NHS
Torbay and South Devon
NHS Foundation Trust

BUILDING A Brighter Future
improving health & care in Torbay & South Devon

Annual Report and Accounts 2024/25

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Torbay and South Devon NHS Foundation Trust

Annual Report and Accounts 2024-25

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

FOREWORD BY THE CHAIRMAN AND CHIEF EXECUTIVE

Welcome to our Annual Report for the financial year from 01 April 2024 to 31 March 2025, which provides an opportunity to reflect with pride on another busy year and acknowledge the progress we have made to deliver our promise of better health and care for people in Torbay and South Devon.

This is our first Annual Report together as Chair and Chief Executive of Torbay and South Devon NHS Foundation Trust and we couldn't be prouder of our people.

Each and every day our people do incredible things to keep you, your loved ones and those who need care at the heart of what they do. They're helping to make improvements in the way we provide care, which they deliver with compassion and kindness, and embracing innovation to improve what we do.

Despite working against a backdrop of increasing demand and significant financial challenges, our people continue to go above and beyond to deliver safe, compassionate care. We want to publicly thank them for everything they do.

We continue to work with our partners across the NHS, local authorities, Healthwatch, and the voluntary sector to provide services which are fit for the future, reduce inequalities, improve people's outcomes and experiences and reduce the time people are waiting for care. By working together we can deliver a truly integrated health and care system, where people can access the services and support they need, in the right place and at the right time.

We are making improvements in key areas and are seeing green shoots of recovery; our waiting times for diagnostics, planned care and cancer treatments are getting better, but we are still not meeting national targets.

With one in two people now developing some form of cancer during their lifetime, we're committed to doing all we can to ensure people can get seen and screened, diagnosed and treated as quickly as possible. We're so proud to be one of the top 20 NHS trusts in the country for cancer performance, thanks to the fantastic work of our teams.

More than 40,000 people can now access faster diagnosis and treatment for conditions including cancer, heart and lung disease since the new Torbay Community Diagnostic Centre (which is run in partnership with InHealth) opened last October. Our new £15million state-of-the-art day surgery and eye surgery theatre continues to play a vital role in helping us to reduce the time people are waiting for care.

Demand for our urgent and emergency care services also remain high and this is putting pressure on our frontline teams and the ambulance service. Our people's unwavering commitment to seeing, treating, admitting or helping people to get home has helped our performance to improve, and we're now one of the top 10 most improved trusts for urgent and emergency care performance in three key areas and the number one trust in the country for the most improved ambulance handover performance.

Our ward teams, community services and social care colleagues are helping to get people home from hospital and back to their own beds by reducing longer lengths of stay, and we're regularly the best in the south west (and often in the top three nationally) for reducing people's length of stay in hospital and getting people back home when they no longer need acute care.

Our organisation and Devon's integrated care system, which has one of the largest financial challenges in the country, remains in National Oversight Framework four due

to our performance and finances, and we receive additional support as well as scrutiny from the national and regional team at NHS England, We are making progress to ensure our financial sustainability (more details about our internal controls can be found on page 49 of our accountability report) and we are working as one system to find innovative solutions to our challenges. This has included joining the One Devon bank to manage our temporary and bank workforce and our procurement services; and our work with our partners in Devon, Cornwall and the Isles of Scilly to ensure the sustainability of some of our services through the Peninsula Acute Provider Collaborative, which is described further on page13.

We have invested in upgrading our digital capability and signed a contract for our new One Devon Electronic Patient Record, Epic, which will significantly improve access to information for both clinicians and patients and help people to receive treatment in the best place and in a joined-up way when it launches next spring.

We take our legal and legal and statutory responsibilities seriously and remain engaged with our regulators and key stakeholders. Our Care Quality Commission rating remains 'requires improvement' following the well-led inspection carried out in 2023/24, but this year inspections of our children's community and inpatient services took place with both being rated as good, which we're incredibly proud of.

Our research teams continue to lead the way, and we became the only NHS hospital trust in the South West to be selected for a groundbreaking cancer vaccine trial, which will give local people hope and better outcomes and experiences.

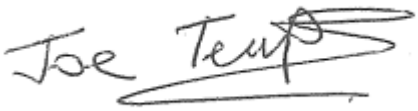
As an anchor institution we continue to think creatively about how we grow a resilient workforce while giving local people opportunities to support our community. We have strong links with South Devon College, Plymouth and Exeter universities to create a pipeline for students to develop careers in our NHS. We are proud of our unique partnership with the Open University, which began last summer and gives local people the opportunity to study for a BSc (Hons) Adult Nursing degree while completing their clinical studies in our acute and community settings.

