South Devon Healthcare NHS
NHS Foundation Trust

Strategic Plan Document for 2015-16

South Devon Healthcare NHS Foundation Trust

1.1 Strategic Plan for y/e 31 March 2016

This document completed by (and Monitor queries to be directed to):

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Date	14 May 2015

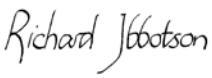
The attached Strategic Plan is intended to reflect the Trust's business plan over the next year. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability and resilience' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Richard Ibbotson

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Mairead McAlinden

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Paul Cooper

Signature 

1.2 Declaration of sustainability and resilience

• ***Declaration of sustainability***	
The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years' time.	***Confirmed***
Re: declaration of sustainability: *The Trust has submitted for stage three assessment under the Monitor transactions process a business case for the acquisition of Torbay and Southern Devon Health and Care NHS Trust. Acceptance of the business case and support of Monitor and the TDA is necessary to ensure the ongoing viability, not only of the Trust but the wider health and care community. This declaration is made on the basis that the proposal as currently submitted is approved. It describes a significant reconfiguration of services across the community, which will ensure the continued delivery of high quality care to a growing and increasingly ageing population. Alongside this, the business case describes a sustainable financial future. However, in 2015/16 the COSRR is expected to fall to a 2, for one year before the financial efficiencies borne from system redesign are realised. From 2016/17 forward, a COSRR of three is expected to be maintained.*	
• ***Declaration re: resilience*** ***After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.***	***Confirmed***

1.3 Executive Summary

This strategic plan describes the further development of an integrated health and social care system serving the population of Torbay and Southern Devon.

We know that demand in our health and care system is set to rise at a level faster than available resources will accommodate. This document includes a detailed, public health lead assessment, clearly describing the care needs of a growing, increasingly elderly population.

Our plans for an increasingly integrated health and social care model are supported by South Devon Healthcare NHS Foundation Trust's (SDHFT) planned service merger, through the acquisition of Torbay and Southern Devon Health and Care NHS Trust (TSDHCT), to create an Integrated Care Organisation (ICO).

In doing so, we will develop or redesign services that meet these demands and that are co-ordinated and integrated in ways that benefit service users. We will develop services that are responsive and flexible and which link, without break, with services of our partner organisations such as primary care and mental health services. All services will be included in this redesign, from acute specialist services and inpatient activity, to continuing health and social care at home.

A major feature of the services we develop with be the promotion of self-care. This will cover the promotion of healthy lifestyles and include support and training of service users and carers in self-management of even the most complex chronic health conditions. Many of the services will be about supporting people in their lives rather than focussing on ill-health. We will base service development on the 'Life-course model' to cover all phases of peoples' lives, with a particular focus on 'family-centred care'. We will support the development of services planned within Local Commissioning Groups and services centred in health and social care zones.

We will develop services that are seamless and provide continuity. Our services will not be constrained by the traditional physical and professional barriers of health and social care. Staff involved in the care of individuals within a community setting, will continue to be involved in the care of that person if they need to be admitted to hospital. Staff who have traditionally worked in the hospital will support or deliver care in the community when needed.

Services will be redesigned to provide the most accessible and best quality evidence-based care possible. This will result in a change in focus from the hospital to the community, and may result in a change in the member of the team providing care. The hospital will become smaller and there will be a shift towards specialist teams providing support to colleagues in the community and in primary care, allowing them to care for people closer to home. We will develop new means of contracting to support this new care model and to remove obstacles to the provision of patient-centred care.

In presenting a Full Business Case in support of our proposed transaction, we have developed detailed service level plans that describe how these changes flow through into a long term financial model that supports the Trust's ongoing viability. We look forward to completing Stage 3 of the Monitor Transaction process and look forward to receiving a risk rating on our proposal in June 2015.

This document and its accompanying financial templates have been prepared on the basis that the transaction proceeds according to the current schedule on 1st August 2015. The Trust expects a satisfactory conclusion to the negotiations currently underway to agree the financing package, now widely accepted as being necessary that will enable completion. Clearly, should the transaction not proceed or be materially delayed, this plan will need to be reconsidered. In that event the Trust would discuss an appropriate resubmission with Monitor.

The strategic direction is clear, and driven by the need to design a health and care system that can be accommodated within the resources available. The challenge for the Trust in 2015/16 is to deliver the transaction and to begin the process of service redesign whilst maintaining focus on addressing the service pressures experienced in 2014/15, most notably in the Emergency Department 4 hour and Referral to Treatment Time standards. This document describes a focus on both agendas; delivering the long term strategy and detailed plans at service level that maximise resilience in the short term.

The Trust is planning for a normalised (post-impairment) deficit of £5.7m in 2015/16. There is increasingly limited opportunity to deliver efficiencies in within the confines of the current system. The new care model, once implemented will create further opportunity, but this is not expected to be possible in any great extent until 2016/17. Through careful management of its cash reserves, the Trust expects to maintain a positive risk rating throughout.

There are a number of significant capital investments planned in 2015/16. As well as addressing some long-standing issues on the main hospital site, there significant investments planned, particularly in Information Technology that will be critical to the delivery of the new care model

This year will see significant changes in the Trust. There are many challenges to overcome but, through this plan we believe that we will build the foundations of a sustainable health and care system that will provide high quality, integrated care for many years to come.

1.4 Strategic Context

1.4.1 Strategic Statement

In its 'Strategic Plan 2014-19', South Devon Healthcare NHS Foundation Trust (SDH) sets out a clear strategy for the development of an Integrated Care Organisation (ICO) through the acquisition of Torbay and Southern Devon Health and Care NHS Foundation Trust (TSD).

In submitting this 'Strategic Plan for the Year Ended 31 March 2016' the Board of SDH confirms that this strategy remains its clear and preferred direction of travel.

1.4.2 Strategic Plan 2014-19

Our 'Strategic Plan 2014-19' described the challenge facing our health and care community.

The needs of a growing and increasingly elderly population will place enormous pressure on services, particularly those that respond in urgent and emergency care situations. That pressure is being experienced now. We serve a population with an age profile that is already well ahead of the national average and, with an increase of 20% in the population aged over-65 expected by 202, this will only get more challenging. Demand for hospital based services, left unchecked is expected to increase by around 4% per annum.

Both commissioners and providers are under significant and growing financial pressure. The cost of meeting the expected growth in demand, if continuing to provide services in their current configuration, outstrips the available funding. From a provider perspective, the two organisations will, by 2019/20 need to be making annual efficiency savings of £25m per annum (6.3% of total costs). This is well beyond that which has been required or delivered in recent years. From a Commissioner perspective, activity levels will drive a contract liability under national terms and conditions well in excess of the affordable levels. Maintenance of the current service model into the future is not financially sustainable for the wider community.

It is clear that, as a system we require significant service redesign if future demands are to be accommodated within available resources across the health and care system. The options available to the local health and care community, narrow down to the driving of service change through horizontal or vertical integration.

For SDH, it quickly became clear that the best option to ensure services improve sustainably and at pace and scale was for the two trusts to merge – a vertical integration. From a strategic perspective, the Board reached this conclusion in the following basis:

Fit with commissioning intentions: The emphasis of all Commissioners in the South Devon area is on joined-up care for all of their patients, ensuring that linkages between all aspects of the care system – primary, community, secondary and tertiary – are as effective as possible. Whilst effective care linkages are possible in a horizontally integrated model, they are most likely to be achieved, and for the largest number of patients, in a vertically integrated model.

Fit with national policy: Either vertical or horizontal models would be supported within the national policy framework, however with the publication of the Five Year Forward View, the establishment of the Pioneer programme, the development of the Better Care Fund and Monitor's guidance on the future of small and medium sized District General Hospitals, there is a clear leaning towards vertical integration for Trusts of our type. The development of competition policy and its application in the context of NHS services has also been a consideration. Within this developing landscape it has become clear that vertical mergers of services, with no overlap in service between respective parties, are less contentious than horizontal mergers, under which patient choice is much more clearly affected. As the proposed merger of Foundation Trusts in Poole and Bournemouth was under the consideration of the competition authorities as this strategy was being developed, the Board were conscious of the challenges posed through wide system horizontal integration.

Maintaining local access for local people: Our local population have told us that they value local service provision, perhaps above all else. In any form of horizontal reconfiguration of services, it will be impossible to drive financial benefit without centralising some services currently provided from the Torbay site in another location, be that Exeter or Plymouth, making access for residents of South Devon more difficult.

Patient experience: Patient survey results are very much aligned with the output of a recent and wide ranging public engagement process run by South Devon & Torbay CCG (SDTCCG). The most important issues to patients are that their care services are well co-ordinated, joined together and with access as close to home as possible. All of these would be best achieved in a vertically integrated model. This emphasises the importance of the patient's experience of the system, rather than an episode of care which would be the focus of a horizontally integrated model.

Potential to drive financial benefits: Despite the financial outlook being more challenging, our modelling suggests significant to drive financial efficiencies through a care model that focuses on better maintaining a population in community settings and avoiding, wherever possible the need for expensive hospital based care. Creating capacity to accommodate higher volumes of acute care through a horizontally integrated model, whilst perhaps addressing the issues around acute Trust viability, would not resolve the funding challenge experienced by Commissioners. Only by changing the model of care and reducing reliance on hospital services can both Commissioner and Provider viability be addressed in parallel.

Clinical sustainability: The volumes of acute activity performed would not reduce, so demand for scarce clinical resource would continue to be a challenge under a horizontally integrated model. A horizontal model, reducing demand for admission and skilling-up a wider range of health professionals to better support people in a community based setting would, we considered, best reduce this demand.

Meets the demographic challenge: The most significant challenge facing the local health economy is to care for an increasing number of frail elderly people, often with number of complex, long term conditions. The complexity of care packages for this patient group means that co-ordination is, perhaps the most important aspect of their care; an aspect that the Board felt is best delivered through a model of vertical integration.

In parallel with this strategic direction being developed at SDH, the Board of TSD were, under the requirements of the Transforming Community Services (TCS) agenda, considering options for their future organisational form. A thorough assessment of TSD's financial position demonstrated that, although there was potential for a viable Foundation Trust bid, TSD would, with its current business model, be unlikely to retain, Foundation Trust status in the longer-term. As a result, the TSD Board resolved not to pursue an independent future but, in agreement with the then Strategic Health Authority, to open a competitive process to identify a suitable merger partner.

The Board of SDH considered this resolution and, in support of its stated strategy, concluded that it should bid to become that partner. SDH was the only bidder and was successful at the pre-qualification stage of the established procurement process. SDH has subsequently had an Outline Business Case for the acquisition of TSDHCT approved by the Trust Development Authority (TDA).

Having been designated 'preferred bidder status', the Trust has worked in close partnership with TSDHCT and has developed a good understanding of the financial and operational positions of the partner organisation. Preliminary due diligence has been completed and a Final Business Case (FBC) developed.

