Torbay and South Devon NHS
NHS Foundation Trust

Final Operational Plan Narrative

Financial Year 2016/17

Contents:

Context and Overview

Torbay and South Devon NHS Foundation Trust was 'formed' on 1st October 2015, through the acquisition by South Devon Healthcare NHS Foundation Trust of Torbay and South Devon Health and Care NHS Trust, creating what we refer to as our 'Integrated Care Organisation' (ICO). In one organisation we now provide acute care, from Torbay Hospital, community services through a network of community hospitals, bases and, increasingly people's homes and Adult Social Care. Our ambition in doing so is to deliver a fundamentally different care model across our health and care system that is well co-ordinated and joined together, designed to support people in managing their own health and wellbeing, easily accessible and responsive to service users and health professionals and provided as close to home as possible.

Examples of the key initiatives, all are aligned with the principle that services should wrap around the person to create a single system of health and care delivery, include:

- Single point of contact – a multi-media gateway to signpost and to mobilise the appropriate assessment and resources;
- Community care – the realignment of community resources and infrastructure to support self-care and prevention;
- Frailty service –a whole system pathway of care, stratifying risk to identify the most vulnerable, largely providing services in a community setting but linking with specialist healthcare of older people and medical admissions avoidance teams;
- Multiple Long Term Conditions service – Providing coordinated multidisciplinary management of coexisting medical conditions in one place at one time; outside of the acute setting where possible and avoiding multiple appointments per condition;
- Referral Management – A framework to facilitate dialogue between professionals to manage patients in the most appropriate and efficient way will ensure that face to face appointments are no longer the automatic default position and that care plans, advice and guidance or specialist support are a viable alternative;
- Musculoskeletal Triage – a triage service through the community physiotherapy team, providing a consistent assessment, active early treatment and, if necessary onward referral to secondary care that is targeted to the right specialist area;
- Heart Failure – Developing a service where patients are treated in an outpatient setting rather than the more traditional treatment as an inpatient.

As a result, our delivery system will look and feel very different in future. There will be:

- Fewer hospital beds and better developed re-ablement facilities;
- A shift in use of specialist teams, as far as possible, from face to face clinical care, to support of primary care and community colleagues and the continued management of people in the community and avoiding unnecessary referral;

- Local Health and Wellbeing Teams, working from Locality Hubs, co-ordinating the care and managing personalised care plans for the frail and those most at risk;
- Significant investment in mobile Information Technology; ensuring that all systems are accessible to all health and care staff;
- A revised contract and risk share agreement, subject to continuation, that supports this new way of working.

The approval of that transaction required the development of a Full Business Case and a comprehensive implementation plan, describing these changes in more detail and the ways in which we expect them to be delivered.

The plan will take two to three years to implement in full. This first draft of the Trust's Annual Plan describes what we expect to deliver in 2016/17. It is entirely consistent with the Full Business Case and Long Term Financial Model presented in support of the transaction, updated only for significant changes in the environment during the intervening period; the most significant example, of course being the introduction of the Service Transformation Fund.

1. Approach to Activity Planning

Over a number of years the local commissioner and this Trust have worked together to achieve an agreed view of the demand that needs to be accommodated in the coming year. This has always included the impact of changes in referral patterns, outsourcing / transfer or repatriation of activity and the estimated level of waiting list reduction needed to achieve the elective waiting times trajectories.

There is an established process for activity planning with the following agreed principles and annual timeline.

1.1 Demand plan

- Demand planning is an inclusive process with commissioners having access to all supporting information. They are also invited to attend the specialty demand planning meetings;
- Delivery of core access standards are agreed with commissioners with initial review and agreement of service performance standards and access times. These include:
    - Stage of treatment waiting times and list sizes that are agreed as necessary to deliver the RTT standard
    - The level of and management of emergency admissions to maintain patient flow and A+E access standards
    - Achievement of all cancer standards and compliance with agreed NICE guidelines
    - Diagnostic waiting times;
- All specialties are provided with the most recent annual baseline of information covering referrals and activity across outpatients and admitted patient care;
- The baseline information also covers the previous 3 years of activity split by month and financial year for annual comparison and trend analysis;
- The actual activity baseline for the activity demand plan uses the most recent 12 month period. This year the period October 2014 to October 2015 has been used. Waiting list size at both the start and end of this period are used to create a baseline plan;
- Referral numbers are reviewed with teams and commissioners to agree any growth that should be applied to the plan. This assessment takes into account factors in the planning period and baseline that may be “one off. Additionally clinical and commissioning intelligence regarding potential future pathway changes and clinical delivery changes is reflected;
- In 2016/17 referral and admission rates will be heavily influenced by the care model changes set out the Business Case supporting the creation if the Integrated Care Organisation. The impact of planned developments, in such services as frailty and advice / guidance clinics, are modelled to reduce OP referral and emergency presentations, particularly toward the end of 2016/17;
- Agreed growth rates are applied to the baseline demand model for new referrals, with subsequent conversion into follow up and admitted activity calculated across the pathway of care;
- Each of the treatment functions have calculated an agreed target waiting list size to deliver a compliant RTT position. Any reduction in waiting list that is required is identified separately in the plan and is added onto the final demand plan for costing.

1.2 Capacity plan

- In parallel to establishing the demand plan the Trusts operational teams complete a capacity planning exercise. This includes a weekly clinic and theatre list plan to describe available capacity after adjustment for annual leave and on call etc.
- Capacity plans reflect both additional resources, principally in community settings, and efficiencies, mainly in length of stay, generated through the Trust’s ICO Care Model implementation.

1.3 Reconciliation

- The demand and capacity for each specialty is published and aggregated to a Trust level.
- The demand and capacity analysis is used, after the implementation of the ICO care model changes, to identify any gaps between demand and capacity.
- Options to balance residual demand and capacity gaps are then described in the Trusts business planning documentation. The operational leadership team will assess options to manage variances that put access standards at risk. These options include:
    - Agreement of clinical efficiency measures that can be built into the activity plan;
    - Investments to increase capacity that may be offered, where these are funded from savings elsewhere;
    - Use of outsourcing to increase capacity and flexibility to manage variation in demand;
    - Engagement with GP's and commissioners to review demand levels and consider alternatives to secondary referral;
    - In 2015/16 a number of action learning sets were created to support this engagement process. Each one chaired by a GP with representation from both primary and secondary care clinicians.
- Specialties with the greatest challenge are supported through a more in-depth capacity and demand planning process using the IMAS flow model used.

1.4 Finalisation of Trust Business Plan

- Where solutions to increase capacity through efficiencies have not been identified, the Trust executive may recommend additional investment in additional capacity or require further redesign of services in order to achieve the performance standards trajectories.
- The Trust recognises that, within 2016/17 the hospital based emergency system requires significant recalibration in order to reliably deliver the 4 hour standard. Recovery action plans and associated investment plans are referenced later in this document and have previously been shared with Monitor. Whilst not planned to increase activity, this is likely to require significant investment in 2016/17.

