NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Healthier Together Matched Funding Grants Guidance Notes & Template

Section 256 “Healthier Together Matched Funding Grants “

Table 1 describes the principles and processes which should be followed in applying for new Healthier Together Matched Funding Grants, and key approval deadlines.

Funding Source	Applicable to which schemes?	What template do I need to complete?	Deadline	Where will final approval happen?	Notes
Healthier Together Matched Funding Grant and matched Local authority budgets	Schemes with an overlap between Local Authority and NHS priority areas	Business Case (Tables 1 & 2)	4 February 2022	CCG Governing Body, or delegated body by 18 Feb 2022	Submit STR Business Case (Tables 1, 2 & 3) **No later than 4th February 2022 to** Jon.lund@nhs.net

Table 1: Funding, principles, processes and deadlines

Guiding Principles of the Funding Schemes

Healthier Together Matched Funding Grants Funding Principles

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

- Funds committed to schemes that accelerate, enhance and benefit the vision and aims of Healthier Together Integrated Care System
- Match funding should be indicated from the local authorities where possible.
- Revenue funding only
- Grant funding gives no commitment to ongoing recurrent funding from either CCG (ICB) nor Local Authority

Points of contact

For questions regarding the Healthier Together Matched Funding Grants process, please email:

Jon.lund@nhs.net

Completed business cases should be submitted to:

Jon.lund@nhs.net

Appendix

Appendix 1 Healthier Together Matched Funding Grant – Business Case Template

Healthier Together Matched Funding Grant – Business Case

Guidance notes in blue

Table 1

To be completed in all cases of requests for S256 funding

<table>
<tr><td>Business case reference:</td><td>To be allocated by PMO</td><td>Date:</td><td>Date submitted to PMO</td></tr>
<tr><td>Business Case title</td><td colspan="3">Embedding Trauma Informed Practice</td></tr>
<tr><td>Author name:
Role:</td><td colspan="3">Sarah Parker
Director of Children's Services, Bristol City Council</td></tr>
<tr><td>Author email:
Tel number:</td><td colspan="3">Sarah.Parker@bristol.gov.uk and bonnie.curran@bristol.gov.uk – Planning and Development Manager, BCC</td></tr>
<tr><td rowspan="2">Outcome:
To be signed once approval is granted</td><td colspan="3">Approval/requirement for further information</td></tr>
<tr><td colspan="3">Section to be completed by finance/business planning following decision by 'CCG Governing Body' authority</td></tr>
<tr><td>Financial summary</td><td>£k</td><td colspan="2"></td></tr>
<tr><td>HT Matched Grant Funding</td><td>£500</td><td colspan="2"></td></tr>
<tr><td>LA Matched Funding</td><td>£500 over two years</td><td colspan="2">Please describe the source of funding
• People Directorate, Bristol City Council (includes resource within children and family services and community safety, adult social care, education and Public Health)
• Commissioning and Procurement Services & workforce development</td></tr>
</table>

Table 2

To be completed in all cases of requests for Healthier Together Matched Grant funding

BRIEF SCHEME OVERVIEW	Summarise the key dimensions of the scheme in terms of the intended change as a consequence of the investment. The importance of transformation work to embed trauma informed practice has been elevated by the impacts of Covid-19 on children, young people and adults. Covid-19 has exposed significant inequality and had implications on the levels of need in relation to bereavement, financial hardship, mental health, domestic violence, housing and complex safeguarding across the population. The further development of trauma informed practice across the system is a shared priority and a key part of our recovery. Rather than being a specific service or set of rules, a trauma informed approach is a process of organisational change aiming to create a culture, environments and relationships that promote recovery and prevent re-traumatisation. It is also about a focus on prevention, understanding the risks of experiencing trauma and adversity, minimising those risks and recognising and responding early where an individual, family or a community is experiencing trauma, not once more serious issues occur. Trauma-informed services can be distinguished from trauma-specific services which are designed to treat the impact of trauma using specific therapies and other approaches. These services are a vital part of our system, but this scheme of work is focussed on system change and not additional trauma-specific provision. Healthier Together have made a commitment to embed trauma informed practice and Bristol is committed to working together with partners to achieve this. This to year scheme of work will include a programme of training and workforce development building on an existing Knowledge and Skills Framework, and the development of additional tools and resources to aid organisations to develop their policy and practice. This work will be undertaken within identified ‘implementation domains’ which will establish monitoring and evaluation processes. Bristol will continue to work closely with BNSGG partners with the view to ensuring tools and resources can be shared across the system through existing networks and partnerships.