The FBC was presented to Monitor in February 2015, supporting our proposal to create a single, integrated health and social care provider organisation to serve our local community.

1.4.3 Service Development Plans

Working jointly with TSD and alongside local commissioners, our FBC and associated service integration plan, has identified eight initiatives that will in aggregate deliver the fundamental changes to the care model that the community seeks. These initiatives are all aligned with a principle that services should wrap around the person and family to create a single system of health and care delivery, and include:

Single point of contact: Describes the development of a multi-media gateway to both signpost appropriately and to mobilise the appropriate assessment and equipment needed.

Community care – locality teams and community hospital beds: Describes the realignment of community resources to further support the self-care and prevention agenda and to help move from a reactive model of care to a proactive model of care. This may include looking at existing community hospitals and utilising them in a different way.

Frailty service: Describes a whole system pathway of care starting with risk stratification of the top 2% most vulnerable and the close working between the Newton Abbot locality 'Pioneer' hub and the facilities at Newton Abbot Community Hospital linked to the specialist services provided by the healthcare of older people team and the medical admissions avoidance team to better support our cohort of frail elderly patients.

Multiple Long Term Conditions service: Describes a new service for people with multiple LTCs. The aim is to provide 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.

Outpatient service redesign: Describes the development of a number of clinical services with the objective of providing care closer to home, self-care and assessment avoiding multiple appointments per condition.

Referral Management Project: This plan sets out one of the projects from Outpatient service redesign 'in focus.' The intention is to focus on implementing a referral management framework which enables dialogue between primary and secondary care to manage patients in the most appropriate and efficient way and form an integral part of the over-arching community wide strategy for referral optimisation. This will ensure that face to face appointments are no longer the automatic default position and that care plans, advice and guidance or specialist support with an existing care plan can be delivered in alternative ways where appropriate, reducing the waiting time for patients as well as unnecessary trips to the acute trust.

Outpatient Innovation 'In Focus': Muscular-Skeletal Triage: This plan sets out another of the projects from Outpatient service redesign 'in focus.' The project aims to provide a triage service for MSK patients through the community physiotherapy team. The intention is to provide a consistent assessment, active treatment in conjunction with the patient and then any onward referral to secondary being targeted to the right specialist area.

Inpatient Innovation 'In Focus': Heart Failure: This plan sets out one of the projects intending to impact upon inpatients (either reducing length of stay or avoiding an admission.) The project aims to develop a service where patients with heart failure are treated in an outpatient setting rather than the more traditional treatment as an inpatient (national evidence has

demonstrated that a third of current heart failure in-patients can be managed on an outpatient basis).

Through these, and subsequent changes we will deliver care to patients that:

- Identifies those people most at risk, providing early support and, where necessary intervention to effectively manage their condition at its earliest stages;
- Is provided as close to home as possible;
- Still offers swift and effective 'acute care' where it is necessary, but avoids it wherever possible;
- Promotes self-care and self-efficacy, engages the capacity of the voluntary and third sectors and support carers;
- Is integrated at an individual user level to as great a degree as possible – patient-centred coordinated care as recommended by National Voices – bringing together the right services to 'wrap around' the person;
- Is integrated across the range of providers, engaging effectively with service provider partners, e.g. primary care, mental health services, local councils;
- Be accessible and responsive to service users and to health professionals needing advice and support;

In delivering this care model, we expect significant changes in the infrastructure of our delivery system, including:

- Fewer hospital beds and better developed reablement 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, with the aim of enabling continued management of people in the community and avoiding unnecessary referral;
- Local Multi-Agency 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 Information Technology; ensuring that all systems are accessible to all health and care professionals through mobile technology where necessary;
- Educational and information-sharing systems using social media including Hiblio videos for service users and for staff education and support;

This transaction will bring significant benefits to the development of the new model of care, including:

- We can make changes faster - improvements to adult social care, community and acute services will not have to work around organisational boundaries, needless transactions and conflicting incentives.
- We can be more ambitious – by overseeing a wider range of services and involvement in a much greater proportion of the care provided, the scale of potential improvements can realistically be greater.
- We can provide more sustainable clinical solutions where patient benefits and community-wide interests are prioritised above individual organisational concerns.
- We will provide many of the services that will empower individuals to take ownership of their own health and care needs – helping manage demand in the system.
- The single organisation will provide services with more financial stability – thereby securing its position within the integrated care model for local people's future.

1.4.4 Strategy – Assessment and Further Developments During 2014/15

In submitting this 'Strategic Plan for the Year Ended 31 March 2016', the Board has considered whether there has been any changes in strategic, operational or financial performance or in the external environment or policy arena that would question this strategic plan. In overall terms, and far from questioning the strategy, the events and experience of 2014/15 have reinforced the rationale ad need for the service integration described

1.4.4.1 Performance Against the Key Strategic Objective

At the time that the 'Strategic Plan 2014-19' was submitted, the Trust's stated intention was to submit its application to Monitor's Transaction Assessment process in October 2014. However, in the summer of 2014, Monitor revised its assessment policy; moving from a one stage to a three stage process. In discussion with Monitor colleagues in the Provider Appraisal team, the Trust Board agreed a course of action that resulted in a Stage 2 review in October 2014, moving quickly to a Stage 3 in early 2015. This enabled early familiarisation with the proposal and the process for both Monitor and Trust staff, and ensured that, before submitting the Stage 3 documentation, the Trust was able to address any key concerns identified in the Stage 2 process. Although slightly delaying the final submission, the Board is confident that its approach has benefited the assessment process, which is now coming to an end.

1.4.4.2 Trust Performance 2014/15

SDH has experienced a range of performance challenges in 2014/15. These have been analysed in detail, discussed at Board and shared with Monitor colleagues. Key performance variances are as follows:

Four hour ED waiting time standard: In common with many other NHS providers, SDH has experienced significant pressure in delivering the 4 hour standard. These pressures have been particularly acute since January 2014. There are multifactorial and complex reasons for the pressures but most are driven by a change in the shape of demand including age and complexity of the patients presenting.