1.5 Timeline

- September – Business planning process launched
- October - Supporting information produced and released to operational teams
- November and December – Specialty team meetings to review baseline demand plan, agree growth rates and service changes.
- November and December – Team complete clinic and theatre level capacity planning.
- Early January – Demand plan signed off together with waiting list positions for waiting time delivery
- Mid January – Activity plan agreed with commissioners
- Late January – Activity plan priced to inform 1st Draft contract activity plan
- Late February – Proposed capacity investments presented.

2. Approach to Quality Planning

2.1 National and Local Commissioning Priorities

The strategic priorities of Torbay Council and Devon County Council, the Health and Wellbeing Boards and the Clinical Commissioning Groups have a number of common themes:

- A continued focus on health inequalities and the most vulnerable;
- Prevention and early intervention;

- Integration of health and social care services;
- Personal responsibility and choice;
- Building social capital and strengthening the local economy.

These reflect the priorities set out in the NHS England 'Everyone Counts' document and the Department of Health outcomes frameworks for the NHS, Public Health and Adult Social Services, and have informed the South Devon and Torbay CCG Strategic Plan 2014/19 which sets out the CCG vision, responsibilities, intentions and identifies a number of priorities that encompass quality (safety, effectiveness, experience):

- Promoting self-care, prevention and personal responsibility
- Developing joined up community hubs closer to home for all
- Leading a sustainable health and care system encompassing, estates, workforce and I.T.

These quality priorities have been translated into areas of focus for: Prevention, Primary Care, Community Services, Urgent Care, Mental Health, Long-term conditions, Learning Disabilities, Planned Services, Medicines Optimisation and Children's Services each with a set of outcomes. These commissioner areas of focus are reflected in the Trust Strategic Plan which describes the provider response to the delivery of the outcomes.

2.2 Provider Quality Goals as Defined by Trust Strategy and Quality Account

The Trust's Strategic Plan Document for 2015/16 set out 5 quality priorities that are also reflected in the Quality Account:

- Redesigning the reliability, accuracy and timeliness of information at the point of handover to enable an effective and safe transfer at each and every juncture;
- Establish a single point of contact for people to access community based health and social care services in Torbay;
- Improve the involvement of carers in the management of medications on admission and at discharge at Torbay Hospital and at our community hospitals;
- improve multi-agency working across Torbay and South Devon through developing and extending the existing multi-disciplinary teams working across the community;
- Create a reliable and consistent ambulatory emergency care service available 7 days a week for patients coming to Torbay Hospital.

The Trust Quality Account priorities have been agreed with stakeholders and the Trust Board.

Safety:

- To improve the consistency and reliability of complaint investigations and associated systems for organisational learning across the wider care system that is now within the remit of the Integrated Care Organisation.
- To integrate and develop the two safety toolkits used separately in community settings (QuESTT) and acute bed settings (EWTT) so they can be used across any health and care setting.

Clinical Effectiveness:

- To improve the timeliness of initial assessment within the Emergency Department as demonstrated through achievement of:
    - Time to triage, initial assessment and vital signs (15 minute standard).
    - Time to see a Doctor (60 minute standard).
    - Compliance with the Sepsis bundle

- To improve the stroke pathway across our organisation through improving coordination and remapping the whole pathway, focussing first on its acute elements.

Patient Experience:

- To test the impact of using the Institute of Health Improvement's 'Teach back' method to improve communication between patients, families and health and care professionals.

2.3 Existing Quality Concerns

The long list of quality priorities above reflects the current concerns identified by the Trust, Monitor, NHSE, CCG and CQC. The CQC inspection is currently in progress, it is anticipated that the report will now be published in June 2016. From initial feedback, we can anticipate that the CQC report will reflect some concern already identified by Monitor and NHS England, including:

- Emergency Department performance and the Emergency Pathway: Despite support from The Emergency Care Intensive Support Team (ECIST) and the implementation of a comprehensive recovery plan the Trust has not achieved the 4 hour target for some months. This represents a significant quality challenge as people accessing emergency services experience unacceptable waits. This is reflected on the Corporate Risk Register.
- Lost to Follow Up: The Trust has identified a number of patients who are lost to follow up in the Urology service. An initial piece of work suggests that this issue may be replicated across other services. This issue was initially flagged by the CCG and is reflected on the Corporate Risk Register.
- Stroke pathway: The Trust has been unable to achieve the national stroke target (SSNAP) target for time spent on a designated stroke ward. This is reflected on the Corporate Risk Register.

2.4 Approach to Quality Improvement

The Trust is going through a period of change with the exciting opportunities of the recent integration combined with the organisational pressures brought about through increasing demand and financial constraints. The Trust needs to develop new service models that are sustainable and resilient. This will require specific skills and a significant and consistent leadership effort to move forward. There are specific well recognised characteristics of high performing health care organisations and health care systems. These include:

- Establish a positive culture of dissatisfaction – we can always improve and do better;
- Continually redefine what "good" for any particular service looks like;
- Having an information system that supports improvement and helps to predict risk;
- Engender a culture where employees own the responsibility to keep patients safe;
- A culture where measurement drives performance and learning;
- Safety is a core organisational value;
- Visible leadership paying attention with integrity;
- A workforce with the skills to "work *in* the system" as well as "work *on* the system".

Some of these characteristics may be described as cultural and a guiding principle of our approach is founded on the conclusion to the Berwick Report 'A promise to learn, a commitment to act' that concludes:

"*Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning …..focus on the culture that you want to nurture: buoyant, curious, sharing, open-minded, and ambitious to do even better for patients, carers, communities, and staff pride and joy"* Berwick (2013).

Whilst establishing the right culture is critical to safe, high-quality care there is also a tangible set of core Quality Improvement skills and approaches to doing work and specifically improving services. In order to provide our staff with this core quality improvement skill set we have an established Improvement Network. The primary objective of the Improvement Network is to build capability and capacity in Quality

Improvement (QI) to support delivery of the organisations key strategic objectives. The following are examples of what the Improvement Network offers to support Quality Improvement across the organisation:

- Map out QI skills across the Service Delivery Units (SDUs) as a stock take of capacity and capability;
- Coordinate uptake of QI development opportunities as offered by the Academic Health Science Network (Patient Safety Officer training) and Institute for Healthcare Improvement (Open School);
- Build a common language and approach to QI across the organisation;
- Provide the QI training programme for clinical teams;
- Provide coaching support to clinical teams undertaking specific projects;
- Provide coaching support to individuals working though the PSOT course;
- Provide a support network and development network for individuals supporting QI;
- Provide a skills resource of specific skill sets to be accessed and used as required by teams running QI projects;
- Building links through Education to incorporate QI into the ILM programme;
- Provide teaching on QI for FI programme;
- Provide teaching and small group facilitation of the Junior doctors management course;
- Develop a web based resource about QI.

