EVALUATION CRITERIA

scheme

No	Criterion	Score
1a	Which partner / partners deliver this scheme?	N/A
1b	Which partners work with this scheme – how does is connect with partner schemes?	
2	What is the funding requirement April 2021- March 2022?	N/A
3	Is this the full cost or a share of total costs of the scheme, service or project? Level of system risk if BCF is withdrawn: • high score = collapse of scheme • low score = does not present a problem	
4	Would there be a significant impact on BCF objectives if this scheme closed or lost some or all of its income? Can we quantify what is delivered by looking at activity and spend? Can we attach VFM to outcomes?	
5	What is the target group for this scheme / what outcomes does the scheme deliver? Identify opportunity to do more for target groups	
6	How well does this scheme match the HWBB strategy, the BCF high level objectives, national conditions and the policy and planning requirements (when known)?	
7	How well does the scheme match the principles for integrated care and the integration aims of the NHS Long Term Plan?	

8	How well does the scheme address the key prevention goals of the system, in the context of health inequalities identified in the Marmot reviews, the Population Health Management programme and the Health Needs Assessment for York? Place PHM priorities: • Mental Health • Frailty • Children and Young People's wellbeing • Prevention – Alcohol, Smoking, Obesity, Diabetes	
9	What will the funding be used for (specific costs eg salary, training, equipment, buying a service from another provider)?	N/A
10	Is there evidence that the scheme is valued by the system, including people who access support, and evidence of the measurable outcomes achieved? Can we compare ROI / SROI from this value?	

Review scoring mechanism

N/A = question does not generate a score

0 = does not meet criteria

1 = partly meets criteria, or is focused in one aspect of the criteria

2 = is a good match / full match for the criteria

3 = outstanding example of integration: prevention, innovation, collaboration

4 = high impact across the system and BCF due to interdependencies and intersection with other schemes

Reference material

www.longtermplan.nhs.uk

Six principles to achieve integrated care

- collaborative leadership.
- subsidiarity - decision-making as close to communities as possible.
- building on existing, successful local arrangements.
- a person-centred and co-productive approach.
- a preventative, assets-based and population-health management approach.
- achieving best value.

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjJ-ovS6LLuAhWmQxUIHaQUB-0QFjABegQIBBAC&url=https%3A%2F%2Fwww.local.gov.uk%2Fsix-principles-achieve-integrated-care&usg=AOvVaw0wT9-bEljsh3giKjBkWJIt

SCIE Logic Model

https://www.scie.org.uk/integrated-care/measuring-evaluating/logic-model

text version:

Enablers

Governance and decision-making

- Strong, system-wide governance and systems leadership.
- Joint commissioning of health and social care.
- Empowering users to have choice and control through asset-based approach, shared decision making and co-production.
- Joined-up regulatory approach.

Resources and capacity

- Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors).
- Integrated workforce: joint approach to training and upskilling of workforce.
- Good quality and sustainable provider market that can meet demand.
- Pooled or aligned resources.
- Integrated electronic records and sharing across the system and with service users.

Components

Person-centred care

- Early identification of people who are at higher risk of developing health and care needs and provision of proactive care.
- Emphasis on prevention through supported self-care, and building personal strengths and community assets.
- Holistic, cross-sector approach to care and support (social care, health (and mental health) care, housing, community resources and non-clinical support).
- Care assessment, planning and delivery are personalised and, where appropriate, are supportive of personal budgets and IPC.
- High-quality, responsive carer support.

Coordinated care

- Care coordination: joint needs assessment, joint care planning, joint care management and joint discharge planning.
- Seamless access to community-based health and care services, available when needed (e.g. reablement, specialist services, home care, care homes).
- Joint approach to crisis management: 24/7 single point of access, especially to urgent care, rapid response services, ambulance interface.
- Multi agency and multi-disciplinary teams ensure that people receive coordinated care wherever they are being supported.
- Safe and timely transfers of care across the health and social care system.
- Care teams have ready access to resources, through joint budgets and contracts, to provide packages of integrated care and support.

Outputs to be determined locally

Outcomes

People's experience

- Taken together, my care and support help me live the life I want to the best of my ability
- I have the information, and support to use it, that I need to make decisions and choices about my care and support
- I am as involved in discussions and decisions about my care, support and treatment as I want to be
- When I move between services or care settings, there is a plan in place for what happens next
- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community

- Carers report they feel supported and have a good quality of life

Services

- The integrated care delivery model is available 24/7 for all service users, providing timely access to care in the right place
- The model is proactive in identifying and addressing care needs as well as responsive to urgent needs, with more services provided in primary and community care settings
- Professionals and staff are supported to work collaboratively and to coordinate care through ready access to shared user records, joint care management protocols and agreed integrated care pathways
- Integrated assessment, care and discharge teams report they are readily able to access joint resources to meet the needs of service users
- Transfers of care between care settings are readily managed without delays

System

- Integrated care improves efficiency because, by promoting best value services in the right setting, it eliminates service duplication, reduces delays and improves services user flow
- Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending
- Integrated care shifts service capacity and resources from higher cost hospital settings to community settings
- The system enables personalisation by supporting personal budgets and Integrated Personal Commissioning, where appropriate

Impact

Improved health and wellbeing

- Improved health of population
- Improved quality of life
- Reduction in health inequalities

Enhanced quality of care

- Improved experience of care
- People feel more empowered
- Care is personal and joined up
- People receive better quality care

Value and sustainability

- Cost-effective service model
- Care is provided in the right place at the right time
- Demand is well managed
- Sustainable fit between needs and resources