Chart 1 : Emergency Department Attenders by Age Band

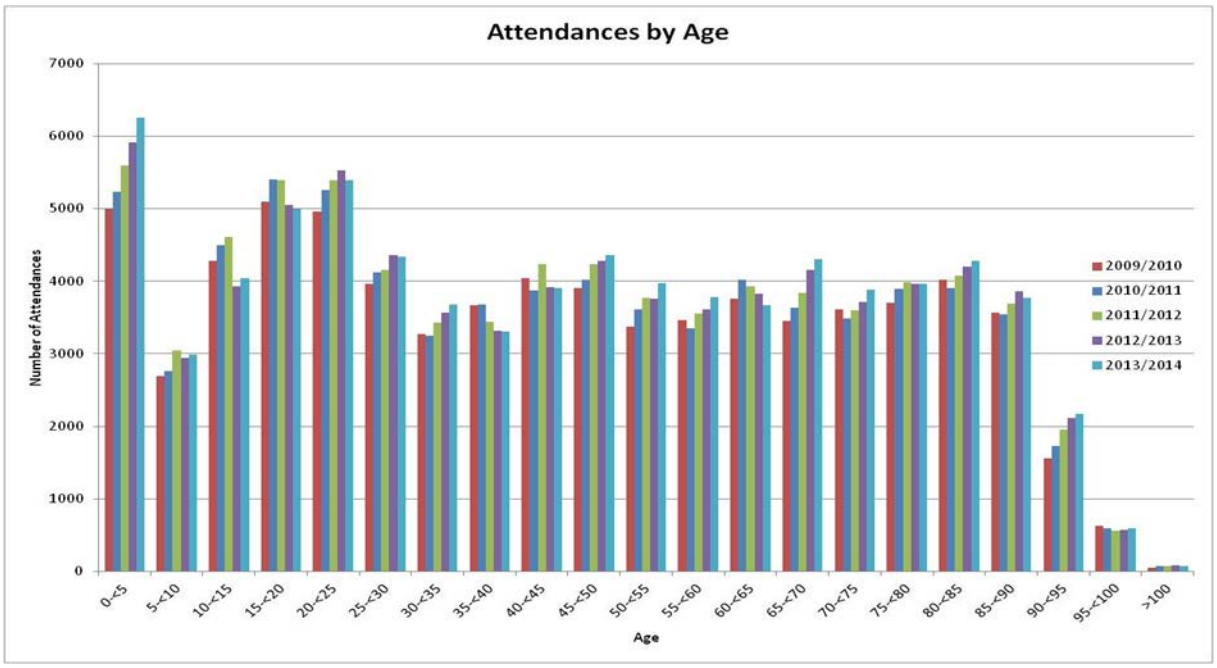


Chart 2 : Ambulance Arrivals in the Emergency Department

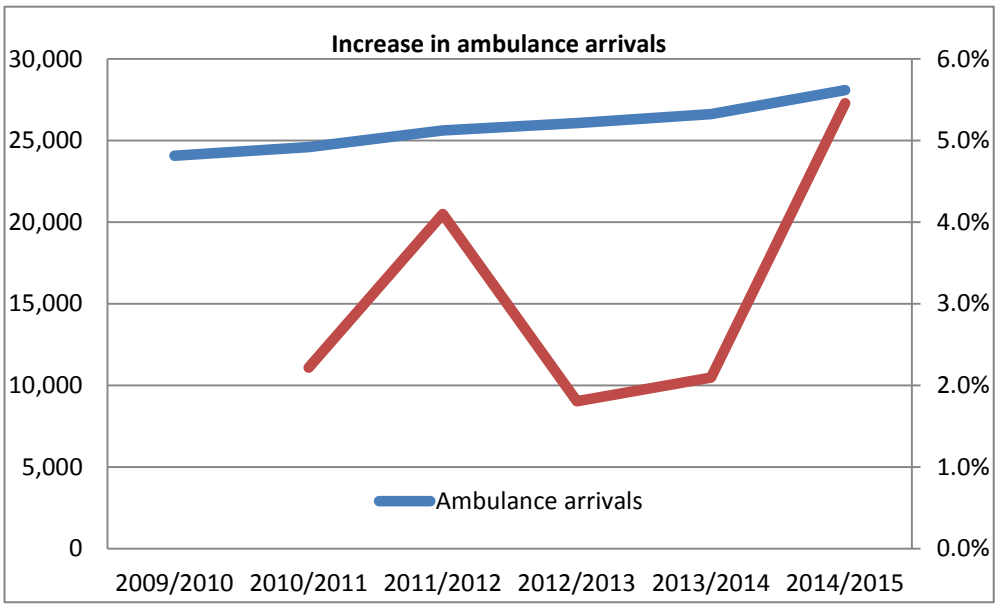
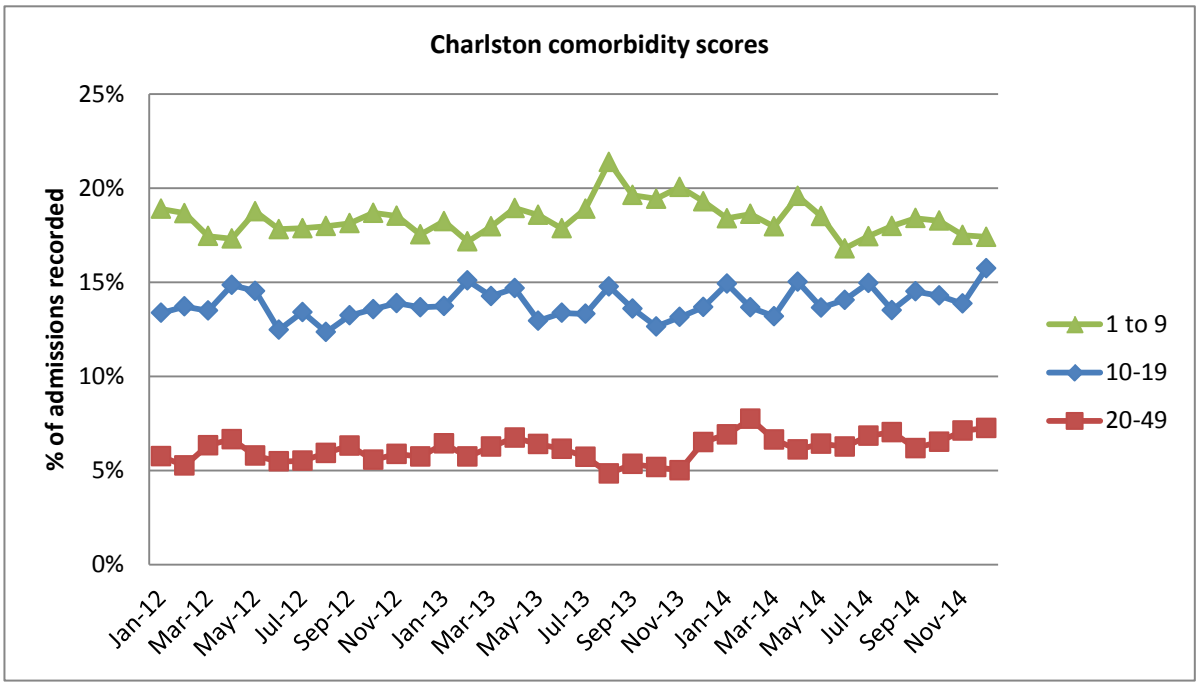


Chart 3 : Charlston Index for All Emergency Admissions



From Charts 1 to 3 above it is clear that the age and complexity of patients presenting in the emergency Department have both increased. Ambulance arrivals, which are a good proxy for case mix had, historically grown at an average of 2.7% until 2014/15 when the growth increased to 5.5%. The Charlston comorbidity index is a predictive measure of mortality for patients who have a range of comorbid conditions. It has been used as a proxy for patient complexity when seeking to understand the pressures services are managing. The above chart analyses all non-elective admissions into groupings of increasing complexity as indicated by the index score, these are then expressed as a percentage of all admissions by month. There may be a discernible trend from January 2014 of the patients with scores indicating increased complexity.

The increased presentation at the 'front door' of the hospital has been matched by a significant increase in emergency admission. In 2014/15 emergency admissions were 6.5% above plan.

Referral to treatment time (RTT) standards: Driven by growth in referral rates, RTT standards in some specialties, particularly Ophthalmology, Dermatology and Plastics, have presented a challenge to the Trust during 2014/15.

In Ophthalmology, growth in referrals for cataracts has been unprecedented over recent months. This is linked to the additional treatments available for macular and glaucoma patients. These positive developments result in more people retaining their sight, thereby increasing the number of patients subsequently developing treatable cataracts. The impact of cataract, glaucoma and macular activity all increasing has been experienced across the NHS provider sector. The resulting pressure on activity and RTT backlog numbers has resulted in the ophthalmology backlog of 18 week RTT patients increasing from 35 in January 2013 to 404 by the 31st March 2015. This specialty now accounts for nearly 50% of the Trusts total RTT backlog.

Pressures in Dermatology are Linked to the NHS "*Be Clear on Cancer*" campaign after which the service along with many others nationally has experienced unprecedented growth. Devon and Cornwall have the highest rates of skin cancer nationally and therefore always have high standardised attendance rates for dermatology. The medical team is small, less than two WTE and has been carrying a vacancy for over a year now. Despite many attempts we have not been able to fill the post. Despite these pressures the team has managed to deliver both the NHS plan cancer standards and the RTT standards. The impact on RTT has however been felt in plastic surgery as the resulting increases in referrals from dermatology feed through to plastic surgery procedures. The impact has been to increase the plastic surgery backlog from 10 in January 2014 to 110 by 31st March 2015. The plastic surgery service is bought in from Exeter and Plymouth Trusts and although additional activity has been sought, these trusts have also had capacity issues and have struggled to respond.

Capacity to treat elective patients has, across all services been affected by reduced bed capacity associated with the significant increase in non-elective admissions

Financial performance: In 2014/15, the Trust posted its first ever deficit. The deterioration in SDHFT's financial performance does need to be seen against a back drop of increasing financial pressure in the acute Trust sector. In Monitor's own portfolio of medium sized acute organisations, of which SDHFT is one, 31 of 38 Foundation Trusts were in deficit at the end of Quarter 3, with a net deficit of £239m. Many of the pressures being described in this paper are common to the wider sector.

Table 1 : SDH Financial Performance 2010/11 to 2014/15

	2010/11 Actual £m	2011/12 Actual £m	2012/13 Actual £m	2013/14 Actual £m	2014/15 Reforecast £m
Income	211.3	219.4	231.7	241.0	243.7
Expenditure	(196.4)	(202.9)	(217.5)	(228.1)	(233.7)
Financing costs	(13.3)	(26.8)	(15.2)	(14.4)	(14.5)
Net surplus / (deficit)	1.6	(10.3)	(1.2)	(1.5)	(4.6)
Impairment	0.9	15.3	3.8	2.2	0.5
Normalised	2.5	5.0	2.6	0.7	(4.1)

The deterioration in financial performance, starting in 2013/14 but more particularly in 2014/15 is clear in Table 1 above. Key points in driving this position are as follows:

- CIP targets have been delivered in all years up to 2013/14, although the proportion delivered non-recurrently has grown throughout the period.
- Up until that point it was possible to compensate each year through achieving a rate of growth in income that offset the efficiency requirement implicit in the national tariff,
- That rate of income growth slowed slightly in 2013/14 and dramatically in 2014/15, largely as a result of the tariff for emergency admissions,
- In parallel, CIP delivery has become more challenging, which particularly reflects the challenge of reducing front line pay costs in the face of significant operational pressures,
- Not only that, but in 2014/15 the Trust has experienced significant cost pressures, largely in the form of agency staffing, in opening escalation capacity and temporarily filling vacancies in posts to which proven difficult to recruit but remain critical to delivering on operational standards,
- These pressures are felt most severely in the urgent care system and, consistent with this picture, SLR data clearly shows increasing losses accruing in those specialties that manage the bulk of the Trust's emergency admissions.

Common thread: There is a clear common thread running through this analysis of the Trust's performance. Increasing demand driven by an ageing and more complex population have placed significant pressure in a range of services; the immediate impact has been manifest in a failure to achieve core waiting times standards. With much of this pressure in urgent and emergency care, the associated growth in income has not covered the cost of meeting the additional demands, creating financial pressure. A reduced capacity to deliver CIP when core services are under such pressure has exacerbated this position.

The Integrated Care Organisation represents a solution to many of these problems. Service developments are designed to reduce demands on traditional secondary care services. The strategy clearly remains relevant and the service pressures that it is designed to resolve have, if anything increased during 2014/15 and made its delivery all the more important.

1.4.4.3 External Environment

The landscape of provision within the local health and care system remains unchanged. There are no new entrants or significant changes in the balance of referral between providers that changes the strategy as currently defined.

In the commissioning environment, there is growing financial challenge. Modelling included in the FBC shows that acute income, calculated under the national draft tariff published in January, being significantly in excess of the value proposed in the LTFM. After 5 years tariff based income exceeds the agreed resource envelope by some £14m.

The management of the cost base in the ICO will make it possible to discount income levels, more closely matching CCG affordability envelopes year on year and therefore significantly reducing risk. In that context, a national tariff based contract does not create the right incentives for the ICO. We are looking to incentivise investment in preventative services, development of proactive community based support services and to reduce acute admissions. The Trust and its Commissioners have, therefore developed a Risk Share Agreement, whereby variance from the planned LTFM income position (both adverse and favourable) are shared equally.

The potential gap between a tariff based contract and the proposed resource envelope has widened under the recently adopted Enhanced Tariff. The Trust's current contract proposal for acute services is a gross value of £160.4m supplemented by transitional support of £4.3m; a total of £164.7m for 2015/16. Predicted volumes at national tariff amount to a little in excess of £168m.

The ICO model is intended to minimise the cost of system delivery. The more challenging resource position of our main commissioner and the destabilising impact upon them of the Enhanced Tariff, makes its delivery and the roll out of the risk share agreement the most significant contributor to the financial health of the wider health and care system.

1.5 Delivery of the Strategy

1.5.1 Delivering the Service Model

The Trust's strategy to create an ICO will deliver with the service model established in the Five Year Forward View. The plan has been developed in partnership across the local health and care system, with full engagement and support from providers – SDH and TSD – and commissioners, both South Devon and Torbay Clinical Commissioning Group and Torbay Council.

The key service developments that will deliver the ambition of the Five Year Forward View have been summarised in Section 1.4.3 above. The outcome of this programme will be to ensure delivery of care standards in large part through reshaping demand, dealing with more patients in a community setting and reducing demand on the most expensive acute facilities. Table 2 below sets out the expected reductions in demand, which represents the key goal over the next five years, with much of the impact driven through actions planned in 2015/16.

Table 2 : Impact of Care Model on Hospital Based Activity

		Baseline (2014/15 FOT)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
A&E attendances	**Demand without ICO**	**80,972**	**81,931**	**83,537**	**85,142**	**86,748**	**88,353**	**89,959**
	ICO impact	-	(8,485)	(25,454)	(33,938)	(33,938)	(33,938)	(33,938)
	Demand with ICO	**80,972**	**73,447**	**58,083**	**51,204**	**52,810**	**54,415**	**56,021**
Non-elective admissions	**Demand without ICO**	**34,713**	**35,071**	**35,416**	**35,780**	**36,158**	**36,550**	**37,001**
	ICO impact on Care Homes	-	(188)	(563)	(750)	(750)	(750)	(750)
	ICO impact on LTC	-	(927)	(2,782)	(3,709)	(3,709)	(3,709)	(3,709)
	ICO impact on MH	-	(36)	(107)	(142)	(142)	(142)	(142)
	ICO impact on emergencies	-	(102)	(307)	(409)	(409)	(409)	(409)
	Demand with ICO	**34,713**	**33,818**	**31,658**	**30,770**	**31,148**	**31,540**	**31,991**
Outpatient attendances	**Demand without ICO**	**408,594**	**412,479**	**422,172**	**431,864**	**441,557**	**451,249**	**460,942**
	ICO impact	-	(7,493)	(22,478)	(29,971)	(29,971)	(29,971)	(29,971)
	Demand with ICO	**408,594**	**404,987**	**399,694**	**401,893**	**411,586**	**421,278**	**430,971**

The Trust has developed a detailed Post Transaction Integration Plan, which includes detailed plans as to how the service developments described in this document will be delivered. Full details of the schemes summarised here, including costings, staff implications and key performance indicators can be found in that document. Table 3 below sets out the key measures of success.