SYSTEM TRANSFORMATION BENEFITS	Briefly set out the qualitative and quantitative benefits of the project, for example: • how will project spending help to support transformation in the system • what are the outputs that will be enabled in service terms • what level of additional activity will be delivered or needs in isolation This work addresses many of the domains of the ICS Outcomes Framework, improving outcomes: • Health of residents – there is an association between adversity and trauma and premature mortality, smoking, poor mental health, educational attainment • Health of services – trauma informed approaches improve patient experience of services and ensures access to services at the point they are needed • Health of staff – reducing sickness absence and improving health and wellbeing by recognising and supporting staff who have experienced trauma. • Health of Communities – for example, reducing levels of domestic violence and abuse. Example Outputs: • Multi-agency training and development programme: utilising the capacity of staff who have just completed a train the trainer course funded by the Home Office. This training will be made available to staff teams across the Council as well as multi-agency sessions made available via the Keeping Bristol Safe Partnership Training offer. • Development of trauma informed commissioning toolkit to enable commissioners to promote a consistent response to adversity and trauma. This will include trauma informed commissioning guidance for policy makers and commissioners, with sample tender paperwork and evaluation criteria, policy standards and expectations with regard to staff recruitment, supervision and training for example. • An evaluation framework to capture the impact of this work across the system – pulling in data from commissioning as well as sources such as the JSNA. This will be supported by recommended performance measures for use within individual service settings / contracts. • HR and workforce wellbeing guidance: This area of work needs to be scoped further in collaboration with relevant service leads but will involve the review and development of recruitment processes, supervision and performance management. This will link to the training and development programme with an offer for training in compassionate leadership and vicarious trauma. • Improved collaboration with the work developing within Healthier Together including expansion of the Bristol ACE Ambassador Network to connect with the BNSSG / Avon and Somerset Practice Network being developed. • Refresh of the web-based resources on the Keeping Bristol Safe Partnership Website with additional content and resources to support on-going work responding to the traumatising impact of racism. Initial scoping of this work has begun within the Adversity and Trauma Health Integration Team • Coordination of advisory support to teams and services: Utilising the capacity of staff who have recently trained as Trauma Informed Practice Educators; for example advising across these domains: Governance and Leadership; Policy; Physical environment; Engagement and Involvement; Cross sector collaboration; Assessment and treatment; Training and workforce development; Monitoring and quality assurance; Financing; Evaluation Preventing adversity and trauma should be seen within the context of tackling inequalities. Research exploring the distribution of traumatic events based on gender, age, ethnic background and socio-economic status has shown that

	traumatic events are more frequently experienced by people in low socio-economic groups and from black and minority ethnic communities. Studies have shown that ACEs are strongly socioeconomically patterned at both the family and area level. For example, research based on the ALSPAC data (local data) found poverty was strongly related to both individual ACEs and clusters. They reported that children whose parents report poverty in pregnancy are nine times more likely to face additional traumatic experiences compared to their wealthier peers. While socioeconomic gradients are strong predictors of health harming behaviours, additional factors explain the resilience and susceptibility of individuals to develop these behaviours and poor outcomes throughout the life course, and this provides opportunities to affect change. This work directly contributes to our ambitions to reduce health inequalities across the life course.
KEY PERFORMANCE INDICATORS PROPOSED	What KPIs will the project use to ensure delivery of benefits. Can this data be collected routinely now? An evaluation framework is currently being developed for this work, including the following components. • drawing together data and intelligence from the JSNA to better understand adverse and trauma experiences in our population, and impact of preventative work, e.g. around domestic abuse • Many of the measures being developed in the ICS outcomes framework will align to this system-wide work, for example, measures of premature mortality and risk factors, measures of experience of our services and indicators of staff wellbeing. • More granular measures would form part of this, e.g. sickness / staff turnover, confidence of practitioners after training, improved experience and outcomes of people supported by or services The resource in this bid will contribute further capacity for evaluation development.

<table>
<tr><td>VALUE FOR MONEY TO NHS</td><td>While this scheme of work cross-cuts specific health priorities it is also focused on system change. The work will deliver value for money in the following ways:

• Prevention: Epidemiological and biomedical evidence link adverse childhood experiences with health-harming behaviours and the development of non-communicable disease in adults. This work aims to prevent and break cycles of adversity that lead to health harming behaviours and preventable illnesses with intensive service requirements. For those who are living with multiple complex conditions, this is still about ensuring access to specialist complex care at the right time, preventing unnecessary escalation of needs.