In ensuring we have the right leadership to continue this journey, this year we welcomed a number of new executive directors and non-executive directors to the Board. This strengthened our knowledge and expertise while bringing new ideas and perspectives to our thinking and our approach. You can read more on page 49.

We're looking to our future, with new leadership in place and regained momentum; our new plan for better care will help us deliver our promise to support people to have the best start in life, to take control of their health, and to age well. It builds upon our strengths to increase quality, performance and value for money, with our commitment to quality and safety at its core. Clinical engagement is embedded across all of our programmes of work to provide safe and quality care that fosters and embeds a learning and improvement culture because these are the things that are important to us.

Listening to the experiences of people who use our NHS is vitally important to improve what we do, and our people fed into national planning; as such we supported hundreds of conversations as part of Change NHS, to help shape a new 10 Year Health Plan for England. As we look forward to 2025/26, we await the publication of this national plan, which we will align to our operating plan, while using the insights and ideas that local people, including our staff, have shared with us to shape how we think about the future of our services – particularly around better access to diagnostics, more preventative services and joining up services better - what our people have told us are their priorities.

On behalf of the Board, we would like to express our sincere thanks to all our staff, volunteers and Governors for their contributions, compassion and dedication over the last year. We are truly grateful for the continued support of our Leagues of Friends, Nurses' League, fundraisers and donors who all help to make things better for our patients, carers and staff It is thanks to everyone's dedication and passion that we have seen improvements during the past year and I hope that we continue to deliver our brighter future for people in Torbay and South Devon.



Professor Chris Balch
Chairman
25 June 2025

Joe Teape
Chief Executive
25 June 2025

INTRODUCTION, PURPOSE AND HISTORY

Our purpose and activities - who we are and what we do

Our purpose is to support the people of Torbay and South Devon to live well and we aim to achieve this by focusing on excellent population health and wellbeing, excellent experience in receiving and providing care, and by providing excellent value and sustainability.

We passionately believe that the best way to care for people is by focusing on what matters to them, putting them at the centre of everything we do and integrating services around them, ensuring provision of care by those best placed to deliver it – be it us or a partner organisation. We believe, and evidence supports, that care delivered as close to home as possible benefits everyone. An approach supported by the three shifts identified by the Government:

- Shift 1: moving more care from hospitals to communities
- Shift 2: making better use of technology in health and care
- Shift 3: focusing on preventing sickness, not just treating it

We are already seeing the benefits digital technology and innovations can make through our virtual wards, community rehabilitation programmes and wearable and trackables technology for people of all ages. Our One Devon electronic patient record, which will be implemented in the next 12 months, will help us transform how we deliver care, standardising pathways to best practice, empowering patients to become partners in their care and reducing bureaucracy and duplication.

We know that we have some of the highest levels of deprivation in the country, and health inequalities have increased over the past few years in our coastal and rural remote communities; which means that focussing on early intervention and prevention in terms of, health education, screening and monitoring is crucial in helping our population to live well both in terms of mental and physical wellbeing.

We have a proven track-record of innovation both in terms of our integrated care services and with some of our specialist clinical services, for example day surgery being nationally recognised for their best practice.

Our commitment to working in partnership to deliver better health and care and improve services underpins everything we do; and we will reflect on this as we approach 10 years as an integrated care organisation. We know that we cannot solve the challenges facing our people and communities alone. Working in partnership has helped us to improve many of our services and make a real difference to people's health and care. To that end we serve our local people by providing children’s services (Children and Family Health Devon (CFHD)) community care, including adult social care (Torbay), and acute care, from Torbay Hospital and a range of community sites.

Increasingly, we are providing more care as close to home as possible for our people, reducing their need to travel, supporting and maintaining independence while helping to keep them safe and live well. More and more we are delivering care directly into people’s homes either through visits or online or telephone appointments and offering as many appointments as we can at local health and wellbeing centres and community hubs.

We provide emergency care at Torbay Hospital and urgent care (for minor injuries and illnesses) in a number of community locations. Our urgent treatment centre in Newton Abbot is open seven days a week and offers an x-ray service. Our community urgent response teams also provide urgent care in people's own homes to avoid admission to hospital, this activity is monitored with a requirement to meet a two-hour response time, which we have met consistently.

We support around 400,000 face-to-face contacts with patients in their homes and communities each year and see over 120,000 people in our emergency department and community minor injury units annually. We serve a resident population of approximately 286,000 people, plus about 100,000 visitors at any one time during the summer holiday season.