We believe that having an approach to QI that builds skills in a consistent, standardised way will help to deliver the organisational culture and skills that empowers and supports teams to develop safe resilient clinical services that deliver the organisations key objectives.

2.5 Quality Improvement and Governance Systems

The Trust Board is accountable for the delivery of safe, high quality care. In order to ensure that the Board has a clear line of sight of performance, those standards outside target trajectory are reported on the Board performance dashboard with accompanying narrative on risk mitigation. Lead Executives report on progress or barriers to progress and are held to account for recovery plans. The Board is supported by the Quality Assurance Committee (QAC) with responsibility for ensuring that data and information provided to the Board on all quality performance measures is accurate and timely. The Quality Improvement Group (QIG) reports to the QAC and receive reports from a number of services and groups who have operational responsibility for delivery of the quality priorities. Leads are held to account for delivery of the quality priorities by the QIG. Sub-groups and task and finish groups where established have designated leads with a clear line of reporting to the QIG.

The three quality priorities included in the Trust Strategic Plan and Quality Account for 2016/17 are identified as Corporate Risks on the Risk Register and are monitored by the Trust Risk and Assurance Committee.

Quality priorities are embedded in the objectives and appraisals of the Executive team to ensure the Chief Executive and Trust Chair have oversight of progress or variance against delivery milestones.

Executive co-leads for safety and quality are: Dr Rob Dyer, Medical Director and Jane Viner, Chief Nurse**.**

These processes have identified the top three risks to quality in 2016/17 and overseen the development of plans for their mitigation:

1. To improve the timeliness of assessment in the Emergency Department. A Task and Finish Group has been established reporting to the Patient Flow Board with the aims of improving timeliness of assessment in the Emergency Department through (a) improvement in flow through the hospital (b) redesign of urgent care pathways and (c) review of ambulatory care requirements. The resultant plan has been shared widely with Monitor colleagues, including timescales for delivery. The plan

describes an 'acute response' including significant changes to medical and nursing job plans and priorities and a reconfiguration of facilities, principally bed stock, and is supported by the Trust's long standing plans to develop enhanced 'out of hospital' care that will reduce demands

2. To reduce the number of patients 'lost to follow-up'. A loss of outpatient follow up was identified where severe harm occurred to 3 patients with Carcinoma of the Prostate. This was due to booking processes for follow-up appointments that were subject to human error. A task and finish group has been convened under the leadership of the Chief Operating Officer (COO) and with cross-organisational clinical and operational representation to reduce the risk of this occurring again. The risk has been assessed as high and is included on the corporate risk register. Mitigations are in place including clear communication (verbal and written) to patients explaining the process and what they should expect, and encouraging them to make contact if the process is not followed. The main objective is to develop an improved IT-based system for booking of appointments across the whole Trust including for community services. A suitable system will be identified in 2016/17.
3. To improve both the time for patients to be admitted to a stroke ward and time spent on a stroke ward. The acquisition of Torbay and Southern Devon Health and Care NHS Trust brought, for the first time acute and rehabilitation facilities for stroke patients into a single organisation, enabling a full pathway redesign which will be completed during 2016/17.

2.6 Sign Up to Safety Priorities

Using Association of Medical Royal College guidance published in June 2014; Guidance for taking responsibility*: accountable clinicians and informed patients,* the Trust has established a number of improvement targets for 2016/17:

- A person admitted to the District General Hospital (DGH) is admitted under the care of the consultant on-call on that day.
- A system of specialty ward-basing means that on transfer from the Emergency Department or the first admission ward, there may be a transfer of care to a new responsible clinician. This decision is based on the clinical needs of the patient and therefore the best ward/unit to continue his/her care. Responsibility for the patient passes to the new responsible clinician automatically unless agreed otherwise.
- The introduction of new ways of working and a new IT system in the Emergency Department has prompted a review of this agreement.
- Results from the National Inpatient Survey 2015 suggest that communication with patients is generally good. Though there is no question referring specifically to the named responsible clinician in the NIP Survey, the answers relating to communication suggest a high level of satisfaction in most areas.
- A more formal policy is required to ensure that the responsible clinician is correct and clear for all admissions. There is also a need to communicate this more effectively to patients and carers. This will be achieved through an established working group (Patient Flow Board) and will be in place by August 2016.

2.7 Seven Day Services

Torbay and South Devon NHS Foundation Trust has a good record on the development of 7-day services. We were an early adopter of 7-day diagnostic services. We have had 7-day consultant-led Radiological services for 10 years and now have a full range of diagnostic services 7-days a week.

Emergency services function effectively across 7 days in all specialties in the DGH. However there is variability in access to multidisciplinary non-emergency services for inpatients at the weekends and holidays. This affects the quality of patient experience and length of stay. It may also be associated with some additional clinical risk. A working group has been established under the leadership of the COO and MD to scope the present availability of services, including medical, nursing and therapy services and social care, and to identify priorities for extension of services across 7-days. This will include availability of

services in the community across all professional groups and functions and including community hospitals. This is expected to report in summer of 2016.

Where a need to extend clinical services is already clear, the development of 7-day services is progressing through redesign of working patterns and through the business planning process for April 2016. Some modest investment is required.

The development of 7-day services in the community is already in train through the implementation of locality health and well-being teams (2 localities are implementing in 2016/17 with implementation of the remaining 3 localities completed in 2017/18), being effected through the ICO Care Model implementation.

Improvement in access to community-based services out of hours is a key feature of the action plan for our Urgent and Emergency Care Vanguard proposals. The 5 work-streams of the U&EC Vanguard are:

- Self-care,
- 111/Integrated Urgent Care,
- Urgent Care Centres,
- Mental Health Services and
- Shared Care Records.

We have a detailed action plan in all these areas including the establishment, within 2016/17 of two Urgent Care Centres, the development of a comprehensive community-based approach to prevention and self-care and recruitment to provide 24 hour 7-day cover for all-age Psychiatric Liaison services. This programme is dependent on funding from the U&EC Vanguard programme (not yet confirmed for 2016/17).

2.8 Quality Impact Assessment

Quality priorities are identified as above through triangulation of national, professional, user and stakeholder involvement activity. Each priority has a quality impact assessment covering the three domains of quality and including risk to delivery, mitigating actions, phases and milestones. The business planning process includes a process and timeframe for Medical Director and Chief Nurse review and sign off, for all service changes and the CIP programme. This is managed and monitored through the Trust Quality Improvement Group and through the Trust Senior Business Management Team.

2.9 Triangulation

The revised Board performance report includes sections on quality, performance workforce and financial indicators. These are under review to ensure the 2016/17 quality priorities are reflected. The Board reviews this information monthly and holds the Executive lead to account for delivery. Where performance varies from anticipated trajectory, Executives are required to produce a recovery plan and are held to account for delivery. In addition the Board receives a RAG rated performance dashboard that clearly shows variance to performance across the domains. The Quality Assurance Committee and the Quality Improvement Group have dashboards in development that brings the quality performance data together.

