Transformation Funding for Urgent and Emergency Liaison Mental Health Services (adults & older adult): Frequently Asked Questions

The below FAQs have been developed from those we have been asked before the process was launched, as well as specific questions we have received since, including during the first webinar on Tuesday 20 December 2016.

A further webinar will be held on Tuesday 10 January 2017; please contact england.uecdeliverypmo@nhs.net if you wish to be added to the invitation list, and for all other queries please contact your regional UEC PMO or send an email to england.adultmh@nhs.net. A member of the national team will respond as soon as possible (though the mailbox will not be monitored between 24 December – 2 January 2017 inclusive).

1. FUNDING

Q: *Is this pump prime revenue funding for one year only?*

A: Yes, this is one-off non-recurrent pump prime funding for one year only (applicants should state whether they are applying for some of the £15m available for 2017/18 or the £15m available for 2018/19 – not both) to accelerate existing service development plans which already have some local funding attached. One of the liaison indicators in the CCG Improvement and Assessment Framework asked CCGs if they have liaison service development plans in place – and the vast majority reported that they did.

There is an established body of research showing that liaison mental health services are cost effective and generate savings. These are mainly related to a reduction in the length of stay of older adults admitted to general hospital wards, many of whom have significant mental health needs linked to dementia, depression or anxiety – but also reductions in re-attendances at A&E and emergency admissions via A&E. The financial modelling underpinning the *Five Year Forward View for Mental Health* and agreed by NHS England and the government before the Spending Review last autumn is works on the conservative basis that one year after a service is operating at the core 24 standard, savings begin to be realised on a 1:1 basis – £1 saved for every £1 invested – which are then reinvested to make the service self-sustaining.

The Centre for Mental Health estimated this at an initial level of £3 for every £1 of investment, stabilising over time at £2.50, so commissioners should be confident of delivering significant return on investment – this is over and above the extremely evident clinical benefits.

Given that the CCG contracting round for 2017-19 has been ongoing, CCGs should already have factored in liaison as a priority within mental health spending. This is explicit in the planning guidance for 2017/19:

- 'Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.' (p 9)

- 'Additional funding underpinning the delivery of the Five Year Forward View for Mental Health must not be used to supplant existing spend or balance reductions elsewhere. This new money builds on both the foundation of existing local investment in mental health services and the ongoing requirement to increase that baseline by at least the overall growth in allocations to deliver the Mental Health Investment Standard. Savings arising from new services (such as integrated Improving Access to Psychological Therapies/Long Term Conditions and Mental Health liaison in A&E) resulting from this new investment need to be reinvested to maintain services and ensure delivery of the commitment to treat an additional one million people with mental illness by 2020/21.' (p 61)

- 'Commissioners and providers must implement funded service development plans to ensure that adult liaison mental health services in local acute hospitals are staffed to deliver, as a minimum, the 'Core 24' service specification.' (p 67)

NHS England is tracking CCG investment in all mental health services against the Mental Health Investment Standard, and the finance tracker asks for CCGs to break down their mental health spend by service type, including for urgent and emergency liaison. We will therefore for the first time be able to transparently see where money is going and how much – and the expectations are that these services should be expanding through local investment (see also the Five Year Forward View for Mental Health Dashboard).

This should all of course be seen in the wider STP planning which is happening now – again, the STP guidance (or aide-memoire as it was called) identifies liaison as a priority for development:

- 'Develop community services, taking pressure off inpatient settings. This means that STP areas have all-age mental health liaison services in acute hospitals. In primary and community care, they have mental health crisis support and home treatment teams, eating disorder services for children and young people and new rehabilitation and services for complex needs, improving the experience of care.' (p 1)

- ‘At least half of all acute hospitals locally should meet the ‘core 24’ standard for mental health liaison as a minimum, with the remainder aiming for this level.’ (p 2)

STPs will be the ones finally submitting the bids to regional UEC PMOs so their involvement in agreeing bids is essential.

Q: *What if we cannot commit to locally recurrently fund the newly-expanded year after receiving transformation funding for one year?*

A: A commitment to locally recurrently fund services following receipt of transformation funding is essential for any bid to be successful. Given all of the strong signals we have set out in products to support local planning and strategy – the CCG IAF, planning guidance, Mental Health Five Year Forward View Dashboard, STP guidance, the recently published liaison implementation guidance and the bidding documentation – we have consistently and very clearly stated that the new funding is one-year pump prime funding and has to be backed by local recurrent funding commitments so liaison services are a core and sustainable part of the acute general hospital, UEC and mental health systems.