We welcome the announcement that Torbay Hospital remains in the New Hospital Programme, although we are bitterly disappointed at the delayed timetable as this presents an increase in risk to our delivery of a safe and well-maintained estate that is fit for purpose. While we move through the process to redevelop our plans to manage our critical infrastructure risks, our hard-working colleagues will continue to work tirelessly to offer the best possible care for our patients.

While we wait for the new hospital construction, we are exploring all other funding avenues available to manage our estates issues, most recently securing £14.2million for improvements to our Emergency Department. We remain committed to working together with our staff, patients and local people to deliver the modern hospital that our Torbay and South Devon communities deserve and need.

We cover a wide geographical area, including parts of Dartmoor (Ashburton and Bovey Tracey) along with Torbay (Torquay, Paignton and Brixham), and the South Devon areas around Totnes, Dartmouth, Newton Abbot, Dawlish and Teignmouth. We employ over 6,300 people to deliver and manage our many services, from porters to consultants, nurses and health care assistants to ‘hotel’ and catering, therapists and security …. and there are many more! We are very proud to employ a workforce which affords local people employment along with highly regarded career opportunities in the NHS.

We currently have a total of 415 active volunteers comprising of 117 senior (over 70) and 53 youth volunteers (16-25). There were 152 leavers during the financial year and a further 33 people currently going through their recruitment checks and training.

There are approximately 94 people volunteering for charities – Torbay and Lifecare Radio, Pets as Therapy, Leagues of Friends and Volunteering in Health, all of which are included in the total figure of 415 active volunteers. The total number that volunteered for our Trust in 2024/25 was 567, and the volunteering service arranged and attended 240 interviews and 158 reviews were completed.

We have continued to forge many strategic and business partnerships in order to deliver, strengthen and improve our services as detailed below:

- we are the lead organisation in the alliance of Children and Family Health Devon (CFHD) which began in April 2018/2019 and is commissioned by NHS Devon; this service is delivered in alliance with Devon Partnership NHS Trust
- we work with our NHS partners (Royal Devon University Healthcare NHS Foundation Trust, Devon Partnership NHS Trust, University Hospitals Plymouth NHS Trust) as well as social enterprise company Livewell Southwest to provide

care to local people and communities
- through the Peninsula Acute Provider Collaborative we are working together to provide safe, high-quality, affordable hospital services as close to home as possible
- we continue to work with Devon County Council and Torbay Council who commission our adult social care services;
- we have a wholly owned subsidiary (SDH Developments Limited) providing an on-site pharmaceutical dispensary at Torbay Hospital
- we are a partner in a Limited Liability Partnership (SDH Innovations Partnership LLP), which is supporting our ambitions to replace out-of-date facilities with new buildings
- we are part of University of Exeter's Academy of Nursing, along with three other Devon NHS Foundation Trusts
- through Torbay Clinical School, we are in a partnership with Plymouth University to promote clinical research
- Through our partnership with our local further education institute, South Devon College, we continue to develop education and career opportunities for our local Torbay and South Devon population
- In 2021 we became a member of the South Local Care Partnership with our NHS, council and voluntary sector partners. There are five local care partnerships across the county
- we are continuing to forge closer partnership with South Devon College to align our workforce and education strategies.

Our history and statutory background of the Foundation Trust

Torbay and South Devon Foundation Trust ("the Foundation Trust or Trust") was established as a public benefit corporation, following its approval as an NHS Foundation Trust by the Independent Regulator of the NHS Foundation Trusts, authorised under the Health and Social Care (Community Health and Standards) Act 2006 on 01 October 2015.

The principal location of the business is Torbay Hospital, Lowes Bridge, Torquay, TQ2 7AA. Our licence registration number with NHS England is: 110102

In addition to the above, we have registered the following locations with the Care Quality Commission:

- Ashburton and Buckfastleigh Hospital, Eastern Road, Ashburton TQ13 7AP
- Brixham Hospital, Greenswood Road, Brixham TQ5 9HN
- Brunel Dental Centre, Brunel Industrial Estate, Newton Abbot TQ12 4XX
- Castle Circus Health Centre, Abbey Road, Torquay TQ2 5YH
- Dartmouth Health and Wellbeing Centre, Wessex Way, Dartmouth, TQ6 0JL
- Dawlish Hospital, Barton Terrace Dawlish EX7 9DH
- Kingsbridge Hospital (South Hams) Special Care Dental, Plymouth Road, Kingsbridge TQ7 1AT
- Newton Abbot Hospital, Jetty Marsh Road, Newton Abbot TQ12 2TS
- Paignton Hospital, Church Street, Paignton TQ3 3AG
- St Edmunds Victoria Park Road, Torquay TQ1 3QH
- Tavistock Special Care Dental Service, 70 Plymouth Road, Tavistock PL19 8BX
- Teignmouth Hospital, Mill Lane, Teignmouth TQ14 9BQ
- Torbay Hospital, Newton Rd, Torquay TQ2 7AA

