



Forward Plan Strategy Document for

South Devon Healthcare NHS Foundation Trust

Plan for y/e 31 March 2012 (and 2013, 2014)

Section 1: Strategy

The Trust's current position and vision are summarised as:

South Devon Healthcare was established in 1991 and became one of the first NHS Foundation Trusts in 2007, and is a medium sized District General Hospital providing patients in the South Devon area with a full range of secondary care services. The Trust serves a resident population of approaching 300,000 people, but this increases by as many as 100,000 visitors at any one time during the summer holiday season.

The Trust has delivered strong financial performance since its inception and will move forward to address the challenges of the next three years from a sound base. In 2010/11 the Trust has delivered:

- A Financial Risk Rating of 4 in Quarters 2, 3 and 4 of 2010/11
- A pre-impairment surplus of £2.5m, representing a £400k favourable variance on the plan
- A strong cash balance of £14.2m
- A cash releasing efficiency programme of £11.3m

The Trust has delivered strong and consistent service performance, maintaining a Green risk rating throughout 2010/11, meeting the requirements for Care Quality Commission registration and delivering exceptional clinical results, with low mortality measures and with excellent results in both local and national patient satisfaction surveys. This track record of performance is central to the Trust's success, contributing to it being the provider of choice for the local population. Whilst there is comparatively little competition in the local healthcare market, principally reflecting the geographically dispersed nature of the South West, we will continue to build on this success and our 'leading edge' reputation for health and social care integration. In doing so, we will protect the provision of comprehensive secondary care services in Torbay that might otherwise be threatened by the combination of economics, designation and increasing specialisation.

In 2010 we published our Summary Strategic Directions – which confirms the themes and issues the Trust must continue to address over the next five years to achieve our ambition: *for South Devon Healthcare to be the best provider of healthcare services delivering excellence in all that we do.*

We have listened to our patients, staff, governors and members during the development of this strategy. Our aim is to use this framework to continue to shape and develop our services to ensure they always meet or exceed the needs of each patient we care for, of the community we serve and of our commissioners and regulators, providing

- Safest care – reducing healthcare acquired infection, avoiding unnecessary deaths or injuries, meeting all regulatory standards and improving our care systems through shared learning;
- No delays – with patients seen as quickly as possible, being fully involved in their care and only staying in hospital for as long as is necessary;
- Best patient experience – providing care that patients and staff would recommend to others;
- Working together – we will work closely with our partners to provide seamless health and social care;
- Delivering better value – making best use of taxpayers' funds, generating sufficient resource to operate sustainably, achieving excellent ratings for use of resources in meeting regulatory standards.

We are confident this framework responds to the local, regional and national priorities for 2011/12 and up to 2013/14.

The Trust's strategy over the next three years is to:

During the course of 2011/12, the Trust will publish a refreshed Corporate Strategy, in support of delivering this ambition encompassing:

- The further development of models for integrated care, working closely with partner organisations in health and social care, delivering effective and efficient pathways for all patients. In providing seamless care of the highest quality to our patients, integration along the patient pathway will deliver significant efficiencies, further reducing length of stay in the hospital setting.
- The principles of lean system design, which will be at the centre of the Trust's delivery programme throughout the period of this plan. We will employ the NHS Institute for Innovation and Improvements 'Productive Series' methodology across all aspects of the Trust's business, both clinical and non-clinical. Not only will this ensure improved care delivery, defining best quality systems and ensuring their spread throughout the organisation, it will also eradicate waste and improve efficiency.
- The further development of clinical systems and processes using the framework set out in the Safer Patient Initiative, which will keep quality and patient safety at the centre of the Trust's agenda.
- A clear focus on encouraging innovation and continuous improvement in all aspects of the Trust's business, building on an existing national profile and taking opportunities for early adoption of national best practice such as Enhanced Recovery.
- To develop the coherence and effectiveness of the board, providing leadership and strategic direction to the Trust and further strengthening relations with the clinical leadership and Governance Board.
- The safeguarding of our estate, addressing its maintenance, safety and function remains a critical objective. The Trust work to deliver its Estate's Strategy, ensuring that our facilities are fit for purpose, contributing to high quality patient care and experience.
- Leading a motivated and flexible workforce that is engaged, understanding and contributing to the Trust's objectives. We will build on strong foundations of clinical engagement, developing a devolved Service Line Management structure within the organisation and actively contributing to a clinically led commissioning process alongside primary care colleagues.
- Investment in information and information technology, supporting the organisation with modern administrative systems, producing high quality business information and delivering efficiency through introducing new technologies.
- A commitment to deliver best value support services through benchmarking and where possible and operationally appropriate entering into shared service arrangements with appropriate partner organisations.
- The further development of education, innovation and research and development, ensuring maximum benefit is derived from our existing facilities and the creation of Provider Skills Networks.
- Implementation of plans to deliver the Trust's sustainability and carbon reduction commitments.
- Implementation of the Equality Delivery System across the Trust.
- The development of the Pharmacy Manufacturing Unit as a mature, commercial business capable of supporting the Trust's wider strategy.

The following table, using the corporate objectives agreed by the Board, describes the key milestones in delivering this strategy between 2011/12 and 2013/14.

Key priorities for the Trust which must be achieved in the three years of the annual plan to underpin the delivery of the Trust's strategy, with milestones of delivery of each over the period of the plan:

Key Priorities	How this Priority underpins the strategy	Key milestones (2011-12)	Key milestones (2012-13)	Key milestones (2013-14)
Leadership	To develop the coherence and effectiveness of the board, providing leadership and strategic direction to the Trust and further strengthening relations with the clinical leadership and Governance Board	Using Service Line Management principles, develop a devolved clinically lead structure for the organisation. Undertake Service Line Management (SLM) pilots in six clinical areas. Develop a framework for clinical leadership across the community.	Commence process for appointment of Chairman . Implement revised management structure. Rollout of SLM across Clinical areas	Rollout of SLM across non-clinical areas
Equality and Diversity	To prepare a project plan and implement the Equality Delivery System within the Trust.	'Connect Programme' to be completed by the Trust Board	Organisational rollout of Equality and Diversity Scheme	Monitor and maintain
Strategy	To be a key player in the development and delivery of an integrated health (and social) care service for the South Devon community.	Publish a refreshed Corporate Strategy. Including approach to integration. Establish effective working relationships with newly enlarged Torbay Care Trust community health and social care provider. Develop links with GP Commissioning Boards	Potential for commissioning 30 days post discharge care	Review effectiveness of system
Safest care	To ensure that patient safety is embedded as the Trust's foremost priority, achieving further improvements in clinical	The improvement of Venous Thromboembolism (VTE) and Stroke services.	Delivery of agreed CQUIN standards Meeting standards as agreed by the South West Quality Improvement programme	

		Safer Patient Initiative priorities - Hospital Standard Mortality Rate (HSMR) Global Trigger Tool and Adverse Events Rate (GTTR); Hand washing ; Safety briefings; early warning system;		
No delays	To minimise the time patients wait to receive emergency, urgent and elective services from the Trust, through service improvement and re-design of pathways.	Delivery of agreed capacity plans. Implement Lean development programme Support the QIPP agenda through joint development of care pathways with primary care.		
Better patient experience	To learn and take action from the experience of the Trust's patients, focusing on the areas of concern raised through the governors, members surveys, complaints and other feedback mechanisms.	Our priorities will be Care and compassion; Dementia; Learning disabilities	To be determined following publication of national patient survey and Governor/ user feedback.	
Delivering improved value	To achieve excellent levels of financial performance, as measured by the requirements of Monitor, and to deliver best value for taxpayers' funds.	Development of Service Line Management The delivery of the Continuous Improvement Programme incorporating Lean service redesign. Delivering the jointly agreed QIPP plan.		
Workforce development	To motivate, support and train our staff in meeting the challenges of budgetary restraint, organisational change, flexible working and demanding performance targets, including implementing changes to the management structure, whilst retaining a strong patient focus.	Develop a skills training framework to support staff in meeting the requirements of changing roles. Design an organisational development programme Develop integrated workforce plans to ensure flexibility in response to QIPP requirements.	Roll out of organisational development programme Develop integrated workforce plans to ensure flexibility in response to QIPP requirements.	Develop integrated workforce plans to ensure flexibility in response to QIPP requirements.

