TORBAY COUNCIL

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Date:	Friday, 19 June 2026	Torquay
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Dear Member

HEALTH AND WELLBEING BOARD - THURSDAY, 25 JUNE 2026

I am now able to enclose, for consideration at the Thursday, 25 June 2026 meeting of the Health and Wellbeing Board, the following reports that were unavailable when the agenda was printed.

Agenda No	Item	Page
7.	**Torbay and South Devon NHS Foundation Trust Strategy**	(Pages 3 - 72)

Yours sincerely

Governance Support
Clerk

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Our People AT THEIR BEST

NHS
Torbay and South Devon
NHS Foundation Trust

OUR STRATEGY

Contents

Foreword

We are shaped by the unique character of our place and our people. We are proud to serve many vibrant and diverse communities—spanning coastal towns, rural villages, and market centres—each with its own history, strengths, and challenges. Ours is a region of natural beauty and deep-rooted pride, but also one where inequalities persist and where health is shaped as much by housing, work and social connection as by access to care.

Our community services, neighbourhood teams, clinics and hospitals are woven into the fabric of local life - trusted and valued, thanks to the compassion and commitment of our colleagues, volunteers, and partners. Every day, they demonstrate extraordinary skill and kindness, supporting people through moments of vulnerability and change.

We stand at a pivotal moment.

Across the NHS, organisations like ours are being called to support the 10-year NHS plan, shifting care: from sickness to prevention, from analogue to digital, from hospital to community. For us this is not a new direction, but a natural evolution - building on our legacy of innovation, integration and partnership.

As one of the largest employers and anchor institutions in our region, we recognise our role in shaping not only the health of our population but the wellbeing of our communities. This means investing in education and skills, supporting local economic growth, promoting fair employment and working with partners across the NHS, local authorities, GPs and the voluntary sector to ensure our actions deliver benefits far beyond our organisational boundaries.

We face enormous challenges: rising demand, an ageing population, workforce pressures, the need to renew our buildings and technology and our current financial position is unsustainable. Yet we also have real strengths - dedicated colleagues and volunteers, pioneering neighbourhood teams, expert hospital services and a strong community and voluntary sector.

This strategy builds on those strengths. It sets out how we will stabilise and strengthen the services people rely on today, while creating the conditions for everyone we serve to start well, live well, age well and die well. It invites us to look beyond organisational boundaries, to act as one NHS and to put human relationships at the heart of everything we do.

Central to this vision is our commitment to strong clinical input, including primary care, into all our decision making. We believe that those closest to care - our clinicians and teams and care partners - should have greater autonomy and the support to shape services, lead change and take responsibility for the outcomes that matter most to our communities. By empowering clinical leaders across our services and fostering a culture of shared accountability, we will ensure our strategy is grounded in real experience and delivers lasting impact while also supporting us to take the difficult decisions that we face.
Given the context which we currently face, we will make brave, transparent decisions to disinvest in services that do not deliver enough impact. We will strive for clinical

consensus but accept that this will not always be possible and we will evaluate our choices using the most up to date clinical evidence.

This isn’t about mapping every step – it's about establishing and sharing the principles that will shape our future direction and guide our decision making.

This is a strategy of renewal. We believe change is possible when we unite around a common purpose and listen to the voices and hopes of those we serve.

We are proud of what has already been achieved: the resilience shown through the pandemic, the creativity and dedication of our teams and the countless acts of kindness that define our daily work. Building on these foundations, our collective task now is to make integrated care not just an ambition, but a lived reality in every street, village and town.

This is not a strategy for one organisation alone. It is an open invitation to everyone with a stake in the health and wellbeing of Torbay and South Devon - our people and communities, our colleagues, partners and volunteers - to play their part in shaping a future that is compassionate, inclusive and sustainable.

Thank you to everyone who has contributed to this vision - colleagues, partners, community representatives and local residents. Your insights and voices have shaped this strategy and will continue to guide its delivery.

Together, let’s create a future where everyone in Torbay and South Devon has the chance to live well, supported by a local NHS at place that reflects the best of who we are and the best of what we can become.

Let’s move forward with confidence, optimism and a shared commitment to making a difference.

Martin Beaman
Chair

Joe Teape
Chief Executive

Executive Summary

A strategy to help people live well in Torbay and South Devon

Why we must change

We stand at a turning point. We serve one of the most complex and rapidly ageing populations in England, with many people living longer with multiple long-term conditions. Levels of suicide and self harm are high, and the number of cared for children within the local authority remains among the highest in England.

Pressures on urgent care, elective recovery and community services are growing, while the cost of living, housing and workforce challenges continue to shape both health outcomes and the way services operate.

Our hospitals face rising demand and constrained capacity – a situation mirrored across the wider health and care system, including primary care. Our workforce is under sustained pressure. Our buildings and technology need renewal. Financially, we must be realistic and disciplined, with an underlying deficit at the start of 2026 of almost £100m. This means we must prioritise, focus on value and ensure every pound delivers the greatest possible benefit for our population.

At the same time, there is opportunity. Across our communities there is resilience, creativity and compassion. New science, data and digital technology are changing what is possible in care.

The new Devon, Cornwall and Isles of Scilly Cluster Integrated Care System provides a platform for genuine partnership and the experience and commitment of our colleagues and volunteers remain our greatest strength.

To meet the needs of the future, we cannot simply work harder within the existing model. Incremental improvement alone will not be enough.

Continuing to respond to rising demand in the same way would place further strain on our people and would not deliver the outcomes our communities need. We must redesign how care is organised and delivered, shifting our focus towards prevention and independence, neighbourhood-based care and supporting people to live well for longer, while keeping hospital care for when it is most needed.

Our shared vision

Our vision is simple:

To support every person, family and community we serve to live well.

This means enabling everyone to start well, live well, age well and die well in a place where care feels connected, personal and compassionate. It means supporting people not only to recover from illness, but to live meaningful, healthy and connected lives, with greater independence and quality of life.

To achieve this, we will act in three complementary roles:

- as a **provider**, delivering excellent clinical, community and remote services with safety, quality and compassion.
- as a **convener**, bringing partners together around shared purpose and outcomes, then connecting information, pathways and people so care feels seamless.
- as an **enabler**, supporting communities, colleagues and volunteers to play their part in improving wellbeing and creating the right conditions for partners to thrive.

What we will become

We will transform from being primarily a service provider to becoming a strong place-based partner with a leading role in how care works together across Torbay and South Devon. This reflects the national direction of travel, with Foundation Trusts playing a broader role in aligning care, prevention and population health improvement with partners across place.

This means:

- organising around people and relationships, not organisational boundaries
- building stronger neighbourhood and community-based care, supported by digital and data systems that connect seamlessly with hospitals
- working with partners across health, care, voluntary, academic and community sectors to align around shared outcomes
- investing in prevention and early intervention to reduce avoidable illness and future demand
- acting as an anchor institution, supporting the social, economic and environmental wellbeing of our area and beyond.

How we will get there

Transformation will not happen all at once. We will balance immediate stabilisation with long-term redesign, staying credible now while building a sustainable future. We describe this through three overlapping stages of change.

1. **Stabilising and building foundations**
   Strengthen core services, improve flow, reduce waiting times and strengthen financial discipline and digital capability. Create the space, capability and confidence for change.

2. **Transforming care together**
   Design and test neighbourhood models of joined-up care, improve co-ordination between hospital and community services and embed learning, digital and innovation into everyday work.

3. **Realising the health and care community we aspire to become**
   Achieve joined-up, adaptive and compassionate care that enables people to stay well, live independently and access specialist care when they need it.

These stages overlap, allowing early innovations while core services are strengthened, ensuring that change is both realistic now and sustainable in the long term.

Our guiding principles

Our five commitments guide every decision:

- **value and sustainability** – using our resources wisely to deliver financial, workforce and environmental sustainability
- **people, purpose and partnership** – placing human connection at the centre of everything we do
- **research, learning and innovation** – continuously improving and adapting
- **safety and responsible care** – protecting people while acting responsibly to improve
- **equity and inclusion** – ensuring equity, belonging and trust for all our people and communities.

These principles guide our decisions, priorities and relationships. They ensure that change is grounded in shared purpose and integrity, not just operational change.

Our signature moves

Our strategy brought to life through five major shifts in how we design and deliver care:

- **living well in our neighbourhoods** – working with communities to make care easy to reach and part of everyday life
- **reimagining acute and specialist care** – modernising hospital services and strengthening their links with community care, focusing specialist care where we can deliver the highest quality and safest care sustainably
- **joined-up care, every step of the way** – supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout
- **smart use of technology for better care** – using digital tools and fresh thinking to make care more personal, easier to access and better connected
- **caring, skilled people ready for tomorrow** – creating a great place to work, supporting people to be their best selves, and building an agile, inclusive workforce for the future.

Each signature move connects immediate priorities with long-term transformation, ensuring that our work today creates the future we want to share.

The enablers that make this possible

To deliver these changes, we will strengthen the core capabilities that underpin the whole strategy. This includes digital and data, innovation and evaluation, talent and growth, inclusive and responsible decision-making, strong partnerships with communities, fit-for-purpose estates and a clear focus on value for money. Together, these enablers ensure our strategy is deliverable, affordable and sustainable over the long term.

Our strategy on a page

OUR VISION

To support every person, family and community we serve to live well

HOW WE MAKE DECISIONS - OUR GUIDING PRINCIPLES

- Value and sustainability
- People, purpose and partnership
- Research, learning and innovation
- Safety and responsible care
- Equity and inclusion

THE FIVE BIG CHANGES WE WILL MAKE - OUR SIGNATURE MOVES

- Living well in our neighbourhoods
- Reimagining acute and specialist care
- Caring, skilled people ready for tomorrow
- Joined-up care, every step of the way
- Smart use of technology for better care

WHAT MAKES THIS POSSIBLE - OUR ENABLERS

- Digital and data: giving our teams the tools they need, when they need them
- Innovation and evaluation: creating safe spaces for people to test new ideas, learn from what works and share improvements
- Talent and growth: supporting all our people to learn, grow and lead change
- Inclusive and responsible decision-making: every decision is guided by a clear ethical framework
- Partnerships and communities: bringing together people and organisations to work as one
- Estates and sustainability: fit for purpose and sustainable places for health and wellbeing
- Value for money: making every pound count

OUR VALUES

Working together for people | Respect and dignity | Commitment to quality | Compassion | Improving lives | Everyone counts

Strategy into action

Over the next 6–12 months we will :

- align this strategy with the wider Devon clinical strategy enabling acceleration of local initiatives
- bring existing programmes under this strategic framework as part of Our Plan for Better Care, using our governance and delivery structures to coordinate transformation
- develop clear implementation plans for our signature moves and enablers
- strengthening financial stability and core operational performance
- work with colleagues, partners (such as GPs and VCSE) and communities to co-create change and build shared ownership.

A shared invitation

This is a strategy for everyone who cares about the future of health and wellbeing in Torbay and South Devon. It invites each of us – our communities, colleagues, partners and volunteers - to shape care that is compassionate, intelligent and sustainable, where support feels joined up and where people can start well, live well, age well and die well.

Together, we can build care that does more to prevent avoidable ill-health and responds when things go wrong, so more people can live well for longer.

Chapter one: why we need to change

Local knowledge, local action

We are rooted in our geography and united by a shared ambition: supporting every person, family, and community we serve to live well.

Our decisions are grounded in local insight, shaped by the lived realities of Torbay and South Devon - and by the expertise of our clinical leaders and teams, who have the autonomy to act on what they know matters most. We know our communities because we are part of them and we believe the best solutions are those designed with and for local people.

A generational shift: putting children and families first

Our future begins with our children. Too many grow up facing challenges that no child should - poverty, unstable housing or the need for extra support at school. The number of children in care here is among the highest in England. We see the impact this has, not just on young lives today, but on the health and wellbeing of our whole community for years to come.

Every child deserves the best start. We're committed to working with families, schools and partners to invest in children and young people, so future generations can thrive.

We believe that, together, we can make a generational shift - giving every child and family the chance of a brighter future.

Understanding our population: local challenges and strengths

Torbay and South Devon is a place of contrasts—full of beauty, diversity, and complexity. We're proud that people choose to spend their lives here and we celebrate our long life expectancy. But with more than one in four of us now over 65, and the proportion of people aged over 85 among the highest in the country, too many of those extra years are spent in poor health. Around half of all adults live with at least one long-term condition and one in five manage three or more.

Our geography is diverse, with rural villages, market towns and coastal communities - each with unique strengths and needs. Some coastal areas face significant hardship, including poverty, loneliness and poor housing.

Yet, there's so much to celebrate. Our communities are full of kindness, generosity and a spirit of looking out for one another. Volunteers, carers, and neighbours step up every day to support those around them. This resilience is our greatest strength and it's what gives us hope for the future - even as the social fabric that sustains wellbeing is under strain.

The NHS in the south west peninsula
The south west peninsula brings together the communities of Devon, Cornwall and the Isles of Scilly. Across this area, NHS organisations, local councils and community partners are working more closely than ever to improve health and wellbeing for everyone.

Our area is served by a new Integrated Care Board (ICB) cluster, which unites NHS leaders from Devon, Cornwall and the Isles of Scilly. This cluster helps us plan and fund health and care services in a joined-up way, making sure resources are used wisely and care is shaped around what matters most to local people.

