Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Non-recurrent Funding – Guidance Notes

Accelerator and System Transformation Reserve Funding Sources

Table 1 describes the various funding sources available, the principles and processes which should be followed, and key approval deadlines.

Funding Source	Applicable to which schemes?	What template do I need to complete?	Deadline	Where will final approval happen?	Notes
£15m Elective Recovery Fund **(Accelerator Programme)**	See Accelerator Programme Guiding Principles	Accelerator Programme Business Case	n/a	Schemes up **to** £150K Bronze Cells up to £250K Silver above £250K Healthier Together DoFs	For schemes > £500K requiring DoF approval, please send to rob.ayerst@nhs.net by close of play on Monday Schemes will be reviewed by DoFs at their regular Friday meeting, and proposers should be available to attend the meeting as necessary
£2m Delegated Transformation Funding (see Table 2 below)	Non-recurrent schemes < £150K (and within delegated budget)	System Transformation Reserve Business Case (Table 1 only)	n/a	Steering Group	Once schemes are approved by the steering group, please complete STR Business Case **Table 1 only** and send to bnssg.htpmo@nhs.net
£3.4m Transformation Funding	All other non-recurrent funding requests	System Transformation Business Case (Tables 1 & 2)	30th July 2021	Executive Group 19th August 2021	Submit STR Business Case (Tables 1 & 2 only) **No later than 30th July 2021 to** bnssg.htpmo@nhs.net
£5m Section 256 Funding	Schemes with an overlap between Local Authority and NHS priority areas	System Transformation Business Case (Tables 1,2 & 3)	30th July 2021	Executive Group 19th August 2021	Submit STR Business Case (Tables 1, 2 & 3) **No later than 30th July 2021 to** bnssg.htpmo@nhs.net

Table 1: Funding sources, principles, processes and deadlines

Steering Group Delegated Transformation Funding

The following allocations have been delegated to Transformation Steering Groups:

Healthier Together Steering Group	Delegated Funding
Acute Care Collaboration	£500,000
Integrated Care	£500,000
Urgent Care	£250,000
Mental Health, LD & Autism	£500,000
Children & Families	£250,000

Table 2: Steering Group Delegated Transformation Funding

Guiding Principles of the Funding Schemes

Accelerator Programme

- We should only commit ERF funds to non-recurrent expenditure
- We should be using ERF funding to support clearing of backlogs on all services, not just those that 'earn' ERF e.g. community paediatrics, MSK interface, diagnostic imaging
- We should not allocate ERF to Mental Health Services or Primary Care as they are eligible for other Restoration and capacity funding sources (Mental Health Spending Review funding, Mental Health Investment Standard funding, and targeted Service Development Funding (SDF)).
- We would not generally use ERF to fund non elective admission avoidance or reduced length of stay schemes, as these should be funded elsewhere in the plan, however could be considered on an exceptional non recurrent basis
- We should use ERF to fund activities that reduce demand and remove patients from waiting lists e.g. shared decision-making tools, admin and clinical time to triage backlogs
- We should only invest in activities that cost less than 100% of tariff for equivalent activity delivery or reduction; to demonstrate value for money, although this could be lifted to 120% by exception, where we are addressing specific more challenging performance or resolving inequalities
- Further value for money assurance checks will be applied to ensure expenditure represents value for money, and to guard against restoring activity at 'any cost', and to avoid adding recurrent costs into the system, e.g. increasing pay costs.
- We should ensure the process & funding flows are simple to operate and enable quick decision-making, as close to the front-line as possible
- Silver Command would need to provide assurance that ERF Gateway criteria will be met; and should fund any requirements if necessary via ERF

System Transformation Reserve Guiding Principles

The System Transformation Reserve should be used for:

- Non-recurrent commitments that help accelerate existing transformation projects, facilitate ICS/ICP development, or newly targeted productivity opportunities. This may be programme management, analytics/business intelligence, finance support etc.
- Areas where additional pump-priming funding, or transition funding is required in order to bridge the gap between present state, and future state transformation schemes which deliver recurrent productivity benefits.

- This may therefore mean that expenditure can be committed to recurrent costs, where it can be clearly demonstrated that recurrent benefits are derived before the end of the 2-year period, and where a clear and prompt exit plan can be articulated, describing how costs can be removed if benefits are not delivered.
- Where organisations are unable to identify a Steering Group through which to direct their Business Case, they can submit STR Business Cases to System Planners and DDoFs **no later than 15 July** for consideration and allocation of an appropriate Steering Group, so these can also be considered for funding.
- Steering Groups are encouraged to refer to the Priorities identified for that Steering Group in the LTP of December 2019.
- Where no relevant SG priorities were articulated, the SG should identify the set of priorities with which the proposal most strongly aligns, provide details in the narrative accompanying the score and justify the score accordingly.

