Appendix 1

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Nottingham City**
Clinical Commissioning Groups	**NHS Nottingham City**
Boundary Differences	**Boundary is coterminous with the City Council**
Date agreed at Health and Well-Being Board:	**26th February 2014**
Date submitted:	**14th February 2014**
Minimum required value of ITF pooled budget: 2014/15	**£10.01**
2015/16	**£24.0**
Total agreed value of pooled budget: 2014/15	**£24.0**
2015/16	**£24.0**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dawn Smith
Position	Chief Operating Officer
Date	

Signed on behalf of the Council	
By	Alison Michalska
Position	Corporate Director of Children and Adult Services
Date	

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Alex Norris
Date	

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

BCF funds now form part of the Integrated Care Programme which has senior sponsorship from Ian Curryer Chief Executive Nottingham City Council, and Dawn Smith, Chief Operating Officer NHS Nottingham City CCG. To ensure operational compliance health and social care providers are involved with this programme via the following groups:-

- The Health and Wellbeing Board
- Health and Wellbeing Commissioning Executive Group (CEG)
- Weekly Better Care Funding sub groups
- The Strategy and Implementation Group for Nottinghamshire South (SIGNS)
- The Urgent Care Board
- The Collaborative Commissioning Congress
- The Integrated Care Programme Board

The Integrated Care Programme aligns with the national agenda for integrating health and social care in which Nottingham City stakeholders and citizens have come together to develop a local vision and programme structure, overseen by a joint board comprising of executive leads from both provider and commissioning organisations under the scrutiny and oversight of the Health and Wellbeing board.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

During the analysis phase of the Programme detailed engagement with citizens and carers took place to understand the issues, concerns and strengths of the current health and social care system. This information was used to shape the integrated care model which is now being implemented with on-going newsletters and documentation keeping stakeholders updated with progress.

An engagement plan to ensure that citizens are involved in decision making throughout implementation of the programme is now in place with discussions underway with 'Healthwatch' Re: mechanisms to support the on-going planning processes.

Discussions have been held with HWB3 – the VCS engagement mechanism of the Health & Well-being Board – in relation to the objectives of the Nottingham BCF, the additive elements and how the VCS can be better involved in the Integrated Care programme moving forward

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Appendix 1

Document or information title	Synopsis and links
Integrated Care Programme Plan	**Detailed Programme plan describing the new model of integrated care and the projects established to deliver the vision.**
Health and Wellbeing Strategy	**Priority 2 describes Integrated Care and how the Health and Wellbeing Board will monitor outcomes of the planned changes to the health and social care system**
BCF Reconciliation Plan	**Provides detailed breakdown of projects.**

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our Vision is to improve the experience of and access to health and social care services for citizens. More citizens will report that their quality of life has improved as a result of integrated health and care services. The number of citizens remaining independent in the community, including after hospital admission will increase with improved and seamless transfers of care.

To deliver this vision we will undertake an extensive system wide Programme of change that will see local services reshaped to deliver joined up care. The emphasis will be on a more generic model of care across the health and social community rather than single-disease specific care pathways. In approaching care in this way we are able to ensure patients are managed in the community more effectively and efficiently, reducing emergency admissions, re-admissions and supporting the discharge pathway.

The changes will involve the following:-

- Agree the configuration of Care Delivery Groups which incorporates groups of GP practices.
- Reconfigure community services to establish neighborhood care teams that work within the care delivery groups.
- Reconfigure primary care services to share clinical and back office functions
- Reconfigure social care assessment to support the Care Delivery Groups.
- Reconfigure intermediate care services, crisis response and LA reablement and emergency home care services to support independence pathways.
- Align specialist LTC support services to support Care Delivery Groups as appropriate
- Support general practice to provide an early intervention and proactive approach to the management of people with LTCs (including the frail elderly)
- Increase operational delivery to 7 days a week
- Utilize assistive and information Technology