As a provider organisation, we work hand-in-hand with the ICB cluster and our partners - delivering hospital, community and neighbourhood care and helping to design services that reflect the needs and strengths of our Peninsula. By working together, we can ensure everyone in our region has the best chance to live well, now and for generations to come.

The bigger picture: what shapes our health

We know that good health is about so much more than just healthcare. It's about having a safe place to live, decent work, strong connections and opportunities to thrive. That's why we work hand-in-hand with our partners - tackling poverty, improving housing, boosting local jobs, and building a sense of belonging.

In Torbay and South Devon:

- we have an eight-year gap in life expectancy between our most and least affluent areas
- many families struggle to make ends meet, and the cost of living hits hard
- good, affordable housing is out of reach for too many
- jobs can be seasonal or low-paid, making it tough to plan for the future
- many people choose to move here to enjoy their later years, but growing older here can sometimes mean facing ill-health, frailty, or feeling alone
- our young people are facing more pressures than ever, with rising challenges around mental health, self-harm and isolation
- many in our communities quietly care for loved ones, often without recognition or support
- our natural environment is a gift, offering green spaces and fresh air that support our wellbeing
- climate change brings new challenges, but also opportunities to work together for a healthier environment.

[pull quote: one in six children in Torbay grow up in relative poverty]

As one of the area's biggest employers and a proud part of our communities, we have a responsibility to use our influence to make life better for everyone who calls Torbay and South Devon home.

What it feels like today

The challenges we face are stark and interlinked. Demand for urgent and elective care is rising, hospital capacity is stretched and too many people wait too long - for diagnosis, treatment or support. Each delay carries a human cost.

Recruiting and keeping staff is tough, especially when the cost of living, lack of public transport and affordable housing make it hard for people to stay. Some clinical and technical roles are particularly hard to fill in rural areas. When colleagues move on, it's not just a gap in the rota - it's a loss of relationships, experience and continuity for the people we serve.

Our buildings are ageing and our digital systems need to catch up with the way we want to work.

Financially, we face tight constraints, requiring disciplined financial stewardship and clear choices about where and how we invest for the future.

These pressures show we need to move from short-term fixes to long-term, sustainable solutions. Real health and wellbeing means looking beyond emergencies and focusing on prevention, continuity and what matters most to people. We cannot meet these challenges through incremental improvement alone. Working harder within the old model will not be enough. The current system is stretched between growing demand, constrained resources and the limits of its design. It's time to work differently – together - so we can build a future that truly supports everyone.

Listening and learning locally

We never make decisions in isolation. We talk to patients, families, colleagues and partners. We ask, "What matters to you?"- and we act on what we hear.

We are committed to embedding lived experience and community voices in how we design, test and evaluate new approaches so that our services reflect what matters most to local people.

People tell us they value the NHS being free when they need it and they want care that's close to home, joined-up and easy to access.

They want us to focus on prevention, not just treatment and to make sure no one is left behind as technology changes the way we deliver care.

By listening and learning from local voices, we can shape services that truly reflect the needs and hopes of our communities.

[pull-quote: "We ask, 'What matters to you?' - and we act on what we hear."]

Breaking the cycle: from crisis to prevention

Too often, people only get help when things have already reached crisis point. We see families and individuals caught in a frustrating cycle - waiting until things go wrong, facing repeated assessments and feeling like they're always starting over. We know it doesn't have to be this way. By working together, we can spot issues

earlier, offer support before anyone reaches breaking point and make sure help is there when and where it's needed most.

Pressure on our services often results from missed opportunities for early help and prevention, leading to more emergencies and hospital visits.

This cycle isn't just costly—it causes avoidable harm and leaves people feeling let down. We want to break that pattern. That means shifting our focus from reacting to crises, to working together as communities to provide earlier, more joined-up support. That's at the heart of our strategy: helping people stay well, connected and confident in their own lives.

We recognise that too many promising innovations stall before reaching the people who need them most. That's why we are considering new ways to bridge the gap between research, innovation and real-world delivery through an evaluation and investment hub. This would help us ensure that what works in theory becomes what works in practice, with lived experience and community voices embedded in every step.

Our promise: health and wellbeing for every stage of life

We believe in supporting people at every stage:

Our ambition is bold, but it is grounded in the expertise and insight of our clinicians and teams. We will achieve our goals by giving clinical leaders the autonomy to innovate, adapt and be accountable for the outcomes that matter to people locally.

Looking ahead: a community-informed future

We're proud to be part of an organisation that brings together hospital and community care - allowing us to design support around people's lives, not organisational boundaries. Our integrated approach means we can listen closely to local voices, invest in children and families and empower clinical leaders to shape care and take responsibility for outcomes delivered within the financial constraints we face. By working hand-in-hand with partners across Devon and the south west Peninsula, we can build a future where clinical leadership and accountability shape every decision.

Our challenges are real, but so are our strengths. By putting children and families at the centre, listening to what matters most and working together, we can create a local NHS that truly belongs to everyone in Torbay and South Devon - now and for generations to come.

With compassionate colleagues, established locality neighbourhood teams, and strong partnerships across GPs, the voluntary sector, universities, colleges and industry, we can help shape a brighter future and give everyone the chance to live well.

Chapter two: Our purpose, vision and role

Our purpose

We exist to improve health and wellbeing for every person, family and community we serve.

This means treating illness well, preventing ill health and using our resources responsibly so they make the biggest difference. We work with partners because health is shaped by more than NHS services – it depends on relationships, environments and opportunities.

Our purpose is not only to deliver care, but to learn, innovate and share knowledge – so that every person, family and community benefits from the best that modern health and care can offer. We will explore new partnerships and proposals to help us generate evidence, support innovation and ensure that improvements are informed by those with lived experience.

Integration is central to our purpose. We will build on what we know works, joining up care across hospitals, neighbourhoods and communities so people experience one connected NHS, not separate services.

Our vision

To support every person, family and community we serve to live well.

We imagine a future where:

- care feels personal, joined-up and close to home
- hospitals, neighbourhoods and communities work as one connected whole
- care is proactive and prevents illness, not just reacts to it
- people are part of a health system that learns and improves every day
- resources are used responsibly and wisely so health, economic and environmental benefits go hand in hand.

We are committed to strengthening clinical leadership in our work so those closest to care have the freedom to shape services and deliver what matters most to our communities.

This vision defines the future we will build together.

Our role

We have a distinctive role in shaping the future of care. This role is not just about what we provide – it is about how we facilitate, connect and enable change across the whole health system.

Our role has three elements:

- **provider**: we will deliver excellent community, hospital and remote services with safety, quality and compassion focussed on best outcomes
- **convener**: we will bring partners together around shared purpose and outcomes, then connecting information, pathways and people so care feels seamless

- **enabler:** we will support communities, colleagues and volunteers to play their part in improving wellbeing and creating the right conditions for partners to thrive. Clinical leaders will be empowered to act on local insight and experience.

We will support integration, act quickly, take managed risks and evaluate what works, so progress is bold, inclusive and grounded.

Our mindset

We will make decisions and lead change, however difficult, with courage and clarity.

We will empower clinical leaders, health leaders and teams to innovate and lead improvement, supported by open feedback and sharing learning.

Our values

Our values guide how we treat people and how we work together. They shape our culture and influence every decision we make. We use the NHS Constitution values as our foundation.

- **working together for people:** patients come first in everything we do
- **respect and dignity:** we value every person and listen to what matters to them
- **commitment to quality:** we earn trust by seeking to get care right every time
- **compassion**: we respond with kindness and humanity
- **improving lives:** we strive to make health and wellbeing better for all
- **everyone counts:** we use resources for the benefit of all and make sure no one is left behind.

These values sit at the heart of how we change and improve. They are the means by which we earn and maintain the trust of our communities, our partners and one another.

Strategic assumptions – the key factors shaping our plan

Our strategy doesn't exist in isolation. Our ambitions are grounded in our reality.

These are the key factors shaping our plan – from national priorities to local realities:

- we will continue to provide community, hospital and remote care while working closely with NHS partners across the Peninsula
- national NHS plans call for more prevention, neighbourhood-based care and digital transformation – and we will drive and support these changes locally
- specialist hospital services will be concentrated in fewer locations to meet national standards
- financial constraint will remain a defining condition, so we must prioritise, contain costs and focus on value
- we will break even and live within the funding available in the next three years
- the Peninsula will move towards shared services and infrastructure, including digital and data
- success depends on partnership, leadership and trust – not just technology or structures.

Our commitment to our people

Colleagues told us they want more freedom to lead change and take responsibility for improving care within the financial constraints in which we work. We have listened - our strategy commits to greater clinical leadership and local autonomy, ensuring those delivering care have a real say in how services evolve.

Chapter three: our guiding principles

Our guiding principles turn our values into action. They shape every decision, design and partnership so we move closer to our vision. They are not words on a page – they are active commitments that define how we act and work together as one connected, compassionate and learning organisation.

Why they matter

Our principles provide coherence in a complex health and care system, connecting today's actions with tomorrow's ambitions. They underpin our decision-making for all future service development and prioritisation

Principle one: value and sustainability

Our commitment:
We will live within our means and invest in services that make the biggest difference to the health and wellbeing of our population. We will make brave, transparent decisions to stop funding services that do not deliver the outcomes we expect.

Why it matters:
Financial sustainability is essential for safe, high-quality care. We cannot deliver for the future if we fail to prioritise resources today.

In practice:

- we define clinical sustainability clearly: services must be safe, high-quality with good outcomes and staffed appropriately, with clinical leaders involved in shaping and reviewing service models
- where services cannot meet these standards or cannot be staffed safely, we will redesign, partner or consolidate rather than compromise care
- we will recognise where partnership is essential to sustain services and act as an anchor organisation to support shared solutions
- we will focus investment on prevention, independence and community-based care, not just treatment
- we will make transparent decisions about priorities and opportunity costs, explaining why some services will change or stop.

Example
When reviewing elective surgery waiting lists, we shift investment towards community-based rehabilitation and prevention programmes that reduce future demand, even if it means reducing low-value elective procedures.

Where specialist services cannot meet quality or staffing requirements, we partner within the south west peninsula or regionally to maintain safe care rather than dilute standards locally.

Principle two: people, purpose and partnership

Our commitment:
This principle recognises that health and care are built on relationships between communities, patients, families and colleagues Compassion, trust and inclusion are the foundation of everything we do.

We act in partnership with others in our roles as convenor and enabler, so that every person experiences joined-up, compassionate and reliable care, wherever and however they encounter the system.

We will attract, develop and retain talented people who share our vision and values. We will create an inclusive culture where everyone feels seen, heard and valued – a place where people belong and can be their best selves at work to deliver the best care.

Why it matters:
Health and care are built on relationships. Purpose is shared, not owned. Partnership and inclusion are how we deliver excellence.

In practice:

- we invest in leadership, learning and development so our people can grow and thrive
- we create a culture of belonging where diversity is respected and everyone feels valued
- we work with partners across health, care and community sectors to connect pathways and make care seamless
- we enable our people, communities, colleagues and volunteers to play an active role in improving wellbeing, with clinical leaders empowered to shape local services.

Example
When deciding whether to invest in a new integrated care hub, we prioritise models that bring partners together (GPs, voluntary sector, social care) and create joined-up pathways rather than isolated services.

We ensure our colleagues have the right support and the right environment to deliver high-quality care.

Principle three: research, learning and innovation

Our commitment:
We learn from anyone and anywhere to bring fresh thinking and action that improves outcomes for local people. We are not afraid to fail fast – without judgement – because every test teaches us something. Curiosity drives us to act, learn and adapt so we can accelerate the adoption of innovation.

We are committed to creating a culture where learning from research, innovation and lived experience is valued and shared.

Why it matters:
A learning organisation adapts and grows. Innovation turns learning into better care and ensures progress is continuous. Research is essential for transforming care and improving outcomes for our people and communities.

In practice:

- we seek ideas from across health, care, communities and beyond – wherever they can add value

- we test, share what works and stop what doesn't, without blame
- we embrace fast, safe failure as a way to learn quickly and move forward with confidence
- we act with curiosity and humility, using evidence and lived experience to guide improvement, with clinical teams leading change on the ground.
- we will involve our people in research which will improve experience, quality and impact.

Example
When considering digital tools for remote monitoring, we pilot first, gather feedback from patients and colleagues and scale only when evidence shows improved outcomes and experience. If a pilot doesn't deliver, we learn why and adapt rather than abandon innovation.

Principle four: safety and responsible care

Our commitment:
We will not tolerate unsafe care. Safety, integrity and trust will remain the foundation of everything we do. We will manage risk actively and transparently and we will use resources responsibly to ensure care is safe today and sustainable tomorrow.

Why it matters:
Safety builds trust. Stewardship (responsible care) ensures that every decision supports long-term quality and resilience.

In practice:
- we extend safety beyond clinical care to psychological, digital and ethical areas, with clinical leaders playing a key role in setting and upholding standards
- we act decisively to remove unsafe practices and continuously monitor and manage risk
- we use resources and the environment responsibly, ensuring decisions today do not compromise tomorrow.

Example
When introducing AI-driven diagnostics, we ensure robust governance for data security and ethical use, ensuring patient safety before speed or cost savings.