Section 256 Funding Principles

Applications to the Section 256 fund should adhere to the following principles:

- Fund is made available to spend over 2 years, with a maximum commitment of £5m in Year 1. The remaining fund could provide mitigation against the increased efficiency requirement in the remainder of 2021/22, as a bridge to delivery of recurrent productivity savings.
- Fund should be committed to areas with an overlap between Local Authority and NHS priority area, including Urgent Care (including Discharge to Assess transition from HDP to business as usual), children's services, learning disabilities & autism, mental health, and may be directed towards integration enabling support functions e.g. IT, workforce planning, commissioning, finance.
- The fund may be committed to Non-NHS commissioned Local Authority services, but must demonstrate value for money to the NHS through a like for like saving of NHS expenditure. This pay-back period should be demonstrated over a maximum three-year period.

Scheme Timelines

Please refer to the following dates, which have been updated following Exec Group feedback 1 July 2021:

Event	Date	Comment
Organisations to submit BCs to System Planners for consideration	NLT 15 Jul	Where there is no dedicated Steering Group to go through
Review by Steering Groups	As required	To support submission by 30 July 2021
SGs submit BCs to HTPMO mailbox	NLT 30 Jul	bnssg.htpmo@nhs.net
PMO/ Finance/ Clinical Cabinet Review Panel review BCs, update funding spreadsheet and refer to SGs and Prog Leads for clarification where required	Ongoing until 6 Aug	Feedback can be provided on BCs submitted throughout the period up to 30 Jul
Prioritisation reviewed by Clinical Cabinet	11 Aug	To receive recommendation from Clinical Cabinet review panel in order to validate clinical prioritisation against LTP objectives
PMO/ Finance make recommendation(s) to POG	13 Aug	
Star Chamber convened at extended POG	16 Aug	SG attendance may be required to resolve priorities - TBC
Approval at Exec Group	19 Aug	To approve recommendation from POG/DOF
Escalation to DoFs if required	TBC	For those which exceed the POG delegation limit
Transfer of funds to providers	As required	Process for transfer of funding to providers, and for monitoring actual costs incurred to be managed through DDOFs

Points of contact

Completed Accelerator business cases should be submitted to the appropriate Bronze cell.

For questions regarding the System Transformation Reserve process, please email:

Nicole.saunders2@nhs.net

Rebecca.dunn8@nhs.net

Rob.ayerst@nhs.net

Completed STR business cases should be submitted to:

bnssg.htpmo@nhs.net

Appendices

Appendix 1 Accelerator Programme – Business Case Template

Appendix 2 System Transformation Reserve and Section 256 Funding – Business Case Template

Accelerator Programme – Business Case

Guidance notes in blue

Business case reference:		**Date:**	
Business Case title	Title of mitigation scheme		
Author & job title			
Outcome: *To be signed once approval is granted*	**Approval/requirement for further information** Section to be completed by finance/business planning		
Financial summary	**In year spend**	**Recurrent cost implications**	
Funding source:	• Accelerator • Elective Recovery Funding • Other – please indicate source		
Cost of delivery – Non - recurrent revenue requirement (£):	All requests for revenue funding should be non-recurrent		
Cost of delivery - Capital requirement (£):	If there is a capital requirement depreciation / PDC and consumable costs must be included below.		
Annual depreciation cost (£)		Please provide an annual cost	
Annual Public Dividend Capital (PDC) costs (£)		Please provide an annual cost	
Annual Cost for consumables (£)		Please provide an annual cost	
Value of activity to be delivered (average tariff prices)	A value must be entered here for all business cases		

BRIEF SCHEME OVERVIEW	Summarise the key dimensions of the scheme in terms of the outputs that will be enabled in service terms as a consequence of the investment.
ELECTIVE RECOVERY BENEFITS	Please set out how the spending set out in this case will help to accelerate elective recovery in the system and the level of additional activity delivered.
WORKFORCE PLANS AND IMPLICATIONS	Please describe how the additional activity will be from a workforce perspective (for example recruitment / agency, WLI / enhanced rates or a different delivery model