Table 3 : Key Performance Indicators

Critical success factor	Key Area	Key measurable outcomes *(refer to metrics section 7.5)*
maintain and improve the **quality of health and care outcomes** delivered for the community it serves, reflecting the changing nature of the community's needs	Care Model	Reduced length of stay Reduce mortality Reduce morbidity Earlier diagnosis and intervention Empower people in their own self care
move the balance of services away from reactive to proactive, with a **greater focus on prevention and self-management**	Care Model	Improve identification of people at risk Earlier diagnosis and intervention Screening uptake Reduced demand
provide services in the most appropriate locations, as **close to patients homes** as possible;	Care Model	Increase access to remote care and 24/7 Reduce hospital admissions Reduce outpatient appointments Reduced length of stay
reduce interfaces between separate health and care services, within and without the ICO;	Care Model	Joined up teams Reduced number of info systems Single care record Reduce multiple patient histories Reduced handovers
meet all **mandatory performance and financial targets**	Org Integration and Care Model	Continue to deliver against targets throughout organisational change
manage increasing demand within a restricted cost base, with greater flexibility to invest resources for the benefit of the community;	Organisational Integration, Corporate Service Developments and Care Model	Demand reduction Change nature of demand Increase productivity "System pathways" Costs contained within resources Pooled budgets Reduce back office costs
develop an appropriately **skilled and dedicated workforce**	Organisational Integration and Corporate Service Developments	Workforce satisfaction Complaints and significant events Temporary staffing levels

The planned transformation of service is expected to drive significant financial benefit, largely driven by the reduction in acute capacity – both beds and clinics. Most significant is the impact of the Frailty Services and their impact on both the numbers of patients admitted to the acute setting and their length of stay. In total, we expect to be able to close a total of 62 beds across our health and care system. This represents another key strategic target for the organisation. In total, once fully implemented gross savings are expected to amount to £12.4m.

Investment is required to effect these changes. In broad summary, investments are required principally in community based staff and packages of care, designed to maintain patients in their own homes for longer. Investment is also required at the 'front door' of the hospital to enable rapid diagnosis and the earliest discharge to these community based services.

Table 4 below summarises the savings and investments by scheme, and the resultant net saving of £6.4m which is expected to be delivered in full by 2017/18. This table describes the ways in which we expect to re-allocate resources across the health and care system to achieve long term sustainability.

Table 4 : Financial Impact of Care Model

	Activity Change			Savings		Investments		
Element	Bed Reduction	ED Attendance Reduction	Outpatient Appointment Reduction	Pay	Non Pay	Pay	Non Pay	Net impact
				£	£	£	£	£
3a Acute Frailty	24	4,000	-	893,405	169,743	849,224	-	
3b Community frailty	-	-	-	175,000	-	310,000	-	
3c Single Point of Contact	-	-	-	-	-	-	20,000	
3d Community Localities	-	-	-	383,790	63,980	425,580	610,332	
3e Community Hospitals	18	3,000	-	2,016,579	1,318,105	-	101,000	
4a – e Acute Innovations	15	24,000	29,500	4,767,850	1,683,171	1,374,420	30,000	
MAAT	8	4,000	-	399,196	65,543	289,312	10,000	
Intermediate Care	-	-	-	-	499,276	-	-	
A&E Investment	-	-	-	-	-	1275,000	-	
Medical skill mixing*	-	-	-	-		-	-	
TOTAL	**65**	**35,000**	**29,500**	**8,635,820**	**3,799,818**	**5284,772**	**771,332**	**TOTAL**
				TOTAL £12,435,638		**TOTAL £6,055,804**		**£6,379,834**

In addition to the efficiencies driven through the care model, there will be additional savings achieved through the further merger of back office functions. Relatively modest in comparison to some transactions, and largely reflecting the existing scope of collaboration between the two organisations, the expected savings are set out in the table below.

Table 5 : Corporate Department Efficiencies

Headline project	Net saving
Estates and facilities management	£362k
IT*	£167k
Finance	£326k
Performance information	£140k
Procurement	£44k
Board, corporate governance and risk	£383k
HR	£564k
Total	**£1,891k**

1.5.2 Efficiency Measures

Alongside the efficiencies and benefits driven through the care model and the effect of organisational integration, the Trust is targeting a CIP programme of £15.7m across the combined organisation.

Table 6 below sets out the key themes of the programme:

Table 6 : CIP Programme

Theme	Target Areas for Savings	Theme Total £'000
Bank and Agency Reduction	Bank and Agency Reduction	£1,020
System Efficiencies	Discretionary spend	£2,833
	Staff Salary Sacrifice Car & Shopping Vouchers	
	Printing and Electronic Communication Strategy	
	Budget Slippage	
	Microbiology VAT saving	
	Leave Accrual Released to I&E	
EFM	EFM Savings	£347
Income	Private Treatment	£795
	Additional income via Utilisation of new Cardiac Lab	
	Increasing market share	
	eLearning Strategy	
	Bowel Scope	
	Use of Estates out of hours	
	On-line medical sales	
	Private Therapy Income	
	Advertising on Trust premises / vehicles	
	Additional clinical income thru commissioning opportunity	
	Car Washing in Car Parks	
Process Improvement	Outpatient Productivity	£213
	Improved clinical pathways	
	Reduce internal drug spend - Troponin	
	Open Access to Plain Xray	
Procurement	Drug savings	£1,294
	Procurement efficiencies	
	Procurement PPSA Savings 2015/6	
	Clinically led procurement	
	Challenge all supplier contracts	
	Reduce Lab Consumable costs	
	Bulk Buy Consumables	
Workforce	Workforce - Benchmarking	£1,460
	Medical Workforce Productivity	
	Nursing Workforce Productivity	
Community Services	Income generation	£3,133
	Productivity	
	Non-Pay	
	Community hospitals	
	Community staffing	
	Corporate	
Adult Social Care	Eligibility	£3,900
	Domicillary care contract	
Other		£250
TOTAL		**£15,244**

1.5.3 Investments in Infrastructure

The Trust has a significant programme of investment planned in 2015/16.

1.5.3.1 Torbay Pharmaceuticals

The development of Torbay Pharmaceuticals remains a key strategic priority for the Trust.

The new facility built during 2014/15 to support the ongoing expansion of Torbay Pharmaceutical has now largely completed its fit out and is beginning the process of regulatory checks and approval. A detailed transfer plan has been developed, under which manufacturing services will move to the new unit in the Autumn of 2015, and be fully operational from January 2016.

1.5.3.2 Major Estates Projects

The Trust has secured loan financing for, and will start work on three major projects in 2015/16.

The re-provision of the Critical Care Unit at Torbay Hospital has been a long standing priority for the Trust. The environment in the existing facility does not meet current standards and we will need, over the next three to five years to increase the numbers of critical care beds available to our population. A key tenet of the ICO plan is to have a smaller hospital, but its patients will be the most acute and complex. It is essential that we have sufficient capacity to care for those who are critically unwell.

The Trust will be replacing its Linear Accelerators in a programme beginning in 2015/16. The current machines are nearing the end of their reliable life. Estates works to create bunker capacity will be completed in 2015/16 alongside the installation of the first replacement machine. The second will follow in 2016/17.

The Trust will also be extending its car parking capacity in 2015/16. An inability to find a car parking place remains the most significant source of complaint from our public and has been a key priority for Governors for some time. Planning permission has now been granted and works will complete in 2015/16.

1.5.3.3 Community Infrastructure

We plan to develop the current community bed stock to support the changing model of care, reducing the reliance on beds as we provide more care as close to home as possible. The plan includes streamlining and increasing the efficiency of existing Minor Injury Units, reducing the number of 'sub-acute' beds and introducing more 'rehabilitation units' in localities with a lack of Nursing Home/intermediate care bed availability.

This development is working in conjunction with the SDTCCG consultation plans with each of the 5 localities, which commenced in Dec 2014, so that the needs of the population are met with more streamlined and efficient facilities to support this.

1.5.3.4 Information Technology (IT)

There are significant investments required in strategic IT infrastructure that will support the delivery of 'out of hospital' based care. Most significant, and delivered in 2015/16, will be the development of a clinical portal. Critical to the success of a care model that treats patients outside of the acute hospital is rapid access to appropriate information where and when it is necessary. The clinical portal enables, through mobile technology, all systems within our system – GP, hospital and community care – to be accessed by appropriately authorised staff from any location.

Other supporting development planned to commence in 2015/16 include:

- The installation of a new Emergency Department system, that will work across the main ED and all minor injury units
- The development of a Single Community Care record for community services
- The implementation of an electronic prescribing system that will operate across the whole health care system, including primary care.

1.5.4 Delivering the Proposed Transaction

SDH continues to work towards a 'go live' date for its proposed transaction of 1 August 2015.

The key dates in the timeline for this approval are as follows:

- TDA Gateway 3 (provisional) — 21st May 2015
- Monitor Board to Board — 29th May 2015
- Provider Appraisal Committee — 16th June 2015
- TDA Gateway 3 (back up) — June 2015 (precise date to be confirmed)
- TDA Gateway 4 — 23rd July 2015

The TDA has established a governance structure around the transaction which is progressing well. The first meeting of the key oversight group – the Transaction Board – was held on 13th May 2015. Beneath this, there are legal, finance and quality and safety groups each meeting regularly.

The Trust has proposed a financing package that will be required for the transaction to proceed. The TDA, from their review process have confirmed their agreement with the quantum being requested. Negotiations are moving forward, now being led by the Transaction Board but, at the time of submitting this plan have not been concluded.

The proposed financing package is as follows:

Trading Risk in Torbay & Southern Devon Health and Care Trust: The trading position of TSD, despite submitting a breakeven plan for 2015/16, holds significantly more risk than that predicted at the outset of the transaction process. Exposure to this risk will detract from the ICO's ability to invest in delivering critical service model changes that will ensure long term system viability.

We currently predict a shortfall in 2015/16 (£4.0m) and 2016/17 (£2.6m) totalling £6.6m.