Principle five: equity and inclusion

Our commitment:
All decisions will be guided by the principle of reducing health inequalities and addressing barriers. Access does not mean only access to healthcare – it includes access to employment, education and prevention. We will design for equity so that everyone can thrive and feel seen, heard and valued.

Why it matters:
Reducing health inequalities is essential if we are to support everyone that we serve to live well. Health outcomes are shaped by more than clinical care – they depend on social and economic opportunities.

In practice:

- we remove barriers that prevent people from accessing care, support and opportunities that influence health, with clinical leaders championing equity and inclusion
- we ensure compassionate, high-quality care for every person, regardless of background
- we actively test decisions against equity and inclusion, considering wider determinants of health such as housing, education and employment.

Example:
When planning new urgent care facilities, we ensure we locate services where transport links and deprivation data show greatest need, not just where estate is available.

We work with partners to connect people to employment and education opportunities that support long-term wellbeing.

Together, these principles guide how we prioritise, invest and innovate - ensuring clinical and health and care leadership and local autonomy and accountability are woven through every decision, so improvements are grounded in real experience and deliver what matters most to our communities.

These principles are our compass – they keep every decision aligned with our vision and values.

Chapter four: making change real

Delivering our vision means changing how we think and work. We will need to make some difficult but necessary decisions to improve our performance and put our finances on a more sustainable footing, while redesigning services for the future. Clinical leaders and teams will be empowered to shape our solutions and improvement.

By connecting research, education and innovation with everyday practice, we aim to build a culture of continuous improvement, where every colleague, partner and community member can contribute to shaping our future.

We have used the Three Horizons framework to connect immediate priorities with long-term goals:

- **year one** (2026/27)**:** taking decisive action to strengthen today (horizon one)
- **years two and three** (2027/28-2028/29)**:** redesign and scale what works (horizon two)
- **years four and five** (2029/30-2030/31)**:** build the future (horizon three).

Year one – caring well now - stabilising today

Before we can transform, we must ensure services are safe, reliable and sustainable, building on what we know already works and strengthening our foundations. We will support clinical leaders and teams to take the lead in stabilising and improving services within the financial resources we have available and building trust through consistent delivery.

Our priorities:

- improve urgent and emergency care and reduce elective waits
- support our people's wellbeing and develop compassionate, inclusive leadership
- put our finances on a sustainable footing and make better use of our resources
- shape, develop and support our teams to meet the needs of today and tomorrow
- stabilise and improve our digital services so they work better for staff and patients
- build trust through consistent, reliable delivery
- work with partners to make the most of collaboration.

What this will look and feel like:

- meeting the financial commitments, we set for ourselves
- teams shaped to meet changing needs, with the right skills in the right places
- faster ambulance handovers and better flow through urgent and emergency care
- more flexible working patterns and wellbeing support to help colleagues stay well at work
- increased access to education and development and career opportunities
- reliable core digital systems that allow clinicians to access patient records without disruption.
- partners working together to design and deliver holistic person-centred care

Years two and three – improving together - redesigning for tomorrow

With greater stability in place, we will accelerate change, redesigning together how we work and spreading new ideas and new ways of working. Clinical leaders and teams will support this redesign, working with partners and communities to test, learn and scale what works.

We will:

- expand integrated neighbourhood teams and wellbeing hubs
- join up hospital and home care with clear pathways
- work as one NHS with shared outcomes and risks
- invest in prevention and early intervention
- use data and rapid testing to learn and innovate
- move to digital systems that work together to support real-time decisions.

What this will look and feel like:

- virtual wards allowing people to stay at home or leave hospital earlier to recover safely at home with remote monitoring and clinical oversight
- shared dashboards showing system-wide performance so partners can act together
- testing new models for frailty care that reduce hospital admissions and improve independence.

Years four and five – realising our shared future

By the early 2030s, we will operate as part of a connected, compassionate and adaptive health and care community that:

- focuses on prevention and health creation, not just treatment
- organises around people and relationships, not institutions
- personalises care and co-designs solutions with communities
- learns and improves continuously through feedback and innovation
- is financially and environmentally sustainable
- builds trust and shared purpose across health, care and community sectors
- is shaped by clinicians and teams who act on local insight and experience.

What this will look and feel like:

- a person with multiple conditions receives care planned jointly by their GP, hospital team and community support – all connected through shared data
- health hubs in neighbourhoods offer clinical care, social support and digital access in one place
- real-time data helps clinicians and community teams adapt services quickly based on what works
- we thrive together creating a future where care, learning and wellbeing are fully joined-up.

This approach connects immediate improvements with long-term transformation. It ensures every decision moves us closer to a future that supports every person, family and community we serve to live well. By empowering clinical and health leaders and teams throughout, we make sure change is grounded in real experience and delivers what matters most.

Chapter five: our signature moves – reimagining care

Translating our vision into action

Our signature moves are the practical changes we will make. They turn our ambitions into real changes for people, colleagues and communities. Each move builds on the last, taking us from stabilising services, through improvements, to a future where care helps people live well, every day and at every stage of life.

Together they deliver the aims of the NHS 10-Year Plan and Devon's commissioning intentions, but they go further - shaped by what we've learned from people, colleagues and partners in Torbay and South Devon. Rooted in local knowledge, they reflect what matters most to our communities, the challenges they face and the strengths they bring.

When we get this right, people will experience care and support that feels personal, joined-up and easy to access. Communities become healthier and more resilient. Colleagues will feel valued and able to make a difference. And together, we will see better health, greater independence and a sense of belonging for everyone in Torbay and South Devon.

Our five signature moves

- **living well in our neighbourhoods:** working with communities to make care easy to reach and part of everyday life
- **reimagining acute and specialist care:** modernising hospital services and strengthening their links with community care, focusing specialist care where we can deliver the highest quality and safest care sustainably
- **joined-up care, every step of the way:** supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout
- **smart use of technology for better care:** using digital tools and fresh thinking to make care more personal, connected and easier to access
- **caring, skilled people ready for tomorrow:** growing a compassionate, adaptable team and a positive culture, so colleagues feel valued and ready to meet changing needs.

Signature move one: living well in our neighbourhoods

Working with communities to make care easy to reach and part of everyday life

Why this matters

Most of what helps us to live well happens where we live—not in hospitals. When care only starts at the hospital door, it's harder for people who face poverty, loneliness or long-term health problems to get the help they need. By moving more care and support into our neighbourhoods, we can make help easier to reach and improve lives.

Neighbourhoods will be places where prevention and care happen together—not just where services are managed. Integrated teams (including GPs and voluntary partners) shaped by local voices and lived experience will work together. Clinical leaders in each neighbourhood will have clear accountability for outcomes that matter locally, supported by research, innovation and shared learning. Over time we aim to shift the care model and balance of investment from hospital to community to support our neighbourhoods.

Neighbourhood care brings our vision to life: everyone in Torbay and South Devon can start well, live well, age well and die well - supported by local relationships, community resources and services that work together around what matters most to each person.

Where we are now

We already have five local hubs:

- Torquay
- Paignton and Brixham
- Newton Abbot
- Totnes, Dartmouth and the Moor (Moor to Sea)
- Teignmouth and Dawlish (Coastal).

These will be strengthened to support us to work with local Primary Care Networks as convener and enabler to design services that fit the needs of their local area.

Our Integrated Neighbourhood Teams (INTs) already bring health and social care together, with approaches shaped by local need. We now have an opportunity to build on this experience, benefit from best practice and shape services for the future, including

- NHS England's Neighbourhood Health Guidelines (2025/26): putting local teams at the heart of planned and responsive care
- a decade of INTs: showing that real integration is about trust, strong relationships and local flexibility
- the Health Innovation Network: highlighting the need for stable teams, time to build trust and good digital systems.

In line with the expectations in the 10-year health plan for England, more services will move out of hospitals and into our communities - making care easier to reach, focusing on prevention and reducing costs of expensive urgent and emergency care. This will mean diagnostics, minor injuries, urgent care, outpatient clinics, rehabilitation and more, all delivered closer to where people live.

Local priorities and partnerships

Creating services that truly work for people means looking beyond our own walls. We already have partnerships that make a real difference for people. Looking ahead we'll deepen our collaboration – bringing together expertise from across the south west Peninsula and the wider region to shape neighbourhood care that works for everyone. Sharing ideas, testing new ways of working and learning from each other as we go.

What this means for people

People won't have to knock on lots of different doors to get help. Instead, there will be one local team they can turn to—making things simpler and more personal. Support will start early, with prevention and practical help available locally and shaped by the voices of their communities. Physical, mental and social needs will be met together, so care feels joined up rather than fragmented. People will be supported to remain at home and only attend hospital for active treatment with more diagnostics available locally. Moving between home, community and hospital will be smooth, with warm handovers and clear communication every step of the way.

These neighbourhood hubs won't be designed in isolation—they'll be shaped by the people who use them. Communities will have a real say in what matters most and how services should work. For example, in a coastal area facing deprivation, a hub might work closely with housing, youth services, schools, faith groups and local organisations to support wellbeing and reduce pressure on GPs and hospitals.

What this means for colleagues and teams

In the neighbourhood hubs, colleagues from primary care, community services and social care will work side by side - planning together and learning from each other as one team. Mental health workers, voluntary, community and social enterprises, volunteers and peer supporters will be fully part of the team, bringing their specialist skills and perspectives. Hospital staff will feel confident that when someone leaves their care, strong local teams are ready to provide the right support.

Each hub will have a health and care professional who is responsible for local outcomes and accountable to the communities they serve, supported by sharing learning, research partnerships and rigorous evaluation. Colleagues will have opportunities to train together and work across sectors, building shared understanding and trust. Because in the end, strong relationships, a common purpose and mutual respect matter just as much as any structure or system.

How we will work

This signature move means:

- **from separate services to joined-up support:** services work together as one team, making it easier for people to get the help they need without navigating lots of different doors
- **from one-size-fits-all to local solutions:** each hub shapes its own approach based on local needs and voices, while following shared principles
- **from reacting to problems to preventing them:** using local knowledge and data to spot issues early and act before crises happen

- **from institutions to community action:** schools, housing, faith groups, businesses and residents all play a part in creating health and wellbeing together.

We will embed improvement science, research and education into daily practice, ensuring every change is informed by evidence and lived experience.

Digital records, secure communication and smart decision tools will help teams work together and provide care that is more personal, proactive and connected.

Starting well together: neighbourhood care for young families

Today
Sophie, 28, lives in Torquay with her partner Dan and their two-year-old son, Leo. When Leo starts showing signs of delayed speech and Sophie feels anxious after returning to work, getting help isn't easy. The family faces long waits for specialist appointments and Sophie worries about taking time off work for GP visits. Support feels fragmented and by the time help arrives, stress levels are high.

In five years time
In our "Living Well in Our Neighbourhoods" model, Sophie's experience looks very different. Instead of heading to A&E or waiting for a GP crisis appointment, Sophie contacts her local neighbourhood wellbeing hub - the first point of support for families. Within days, a family wellbeing coordinator meets them and brings together the right team: a health visitor, early years practitioner, community mental health nurse, paediatric link clinician and local voluntary partners.

Leo joins a child development playgroup linked to speech therapy, while Sophie connects with a parenting peer group and gets a mental health check-in supported by digital self-help tools. Within weeks, Leo is making progress, Sophie feels supported and confident, and the family feels connected rather than isolated.

What changes?
- **for families:** help comes earlier, stress is reduced, and support feels local and personal
- **for colleagues:** teams work proactively and together, spotting issues early through trusted relationships
- **for the NHS:** fewer crises, avoided unplanned contacts, lower long-term costs and stronger community resilience.

Ageing well together: neighbourhood care for older people

Today
Margaret, 82, lives alone in Paignton. After a fall, she spends weeks in hospital waiting for a care package to be arranged. When she finally returns home, she feels isolated and struggles to manage daily tasks. Her family worries about another crisis.

In five years time
Margaret's local neighbourhood hub spots the risk before it becomes a crisis. A wellbeing coordinator visits her at home within days, supported by a team that includes a physiotherapist, occupational therapist, social care worker and local voluntary partners. Together, they create a plan that includes home adaptations, strength and balance classes at the community centre and a volunteer befriender who visits weekly. Digital monitoring tools help the team check in without constant appointments.

Margaret stays independent, feels connected and avoids another hospital stay.

Impact:
- **for Margaret:** confidence, independence and social connection.
- **for colleagues:** joined-up planning and proactive support.
- **for the NHS:** fewer admissions, shorter hospital stays, reduced long-term costs.

Living well with long-term conditions: neighbourhood care for people with diabetes

Today
Ahmed, 55, lives in Newton Abbot and has type 2 diabetes. He struggles to manage his condition and often ends up in the Emergency Department with complications. Care feels fragmented - different appointments for diet, medication and mental health support.

In five years time
Ahmed's neighbourhood hub brings everything together. A wellbeing coordinator connects him with a diabetes nurse, dietitian, mental health practitioner and local exercise group - all working as one team. He uses a digital app to track blood sugar and share updates with his care team. Peer support groups in the hub help him stay motivated.

Instead of crisis visits, Ahmed feels in control and supported close to home.

Impact:
- **for Ahmed:** better health, less stress, more confidence.
- **for colleagues:** integrated care planning and shared decision-making.
- **for the NHS:** reduced complications, fewer emergency admissions, improved quality of life.