MONTHLY ACTIVITY PROFILE

Month	**Elective activity (000s) (ord, day case and OP procedure)**	**% of 2019/20 activity**	**Outpatient activity (000s) (first and follow-ups)**	**% of 2019/20 activity**
April				
May				
June				
July				
August				
September				
TOTAL				

System Transformation Reserve & Section 256 Funding – Business Case

Guidance notes in blue

Funding Source	Tables to be completed		
	Table 1	Table 2	Table 3
Delegated Transformation Funding	Yes	-	-
Transformation Funding	Yes	Yes	-
Section 256	Yes	Yes	Yes

Table 1

To be completed in all cases of STR and S256 funding

Business case reference:	To be allocated by PMO	**Date:**	Date submitted to PMO
Business Case title	PAUSE programme		
Author & job title	Gail Rogers Head of Children's Commissioning BCC		
Outcome: *To be signed once approval is granted*	**Approval/requirement for further information**		
	Section to be completed by finance/business planning following decision by 'sign off' authority		
Funding Source	Section 256		
Financial summary	**Y1 in year spend[1]**	**Y2 in year spend**	**Recurrent cost implications**
Cost of delivery – Non - recurrent revenue requirement (£):	**£490,000**	**£385,500** **Prog covers 21 months**	**£490,000 per year and £875,000 for one 21 month cohort**
Financial Benefits	£1,240,000	£829,000	Tot 2,069,000
Non-Financial Benefits	Improved health/life outcomes for women. Reduction in babies born and developing complex need through their difficult start in life		

[1] Note STR funding should have Y1 in year spend only

Table 2

This table is not required for STR applications which fall within the allocations which have been delegated to Transformation Steering Groups (detailed above)

BRIEF SCHEME OVERVIEW	Pause is an intensive trauma-informed relationship-based model that aims to reduce the damaging consequences of children being taken into care. The programme does this by working with women who have had multiple children removed from their care, and who are at risk of having future children removed, supporting them to break the traumatic cycle of repeat pregnancies and removals. The Pause programme is delivered through a Pause Practice – a team of dedicated practitioners who work intensively with women over a period of 18-months, to deliver individually tailored packages of support to deal with entrenched detrimental patterns of behaviour. This is combined with agreement to use long-acting contraception. Disempowerment and an absence of choice leads to a cycle of conceptions, births and removals and sees babies born with little chance of remaining with their mother due to the level of risk this would hold. But for the women, each pregnancy and each removal add to their trauma and compounds their harmful lifestyles. What is known from scoping data that is collected by Pause from other Local Authorities across the UK is that on average 83% have experienced domestic abuse, 67% have a mental health diagnosis and almost 50% have experience of care themselves. They typically have a range of other complex and often undiagnosed needs, including substance misuse, homelessness, involvement in criminal justice, low levels of literacy, learning difficulties, low self-esteem and poor self-care. The data collected by Pause from Local Authorities who have Pause programs shows that at least 70% of women approached sign up to the programme. **Bristol's** scoping case in 2016 counted at least 88 women in Bristol with two or more removals and who had 301 children removed between 2010-15 (one woman had nine children removed and the average was 3.42). A review using the same methodology in 2020 counted 59 women. There are signs now that the pandemic has created new levels of need: Bristol has seen a doubling of referrals to legal panel for unborn children from 19% of all referrals to panel in Q4 2019/20 to 36% in Q4 2020/21, NS and SG are seeing this same pattern. For **South Gloucester**, analysis of data shows that in the last financial year 10 women would be eligible for Pause. These are women with multiple children taken into care and with identifiable issues of domestic abuse, substance misuse etc in their lives. The number of children affected through this cohort was 35-40 showing the same average levels as Bristol. **North Somerset** have counted 11 eligible women using data for the last two years and with a similar number of children affected. Here, a review of care proceedings data suggests a rise over the last two years in particular in re-occurring proceedings and numbers of children removed.

A combined project for BNSSG will have capacity to work with 42 women. Pause evidence shows that the annual birth rate for this cohort of women is 0.31 per year which equates to 13 babies. To extrapolate further, having long-acting reversible contraception in place over the 18-month programme provides at least 27 birth free months, without which 29 children are likely to have been born.

The Cost of Doing Nothing

The cost to local authorities of care proceedings for one baby averages at above £33,640, with ongoing costs of over £7,000 a year[2]. At c.£40,000 per child this comes to a **total of £1,120,000** for our BNSSG LAs The costs for children (around one in five of those in repeat proceedings) who are fostered are also high at £34,000 (NS). This equates to six children with annual and recurring costs of **£204,000** per year.