3. Approach to Workforce Planning

The Trust has developed an Integrated Workforce Strategy that sets out how it intends to deliver a fit for purpose workforce to deliver the Trust's model of care for the future. The Strategy was developed from the Trust's business case for an Integrated Care Organisation, working with the Strategic Business Management Team. The Strategy:

- Outlines the key drivers that are influencing the future shape of the health and care workforce in South Devon.
- Summarises at a high level the impact this will have on the workforce and some of the key challenges associated with these changes.
- Identifies the additional challenges that this will present in terms of workforce planning and development and consequent need for an Integrated Workforce Strategy.
- Identifies a route to achieve the required outputs of the strategy, the required resources and governance structure.

This Strategy has been communicated to the organisation and managers have been asked to prepare annual workforce plans in accordance with that strategy.

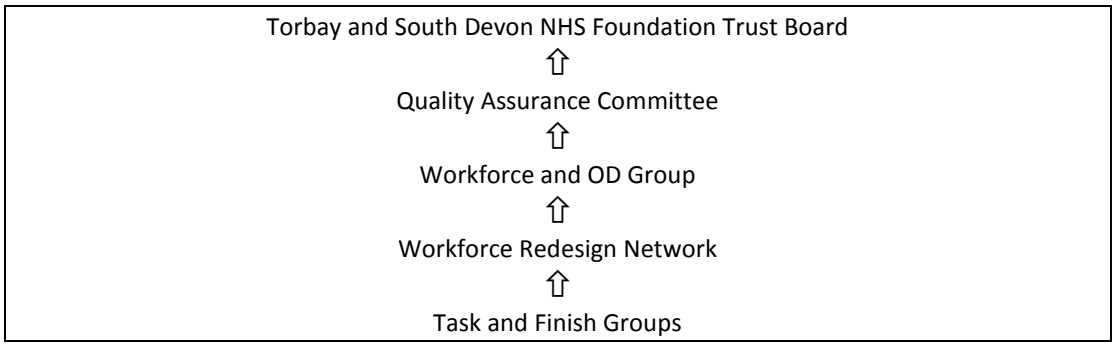
Each year the Trust undertakes an annual workforce planning exercise as part of the business planning process. This process engages clinicians both at the top level using the triumvirate management structure for each Business Unit and by engaging managers for individual specialties in the workforce planning exercise. Taking account of the Integrated Workforce Strategy the workforce planning exercise enables managers and their staff to:

- Identify their current and future service description and workforce profile.
- Identify known and anticipated Workforce changes and challenges (growth, contraction, realignment etc.) now, in the next 2/3 years, and the next 5 years.
- Identify their workforce continuous improvement programme (CIP) savings required and plans for achieving them.
- How they will meet their challenges using transformation i.e. 'Redesigning the Workforce'.
- How they plan to align their workforce to work with partner agencies to cover the whole care and treatment pathway.
- Share any issues in respect of staff morale and job satisfaction and actions to improve and/or where more support is required.
- Highlight their most significant risks and Issues.

The information produced by the Business Units is used to inform:

- The annual plan
- Workforce plans for the organisation
- Education and Development plans
- Reports to the Workforce Redesign Network, Workforce and OD Committee and Trust Board.
- Reports and demand forecasting via the Local Education Training Board and Health Education England.

The Integrated Workforce Strategy and Workforce Plans are subject to the governance process shown in the table below. In addition, as part of the annual business planning process workforce plans included in that process will be subject to Board approval. Where CIP plans include workforce changes quality impact assessments are completed as part of that programme.



As detailed above the Trust is focusing its workforce planning on transformation. The Strategy concentrates on workforce redesign and 'growing our own' and the development and use of the following:

- Apprentices – All posts band 2/3 both clinical and non-clinical should be considered as an apprentice in the first instance.
- Assistant Practitioner – When posts at bands 2, 3, 4 and 5 become vacant in clinical areas the skill mix should be reviewed to identify if an Assistant Practitioner post would be a more suitable replacement. This would support the "growing our own" philosophy and support recruitment difficulties.
- More Holistic Roles – There will be a growing requirement for posts that have a broader role to enable them to provide more holistic care. The potential for doing this should be considered within the regulatory framework. Examples already exist such as Health and Social Care Coordinators (HSCC's)
- Physicians Associates – Where difficult to recruit medical posts are identified the redesign of the workforce to include Physicians Associates should be considered. Training numbers have already been commissioned with higher education via the Deanery.
- Advanced Practitioners – Further use of Advanced Practitioners to potentially fill parts of roles for which Medical staff cannot be recruited should be considered.
- Consultant Nurses – As for Advanced Practitioners, Consultant Nurses should be considered as alternatives for Medical and high level skilled roles
- Hybrid Medical Posts – Developing medical posts can cover across acute, community and primary care.
- Surgical Care Practitioners – To support surgical clinicians should be considered where appropriate.
- Personal Care – Exploratory work with Devon County Council and Torbay Council and independent Personal Care Providers has identified a willingness to look at career pathway models that could support the development of Personal Care Workers to enable them to further their career in Health and Social Care. The intention would be to support the recruitment into the ICO and also into the Personal Care market.
- New Roles – In addition as care pathways develop new roles with skills and competencies that would provide a more responsive service will need to be developed.

Current developments include:

- The development of Local Health and Wellbeing Teams working in community hubs and including well-being coordinators providing holistic support and advice in one place.
- The training and employment of Physicians Associates to provide appropriate alternatives to hard to fill medical posts and reductions in junior doctors training placements.
- Improving access to and widening the range of apprenticeship programmes. Including in front line roles as part of 'growing our own'. The Trust will be required to achieve 6% of staff undertaking apprenticeships including 3% apprentices by 2017. We currently have 8% of our staff undertaking apprenticeships of which 2% are apprentices.
- Further work to improve our nurse career pathway to make it genuinely possible to join the Trust in an apprentice role and follow the career pathway to become a Registered Nurse.
- Further use of Surgical Care Practitioners.

The above plans focus on the Trusts desire to provide a different model of care and to meet the presenting workforce challenges including reducing reliance on bank and particularly agency. Currently approximately 92.5% of the Trusts workforce is permanent staff and we cover the majority of the balance using bank but with a smaller but more expensive agency component. We are currently implementing a number of initiatives to reduce any agency to a minimum and to comply with the nursing agency cost ceiling including:

- Recruitment initiatives including overseas, return to nursing, targeting newly qualified, corporate recruitment, sponsorship for training and as reported above alternative roles and growing our own.
- The implementation of a weekly payroll for bank staff to incentivise existing bank staff and those currently working for agencies to do more bank shifts or move across from agencies.
- A number of financial incentive schemes to incentivise bank working compared to working for an agency.

As proposed in the feedback in respect of our draft plan we have arranged an initial discussion with the Monitor workforce efficiency team to discuss planning and best practice more generally to identify any further actions to reduce agency usage.