Mental health and community connection: neighbourhood care for young adults

Today
Ella, 19, lives in Teignmouth and struggles with anxiety and depression. She waits months for specialist help and feels isolated from friends and family. By the time she gets support, her condition has worsened.

In five years time
Ella's local hub offers early help without long waits. A wellbeing coordinator introduces her to a mental health nurse, youth worker and voluntary sector partners. She joins a creative arts group at the hub and uses digital self-help tools alongside regular check-ins. Her family is involved in planning, and she feels part of a supportive community.

Ella's mental health improves, and she avoids crisis care.

Impact:
- **for Ella:** faster support, stronger social connections, improved wellbeing.
- **for colleagues:** collaborative working across health, social care and voluntary sectors.
- **for the NHS:** reduced demand for specialist services, better outcomes for young people.

Neighbourhood care: creating value and sustainability

Neighbourhood care isn't just about moving services closer to home - it's about making health and care work better for people and for the NHS. When support is local, we can prevent problems earlier, improve everyone's outcomes and experience, reduce pressure on hospitals and make the most of our resources. This means:

- **fewer emergencies, shorter stays**: strong neighbourhood teams help people stay well, avoid unnecessary admissions and readmissions and recover faster when hospital care is needed
- **shared resources, less duplication:** working together across health, social care and community partners means we use our people, facilities and funding more effectively and efficiently
- **early help saves costs:** prevention and rehabilitation reduce the need for long-term, high-cost care
- **partnerships amplify impact:** community organisations bring local knowledge and networks that help make care more personal and make every pound go further
- **care where it makes sense:** moving suitable services into neighbourhood hubs improves access and makes better use of buildings and workforce.

Neighbourhoods and hospitals will work as one seamless loop of care – virtual wards, shared records and joint decision-making will make transitions smoother and safer:

- neighbourhood hubs support people day to day and feed forward into reimagined acute services when needed
- hospitals feed back into supported recovery at home, with virtual wards, shared records and joint decision-making
- more diagnostics are available locally in people's communities, reducing the need to travel and widening access
- digital tools and smart technology will help teams work together, making care more personal and proactive.

Our focus	Milestones
Year one (2026/27)	• We will expand The Harbour, our community frailty hub, including the development of a fracture liaison service. • We will work closely with GPs and primary, voluntary and social care partners to turn neighbourhood working into reality, using our capacity and capabilities to accelerate progress. • We will expand and invest in virtual wards, the Medical Admissions Avoidance Team (MAAT) and hospital-at-home services. • We will bid for neighbourhood funding through the Local Care Partnership to support delivery at scale. • We will reduce ambulance arrivals and delays by developing alternative urgent care pathways. • We will upgrade core IT systems for neighbourhood teams, enabling effective risk stratification so support is focused on those most in need. • We will review our bed-based offer to ensure it supports reablement, promotes independence and delays unnecessary moves into long-term bed-based care.
Years two and three (2027/28-2028/29)	• We will expand neighbourhood teams and wellbeing hubs, building capacity closer to home. • We will join up hospital and home-based care through clear pathways for long-term condition management, with a strong focus on prevention. • We will implement anticipatory care planning across neighbourhoods to prevent escalation into crisis. • We will test new models of frailty care, learning quickly what works best for people and teams. • We will use data and rapid testing to support learning, improvement and innovation. • We will develop shared dashboards to support system-wide oversight of performance and outcomes.
Years four and five (2029/30-2030-31)	• We will deliver diagnostic and outpatient appointments in community settings wherever this can be done safely and effectively. We will increase the proportion of specialist appointments delivered virtually or in the community, supported where appropriate by neighbourhood and community teams.

Signature move two: reimagining acute and specialist care

Modernising hospital services and strengthening their links with community care, focusing specialist care where we can deliver the highest quality and safest care sustainably

Why this matters

Over the course of our lifetime, an accident, a sudden illness or the need for specialist treatment is almost inevitable for all of us – and when that happens, people need somewhere they can trust. Torbay Hospital is that place: a safe, skilled and compassionate environment where care happens quickly and confidently.

Our hospital exists for a clear purpose: to provide excellent local diagnostics, access to time-sensitive services and specialist care that meets the needs of our population. But demand is rising faster than capacity and hospitals everywhere are under significant pressure. Improving parts of the hospital pathway helps, but it does not address the underlying problem. We need to reduce demand on acute services through our neighbourhood model and by redesigning our services.

While it's difficult, we also need to recognise that we can't do everything we are currently doing. Where it makes sense—because of quality, staffing or cost—we will work in networks or provide care differently, always guided by what's best for people and communities. Every decision will weigh the impact on patients, colleagues and the wider pathway, not just the hospital in isolation.

This isn't about doing more of the same, faster. It's about creating acute and specialist services that learn, adapt and connect - moving from best practice to next practice, embedding research and innovation alongside humanity.

Where we are now

Torbay Hospital faces the same challenges being seen nationally: significant financial constraints, rising demand, complex discharge delays and an ageing estate. These pressures are made worse by health inequalities. But we also have strong foundations:

- an integrated health and care system, giving us a unique chance to rethink the relationship between hospital and community
- Hospital@Home and Virtual Ward models, already showing how care can safely extend beyond hospital walls
- a clear clinical framework under development, strengthening surgical and diagnostic capacity, modernising theatres and expanding day-case and elective pathways
- a Frailty support model that redesigns pathways across acute, community and neighbourhood care.
- early involvement in cancer vaccine trials, signalling our growing role in advanced therapies and innovation partnerships.

We will build on these to create a hospital that is high-performing and human-centred - technologically advanced, but defined by dignity, safety and experience.

What this means for people

Urgent and specialist care will be quick, compassionate and clear. Leaving hospital will be safe and connected to the right care at home.

Where we cannot deliver a high standard of care alone, we will work in networks so our population has access to excellent care – often closer to home through outreach clinics, telemedicine and neighbourhood hubs. For those facing barriers, extra support will make sure care is equitable and accessible.

We will embed personalised medicine and shared decision-making into every acute care pathway, ensuring people are active partners in their care. This means clinicians and patients working together to make decisions that reflect both the best available evidence and what matters most to the individual. Whether planning surgery, managing long-term conditions or responding to urgent needs, we will support people to understand their options, weigh up the benefits and risks and make choices that align with their goals and values. This approach builds trust, improves outcomes and ensures that every encounter in acute care is grounded in dignity, clarity and compassion.

At the same time, we will strengthen the role of diagnostics in acute care by expanding access to rapid, high-quality testing both within and beyond the hospital. Our Community Diagnostic Centre in Torquay will continue to ease pressure on acute services by providing timely access to imaging and cardiac investigations closer to home. We will also explore the use of point-of-care testing, mobile diagnostics including an x-ray car and AI-enabled tools to support faster decision-making and reduce delays. By integrating these innovations into acute pathways, we will ensure that people receive the right care, in the right place, at the right time - improving flow, reducing admissions and enabling earlier, more accurate treatment.

What this means for our colleagues and teams

Teams will work in an environment that feels safe and supportive, with time protected for what matters most - high-quality, compassionate care.

Collaboration across hospitals, neighbourhood and primary care will be routine, supported by real-time data, digital tools and research. We will support professional growth through shared learning, simulation and opportunities to be involved in research.

Above all, our culture will value inclusion, psychological safety and learning.

How we'll work

Reimagining acute and specialist care means:

- **from reactive to proactive:** using predictive tools to anticipate demand and reduce delays
- **from stand-alone to connected:** linking digitally and clinically with neighbourhood and primary care teams for shared care as well as with partner organisations across Devon and the south west Peninsula
- **from one-off episodes to continuity:** making recovery and rehabilitation part of the pathway

- **from isolation to networks:** creating shared standards, joint governance and mutual support across services and sites so every part of the pathway feels equal and valued
- **from top-down to empowered teams:** giving teams real-time insight and shared leadership
- **from rigid spaces to flexible design:** modernising our estate for adaptable use and better experience
- **from best practice to next practice:** embedding innovation and learning at every level.

Digital transformation will support this change, with shared records, AI-enabled diagnostics, real-time dashboards and automation to free up time for care.

From long waits to seamless flow

Today
John, 67, arrives at Torbay Hospital with breathlessness. He waits hours in A&E because beds are full and staff are stretched. After tests, he's admitted for observation, but discharge is delayed because community support isn't ready. John spends extra days in hospital, feeling anxious and disconnected from home.

In five years time
When John arrives, predictive analytics have already flagged bed availability and care pathways. He's assessed quickly, tests are fast-tracked using AI-enabled diagnostics, and his care team includes hospital clinicians and neighbourhood partners from the start. As soon as he's stable, a virtual ward and home monitoring plan are activated. Community teams are ready and John goes home sooner—with confidence that support is in place.

Impact:
- **for John:** faster care, safer discharge, less stress
- **for colleagues:** real-time data and shared planning reduce delays
- **for the NHS:** shorter stays, fewer readmissions, better use of resources.

Planned surgery – from uncertainty to personalised care

Today
Maria, 54, needs a hip replacement. She faces long waits, multiple pre-op appointments and unclear timelines. On the day of surgery, delays mean her procedure is cancelled and rescheduled weeks later. Recovery feels fragmented, with limited follow-up support.

In five years time
Maria's journey starts with a single digital care plan. She has access to an App she can use to support both prehabilitation and rehabilitation and is confident to use this. Pre-op checks are streamlined, and day-case surgery is scheduled with precision using AI-driven scheduling. Her recovery includes physiotherapy at a neighbourhood hub and virtual check-ins with her surgical team. She feels

informed and supported throughout, with fewer hospital visits and a faster return to independence.

Impact:

- **for Maria:** predictable, personalised care and quicker recovery
- **for colleagues:** integrated planning and reduced cancellations
- **for the NHS:** efficient use of theatres, improved outcomes, lower costs.

Frailty – from crisis to prevention and continuity

Today

George, 83, falls at home and is admitted with a fractured hip. While in hospital, he becomes deconditioned and loses confidence. Discharge Leaving hospital is delayed because he needs extra care at home. When he returns home his muscles are weaker and he is at risk of another fall.

In five years time

George's frailty risk is flagged early through shared data. His risk of osteoporosis is identified and treated. When he falls, the hospital team and neighbourhood hub coordinate immediately. His hospital stay is short, and discharge includes a personalised recovery plan with home adaptations, strength classes and digital monitoring. Community teams check in regularly, preventing further crises.

Impact:

- **for George:** faster recovery, independence and confidence
- **for colleagues:** joined-up working across acute and community care
- **for the NHS:** reduced readmissions, lower long-term costs, better quality of life.

Children's specialist care – from fragmented support to family-centred excellence

Today

Tom, aged 7, lives in Totnes and has a complex neurological condition. His parents juggle multiple hospital appointments in Torbay and Plymouth, and sometimes Bristol for specialist care. These journeys mean time off work and school, and care feels fragmented - different specialists, separate clinics, and long waits for therapy. Communication between hospital teams, the GP and school is patchy, leaving Tom's family stressed and uncertain.

In five years time

Tom's care starts with a single, shared digital plan that brings together hospital specialists, his GP, school nurse and neighbourhood hub. Many consultations happen virtually, reducing travel and disruption. Diagnostics and routine checks are available closer to home through outreach clinics and mobile units.

The hospital acts as an anchor for advanced care and innovation, offering access to cutting-edge therapies and research trials. Rehabilitation and family support are

integrated into the plan, with mental health and peer networks available locally. Tom's parents feel informed and supported, and his school is part of the conversation - helping him thrive both medically and socially.

Impact:

- **for Tom and his family:** less travel, faster access to care and a joined-up approach that supports school and home life
- **for colleagues:** collaborative working across acute, community and education sectors
- **for the NHS:** improved outcomes, reduced delays and stronger partnerships for children's health.

What will we do in the first year of this strategy:
We will work with key teams where the pressure is greatest and ask ourselves key questions:

- is this the care our population needs?
- are we delivering care to the standard that we would wish to receive, recognising that standards are changing as new treatments emerge.
- can we deliver this sustainably? This may relate to people, finance or our estate.

If **all** the above are true, we will deliver these services, in particular, time-critical services for our population. However, this may mean that we need to consider a different way of delivering some services. This might include networking services with other providers across Devon.

We also want to build on areas of strength and ensure local care is provided where we can do so sustainably and to a high standard.

Our focus	Milestones
Year one (2026/27)	• We will review six specialties against clear service viability criteria, including quality, safety, workforce sustainability and value for patients. • We will continue to progress legacy projects already underway to stabilise and strengthen fragile services. • We will roll out service line reporting across all specialties, using best practice and GIRFT standards to support consistent improvement. • As part of this, we will review productivity indicators and implement a productivity programme across hospital specialties, focused on reducing variation and low-value activity. • We will expand elective capacity, including additional anaesthetists and orthopaedic surgeons, to meet growing demand where this is safe and sustainable. • We will implement a new model of clinical leadership across acute and specialist services,

	strengthening accountability and improvement at specialty level.
Years two and three (2027/28-2028/29)	• We will support the Integrated Care Board's reviews of birthing services, paediatric care, and the urgent and emergency care front door. • We will reduce reliance on independent sector provision by bringing activity back into NHS services where this delivers better value and patient experience. • We will continue to expand our planned care offer at the Torbay Hospital site. • We will expand our use of telemedicine to improve access, continuity and specialist support. • We will embed GIRFT standards and strengthen research partnerships to support evidence-based improvement.
Years four and five (2029/30-2030-31)	• We will develop fully integrated acute and community pathways to support safer transitions and better outcomes. • We will introduce AI-enabled diagnostics where they are safe, effective and supported by robust clinical governance. • We will deliver excellent outcomes for the services our acute hospital provides, aiming for upper-quartile performance where appropriate and measurable.