Women in this cohort engage late with maternity care through mistrust, drug use, domestic abuse and fear (Revolving Doors). Some are not registered with GPs. These factors lead to vulnerable women giving birth earlier than expected with health risks to mother and baby and use of specialist services. Health costs are higher at the point of birth, with a significant number of babies requiring critical neo-natal care at a cost of £833 per day (NHS National Cost Collection). If half of the babies use neo-natal care for 12 days each, the cost is **£210,000**.

In terms of prevention, evaluation shows that Pause participants do not fall pregnant as a direct result of the programme. Stat guidance template (publishing.service.gov.uk) therefore preventing the need for specialist midwifery services. For this programme, 28 pregnancies would be avoided with associated costs. Once a child is born, additional Child Protection and Safeguarding services are in place, and Health are required to provide services for looked after children through to maturity. For the children who go on to develop complex care needs, Health contribute of c.10.5%. In Bristol, this adds up to £500,000 per year. Across the three LAs, we could assume this to be £1,000000. Using the calculation above of 1:5 children being fostered, the cost which could be avoided is £200,000 per year and **£360,000 over 21 months**.

We have recently seen more of our complex children are self-harming and presenting with unstable mental health. The cost to the NHS of 1 child being admitted is £59,623 and of a bed (annual) £244,500 with average stay of 67 days or 10 weeks. If two of these children subsequently require a Tier 4 provision, the cost is **£119,246 + £94,000** (NHS Benchmarking network). This discounts the life-time costs for adolescents who have begun to exhibit mental health, and where evidence tells us that this will become a chronic issue for them and continue to be a cost pressure for Health services.

The prevalence of domestic abuse and substance misuse impacts on acute care presentations and ongoing health costs. A unit cost of domestic abuse (DA) to Health is £1,200 per woman per year. In Bristol,

	100% of women were experiencing DA and if this were reduced to 80% for the cohort of 42, costs to the Health system would be £41,000 per year and **£75,000 over the programme term.** Other services used by these women are mental health services and substance misuse services. It has been difficult to find local cost data, but behavioural activation sessions (non-professional) cost £225 per person (Unit Costs of H&S Care 2020). Additional costs are in GP services, ambulance call-outs at £743 per trip to outpatient (Recovery of NHS charges), reduced life expectancy with these women 36 times more likely to die before the age of 40 than the general population. We have estimated **the costs of these combined services to be £100,000** This programme prevents costs for the future across many agencies. The figures provided are costs for the life of the project rather than long-term benefits which we could assume to be significant. This is cost avoidance and a reduction in demand in very high pressure areas for both organisation. Although it has been difficult to fully establish the cost benefits, a life-course projection of these costs would be significantly higher in all areas. **Impact** An evaluation of the first cohort run in Bristol with 24 women engaged evidenced the prevention of 14 conceptions/babies alongside numerous wider benefits. For women completing the programme, 55% had more secure Housing, 65% access education and work, 41% report a reduction in DA, 71% report improved physical and mental health with 65% improved resilience and wellbeing, 70% have increased self-esteem, 68% have improved coping with loss, 60 and 62% have better relationships with their children and their personal relationships and family. Pause national independent evaluation (Sussex) evidences that for every £1 spent there is a cost saving of £4.50 over four years per women in each LA that utilises Pause. Cost benefits to the Health system have not yet been fully evaluated, but this is a piece of work that has recently been commissioned by Pause, the national team and should be available in the next 12 months. This will provide a robust means of measuring cost avoidance and impact.

[2] https://www.familylaw.co.uk/news_and_comment/pause-makes-a-difference

SYSTEM TRANSFORMATION BENEFITS	• Pause is an evidence-based programme delivering whole system benefits (outcomes and financial) • The outcomes for women and their children evidence reduction in significant health inequalities • Pause stands to benefit the wider system: Criminal Justice, Health, Housing, Social Care, Job Centre Plus • There is emerging evidence that need for women facing multiple deprivation is rising post Covid as services have been less accessible • The programme fits well with the BNSSG supported approach to multiple disadvantage and outcomes framework. • S256 presents an opportunity to sustain the scheme in Bristol and expand to cover SG and NS, thereby delivering benefits across the BNSSG system • The continuation/development of Pause has been presented to and is supported by the Children, Families and Maternity Steering Group for ICS. • This aligns with the multi-system Changing Futures programme funded by MHCLG which is taking a system learning approach to adults with multiple complex need. • This aligns with the Reducing Inequalities driver for the system