The Trust currently uses an e-rostering system and regularly reviews its nursing levels as part of the safer staffing process. Our planned Cost Improvement Programme (CIP) includes a further review of rostering practices to ensure effectiveness is being maximised.

Workforce metrics are regularly reported to the Workforce and OD Group and Board and are also triangulated with quality and safety metrics as part of the integrated performance report to the Board. In addition the same set of performance metrics are discussed with each Business Unit at regular performance management meetings.

The Trust is part of an Urgent and Emergency Care Vanguard in South Devon and it is anticipated that this will support the redesign of our workforce and improved productivity.

There is a risk register for workforce and OD risks which has been updated following the creating of the ICO. The risk register is regularly reviewed, updated and discussed at the Workforce and OD Group and where the risk has a score that means it is on the Corporate Risk register it is discussed at the Risk Group and reported to the Board.

4. Approach to Financial Planning

4.1 Overview

The Financial Plan for 2016/17 described in this document and its associated templates is built around the Transaction LTFM submitted to Monitor in support of the Foundation Trusts acquisition of Torbay and Southern Devon Health and Care NHS Trust, which took effect on 1st October 2015. The model has been updated to reflect changes identified since the transaction date,' most significantly:

- Acceptance of the Service Transformation Fund (STF) and its associated targets;
- Agreement of investment plans to support the delivery of the ICO care model which, alongside further agreed investments in acute services will secure the improvement trajectory for the Emergency Department standard;
- At this stage, a revised income model, based around a PbR model that reflects the challenges experienced in agreeing a financial settlement with our main Commissioner that secures the ongoing viability of the former Risk Share Agreement.

The financial plan for the year, described in detail in the supporting template submission, is summarised below:

2016/17 Financial Plan		**£m**
Operating Income		393.25
Operating Expenses		(374.15)
EBITDA		19.10
Other Operating Income/(Expenses)		(11.43)
Non Operating Income/(Expenses)		(5.93)
Surplus/ (Deficit)		1.74

The Trust's target surplus, described in the STF is £2.0m, and the Trust's plan slightly exceed this target as follows:

2016/17 Trust Plan		£m
Surplus/Deficit (normalised)		4.235
Less: Gain/(loss) on asset disposals		0.000
Less: Donations & Grants received of PPE & intangible assets, total		2.600
Less: Depreciation and Amortisation - donated/granted assets		(0.641)
Plan adjusted for donations and asset disposals		**2.276**

4.2 Contract Income

Engagement with wider system Regulators since the submission of the Draft Operational Plan in February has described the financial challenge across our Health and Care System. Representation has been made to seek flexibility in control totals and use of CCG headroom to facilitate a compliant plan that secures the STF for this system.

As a result, South Devon and Torbay Clinical Commissioning Group have been unable to commit to the baseline income level set out in the Long Term Financial Model and that would have enabled the continuation of the Risk Share Agreement (RSA) as a contractual model for the forthcoming year. The alternative position referenced in the RSA and noted by our regulators as the default in the absence of the RSA, being National PbR Contract for acute services and a cost based block contract for community services, has therefore been agreed as the inevitable basis of this submission.

Both this Trust and South Devon and Torbay Clinical Commissioning Group remain committed to the principles of the RSA and will work in the coming weeks to develop proposals which, we hope with Regulator support, will enable continuation of a form of risk sharing arrangement best suited to the objectives of an Integrated Care Organisation.

In the interim there will be no change in approach. The Trust is committed to deliver the care model changes that underpin the system plans for integrated health and social care. The investments will continue and the plan to reduce system cost during 2016/17 and into 2017/18 will still enable the benefit of reduced acute activity to flow to Commissioners in either contractual form.

As a result of moving to an alternative contract form from the RSA, the Trust is seeking to secure a bi-lateral agreement with Torbay Council for the provision of adult social care. The baseline values and the outline terms of the risk share agreement are in place.

The Trust has confirmed a contract position with local Commissioners based on the national contract as follows:

South Devon & Torbay CCG (CCG)

	£'000
Acute	161,140
Community	75,898
Total	237,038

This value is net of £9,480k of QIPP schemes presented by the CCG. These have been targeted in areas where cost reduction for the Trust is possible, principally:

- Areas of pass through payment (£2,860k)
- Areas matched with out-sourcing expenditure plans within the Trust (£2,600k)
- Areas where scheduled investments can be realigned (£2,250k)

Torbay Council

- Baseline income of £38.7m.
- Annual volume reduction of 3% per annum
- Inflation uplift of 2%.

Other healthcare income, principally from Specialist Commissioners, NEW Devon and NCA's has all been priced at national tariff. Provision has also been made for negotiated 'tapering relief' in respect of the stepped costs incurred through Trust's capital investment in replacing Radiotherapy buildings and equipment. It has been a challenge to secure sufficient engagement by Specialist Commissioners and at this stage the detail of the agreement is not yet in place for 2016/17.

All other income has been rolled forward, uplifting for inflation and known and specific changes.

4.3 Revenue Expenditure

Service Delivery Units and Corporate Department managers have been set budgets that reflect their run rate of expenditure in 2015/16 adjusted for known inflationary pressures, planned investments in the ICO Care Model and a requirement to deliver a composite £13.9m of cost improvement in 2016/17.

The contract structure described above has, effectively reduced the CIP requirement to a more manageable level for the Trust. Care model savings predicted to be delayed, largely the result of transaction and consultation timeframes, has been offset by higher levels of income driven through the PbR based model for acute services.

The following assumptions have been developed as part of the long term financial modelling:

Inflation	**£'m**	%
Pay Award/Pensions NI/Increments	£6.2	2.9
Non Pay general inflation	£1.8	1.4
Pass through growth/inflation	£3.6	18.7
Other drugs inflation	£1.0	8.6
CNST	£0.8	17.3

Employee inflation has been based on a 1% pay award (with underlying assumptions as nationally agreed last year) supplemented by an assessment of incremental drift, clinical excellence awards and the National Insurance and pensions changes:

Pay Inflation	**£m**	**%**
Pensions NI	3.7	1.7
Increments	1.1	0.5
1% pay award	1.2	0.6
Clinical Excellence Awards	0.2	0.1

The Trust has scheduled significant investment in the emergency care pathway, as per the below table, to ensure the Trust reaches the planned recovery of the 4 hour target, and has access to the Sustainability & Transformation Fund (STF):

	£'000
Increased nursing input - Emergency Department	1,172
Establishment of Acute Medical Unit	309
Enhanced Resource in Emergency Assessment Units	268
Permanent establishment of former escalation ward	1,000
Total	2,749

The Full Emergency recovery plan describing the impact of these funds can be seen at Appendix 1. This plan ensures the Trust recovers to the national target position for the 4 hour wait within emergency departments and recommendations from the Care Quality Commission (CQC).