Investment in Transaction Delivery: SDH has absorbed significant costs of progressing the transaction, costs that have been recognised by Monitor as 'exceptional' for reporting purposes. These amount to £1.5m and have absorbed cash that would otherwise have been available for investment in delivering service change.

Investment in Service Transformation: As an acquiring Trust, SDH recognises the significant change management associated with such a significant redesign of care models and systems. To under-resource this change would jeopardise the realisation of benefits critical to success. The importance of this aspect of the case was identified by professional advisors and stressed by Monitor during the Executive Challenge meeting conducted in concluding their Stage 2 review of the transaction in December 2014.

The estimated costs of transition are in the table below. Broadly they include project management office (PMO), delivery team, project delivery cost and other programme wide cost. With our proposed care model being entirely congruent with the Five Year Forward View, SDH initially submitted a bid against the Transformation Fund, intended to support health communities in developing care systems of this nature. We believe that our plans map well to the draft criteria for the fund that are currently in circulation. Our bid was submitted in the 'Smaller Viable Hospitals' category.

Unfortunately the decision timetable for this category has been delayed. The FT has engaged through both Sam Jones, Director of the Future Models of Care Programme and NHS England Area and Regional Directors in an attempt to progress funding through this route. We are awaiting a formal response but, informally understand that no decision is likely until at least June 2015. In the interim, the Chair of the Transaction Board has agreed to progress alternative sources of funding with NHs England on our behalf.

In total, transition costs amount to £12.3m over six years as follows:

Table 7 : Transformation Costs

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
PMO	£225,917	£225,917	£225,917	£225,917	£225,917	£225,917	£1,355,503
Delivery team	£1,012,278	£952,876	£893,474	£687,554	£687,554	£0	£4,233,736
Project delivery costs	£2,989,725	£2,887,225	£600,000	£0	£0	£0	£6,476,950
Other costs	£115,000	£40,000	£15,000	£15,000	£0	£0	£185,000
Total	£4,342,920	£4,106,018	£1,734,391	£928,471	913,471	£225,917	£12,251,188

Working Capital: To maintain a liquidity rating of 3 throughout the LTFM period, and to ensure sufficient liquidity to effect changes as planned, SDH will, to supplement these funding sources seek to secure a working capital loan of £6m in FY 2016/17.

In addition, the FT has assumed early settlement of long term client debt, amounting to £2.3m from Torbay Council as part of the LFTM. In the event that this is not secured an additional working capital facility of that value would be required.

At present, the required financial support is reflected in the Trust's LTFM on the following basis:

- £8.2m of PDC, nominally linked to the TSD trading risk
- £12.2m of revenue grant to cover service transformation
- £6m working capital loan

Negotiations are expected to conclude over the coming weeks. The Trust has set out a number of alternative funding scenarios that can be accommodated within the LTFM. In the event that the final package varies from that described at present a revised LTFM can be submitted.

The Council of Governors have been engaged throughout the development of the acquisition proposal. They have considered the FBC in some detail; writing formally to the Chair with 'in principle support' subject to the receipt of a satisfactory risk rating from Monitor.

1.6 Plan for Short-Term Resilience

1.6.1 Quality Priorities

The trust has identified five quality improvement priorities for the year. These have been developed through discussions with clinical teams, care colleagues, our commissioners and the senior clinical and business leaders in our organisation.

In recognition of the development of a joined-up care system we have worked closely with the TSD to develop a shared set of improvement priorities. We have also taken into account the views of key stakeholders when discussing and agreeing the priorities for 2015/16. These priorities have been signed off by both Trust Boards.

1.6.1.1 Priority 1: Redesigning the reliability, accuracy and timeliness of information at the point of handover

During a patient's stay it is often necessary to transfer the care of that patient to another hospital, care agency and/or another department/ward within the hospital. These hand overs are described as a transfer of care and, as such, need to be planned and properly performed to ensure the patient's wishes and safety remains paramount. Evidence has shown that poor communication at these handovers can have detrimental effects on the patients' health and harm can occur e.g. medications not being sent with patients and next of kin details not available

The aim of this initiative is to design a reliable and capable process, for these transfers that involves the patients and carers, health professionals and relevant agencies in passing on and receiving the relevant information, medication and equipment at each and every juncture. It is being designed in collaboration with acute and community hospitals, community care providers, patients and family members and the relevant multidisciplinary teams across a number of health sectors in producing a transfer care bundle that is fit for purpose, understandable and completed in a timely and reliable way.

Objective 2015/16: create & test a 'transfer of care bundle' across a number of pathways with direct patient/carer involvement

Individual objectives.

- Understand the size, number and scope of transfers within the health and care community and the issues that affect the transfer
- Design in, direct patient, relative and carer involvement
- Design a 'transfer of care bundle' and test extensively making changes and re testing based on in situ learning

1.6.1.2 Priority 2: Establish a single point of contact for people to access community based health and social care services

The aim of this new service is to make it as easy as possible for people to access the advice, assessment and support which they need over the telephone This will include providing information about local services as well as undertaking assessments with people while they are on the 'phone and agreeing to arrange and provide support and assistance at home on the basis of the telephone call. The service will also provide people already receiving services with a direct line of communication if they want to discuss any aspects of those services or have concerns about the care they are receiving.

The new service (SPoC) will also support health and social care staff working out in the community by co-coordinating and arranging services to provide urgent care and support at home to avoid the need for someone to be admitted to hospital or a care home. The SPoC and Care Direct Plus, which already serves Southern Devon, will provide support for people who are likely to need one off or short term interventions and would not normally need to be visited at home as part of the assessment process.

Objective 2015/16: set up a single point of contact service (SPoC) in Torbay.

Individual objectives:

- Set up the single point of contact for Torbay.
- Set up a Directory of Services that contains up to date information about the services and support which are available to people in Torbay.
- Measure and monitor the changes and evaluate the first year of its operation. People who use this service will be involved in the evaluation process.
- Develop linkages between the single point of contact service and specialist long term condition services based at Torbay hospital.
- Improve the understanding of the aims of the single point of contact service and Caredirect Plus service with the Torbay hospital ward hospital and the long term condition specialist teams.

1.6.1.3 Priority 3: Improve the involvement of carers in the management of medications on admission and at discharge

We believe that carers are key member of the health and care team and we are committed to improve the involvement of all carers in all aspects of a patient's journey. Carers are often the people who know their family members best and are an invaluable source of support and information. Information sharing is a two way process. Clinical staff need to understand a patient's background, their health, and if admitted to a hospital, any medications being taken. For carers, prior to their loved ones discharge, they need information about changes to medication regimes, possible side effects and methods of

administering the drugs.

Feedback from the national NHS inpatient survey tell us that most hospitals perform poorly in ensuring people are given appropriate information about medications at discharge. We have chosen to focus on working with carers and build on the good work in 2014/15

Objective 2015/16: to test the process for identifying and involving carers in medicines reconciliation

Individual objectives:

- Design a reliable process to identify carers when patients are admitted to a ward in a community hospital or at Torbay Hospital.
- Design and test with carers, pharmacy and the ward teams a reliable process to involve carers in medicines reconciliation on admission.
- Design, test and develop a process to include carers' involvement in discharge medication regimes including medication changes, side effects and modes of administration.

1.6.1.4 Priority 4: improve multi-agency working across Torbay and South Devon

Multi-disciplinary teams typically include community nurses, physiotherapists, occupational therapists and social workers. Their joint aim is to provide people at risk of admission to hospital or care homes with the intensive support they need to remain living safely at home.

These multi-disciplinary teams will complement the work of the Single Point of Contact Service in Torbay and Care Direct Plus in South Devon. The multi-disciplinary team will provide support for people whose circumstances are uncertain or require face to face contact to assess their needs and coordinate the care they need.

Objective 2015/16: Develop and extend the multi-disciplinary teams in Torbay and the complex care teams in South Devon, through integrated working with clinicians in Torbay Hospital and developing closer working relationships with other local services. This includes GPs and local voluntary organisations.

Individual objectives:

- Set up two multidisciplinary teams, one for Torquay and one for Paignton & Brixham.
- Pilot in at least two localities (one in Torbay and one in South Devon) to see how these multidisciplinary teams can be supported by specialist teams. This may involve moving out-patient clinics and other clinical support activities out into the community from Torbay hospital.
- Pilot in at least two localities how these enlarged multi-disciplinary teams can work in partnership with other local services, including general practice and voluntary organisations.
- Measure, monitor and evaluate the changes included the impact of the enlarged multi-disciplinary teams on patient/client experience. People who use this service will be involved in the evaluation process.

1.6.1.5 Priority 5: create a reliable and consistent ambulatory emergency care service available 7 days a week

The underlying principle of ambulatory emergency care is that a significant proportion of adult patients requiring emergency care can be managed safely and appropriately on the same day either without admission to a hospital bed or through admission for only a few hours. Nationally many organisations have implemented ambulatory emergency care as part of an action plan to address the non-achievement of the 4-hour standard in A&E. Ensuring 98% of patients spend less than 4 hours in the emergency department has been a significant challenge for the Torbay hospital, particularly over this last year. 32

As part of a larger piece of work to try and address this problem and to improve the patient experience of emergency care, small tests of change have been in operation on the two Emergency Assessment Units since July 2014.

Our plan is now to expand the ambulatory emergency care service to ensure only those people who require bed based care are admitted and ensuring medical patients receive assessment by a physician as soon as possible after attending. In addition it is anticipated that this will significantly improve patient flow through the emergency department and healthcare system.

Objective 2015/16: create a reliable and consistent ambulatory emergency care service available 7 days a week

- Provide an Ambulatory Emergency Care Unit comprising 8 chairs, 4 trollies within 2 bays on an Emergency Assessment Unit that will be open 7-days a week.
- Reduce the proportion of medical patients requiring an overnight stay when safe and appropriate to do so.
- Improve the experience of emergency care for medical patients seen within the Ambulatory Emergency Care Unit.
- Reduce the number of bed days utilised by patients with ambulatory case sensitive conditions.
- Contribute to an improvement in patient flow through the emergency department as measured by achievement against the 4-hour standard.

1.6.1.6 CQUINN Targets

SDH and TSD have agreed a joint CQUINN programme with South Devon and Torbay Clinical Commissioning Group. The programme is summarised in Table 8 below.