One of the key criteria in the call to bid document which prospective applicants have to agree to before proceeding with their applications is that ‘The mental health liaison service will be self-sustaining within one year of achieving the core 24 standard, and that funding will be reinvested recurrently’.

The essential point is that commissioners should be confident of delivering significant return on investment from liaison services.

Q: *The bidding documentation states that ‘All bid participants must have agreed control totals before any transformation funds will be released.’ What does this mean in practice?*

A: This is about control totals being agreed in the future years, not about meeting them this year. Beneficiaries of the transformation funding should have agreed plans in place around control totals. This should not stop prospective bidders from applying, but final decisions will ultimately be taken, including on any criteria for the release of funding, by the Investment Committee in February.

Q: *Are people bidding for both years this year, or will they be able to apply for 2018/19 funding next year?*

A: No – just for one year – either 2017/18 or 2018/19 and applicants should state for which year they are seeking funding in the application form (question 4i).

Q: *Do I have to bid for Wave 1 to be eligible for Wave 2?*

A: Absolutely not – quite the opposite, in fact. Hospitals that are successful in Wave 1 will not be eligible to bid in Wave 2. In Wave 1 we are prioritising those hospitals that are closest to core 24 who can use the additional pump prime funding available for 2017/18 or 2018/19 to push them over the line. Bids should state whether funding is being applied for for 2017/18 OR 2018/19 (not both years).

Wave 2 – for £90m over 2019/20 and 2020/21 – will be launched probably in late 2018. So for those hospitals which are currently further away from core 24, CCGs and providers have two years to locally fund and implement service development and improvement plans to put them in a strong position to bid for funding in Wave 2.

Q: *Can you apply now but defer funding until 18/19?*

A: Yes – this Wave 1 process is for funding available in 2017/18 and 2018/19 – so applicants who wish to bid for funding in 2018/19 should apply now.

Q: *Can you confirm if the Autumn 2018 Wave 2 funding is £19m or £90m for 2019/20 and 2020/21?*

A: £90m, subject to confirmation of NHS England future budgets – the indicative breakdown as things stand is £54m for 2019/20 and £36m for 2020/21.

Q: *Will successful bids be agreed in full or is there likely to be a scaling down if the fund is over-subscribed – as there may be issues with rolling out a partial service?*

A: The national panel will consider the quality and appropriateness all of the bids in the round and make recommendations to NHS England's Investment Committee, who will ultimately take all final decisions. However, as this funding is available explicitly to help hospitals achieve the core 24 standard, bids which clearly evidence that they will realistically be able to achieve this using the amount bid for are likely to be prioritised.

Q: *Liaison funding of £15 million was made available in 2013/14. Are we building on the baseline from this?*

A: The baseline is the current provision of acute hospital urgent and emergency liaison mental health services, and current service development and improvement plans including local funding that has been committed for future expansion in 2017/18 and 2018/19.

Q: *The funding for liaison mental health in the Five Year Forward View for Mental Health implementation plan is £15m, £30m, £84m and £120m. Will trusts be able to apply for 18/19 funding again this time next year?*

A: No – this Wave 1 funding is for 2017/18 as well as 2018/19. Applicants can bid for funding for either year, but not both years. The figures cited above are cumulative totals for the central pump-prime funding available from 2017/18-2020/21.

Q: *Wave 2 funding should be agreed many months before 2019 so adverts can be put out for staff to be in place in April 2019 rather than a time delay.*

A: Thank you for this suggestion. We anticipate that the process for Wave 2 will be run in autumn/winter 2018. Final decisions will be taken closer to the time.

2. OUR APPROACH

Q: *Why are you only inviting those hospitals that are already closest to core 24?*

A: Wave 1 of funding aims to allow those hospitals who are closest to core 24 and have the most robust and credible improvement plans already in place to reach this level.

Given the level of transformation required and the current significant gaps, it will take time to grow the workforce with appropriate skills and competences to deliver the expansion in services and associated improved outcomes and experience for people experiencing mental health crisis. More funding is therefore available in Wave 2 from 2019/20-2020/21, and details for the Wave 2 process will be made available during 2018.