Also critical to supporting the Urgent and Emergency Care pathway is the planned investment in delivering the ICO care model. This is summarised below:

	Actual Spend 2015/16 (£)	Requested in Pipeline 2016/17 (£)	Planned additional Investments (£)	Total (£)
Locality Development		832,262	3,769,026	4,601,288
Acute Innovations including Acute Frailty	273,916	373,973	282,966	930,855
Voluntary Sector Development	157,700	387,000		544,700
Total	431,616	1,593,235	4,051,992	6,076,843

The table above reflects planned expenditure to completion of the care model in 2017/18. A total funding pool of £3.9m is established in 2016/17, and developments will be prioritised and phased to fit within this amount.

The Trust is challenged by the nationally introduced agency caps particularly around access to the approved contracts at capped rates in the South West for both medics and nurses. The Trust has planned a budget of 2.7% of its staff cost to cover the supplementary cost of agency staff. This is achieved in the full year, but rates are likely to exceed the agency cap in quarters 1 and 2 before planned actions effect a significant reduction. To achieve this, the Trust has embarked on a further overseas recruitment drive, is reviewing rostering practices and will deliver planned investments in the service redesign under the care model. From a medical perspective, we are investing in additional Trust Fellows (doctors not in formal training) in addition to the Physician's Assistants we already have in training. The Trust is also hoping to receive some support from the National agency cap team to address the increased problems of access the national cap has caused in the South West.

Non-Pay inflation has been based on historic trends for drugs, separately looking at pass through and hospital prescribed drug spend, and informed by a bottom up review of expected cost pressure and new drugs conducted within clinical services.

Capital charges have been based on the capital programme and assume appropriate Foundation Trust Financing Facility Loans will be available and used to fund the long term assets at current interest rates.

Corporation tax on Pharmacy Manufacturing Unit has been assumed to be nil in line with current taxation of Foundation Trusts.

4.4 Efficiency and Savings

The Trust has, historically, had a good record on delivering against its CIP Targets. This has been possible through the organisation's ability to scope opportunities, produce good quality data and identify and resource dedicated project teams and project managing schemes that deliver on time, supported by a robust CIP performance management and Project Management Office (PMO) function. However, like most other NHS organisations, we acknowledge that identifying and delivering recurrent savings, in particular, is proving increasingly challenging and requires a different approach.

The CIP programme for 2016/17 builds on the strategies of the past and also seeks to addresses the challenges faced through a constructive, inclusive approach to deliver authenticated schemes. The proposed portfolio is partially based upon the Trust's 5 year plan that was previously submitted to Monitor in 2015 and was the product of Healthcare benchmarking provided by the NHS Benchmarking authority, trust-wide engagement and regional networking as well as a review undertaken by Ernst & Young. It has been cross referenced to the findings of the Carter Review.

We have a total of 70 potential CIP schemes for 16/17. This number is dynamic and changes as schemes progress through the development stages. The following schedule provides a summary view of CIP projects and their current status:

Scheme Status	Value £m	Consolidated overview of CIPs
Fully delivered	£0.274	Schemes here include Salary Sacrifice and Managed service contracts.
Plan Identified	£4.672	£0.9m Nursing review (Reduction in agency, review senior nursing management). £0.7m Redesign of the "Placed People" service. £0.6m EFM redesign, £0.9m Procurement efficiencies. £0.4m Review of OT service provision with Independent Sector £1.2m various schemes including Print management, Medical Electronics reorganisation, CHC Panel process, Mobile Phone review, Bowel screening, etc.

Opportunity identified and plan under development.	£5.790	£1.2m is associated with ICO back office department synergy savings from integration. £2.7m from Community service reconfiguration created from ICO opportunities and re-assessment of client care needs / eligibility. £1.5m is associated with Clinical and back office workforce redesign and productivity schemes £0.4m Sickness management
Opportunity identified, validation under way.	£3.164	£1m identified as potential from the cross check to the Carter review, principally sourced through back-office benchmarking data from the NHS Benchmarking network to help scope this project. £2.2m of specific schemes identified in clinical division business planning processes. An element of this saving will be non-recurrent and will be derived from Pay Slippage.
Grand Total	**£13.900**	

- Workforce savings will be achieved through a range of initiatives focussing on reducing the need for expensive temporary staff, improved rostering, revised skill-mix, management-restructuring and reduced absenteeism.
- Income will be created through partnerships with our neighbours for example utilisation of capacity, within our Cardiac Catheterisation lab, and through exploiting volume based commissioning arrangements where possible. The trust will also continue to run profitable franchised services and further expand salary sacrifice schemes.
- A number of procurement schemes, will continue to reduce the costs of our consumables and our cost-base will be further lowed through a range of Pharmacy initiatives to reduce drug spend.
- Within Community services, we will continue to reduce costs through further utilisation of the independent sector and improved management/review of care packages through earlier intervention with our primary care provider. We will seek to support greater independence through supported living for our clients with learning disabilities, re-structure our packages of care and remove double handling. The service will also benefit from reduced costs in areas such as insurance as a result of integration.

At present, the 16/17 CIP programme comprises £5.9m of confirmed recurrent and £8m that is yet to be confirmed as recurrent. We will continue to drive these schemes towards recurrent status, though our longer term objective is to drive out sustainable recurrent savings from the integration of Acute and Community services. Non-recurrent schemes would be used as short term solutions to help deliver the bottom line.

CIP delivery has been phased to reflect expected lead times to delivery which, with a number of schemes yet to be fully developed, inevitably increases in scale as the year progresses.

The programme comprises projects that span all areas of our recently integrated community and acute services. The anticipated benefits will be delivered in parallel with the synergies achieved through integration and a new care model that seeks to provide the right care in the right place at the right time for our patients.

The Trust recognises that successful delivery requires projects that are feasible, clear leadership, sufficient delivery resource and a robust governance framework to ensure visibility and accountability. These principles, together with a supporting action plan that revalidated each scheme have been endorsed by our Executive team.

The key steps to date are set out below:

- Each potential scheme within the draft programme was allocated an executive lead to determine desirability and to appoint a project owner for detailed appraisal;
- Designated project owners provided specialise expertise to assess feasibility, scope and scale
- Projects consolidated into an outline programme that is submitted as part of the 1st draft submission.

The Trust has appointed an interim deputy Chief Operating Officer to provide additional professional input to the process. The Trust has also created a dedicated Transformation project delivery team who will assist with the delivery of the ICO based CIP projects. In addition, the successful PMO and Finance reporting tools are being further enhanced to ensure the timely reporting of scheme delivery progress to the Executive board. Appropriate action will be taken to get any delayed schemes back on track (or devise replacement schemes).

The next phase sees outline planning for each project to establish key metrics such as timeline, resources, workforce implications and risks. These will be set out on a standard Project Inception Document for all schemes over £50k. A quality impact assessment will also be produced and signed off by the Medical Director and Chief Nurse to ensure any risks to patient care are resolved. All 'approved schemes' will be managed through a revised governance process that includes a more robust reporting, assurance and escalation through a bi-weekly CIP review meeting with key managers. Reporting to Board is secured through e reporting structure through the Senior Business Management Team meeting, through Finance Committee to Board. Detailed scheme level reporting will be in place across all of these levels.