Table 8 : CQUINN Programme

Number	Goal Name	Description of Goal	CQUIN
1	Acute Kidney injury	Improvement in recording AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge,	National
2	Sepsis	Improvement in sepsis screening & antibiotic administration	National
3	Dementia & delirium	Improvement in dementia & delirium screening, assessment & management alongside improved staff training and support for carers	National
4	Unplanned emergency care	Reduction the Proportion of Avoidable Emergency Admissions to Hospital & Improvement in recording diagnoses and Re-attendance Rates of Patients with Mental Health Needs at A&E	National
5	Nutrition & hydration	Improvement in nutrition & hydration care system wide	Local
6	Incident investigation	Improvement in incident investigation care system wide	Local
7	Patient experience	Improvement in patient experience care system wide	Local
8	Staff experience	Improvement in staff experience care system wide	Local

1.6.2 Operational Requirements

1.6.2.1 Resource Plans

Activity plans, designed to achieve the national standards, have been developed with input from the each Directorate within the Trust and from our Commissioners. These have been agreed using a full year's activity to August 2012 and set at a level which is intended to reflect a continuation of historic referral, conversion rates, waiting lists and activity. Growth in referral has been modelled in line with current experience and reflecting changing demographics. Non-recurrent activity has then been added to reflect the need to reduce the total waiting list in order to sustainably achieve the 18 week RTT standard. This has added significant volumes in a number of specialties, mainly Ophthalmology.

The ICO will also, for the first time report community activity. Data quality is limited with significant amounts of manual records in use. TSD is seeking to implement a community IT system that should improve the quality of data supporting community activity. Information is reported from Quarter 2, with the Quarter 2 position representing a consolidation of the half year post transaction.

Table 9 below summarises the activity plan agreed with Commissioners:

Table 9(a) : Activity Plan - Acute

Activity - Acute & Specialist		Out-turn Year Ending 31-Mar-2015	Plan Q1 Quarter Ending 30-Jun-15	Plan Q2 Quarter Ending 30-Sep-15	Plan Q3 Quarter Ending 31-Dec-15	Plan Q4 Quarter Ending 31-Mar-16	Plan Year Ending 31-Mar-16
Elective inpatients	Spells	4,935	1,333	1,342	1,295	1,355	5,325
Elective day case patients (Same day)	Cases	31,778	8,139	8,352	8,873	8,805	34,169
Non-Elective	Spells	33,200	7,628	8,189	8,361	7,803	31,981
Outpatients - first attendance	Attendances	87,851	23,472	23,529	24,099	22,972	94,072
Outpatients - follow up	Attendances	213,757	57,253	57,736	61,314	58,275	234,578
Outpatients - procedures	Procedures	69,416	17,653	17,951	18,752	17,695	72,051
A&E	Attendances	78,163	20,848	21,276	19,179	18,614	79,917

Table 9(a) : Activity Plan - Community

Activity - Community	Plan Q1 Quarter Ending 30-Jun-15	Plan Q2 Quarter Ending 30-Sep-15	Plan Q3 Quarter Ending 31-Dec-15	Plan Q4 Quarter Ending 31-Mar-16	Plan Year Ending 31-Mar-16
Total number of contacts		212,499	97,475	97,475	0

Informed by this baseline, future growth expectations, the impact of both CIP and the care model changes described earlier in this document, the Trust has compiled a detailed workforce plan for the next five years. The expected workforce numbers for 2015/15 are set out in Table 10 below.

Table 10 : Workforce Plan

	Out-turn Year ending 31-Mar-15	Plan Q1 Quarter Ending 30-Jun-15	Plan Q2 Quarter Ending 30-Sep-15	Plan Q3 Quarter Ending 31-Dec-15	Plan Q4 Quarter Ending 31-Mar-16
Analysis of Workforce Numbers					
Medical and Dental staff	425.0	460.7	470.9	470.9	470.9
Registered Nurses, midwives and health visiting staff	848.5	886.4	1,284.3	1,274.4	1,270.3
Qualified Scientific, Therapeutic and Technical Staff	698.8	749.4	1,053.0	1,050.7	1,050.7
Support to clinical staff	486.4	478.0	910.0	903.9	899.8
Managers and Infrastructure Support	1,315.0	1,303.8	1,725.5	1,702.7	1,690.0
Total WTEs	**3,773.7**	**3,878.3**	**5,443.7**	**5,402.6**	**5,381.7**

The workforce challenge in creating the ICO is to be increasingly effective in the use of our shared people resources, in the context of national recruitment and retention challenges in key professional employment markets. This can be done by making improvements to the model of care through integration as described in this business case.

Our strategy includes:

- Equipping our leaders to develop the organisations effectiveness and to lead a consistent health and care system as one joined up organisation;
- Further develop our culture in line with the laws of integrated care to live the values and behaviours, manage risk and deliver one system to patients removing perceived barriers;
- Realign and flex our people resources from an acute hospital setting to community settings to support Mrs Smith and her family in the community. To facilitate care and treatment closer to home and develop our peoples thinking about flexibility in working across settings. This includes giving a greater provision of specialist medical support in community settings closer to home ;
- Make changes to the ratios between our registered and non-registered roles away from a very profession centric workforce to one of skilled care workers to provide career progression, to manage supply issues in the employment market, provide career pathways and use our resources more effectively;
- Introduce new and different generic role designs at both a professional level e.g. Associate Physician and care worker level, alongside the developing multi-agency teams. This particularly relates to more joint health and social care roles to work across settings to facilitate quicker personalised and joined up care e.g. rehabilitation support workers. This also involves having skilled people in roles which enable rapid, proactive and appropriate assessment and care planning that enables the most effective and relevant package of support to be delivered to the individual in the correct setting or referral to other agencies;
- Educating, developing and training our workforce to take a holistic, preventative approach to caring for people in all settings;
- To ensure efficiency and system gains in respect of people resources in particular support functions are delivered e.g. through shared service. Such gains in expansion of skills and knowledge can only benefit the wider organisation and have a positive effect on the effective implementation of the Care Model.

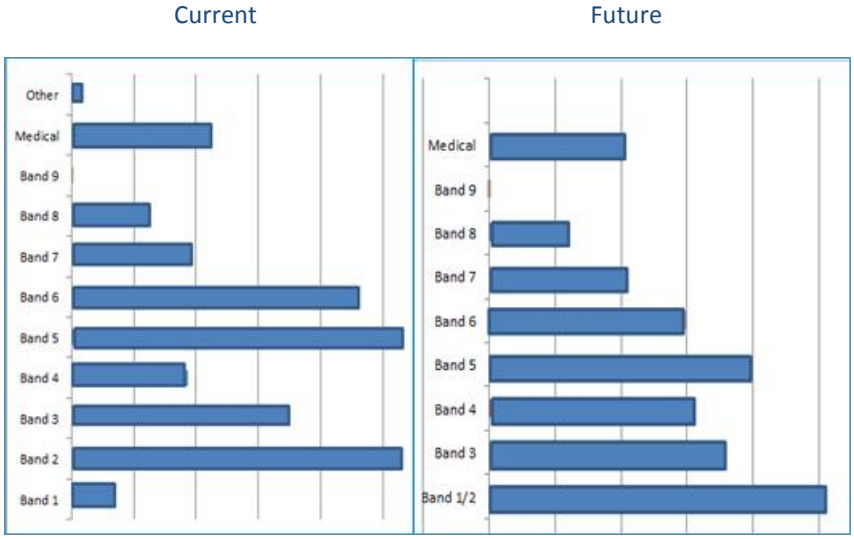
The current overall picture for the workforce for both SDH and TSD shows that the current design heavily relies on professional roles. There is potential within the workforce to reduce the number of roles and create progression routes through the organisation into professional roles with a more balanced design. The organisation can do this by introducing skilled workers and introducing new and different specialist roles to support specialties e.g. physicians associates and advanced nurse practitioners. Therefore our objectives will be to develop career progression routes and change the skill mix of the organisation to unlock potential and manage capacity whilst realising savings.

Our ambition is to change the shape of the workforce, improving skill mix, reducing numbers and introducing new and differently configured role types. We will use the King's Fund service design principles in which act to achieve this aim. The key changes to workforce and assumptions are:

The Care Model will require up front start up investment and additional posts in year one and two posts;

- The decrease in demand for inpatient services, lengths of stay and reducing growth in outpatient appointments in the acute setting will allow realignment of medical, registered nursing, clinical support posts to the community setting. Revised skill mix expectations are set out Chart 4 below.
- There will be a shift from qualified to skilled staff in realigning posts to community settings;
- Development of Single Point Of Contact (SPOC) will result in realigning and reducing staff. Set up of SPOC will realign the workforce currently within community services teams.
- Increased utilisation of staff across the whole health and social care system to prevent referrals and admissions will lead to efficiency savings in WTE over five years
- Proportionally more CIP Saving and Care Model Saving in corporate services functions;

Chart 4 : Workforce Skill Mix



Plans to develop the estates and IT infrastructure are included in section 1.5.3 of this plan.

1.6.2.2 Key Performance Risks

Emergency Department 4 Hour Standard: In July 2014, the Trust and our local CCG asked for support from the NHS Emergency Care Intensive Support Team (ECIST). The report from ECIST resulted in the Trust developing an extensive action plan which is being managed through the local system resilience group. The Trust has also secured on-going support from ECIST and through membership of the ambulatory care network.

The action plan is owned by the Trusts Chief Operating Officer and overseen by the governed local System Resilience Group supported by the Urgent Care Board.

As an illustration some of the key actions already in place are:

- Establishment of an Acute Medical Unit to receive direct admissions from GPs
- Establishment of short stay paediatric assessment unit;
- Review use of medical time to maximise shop floor cover' ambulatory area, discharge lounge, and clinical decision unit, particularly during evenings and weekends;
- Collaborative work with the GP out of hours service and GP's from the CCG to support the department at peak times;
- Further development of the Psychiatric Liaison Service;
- Fast track models for specific conditions including fractured neck of femur and stroke;
- Investment in discharge management and social care capacity.

The operational team across the hospital continues to adapt and respond as quickly as possible to support improvement to the patient experience in ED. The Trusts main CCG commissioner has agreed a trajectory for improvement that delivers the standard by the end of July 2015.

Performance standards have improved considerably during April and May of 2015/16 and the Trust is forecasting sustainable delivery from Quarter 2.

Referral to Treatment Standards: Section 1.4.4 of this plan describes those specialties in which the Trust has experienced capacity / demand pressures during 2014/15.

Plastic surgery :

- Use outsourcing with local private provider – process established and has capacity to meet current and anticipated peaks in demand from repeat of skin awareness campaign and referrals from Dermatology;
- In-house capacity for delivery using visiting consultants has been reviewed and plans to maintain continuity of capacity for 2015 confirmed;

Upper GI surgery:

- Clinical teams have capacity to pick up additional lists when available and resources align.
- Agreement to run Saturday operating lists across General Surgery specialties to create additional in week lists for Upper GI surgery. This is pending internal agreement.
- Outsourcing (low numbers) agreed with local private provider
- Clinical review of hernia service to review pathway and approach being offered with aim to increase range of clinicians contributing to the service provision. This forms part of the action learning set approach described in the main paper.

Ophthalmology:

- Increase in demand for cataract surgery and clinical priority non-admitted pathways for macular and glaucoma recognised by commissioners.
- Action learning set established (primary and secondary care clinical leadership)
- Outsourcing to local NHS and non-NHS providers in place.
- In house theatre constraints being addressed through business case to improve theatre capacity.
- Short term increase in capacity with mobile theatre being evaluated.
- Nursing workforce plan in place to increase numbers and build resilience into the ophthalmic specialist nurse who support the cataract and macular treatment pathways.