Our vision is shaped by, and continues to be shaped by our citizens and our staff. As an integrated programme of work our citizens will find that:-

- Access to services will be less complex through single points of access and use of web based information allowing self-access
- People will only tell their story once as assessment functions are joined up and information is shared across health and social care
- Citizens will have greater choice and control over their lives and greater support in self care.
- People will have greater self-awareness of how to improve their own health and wellbeing through prevention and healthy lifestyles

- Local communities and individuals will be healthier, live longer and more independently. They will be supported to live with risk and will be less reliant on statutory services
- Hospitals and long term care will be last resorts and only when there is an absolute need that cannot be met outside of these environments
- Organisations will be joined up and will work together to share resources and learning

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The long term aim of Nottingham City CCG and Nottingham City Council is that through integrated strategies citizens will see a transformed health and social care system. This will be achieved by:

- removing false divides between physical, psychological and social needs
- focussing on the whole person not the condition
- supporting citizens to thrive, creating independence not dependence;
- being tailored to overall need - hospital will be a place of choice, not a default; and
- not incuring delays, people will be in the best place to meet their needs

These aims will be delivered by the following objectives:-

- Develop community health services with social care support linked to groups of GP practices working in geographically proximate areas
- The right care delivered at the right time through Primary care, community services and social care working together in localities; accessing secondary care appropriately.
- Coordinated care through services being delivered by multi-disciplinary teams holding regular MDT meetings.
- Ensure that there is a single person responsible for coordinating the care of citizens with complex needs
- Early identification and intervention of on-going health and social care needs building on risk stratification, risk registers and data held by relevant agencies
- A proactive approach to identify citizens at risk of needing an increased level of care to ensure appropriate support is in place before a crisis situation occurs.
- Restructure and skill up our workforce so that health and social care services work better together to deliver the right care at the right time
- Personalised care planning with access to appropriate specialist support in the community.
- Support to ensure that citizens are empowered to manage their own condition/s
- Support citizens maintain their independence and manage their own care through the creation of effective networks with community, housing and health support services

- Improved transition of care between hospital and community setting.

A performance dashboard will be created and monitored via the Health and Wellbeing Commissioning Executive Group (HWBCEG). The HWBCEG will monitor the following indicators

- Non-elective admissions aged 65+ per 1,000 pop 65+
- Non-elective bed days aged 65+ per head of 1,000 pop 65+
- Non-elective re-admission rate within 30 days
- Non-elective re-admission rate within 90 days
- Excess winter deaths for over 65s
- No of delayed transfer of care days aged 18+ per 100,000 pop
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation
- Proportion of people aged 65+ discharged direct to residential care
- Outcome of short-term support to maximise independence for new and existing clients (STS002a/b)
- Permanent admissions to residential / nursing care aged 65+ per 100,000 pop 65+
- Count of clients receiving long-term services (LTS001a)

The following health gains will be seen across the City:-

- Citizens will report that their quality of life has improved as a result of integrated health and social care services
- Reduction of re-admissions <90 days
- Reduction in Length of Stay for General Medical conditions (Frail elderly, LTC)
- Reduction in avoidable emergency admissions
- Increase of earlier diagnosis of dementia
- An increase of older citizens remaining independent after hospital admission
- An increase in citizens who are satisfied with their care and support

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

This plan fits with the wider approach to improving health and wellbeing in the city and is a key enabler of the Nottingham Plan (Local Authority strategy for wellbeing) and the Clinical Commissioning Groups 3 year commissioning strategy. The key objective of the Better Care Fund proposal is to improve citizens' experience of care through the delivery of more integrated primary, secondary health and social care services.

Integrating care presents significant transitional and operational challenges. In order to realise our overarching benefit of an Integrated Nottinghamshire, there will be a number

of key success factors:

Strong and Deliberative Engagement - Engagement with all our stakeholders is key to making sure that there is a strong sense of ownership of the change. We will have dedicated groups in place to facilitate this, including our Citizens' Panels and engagement workstreams. We will commission an independent communications team that will work with all parties to ensure engagement and communication is carried out effectively for all stakeholders.