Signature move three: joined-up care, every step of the way

Supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout.

Why this matters

Imagine a person's care as a thread. When that thread frays - at **leaving hospital**, referral or handover - the whole fabric of care begins to unravel. People feel lost, anxious and uncertain. Clinicians feel pressured, with little time for conversations that matter. We know these moments of fragmentation create risk, delay and frustration.

Our ambition is simple: to make every transition seamless so people feel safe and supported and teams share accountability for a person's whole care

Joined-up care is not about doing everything everywhere. It is about focusing on what matters most: relationships, clarity and continuity. It is about reducing "failure demand" by getting things right first time. And it is about creating a place that feels coherent, compassionate and trustworthy - for people and for those who care for them.

Crucially, this move will be shaped by the voices of people and communities with lived experience. Their insights will guide what continuity really means in practice - what feels supportive, what feels confusing and where the gaps are. We will co-design solutions with those who use services, so that joined-up care reflects real lives, not just organisational intent.

Where we are now

We have strong foundations:

- our discharge improvement and flow programme has reduced long stays and improved experience
- evidence-based pathways are in place
- virtual Wards and Hospital@Home are bridging acute and community care
- Shared Care Records are extending across Devon and the south west Peninsula, enabling shared data
- integrated health and social care teams with experience in multi-agency working
- collaborations with GPs and mental health partners to improve integration.

But gaps remain - people still experience disconnection, especially at boundaries of acute, community and mental health care. Clinicians tell us there is rarely time for conversations that build trust. This is our opportunity to turn every transition into a moment of continuity and learning.

What success looks like

Success means clarity and focus:

- advice and guidance prioritised for urgent and elective care
- new multidisciplinary teams for the highest-risk populations
- a stocktake of all pathways to understand performance and productivity
- a financial framework that enables activity to move across partners

- greater adoption of digital tools - from shared records to the MY CARE app - so people can be partners in their own health
- clear roles: what we provide and what we enable others to do.

And above all, success means our people and communities recognise their voice in the design. We will measure not only operational improvements but also the experience of people (those receiving and giving care).

What this means for people

For people, joined-up care means a single, coordinated plan that everyone involved understands and follows. It means that moving from home to hospital and back again feels smooth and supported, with follow-up calls and virtual check-ins that provide reassurance. Instead of juggling multiple appointments for physical, mental and social needs, people experience care that is connected and coherent.

For those living with frailty, dementia or complex conditions, this continuity of relationships and information can be life-changing. It brings clarity about who to contact, what happens next and what support is available. Most importantly, it creates a sense of dignity, partnership and trust - so people feel cared for, not passed around.

We will work with communities and people with lived experience to shape these improvements, ensuring that what matters most to them drives our priorities.

What this means for our teams

For us, joined-up care means sharing accountability for the whole patient journey, not just the part we touch. It means having access to the same digital information and care plans across settings, so decisions are informed and consistent. It means clarity on roles, escalation routes and shared priorities, reducing duplication and confusion.

It also means stronger relationships between acute, community, primary care and voluntary partners - relationships built on trust and collaboration rather than transactional referrals. And it means embracing a learning culture, where every stage of care becomes an opportunity to improve, adapt and innovate together.

All our leaders will champion this culture, supported by research and improvement. Feedback from people and families will inform how we work, so improvement is grounded in reality, not assumptions.

By supporting our teams' health, prevention and wellbeing, we help them do their best work - delivering safer, more compassionate and more sustainable care for our population.

How we will make it happen

We will deliver five interlocking shifts:

- **from referral to relationship:** we will replace transactional hand-offs with shared planning and responsibility across pathways, bringing our specialists together with our primary care community to agree new pathways

- **from fragmented information to shared understanding**: we will have real-time, interoperable data connecting hospital, neighbourhood, primary and social care
- **from discharge to continuity:** we will embed coordinated discharge planning from admission, including home-first principles
- **from inequality to inclusion:** we will design pathways that anticipate needs and ensure equitable access and follow-up
- **from episodic improvement to system learning**: we will use every stage of care as an insight opportunity to identify friction and unmet need.

Digital and data capabilities—shared records, care navigation apps, predictive analytics and AI-supported decision tools—will underpin these shifts.

This will be supported by investing in our people - equipping our teams with the skills, confidence and support to look after their own health and wellbeing and to support one another, so they can deliver these changes safely and sustainably.

Where prevention meets treatment

Neighbourhood teams provide continuity before and after hospital care while acute and specialist services deliver excellence at the point of highest need. Joined-up care is the connective tissue that binds these together.

By integrating digital, clinical and relational pathways across settings, we create one continuum—where prevention, treatment and recovery are not separate events but part of the same seamless story. This alignment makes every patient's experience safer, smoother and more humane. And it makes every interaction more intelligent, reducing friction and enabling care that feels coherent and compassionate.

Our focus	Milestones
Year one (2026/27)	• We will review all pathways against best-practice evidence and make changes where care is not meeting that standard. • We will identify and develop proposals for care that can safely and appropriately be delivered closer to home. • Where possible, patients will have the right assessments and diagnostics completed before referral to the acute hospital. • We will build prevention into pathways wherever possible, learning from successful models such as Joint School. • We will expand advice and guidance pathways to support earlier decision-making and reduce unnecessary referrals. • We will continue to expand our virtual ward capacity, supporting safe care at home and avoiding unnecessary hospital admission.

	• We will roll out MYCARE to support better communication, coordination and patient experience.
Years two and three (2027/28-2028/29)	• We will embed shared care records across all settings, enabling primary and secondary care teams to plan and manage care together. • We will strengthen integrated in-reach discharge planning, supporting earlier coordination and safer transitions of care. • We will co-design pathways with people who have lived experience, ensuring services reflect real needs and experiences.
Years four and five (2029/30-2030-31)	• We will use predictive analysis to support proactive planning, enabling more personalised care and tailored remote monitoring where it adds value. • We will support more joined-up workforce models, enabling rotational roles and varied career portfolios across health and care. • We will introduce interoperable care navigation tools that support personalised care plans and clearer coordination for patients and professionals.

Signature move four: smart use of technology for better care

Using digital tools and fresh thinking to make care more personal, easier to access and better connected

Why this matters

Technology and innovation should make life easier for people and teams. Used well, it frees time for human connection and gives people more control. Used poorly, it creates barriers.

Our aim is simple: combine smart tools with fresh thinking so care feels seamless, personal and safe. Every solution will be shaped by lived experience – feedback from people using our services and those delivering care. We will work with partners across the south west Peninsula to share learning and innovation, so that technology becomes a trusted part of care – not a distraction from it.

Where we are now

We've made real progress in building the foundations for smarter, more connected care – but the experience is still uneven.

We've laid strong foundations:

- our electronic patient record (EPR) programme will bring systems together
- Shared Care Records enabling safer coordination
- AI-enabled imaging pilots for early cancer detection
- remote monitoring and telehealth supporting people at home
- partnerships with universities and Health Innovation Networks for co-design and evaluation
- our Digital Futures Hub is nationally recognised as an NHS England blueprint site for XR innovation.

But digital maturity is uneven. Many colleagues still juggle multiple logins and slow systems. Real-time data isn't always available when decisions need to be made. We need to turn strong foundations into a seamless, human-centred digital experience.

What success looks like

Success means more than systems going live – it's about creating a health and care experience that feels seamless, personal and efficient. Technology and innovation will become part of everyday practice, not an add-on. People will feel the benefits in their daily lives and teams will have the tools and insight to work smarter, not harder.

We will know we've succeeded when:

- our EPR is live and delivering measurable benefits – improving flow, reducing duplication and enhancing patient experience, while maintaining performance during rollout
- AI moves from pilots to practice – supporting early diagnosis (for example phlebotomists uploading skin images for remote analytics) and predictive planning for prevention
- wearables and remote monitoring are mainstream – helping people stay safe and independent at home, for example alarm-sensors on mattresses which could alert agencies to potential falls
- legacy systems are retired and digital-first culture embedded – paper disappears and colleagues feel confident using intuitive, integrated tools

- business intelligence and data-driven decision-making are the norm – insight flows to every team, supporting continuous improvement
- our digital offer connects nationally – integrated with the NHS App and aligned with national standards.

What this means for people

For patients and families, care will feel more joined-up and personal. People's information will follow them wherever they go, so they won't have to repeat their story. People will be able to see their records, care plans and test results online, book appointments digitally and use virtual consultations when it suits them. Remote monitoring and smart devices will help people stay well at home and AI will support earlier diagnosis and tailored treatment.

Digital inclusion will be a priority – whether people are confident with technology or need extra support, they'll have the tools and help to benefit from these changes. We will work with partners such as the Good Things Foundation to reduce digital poverty in our most deprived communities so that no one is left behind. Care will feel easier to access, more responsive and more connected to people's lives.

What this means for our teams

For our teams, this will mean that technology works for them, not against them. No more juggling multiple logins or waiting for slow systems – instead, one login and integrated platforms will free up time for care. Real-time dashboards will give colleagues the information they need to manage flow, safety and workload. Our teams will be digitally skilled and enabled through training and development, supported by digital volunteers and champions.

Digital tools will reduce duplication and error, making decision-making faster and more confident. Innovation will become part of everyday practice, with teams able to test, evaluate and shape new ideas quickly. We will be able to better support research and education through simulation, immersive technologies and data-driven learning. Clinical leaders will play a key role in adoption, ensuring digital tools enhance care rather than distract from it.

We will also use digital tools to make how we work simpler and more effective in our corporate services, such as our financial and people services - freeing up time and resources to focus on frontline care.

And with better data and insight, improvement will feel easier and more rewarding. Ultimately, technology will help colleagues spend more time with patients and less time wrestling with systems.

How we will make this happen

We will:

- complete the digital foundations – deliver the EPR and ensure systems are interoperable across acute, community and social care
- make technology work for people – simplify access with single sign-on, intuitive tools and real-time information for colleagues, support people to see their records, appointments and results online

- build on our Digital Futures Hub, a recognised innovation space where clinical teams, technologists and people with lived experience work together using our three-way interface model
- turn data into insight – build a strong Business Intelligence function and an analytics engine that gives every team actionable intelligence for safety, flow and planning
- harness AI and predictive tools – expand beyond pilots, define risk appetite and partner with innovators to push boundaries
- champion digital inclusion and work with partners to address digital poverty – provide support and increase confidence and access so everyone can benefit, regardless of age, location or digital skills
- retire legacy systems and unlock existing capabilities – streamline the digital estate and make full use of tools we already have.

Benefits for today and tomorrow

This will:

- release time for care by reducing duplication, delays and administrative burden
- improve flow and efficiency through real-time insight and predictive planning
- prevent problems earlier with data-driven and AI-enabled approaches, reducing high-cost reactive care
- make resources go further by automating routine tasks and optimising workforce deployment
- spread benefit and reduce risk through shared investment and innovation partnerships across the south west Peninsula.

Technology and innovation will amplify human connection – not replace it.

How it all links together

Technology and innovation run through everything we do – the strong, continuous threads that hold everything together and give it resilience. They run through every signature move, enabling joined-up care, smarter use of resources and better experiences for people and teams.

By making digital and innovation part of everything we do, we create the conditions for better access, better experience and better outcomes – for people, for teams and for the NHS.

Our focus	Milestones
Year one (2026/27)	• We will implement our new acute and community electronic patient record in April 2026, supporting safer, more joined-up care across settings. • We will build digital skills and peer support across all roles, so colleagues feel confident using new tools in their everyday work. • We will strengthen partnerships with universities and Health Innovation Networks to deliver joint projects that improve care and learning. • We will review the evidence for AI-supported triage tools and introduce them where appropriate, such

	as in dermatology, to support timely and effective care. We will support community teams with up-to-date technology for care at home, including remote monitoring where it adds value.
Years two and three (2027/28-2028/29)	• We will strengthen integrated health, social care and community platforms to support more joined-up care around people. • We will use insight and predictive tools to better anticipate demand, plan our workforce and target prevention where it can make the greatest difference. • We will jointly design and evaluate digital pilots with our partners, learning quickly what works and what adds value. • We will continue to expand remote monitoring, virtual wards and AI-supported triage where they support safe, effective care. We will develop a learning academy that brings together clinical skills, simulation and digital capability to support learning, confidence and professional development across roles.
Years four and five (2029/30-2030-31)	• We will work towards a fully interoperable digital health environment across Devon, supporting joined-up care wherever people are seen. • We will strengthen a learning health system, using insight and AI-supported tools to help clinicians make informed decisions in day-to-day practice. • We will build a connected innovation network, linking health providers, universities and industry across Devon and Cornwall to learn, test and improve together. • We will develop personalised digital support and AI-enabled care navigation tools to help patients better understand and manage their care.