1.6.3 Financial Forecasts

1.6.3.1 Headline Financial Forecast

A summary of the overall financial plan for 2015/16 is set out in Table 11, with quarterly phasing set out in Table 12.

Table 11: Financial Plan Summary

	units	sense	Actual 2012-13	Actual 2013-14	Out-turn 2014-15	Plan 2015-16
Summary Income and Expenditure Account						
Operating income (inc in EBITDA)						
NHS Clinical income	£m	(+ve)	195.767	201.947	203.382	289.146
Non-NHS Clinical income	£m	(+ve)	1.246	1.253	1.314	50.256
Non-Clinical income	£m	(+ve)	34.282	37.112	38.562	37.580
Total	£m		**231.295**	**240.312**	**243.259**	**376.982**
Operating expenses (inc in EBITDA)						
Employee expense	£m	(-ve)	(143.193)	(149.599)	(156.221)	(209.881)
Non-Pay expense	£m	(-ve)	(74.320)	(78.513)	(77.211)	(154.569)
PFI / LIFT expense	£m	(-ve)	0.000	0.000	0.000	(0.895)
Total	£m		**(217.513)**	**(228.112)**	**(233.432)**	**(365.345)**
EBITDA	£m		**13.782**	**12.200**	**9.826**	**11.637**
margin %	%		*6.0%*	*5.1%*	*4.0%*	*3.1%*
Operating income (exc from EBITDA)						
Donations and Grants for PPE and intangible assets	£m	(+ve)	0.372	0.046	0.811	0.200
Operating expenses (exc from EBITDA)						
Depreciation & Amortisation	£m	(-ve)	(8.746)	(9.312)	(9.102)	(11.816)
Impairment (Losses) / Reversals	£m	(+/-ve)	(3.225)	(1.584)	(5.624)	(0.500)
Restructuring costs	£m	(-ve)	0.000	0.000	(1.200)	0.000
Total	£m		**(11.971)**	**(10.896)**	**(15.926)**	**(12.316)**
Non-operating income						
Finance income	£m	(+ve)	0.118	0.074	0.081	0.111
Gain / (Losses) on asset disposals	£m	(+/-ve)	0.008	(0.006)	(0.033)	0.000
Gain / (Losses) on transfers by absorption	£m	(+/-ve)	0.000	0.000	0.000	(6.028)
Other non - operating income	£m	(+ve)	0.000	0.000	0.000	0.000
Total	£m		**0.126**	**0.068**	**0.048**	**(5.917)**
Non-operating expenses						
Interest expense (non-PFI / LIFT)	£m	(-ve)	(0.395)	(0.682)	(1.162)	(3.019)
Interest expense (PFI / LIFT)	£m	(-ve)	0.000	0.000	0.000	0.000
PDC expense	£m	(-ve)	(2.490)	(2.263)	(2.248)	(2.741)
Other finance costs	£m	(-ve)	0.000	0.000	0.000	0.000
Non-operating PFI costs (e.g. contingent rent)	£m	(-ve)	0.000	0.000	0.000	0.000
Other non-operating expenses (including tax)	£m	(-ve)	0.000	(0.022)	0.000	(0.012)
Total	£m		**(2.885)**	**(2.967)**	**(3.410)**	**(5.772)**
Surplus / (Deficit) after tax	£m		**(0.576)**	**(1.549)**	**(8.650)**	**(12.167)**
Profit/(loss) from discontinued Operations, Net of Tax	£m	(+/-ve)	0.000	0.000	0.000	0.000
Surplus / (Deficit) after tax from Continuing Operations	£m		**(0.576)**	**(1.549)**	**(8.650)**	**(12.167)**
Memorandum Lines:						
Surplus / (Deficit) before impairments and transfers	£m		**2.649**	**0.035**	**(3.025)**	**(5.639)**
One off income/costs	£m		(2.845)	(1.544)	(6.045)	(6.328)
Normalised Surplus / (Deficit)	£m		**2.269**	**(0.005)**	**(2.604)**	**(5.839)**
margin %	%		*1.0%*	*(0.0%)*	*(1.1%)*	*(1.6%)*

Table 12: Annual Plan Phasing

	S Devon 2014/15 Plan £m		S Devon 2015/16 Q1 £m	ICO 2015/16 Q2 £m	ICO 2015/16 Q3 £m	ICO 2015/16 Q4 £m	ICO 2015/16 Full Year £m
Income and Expenditure							
Income	244.1		60.4	128.6	94.7	93.5	377.2
Operating expenses	(233.4)		(59.5)	(127.7)	(89.7)	(88.5)	(365.3)
EBITDA	**10.6**		**0.9**	**0.9**	**5.0**	**5.0**	**11.8**
Non-operating revenue			-	-	-	(6.0)	(6.0)
Non-operating expenses	(19.3)		(3.4)	(5.0)	(4.5)	(5.1)	(18.0)
Net surplus / (deficit)	**(8.6)**		**(2.5)**	**(4.1)**	**0.5**	**(6.1)**	**(12.2)**
Nominalised surplus	(3.0)		(2.5)	(4.1)	0.5	0.4	(5.7)
...included in the above :							
Impairment/Asset disposal loss	(5.6)					(6.5)	(6.5)

The deficit in Quarter 1 reflects the CIP delivery profile in SDH. The Quarter 2 position is driven by the consolidation of the half year results of TSD, which shows a combined deficit of £1m. Quarter 3 reflects increased tariff income over the quarter, the impact of the ICO CIP and transaction savings along with the increased sales from the Torbay Pharmaceuticals facility flowing through giving a small surplus. Quarter 4 is affected by the loss on disposal of the assets relating to the West Devon Contract for community services that NEW Devon CCG will move to a Plymouth located provider. Prior to that loss on disposal Q4 has a small surplus.

1.6.3.2 Strategic Initiatives

The financial plan reflects, as agreed with Monitor, reflects the proposed acquisition of TSD effective from 1 August 2015.

By virtue of the transaction, full year income and expenditure of TSD will be consolidated into SDH's financial result for 2015/16. The significant variances between 2014/15 and 215/16 seen in Table 11 above are, in the main explained by this factor.

The transaction is processed during quarter 2, for which the plan set out above represents planned quarter 2 performance for the existing business, uplifted by the consolidated half year of TSD.

The financial plan set out in this document is consistent with that currently under assessment in support of the proposed transaction.

1.6.3.3 Income

Table 13 below sets out income by main commissioner for 2015/16.

Table 13 : Income by Commissioner

		Acute £'000	Community £'000	Other £'000	Total £'000
Clinical	South Devon & Torbay CCG	160,399	61,147		221,546
	NEW Devon CCG	5,195	1,936		7,131
	NHS England	32,120	3,783		35,903
	Torbay Council	2,101	39,945		42,046
	BCF		12,699		12,699
	Other	5,798	18,275	200	24,273
Non-Clinical		29,241		4,343	33,584
Total					377,182

For our host Commissioners, South Devon & Torbay CCG (SDTCCG) and Torbay Council, the plan described above represents income as expected under the proposed Risk Share Agreement for the Integrated Care Organisation. In broad outline, income is based around a fixed contract sum that combines health and social care income. Where actual income or expenditure drive a variance in the planned surplus / deficit, the impact will be shared on a 50 / 50 basis by host commissioners and Provider.

NHS England and NEW Devon are both full national contracts operating under the Enhanced Tariff.

As described in Section 1.6.2, SDTCCG have worked with the Trust and more specifically the individual specialties to agree the

demand plan for acute services, which would, if delivered drive gross income of £168m; a level some £12m in excess of that which is affordable by SDTCCG. The baseline assumption for the ICO, and included in this financial plan is £160.4m. Substantially less than compared to the ICO proposal, this underlines the commitment being made by the Trust to devise a service model that fits far more closely to our Commissioner's resource envelope than would otherwise occur.

At the point of writing, and until the transaction completes, the Trust is operating under a national tariff and national contract arrangement for acute services; the Trust has opted for the Enhanced Tariff Offer. Community services are operating on a block contract basis within TSD.

There is risk to both parties in terms in this arrangement. However the Trust's assessment is that, working from a baseline value of £168m, the net impact of penalties, risk of under-performance, CQUINN risk will not drive an income level lower than the proportionate share of £160.4m in the early part of the year and until the transaction proceeds.

Additional income has been processed, as set out in Section 1.5.4 in respect of revenue support to effect the Care Model changes set out in this plan.

1.6.3.4 Expenditure

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

Table 14 : Cost Assumptions

	15/16 %
Employee Inflation	1.65
Non Pay inflation	2.68
Other income	1%

- Employee inflation has been based on the national pay award supplemented by an assessment of incremental drift, clinical excellence awards and other pay pressures;
- Non-Pay inflation has been based on historic trends for drugs separately looking at pass through and hospital drug spend and a bottom up review of expected cost pressure by divisions;
- 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.

Expenditure budgets have, in addition been adjusted to reflect:

- Across the combined budget, a CIP target of £15.2m; outline plans to achieve this are set out earlier in this document;
- Additional costs of building capacity to meet demand;
- The impact of the care model changes

In reviewing its savings potential, the Board's assumption that cost improvement programme will continue to be an increasingly difficult challenge, has been reflected in the planned deficit position. This reflects the need to maintain the quality of patient services.

1.6.3.5 Capital

The Trust has developed a capital expenditure plan that focuses on ensuring business continuity, addresses high risks in a timely manner and also enables the Trust to invest in some key Information & Management Technology (IM&T) projects. These IM&T projects will both improve the safety of patient care and will also ensure that patients can continue to be treated in the most appropriate environments.

The total value of the planned capital expenditure in 2015-16 totals £29.1m, of which £25.0m relates to planned investment in South Devon Healthcare NHS FT sponsored projects. The balance of £4.1m relates to planned investment in Community Hospitals and other Community Services that upon the successful acquisition of Torbay and Southern Devon Health and Care NHS Trust, the Trust will become responsible for on 1st August 2015.

The Trust will be reliant upon further external investment in order to deliver these capital plans in full during 2015-16. Some of this external investment has already been secured through the Independent Trust Financing Facility (ITFF) but a number of planned loans to fund investment have yet to be secured. Loan applications will be submitted to the ITFF upon completion of Outline Business cases.

The principal projects that the Trust plans to deliver during 2015-16 and the source of finance is set out below.

Trust wide Backlog Maintenance Program: The Trust is planning to invest £4.4m in building maintenance projects during 2015-16. Schemes such as replacement of non-compliant sanitary ware, water safety improvement works, replacement condensers and re-roofing works. These will be funded from internal Trust cash resources. Investment is also planned within the Mortuary, Fracture Clinic and the Emergency Department. These latter schemes will be commenced during 2015/16 with anticipated completion in 2016/17. The planned investment in 2015-16 is reliant upon ITFF funding totalling £0.4m. These loans have not yet been secured. Loan applications will be submitted to the ITFF upon completion of Outline Business Cases.