Clinical and Organisational Leadership - Leadership is the single biggest contributory factor to the success or failure of a complex change programme. We will ensure our clinicians and leaders are involved. This programme of change will be led by the Health and Wellbeing Board to ensure the integrity of the programme and drive benefits for citizens.

Programme Management - We understand the necessity of rigorous programme management and will ensure this is identified via the ITF plans so we can assure ourselves on the delivery of our plans, management and escalation of our risks and evaluation of our outcomes.

An Integrated Delivery Team - Our delivery teams will include representation from major stakeholder groups, programme management, design, clinical leadership, information, estates and workforce transformation.

Innovative Finance and Contracting - We are considering how to use contracting mechanisms to promote provider collaboration to ensure optimum outcomes for citizens that are also good value for money. We aim to explore new commissioning models such as Capitated and Outcome-Based Incentivised Contracts (COBIC).

Timely access to Data and Systems - All of the interventions proposed require technology enablement. Our organisations are committed to working on sharing data and providing single records for health and social care through Connected Nottinghamshire.

Workforce and Culture - We are committed to delivering a workforce that meets the needs of patients through innovation, inclusiveness and engagement. Strategic direction is provided by the East Midlands Local Education and Training Board (LETB) and Training Council (LETC). Our culture is also one that is hungry for change. Our staff and our citizens see the value of what we are doing and are proud to be a part of such an important transformation.

The delivery of this project will be carried out in the following 3 phases:

Phase One:-
By end January 2014

Workforce

- The following teams will be reconfigured to support the eight Care Delivery Groups:
  - Community Matrons
  - Community Nursing and rehabilitation including support staff
  - Social care assessment (named link)

- The **care coordinator role** will be established an operational from 8am – 8pm, Monday – Friday.
- Champion roles will be established to support teams implementing new ways of working.
- Workforce engagement plan will be in place

Contractual requirements

- Service specification for the care coordinator service will be agreed.
- Service specification for neighbourhood teams will be agreed.
- Agreement re: approach to the 'alignment' of the services supporting the independence pathway model.

Operational processes

Minimum requirements for Operational processes will be in place for the following:

- MDT team meetings (NB this is supported through the risk stratification DES)
- Access to services in scope of the programme including the care coordinator
- Secondary care interface 'choose to admit' and 'transfer to assess'

Access and navigation

- Proposal to simplify access to services and navigation around the health and social care system will be agreed and a detailed implantation plan in place.

IT and estates

- Information sharing agreements across health and social care will be in place**.**
- Relevant health and social care staff will have access to SystmOne and Care First.
- 8 bases for care delivery coordinators will be confirmed.

Secondary Care interface

- Services will be redesigned to support 'choose to admit' and 'transfer to assess'.

By April 2014

Workforce

- The following services will be aligned to support the independence pathway model:

Reablement pathway	Urgent Response Pathway
Intermediate care at home mainstream (CityCare)	Crisis Response service (CityCare)
Intermediate care at home mental health (CityCare)	Nottingham Emergency Homecare Service NEHCS (NCC)
Intake service (NCC)	Through The Night service (NCC)

Contractual requirements

- Assistive technology: A new telehealth service will have been procured and be operational. Telecare expansion to targeted groups will be in place.
- Service specifications to support independence pathway will be agreed.
- The joint venture will be explored as a mechanism to support the independence

pathway model.
- Agreement re: FAQs eligibility and independence pathway processes.

Operational processes
Minimum requirements for Operational processes will be in place for the following with local implementation developed in the CDGs:
  - Case management
  - Key worker role
- Agreement re: criteria for reablement and community beds to support signposting to appropriate pathway.
- Implementation of the self care pathway to support early intervention.
- Agreement re: how social care assessment process will support the independence pathways.
- Plans for the implementation of comprehensive geriatric assessment will be developed.