- Totnes Hospital, Coronation Road, Totnes TQ9 5GH
- Walnut Lodge, Walnut Road, Torquay TQ2 6HP

We are registered with the Care Quality Commission (CQC) without conditions and provide the following regulated activities across the stated locations:

- assessment or medical treatment for persons detained under the 1983 Act
- diagnostic and screening procedures
- family planning services
- management of supply of blood and blood derived products
- maternity and midwifery services
- personal care
- surgical procedures
- termination of pregnancies
- transport services, triage and medical advice provided remotely
- treatment of disease, disorder or injury.

As a Foundation Trust responsible for public funds, the Board of Directors is accountable to a range of stakeholders and crucially the local people that use our services. Our local population is formally represented within our governance structure by the Council of Governors. Governors are elected from each constituency, with the number of positions weighted by the population living in the locality. Full guidance on how Foundation Trusts are required to operate is available from NHS England.

Our values and the NHS Constitution

At our core, we are deeply connected to, and rooted in, the values of the NHS. We work together for patients and our communities.

We have adopted the NHS constitution values which apply across the NHS in England. Patients, public and our people developed these together. Our shared NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.

Our values are:

- respect and dignity
- commitment to quality of care
- compassion
- improving lives
- working together for people
- everyone counts.

Our people promise is a nationally developed framework and reflects our commitment to each other, including being aware of our own behaviours (including leadership behaviours) which will help us demonstrate and deliver the NHS values and improve retention. We know that good staff experience leads to good patient experience, and our people promise incorporates seven elements:

- we are a team
- we are safe and healthy
- we are compassionate and inclusive
- we each have a voice that counts
- we work flexibly
- we are always learning

- we are recognised and rewarded.

Our people priority is to build a culture at work where our people feel safe, healthy and supported. To support us to achieve the different components of the NHS people promise we have identified three priority areas for action:

- fostering a consistent culture of compassionate leadership where it 'starts with me' to ensure that everyone is included with care, listened to with genuine curiosity and that we all act with courage
- enabling the creation of a sustainable workforce (our people and teams) to achieve our strategic goals
- creating and embedding a culture of inclusion.

We measure our progress against these priority areas on a dashboard which includes key metrics, including staff experience, retention, sickness absence and turnover. In September 2023 we launched our co-created compassionate leadership framework and our associated leadership and management development which, based on feedback received, is having a positive impact in helping us to learn, grow and foster the culture we want for our organisation; whilst we have undertaken some of that learning we have had some difficult conversations and reflection to do, for which we are very grateful to our staff for their candour and openness . In complement to this work, our inclusion training module, aimed at increasing awareness of cultural differences and increasing cultural competence, launched in January 2024, has been completed by over 5,000 of our people. Our Board solidified their commitment to this work programme in early 2024 through approval and adoption of our culture charter.

Our quarterly and annual people awards are grounded in our people promise, recognising and rewarding our people for excellence in the different areas of our people promise and for living our values.

Our partners

Our purpose, to support the people of Torbay and South Devon to live well, is delivered in partnership with local organisations and communities. We do this by working with our Local Care Partnership (LCP) and across the wider Integrated Care System (ICS) with health and care providers across Devon, Cornwall and the Isles of Scilly.

At a local level we have strong relationships with GPs and other primary care providers such as pharmacists, opticians and dentists, our local and regional voluntary, community and social enterprise organisations, and our independent sector partners who provide care home support and domiciliary care.

We work closely with Devon County Council and Torbay Council as well as the business community to improve the wider determinants of health. We take our leadership role as an anchor institution for our local communities very seriously and we have affirmed our commitment to this through a memorandum of understanding to be an active partner in community wealth building; we believe in using our influence, skills and resources to benefit the communities we serve.

We recognise the challenge of both maintaining and developing our own organisation while collaborating to improve the health and wellbeing of everyone, not only in Torbay and South Devon but in the county of Devon as a whole.

The Integrated Care System for Devon

The Integrated Care System, known as One Devon, is a collaboration of the NHS, local councils and a wide range of other organisations, including the voluntary and

community sector, who are working together to improve the lives of people in Devon.

Through One Devon, NHS Devon aims to effect the changes to health and care set out in the NHS Long Term Plan. This is intended to meet the growing challenges of providing community and hospital care and social care when demand is dramatically increasing. Through the One Devon Integrated Care Strategy and our Five-Year Joint Forward Plan we set out how we will meet the needs of the local population.