Safeguarding our estate	To ensure that the key estate risks are prioritised and addressed through the capital programme, and to optimize use of the estate in delivering the Trust's service objectives.	Delivering the three year capital programme in line with the Estate Strategy Secure capital funding in support of the programme.		
Sustainability	Delivers the Trust's requirements under the NHS Sustainability agenda and Carbon Reduction targets.	Develop and approve a Sustainability Strategy. Deliver the agreed targets against each of the eight identified areas for sustainability as outlined in the Trust's sustainability strategy	Agreeing benchmarks to 2015 and continued implementation.	
Information & Information Technology	To ensure that the board, clinical leaders and managers receive reliable and timely business intelligence, and to focus information technology developments on improving business intelligence, clinical effectiveness and patient safety.	Refresh the IM&T strategy. Utilising the ASCC framework, develop a business case for a replacement Patient Administration System (PAS). Targeted developments to support clinical activities and productivity improvement Develop business information to support the challenges of the efficiency agenda.	Implement PAS replacement Targeted developments to support clinical activities and productivity improvement	Targeted developments to support clinical activities and productivity improvement
Pharmacy Manufacturing Unit	To maximize the potential of the Pharmacy Manufacturing Unit in supporting the Trust's core business, proceeding with the planned investment in additional capacity, further developing the management structure and delivering stretching performance targets.	Complete procurement and approve business case for PMU expansion.	Commission new facilities scheduled for completion in October 2013	

Section 2: External Environment

The table below reflects the significant external impacts on the Trust's plans.

Key External Impact	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
<p>4% Cost improvement requirement built into tariff.</p> <p>Additional cost improvement requirement in future year should demand management aspects of the Quality Innovation Productivity and Prevention (QIPP) agenda fail to deliver.</p>	<p>Failure to achieve Cost Improvement Programme (CIP) target, leading to risk in delivery of financial duties and an inability to secure capital funds to deliver the estates refurbishment programme.</p>	<p>Establishment of strong governance and programme management arrangements.</p> <p>Development of a Lean Programme, building understanding and capacity for service redesign within the Trust.</p> <p>Implementation of Service Line Management, engaging clinical management teams and ensuring that they deliver on all aspects of service performance, including financial requirements.</p> <p>CIP plans for 2011/12 have been agreed.</p> <p>A programme of service redesign for 2012/13 and 2013/14 is currently being developed.</p>	<p>The Trust expects to deliver CIP requirements.</p>	<ul style="list-style-type: none"> • CIP plans have been agreed for 2011/12 and removed from budget. • Monthly monitoring of financial position through CIP Board, Finance Committee and Trust Board. • CIP action plans across all three years monitored by Programme Management Office, with exceptions fed into CIP Board for agreement of remedial action plans. • With the support of the Programme Office, the Chief Operating officer monitors actions with each Division as part of normal line management arrangements.
<p>QIPP initiative is planned to significantly reduce demand for Trust services.</p>	<p>Failure or inability to reduce cost in line with demand reduction, leading to risk in delivery of financial duties and an inability to secure capital funds to deliver the estates refurbishment programme.</p> <p>QIPP schemes at an early</p>	<p>The Trust has agreed with Torbay Care Trust that income reduction associated with QIPP schemes is phased over three years -20% in year 1 (non-pay), 60% in year 2 (staff) and 20% in year 3 (overhead) – reflecting the Trust's cost structure.</p> <p>Allowing for this phasing, QIPP</p>	<p>Performance is monitored at the cross community executive group known as Transforming Patient Care (TPC).</p> <p>The Trust's consultants are working with local GP's on designing revised patient pathways in Clinical Commissioning Groups which report back to TPC Group on</p>	<p>The Chief Operating Officer is responsible for ensuring that the Trust is playing its part in delivering this agenda.</p> <p>QIPP has been removed from budgets and is monitored at both the CIP board, Trust Finance Committee and Trust Board.</p>

	stage of development, resulting in uncertain timing of demand reduction and risk to delivery of service standards.	<p>schemes removed from budgeted income and expenditure.</p> <p>QIPP schemes defined to individual service level.</p> <p>Workforce plan in place, identifying and building the flexibility to respond as demand reduces.</p> <p>The Trust has agreed with commissioners that QIPP schemes must reduce cost to the whole community not just provide a contractual saving.</p> <p>Contract terms dictate full payment for all activity undertaken by the Trust.</p> <p>Monthly adjustment to cost reduction target.</p>	<p>progress.</p> <p>Contracts provide for the Trust to receive payment in full should these initiatives fail to deliver.</p>	<p>Performance system will monitor referral levels.</p> <p>Monitoring of workforce flexibility through HR systems ahead of QIPP delivery.</p> <p>Financial monitoring at Budget Holder level, and ultimately through to Finance Committee and Trust Board will ensure that appropriate management action delivers income and expenditure balance.</p>
Cost inflation is above that assumed in the Tariff	Additional cost leading to risk in delivery of financial duties and an inability to secure capital funds to deliver the estates refurbishment programme.	<p>The Trust has set budgets to reflect expected inflation.</p> <p>Central reserves held to address items that budget holders cannot be expected to manage.</p>	The Trust expects to be able to deliver its budgeted position.	<p>Budgets are devolved to named individuals who are accountable for ensuring delivery of services within that budgeted level.</p> <p>Monthly budget holder review process lead by Divisional General Managers and Finance Team.</p> <p>Monthly monitoring of financial position through CIP Board, Finance Committee and Trust Board.</p>
Restrictions in access to capital funding	The Estates development set out in the plan relies on the Trust raising loan finance.	<p>Delivery of strong financial performance - see above.</p> <p>Maintenance of relationship</p>	<p>Borrowing secured.</p> <p>Non-loan options papers developed for Board</p>	<p>Regular updates to Finance Committee and Board.</p> <p>Non-loan options paper.</p> <p>Signed Loan Agreements</p>

	Those plans will be reduced should either funds not be available or the Trust's financial performance precludes further borrowing.	with the Foundation Trust Financing Facility Continue to pursue commercial finance options. Investigate joint venture and bond finance options during 2011/12.	consideration.	
Risk of competition from other secondary care providers and / or policy driven reconfiguration centralising acute services away from South Devon.	Loss of significant activities resulting in the need for additional cost savings. Clinical interdependencies and adjacencies further undermine core services.	Maintenance of high clinical standards. Investment in estate and infrastructure such that service offering is of the best standard. Pursue further integration of secondary and community care such that the impact of its loss would outweigh any benefit of secondary care rationalisation.	Maintain the existing range of mandatory services. Maintain dialogue on service and organisation integration.	Clinical performance outcomes reported to and monitored by the Board – ongoing. Delivery of the capital programme to plan. Management of the integrated care pilot through the TPC Group.
Risk of competition from / less inclination for organisational integration with the enlarged Torbay Care Trust community provider.	Loss of significant activities and / or savings potential resulting in the need for additional cost savings.	All organisations in the community agree strategy at the TPC Group. This group have agreed that any re-provision of services will only occur where there is an overall saving to the health community. Preparation for new contractual arrangements for care 30 days post discharge.	As there is a cooperative approach in the community and the commissioners are working with the Trust agreeing QIPP schemes the effect of competition from the enlarged community is expected to be managed. Maintain dialogue on service and organisation integration.	The Trust Chief Executive and key executives are part of the TPC Group. QIPP is monitored as described above.
GP Commissioning Groups have a negative impact on the Trust's income.	Failure to deliver the Trust surplus will limit the ability to borrow which will slow the hospital refurbishment programme.	The Trust is increasing the personnel in its contracting function to be better support clinically lead liaison with the developing GP Commissioning Groups. The Clinical Links with GP's	The Trust expects to manage the relationship with GP Commissioning Groups effectively. GP Commissioning Groups are represented in the community TPC executive group.	The Finance Committee monitors activity and income levels monthly. The Board receives feedback from the TPC group.

		have been formalised through the Clinical Commissioning Groups at a specialty level. Creation of a Clinical Cabinet - Medical Director of SDHFT / TCT plus Practice Based Commissioning (PBC) Chairs – to oversee development of the health community.		
Local Authority funding settlement undermines the benefits achieved through health and social care integration.	Increased length of stay, resulting in additional cost and leading to risk in delivery of financial duties and an inability to secure capital funds to deliver the estates refurbishment programme.	Continued active support of Torbay Care Trust in this agenda. Board level engagement with Local Authority Members to encourage continuation as far as possible.	Continued integration.	Monitoring through TPC Group. Monitoring of key performance indicators – length of stay, delayed discharges.
Demographics of the local population result in growth in demand.	Inability to accommodate within existing resources and possible failure to achieve service standards.	Systems to monitor demand in place. Development of a Lean Programme, building understanding and capacity for service redesign, delivering expanded capacity within existing resources	Maintenance of service standards.	Monitoring of referrals levels and service standards. Managed through Operational Capacity Group and reported to Finance Committee and Board.
Toughening regulatory regime / adverse regulatory event.	Need to maintain registration with Care Quality Commission. Loss of public confidence and associated loss in service demand associated with an adverse regulatory event.	Continued monitoring of regulatory requirements through Workstreams.	Maintenance of regulatory requirements.	Continued registration without condition. All requirements allocated to specific Workstreams, each of which is chaired by a Non-Executive Director Performance dashboards considered at each Workstream, and summarised for the Trust Board.