Access and navigation
- Nottingham Health and care Point will be integrated to support access to integrated services.

IT and estates
- Shared platform for information sharing to be implemented by 'Connecting Nottinghamshire'

Secondary Care interface
- All referrals from the hospital care coordination team will be transferring patients with a description of care needs, appropriate support will be sourced by the community care coordinators.

Phase Two:-

From April 2014
Workforce
- CDG teams will be supported with additional staff to up skill in Long Term Condition management
- Review of specialist services and integration into neighbourhood teams as appropriate
- Review of social care assessment in pathways including the development of trusted assessors.
- Development of shared roles / holistic worker.
- Reconfigure independence pathway teams to support CDGs as appropriate.

Contractual requirements
- Implementation of joint venture to support independence pathway if agreed.

Operational processes
- Formalise processes to support links to housing and the community and voluntary sector, including workforce opportunities.
- The integrated AT service will be established.
- Support for primary care to work in natural communities.

Access and navigation

- Further development to ensure coordinated support with services out of scope of the programme, for example mental health services.

IT and Estates

- Services supporting CDGs will be collocated where possible.

Phase Three:-

- Continued transfer of specialist support as appropriate into CDGs.
- Continued roll out of IT to support integrated care.
- Continued development of holistic worker role
- Continued development of primary care role in CDGs
- Explore the roll out of integration to other service areas, e.g. mental health services.

Complexity - The model incorporates different levels of complexity to ensure a targeted approach and an appropriate response as citizens move between levels requiring different types of support.

- Complex needs requiring an intensive case management approach, citizens at high risk of unplanned hospital admission.
- Complex LTC and/or care needs deterioration can be managed by a low intensity case management/ monitoring approach, moderate risk of hospital admission.
- Complex LTC (1 or multiple), require enhance support from GP as well as supported self-care.

Secondary Care interface • All referrals from the hospital care coordination team will be transferring patients with a description of care needs; appropriate support will be sourced by the community care coordinators.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The biggest risk to the savings not being realised, is a failure of the integrated care programme to achieve a sufficient magnitude of reduction in demand for acute care. If the required demand reductions are not achieved, then one of 3 situations is likely to occur

- Acute services will not be able to be reduced; There will consequently be a financial shortfall where these were anticipated to be delivering the NHS savings
- Acute services that had already been reduced to achieve the required savings will require putting back in at short notice to deal with the unplanned level of demand. History suggests that having to rapidly put in additional/temporary services is more

costly and provides lower quality than if they were planned.
- Acute services that had already been reduced are unable to be increased to cope with the unplanned demand (either due to inability to recruit necessary staff, or lack of funding in the system to fund the increase in services), resulting in impacts on quality and experience to patients, increased risk of harm, non-achievement of access targets/service standards, and a significant risk to organisational reputations.

The integrated programme aims to mitigate the risks of additional activity in the acute setting by:-

- Enabling, promoting and developing care into the community. This will involve increasing capacity in provision and workforce and working with the local authority to identify gaps and analysis in current provision.
- Prevent additional acute activity by targeting and managing conditions prior to escalation in a holistic way, thus reducing avoidable admissions and ED attendances.
- The plans will be underpinned by data obtained from the Utilisation Review of un-scheduled medical in-patient admissions at NUH, in-patient admissions to Lings Bar Hospital and the Intermediate Care Utilisation Review of bed based and home based services. The 2010 review identified the following reason for admission reviews not meeting the criteria for admission were:
- (one third) External factors e.g. availabilty of Nursing Home Care, community provision, assessment
- (Two-thirds) Internal Trust factors e.g. waits for clinical assessment.
- Appropriately 28.4% did not have a continued need for an acute stay. In most cases, the failure to pass admitted patients from acute to a more appropriate level of care was due to external processes such as capacity constraints in existing services or incomplete discharge planning. Those patients who did not meet the continued stay criteria could have been managed at a lower level of acute care or Home Care or at home with a returning out patient appointment.

