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

Business case reference:	To be allocated by PMO	**Date:**	Date submitted to PMO
Business Case title	Investing in IT Systems to improve patient outcomes, information sharing, and referral pathways for people accessing substance use (including tobacco) treatment services		
Author name: **Role:**	Leonie Roberts Consultant in Public Health Bristol City Council		
Author email: **Tel number:**	Leonie.roberts@bristol.gov.uk 07920727216		
Outcome: *To be signed once approval is granted*	**Approval/requirement for further information**		
	Section to be completed by finance/business planning following decision by 'CCG Governing Body' authority		

Financial summary	**£k**	
HT Matched Grant Funding	90	
LA Matched Funding	90	Project ADDER (BCC)

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. To improve information sharing between caseload and database systems across primary care and statutory and community services. There are 3 aims to this project: • To ensure continuity of care for people who use drugs and alcohol, by linking Theseus, our drug and alcohol treatment case database, with Connecting Care, the local platform used by health care professionals to view health and social care databases across the system. • To promote better health outcomes for people leaving prison by ensuring that relevant prescribing information is effectively communicated to GPs and other health professionals in primary care services • To reduce administrative barriers to referrals into community stop smoking services from acute trusts and AWP, by developing new IT systems where referrals will be automatic at the time of discharge, maximising entry to this service.

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 This program of IT system improvements will speed up GPs and other health care professionals accessing health and social care information about service users who are engaged with substance use treatment services, or those who have a treatment need, improving information sharing, collaborative working and better patient outcomes across the system. For example: • Primary care professionals will be better able to view patient care records for those engaged in substance use treatment services including relevant prescribing information, and any safeguarding or risk information, to inform quality care and joined up working. • Health and social care staff in this region can immediately view prescriptions and proposed care plan, and so provide services as soon as offenders are released to ensure that continuity of care is provided. The right care at the right time and in the right place. This will be a marked improvement on current state. • The project spending will help to support transformation in the system by linking North Bristol Trust (NBT), University Hospitals Bristol and Weston (UHBW and Avon and Wiltshire Partnership Mental Health Trust(AWP) referral and reporting processes for stop smoking support with community services provided not only by the three BNSSG local authorities, but also with out of area services. • More efficient referral will support a substantial increase in the number of cessation attempts started in hospital and continued after discharge. It will also provide a rapid referral mechanism further along the LTP project for patients seen in outpatients who would benefit from preoperative smoking cessation support in the community. This will have a positive impact on reducing the number of smokers, particularly in the cohort with conditions which need hospital treatment. • It will enable BNSSG ICS to meet its ambitions and targets as part of the NHS Long Term Plan Tackling Tobacco Dependence Programme.

KEY PERFORMANCE INDICATORS PROPOSED	What KPIs will the project use to ensure delivery of benefits. Can this data be collected routinely now? - KPIs will include: - Quality audit to show how many Theseus records are accessed in Connecting Care. - Survey with health care professionals to check they can access the information they need to support high quality, efficiently care. - Reduction in no. of safeguarding incidence and/or near misses, such as risk of prescribing twice. - Number of referrals to community stop smoking services from NBT, UHBW and AWP. (Although the data can be collected routinely now it requires is time consuming as it requires manual searches) - Number of successful quit attempts as a result of referrals. (Although the data can be collected routinely now it requires is time consuming as it requires manual searches)	
VALUE FOR MONEY TO NHS	Please describe how the project demonstrates value for money to the NHS compared to equivalent NHS expenditure - Improved efficiency of health care professional time. For example, a GP will be able to instantly access drug treatment information about a patient rather than contacting a number of services to gather information. - Better value from other services – with better information sharing health care professionals and drug and alcohol treatment workers can make more effective referrals into other services such as rehab. - Better health outcomes from this group of patients through better coordinated, joined up care, with the associated health cost savings including minimizing drug related deaths - By optimising the likelihood of a patient engaging in stop smoking interventions initiated at the teachable moment in hospital by ensuring a seamless referral pathway and process to community support. This will ensure that the NHS funding used to provide interventions and nicotine replacement therapy is used to maximum impact.	
EXIT STRATEGY	At the point grant funding ends what would be the next steps? Eg. project stops, request for future ongoing funding, savings delivered There will be no ongoing funding required as this is a one-off piece of work to build digital infrastructure.	
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) We would propose these steering groups could sponsor this project: - Population Health & Inequalities - Digital	
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	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. 1 based on the following priorities outlined in the NHS Long Term Plan: Doing things differently: we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities. Making better use of data and digital technology: this project ensuring we leverage existing digital tools to provide the best outcomes for patient records for staff. Getting the most out of taxpayers' investment in the NHS: we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered… and reduce spend on administration. The NHS will increasingly be: more joined-up and coordinated in its care. Breaking down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care; Recognising the move to 'population health management', using predictive prevention (linked to new opportunities for tailored screening, case finding and early diagnosis) to better support people to stay healthy and avoid illness complications; We also believe this program contributes to dissolving the historic divide between primary and community health services. Tackling Tobacco Dependence is a key element of the NHS Long Term Plan and the progress of the BNSSG programme is reported through the PHI Steering Group. Funding has been allocated to provide specialist cessation support in NBT, UHBW and AWP. This scheme would enable us to align an element of the IT to provide an easy to use and robust referral process. The NHS Long Term Plan – a summary