Impact of centralised Pathology service for Devon & Cornwall / commercial provider of Pathology services established.	<p>No impact if service and cost neutral.</p> <p>Concern that loss of GP direct access referrals would undermine 'on-site' hot facilities.</p> <p>Centralisation of processing could adversely affect continuity due to limited access to integrated records.</p>	<p>Executive level involvement in Working Group.</p> <p>Presentation of business case for change to the Trust Board for informed decision.</p>	Informed decision by the Trust Board.	<p>Regular feedback to the Trust Board.</p> <p>Business case for review.</p>
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Section 3: Trust plans

Financial plans: income

Activity plans, designed to deliver all national performance standards and driven by agreed rates of referral, have been agreed with Commissioners, at service level for 2011/12. Plans reflect gross (pre QIPP) and net (post QIPP) activity plans. The gross income associated with the baseline activity plan would be expected to be £188,249k. However, the QIPP challenge – essentially accommodating growth in demand in a flat cash environment – means that Commissioners are unable to afford this level of activity. The Trust has therefore assumed net activity in deriving contract income for 2011/12, which totals £184,288k for the year.

Torbay Care Trust (TCT) has reduced its liability by the development of a range of QIPP schemes totalling £3.7m. However, recognising the time delay between activity and cost reduction, TCT has provided £2,960k of non-recurrent funding in 2011/12. This represents 80% of total tariff and reflects the proportion of fixed and semi-fixed costs inherent in the Trust's cost base. With all Commissioners the Trust has been clear that the terms of the National Contract for Acute Trusts will apply. In this context, TCT's approach reflects some lack of confidence in the QIPP scheme's ability to deliver in year, effectively budgeting 'up front' for expected over-performance. This will be reflected in the contract structure for TCT, with over-performance in affected services being chargeable at 20% of tariff to the extent of the QIPP adjustment, moving to 100% thereafter.

NHS Devon has taken a different approach. As well as removing QIPP schemes totalling £3m at full tariff they have, for reasons of affordability, reduced their initial assessment of demographic growth by £221k – approximately one sixth of the forecast. In this context, the contract terms agreed with NHS Devon are fully variable, with all activity funded at 100% of tariff. Given that NHS Devon's QIPP schemes appear no further developed than those in Torbay, there is a significant likelihood of contract over-performance in year.

Income assumption for 2012/13 and 2013/14 reflect a net 1.5% reduction in tariff and the QIPP activity reduction plans published by Commissioners.

The majority of Trust income is priced at the national tariff for Payment by Results (PbR). Where national prices do not exist activity has been priced in the following order:

1. National, indicative tariff where published, or
2. National average reference cost from 2009/10 uplifted by inflation, or
3. Local prices.

In 2010/11 the Trust had given a discount to the PCT's to offset some of the movement to HRG 4 from HRG 3.5 this amounted to £3.5m, the Trust had also rolled over the block contracts rather than reviewing the actual cost base of those services. In contrast the 2011/12 contract the Trust has agreed with commissioners it will run the full HRG4 tariff with no discount. This activity totals, by value £141,888k.

In securing agreement to move to latest national average reference costs for significant elements of the non-PbR block contract, the Trust has secured a pricing benefit in 2011/12. Commissioner have agreed to shadow monitor the cost and volume effect in 2011/12 with the expectation of moving to full cost and volume at national average reference cost for 2012/13. The Trust has also reviewed the impact of driving more clinical procedures to the outpatient setting and achieved agreement to 'top up' the tariff for the additional costs of delivering activity in this setting over the normal outpatient attendance.

The income position described assumes full recovery of CQUINN income.

The impact of the Trust not being paid for emergency readmissions within 30 days of a previous hospital discharge is assessed at £2,520k. This position, reflected in the plan, is the 'worst case' scenario without applying any allowance of 'demonstrably unrelated readmissions', the definition of which is still the subject of negotiation with Commissioners.

The rebate for emergency admissions above the 2008/09 baseline being funded at just 30% of tariff is estimated to be £1,479k.

Key income risk	Amounts and timing 2011/12 2012/13 2013/14		Mitigating actions and delivery risk
Commissioners (NHS Devon) have insufficient funds to settle contract over-performance.	2011/12 – Circa £3m to £4m 2012/13 and 2013/14 – To be determined in contract settlement for those years.		Contract risk through Annual Operating Plan sign off meeting with NHS South West Strategic Health Authority. SHA reserves and ‘Headroom’ fund still uncommitted. Formal referral monitoring and contract performance agreement with Commissioners, in which prior approval to move ahead and treat referrals ahead of plan is sought.
Failure to deliver CQUIN milestones.	2011/12	£2,543k	Clear action plans in place for each CQUIN standard – each with a clinical and managerial lead. All schemes risk assessed and approved by the Clinical Management Group (CMG) prior to commitment. Monthly progress review through CMG. Staged rewards set for a range of schemes
	2012/13	£2,504k	
	2013/14	£2,467k	
Contractual challenge on over performance. When under financial pressure, NHS Devon have, historically developed an approach that challenges coding practice, patient classification and waiting list management systems.	Value uncertain.		Full schedule of agreed prices set out in the contract including specific reference to those situations where local supersedes national tariff. Activity plans agreed with Commissioners and derived from integrated waiting list and referral model. Monthly monitoring regime established. Regular audit and benchmarking of clinical coding.

Failure to deliver planned activity levels.	Value uncertain.	<p>Capacity plans agreed at specialty level as part of the business planning process.</p> <p>Weekly monitoring of activity levels through Operational Capacity Group.</p> <p>Monthly monitoring of activity levels through Finance Committee and the Trust Board.</p>
Penalty for under achievement of 18 weeks Referral to Treatment Time (RTT) standard.	0.5% of the monthly sum for each 1% that the target is missed or part thereof.	<p>Capacity plans agreed at specialty level as part of the business planning process.</p> <p>Weekly monitoring of activity levels through Operational Capacity Group.</p> <p>Monthly monitoring of activity levels through Finance Committee and the Trust Board.</p> <p>Monitoring of referral levels and invoking of contract terms for capacity management plans as appropriate.</p> <p>Implementation of RTT compliant Patient Tracking List (PTL)</p>
Penalties for Clostridium Difficile cases above the previous years out-turn.	If the number exceeds 50 cases, penalties will start to apply.	<p>Continued delivery of the Infection Control plans within the Trust.</p> <p>Liaison with Primary and Community Care to address inherent C-Diff infection in Nursing and Residential Homes.</p>
Penalties for non-delivery of action plans to address contract non-compliance.	Up to 2% of the monthly sum may be withheld for non-agreement of action plans, up to 10% for non-delivery of milestones. First breaches represent delayed cash settlement only, with second breaches permanently resulting in sums being permanently withheld.	<p>Contract management database established. Process for registering, monitoring and addressing delays in delivery of agreed actions in place.</p>

Discharge letter within 24 hours to GP and at time of discharge provide discharge letter to Patient.	2011/12, 2012/13 and 2013/14 Standard Contract clause applies therefore up to 10% of monthly sums.	As for CQUIN
Penalties for Mix Sex Accommodation - subject to local negotiation and yet to be agreed.	£250 per day per affected patient.	Capital works completed in Day Surgery Unit, with agreement that no penalties would apply in this area until 31 May 2011. Process established for agreeing clinically acceptable breaches.

Financial plans: Service developments

Service development priorities	Contribution to the strategy	Key actions and delivery risk	Key resource requirements	Measures of progress		
				2011/12	2012/13	2013/14
Organic / innovation:						
Pharmacy Manufacturing Unit expansion	See Capital section					
Acquisition, etc.:						
None						
Transferred / discontinued activity:						
None						

Financial plans: activity and costs

The key challenge for the organisation is the ongoing cost improvement requirement, coupled with the management of QIPP, both of which are covered in full under the financial narrative.