The vision for One Devon is: equal chances for everyone in Devon to lead long, happy, and healthy lives.

NHS Devon plays a pivotal role in transforming healthcare delivery for the Devon population by fostering a more integrated, efficient, and patient-centred approach.

Our focus is on reducing waiting times, ensuring quality and safety across our services, while supporting longer term reform in areas such as prevention, development of neighbourhood health services and digital innovation.

Across our organisation and system, we have made good progress in many areas recently, including with the National Oversight Framework (NOF), our annual plan and operational plan.

Our recent engagement with the Devon population on the 10 Year Plan for the NHS will also help to shape national and local priorities on how we best allocate NHS resources to deliver the right outcomes for our population.

There are also several significant programmes of work underway to improve collaboration and reduce inefficiencies for example, bringing together NHS Trust procurement teams, introducing a single HR system across all NHS organisations in Devon, alongside greater collaboration in other corporate services.

Devon 10 Year Plan engagement programme

NHS Devon, in collaboration with Healthwatch, designed the first genuine system-wide engagement programme to embed the voice of the people and communities of Devon into the national 10 year plan development whilst informing local priorities and pieces of work.

The programme provided very clear roles and responsibilities that ensured the most appropriate partners were reaching their communities as either the trusted voice or the leader of health and care services in their area. These include:

- acute and mental health provider colleagues
- Local authorities
- NHS Devon staff
- Healthwatch Devon, Plymouth and Torbay
- Voluntary, Community and Social Enterprise (VCSE) organisations.

All acute and mental health provider trusts led their own engagement campaigns to ensure their staff, volunteers, governors and patients had the opportunity to share their views. As part of the system engagement campaign, there were five engagement days across the county which were supported by communications and engagement colleagues from the providers. In addition to the 10 workshops that took place as part of the engagement days, the trusts also held 20 workshops in their organisations.

As part of the engagement programme design, there were numerous ways that the people and communities of Devon could get involved:

- complete an online survey

- attend a workshop – either online/face to face
- participate in one of the five engagement days held across Devon
- complete an engagement postcard
- telephone Healthwatch Devon, Plymouth and Torbay who would take the feedback for our digitally excluded communities or those who preferred to give feedback verbally.

NHS Devon provided a toolkit to system partners, and trusts were empowered to use the information to reach the people and communities they serve. The trusts' support in promoting the survey ensured that responses received were representative of voices from across the county.

At the time of writing the 10 Year Plan engagement in Devon has achieved 3,137 pieces of individual feedback.

The approach taken in Devon has been seen as an exemplar of best practice and has been recognised both regionally and nationally. It has given the NHS in Devon a foundation for any future system wide engagement campaigns.

Working better together across the peninsula

The Peninsula Acute Provider Collaborative (PAPC) was created in 2022 to help hospitals in Devon, Cornwall and the Isles of Scilly work more closely together. Through the PAPC we are committed to working together to provide safe, high-quality and affordable hospital services, as close to home as possible for our local people and communities.

During 2024/25 work has focused on delivering phase two of our peninsula acute sustainability programme.

We worked with clinicians to understand the strategic challenges we face as providers of hospital services and developed our case for change, engaging with our local Overview and Scrutiny Committees as part of this process. Our work here involves medical, surgical, paediatric, maternity and neo-natal services, working with clinicians to develop potential scenarios that will address the challenges and modelling those scenarios as we understand the possible implications for patients, their families and our staff.

Through our tactical service change work, we prioritised stabilising and sustaining services in the short to medium term while reducing duplication of specialist services where possible to improve equity and productivity – giving people better access and reducing waiting times. Our tactical work involves cardiology, dermatology, diagnostics, oral and maxillofacial surgery, stroke, surgery in children and urology. During the year we started a new project to design a regional sarcoma (rare cancer) service that provides sustainability across the peninsula and meets national standards.

Our clinical effectiveness workstream includes developing a new regional cancer plan in partnership with the Cancer Alliance to ensure local services align with national expectations, sustainable radiopharmacy services and procurement on a PET-CT (specialist cancer scans) for the peninsula.

Over the autumn and winter, we supported local engagement on the 10 year health plan for England. These findings will be used to inform the refreshed Case for Change as we move into phase three of the programme in 2025/26.

PART I – PERFORMANCE REPORT, OVERVIEW, RISK AND ANALYSIS

Summary of our performance

The purpose of this section is to provide information about our organisation, our purpose and main objectives, the key risks to the achievement of our objectives, and how we have performed during the year. More detailed information on the arrangements in place and our approach to ensure services are well-led is given in the Performance Analysis Report and the Annual Governance Statement.