Signature move five: caring, skilled people ready for tomorrow

Creating a great place to work, supporting people to be their best selves, and building an agile, inclusive workforce for the future

Why this matters

The future of health and care depends on people – their compassion, creativity and ability to adapt. Technology and infrastructure matter, but transformation is powered by relationships, behaviours and culture.

We face a generational shift: new ways of working, new roles and new expectations from colleagues and communities. To thrive, we must become an organisation that talented people want to join and where they can stay, grow and thrive. That means creating a great place to work, supporting people to do their best work and embedding a culture of learning, inclusion and accountability.

As the largest employer in Torbay and South Devon, we have a unique responsibility and opportunity. We are not just a health and care provider – we are an anchor institution, shaping the wellbeing, economy and future of our communities. How we recruit, develop and support our people has a ripple effect far beyond our walls: it influences local prosperity, education and social inclusion.

This is not just about recruitment – it's about careers, retention, development and agency: giving people the confidence, flexibility and support to lead change, learn continuously and make decisions that improve care.

By creating a great place to work and investing in home-grown talent, we strengthen our teams, our services and our communities. When we help people to be their best selves, we don't just improve patient care – we create opportunities, reduce inequalities and build resilience in our communities.

We will embed research, education and lived experience at the heart of our approach. Our Learning Academy will offer research opportunities, multidisciplinary education and leadership development for all our colleagues. Lived experience – of colleagues, patients and communities – will shape our programmes and priorities, ensuring that every voice is heard and valued.

Where we are now

We have strong foundations:

- a history of organisational commitment to research, education and innovation.
- a multi-professional approach to developing our people
- quality improvement (QI) programmes have helped teams deliver measurable improvements
- initiatives like Care Under Pressure to promote psychological safety and wellbeing.
- excellent clinical and medical education and training and improved development opportunities for all
- strong partnerships with the local Universities, Colleges and Health Innovation Networks

But these strengths are not yet systemic. Learning is still not accessible to all, talent management is underdeveloped and leadership capacity and capability needs review. We lack a robust Business Intelligence approach to workforce planning and we need a clearer picture of the shape of services before defining future roles and career pathways.

Our people and teams are committed and skilled, but we face challenges:

- recruitment and retention pressures
- gaps in transformation, digital, research, people and education capacity and capability
- limited agility to respond to changing needs
- cultural inconsistencies in behaviours and accountability.

Our ambition is clear: to create future-ready teams who feel valued, included and empowered to lead change great care.

What success looks like

Success means more than filling vacancies – it's about building thriving, adaptive teams and a supportive, compassionate, learning culture.

We will know we've succeeded when:

- health and wellbeing and a just and learning culture are embedded - psychological safety, reflection and ownership for action become the norm
- inclusion and engagement are real - colleagues feel they belong, can speak up and see their lived experience reflected in decisions
- leadership and management are strong - clear behaviour standards and accountability, coaching and distributed leadership are present at every level
- our teams and roles are future-ready - integrating research, education and digital skills
- research and innovation are part of everyday work, with colleagues supported to participate and lead
- lived experience is visible and valued, sharping our learning, improvement and service design
- we are recognised as a great place to work and an anchor institution – attracting and retaining the best people while driving local employment, skills and career development
- talent management is proactive – identifying gaps, new and emerging roles and sponsoring career development
- agility and flexibility are built in – new roles, shared services and adaptive teams ready for change.

Alex – a newly qualified nurse, Coastal Community Nursing Team
Today
Alex has access to a named buddy and preceptorship support, but service pressures make it hard to protect learning time. Digital systems feel clunky and research opportunities seem distant. Wellbeing resources exist, but they're not always visible. Alex wants clearer career pathways and more say in shaping care.
In five years' time
Alex's development is guided by the Learning Academy, with easy access to research, digital skills, and peer support. Alex co-leads a project to improve patient

safety, and wellbeing resources are part of daily life. Career progression is clear, and Alex feels valued and heard.

Impact:

- For Alex: more confidence, better support, and a sense of belonging
- For colleagues: shared learning and innovation
- For our organisation: higher retention, improved care

What this means for our people and teams

Colleagues will feel safe, valued and supported to do their best work. They'll have opportunities to learn, grow and lead— whether through the Learning Academy, leadership and coaching programmes and research involvement. Inclusion will be visible and meaningful and leadership will feel accessible and empowering. Our colleagues will feel safe to speak up, confident to act and supported to do their best work through continuous engagement.
Everyone will feel they can contribute fully and have the flexibility to shape their careers, take on new roles and adapt as health and care evolves.

Colleagues will see their lived experience and insights reflected in our programmes and priorities and will have opportunities to co-design education, research and improvement initiatives.

Teams will become hubs of learning and innovation. Improvement won't be a project – it will be part of daily work. Collaboration across disciplines will be routine, supported by shared learning, research involvement and digital tools.

Managers will lead with clarity and compassion, setting behaviour standards and creating psychological safety. Teams will have the data and insight to make decisions and the confidence to act on them. Ultimately, teams will feel empowered, connected and proud of the difference they make.

Priya – Admin Team Leader, Cancer Services

Today

Priya manages an admin team. Leadership training is generic and not tailored to her role. Recognition is rare, and development feels focused on clinical staff. Priya wants more practical support and a voice in Trust decisions.

In five years' time

Priya has completed a bespoke leadership programme and mentors new team leaders. She's part of a cross-team improvement group, and her lived experience shapes flexible working policies. Achievements are celebrated, and Priya feels empowered as a leader.

Impact:

- For Priya: tailored development and recognition
- For colleagues: stronger teamwork and inclusion
- For our organisation: more effective, motivated teams

What this means for our patients and communities

For patients and communities, success means care delivered by confident, compassionate teams who listen and learn. They'll experience services that feel

joined-up and responsive, because colleagues have the skills and flexibility to adapt to their needs.

They'll see improvements shaped by community voices and benefit from innovations that make care safer, more accessible and more personalised. Teams who feel valued and supported means better experiences, fewer delays and higher-quality outcomes for people and their families.

Sam – Healthcare Assistant, Intermediate Care Team, Moor to Sea
Today
Sam enjoys working as an HCA but feels overlooked for training and development. Decisions seem distant, and feedback isn't always acted on. Sam wants more opportunities to learn and contribute.
In five years' time
Sam has completed an apprenticeship and co-leads a research project on dementia care. Sam's feedback shapes service improvements and peer support is routine. The culture is open and inclusive and Sam is proud to help lead change. Sam is a staff network lead and co-chairs a staff forum that influences organisational policy.
Impact:

- For Sam: new skills, influence, and pride
- For colleagues: continuous learning and support
- For our organisation: better care, stronger staff engagement

How we will make it happen

We will:

- **prioritise health and wellbeing and a just and learning culture** – with wellbeing offers, psychological safety and improvement embedded in daily work
- **champion and strengthen inclusion and engagement** – co-designing education and development programmes with colleagues, patients, partners and communities; celebrating lived experience
- **strengthen leadership and management** – clear standards, training and development, coaching and mentoring, distributed leadership and accountability
- build a Learning Academy integrating education, research, simulation and digital capability
- embed talent management and succession planning—developing local talent through apprenticeships and partnerships
- foster agility and flexibility—new roles, shared services and adaptive workforce models
- strengthen partnerships with universities, colleges and community groups to expand research and education opportunities for all colleagues.

The difference this will make

Investing in people and culture will transform care for patients and communities:

- improved safety and quality – confident, well-supported teams reduce errors, improve reliability and respond faster to risks

- improved patient experience – compassionate, engaged colleagues create more positive interactions and continuity of care
- faster access and fewer delays – agile teams and new roles help manage flow and reduce waiting times
- more personalised care – colleagues and teams skilled in digital, research and innovation can tailor interventions to individual needs
- stronger relationships and trust – inclusive, learning cultures ensure patients feel heard and involved in shaping services.

And on a practical level for us this means:

- a more attractive place to work, people actively wanting to join us
- higher retention and lower turnover costs, reducing reliance on temporary staff.
- greater adaptability to meet changing needs and integrate new models of care
- leadership capacity and capability at every level, driving improvement and innovation.

This is how we create teams that are ready for tomorrow – and a culture where everyone can do their best work for the people and communities we serve.

Our focus	**Milestones**
Year one (2026/27)	• We will introduce a strengthened health and wellbeing offer, supporting our people to stay well and helping reduce sickness absence while improving retention and performance. • We will co-design and launch a Learning Academy to attract and help people grow into future roles, including preventative, community-based and digital roles. • We will introduce a renewed leadership and management programme, equipping leaders with the skills to create positive working environments and support safe, effective care. • We will co-design and agree our advancing practice strategy, supporting new and evolving roles across health and care. • We will implement a clear culture charter and accountability framework, setting consistent expectations for leaders and managers. • We will create safe spaces where people feel confident to speak up, share experiences and learn together. • We will strengthen our people and culture insight, helping us identify priorities early and provide proactive support for teams.
Years two and three (2027/28-2028/29)	• We will establish an integrated approach to professional development through our Learning

	Academy, bringing together simulation, quality improvement and research capability. • We will develop joint learning and evaluation frameworks with system partners, supporting shared improvement and learning across organisations. • We will expand research opportunities and support for people at all levels, aligned with our ambition to attract, develop and retain talent. • We will embed lived experience as a core part of all development pathways, strengthening person-centred and people-centred care.
Years four and five (2029/30-2030-31)	• We will develop a new and expanded Learning Academy, creating the space and capability to support learning, development and innovation. • We will embed research, education and innovation into everyday work, supporting our people to learn, adapt and lead change. • We will ensure lived experience shapes all programmes and improvement work, with regular recognition and celebration of its impact.

Chapter six: making change possible – the enablers of our vision

Why this matters

Our vision is ambitious: to help every person, family and community that we serve live well, now and for generations to come. Our signature moves describe what we will change. Our enablers set the environment and conditions that make those changes possible and sustainable.

They are the essential foundations that make transformation possible - ensuring every improvement is sustainable, every innovation is ethical and every person can benefit from the generational shift we are leading.

They equip our people and teams at all levels with the tools, support and culture needed to deliver change confidently and collaboratively.

Digital and data	Giving our teams the tools and information they need, when they need it, by connecting insight, decisions and action through reliable, secure, and integrated systems
Innovation and evaluation	Creating safe spaces for people to test new ideas, learn from what works, and share improvements, so we can keep getting better together
Talent and growth	Supporting all our people to learn, grow and lead change, with clear pathways for development and a culture that values every colleague
Inclusive and responsible decision making	Building a culture where every decision is guided by our ethical framework, where we listen to people, act equitably and support colleagues and each other to make the right choices, even when they're difficult
Partnerships and communities	Bringing together the NHS, councils, universities, voluntary and community partners to work as one, sharing responsibility and shaping better outcomes for everyone
Estates and sustainability	Providing sustainable, flexible and digitally connected places that help people to deliver and receive great care, wherever it's needed
Value for money	Making every pound count by using our resources wisely, investing where it matters most, and ensuring we remain sustainable for the future

Enabler one – digital and data

Giving our teams the tools and information they need, when they need it, by connecting insight, decisions and action through reliable, secure, and integrated systems

We will provide reliable, secure and integrated systems that connect information and decisions across all our services, enabling personalised and proactive care.

A connected infrastructure will make new ways of working possible, such as virtual wards, population health dashboards, shared care records and intelligent automation, while keeping data governance, privacy and security fundamental to how we work.

Clinical leadership will guide how digital tools are designed and adopted, ensuring they improve patient safety, reduce variation and support evidence-based care. Clinicians will champion digital inclusion and lead conversations about ethical use of AI and automation.

Using digital tools to simplify how we work will help release time, energy and resources, for example in corporate services such as financial and people services - so more can be focused on supporting frontline teams and patient care.

What this involves

- unified architecture: a single digital framework across health and care, interoperable with regional and national platforms
- real-time integration: bringing together clinical, operational and population datasets for faster, safer decisions
- simplified workflows: secure, user-friendly interfaces that reduce duplication and support multidisciplinary collaboration
- actionable intelligence: analytics and automation to support proactive care and free up clinical time
- trust and security: strong governance and ethical oversight to maintain public confidence
- networked systems across Devon to support shared functions

Our focus	Milestones
Year one (2026/27)	• We will streamline core systems through the implementation of EPR and MYCARE, supporting safer and more joined-up care. • We will implement a clear business intelligence and data approach to support better decision making at every level. • We will agree a shared target operating model for digital and intelligence across Devon, supporting consistent ways of working. • We will establish a clinical leadership group to guide digital transformation and ensure it supports patient care. • We will use data and insight to inform decisions and improvement, focusing on what makes the greatest difference to care. • We will implement shared financial services to reduce duplication and improve efficiency.

Years two and three (2027/28-2028/29)	• We will develop integrated platforms across our services to support smoother coordination of care. • We will continue to expand remote monitoring and virtual wards, supporting safe care at home where appropriate. • We will support clinician-led review of AI and automation to improve safety, quality and efficiency. • We will expand shared support platforms, including people services, working across Devon where this adds value.
Years four and five (2029/30-2030-31)	• We will work towards a fully interoperable digital environment across Devon, supporting joined-up care across settings. • We will embed digital inclusion as standard, ensuring people and communities are not left behind. • We will use predictive analytics to support population health, prevention and earlier intervention. • We will support clinical leaders to champion ethical governance and patient-centred design in digital and data use.