Running the process in this way means that in the interim period between now and 2018, services that are currently further away from meeting the core 24 level will have the opportunity develop and implement robust, locally funded improvement plans to move closer to the core 24 standard and maximise their chances of successfully bidding for Wave 2 transformation funding.

Q: *You say this is for 'adults' and 'older adults' but what does that actually mean? What about children and young people?*

A: The core 24 service standard applies to services for adults from the age of 18 to the end of life, so the services this Fund will help to expand cover that age range. Many people seen by liaison services are older adults with mental health problems and dementia, and the majority of the financial and clinical benefits that liaison services bring to hospitals come from these patients being seen. Seeing and treating these older people in acute general hospitals is therefore a crucial part of the work that liaison teams do. Services that meet the core 24 standard have access to specialist professionals who are experts in older age psychiatry.

There is a lack of evidence about the models of care that work best for children and young people experiencing a crisis. As a result, we are investing £4.3m this year to pump-prime investment in the 8 Urgent & Emergency Care Vanguards so they can rapidly test and evaluate different models of children and young people's liaison mental health and crisis services. This is to build consensus about what works and what is effective, with a longer-term view to establishing an evidence base which can inform future cases to secure new investment. This testing is informing national guidance that is currently in development. Work is underway alongside this to help us build a better picture of the different services that are currently available across the country for children and young people experiencing a crisis. Moreover, at the end of September, NHS England announced that an additional £25m was being made

available to CCGs in 2016/17 to improve mental health services for children and young people, including for plans to pump-prime crisis, liaison and home treatment interventions suitable for under 18s, with the goal of minimising inappropriate admissions to in-patient, paediatric or adult mental health wards. This builds on existing work on crisis care that forms part of areas' Local Transformation Plans (LTPs) for children and young people's mental health and wellbeing.

Q: *Why do liaison services need to be commissioned to operate 24/7? What about hospitals where it is believed that there is no MH demand to justify 24/7 cover?*

A: The funding is available only for hospitals with 24/7 A&E departments. We have taken this approach on the basic principle that if an A&E department provides 24/7 care for people with physical health problems, then it should provide 24/7 care for people with mental health problems – not to mention that the huge prevalence of people with co-morbid mental and physical health issues means that liaison services being available 24/7 improve overall care for many more people than 'just' those with primary mental health needs.

Evidence from the CQC and other sources suggests that the peak time of A&E presentations by those with urgent & emergency mental health needs are 'out of hours' – often late at night or in the early hours of the morning.

We also know that where liaison services have extended their operating hours to 24/7, they have seen significant increases in unforeseen and unpredicted demand – what was effectively unknown and unmet need previously. Exeter saw an overall increase in referrals of 40%, and an increase of over 80% just for referrals from A&E.

However, we of course expect local partners to base any bids on their understanding of demand and strategic regional considerations. Different liaison MH service models will require different levels of staffing, which will also need to be adapted according to local need, hospital size, population size and ED footfall.

Q: *Should we focus on ED rather than inpatient U&E work?*

A: Local commissioners and providers will need to consider how they assess need and demand in both ED and on wards, and the robustness of their approaches to doing so – especially as we know that the quality of diagnostic coding is generally poor and variable and therefore does not give an accurate picture of mental health needs among people who present to EDs. We expect teams operating at core 24 with the aid of this 'top up' funding to be able to provide a one hour response to emergency referrals from EDs and acute general inpatient wards, and a 24 hour response to urgent ward referrals.

Q: *With respect to MHA assessments and response times - we believe we can meet the start time target for MHA assessments - however how do we address downstream pressures such as AMHP availability and bed availability?*

A: Local partners need to work together to consider the implications of the new implementation guidance (with similar guidance for other urgent and emergency mental health and acute mental health care pathways to be published in the coming months) within the context of whole pathways and systems.

Q: *I understand this funding for acute settings - how does this fit with new clinical hubs i.e. trying to move activity out of A&E?*

A: Liaison mental health services are and should be seen as one part of a wider, responsive and accessible urgent & emergency mental health care system. Their provision needs to be balanced with the provision of 24/7 community-based crisis services out of hospital, and CCGs are receiving extra funding for this in their baselines from 2017/18 for the expansion of Crisis Resolution Home Treatment teams.