Cost Improvement Plans (CIPs)

Table A (Items included in the CIPs worksheet in the financial template):

Key operating efficiency programmes	Amounts and timing	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Transformational Efficiency Schemes	2011/12 £4m	<p>Delivery required to achieve planned surplus and therefore secure financing to deliver hospital refurbishment ambitions.</p> <p>Lean process methodology improves standards delivered to patients.</p>	<p>Project plans defined with named project managers.</p> <p>Principle areas:</p> <p>Admin review : Medical secretary reduction, digital dictation, 'self check in' in outpatients, centralised booking.</p> <p>Theatre Review</p> <p>Nursing shift pattern review.</p> <p>Delivery risks centre around staff consultation, IT implementations and staff morale.</p>	<p>Key programme supported by a dedicated team of project managers and supported by the Birch Group from Warwick University using the 'Lean' methodology.</p> <p>IT implementation around rostering system and software solutions for other projects.</p>	<p>Projects defined with assessed delivery targets and milestones.</p> <p>Fully developed Performance monitoring and Executive Continuous Improvement Board in place to ensure delivery achieved to meet targets.</p> <p>Roster system implemented in 2010/11 rolling out to non-clinical staff groups 2011/12, embedding working practices and data collection Q1 supporting consultation on working pattern changes.</p>
<i>Divisional Schemes</i>	<p>2011/12 £8.9m</p> <p>Split:</p> <p>Medicine £2.6m</p> <p>Surgery £2.2m</p> <p>Women's, children's</p> <p>Diagnostics and</p>	<p>Delivery required to achieve planned surplus and therefore secure financing to deliver hospital refurbishment</p>	<p>400 projects spread over the divisional structure.</p>	<p>Operational management responsible for scheme development and implementation.</p> <p>Requires the balancing</p>	<p>Scheme plans developed with delivery milestones agreed.</p> <p>Monitored monthly via divisional structures</p>

	Therapies Estates Support	£2.0m £1.6m £0.5m	ambitions		of operational capacity directed at delivery of capacity plan, QIPP and CIP programme.	and reported to the Executive Continuous Improvement Board, Finance Committee and Trust Board on a monthly basis.
<i>Lean programme</i>	2012/13 2013/14	£9.2m £9.0m	<p>Delivery required to achieve planned surplus and therefore secure financing to deliver hospital refurbishment ambitions.</p> <p>Lean process methodology improves standards delivered to patients.</p>	Development of detailed plans in 2011/12	<p>Development of Service Line Management (SLM) operational management structure.</p> <p>Investment in Lean methodology training throughout the Trust</p> <p>Investment in SLM support in finance to drive the clinical engagement the Lean agenda to deliver quality services at reduced cost.</p>	<p>Outline plans for 2012/13 to Executive Team by 30 September 2011.</p> <p>Detailed implementation plans by 31 January 2012.</p> <p>Outline 2013/14 plans by 31 March 2012.</p>

Table B (Other savings/efficiencies – not included in the CIPs worksheet in the financial template):

Other savings/efficiencies	Amounts and timing	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
QIPP	<p>Torbay care Trust:</p> <p>2011/12 £3,723K 2012/13 £2,306k 2013/14 £1,727k</p> <p>NHS Devon :</p> <p>2011/12 £3,581k 2012/13 £2,138k 2013/14 £2,108k</p> <p>2011/12 includes the following initiatives:</p> <p>Reduced First to Follow up Ratios £3,931k</p> <p>Low Value /Low Priority Procedures £1,589k</p> <p>High Cost Drugs payments £337k</p> <p>Non-elective admission avoidance £1,447k</p>	<p>QIPP has been removed from the plan on the assumption that plans will be delivered.</p> <p>Net 11/12 Potential income reduction:</p> <p>Total Devon £3,574k (split 80/20 pay non pay)</p> <p>Total Torbay £744K (split 80/20 pay non pay)</p>	<p>Clinical Commissioning Groups established - meeting of Consultants and GP's at specialty level to agree appropriate pathways.</p> <p>Trust Finance and management meet with Commissioners to ensure alternative pathways will be a saving to the whole health economy and that associated contract changes do not inappropriately shift the balance of financial risk.</p> <p>Timing of demand reduction is unclear as plans have yet to be finalised.</p> <p>Increasing the ratio of variable to fixed pay costs.</p> <p>Training and reallocation of affected staff via the Job Shop, including staff side agreement.</p>	<p>Consultant time taken from SPA's</p> <p>Management and finance input for existing resources.</p> <p>Detailed referral and QIPP scheme monitoring.</p> <p>HR, Divisional and Clinical Manager input to deliver cost base flexibility.</p>	<p>2011/12 Plans Developed via Clinical commissioning groups by 30 June 2011.</p> <p>Monitored via joint Commissioning and Trust Care Redesign groups – Ongoing</p> <p>Effectiveness of Programme monitored by cross community executive level Transforming Community Services Group – Ongoing.</p> <p>Capacity reductions agreed as</p> <p>Detailed QIPP plans for 2012/13 and beyond to be presented</p>

Financial plans: Workforce

Key workforce priorities	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14						
Ensuring a flexible workforce	<p>The Trust and its Trades Unions share a common aim of safeguarding employment while maintaining job opportunities.</p> <p>The requirement for posts at all levels will be subject to rigorous ongoing review and service redesign, enabling the release of staff to fill critical roles as they become vacant or established whilst reducing the overall headcount.</p>	<p>Build further on the established Job Shop through which ‘at risk’ staff are given the opportunity of redeployment.</p> <p>Establishment of Supporting Staff Through Change Group as a formal forum to oversee this process.</p> <p>Development of briefing, coaching, facilitated staff support and skills training programme to better equip staff for changing roles or redeployment.</p>	<p>Training and Development Team resource.</p> <p>Commissioned external training resources as required.</p>	<p>2011/12 – Skills training programme in place.</p> <p>Workforce reductions:</p> <table><tr><td>2011/12</td><td>95.7 wte</td></tr><tr><td>2012/13</td><td>126.6 wte</td></tr><tr><td>2013/14</td><td>158.5 wte</td></tr></table>	2011/12	95.7 wte	2012/13	126.6 wte	2013/14	158.5 wte
2011/12	95.7 wte									
2012/13	126.6 wte									
2013/14	158.5 wte									
Equality Delivery System (EDS)	<p>The EDS is designed to help NHS organisations improve quality performance and embed equality into mainstream business.</p> <p>Meet the requirements of the Equality Act and will be better placed to meet the registration requirements of the Care Quality Commission.</p>	<p>The success of the EDS is predicated on leadership.</p> <p>South Devon Healthcare Foundation Trust and Torbay Care Trust Boards will be participating in the Connect Programme together.</p>	<p>Connect Programme and Board time and commitment.</p>	<p>2011/12 – Board Programme</p> <p>2012/13 and 2013/14 – Organisation roll out.</p>						

Continued Organisational Development (OD) programme	Appropriate and targeted OD can unite and create a shared vision and foster values to drive the culture. The Trust recognises that organisations with a strong shared culture tend to enjoy better performance, expressed in terms of organisational commitment, enhanced recruitment and retention of highly skilled and motivated staff and higher patient satisfaction.	Design and roll out an Organisational Development Programme.	Human Resource (HR) time.	2011/12 – Design Programme. 2012/13 and 2013/14 – Organisation roll out.
Integrated workforce Plan – one to three years	Support the delivery of our financial savings programme and QIPP plans, taking a proactive approach to staff training and development; addressing new ways of working to increase efficiency whilst sustaining and improving quality; and maximising flexibility in order to retain and enhance the skills of our staff.	Complete workforce plans.	Operational and HR management time.	2011/12 - Initial workforce plans completed. 2011/12, 2012/13 and 2013/14 – Ongoing implementation, review and amendment as required.
Staff survey	Eight areas of the 2010 staff survey revealed room for development.	Listening into Action Groups to establish key issues. Develop action plans. Review subsequent survey results and refine.	HR time	2011/12 – Development of action plans implementation. 2012/13, 2013/14 – Review survey results and take remedial action as required.