Enabler two – innovation and evaluation

Creating spaces for people to test new ideas, learn from what works, and share improvements, so we can keep getting better together

We will make innovation everyday practice – time-boxed testing, clear measures, permission to learn and courage to stop what doesn't work. Too many promising innovations stall between proof of concept and business-as-usual delivery. Our approach will bridge this gap by connecting discovery, development, evaluation and implementation as one continuous process.

Clinical and health and care leaders will co-design innovation priorities, lead evaluation of new care models and ensure that every improvement is clinically sound and delivers better outcomes for patients. Their involvement will build trust and accelerate adoption. We will use our established three-way interface model, bringing together patient experience, clinical expertise and digital innovation capability, to ensure solutions are grounded in real need.

What this involves

- innovation and evaluation hub: a single place for research, practice-led testing and deployment-ready evidence, where clinical teams work alongside researchers with academic and industry partners

- integrated improvement: so innovation, operations and evaluation move together with a clear pipeline from innovation through to IT implementation and business as usual
- one front door for ideas: with design, analytics and evaluation support
- rapid-bid innovation fund: to unlock frontline ideas with light-touch governance
- implementation infrastructure: a dedicated digital transformation capability to bridge the gap between successful pilots and sustained adoption at scale.

Principles for success

- **fleet of foot**: start small, scale fast - time-boxed testing cycles and evaluation cycles with clear stop/go criteria
- **bravery and incentives:** permission to fail, recognition for learning and rewards for bold ideas
- **spend to save:** prioritise innovations that deliver efficiency and cost avoidance
- **replace, don't layer:** innovation should simplify, not add complexity.
- **baseline and evaluation upfront:** every project defines starting point and success measures before launch
- **learning repository:** capture and share lessons from every initiative to avoid repeating mistakes.
- **propulsive evaluation:** evaluation that generates deployment-ready evidence packages, not just assessment

Our focus	Milestones
Year one (2026/27)	• We will establish an innovation and evaluation hub to support testing, learning and improvement. • We will re-establish a transformation function to support delivery of our strategy and help turn ambition into action. • We will publish a clear set of shared measures and appoint clinical theme leads to guide improvement and innovation. • We will establish a clear innovation-to-implementation pipeline, with agreed handover points between innovation, transformation and business-as-usual services.
Years two and three (2027/28-2028/29)	• We will rapidly test and evaluate new models of care, learning quickly what works and what adds value. • We will develop an integrated learning repository that is accessible across our organisation, supporting shared learning and improvement. • We will introduce clinically led stop-go gateway reviews at each stage of the innovation pipeline, ensuring safety, value and focus. • We will strengthen routine feedback loops, connecting frontline experience to innovation priorities and improvement work.

Years four and five (2029/30-2030-31)	• We will identify priority innovations for NHS Innovation Passport accreditation, focusing on those with the greatest potential benefit for patients and services. • We will co-design innovations with communities, embedding lived experience throughout to ensure care reflects real needs and experiences. • We will ensure evaluation routinely considers value, equity and environmental impact, alongside quality and safety. • We will support clinical leaders to mentor and develop frontline improvers across the system. • We will develop sustainable income from innovation, including testbed services, intellectual property and commissioned evaluation, to reinvest in improvement.

Enabler three – talent and growth

Supporting all our people to learn, grow and lead change, with clear pathways for development and a culture that values every colleague

We will provide shared development pathways, coaching and wellbeing support so people can grow with confidence and lead change together.

Clinical leadership development will be a core strand of our learning academy and we will accelerate this, with programmes that equip clinicians to lead transformation, steward resource and influence system-wide decisions. We will create visible clinical leadership roles in every major change programme.

What this involves

- **a learning and development academy**: bringing education, leadership, improvement and digital together
- **shared learning pathways**: across health, care and voluntary sectors to enable mobility and shared competence
- **leadership at all levels**: focused on compassion, stewardship and collaboration
- **wellbeing first:** with proactive mental health and peer support
- **research opportunities for all colleagues:** with support to participate in and lead research projects
- **co-designed programmes** that draw on lived experience, ensuring our development pathways reflect the realities and aspirations of our people
- **regular feedback loops** and recognition schemes to celebrate lived experience and improvement.

Our focus	Milestones
Year one (2026/27)	• We will review and implement a revised management structure that supports clear leadership, accountability and delivery. • We will deliver and embed our culture charter and action plan, including a co-designed approach to health and wellbeing. • We will maintain a rolling programme of engagement and communication, keeping our values and behaviours at the heart of everyday work. • We will develop and deliver a refreshed leadership development programme, aligned to the national framework and the needs of our services. • We will increase apprenticeship pathways for new and existing colleagues, including digital and community-based roles. • We will complete a full policy review to embed a just and learning culture across how we work. • We will remodel people and education services so they are fit for the future and able to meet the needs of our organisation and teams. • We will maintain strong workforce controls and implement e-rostering tools, including dashboards and medical e-rostering, to support safe and effective staffing. • We will support the delivery of workforce transformation programmes across administrative, operational management and corporate roles. • We will sustain compliance with the Resident Doctor ten-year plan, supporting safe training and working environments.
Years two and three (2027/28-2028/29)	• We will broaden access to employment opportunities for under-represented and vulnerable groups, including care leavers and young people not in education, employment or training.
Years four and five (2029/30-2030-31)	• We will build agility and inclusion into how we work, so flexibility, fairness and opportunity are the norm. • We will strengthen clear clinical accountability and autonomy within teams, supporting confident decision making and improvement. • We will embed wellbeing and mental health support as part of everyday practice, not as an add-on.

	• We will support continuous learning through regular feedback, reflection and improvement. • We will embed wellbeing, inclusion and lived experience across all programmes, with regular recognition and celebration of the contribution people make.

Enabler four – inclusive and responsible decision-making

Equity-led, evidence-based decisions — even when views differ

We will build a culture where every decision is guided by a clear ethical framework, listening to people, acting fairly and supporting colleagues and each other to make the right choices, even when they are difficult. This means embedding principles that prioritise patient safety, outcomes, inclusion, support for the most vulnerable and financial sustainability while maintaining transparency and trust. We will be open about why decisions are being made, the evidence behind them, and their impact and we will always stay transparent and respectful, recognising that not everyone will agree with the direction of travel.

Our ethical decision-making framework will be aligned with our equality impact assessments and grounded in lived experience, so decisions reflect real-world impact and reduce avoidable inequality. We will strengthen how research, improvement and education inform decisions, ensuring choices are evidence-based – with quality and equity considered as standard, not as an afterthought. . Clinical leadership will be central – leading structured conversations about risks and ethics, modelling openness and supporting consistent decision-making in everyday practice.

What this involves

- **ethical decision-making framework:** clear principles and criteria for what makes a decision ethical, considering societal and organisational impact, equality and sustainability
- **risk and ethics dialogue:** embedded in operational and leadership forums
- **clinical and quality integration:** safety, outcomes and equity guide choices alongside financial stewardship
- **community voices:** lived experience informs service design, research, simulation and evaluation
- **responsible AI and transparency:** bias checks and clear governance to maintain trust
- **education and improvement:** ethics and inclusion modules in leadership programmes and simulation-based learning for complex decisions.

Our focus	Milestones
Year one (2026/27)	• We will agree a clear ethical decision-making framework to guide choices at every level. • We will establish a network-based ethics oversight model, supporting shared ownership and learning rather than central control. • We will build trust through consistent delivery and clear follow-through on decisions.

	• We will review leadership programmes to ensure ethics, equity and inclusion are embedded throughout.
Years two and three (2027/28-2028/29)	• We will launch ethics simulation training for clinical leaders, supporting confident and reflective decision-making. • We will develop clear guidance on financial impact to support responsible, evidence-based decisions. • We will embed ethical frameworks and lived experience into service redesign, from the outset. • We will integrate responsible AI principles and bias checks into digital governance as standard. • We will embed equitable processes for recruitment and promotion, supporting opportunity and inclusion. • We will publish transparent decision logs, explaining why decisions are made and the evidence behind them. • We will hold structured conversations about risk, safety and quality as part of everyday leadership. • We will expand research partnerships to evaluate the impact of ethical decision-making. • We will introduce improvement collaboratives focused on equity and safety. • We will make ethical decision-making and equality impact assessment standard practice in all major decisions.
Years four and five (2029/30-2030-31)	• We will embed open dialogue and community voices in all significant changes. • We will use staff and patient feedback to evidence trust, inclusion and confidence in our decisions. • We will support clinical leaders to mentor new decision-makers and lead ethics simulations. • We will publish an annual ethics and inclusion report, sharing learning and progress openly. • We will deliver a continuous education programme to support emerging leaders.

Enabler five – partnerships and communities

Bringing together the NHS, councils, universities, voluntary and community partners to work as one, sharing responsibility and shaping better outcomes for everyone.

We will connect partners and communities to act with shared outcomes and risks, pooling intelligence and resources in our triple role as provider, convener and enabler.

Clinical leadership will strengthen partnership working through networks across organisations, ensuring collaboration is grounded in shared clinical priorities and evidence-based practice.

What this involves

- **shared ownership framework**: with south west Peninsula partners, councils, VCFSE sector, colleges and universities
- **as a system convenor:** enabling VCFSEs to provide even greater support to the delivery of integrated solutions
- **collaborative planning forums**: at neighbourhood, place and system level.
- **joint investment and risk sharing:** with clear benefits and accountabilities
- **partnership capability:** through training, facilitation and shared learning
- **shared data and insight:** for population-level insight and learning.

Our focus	Milestones
Year one (2026/27)	• We will scope, review and evaluate all VCSE agreements — including those through the BCF, ICB and direct commissioning — to strengthen and simplify our partnerships with the voluntary sector. • We will agree future arrangements for the delivery of adult social care and continuing health care, working closely with partners to support continuity and quality. • We will take a leading role in acute provider collaborations, strengthening shared clinical leadership and delivery. • We will re-establish clinician-to-clinician forums for our top ten acute specialties, funding the time needed for GPs and consultants to work together on shared challenges. • We will convene and support joint GP and consultant forums, working with the Primary Care Collaborative Board to enable practical problem-solving across pathways. • We will take a leading role in the Health Innovation Network, supporting the faster adoption of evidence-based innovation. • We will strengthen partnership capability through development programmes for leaders and clinicians. • We will strengthen partnerships with schools and colleges, supporting skills development and future career pathways.
Years two and three (2027/28-2028/29)	• We will use population risk stratification to identify those most in need and put anticipatory care plans

	in place for the top ten per cent of our population, supported by multidisciplinary working across partners. • We will strengthen partnerships with children's services, creating pathways into employment for care leavers and young people not in education, employment or training. • We will establish priority partnership networks focused on mental health, prevention and health inequalities. • We will review and strengthen our partnership with the hospice, investing in high-quality end-of-life care. • We will deepen partnerships with universities, the voluntary sector and community organisations. • We will develop joint clinical outcomes dashboards with partners to support shared learning and improvement.
Years four and five (2029/30-2030-31)	• We will make shared services and joint investment the norm for functions that can be delivered together across Devon. • We will support clinician-led, cross-organisational improvement collaboratives, linked to our priority networks.

Enabler six – estates and sustainability

Providing fit-for-purpose and sustainable places for health and wellbeing that are flexible, adaptable and future-proofed

We will provide sustainable, flexible and digitally connected places that support people to deliver and receive great care — wherever it is needed and wherever it happens. Our estate will enable modern models of care, support flow and multi-disciplinary working and adapt as needs change over time.

Alongside maintaining and improving our existing estate, we will lay the foundations for the New Hospital Programme. While the main construction phase is expected to begin beyond the lifetime of this strategy (around 2033–34), the programme is critical to delivering the NHS 10-Year Health Plan for England and to our long-term vision for planned care, diagnostics and elective recovery. Decisions we make now - about estate, infrastructure, digital readiness and clinical models - will shape the success of that programme.

Clinical leaders will play a central role in shaping our estate. They will influence design so spaces support modern care models, patient flow and integrated working, and they will help prioritise investment based on clinical need, safety and long-term value.

What this involves

- **integrated estates strategy and delivery model:** aligning with neighbourhood care models and acute site redevelopment supported by strengthened governance
- **make best use of current estate:** ensuring safe, efficient and integrated care
- **disinvestment and reinvestment:** rationalise or exit estate that cannot meet modern healthcare standards, reinvesting in facilities that deliver quality, value and sustainability
- **modern hubs and hospital redesign:** digitally enabled neighbourhood hubs (physical and virtual), improved diagnostics and elective pathways, supported by resilient infrastructure and additional car parking. This will also provide the platform for our future hospital redevelopment through the New Hospital Programme
- **co-location:** with partners to make best use of public estate and supporting joined-up care
- **sustainability:** incorporating energy efficiency, renewable energy, Electric Vehicle (EV) infrastructure, and circular economy principles into all projects
- **risk management:** embed proactive compliance audits and integrate estates risks into organisational governance.