Further analysis through the SIGNS group in 2013 concluded that 2,596 patients could have been discharged earlier freeing up 14,090 bed days, over one year. These patients required a range of services in the community including therapy and assessment, 24 hour intensive nursing/therapy assessment, complex sub acute nursing and therapy, nursing and therapy needs which could be managed in the home or low level Reablement services.

The integrated Programme work will see an impact in the acute sector from November 2014

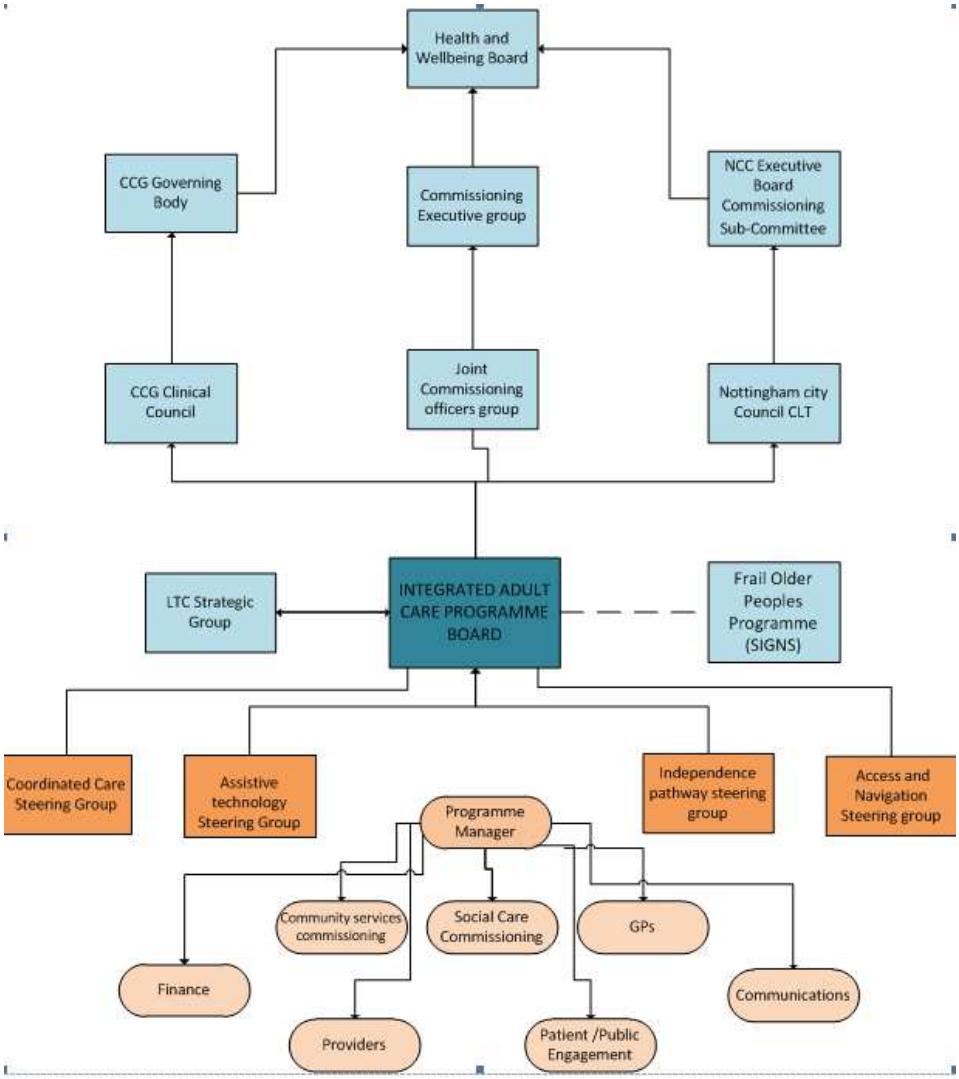
e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The Commissioning Executive Group (a commissioning sub group of the Health and Wellbeing Board) will hold this transformation to account under the Integrated Care Programme in which clinicians, providers and the Local Authority are key members. Through monthly meetings the HWBCEG will regularly evaluate programme delivery and

financial benefits realisation, ensuring that there are high levels of satisfaction with services through patient, carer and staff feedback, via a performance dashboard of integrated care metrics. An Annual Report will be presented to the Health and Wellbeing Board and subsequent Governing bodies each year. (please see governance map below).