Liaison services help manage existing mental health demand in acute hospitals, which is often unmet. We know that people with mental health needs in A&E often have a poor experience. Our expansion of liaison services will ensure that people experiencing a mental health crisis who present to A&E will receive the same timely access to high quality evidence-based care as people who present with urgent & emergency physical health needs, though this is by no means the only focus of our overall national work on urgent and emergency mental health care.

Q: *You do not mention ambulance response, nor anything about to link the presentations via 111 and the routing towards ED?*

A: Our new implementation guidance for urgent and emergency liaison mental health services does state that one of the steps services should take to help understand local demand is to seek to 'understand the reasons for ED attendances and general hospital admissions for people with mental health problems, including referral routes from primary care and NHS 111, and transport by ambulance services' (p. 38).

Q: *If patient experience is the key criterion, why is it only scored at 3% in bid assessment?*

A: The key criterion for the transformation process funding is that acute hospitals can use the 'top up' funding to achieve the core 24 service standard and then sustain and locally recurrently fund at least the same standard.

Patient experience is the key criterion by which we will be measuring adherence to NICE-concordant care for liaison services and all other urgent and emergency mental health services in the longer term, as set out in the new implementation guidance (see pp. 35-7).

Q: *Our clinical advisors note that the principle presentation is up to midnight. What are the liaison teams going to be doing the rest of the time? Also Core 24 does not include Approved Mental Health Social Workers. Any comments?*

A: The evidence we have considered to date from the CQC and other sources suggests that the peak time of A&E presentations by those with urgent & emergency mental health needs are 'out of hours' – often late at night or in the early hours of the morning.

We also know that where liaison services have extended their operating hours to 24/7, they have seen significant increases in unforeseen and unpredicted demand – what was effectively unknown and unmet need previously. Exeter saw an overall increase in referrals of 40%, and an increase of over 80% just for referrals from A&E.

However, we of course expect local partners to base any bids on their understanding of demand – including an appraisal of how this is being measured and whether there is confidence that this is done reliably – and strategic regional considerations. Different liaison MH service models will require different levels of staffing, which will also need to be adapted according to local need, hospital size, population size and ED footfall.

Although the core 24 service standard as measured by NHS England does not include mental health social workers, the new implementation guidance makes clear that liaison mental health services should have access to appropriate Approved Mental Health Professionals either on the team or through contractual arrangements. It adds that liaison mental health services should have joint ownership and governance arrangements between acute trusts, mental health trusts and other local providers including senior clinical and operational leadership from those providers. This should improve partnership working between the liaison service and local providers of community, primary, social care, housing, public health (including drug and alcohol use) and voluntary sector services.

Q: *Core 24 staffing levels seemed to be based on 500 bedded DGH. Will they be scaled up to reflect 1500 bedded tertiary acute teaching hospital with local population with high prevalence of mental illness?*

A: As our recently published implementation guidance states, these are sample staffing levels for core 24 based on a 500 bedded DGH though are what NHS England views as a minimum standard. Other sample staffing levels for larger hospitals are also included (for the 'enhanced 24' and 'comprehensive' service standards). In general, different service models will require different levels of staffing, which will also need to be adapted according to local need, hospital size, population size and A&E department footfall. Commissioners and providers will need to decide what is appropriate above and beyond core 24 based on the sample levels and these other considerations.

Q: *Can you just clarify that the age for the funding is 16 and upwards?*

A: The funding available is for adults and older adults above 18 (the core 24 standard has always been 18+), other than where teams are already commissioned to provide service to 16-18 year olds and there are such arrangements in place via access to adolescent mental health specialist expertise. However, this funding is not for the provision of adolescent mental health expertise, and all applicants will need to make clear that the liaison service will have access to older adult expertise.