In this section, we highlight the main developments in our services and the improvements we have made over the past 12 months. We also report our performance against key national and locally determined clinical standards.

This report outlines our position on 31 March 2025 and provides commentary on relevant post year-end matters.

Chief Executive's statement on performance

As noted, our organisation faced challenges meeting operational performance targets across emergency care, planned care, cancer care and diagnostics, similar to other healthcare providers over the past year. We observed an increase in attendance of 5.3% at our emergency department and urgent treatment centre and an increase in referrals to planned care 5%, cancer care, diagnostic, community, and children's services compared to the previous financial year. This performance challenge was further complicated by industrial action, seasonal pressures and workforce challenges.

Despite these obstacles, our teams within emergency care pathways implemented evidence-based and best-practice quality improvement initiatives resulting in positive performance improvement. We remain committed to continuing these efforts in the current financial year and meeting the national performance expectations. Leveraging our strength as an integrated care organisation, we prioritise admissions avoidance and early discharge of people from hospital to the community in the most suitable settings.

Significant progress has been made across planned care pathways, notably in reducing waiting times for people. We aim to build on this success by working closely with our system partners to further enhance patient access experience and the use of resources, and through improving productivity within existing resources, whilst building capacity in substantive workforce and facilities where needed to meet ongoing and new demands.

In cancer care and diagnostics, we surpassed our set ambitions for the year. Moving forward, we are determined to exceed the targets we have set to deliver exceptional outcomes for our people and communities.

Our commitment to collaboration across professional groups has been instrumental in addressing population health needs. Our Families and Community team, along with Children and Family Health Devon, exemplify the collaborative spirit and dedication of our workforce in delivering exceptional care and support to our communities.

An assessment of our progress and performance more generally can be found within the performance report and supporting analysis, below.

For their oversight and assurance during the year, the Board of Directors considered an integrated performance report at each meeting which described performance against these targets and any action being taken to address dips in performance.

This is informed by detailed review at the Executive, Care Group and Committee level before each Board meeting.

There was also detailed scrutiny of the different elements of the integrated performance report through the Finance and Performance Committee, People Committee and Quality Assurance Committee. At each financial quarter end, the Board confirms the position of each of these metrics to NHS England. Details of our performance during the year can be seen below.

We look forward to another year of progress, innovation, and partnership to continually improve healthcare services and outcomes for our people and communities.

Performance overview continued: our highlights, our challenges and risk profile, our successes, opportunities and our key events

Below is a summary of our highlights and risk position, noting our challenges, our opportunities and context within the Devon locality.

Our year in highlights 2024-25

As outlined in our introduction, this year we have continued to adapt and transform to meet the changing needs of our people and communities. We have continued to see a sustained high demand for our services across our organisation which has continued to affect our performance, in addition to the impact of seasonal illnesses. Thanks to the commitment of our people, closer working with our partners and delivery of key capital developments over the past few years, we have seen significant reductions in waiting times in our planned care services, cancer services and diagnostics although there is still much more work to do in all our services to ensure people are seen as quickly as we would wish.

We are working closer than ever before with our partners and with our people and teams, exploring different ways of working to reduce the time that people are waiting for care, improve patient outcomes and experience, and improve the sustainability of all our services. A good example of this is the One Devon elective pilot which is changing the way surgical teams work by widening the use of, and embedding, nationally recognised best practice processes across three specialties: orthopaedics, ophthalmology and spinal surgical services.

More highlights of our year were:

- **Regaining independence:** Working in partnership with Torbay Council and Pendennis, an independent care provider, we opened the Jack Sears Rehabilitation Centre in Paignton which provides active recovery for all individuals with recent changes to their health needs to support with regaining independence and returning home in a strength-based approach.
- **Education and people**: Our teams continue to work closely with our communities to widen participation and employment opportunities and this year we partnered with the Open University to become the first trust to guarantee clinical placements locally alongside entry criteria widening participation, meaning that people can train close to home and have access to higher education. We also celebrated the eleventh year of our ASPIRE programme in partnership with South Devon College (a supported internship for students who have an education, health and care plan). We have over 250 staff currently completing apprenticeships from both clinical and enabling workforce and have increased capacity for both Nursing and Allied Health Professionals (AHP) placement areas to over 300 this year. We have also

increased the number of foundation doctors within our organisation through expansion of foundation programme training posts.