Financial plans: Capital programmes (including estates strategy)

Key capital expenditure priorities	Amounts and timing (including financing schedules)	Contribution to the strategy (incl. service delivery)	Key actions and delivery risk (inc. finance risks)
Development:			
Pharmacy Manufacturing Unit (PMU) - Redevelopment	The expenditure profile of the scheme is as follows: - 2011/12 £1.7m 2012/13 £12.5m 2013/14 £1.8m	The financial contribution the PMU makes to the Trust will continue to be invested in healthcare and to enable the Trust to accelerate its refurbishment and backlog maintenance program. Wider NHS benefit as the PMH is the sole supplier of a range of drugs essential to all hospitals.	Finance for the project has been secured. The FBC is being considered by the Trust Board in September 2011. The Trust has designed the contracts and the procurement dialogue to ensure that the interface between the two potential contractors is successful. A dedicated project manager for the project has been appointed. Risks that have been considered by the Trust and addressed at the OBC stage include loss of market, loss of products, and impact upon the Trusts Private Patient Income cap. All of these risks have been demonstrated to be manageable and are outweighed by the envisaged benefits.
Maintenance:			
Backlog Maintenance Program	Work has commenced on this program and is planned to continue over the next three years as follows: - 2011/12 £9.4m 2012/13 £8.4m 2013/14 £8.5m	The Trust has undertaken a full site conditional appraisal. This appraisal identified that a number of backlog maintenance issues required to be addressed in order to ensure business continuity and maintain patient and staff safety.	The Trust is the process of selecting a new partner from the Procure 21+ framework. Programme of works for 2011/12 is agreed and operational interface is managed through an Estates Steering Group. The main risks to this programme relate to the Trusts ability to secure external finance in 2012/13 and 2013/14. Dialogue with the Foundation Trust Financing Facility is continuing, commercial options continue to be explored, including loan, bond finance and joint venture arrangements.

Theatres 3 & 4, Plant Room, Air Handling Units & Refurbishment	The work will be phased over two financial years, the first part taking place in 2011/12, (£2.1m) and the remainder in 2012/13 (£1.5m).	Work is required in two of the Trusts main operating theatres to maintain the adequacy of the ventilation systems and to address a number of backlog maintenance issues. The new theatres will be a better functional fit and will incorporate better technology to assist in ongoing clinical training. Business continuity. Improvement in patient care and ability to ensure waiting times are minimised.	The greatest risk posed by this development is a reduction in operating capacity during the construction phase. The Productive Theatre Programme will develop throughout efficiencies to partially mitigate this risk. Other mitigations include partial refurbishment of a treatment room to create capacity in advance of the main works, evening and weekend working, leasing facilities from local providers.
Relocation of Critical Care Unit (CCU)	£0.3m will be spent on design works in 2011/12 to enable the Trust to commence construction work in 2012/13. The overall cost of the scheme has been quantified as £3.5m	To secure business continuity and an improvement in both patient environment and patient care. The current CCU requires a significant amount of backlog maintenance to be undertaken and the Trust has forecast that the current facility will no longer be functionally suitable in the short to medium term.	As with many of the Trusts capital development plans for 2012/13 and 2013/14, they are dependent upon the Trust being able to secure external finance. An application will be made to the FTFF for future funding during 2011/12.
Improvements to Paediatric Outpatients	The scheme cost is £0.4m and will take place during 2011/12.	Improvement in patient environment, reduced waiting times and compliance with CQC and NSF. The scheme will ensure that all children are seen in an appropriate environment. The scheme will also create additional consulting rooms which will improve team work, reduce pressures on paediatric inpatient facilities and ultimately reduce waiting times.	A project group has been established to further consider the design of the facility and to ensure that activity can continue during the construction phase of the project.
Other	Included within the 2011/12 capital expenditure are other smaller capital schemes that sum to £1.0m for Property maintenance work and £0.3m for Other Equipment. Values of £0.9m and £4.5m have been set aside in 2012/13 and 2013/14	Improved patient environment, improved patient care and compliance with CQC requirements.	A number of schemes within the 2011/12 program of works are either ongoing or have now been completed. The designs of the remainder are being finalised. As with many of the Trusts capital development plans for 2012/13 and 2013/14, they are dependent upon the Trust being able to secure external finance.

Other capital expenditure:			
Medical Equipment	The Trust is planning to invest a total of £4m per annum over the next three years. Significant items include replacement interventional radiology suite, CT, MRI and Linear Accelerators.	Business continuity, improved patient care and compliance with waiting time requirements. Circa £1m will be spent per annum on a rolling replacement program (RRP) and the remaining £3m will be allocated based upon a risk assessment of needs.	As with many of the Trusts capital development plans for 2012/13 and 2013/14, they are dependent upon the Trust being able to secure external finance.
Information Technology	<p>In 2011/12 the Trust will spend £3.5m on IM&T.</p> <p>A further £3.0m has been set aside in both 2012/13 and 2013/14.</p> <p>Key aspects include: implementation of a new A&E system critical to the management of new performance standards and HRG4 Order Comms and e-Prescribing in support of both quality and efficiency. Architecture investment for implementation of ASCC procured PAS replacement in 2012/13.</p>	Business continuity, patient safety and efficient use of resources. The Trusts IM&T needs are continually assessed and our local plans take into account of the proposed national procurement strategy	<p>A rolling procurement strategy has been approved by the Trust. This strategy is updated on a regular basis to ensure compliance with relevant requirements, to maximise opportunities and to ensure business continuity. Project teams are in place to enable implementation.</p> <p>As with many of the Trusts capital development plans for 2012/13 and 2013/14, the full scale of investment is dependent upon the Trust being able to secure external finance. An application will be made to the FTFF for future funding during 2011/12.</p>
Theatres 3 & 4	As referred to in the 'maintenance' section above, the Trust has prioritised the need to improve two of its main operating theatres. Of the total cost of £3.6m, £0.5m will be spent in 2012/13 on new Theatre medical equipment and on audio visual links to Training rooms.	As above.	As above.
Pharmacy Manufacturing Unit (PMU) – Redevelopment	As referred to in the 'development' section above the Trust is at an advanced stage of the procurement of this development. If the FBC is approved by the Trust Board,	As above.	As above.

	circa £4m of the procurement will be spent on funding the purchase of new processing and laboratory equipment. Circa £2.2m will be expended in 2012/13 and a further £1.8m in 2013/14		
Other	The Trust is planning to replace a number of vehicles in its Transport fleet during 2011/12. The cost of this is envisaged to be £0.2m Provisional sums of £0.2m for both 2012/13 and 2013/14 have been set aside in this plan.	Business continuity	Prior to placing orders for the vehicles the Trust will obtain lease quotes to ensure the most economical procurement takes place.
Other estates strategy			
None			

Clinical plans

The Trust's key corporate objective is to deliver the safest possible care, a commitment we have been working to since our initial involvement with the Safer Patient Initiative now over five years ago.

Our record of achievements allows us some confidence that the systems and processes we have in place for improvement bring sustainable and embedded changes.

Our focus for 2011/12 quality priorities are detailed below. These are consistent with our CQUIN goals and our priorities documented in the Trust's Quality Accounts.

Quality issues and measures	Contribution to the strategy	Key actions and delivery risk	Performance in 2010/11	3 year targets / measures for
				2011/12 2012/13 2013/14
Goal Blood clot prevention - Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE) Measures 10 random drug chart review per ward per month	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the Commissioning for Quality and Innovation framework (CQUIN) will allow full contract income to be secured.	Key actions Monitoring & improvement of systems set up in 10/11. Delivery risk Winter pressures Workforce changes (Junior Doctor's rotation)	89% on average risk assessed on admission 95% on average appropriate prophylaxis	2011/12 Minimum standard of 90% of patients risk assessed on admission month on month Minimum standard of 90% of offered VTE prophylaxis month on month 2012/14 Minimum standard 90% compliance across all appropriate areas
Goal Patient experience - Improve responsiveness to personal needs of patients Measures Real time survey feedback Observations of Care	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the CQUIN will allow full	Key actions Continue with real time feedback systems set up 10/11 Collect & evaluate data/observations & feedback around care & compassion 10/11	Inpatient survey overall 73.2 score	2011/12 Maintain the performance value as a minimum against each of the five elements of the adult inpatient survey Measure 'Care and Compassion' towards