The operational management of the Integrated Transfer Funds will be the responsibility of the ITF programme Manager. This will be incorporated within the ITF plan, and will be a shared position between health and the local authority.



Appendix 1

NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

The core commissioning Stakeholders can confirm that the eligibility criteria for accessing adult social care will remain the same. In Nottingham City the eligibility threshold is High Moderate.

In addition to maintaining the current eligibility criteria the local definition of protection for social care services includes the following:

- Ensuring that we can respond to demographic pressures/increasing levels of need in particular; dementia, long-term conditions and younger adults with complex care needs
- Promoting innovation in social care and integration with Health in line with transformation plans to improve social care outcomes and realise savings and efficiencies in both health and social care budgets
- Future proofing – capacity for Care Bill implementation
- Maintaining (not compromising) existing social care model – essential core services, enhancing personalisation, focus on support for carers, promoting enablement, building community capacity

Please explain how local social care services will be protected within your plans

Schemes identified in the plan support the model of integrated care currently being implemented and will therefore support delivery of objectives.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Nottingham City sees 7 day working as a critical component for its planning assumptions to support hospital discharge and avoid admissions to both hospital and care homes.

A crisis coordination team has already been commissioned to support discharge over 7 days with a number of seven day services already in place, such as Rapid Response Teams and Intermediate Care Teams, new services are outlined in the BCF plan that will require further development to ensure that services are in place to meet the identified needs of patients through established working groups while working within the strategic direction of the Adult Integrated agenda.

All relevant providers have been informed of plans to further expand 7 day working

through the 2014/15 contract negotiations.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The core commissioning Stakeholders can confirm that they are not using the NHS Number as the primary identifier across all health and care services

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

NHS Nottingham City and Nottingham City Local Health Authority are signed up to the Productive Notts IT Programme. A recent IT summit has been held in which all key provider organisations within Nottinghamshire have signed up to IT principles. These principles include shared information and data and the use of the NHS Number as the primary identifier. A rollout of shared data (including single use of the NHS Number) is now planned for summer 2014.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)

The stakeholders are committed to sourcing systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Nottingham City is a member of the newly formed Record Sharing Group. This group comprising of clinical, and governance/ Caulidcott leads works together as a health and social care community to develop and implement system-wide best-practice information policies that support the sharing of citizen information. This group works within best practice guidance to ensure the appropriate level of information is available to support the delivery of this programme, safely, securely and in line with legal requirements.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to

risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Multi-disciplinary teams comprising of both health and social care staff will be working with primary care to identify patients at high risk using the Devon risk stratification tool. Joint decisions re: management of patients will be made at multi-disciplinary meetings. Plans to identify a key worker (lead professional) supported by a joint assessment and care management process are currently underway and will be implemented in April 2014.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Acute provider already has significant Cost reduction targets which could impact on quality and delivery if not managed prior to money being removed.	High	Ensure a proposal is discussed around phased activity and finance, to ensure core services are not significantly affected
Increase in ED and admissions capacity	High	Ongoing monitoring of activity with close links to community provision to scale up and down as required
Insufficient skilled resources to manage increased complexity within the community	High	Collaboration with community providers to ensure training and development programmes are in place to manage influx and increase of skills needed.
Implementation of NHS Number	High	Working collaboratively with productive IT to develop Data sharing protocols and systems requirements
Existing contract not fit for purpose to meet shared responsibility	High	Work with stakeholders to understand implications and scope opportunity of developing shared responsibility.
Impact on workforce in regards to remit, responsibility and job description	Medium	Work with HR to ensure staff are engaged with during the process and undertake a training needs analysis.
Insufficient internal resource to streamline discharge of care from acute to community	Medium	Work with NUH to monitor performance of discharge to transfer to assess workgroups.
Confusing access and navigation points	Medium	Collate and migrate existing access points to streamline and remove fragmentation.
Sign up and cultural changes required to enable whole scale change from all partners, including changes to ways of working is not achieved within the timescale	High	On-going leadership from the Integrated Programme Board Early engagement of partners with work programmes agreed in partnership at a senior level