• Workforce: Supporting staff wellbeing and staff retention by embedding procedures to support staff with trauma histories and/or those experiencing secondary traumatic stress or vicarious trauma from their work. This has become a heightened priority in the context of the Covid-19 pandemic.

• Improved coordination: This scheme of work will bring improved coordination to some initiatives within the system and better enable the long-term benefits of those projects.

• Evidence informed: this additional resource will help ensure a strong interface between research and policy and practice. This includes ensuring that research is translated into policy briefings with clear practice implications, and that there is thorough evaluation and research of policy and practice developments. This will be of benefit locally and more widely.</td></tr>
<tr><td>EXIT STRATEGY</td><td>At the point grant funding ends what would be the next steps? Eg. project stops, request for future ongoing funding, savings delivered
There is commitment from the Bristol Health and Wellbeing Board, One City Partnership and Keeping Bristol Safe Partnership to embed a trauma informed approach across the city, and a shared understanding that achieving this requires a long-term approach. Bristol City Council has already committed resources (described here in match funding) to support development and coordination of this work and has worked with partners to identify ways in which this work can be ‘mainstreamed’ and built into policy and procedure to ensure lasting change. The work included here will significantly advance these shared ambitions by developing evidence -informed tools and resources that can be used by organisations and services across sectors to drive change beyond the term of this investment. This includes train the trainer resources and the commissioning toolkit for example.</td></tr>
</table>

INTERDEPENDENCIES	Is the project aligned or dependent on another HT Programme Area? Which Healthier Together Steering Group would you propose sponsoring the project? (Mental Health & Learning Disabilities; Integrated Care; Children & Families; Population Health & Inequalities; Digital) Within Bristol this work is led by the Adversity and Trauma Health Integration Team (HIT), supported by Bristol Health Partners (BHP). The BHP Executive is now the Research and Innovation Steering Group within Healthier Together which will ensure valuable connection to research, evidence and knowledge mobilisation. The HIT has worked closely with the Mental Health & Learning Disabilities Trauma Subgroup and the two groups are currently developing a shared workplan. The Healthier Together Executive agreed (in June 2021) to develop as a trauma informed ICS and are in the process of considering the position of that subgroup and whether it would be better placed as a cross-cutting workstream due to the relevance of the work across the piece. For example, the Children and Families Steering Group have a number of projects of relevance to this work, including the Vanguard project (Framework for Integrated Care) for children and young people with complex needs, and the implementation of the Mental Health Teams in Schools.	
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	1 Strong alignment To 5 no alignment 1	Please outline the extent to which the project aligns with the system's Long Term Plan priorities particular to the project Steering Group, or other relevant priorities. - Preventing illness and tackling health inequalities - Preventing health harming behaviours - Backing the workforce - Embedding our agreed BNNSG principles for trauma informed practice will empower communities and service users by giving them choice and control, and direct involvement in shaping services
Risk of recurrent costs to the NHS	1 Negligible risk To 5 very high risk 1	Scheme needs to incur no ongoing NS revenue costs The scheme will not incur recurrent costs
Impact on health inequalities	1 Significant positive impact To 5 negligible positive impact 1	Please outline the extent to which the project delivers positive impact on health inequalities A trauma informed system will would have a positive impact on health inequalities. Described above.
Measure of project risk/ maturity/ uncertainty	1 Risks well defined & managed To 5 Significant risks & uncertainties 1	Please describe the level of maturity of the understanding of the project delivery risks There are well developed structures in place for the delivery of this work and high level buy in. There is a low level of risk and these can be managed.
TOTAL	Insert total: 4	

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) There is a developing evidence base for the cost -benefit of investment in ACEs and trauma (e.g. Hughes et at). There is increasing understanding of the importance of this work at system level as well as a growing evidence base about where investment can have the greatest impact in prevention and treatment. This scheme of work will ensure commissioning and service development is based on this available evidence to improve outcomes and ensure best value. The BNSSG Principles of Trauma Informed Practice are well aligned with Value Based Health Care. While the cost-benefit is increasingly clear, and aids the efficient allocation of resource, the model of trauma informed practice places emphasis on the quality of relationships and patient experience and a person centred approach where an individual's needs are understood and responded to. The parallel work to ensure the workforce is supported in their practice, with clarity about their role and their impact, is intended to counter burnout and compassion fatigue.