Construction of a new Critical Care Unit and Hospital Front Entrance: The Trust's current Critical Care facilities are not compliant with technical standards, the privacy and dignity of patients is heavily compromised, and there is restricted space around the patient's bed. The plant that serves the current facility is aging and there are no decant facilities within the Trust to enable this plant to be replaced without severely compromising service. In addition there are insufficient numbers of Critical Care beds. This is evident in the number of elective procedures cancelled due Critical Care Unit capacity and also by the Trust having the lowest number of critical care beds per head of population in the South West Peninsula. The Trust has now finalised the design of the new facility, a contractor has been appointed and finance from the ITFF has been secured. The total planned investment in 2015-16 totals £6.7m. The project is due to be completed in 2017.

Construction of a new Linear Accelerator Bunker and associated works: The Trust provides Radiotherapy treatments to a large number of patients within the South Devon Area. The Trust's two Linear Accelerators are operated at near capacity and are in need of replacement. The Trust plans to replace the older machine in 2015-16 and the slightly newer machine in 2016-17. However in order to replace one of the two machines a third 'bunker' will first of all need to be constructed. This is because treatment demand could not be met by the Trust through the use of one machine and neighbouring Trusts have no significant additional treatment capacity. Further, attempting to run a Radiotherapy service on one aging Linear Accelerator would pose too greater a risk to Patient safety where treatment episodes have to be delivered in rapid succession. Finance for the project has been secured from the ITFF, a contractor has been appointed and construction works have started. The sum of investment on building works that will take place during 2015-16 totals £2.7m

St Kilda – Construction of a new Secondary care and Primary care facility at Brixham Hospital: This project is currently sponsored by Torbay and Southern Devon Health and Care NHS Trust. The total project cost is circa £6.9m of which £2.5m is planned for 2015-16. This project is dependent upon ITFF funding. A loan application for the scheme will be submitted upon completion of the FBC. The project will provide a purpose built 36 bedded integrated health and social care 'hub' for the population of Brixham, bringing together primary care, community health services and social care.

Expansion and Improvement of Car Parking Facilities: External Finance from the ITFF has been secured for this project. The project will enable substantial increases in the number of patient and visitor spaces on site. The total value of the proposed investment in 2015-16 is £1.8m

Implementation of an Electronic Document Management System (EDMS) to support Clinical Decision making: The Trust is investing significant sums of money in IM&T projects that will both improve Clinical Care and create efficiencies. A key component of this overall investment is investment in EDMS. The successful implementation of EDMS will enable the Trust to vastly reduce the need to maintain paper copies of Patient's Medical Records which in turn will improve the speediness of clinical decision making and produce significant levels of CIP. The project is likely to take two years to deliver in full. The investment of £1.0m in 2015-16 is reliant upon external ITFF funding. A loan application will be submitted to the ITFF upon completion of a Full Business Case.

Implementation of a Shared Community Care Record Application: This project is also currently sponsored by Torbay and Southern Devon Health and Care NHS Trust. The project will be delivered from internally generate cash resources. The project will replace paper communications for Health and Social Care staff by interfacing systems. The total planned investment in 2015-16 is £1.2m.

Other IT schemes – Intangibles IM&T and Tangibles: The combined value of these schemes in 2015-16 totals £3.3m. These schemes are being funded from internally generated cash resources. The spend in 2015-16 will enable amongst other schemes, the implementation of a Clinical Portal (i.e. a 'hub' where all patient related clinical data will be stored), electronic order communications for pathology test requests and results, clinical handover systems for use by Acute Medical and Nursing Staff and the upgrading of some of the Trust's IM&T infrastructure/hardware. The investment will also enable the commencement of the Electronic Prescribing System implementation.

Medical Equipment: The Trust plans to invest a total of £3.8m on Equipment during 2015-16. The two largest components of which are the replacement of one of the Trust's two Linear Accelerators (£2.2m) and the replacement of the Trust's aging Cardiac Catheter Laboratory equipment (£0.6m). A further £1.0m will be invested in replacing other items of Medical Equipment The replacement Linear Accelerator is funded by a secured ITFF loan. The other items of Medical Equipment are being funded from internally generated cash resources.

Other – Capitalisation of development costs to secure and maintain pharmacy manufacturing licences: The Pharmacy Manufacturing Unit (PMU) currently provides the Trust with a significant revenue scheme which is used to subsidise the cost of the Healthcare provided by the Trust. The Trust has over recent years invested significant sums in expanding production capacity through ITFF secured loans. The Trust plans to invest further sums of money to secure pharmaceutical manufacturing

licences to protect and enhance market share of revenue. The proposed £0.3m of investment in 2015-16 will be financed from internally generated resources.

Other – Purchase of PMU equipment to complete the fit out of the new facility and to meet business continuity needs: The further investment of £1.4m in 2015-16 will enable the fit out of the new PMU facility to be completed. The investment will be financed from internally generated resources.

Other – Estates and Facilities – Replacement equipment: A relatively small sum of £0.1m has been set aside to enable part of Estates and Facilities Management equipment to be replaced in year. Funds for which are from internally generated cash resources.

Included within the 2015/6 planned Statement of Comprehensive Income (SOCI) is an anticipated impairment charge of £0.5m. This impairment charge relates to the forecast Modern Equivalent Asset valuation adjustment that will be necessary to apply to the capitalised cost of specialised building assets that are brought into use during the financial year. The annual valuation adjustment is provided by the District Valuation Office.

1.6.3.6 Statement of Financial Position

The statement of Financial Position, which reflects the trading activities and capital investments above, is set out in Table 15.

Table 15 : Statement of Financial Position

			Actual 2012-13	Actual 2013-14	Out-turn 2014-15	Plan 2015-16
Non-current Assets						
Intangible assets	£m	(+ve)	3.080	1.835	1.411	9.726
Property, Plant & Equipment	£m	(+ve)	96.295	119.637	121.225	169.059
On-balance sheet PFI	£m	(+ve)	0.000	0.000	0.000	18.886
Other	£m	(+ve)	1.885	2.315	2.243	2.228
Total	£m		**101.260**	**123.787**	**124.879**	**199.899**
Current Assets						
Cash and cash equivalents	£m	(+ve)	16.615	18.472	12.061	18.813
Other current assets	£m	(+ve)	16.228	18.284	14.999	18.838
Total	£m		**32.843**	**36.756**	**27.060**	**37.651**
Current Liabilities						
Overdrafts and drawdowns in committed facilities	£m	(-ve)	0.000	0.000	0.000	0.000
PFI / LIFT leases	£m	(-ve)	0.000	0.000	0.000	(0.551)
Other borrowings	£m	(-ve)	(0.929)	(2.800)	(3.366)	(3.723)
Other current liabilities	£m	(-ve)	(20.779)	(25.640)	(19.279)	(29.678)
Total	£m		**(21.708)**	**(28.440)**	**(22.644)**	**(33.952)**
Non-current Liabilities						
PFI / LIFT leases	£m	(-ve)	0.000	0.000	0.000	(20.726)
Other borrowings	£m	(-ve)	(16.007)	(35.023)	(37.293)	(51.277)
Other non-current liabilities	£m	(-ve)	(3.734)	(3.715)	(3.587)	(3.587)
Total	£m		**(19.741)**	**(38.738)**	**(40.880)**	**(75.590)**
Reserves	£m	(+ve)	92.654	93.365	88.414	128.008

1.6.3.7 Continuity of Service Risk Rating

The Continuity of Service Risk Rating (COSRR) for each quarter is set out in Table 16 below:

Table 16 : Continuity of Service Risk Rating

			Actual 2012-13	Actual 2013-14	Out-turn 2014-15	Plan 2015-16
Capital Service Cover						
Material Adjustments to:						
Revenue Available for Capital Service	£m	(+/-ve)	0.000	0.000	0.000	0.000
Capital Service	£m	(+/-ve)	0.000	0.000	0.000	0.000
Revenue Available for Capital Service	£m		13.900	12.252	9.907	11.736
Capital Service	£m		(3.212)	(4.233)	(6.745)	(9.788)
Capital Service Cover metric	0.0x		**4.33**	**2.89**	**1.47**	**1.20**
Capital Service Cover rating			**4**	**4**	**2**	**1**
Liquidity						
Material Adjustments to:						
Working Capital for CoSRR	£m	(+/-ve)	0.000	0.000	0.000	0.000
Operating Expenses within EBITDA, Total	£m	(+/-ve)	0.000	0.000	0.000	0.000
Working Capital for CoSRR	£m		5.413	1.947	(1.634)	(2.350)
Operating Expenses within EBITDA, Total	£m		(217.513)	(228.112)	(233.432)	(365.345)
Liquidity metric	Days		8.96	3.07	(2.52)	(2.32)
Liquidity rating			**4**	**4**	**3**	**3**
2* Override			**No**	**No**	**No**	**No**
Continuity of Service Risk Rating			**4**	**4**	**3**	**2**

The deficit position is driving the debt service element of the COSRR to be a '1' in 2015/16. The creation of the ICO adds to the challenge for this ratio as TSD has two Private Finance Initiative funded community Hospitals.

The financing arrangements to the cover the balance sheet deficit in TSD and the ICO change fund could also impact on this rating if these are finally agreed to be loan funded. They could also compromise future borrowing capacity for the new ICO.

The liquidity element of the COSRR remains a '3' reflecting the relatively good cash and cash equivalent position SDHCFT carries forward into 2015/16, the assumption that the change fund is provided by NHS England and that Torbay Council takes back the historic client debt associated with Adult Social care that currently sits in TSDHCT books.

This drives a COSRR of 2 across the first year of the ICO whilst the care model changes are implemented and the synergies of integration are being delivered.

1.6.3.8 Sensitivities

As part of its FBC, the Trust has modelled an extensive range of downside financial scenarios and proposed mitigations. Those affecting 2015/16 have been summarised in Table 17 below. In summary these reflect a 20% reduction in CIP delivery, a 12 month delay in delivering care model savings and a 50% reduction in the planned growth in surplus derived from Torbay Pharmaceuticals.

Table 17: Sensitivities

Sensitivities 2015/16	£m
Decrease in Pay CIP Delivered	£2.7
Delay in Pay synergies	£2.5
Decrease in TP* Other Income Growth	£0.4
Downside Total	**£5.6**

(*TP, Torbay Pharmaceuticals)

The most significant planned mitigation against these risks is the operation of the Risk Share Agreement under which, to the extent that any downside increases the Trust's planned deficit, our Commissioners will provide funding for 50% of their impact. There is sufficient liquidity in the Trust's position to accommodate any balance in 2015/16.