	<p>contract income to be secured.</p> <p>Provide assurance to patients, carers, families and stakeholders regarding the quality of care – Agreed Quality Account priority area for 11/12.</p>	<p>Delivery risk</p> <p>Capacity of the Working with Us Panel</p> <p>Closure of wards</p>		<p>older people in response to the 2011 Health Ombudsman's report and act on findings</p> <p>2012/14</p> <p>Year on year improvement of patient experience as defined by a range of quality markers</p>
<p>Goal</p> <p>Care planning summaries (CPS)- Improve the timeliness and quality care planning summaries</p> <p>Measures</p> <p>No of inpatients (excluding day case) receiving a CPS within 24 hours - recoded via Info flex</p> <p>Data quality survey/audit of CPS</p>	<p>Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience.</p> <p>Delivery of the CQUIN will allow full contract income to be secured.</p>	<p>Key actions</p> <p>Monitoring & improvement of systems set up in 10/11.</p> <p>Delivery risk</p> <p>Winter pressures</p> <p>Workforce changes (Junior Doctor's rotation)</p>	<p>53% on average within 24 hrs</p>	<p>2011/12</p> <p>Achieve 77% CPS completion (CQUIN target) within 24hrs during the weekday</p> <p>2012/14</p> <p>90% compliance across all appropriate areas</p>
<p>Goal</p> <p>Intentional rounding – Improve patient care through undertaking intentional rounding on identified high risk patients of falls, malnutrition or pressure sores, within the first 24 hour period</p> <p>Measures</p> <p>Number of charts completed correctly over the first 24 hour period from the sample selected</p>	<p>Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience.</p> <p>Delivery of the CQUIN will allow full contract income to be secured.</p> <p>Provide assurance to patients, carers, families and stakeholders regarding the quality of care –agreed Quality Account priority area for 11/12</p>	<p>Key actions</p> <p>Set up intentional rounding processes, monitor, evaluate & improve.</p> <p>Delivery risk</p> <p>Clinical pressures</p> <p>Cultural</p>	<p>Not applicable</p>	<p>2011/12</p> <p>90% compliance on two wards by the end of the year</p> <p>2012/14</p> <p>90% compliance across all appropriate areas</p>

<p>Goal To improve the ward environment/process with the aim of releasing time to care using the 'productive ward' methodology</p> <p>Measures Productive ward modules</p>	<p>Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the CQUIN will allow full contract income to be secured. Provide assurance to patients, carers, families and stakeholders regarding the quality of care –agreed Quality Account priority area for 2011/12</p>	<p>Key actions Implementation of modules. Setting up a process of continuous quality improvement</p> <p>Delivery risk Winter pressures</p>	Not applicable	<p>2011/12 Complete 58 modules of 'Productive Ward' methodology with the outcome of releasing time back to direct patient care</p> <p>2012/14 Complete remaining productive ward modules across all wards</p>
<p>Goal Reduction in overall caesarean section rate</p> <p>Measures Number of planned & emergency sections Compliance with agreed pathways/protocols</p>	<p>Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the CQUIN will allow full contract income to be secured.</p>	<p>Key actions Agreement & introduction of revised local guidelines. Clinical engagement of standardised approach. Process for clinical review and feedback.</p> <p>Delivery risk Non compliance External factors</p>	22%	<p>2011/12 Reduction in overall caesarean section rate</p> <p>2012/14 Maintain as a minimum the standard of performance achieved</p>
<p>Goal To improve End of Life Care Services through monitoring compliance and outcomes against the community wide End of Life Care Rapid Discharge Pathway</p> <p>Measures Root cause analysis on patients where rapid discharge has not occurred</p>	<p>Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the CQUIN will allow full contract income to be secured. Provide assurance to patients, carers, families and stakeholders regarding the quality of care –agreed Quality Account priority area for 11/12</p>	<p>Key actions Measure against each patient referred the outcome of the assessment and compliance against the pathway for the whole of the patient's pathway. Data collection will include information on patients deemed to be unsuitable for rapid discharge and reasons for this.</p>	Not applicable	<p>2011/12 Outcome of investigations. Identify gaps in end of life care services</p> <p>2012/14 Build on work started in 11/12</p>

Goal Clinician peer review Measures Number of clinicians engaged in peer review process	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the CQUIN will allow full contract income to be secured. Supports revalidation & strengthen appraisal of doctors	Key actions Set up processes, for clinician peer review. Monitor, evaluate & improve. Delivery risk Clinician capacity	Not applicable	2011/12 30 clinicians completing peer review 2012/14 All consultants & SAS doctors undertake peer review (3 yr cycle)
Goal To improve the overall care of people with a learning disability Measures Action plan against regional learning disability standards	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the CQUIN will allow full contract income to be secured.	Key actions Delivery against updated action plan 10/11. Develop LD pathway and undertake mortality reviews. Delivery risk Clinical and public engagement	10/11 CQUIN met	2011/12 Completion of action plan to agreed timelines. 2012/14 Continuation of continuous quality improvement in relation to learning disabilities
Goal To improve the overall care of people with dementia Measures Peer review & action plan against regional dementia standards	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the CQUIN will allow full contract income to be secured.	Key actions Undertake South West Dementia hospital self-assessment and develop an action plan and evidence completed actions. Develop & embed dementia champions. Delivery risk Clinical and public engagement	10/11 CQUIN met	2011/12 Completion of action plan to agreed timelines. 2012/14 Continuation of continuous quality improvement in relation to dementia
Goal Embed enhanced delivery across all clinical specialities Measures Compliance with enhanced recovery pathways, Patient feedback, Length of stay,	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the CQUIN will allow full contract income to be secured. Provide assurance to patients, carers, families and stakeholders regarding the	Key actions Enabling work - Confirmation of pathways and timelines. Baseline data collection. Patient information leaflets for each enhanced recovery pathway Delivery, review & improve	Variable from 90% to 45%	2011/12 50% of patients are discharged on or before the intended median post op day length of stay 90% of patients on an enhanced recovery pathway (excluding

Admission on day of surgery	quality of care –agreed Quality Account priority area for 11/12	Delivery risk Service engagement & change in all discipline		colorectal) will be admitted on their day of surgery 2012/14 Meeting national standards
Goal Continue to deliver Safer Patient Initiative (SPI) Programme Measures IHI dashboard	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience.	Key actions Delivery through established work streams with executive lead, monitored through dashboard measures by the Safety Improvement Group. Key indicators include Hospital Standard Mortality Rate (HSMR) Global Trigger Tool and Adverse Events Rate (GTTR); Hand washing ; Safety briefings; early warning system; SBAR	Agreed standards met	2011/12 10% reduction in HSMR, GTTR <50, Processes measures 95% compliant 2012/14 Meeting standards as agreed by the South West Quality Improvement programme
Goal Participation in National Audit Programme & Implementation of NICE guidance Measures Compliance rates & action plans	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience.	Key actions Audit programme agreed for 2011/12 to meet National Audit requirements. This will underpin the actions being taken to comply with NICE guidance.	90% participation in national audits 100% participation in National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	2011 -14 Maintenance of 2010/11 standard as a minimum
Goal Reduction of MRSA & C Difficile Measures MRSA & C Diff rates	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience.	Key actions Monitoring compliance and actions Developing/improving systems including joint work in Community facilities with health and social care partners. Delivery risk	Overachieved national reduction rates Trust rates C Diff - 26 MRSA - 1	2011/12 Compliance with national reduction rates

		C-Diff target is very low for a population of the type served by the Trust. Incidence of inherent infection in the wider community will make a further reduction difficult to achieve.		
Goal To improve the theatre environment/process with the aim of releasing time to care using the 'productive theatres ' methodology Measures Productive theatre modules	Delivery will contribute to the corporate objectives of safer care with no delays, improving value and providing a better patient experience. Delivery of the CQUIN will allow full contract income to be secured.	Key actions Setting up a process of continuous quality improvement Delivery risk Winter pressures	Not applicable	2011/12 Completion of Foundation and Enabler modules (5) of the Productive Operating Theatre in 11 theatres 2012/14 Completion of remaining modules across all appropriate theatres

Clinical plans: assurance

Monitor's Quality Governance Framework covers four main areas:

- Strategy;
- Capabilities and culture;
- Processes and structure; and
- Measurement.

The Trust has an integrated governance approach to quality governance in line with the requirements of the Foundation Trust compliance framework which is outlined within the Risk and Assurance Strategy. It defines standards for governance, the provision of quality services and financial management by which the organisation is monitored and controlled, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

The corporate assurance framework is the tool which the Board uses to gain assurance that controls are in place to assist the organisation in meeting the strategic objectives and that identified risks to quality governance are being managed appropriately.

The process of quality governance is driven by the five operational Work streams:

- ensuring required standards are achieved;
- investigating and taking action on sub-standard performance;
- planning and driving continuous improvement;
- identifying, sharing and ensuring delivery of best-practice; and
- identifying and managing risks to the quality of care.