3. THE PROCESS

Q: *What is the role of NHS England regions in this process?*

A: We are engaged in continued discussions with regional colleagues as to their role, including in assuring bids that come to them on 18 January before they send them on with advice/steers to ourselves in the national team on 27 January. We have agreed that it would be helpful for regions to support prospective applicants in determining whether their bids would be realistic and appropriate based on the five key criteria as set out below:

Before proceeding with the application, please consider the checklist below for the minimum criteria to be considered to be deemed 'core 24'. If the answer to any of the questions below is 'No', then please do not apply.
The service will be commissioned to operate as an on-site, distinct 24/7 service in the acute hospital within one year of receiving the funding
The service will be in line with or close to the recommended staffing level for a core 24 service within one year of receiving the funding
The service will be commissioned to provide a 1 hour response to emergency referrals and a 24 hour response to urgent inpatient ward referrals within one year of receiving the funding
The mental health liaison service will be self-sustaining within one year of achieving the core 24 standard, and that funding will be reinvested recurrently
The application is for general acute hospital(s) with 24/7 A&E department(s)

The role for regions is to facilitate communications between prospective applicants and the national team, and to provide support for bidders primarily during the development of bids. Prospective applicants should therefore contact their regional UEC PMO as early as possible so the PMO is aware of their intentions, and can offer advice as to the appropriateness of the potential bid.

We are also asking regional UEC PMOs to link up with regional mental health leads given the cross-cutting nature of acute hospital liaison services, and the unique and valuable knowledge and expertise that colleagues working in the differing structures can bring.

Q: *How many bids are you realistically expecting nationally?*

A: This is difficult to say. There are over 170 eligible services nationally, though Greater Manchester is excluded (due to devolved funding arrangements), and bids from the 18 services that are already that core 24 will be less of a priority (but not excluded outright). However, the spreadsheet we have provided to regions with data from the 3rd annual national survey of Liaison Psychiatry Services in England (LPSE-3) undertaken by Plymouth University can provide a useful guide, along with the key five criteria above, for regions to assess the suitability of bids for hospitals within their regions that can realistically get to core 24 using this 'top up' transformation funding. We envisage that the involvement and oversight from STPs and regional UEC PMOs throughout the bidding process will help narrow down the pool of

applicants according to the above criteria and regional considerations/judgements that need to be made. Ultimately each bid will be considered on its own merits.

Q: *Will there be a proportional split of funds across the 4 regions?*

A: No – this is a national process and bids will be considered on their own merits by the national panel that will provide recommendations to NHS England's Investment Committee. We do however expect there to eventually be a good split across the regions, and the recommendations that the national panel will make will be in the context of the overall funding available which has been secured to deliver the *Five Year Forward View for Mental Health* ambition that at least 50% of acute hospitals with 24/7 A&E departments are operating at core 24 by 2021.

Q: *Is there any flexibility in the timeline?*

A: Unfortunately not. However, we have managed to secure a period of regional assurance between 18-27 January, after which regional UEC PMOs will forward final bids to the national team for the expert panel to review.

Q: *Is it possible to submit one bid across 3 STPs?*

A: Theoretically this is possible and we would welcome regional-level plans where they are presented coherently. However, the application form(s) would need to make very clear which acute hospitals such a bid covers, along with all of the requisite information on a hospital-by-hospital basis, including the current and projected provision of each hospital against the core 24 standard and recurrent locally-committed funding from CCGs to sustain the new levels, if successful. Accordingly any bidders who are submitting a bid covering multiple hospitals are permitted to extend the word limit proportionally (which is currently set out on a 'per acute hospital' basis).

Q: *My trust covers 4 acute providers in one STP: how many bids can we put in? 1 or 4 (one for each provider?)?*

A: Presuming this is question from someone working in mental health trust, it is important to note that we are only accepting bids from A&E Delivery Boards to regional UEC PMOs via STPs. Therefore it would be prudent to check with your STP lead if they would be happy to submit one bid for the four acute providers and however many acute hospitals they provide by including information broken down by individual acute hospitals. It is also important to note that the funding is available for

hospitals closest to core 24 as a ‘top up’ to existing committed local funding – so it should not be automatically assumed that all acute providers/hospitals within a certain geographical (e.g. mental health trust) footprint would or should be appropriate to include in bids.

Q: *Our trust covers 4 hospitals and runs 3 distinct teams – do we complete a fresh bid for each team or one overarching bid?*

A: As the information we require needs to be set out by acute hospital, it is perfectly acceptable to submit one overarching bid while making clear how each team working in each hospital will achieve and sustain the core 24 service standard.