- **Digital inclusion**: Last year we began working with the Good Things Foundation to offer low-income families, health and social care staff and the people they care for pre-paid SIM cards for their mobile phone to help them to get online. By providing free SIM cards, we are empowering individuals to stay connected, access essential services, and improve their opportunities and addressing digital exclusion in some of our most deprived communities. Take up of this opportunity has been slower than expected, however we continue to raise people's awareness and encourage people to be identified or signposted to the opportunity so that we can support them better through inclusion.
- **Research and development**: Our Research and Development department continues to grow from strength to strength and, as a site, we remain one of the best performing Trusts of our size for number of recruiting studies and commercial studies. We are proud to have a record number of clinical specialties developing their own commercial research portfolios. Having been chosen as the only site in the South West to treat patients through the Cancer Vaccine Launchpad, we have opened our second personalised cancer vaccine study. Our excellence in research has enabled us to successfully bid for £800,000 which was used to purchase essential surface-guided radiotherapy equipment which will help improve the treatment of all our radiotherapy patients. We are the only site in the South West taking part in the Chariot MS study exploring disease modifying therapies in slowing the progression of Multiple Sclerosis. In addition to supporting our medical colleagues to bring research to our population, we continue to support the development of our non-medic Principal Investigators and have a growing number of nurses, midwives and allied health professionals undertaking their PhD training to address our local health needs.
- **Focus on improvement**: Throughout everything we do, we continually strive to improve and deliver excellent, high quality, safe care to people who use our services in partnership with them. We passionately believe that the best way to care for people is by focusing on what matters to them, putting them at the centre of everything we do and integrating services around them. We believe that care as close to home as possible benefits everyone. This remains at the heart of our vision and our strategy.
- **NHS Change**: It was both heartening and inspiring to see our vision reflected in the Darzi review and the three shifts the Government wants to see the NHS making in the 10 year health plan which will be published later this year. Our thinking about our local plans has benefited from the conversations with have had with our people and communities over the winter about the 10 year plan and what matters to them.

Our challenges and risk profile

Our significant challenges and risks are derived from our financial position, the delipidated state of our physical and digital environments, the delay in access to services, maintaining our workforce and caring for our people (reducing turnover) in a difficult operational environment both regionally and nationally. The Trust uniquely provides Adult Social Care and Continuing Healthcare for the population. This comes with significant financial risk that is not held by any other Trust in the South West.

The oversight and management of these is reflected in our board assurance framework which allows us to distil our strategy into key themes (objectives) and manage our risk to delivery, monitoring any gaps in assurance that we will deliver as well as our corporate risk register. A summary of the challenges, we have and continue to face, can be found below:

- delivery of a challenging financial plan, including significant savings and productivity initiatives while maintaining a personalised and safe patient experience for all of our users
- delivery of a challenging portfolio of cost improvement programmes to maintain value for money, whilst delivering quality services
- innovation to improving operational productivity and quality whilst managing a challenging operational and financial position
- managing and reducing increased waiting lists, while improving and innovating the ways in which we deliver services; while delivering NOF4 exit criteria performance levels
- managing and making safe our estate within the capital funds envelope available to us for maintenance and build
- challenged workforce capacity and resilience: burnout/fatigue arising from ongoing significant operational pressures, risk of lack of talent pipeline and supply, and recruitment and retention of staff across specific specialties/ professional groups. This is due to no strategic business or workforce planning nationally (whilst we note the opportunity provided in the NHS workforce plan published in year)
- creating capacity for learning and development opportunities for our leadership teams and people in general due to the workforce capacity and resilience matters outlined above
- risk of unaffordable workforce costs due to increased use of bank and agency staff
- risk of inadequate management and leadership capacity to deliver transformation along with business as usual.
- risk of inability to build a culture where people feel safe, healthy and supported due to rising number of equality, diversity and inclusion (EDI) related grievances and a reported decline in workplace experience by those with disabilities or from a Black, Asian and Minority Ethnic (BAME) background.

A detailed analysis of these and our risk management framework can be found within the Annual Governance Statement, pages 107-128.

Our successes, priorities and opportunities: strategic delivery

This annual report (year ended March 2025) aligns to the revised strategy adopted by the Board in February 2022, which is reviewed annually. Key activities aligned to our strategic priorities and intent are:

What matters to you? Providing personalised and preventative care

In the autumn, we celebrated 20 years of our breast screening service. Over the past two decades, our local screening programme has screened around 200,000 women and detected around 2,000 cancers; we are saving lives.

Since the 1970s, deaths from breast cancer have decreased by 40% in the UK thanks mostly to the roll-out of the screening programme. During this time we have introduced new medical treatments and technologies like tomography and are able to offer our patients more surgical breast reconstruction opportunities than ever before. We are also offering our patients the chance to enrol in research trials and we are striving to increase the uptake of breast screening to 80% by 2028.