How this evolves

Our focus	Milestones
Year one (2026/27)	• Recruit a sustainability lead and re-establish our sustainability group • Prioritise and address high-risk capital backlog through the estates safety fund • Implement a new Computer Aided Facilities Management (CAFM) system • Establish strong clinical leadership within EFM and capital functions • Strengthen estates governance with clear board visibility of risk • Equip the EFM function with technical resources proportionate to estate need • Update the estates master plan to reflect our strategic direction and future hospital programme • Develop a long-term strategy for staff accommodation • Implement a risk-based programme to reduce backlog maintenance and mitigate critical infrastructure risk
Years two and three (2027/28-2028/29)	• Review and refresh our Green Plan based on learning from year one • Exit community estate that is not fit for purpose • Establish a new health and wellbeing hub in Torquay and/or Paignton

	• Deliver a multi-storey car park and sustainable travel strategy at Torbay Hospital • Build a new four-ward block to replace the Tower Block • Expand partner co-location at priority sites • Deliver energy efficiency, renewables and EV infrastructure projects • Embed social value in procurement and design to benefit local communities • Strengthen clinical design reviews at every gateway • Build EFM and capital capability through targeted skills and role development
Years four and five (2029/30-2030-31)	• Deliver estate solutions that optimise our neighbourhood care vision • Secure funding and develop designs for a new planned care centre at Torbay Hospital, aligned with the New Hospital Programme • Demonstrate sustained reductions in high and significant backlog with resilient infrastructure planning • Ensure universal digital connectivity across hubs • Embed structured post-occupancy clinical evaluations to track flow, experience and safety and inform future capital design

Enabler seven – value for money

Making every pound count by focusing on what genuine improves outcomes, experience and independence for patients while remaining financially sustainable for the future

Value for money starts with delivering the right care, at the right time, in the right place. We will use our resources wisely by prioritising interventions that improve outcomes, reduce harm and support people to live well - including avoiding unnecessary tests, treatments and hospital stays that add little value for patients.

We will steward public money responsibly by strengthening financial literacy, linking investment decisions to clinical outcomes and experience, and focusing resources on care that delivers the greatest benefit. This means aligning financial decisions with evidence-based practice and values-based medicine, rather than activity for its own sake.
Clinical leaders will play a central role. They will be supported to understand the financial impact of clinical choices and involved in investment decisions, ensuring resources are directed to interventions that deliver meaningful patient benefit — improving quality, safety and independence, while reducing unwarranted variation and low-value care.

This approach will support delivery of the Medium-Term Financial Plan, with a clear three-year trajectory to break even, improve the underlying position and recover £99m through efficiency, income capture and reinvestment. Financial sustainability will be achieved by improving how care is delivered — not by compromising quality or access.

There will be times when we need to stop or redesign services that do not deliver sufficient benefit for patients. We will seek clinical consensus wherever possible, but we recognise this will not always be achievable. In these cases, decisions will be guided by the best available clinical evidence, patient outcomes and experience, equity and long-term sustainability.

What this involves

- **clinical and financial literacy for all:** understanding of value, outcomes and cost embedded into leadership and professional development, supporting informed clinical and operational decision-making
- **value focused productivity:** a targeted programme of productivity reviews that focus on reducing waste, duplication and low-value activity - aiming for top quartile NHS performance in all of our clinical specialties and shared services while protecting quality and experience
- **service Line Reporting (SLR):** will become the norm, linking cost, productivity, outcomes and experience so teams can understand and improve the value of care they deliver
- **reducing low-value care:** actively reviewing where tests, procedures or pathways do not add sufficient benefit, redesigning care to reduce harm, inconvenience and unnecessary interventions
- **value dashboards:** integrating finance, quality, safety and experience data to make value visible and supporting evidence-based decisions
- **aligned investment and portfolio management:** aligning investment decisions to clear impact and benefit trajectories, prioritising prevention, community-based care and early intervention
- **income and reinvestment:** maximising income and investment opportunities through education, research and innovation**,** alongside accurate coding and best value procurement
- **clear governance for complex services:** strengthening governance for continuing healthcare, adult social care and uncommissioned services to ensure sustainability and appropriate use of resources
- **joint finance and design teams:** bringing clinical, financial and design expertise together to evaluate new models of care focusing on outcomes, experience and value
- **partnership finance forums:** co-creating reinvestment approaches that support shared outcomes and reduce duplication
- **south west Peninsula alignment:** supporting joint investment in shared services, estates and digital infrastructure where this improves value and quality of care.

How this evolves

Our focus	Milestones
Year one (2026/27)	• We will begin accreditation of our finance function as part of a wider programme to strengthen financial skills and capability. • We will implement shared finance and procurement services across Devon, supporting best value and reducing duplication. • We will ensure all care we deliver is fully understood, counted and accurately coded, so activity and value are visible. • We will deliver a Trust-wide productivity and efficiency programme, focusing on opportunities highlighted through benchmarking and evidence. • We will implement a clear and consistent accountability framework across all services. • We will pilot value dashboards in priority services, bringing together outcomes, experience and cost.
Years two and three (2027/28-2028/29)	• We will explore a range of funding options to support investment, including capital allocations, public loans, partnerships and asset disposals. • We will roll out financial skills training for all budget holders, supporting confident and informed decision-making. • We will implement clear financial strategies for education, research and development, diversifying income and strengthening resilience. • We will establish partnership finance forums with clear principles for reinvestment. • We will strengthen portfolio-based resource management, supporting clearer prioritisation and investment decisions. • We will expand service-level reporting to support productivity improvement and better outcomes.
Years four and five (2029/30-2030-31)	• We will fully implement value dashboards, shared services and advanced financial models to support predictive modelling of strategic investment. • We will embed outcome-based investment decisions, with clinical leaders co-chairing investment panels. • We will maintain a clear trajectory to break even while improving our underlying financial position.

Chapter seven: financially sustainable and affordable

Where we are now

We want to deliver great care for the people and communities we serve — now and for the long term. To do that, we need to live within our means and invest in what makes the greatest difference.

We operate in a challenging financial environment. Rising demand, workforce shortages, inflationary pressures and ageing infrastructure all add complexity. Our income is largely set through national allocations and commissioning agreements, while costs are shaped by pay awards, energy prices and the needs of our people and communities.

We start 2026/27 with an underlying deficit of almost £100m, around 15% of our annual operating spend. We have a statutory duty to breakeven. In the early years of this strategy we will need to make significant changes so that the care we provide is affordable and sustainable – while remaining safe, compassionate and effective.

Alongside this, we face major infrastructure challenges. We carry signfiicant risk in parts of our estate and critical infrastructure and we will need to explore new ways of generating funds to invest in the buildings, equipment and digital technology required to transform services.

This is not about asking people to work harder. We know our teams are under pressure. It is about working differently – reducing waste and duplication, focusing on what adds real value for patients and making clear decisions about services and ways of working that we can no longer sustain.

Why this matters

Financial sustainability is what makes the rest of this strategy deliverable. Without a credible and affordable plan, even the best ideas cannot be delivered or sustained.

Our communities rely on us to use every pound of public money wisely - balancing immediate recovery with investment in prevention, neighbourhood care and innovation for the future. Every financial decision affects real lives, the services people can access, the experience of care and the support available to colleagues.

Alongside day-to-day financial pressures, we also need to plan responsibly for major long-term investment. The New Hospital Programme, with construction expected beyond the lifetime of this strategy, is a critical part of delivering the NHS 10-Year Health Plan for England. While delivery sits in the next decade, the financial discipline, productivity improvements and capital planning decisions we make now will determine whether that programme is affordable and deliverable.

By being open about our financial position and clear about our priorities, we build trust with our communities, partners and our colleagues.

Our approach

Our financial model is built on clear assumptions about funding, cost drivers, demand and investment needs. Decision-making will be guided by principles of stewardship, transparency, value for money, equity and adaptability, and by strong alignment with our partners across Devon and the south west Peninsula.

Clinical input will be central. Clinicians will help shape priorities and investment decisions so that changes protect safety and outcomes and focuse resources on interventions that deliver the greatest patient benefit. This includes using the best available evidence to reduce low-value activity and unwarranted variation.

Our Medium-Term Financial Plan sets out the scale of the challenge: recovering from current deficits, investing in transformation and delivering savings without compromising quality or safety. It requires discipline, clarity and transparency – staying realistic about what we can deliver while keeping sight of our long-term direction.

There will be times when we need to stop, redesign or change services that do not deliver sufficient benefit for patients, or that we cannot sustain. We will seek clinical consensus wherever possible, but we recognise this will not always be achievable. Where views differe, we will be clear about the evidence, the reasons for decisions and what they mean in practice.

Building sustainability

In the short term, our priority is to stabilise our finances through credible savings, improved productivity and restoring confidence in our ability to live within our means. This creates the headroom needed for investment.

As we build confidence and create headroom, we can invest in changes that deliver better outcomes and greater value - digital transformation, new models of care and workforce development. Our plan for better care sets a clear trajectory: from deficit to break-even, then reinvesting savings to drive improvement.

Strong governance and regular review will keep us on track and we will adapt our approach as the external environment changes.

Affordability and options

Delivering this strategy requires significant investment in digital, estates, people and new models of care. We will prioritise investments that have the greatest impact on people’s lives and the sustainability of our local NHS. Affordability will be tested at every stage, with clear criteria and phased delivery where needed.

We will explore financing options - including capital allocations, system loans, partnerships and asset disposals - to maintain flexibility. We will use scenario planning to prepare for different futures and to make informed choices about where we invest, what we redesign and how we work differently with partners.

Measuring progress

We will track progress through:

- a clear timeline to achieve and maintain financial balance
- how investment shifts towards prevention and community-based care
- productivity benchmarks aligned with best practice
- progress in shifting resources into shared and neighbourhood based approaches.

Progress will be reported openly to our Board, partners and the public.

Shifting our approach

We are moving from a narrow focus on cost control to a broader stewardship role - maximising value across our health and care community and acting as an anchor institution for our communities.

Clinicians will be embedded in financial governance, ensuring decisions reflect frontline insight and patient impact. We will work with partners to develop shared investment approaches and support community-based ownership of resources where this improves outcomes and reduces inequity.

Financial sustainability is what turns ambition into reality. It gives us stability and confidence to invest where it matters most, change what no longer serves patients well and deliver our vision – helping every person, family and community to live well – now and for generals to come.

Chapter eight: turning vision into action

Our vision is about people – every person, family and community we serve and every colleague who makes care possible. This chapter sets out how we will move from words to action, creating a local NHS that feels different because it works differently: more connected, more compassionate and more focused on what matters to people.

From strategy to everyday change

This isn't about a rigid plan. It is a dynamic approach that learns, adapts and grows with the people it serves. We will balance two essentials:

- *making today better* – stabilising and strengthening the services people rely on now
- *building tomorrow together* – investing in new ways of working that reflect the generational shift towards personalised, digitally-enabled and community-rooted care.

Clinical and health and care leaders will play a central role in shaping priorities, guiding redesign and ensuring every change improves outcomes and experiences.

How we will work

Delivery will be organised so that everyone – from front-line teams to south west Peninsula partners – can see how their work connects to our vision. We will:

- join up planning, finance, people and improvement so decisions make sense for people, not just processes
- create space for reflection and learning, so we scale what works and stop what doesn't
- keep progress visible and honest, so trust grows.

Our delivery principles

These describe how we will organise and implement change in line with our core values and behaviours outlined in chapter three (our guiding principles):

- *coherence* – aligning programmes, signature moves and enablers so they deliver on our person-centred, equitable vision
- *participation* – involving colleagues, partners and communities, with clinical leadership at the centre of shaping priorities and defining success
- *transparency* – making progress and learning visible to build trust and shared ownership
- *adaptability* – refining as we learn so we stay responsive to people's needs and future opportunities.

Creating the conditions for success

To make change real, we need strong foundations. That means:

- tackling immediate pressures so care feels safe and reliable
- clarifying who owns what, so accountability is clear
- building integrated systems for planning, finance and performance
- setting up a dedicated Transformation Delivery Unit to coordinate and support change
- keeping communication open, so everyone feels involved and connected.

Governance that enables, not restricts

We will keep governance simple, clear and connected:

- a Delivery Oversight Group chaired by the Chief Executive reporting directly to the Trust Board.
- programme leads for each signature move and enabler.
- a Transformation Delivery Unit with expertise in change, analytics and engagement
- one strategic delivery plan that brings short-term improvements and long-term ambitions together
- regular learning cycles to adapt and improve
- strong links with ICB cluster governance and south west Peninsula priorities.

Learning and course correcting as we go

We will embed evaluation into everything we do:

- agree shared outcomes that matter to people – quality, experience, equity and value
- build data and insight capability for real-time learning
- use feedback loops to scale what works
- work with academic partners to strengthen evidence and share impact.

Financial stewardship

Transformation must be affordable and add value for people and communities:

- apply the financial and value framework to guide investment
- review services to identify improvement or redesign opportunities or to cease services we can no longer afford to deliver
- implement shared services and procurement with partners
- align estates, digital and workforce plans for maximum benefit.

Next six months

Our immediate focus:

- finalise the delivery framework and governance
- bring existing programmes into the new structure
- audit foundational enablers and prioritise capability building
- engage clinicians in shaping future models of care
- define evaluation and benefits-realisation
- prepare implementation and communication plans.

This is more than a technical exercise. It's a cultural shift – towards openness, collaboration and care that feels personal. By working together differently, with clinical leadership at the centre, we can create a future where every person, family and community we serve has the chance to live well.

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