		Planned change management approach for all organisations involved to engage and communicate these changes to the front line
There is a risk that as performance related funding is reliant on outcomes these may not be evidenced in the short to medium term	High	On-going monitoring of outcomes at a senior level through the Integrated Programme Board and Commissioning Executive Group with a robust approach to performance management On-going monitoring and evaluation of programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers
Future changes to national policy in respect of Urgent and Emergency Care (primary care, A&E and OOH) and changes to the primary care contract may impact on delivery of the plan	High	Maintain and sustain strong links and communication channels with Area Team, NHS England
There is a risk that implementation of the changes will impact on the financial stability of providers	High	On-going leadership from the Integrated Programme Board Early engagement of partners with work programmes agreed in partnership at a senior level through Commissioning Executive group Ensure individual projects and overall programme subject to robust analysis and modelling to ensure any financial impact on providers is clear
There is a risk that staff moving from existing services to care delivery groups will destabilise existing services leading to overall loss of performance	High	Reduce scale of services and / or phase delivery to accommodate extended recruitment timescales Use of agency staff to bridge gaps

Appendix 1

		Early discussions with regional workforce development teams to facilitate long term recruitment and development planning
Access to Risk profiling Data. Legalities around access.	High	Work collaboratively with information governance team to identify impact, risk and outcomes in a bid to produce a legally appropriate response.
Monitoring data for Delayed transfer of care may not be as accurate as required due to process of 'calling off' section 5 requests to local authority.	High	Working with NUH and LA to ensure accurate process is in place in regards to use of Section 2 and 5.
There is a risk that there is public resistance to the proposed changes and that population behaviour change will not materialise	Medium	Plan to be supported by the on-going development and implementation of a communication and engagement strategy
There is a risk that implementation of the changes will result in an increase in admissions to care homes	Medium	On-going leadership from the Commissioning Executive Group to monitor Bed availably in care home Intermediate Care / Assessment Beds to be used flexibly when necessary
There is a risk that social care funding challenges result in a reduction of available care packages to support long term care resulting in a shift in cost of long term care	High	Ensure individual projects and overall programme are subject to robust analysis and modelling to ensure that the impact of funding cuts is identified and included
There is a risk that implementation of the changes will impact on the financial stability of providers		Early engagement of partners Via Integrated Programme Board. Ensure individual projects and overall programme subject to robust analysis and modelling to ensure any financial
There is a risk that as performance related funding is reliant on outcomes these may not be evidenced in the short to medium term	High	On-going monitoring of outcomes at a senior level through the CEG with a robust approach to performance management On-going monitoring and evaluation of programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales Services to be procured on an outcomes basis with funding

		linked to outcomes therefore a shared risk between commissioners and providers
There is a risk that if the existing contractual arrangements with Nottingham University Hospitals NHS Trust remain unchanged this will have a negative impact on delivery of the plan	High	Early engagement of partners with work programmes agreed in partnership at a senior level
There is a risk that the sign up and cultural changes required to enable whole scale change from all partner organisations, including changes to ways of working is not achieved	Medium	Early engagement of partners with work programmes agreed in partnership at a senior level Planned change management approach for all organisations involved to communicate these changes to the front line