4.5 Cash and Balance Sheet

A number of planning assumptions used in the Transaction LTFM have been further refined during the course of the preparation of this year's Annual Plan. These changes have impacted upon the forecast cash balance as at 31st March 2017. The Transaction LTFM indicated that the value of cash that would be held by the FT at 31st March 17 would total £26.4m. This draft of the Annual Plan is now forecasting a cash balance of £18.5m, a movement of £7.9m. The most significant components of this movement relate to the timing of loan drawdowns and therefore are not directly associated with the underlying performance of the Trust, and are summarised as follows:

	£'m
Timing / Phasing Issues:	
Earlier repayment of £21.0m working capaital loan	(2.10)
Movement in capital loan phasing	(2.80)
	(4.90)
Other Issues :	
Torbay & Southern Devon Health and Care NHS Trust performance pre-transaction date	(1.60)
Underlying ICO cost pressures reflected in revised Annual Plan submission for 2015/16	(2.50)
Net benefit from STF	1.10
Total	(7.90)

4.6 Capital Plans

The Trust has developed a five year capital plan to enable the Trust to continue to deliver safe patient care and meet the operational needs of the organisation. From this base point a detailed scheme level programme has been confirmed for 2016/17.

The five year program relies upon some external sources of funding, namely Independent Trust Financing

Facility (ITFF) loan funding. Some of this loan funding has already been secured and the Trust plans to draw down this residual approved funding in 2016/17 to support the completion of the new Critical Care Unit development and to complete the replacement of its Linear Accelerator needs. The sum of this approved residual funding totals £10.9m. In addition, over the next five years, the Trust will be applying for further loans totalling £20.1m across the next three years to support the following developments: -

- Implementation of an Electronic Document Management System to support paperless Clinical processes
- Reconfiguration of the Emergency Department and Emergency inpatient assessment areas.
- Improvements required to inpatient wards including increased provision of single rooms.
- Refurbishment of existing operating theatres and investment in new Theatres to increase capacity.

Of this amount £7.71m of loan financing is required to support the 2016/17 programme. To mitigate against the potential for this sum being unavailable, schemes to this value that would need to be delayed have been identified. In broad order they represent a reduced investment in the Emergency Department development and delays in a range of IT and Estates related backlog maintenance. These schemes will not proceed until loan finances have been confirmed. Applications are close to finalisation.

The Trust uses a robust risk management process to identify and prioritise essential capital investment requirements. This risk management process has contributed to the financial success of the Trust in ensuring that assets are only replaced when the need arises and in ensuring that the Trust explores asset utilisation rates before new investment takes place.

The Trust with support from Commissioners is also continuing to develop Community Care Models. These care models are innovative and will enable a greater number of patients to be treated both at home in other community settings. To support this model a thorough review has been undertaken on the use of the recently acquired community facilities. The exercise has identified a number of facilities that are not being used to capacity. Where this is the case some rationalisation is likely and alternative investment taking place, the effects being neutral in overall planning terms.

To support the Care Model significant IM&T strategy investment is taking place within the Trust. This investment will enable both acute and community healthcare workers to access reliable and up to date care data.

4.7 Sensitivities

A range of sensitivities have been modelled in the planning templates supporting this document, most significantly the withdrawal of the STF should performance recovery trajectories not be achieved and a failure to deliver the CIP programme.

The Trust's Risk Share Agreement with Commissioners no longer represents a mitigation, whereby any downside from the financial result set out in the Transaction LTFM is shared 50 / 50 with principal Commissioners; South Devon and Torbay Clinical Commissioning Group and Torbay Council. Mitigations therefore focus on reducing demand, management of costs (pay and non-pay) and capital re-phasing.

4.8 Financial Sustainability Risk Rating (FSRR)

The planning assumptions set out in this section will deliver a Financial Sustainability Risk rating of 3 for 2016/17 remaining consistent with the Acquisition LTFM.

5. Link to the Emerging 'Sustainability and Transformation Plan' (STP)

5.1 System Place-Based Context

The planning process gives local health and care organisations the opportunity to develop a shared health and well-being vision, agree improvement priorities, develop new care models and deliver the dynamic place based transformation plan to accelerate implementation of the 5 Year Forward View.

Partners from across the South Devon and Torbay health and care economy have been collaborating and engaging with the local community on how best to meet the triple aim as set out in the Five Year Forward View and achieve lasting change in the health and wellbeing of all the people who live in South Devon and Torbay.

As a result we have developed a clear shared vision and sense of purpose; agreed priorities for improvement including a focus on health and well-being and implementing new care models; and developed an ambitious local transformation plan for accelerating implementation of the Forward View, based on a place-based approach.

Leaders from all the local NHS and council organisations involved in health and care (the CCG, Torbay and South Devon NHS Foundation Trust, Devon Partnership NHS Trust, Torbay Council, Devon County Council, Rowcroft Hospice and Torbay Community Development Trust) – have been working together – originally through the JoinedUp Board and now through the new Systems Resilience Group - to a common set of priorities and taking joint decisions in line with our shared vision. They are working with the voluntary sector and local community groups in an entirely new way, to improve the quality of life of local people. The overall aim is to join up the health and care system so that patients and people using services don't have to struggle to get what they need. They will be able to tell their story once, and get coordinated care that really meets their individual needs, and over which they will have control.

In developing our STP we will build on the JoinedUp approach and our integration track record (well established integrated social and community care provision and first wave integration Pioneer) and maximise the potential to accelerate improvement from our latest new models of care developments (Urgent Care Vanguard and first Integrated Care Organisation).

Our shared vision is *'...a community where we are all supported and empowered to be as well and as independent as possible, able to manage our own health and wellbeing, in our own homes. When we need care, we have choice about how our needs are met, only having to tell our story once.'* Our agreed strategy, with commitment from all parties, has at its core a set of shared principles derived from extensive community engagement.

Together, we want to ensure full development of our locality based model of care which sees GPs, community health and social care teams and the voluntary sector working together to provide for the vast majority of people's health and wellbeing needs. It is founded on joined-up care across the whole community. We want to be able to provide care as close to home as possible, supporting people to remain independent and in their own homes, reducing reliance on bed-based services, with local communities actively helping to support the wellbeing needs of the local population. This is what patients have told us they want.

As part of this work we are developing a holistic approach to long term condition management with both specialist outreach services and within local health and wellbeing teams, with milestones on track to be delivered from May 2016. This work will be underpinned by safe, effective and efficient acute services, a sustainable workforce, IT interoperability and a truly Single Point of Access. The single point of contact model is agreed and the implementation plan in place. Engagement with the community voluntary sector will be led by the Trust through a new engagement mechanism, partnering with two umbrella organisations and the establishment of funded posts - HWB Coordinators- to develop community capacity to care.