Q: *If there is significant variation within an STP footprint to achieve core 24 would you expect more than 1 bid per STP footprint?*

A: We expect bids which STP sponsors feel confident to sign off as realistic, and that set out how acute hospitals involved in applying will achieve and sustain the core 24 service standard. We appreciate there is significant variation in terms of current and planned provision. We have provided regional teams with hospital-level data from the 3rd annual national survey of Liaison Psychiatry Services in England (LPSE-3) undertaken by Plymouth University which should give them an idea of which acute hospitals within their regions seem closest to core 24 and therefore best placed to be encouraged to apply for this funding. This will also depend on how much funding is being provided locally, as well as commitments to full recurrent funding in future years.

Q: *Can we add appendices to our bid to provide additional information to support the bid?*

A: As the application form advises, in responding to question 4 (‘Financial information’), applicants may provide supporting written text. In terms of additional appendices only where it is deemed absolutely essential to the bid would we expect to see and take into consideration any additional information provided in this way. Otherwise we would very strongly advise applicants to provide concise answers on the application form. Those unsure should seek advice from their regional UEC PMOs in the first instance.

Q: *There is a lot of information being asked for in a very short time with limited word limits. On the application form how can we get the required amount of information in with these constraints?*

A: We appreciate this is not straightforward and are grateful for the continued efforts of applicants. However, regional colleagues undertaking assurance of bids and the national panel could potentially be dealing with a vast number of bids. The word limits are therefore to make the process manageable as well as encouraging applicants to provide concise information based on the clear priorities in the bidding and supporting documentation.

Q: *There is a lot to cover here bearing in mind that applicants may simultaneously be applying to transformation funding processes to support delivery of programmes for urgent & emergency care, cancer, new care models etc. What advice would you give on approaching this?*

A: We believe that our minimum key criteria checklist and priorities in the bidding and supporting documentation should make clear to applicants whether or not they should be bidding for the UELMH transformation funding. We also hope that the value framework approach provided by Finance colleagues across all of the transformation funding processes gives applicants a consistent idea of that aspect of bids that the national review panels will be looking for. Ultimately applicants and their support structures will need to consider their priorities based on suitability as well as e.g. the planning and contracting round, STP proposal development etc.

Q: *In our service our staff complement exceeds core 24 but not all staff are focussed on providing urgent or emergency care and the service operates 12 hours per day - is it reasonable to subtract these staff from our bid documentation or should we include them and request funding to reach the 24/7 level of cover?*

A: The bid will need to clearly set out what the current liaison staff complement is for urgent and emergency mental health care, and the current urgent and emergency provision accordingly (appears to be 12/7), as well as what it is envisaged that the new funding will achieve (over and above existing committed local funding) – which, as per our core 24 criteria, should be that teams are resourced in line with (or close to) the recommended staffing numbers and skill mix which enable them to operate on a 24/7 basis (including access to older adult clinical expertise). Consideration should be given as to whether the rota could be adjusted to provide a 24/7 service without additional funding, or whether new funding is being sought through this process for additional staff which will enable a 24/7 urgent and emergency liaison MH service. It should be remembered that commitment from commissioners to recurrent local funding is required in the latter case.

Q: *We plan to bid for a staffing level that will meet the anticipated demand in ED rather than one that simple provides cover for 24/7 shifts. This will inevitably be more expensive - does this make it less likely that we'll be successful - should we propose a range of staffing models to meet the demand?*

A: It should be noted that bids must set out what local funding is already being committed from CCG budgets as compared to the pump-prime funding being requested through this process, and what it is expected that each funding stream will achieve. We welcome and encourage this approach in seeking to meet anticipated demand, if it is well evidenced. Applicants may propose a range of staffing models in line with the bidding documentation and the new implementation guidance if they so wish – the most important consideration is that any proposals included are realistic and achievable in light of the key criteria for bids.

Q: *The proposed core 24 model suggests a mix of B6 and B7 nurses. Our experience suggests it would be practically challenging to provide a robust rota with this mix. Would a bid that favoured B7 nurses only be at a disadvantage?*

A: No. Where applicants can set out clear and reasonable evidence to justify this approach, they will not be at a disadvantage.

Q: *Is the information that was shared relating to the gap and staffing requirements to achieve Core 24 by acute site what you will expect to see in bids?*

A: We expect to see up-to-date current staffing levels, those projected that current local funding from CCG budgets will help to achieve and those projected that this pump prime transformation funding will help to achieve. Although these levels do not need to be set out in the same way as in the spreadsheet, applicants and reviewers may find it helpful to do so.