Each of the Work streams is led by an Executive Director and chaired by a Non-Executive Director. The Work streams have a risk register linked to the Trust's strategic objectives.

The five Work streams which operate below Board level are as follows:

1. Patient Safety
2. Patient Experience & Community Partnerships
3. Finance
4. Human Resources & Educational Governance
5. Infrastructure & Environment

With regards to quality priorities including those already detailed in this section, there are proper internal controls over the collection and reporting of the measures of performance. These controls are subject to review by the Work streams and the Board of Directors to confirm that they are working effectively in practice. Clinical data is also reported at Board level, with evidence of Board challenge in response.

In addition, serious untoward incidents (and complaints) are fed through a serious Untoward Event Group chaired by the Director of Nursing and Governance with the Chief Executive, Medical Director, Chairman and a Non-Executive Director and Non-Executive Director and the Chair of the Patient Safety Committee are members. Investigations are robust and learning is shared across the organisation and our Work streams. At the last Monitor Trust visit this was cited as an example of excellent practice.

Section 4: Regulatory requirements

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
Financial Stability	Impact of Tariff deflator/ inflation assumptions verses actual cost increase over the three years	Increased focus on CIP with support from the Birch Group to embed lean working within the Hospital. Implementation of Service line Management to focus clinical management on ensuring that the service lines deliver clinical quality, waiting times and deliver surplus for future investment.	CIP plans, Annual Budget. 2011/12 Service Line Management Pilots. 2012/13 Service Line Management Roll out. 2013/14 Service Line Management fully operational
Financial Liquidity	Ability of commissioners to pay for over performance should QIPP not deliver to required Levels	The Trust is working with commissioners to develop pathways to limit growth in secondary care activity. Performance is monitored at the TPC cross community executive group. The Trust's consultants are working with local GP's on designing revised patient pathways in Clinical Commissioning Groups which report back to TPC on progress. Contracts provide for the Trust to receive payment in full should these initiatives fail to deliver. NHS South West has held 2% of commissioner's budgets to provide a risk pool and NHS Devon have highlighted the risk of over performance to the Strategic Health Authority as part of the annual planning process.	Monitor risk ratings monitored monthly. QIPP monitored monthly internally and at community TCS.

Financial Profitability	Ability to deliver the Continuous Improvement Schemes, the scale of delivery of QIPP schemes and the ability to remove cost quickly in response, the management of costs within the budgeted expenditure and the ability to deliver the agreed capacity plan plus any volume where QIPP does not deliver.	See Cost improvement under Financial Stability above. Also see QIPP under Section 2 above	See Cost improvement under Financial Stability above. Also see QIPP under Section 2 above
Service Performance	The cumulative effect of significant CIP programmes could undermine the ability of the Trust to deliver the required activity levels at the required quality.	Activity is monitored weekly at the Trust's operational meetings. The Trust focus is on quality in order to develop and to deliver the Continuous Improvement Programme. Quality is monitored via the Trusts Workstreams and is reported to the Board Monthly.	Activity is set out in the contract schedules with the Commissioners and actual performance is monitored against that. The CIP programme is set out in a plan and performance is monitored against that plan.
Maintaining compliance with national targets	Activity levels increase beyond national and local estimates putting adverse pressure on parts of the business e.g. accident and emergency which could have a knock on effect on key performance indicators.	Actions plans in place with Board approval. Regular monitoring by Workstream 3 and Board of Directors. Reports from Monitor regarding Annual Risk Assessment and quarterly submissions.	Monthly and cumulative performance reviews by Workstream / Division to the finance Committee and Trust Board in line with plan. Outcomes from External reviews e.g. assessments conducted by the Care Quality Commission.

Section 5: Leadership and governance

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2011/12 2012/13 2013/14
Continue to develop the coherence and effectiveness of the Board of Directors to deliver future strategy.	Ensuring the Chairman and Non-Executive Director (NED) posts are replaced appropriately during 2011/12 and 2012/13.	The appointment process to replace one NED whose term of office comes to an end on the 29 February 2012 will be agreed by the Nominations Committee in September 2011.	2011/12 – selection process, interviews and appointment of NED by the Governance Board. 2012/13 – new NED in post. 2012/13 – selection, process, interviews and appointment of Chairman by the Governance Board. Post holder to commence employment after 1 March 2013. Ongoing development throughout the year.
Continue to develop and strengthen the relationship, skills and knowledge of Trust Governors, particularly in light of the expanded Governor role set out in the Health and Social Care Bill.	Ensuring all Governors have the appropriate skills and knowledge to carry out their official duties. Uncertainty around the Health and Social Care Bill and the specific impact this will have on Trusts and their Governors.	Continue to improve the induction and ongoing development processes in consultation with Governors, building in requirements of the Health and Social Care Bill once finalised.	2011/12 - Number of governors who have attended the Trust's induction process and any external training opportunities e.g. put forward by the Foundation Trust Network. 2011/14 – Feedback from Governance Board self-assessment. Ongoing development throughout the year.
Strengthening relations with the clinical leadership.	Ensuring key decisions such as those impacting on service improvement continue to involve clinical representatives.	Continue to evolve and improve the governance processes having formed the Clinical Executive Group and Clinical Management Group in 2010/11. Develop Service Line Management.	2011/12 – review the new governance arrangements put in place in 2010/11. 2012/13 – all arrangements in place. 2011/12 Service Line Management Pilots. 2012/13 Service Line Management Roll out. 2013/14 Service Line Management fully

			operational
Leadership across the Health Community for effective integration	<p>Effective and positive engagement of GP commissioners and external stakeholders.</p> <p>During the process of planning and delivering significant structural change, perceptions may arise that lead to concerns on the part of stakeholders in the process, for example, patients, service users, staff, governors and partners in the local health economy.</p>	<p>Joint Board / management team meetings.</p> <p>Chief Executive/Chair meetings with TCT and NHS Devon;</p> <p>Governance Board meetings and Board-to-Governance Board meetings.</p> <p>Establishment of clinical cabinet - Medical Director of SDHFT / TCT plus Practice Based Commissioning (PBC) Chairs.</p> <p>SDHCT Medical Director to sit on PBC Board;</p> <p>Clinical Community Groups</p>	<p>2011/12 - agreed framework of professional leadership for health and social care established in partnership by both the Trust and Torbay Care Trust in support of service integration.</p> <p>2011/12 – finalise and agree Terms of Reference for Clinical Cabinet.</p> <p>2011/12 - continue to develop relationships with PBC.</p> <p>2011/12 - Medical Director from SDHFT to sit on PBC Board.</p>
Maintaining the Trust's estate	<p>Delivery of a high quality, fit for purpose physical structure within financial and resourcing constraints. Any shortfall in the allocation of capital funds (as outlined in the Estates Strategy) prevents longer term planning and delivery of a structured programme.</p>	<p>Estates Strategy and three year capital programme agreed by the Trust Board.</p> <p>Completed action plans from Internal Audit reviews.</p> <p>Regular monitoring by Workstream 5 and Board of Directors.</p>	<p>2011/12 - delivery against the capital plan agreed by Workstream 3 (Finance Committee) and Trust Board.</p> <p>PEAT (Patient Environment Action Team) assessment.</p> <p>Care Quality Commission submissions/assessments.</p> <p>2012/13 – delivery against the capital plan agreed by Workstream 3 and Trust Board.</p> <p>2013/14 – delivery against the capital plan agreed by Workstream 3 and Trust Board.</p>

In preparing the Trust's forward plan the Board of Directors engages with Governors on several occasions throughout the year both formally and informally.

The formal process involves an annual survey being distributed with our Annual Review document in October, to all public members, which continues to generate response rates in excess of ten per cent. The survey is developed by the Mutual Development Group which is a sub-group to the Governance Board and is chaired by one of our Governors. Surveys are categorised according to area which enables all 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-Governance Board meeting in March. The feedback from Governors to the Board of Directors is received informally and then presented more formally at the next Governance Board meeting in April.

Informally, Governors continue to engage with its membership several times throughout the year such as Medicine for Members events and via its quarterly newsletter.

Engagement with members and Governors is carried out ahead of our plans being drawn up for the year ahead (2011/12), so that the views from our local community can be taken into account.

In addition, for 2011/12 the Board of Directors has adopted a set of key corporate objectives, linked to the Annual Plan, against which the Board will collectively review its performance towards the end of the financial year. The objectives for 2011/12 have been shared with Governors both informally and then more formally at its Governance Board meeting in April. At the same meeting the Chairman provides Governors with the Board of Directors assessment of the extent to which the previous year's key corporate objectives were achieved.