The plans also include transformation of the acute medical model to better meet current and future need, linking to Community Hospital reconfiguration (consultation pending) and bed remodelling as part of our ED recovery plan and in response to metrics indication of an under-provision of c30 acute beds, and in line with the local Vanguard plan for 2 urgent care centres this year.

5.2 STP planning Footprint

Agreement was reached with all partners that the preferred STP planning footprint for the majority of services should cover the population of Torbay and South Devon, reflecting population flow and our shared focus on integration of local health and social care provision. Partners recognised that for very specialist services, a larger wider Devon population footprint was appropriate and confirmed that the CCG and providers within Torbay and South Devon would collaborate to ensure effective configuration of very specialist services for the wider population.

The CCG was asked to resubmit its footprint submission in favour of a Wider Devon Transformation Partnership (working title) planning footprint coterminous with the entire boundaries of NEW Devon CCG and South Devon and Torbay CCG, incorporating the whole of the County of Devon, Plymouth City and Torbay local authorities with overall responsibility for a population of circa 1.17 million people. The Partnership's focus will be addressing the national challenges set out in the planning guidance including how to address the gaps around health and wellbeing, care and quality, finance and efficiency and delivering the Government's mandate.

Whilst acknowledging the wider STP planning footprint will add value in some specialised services, both CCGs have stressed the need to maintain a delivery focus at locality level. The umbrella governance arrangements across this wider STP planning footprint will build on existing extensive joint planning arrangements, and complement existing governance structures.

There are a number of wider planning considerations that need to be taken into account outside of this footprint such as other cross boundary flows eg with Cornwall; specialised service links into the rest of the south west; trauma networks and other legitimate networking arrangements between providers outside of this footprint.

5.3 The ICO's Role in Delivering the STP

Being amongst the first organisations nationally to achieve structural integration via the ICO model gives us an excellent basis from which to deliver the aspirations of the Five Year Forward View in a local context.

Becoming an ICO is an exciting milestone as, for the first time, one single organisation is now responsible for acute and community healthcare along with adult social care services. Our purpose is completely aligned to the system wide aspirations and our operational plans reflect our commitment to the local health and care system's shared vision. Our contribution is to provide high-quality, safe health and social care at the right time and in the right place to support the people of Torbay and South Devon to live their lives to the full.

We want to work in partnership with people and communities – putting them in the driving seat of their own health and care needs. We want services to be easily accessible and work in a way that means people only need to tell their story once. Most importantly, our vision for the future is that care is provided in or as close as possible to a person's home.

We acknowledge we have to transform the way we provide services and we will take the opportunity afforded by the ICO to build on our track record of focussing on the needs of individuals. We use the stories of 'Mrs Smith' and her family to remind ourselves that we have to ask what matters to people, not just

what is the matter with them. However complex people's needs are, we see them as individuals with a life that sits outside their experience as a patient or service user.

Our aim is to support everyone in living well and ageing well. We will place greater emphasis on promoting healthy lifestyles, preventing ill-health and enabling self-care. When people do need care, our staff will provide it with compassion because of their dedication, commitment, shared culture and values. Different roles and career pathways will evolve to meet the changing needs of our population, offering our staff new opportunities to grow and develop.

We will invest in technology and shared information to make sure that people need only contact one organisation and tell their story once, whatever their health and care needs. We will assess their situation and arrange the right level of support as close to home as possible, whether it's co-ordinating volunteer hospital drivers, arranging community nurse visits, signposting health information advice, or booking a hip replacement followed by rehabilitation; we will act as a one-stop shop.

We believe that the creation of our integrated care organisation will not only improve local health and social care services through the delivery of our new care model - it will also ensure sustainable services for the future. As an integrated care organisation, we will make best use of our limited resources, confident that we are efficient as well as effective.

The ICO will continue to be engaged in both the local and wider strategic planning discussions and processes to fulfil our aspirations of a better future for local people. We will be opportunistic, taking full advantage of developments that enable us to accelerate our plans. For this reason, as part of the 2016/17 planning response we have submitted an expression of interest in trialling the reinvention of the acute medical model in small district general hospitals, which has the full support of the CCG.

6. Membership and Elections

Governor elections predominantly take place in the autumn each year as the results are welcomed by Governors at their Council of Governors meeting in December. Following the integration with Torbay and Southern Devon Health and Care NHS Trust on 1 October 2015, the Company Secretary delayed the start of the routine elections in order to concentrate on filling two new community staff seats. Four candidates put themselves forward and the results were announced on 5 January 2016. A turnout of 13 per cent was recorded. When public elections are contested, the turnout rates are in excess of 30 per cent suggesting that the public membership is well engaged in appointing new public governors.

Having been a Foundation Trust since 1 March 2007, a number of public Governors are coming to the end of their nine years in office. Combined with Governors stepping down after three years, the Trust has 11 seats to fill from 1 March 2016. As at 31 January 2016, all four Teignbridge seats have been filled uncontested, one of the two South Hams and Plymouth Constituency seats has been taken up and the Torbay Constituency seats are being contested with the results due on 8 February 2016. Unfortunately, no members of staff have put themselves forward for the two non-clinical staff seats. A new election process will commence in February to try and fill these vacant seats.

New Governors are offered the opportunity of attending the external GovernWell induction course as well as the Trust's corporate induction. Due to the number of seats being filled in 2016, the Trust has invited the London-based GovernWell course to Devon and will be offering this course to all Governors. During 2015, the majority of development sessions offered to Governors were in relation to the forthcoming integration and ensuring governors had the necessary information to make an informed decision on the significant transaction that this represented. Alongside this, Governors have been offered training in performance management, patient safety, finance and public relations.

Informally, Governors continue to engage with the Trust's membership several times throughout the year, using a variety of means such as Medicine for Members events, its newsletter, accompanying local Councils at events and setting up local stalls. The formal process involves an annual survey being distributed along with our annual review document to all public members in September, which in previous years has generated a response rate in excess of 30 per cent. The survey is developed by the Mutual Development Group which is a sub-group to the Council of Governors and is chaired by one of our Governors. Surveys results are analysed according to area which enables public Governors to review responses from their respective constituencies. One Governor from each of the three public constituencies is nominated to provide a combined response to the Board-to-Council meeting in March each year. The feedback from Governors to the Board of Directors is received informally and then presented more formally as an agreed improvement plan at the next Council of Governors meeting in April. The 2015/16 improvement plan was reviewed at the Council of Governors meeting in December 2015.

Working in partnership with the Clinical Commissioning Group (CCG), the Trust has developed the Joint Equalities Cooperative to continually engage with the diverse groups of our local community. The Governor-led Mutual Development Group is keen to engage again with Black and Minority Ethnic (BME) groups as well as other under-represented demographic groups within our constituency areas. The challenge to find new members remains and although the Trust has considered targeted campaigns in the past it is likely to revisit patients, service users and clients rather than trying to recruit from the general population at significant cost.

Appendix 1 - **Action plan developed in response to CQC / NHSE / Monitor and approved by SRG in February**