Risk of recurrent costs to the NHS	1 Negligible risk To 5 very high risk	Scheme needs to incur no ongoing NS revenue costs 1 No planned ongoing costs. Possible changes in IT systems within the ICS may present some risk. It would be expected that the partner where this arose would bear the cost of any future change.
Impact on health inequalities	1 Significant positive impact To 5 negligible positive impact	Please outline the extent to which the project delivers positive impact on health inequalities 2 There are a number of ways this project contributes to a positive impact on health inequalities for example: • There is a systematic relationship between levels of deprivation and the worst health outcomes. Drug misuse deaths (PHOF) for example map onto this systematic relationship, therefore drug and alcohol services support many of our most deprived and excluded residents who experience the worst health outcomes. This project will help us shape our system to better serve these excluded groups to achieve better health outcomes for and with them. • Smoking is the main cause of preventable illness and premature death. It is the primary reason for the gap in healthy life expectancy between rich and poor and accounts for more years of life lost than any other modifiable risk factor. People with serious mental illness are 2-4 times more likely to smoke than the average. Addressing smoking successfully in hospital will have a marked impact on health inequalities. A seamless referral pathway will ensure that support initiated in hospital will continue immediately on discharge making it both effective and cost effective.
Measure of project risk/ maturity/ uncertainty	1 Risks well defined & managed To 5 Significant risks & uncertainties	Please describe the level of maturity of the understanding of the project delivery risks 1 This is a well-defined piece of work with very specific outcomes. Similar work has been undertaken in the pilot sites across Manchester and the learnings have been taken from that programme to inform delivery across England. NHSE has set out the criteria for the programme. Connecting Care and Theseus are locally embedded systems with licensing and monitoring processes already in place. Both platforms have been used by professionals for some time. This project is based on demand from professionals and service user feedback. Possible changes in IT systems within the ICS may present some risk. It would be expected that the partner where this arose would bear the cost of any future change.
TOTAL	5	

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

PHOF indicators for successful completion of drug and alcohol treatment (C19a, b, c), rates of engagement among adults with treatment services (C20) and deaths from drug misuse (C19d) in Bristol are within the worse 95% when compared to the England average, with either worsening or plateaued trends. The proposed investment will reduce the health care costs associated with these figures, by better joining up primary and community care, support more efficient and joined up practice.

As for smoking, Tobacco dependence is a chronic, relapsing, long-term condition, and still far more prevalent than many other long-term conditions routinely treated by the NHS. It affects almost all patient pathways, both medical and surgical, from pregnancy and neonates through to children and adults.

There were an estimated 5,000 hospital admissions across BNSSG in 2018/19 attributable to smoking (PHE, 2021). A wide range of diseases and conditions are caused by smoking, including cancers, respiratory diseases, coronary heart and other circulatory diseases, stomach and duodenal ulcers, erectile dysfunction, infertility, osteoporosis, cataracts, age related macular degeneration and periodontitis.

For many smokers admitted to hospital, particularly those with a condition exacerbated by smoking, it provides the 'teachable moment for the provision of support to stop smoking. To make the most of this in terms of efficiency and cost efficiency of intervention, along with the best possible cessation outcome for the patient, a simple and effective referral system to community cessation services is needed. This will help ensure continued support and the greatest likelihood of a successful quit. The most efficient and cost-effective way to provide this is through the IT scheme proposed.

- Identifying and improving the outcomes and experience that matter to people

Service user feedback tells us that restating their case history to multiple professionals can be retraumatising. Better communication between professionals they work with will therefore benefit their experience of care in a way they have told us matters to them. They will have a more positive experience with services, being referred appropriately to the right services for them.

Furthermore we know that there is a high risk of people leaving prisons returning to illicit drug use (and the relevant social and individual harms associated with this) if relevant Opiate Substitute Therapy prescribing information is not communicated to community healthcare professionals at the time of prison exit. This program will support the timely transfer of information.

For smoking, we would know that stopping smoking successfully will contribute to the greatest health benefit for the patient. For staff, being asked and encouraged to provide advice, support and to prescribe NRT to patients, a system which is easy to use will improve their experience of making referrals, while the proposed system will also provide feedback to demonstrate the positive impact their intervention is having.

- 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 has been a strong request from local GPs for this program of work and as such we know there is demand for it. As a one-off cost project there are no ongoing costs to accumulate overtime which might affect cost effectiveness. Therefor we would evaluate this as a wanted, cost-effective service that will be taken up by professionals who want it to improve their practice, and which would benefit patients by, for example, supporting our work to move towards a trauma informed system. The stop smoking interventions which are currently delivered across BNSSG community services and the interventions which will be delivered across the trusts are all evidence based, and both effective and cost effective. The model being rolled out across the three trusts is the CURE model, piloted by NHSE in Manchester. It is based on the Ottawa model which has been delivering effective cessation support in Canada since 2004. The CURE model returns a cost per QALY of £487