Our Annual Plan for 2011/12 is therefore based on the continuing strategies for safer care, reducing delays and improving the patient experience such as communication at all levels, both internally and externally.

Detailed Financial Summary		2010-11	2011-12	2012-13	2013-14
£m		Actuals	Plan	Plan	Plan
Total operating income		211.3	210.6	202.1	196.2
Employee Expenses		(131.4)	(129.2)	(119.4)	(111.2)
Drugs expense		(15.1)	(15.7)	(15.9)	(16.1)
Supplies (clinical & non-clinical)		(18.8)	(22.7)	(22.4)	(22.1)
PFI expenses		0.0	0.0	0.0	0.0
Other Costs		(31.2)	(28.9)	(27.8)	(27.7)
Total operating expenses		(196.4)	(196.5)	(185.6)	(177.1)
EBITDA		14.8	14.0	16.6	19.1
Net Surplus / (Deficit)		0.7	2.1	2.3	2.2
EBITDA % Income	%	7.0%	6.7%	8.2%	9.7%
CIP% of Op.Exp. less PFI Exp.	%	5.4%	4.3%	4.7%	4.9%
Capital expenditure		(9.6)	(22.9)	(33.5)	(21.8)
Net cash inflow/outflow		5.4	(5.2)	1.7	2.5
Cash and cash equivalents		14.2	9.0	10.7	13.2
Liquidity days		29.2	25.3	27.8	34.9
Net current assets/(liabilities)		5.8	3.8	4.6	7.9
Planned borrowings		0.2	10.8	34.1	44.8

Cost Improvement Plans (CIPs) Totals		Actual for Year ending 31-Mar-11	Plan for Year ending 31-Mar-2012	Plan for Year ending 31-Mar-2013	Plan for Year ending 31-Mar-2014
Totals			Value £m	Value £m	Value £m
Analysis of Revenue Generation and Expense CIPS					
Recurring CIPs + revenue generation schemes		7.691	8.915	9.202	9.058
Non-recurring CIPs + revenue generation schemes		3.548	0.000	0.000	0.000
Total (agrees to above)		11.239	8.915	9.202	9.058
1 Short Name or Description					
Total revenue generation scheme effect			0.000	0.000	0.000
2 Short Name or Description					
Divisional & transformational schemes					
Total revenue generation scheme effect			8.915	9.202	9.058

List of Directors, Governors and elections for South Devon Healthcare NHS FT

Directors (at 31 May 2011 or date of submission, whichever is earlier)

Role	Job Title	Name of Director	Tenure	Date appointed
Chair	Chairman	Peter Hildrew	Permanent	01/03/2008
NED	Non-Executive Director	Duncan Barnes	Permanent	17/12/2007
NED	Non-Executive Director	Jack Buckner	Permanent	01/11/2005
NED	Non-Executive Director	Les Burnett	Permanent	01/03/2008
NED	Non-Executive Director	Andrew Cooper	Permanent	01/12/2003
NED	Non-Executive Director	Philip Johnston	Permanent	01/01/2007
NED	Non-Executive Director	David Murray	Permanent	29/06/2010
Chair	Chief Executive	Paula Vasco-Knight	Permanent	04/09/2008
Nursing Director	Director of Nursing and Governance	Elizabeth Childs	Permanent	01/09/2000
Finance Director	Director of Finance, Performance & Information	Paul Cooper	Permanent	19/07/2010
Medical Director	Medical Director	John Lowes	Permanent	01/10/2009
Other Board Director	Chief Operating Officer	Paul Mears	Permanent	23/03/2009
Other Board Director	Director of Workforce and Organisational Development	Adrienne Murphy	Permanent	20/04/2009

Governors (at 31 May 2011 or date of submission, whichever is earlier)

Constituency Type	Full Name of Constituency	Name of Governor	Origin	Date appointed/elected
Public	Torbay Constituency	Stephen Acres	Elected (Uncontested)	01/03/2009
Public	South Hams and Plymouth Constituency	Roy Allison	Elected (Uncontested)	01/03/2011
Public	Teignbridge Constituency	Terry Bannon	Elected (Uncontested)	01/03/2011
Public	Teignbridge Constituency	Barrie Behenna	Elected (Contested)	01/03/2009
Public	South Hams and Plymouth Constituency	Christina Carpenter	Elected (Uncontested)	27/04/2011
Public	Teignbridge Constituency	Cathy French	Elected (Contested)	01/03/2012
Public	Torbay Constituency	Sylvia Gardner-Jones	Elected (Uncontested)	01/03/2011
Public	Torbay Constituency	Philippa Grantham	Elected (Contested)	01/03/2010
Public	Teignbridge Constituency	James Hartley	Elected (Contested)	01/03/2010
Public	South Hams and Plymouth Constituency	Anne Haney	Elected (Uncontested)	01/03/2010
Public	Torbay Constituency	Rick Hillier	Elected (Contested)	01/03/2010
Public	Teignbridge Constituency	Alan Hitchcock	Elected (Contested)	01/03/2010
Public	Teignbridge Constituency	George Alfred Husband	Elected (Uncontested)	01/03/2010
Public	Torbay Constituency	John Hyde	Elected (Uncontested)	27/04/2011
Public	Torbay Constituency	Ian Oxley	Elected (Contested)	01/07/2010
Public	Teignbridge Constituency	David Wakefield	Elected (Uncontested)	01/03/2011
Public	Torbay Constituency	David Wootten	Elected (Uncontested)	01/03/2011
Staff	Staff Constituency	John Broomhall	Elected (Uncontested)	01/03/2010
Staff	Staff Constituency	Michael Fisher	Elected (Uncontested)	01/03/2011
Staff	Staff Constituency	Simon Pace	Elected (Contested)	01/03/2010
Staff	Staff Constituency	Liz Williams	Elected (Uncontested)	01/03/2009
Stakeholder	Torbay Council	Neil Bent	Appointed	01/09/2010
Stakeholder	Parents and Carers	Julia Blood	Appointed	01/03/2010
Stakeholder	South Hams District Council	Michael Hicks	Appointed	01/06/2010
Stakeholder	Devon Partnership Trust	Gill Montgomery	Appointed	01/03/2010
Stakeholder	Devon County Council	Trevor Pennington	Appointed	01/12/2009
Stakeholder	Torbay Care Trust	Jon Welch	Appointed	01/03/2010
Stakeholder	NHS Devon	Jenny Winslade	Appointed	01/06/2008
Stakeholder	The Peninsula College of Medicine and Dentistry	Vacant	Appointed	n/a
Stakeholder	Teignbridge Council	Vacant	Appointed	n/a
Stakeholder	Voluntary Services	Vacant	Appointed	n/a

Elections Held (between 1 April 2010 and 31 March 2011)

Constituency Type	Full Name of Constituency	No. of candidates	No. of Votes cast	Turnout	No. of Eligible voters	Date of election
Public	South Hams and Plymouth Constituency	1	0	0.0%	n/a	27/04/2011
Public	Torbay Constituency	1	0	0.0%	n/a	27/04/2011

Membership return for South Devon Healthcare NHS FT

Membership size and movements

Public constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	15,736	14,877
	New members	+ve	30	500
	Members leaving	+ve	889	500
	At year end (31 March)		14,877	14,877
Staff constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	3,397	3,355
	New members	+ve	349	270
	Members leaving	+ve	391	335
	At year end (31 March)		3,355	3,290
Patient constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	0	0
	New members	+ve	0	0
	Members leaving	+ve	0	0
	At year end (31 March)		0	0

Analysis of membership at 31 March 2011

Public constituency		31 Mar 2011 Actual members	31 Mar 2011 Eligible membership
Age (years):			
	0-16	0	76,587
	17-21	10	19,565
	22+	14722	293,194
	Unknown	145	0
			389,346
Ethnicity			
	White	13,033	386,218
	Mixed	9	1,974
	Asian or Asian British	27	734
	Black or Black British	5	420
	Other	21	0
	Unknown	1,782	0
Socio-economic groupings*:			
	ABC1	0	0
	C2	0	0
	D	0	0
	E	0	0
	Unknown	14,877	389,346
Gender:			
	Male	6,340	188,793
	Female	8,394	200,553
	Unknown	143	0
Patient Constituency		31 Mar 2011 members	Eligible membership
Age (years):			
	0-16	0	0
	17-21	0	0
	22+	0	0
Staff Constituency		31 Mar 2011 members	Eligible membership
	Members	3,355	3347