IMPLICATIONS ON OTHER FUNCTIONS	Briefly describe what impact the project will have on the following functions, identifying any dependencies or benefits: • **Providers** - In Bristol, One25 is the provider of Pause. They have been grant funded for three years and have significant experience of working with women with intersectional need. North Somerset and South Gloucester do not have an accredited Pause provider, but Somerset is running Pause through the Nelson Trust who have been involved in early discussions with One25 to support the initial paper to the C,F&M Steering group which has led to it being supported as a priority across the system. • **IT** - There are no implications on IT of this proposal. At the outset, each LA Children's case management system will be interrogated by the national Pause team to provide a clear baseline of women who could be invited into the programme (this cannot take place until contracts are in place due to information governance). Once the programme is running, the provider undertakes the management of ongoing data. Home systems can consider whether they develop reportable fields within the case files to support the evidence base. The service should work with the local Health system to build in means of understanding Health benefits. • **Workforce** – There are no implications for the workforce of this programme. In Bristol where Pause has been run, the programme does not create additional activity for social workers, Police, Community Health services or other professionals as it runs behind the statutory work, usually preventing statutory work. Where women have a social worker for their own needs, this programme adds support. • **Procurement support** – As the programme expands across the BNSSG, the current grant funding for the service in Bristol may not be appropriate. Procurement advice will be sought and sourced from within the Local Authority and a compliant process will be used to contract with one or multiple providers. • **Legal and Contracting** – The legal and contracting work for this would be expected to be minimal; contracting would be supported through Bristol if One25 flex across the area. • **Facilities –** Pause utilises the space within its Womens' centres. Either One25 or Nelson Trust will operate from existing and developing centres.
PRIORITISATION ASSESSMENT:	Please score each facet below **and** provide a narrative justification for the score. These will be used to prioritise spending.

	Score	**Narrative**
Alignment with system priorities	5	The programme aligns to the long-term plan and is supported by the Children, Families and Maternity Steering Group
Risk of recurrent/ capital costs	2	This is a programme that requires ongoing revenue funding. It has been funded in Bristol by innovations funding from DfE and LA single funding. It has not been funded in NS or SG to date. This bid is on a cost avoidance basis and should be considered as a lead in to diverting sustainable funding as outcomes are proved, system improvements and cost avoidance is evident. The programme will implement a cost avoidance capture tool in order to develop the case for sustainable funding.

Impact on health inequalities	1 Significant positive impact	Outlined above
Measure of project risk/ maturity/ uncertainty	1 Risks well defined & managed	Pause is an evidence-based model, delivering locally and ready to scale to cover BNSSG with funding. Needs analysis across BNSSG is complete and the programme is supported by the ICS Steering Group for Children, Families and Maternity. Pause national team has confirmed that timescales would be 3-4 months from funding confirmation to establish governance, pathways and to recruit staff.
TOTAL	Insert total	
VALUE ASSESSMENT	Briefly outline how the project supports the goals of Value Based Health & Care: • Allocating resources efficiently across our system so that we achieve the overall best possible outcomes • Identifying and improving the outcomes and experience that matter to people • Commissioning and delivering effective services that avoiding overuse of low value interventions (unwanted or not cost-effective) and underuse of high value interventions (deemed cost-effective but not taken up by those who would benefit)	

Table 3

This table is only required for Section 256 funding applications.

NHS FUNDING AREA	overlap between Local Authority and NHS priority area, including Urgent Care (including Discharge to Assess transition from HDP to business as usual), children's services, learning disabilities & autism, mental health, and may be directed towards integration enabling support functions e.g. IT, workforce planning, commissioning, finance.			
Financial Impacts of scheme to:	**Costs**		**Savings**	
NHS	£875,500		££958,000 immediately quantifiable	
Local Authority	£0		£1,324,000 immediately quantifiable	
VALUE FOR MONEY TO NHS	This is quantified and described in the section `The Cost of Doing Nothing' The value in terms of prevention is significant, as women with multiple complex needs are high users of Health services, and children born to them result in life-time costs.			
	Year 1	**Year 2**	**Year 3**	**Total**
	£500,000	**£441,000**	£	**£958,000**

Cost savings NHS over life of programme (21 months)

Critical care cost	£210,000
Complex care contributions @10.5%	£360,000
Tier 4 bed for 2 children	£213,250
Domestic Abuse (Health) services	£75,000
S/misuse, GP, Ambulance call out, use of ED	£100,000 (estimated)
Total	**958,250**