One in seven people live with migraine, and we run a number of clinics that focus solely on treating headache and migraines. We are actively supporting around 600 people within our Migraine Clinics and headaches services, helping people live better lives and supporting some to return to work. We are also helping to lead the way by offering CGRP (calcitonin gene-related peptide) monoclonal antibodies to over 120 people. CGRP are the first preventive medicines specifically developed for the treatment of migraines.

Nurses and therapists at Newton Abbot Community Hospital set up a new breakfast club to encourage and support their patients on Teign Ward to prepare and eat the most important meal of the day as part of their plan to leave hospital. Eating nutritious meals and drinking plenty of water plays a vital role in people's recovery, and while patients on Teign Ward are not acutely unwell, they still rely on nurses and healthcare assistants to bring them their meals and drinks. Supporting patients to make their own breakfast encourages them to get out of bed, regain their mobility and remain active and socialise with other people to avoid loneliness, particularly those who are staying in single bedrooms.

Reducing inequity and building a health community with local partners

We are proud to have full baby friendly accreditation from UNICEF UK and this year we opened a new infant feeding room at Torbay Hospital to provide a more comfortable environment for staff, patients and visitors who are breastfeeding.

It is open 24 hours a day and is equipped with comfortable seating, nappy changing facilities and a fridge to store milk. A small number of breast pumps are available for those unable to bring their own.

In our communities, our Torbay public health nursing team has been accredited with the gold award by UNICEF's Baby Friendly Initiative (BFI). This award makes the team only the second community service in the South West to achieve this level.

Through our Family Hubs we run weekly feeding and support groups to help new breast-feeding mothers and their partners to connect with our trained infant feeding peer supporters and other parents. It is initiatives such as this that help Torbay to be a child friendly place right from birth.

Through our partnership with The Good Things Foundation local people are being given free SIM cards to combat digital exclusion. The partnership is offering data on pre-loaded SIMs to anyone who is older than 18 and is from a low-income household and either has no or insufficient access to the internet at home, or cannot afford their existing monthly contract or top-up.

More and more people are using the internet and social media to manage their health appointments, do their shopping and keep in touch with friends and family. We have some of the most deprived communities in the country and want to do more to help people who are struggling financially by giving them free data to get online without having to worry about money.

Our Torbay and South Devon NHS Charity is bringing new monies into our communities with successful bids for grants to run a smoking cessation project to reach a new cohort of women in the early stages of pregnancy with support and advice and to fund a 'magic mirror' interactive projection system for our service which supports adults with severe disabilities. Other projects delivered through our Charity this year include improvements

to the maternity bereavement room, the installation of vinyls on our children's ward which has transformed the look and feel of the ward and vinyls in our Ear Nose and Throat and Audiology waiting areas.

A relentless focus on quality improvement underpinned by people, process and technology

We delivered significant reductions in the number of people waiting for treatment and care across a range of specialties. 63.8% of people are now waiting 18 weeks or less and for the first time in four and a half years, the number of people waiting 52 weeks or more is below 1,000. We know this is still far too long but we are proud of the work our teams have done to make these improvements and we are committed to working together to make further improvements.

We are now in the top 10 most improved trusts for urgent and emergency care performance in three key areas. Our four-hour performance for type 1 Emergency Department care has improved by 18% in 12 months, while our total Emergency Department four-hour performance has improved by 10%. Our ambulance handover performance has improved by 39% and we are the top (most improved) trust in the country in this area.

Aligned to our commitment to care as close to home as possible, we have one of the lowest length of stays in the country and one of the lowest no criteria to reside. Our community urgent care response usually exceeds the national target.

Our people work across our adult social care, community and acute services to support people to receive care in the most appropriate place for them, using the latest technology available to provide additional support where required. Our community physiotherapists are embracing virtual and augmented reality to deliver rehabilitation directly into people's homes, while our breast care and multiple sclerosis services are using HoloLens to support people at home and reduce the need for people to travel to hospital or community sites.

Our cancer performance has put us in the top 20 trusts in the country and we are consistently punching above our weight in recruitment to cancer trials and bringing cutting edge trials to local people. Not only is this important as it contributes to the development of new treatments, but studies have suggested that participating in cancer trials may be associated with improved outcomes, especially for people with rare or hard-to-treat cancers.

Building a culture at work where people feel safe, healthy and supported

As above, where we describe our compassionate leadership framework, we are mindful of our commitment to lead our teams and not only create but nurture a culture which aligns with our values. We have therefore acted on the messages from our staff, provided by our staff surveys, feedback received during the year and are especially proud of and grateful to those staff members who have raised concerns (anonymously and directly) to ensure our Trust is a safe, healthy and supportive place to work.

We launched our partnership with the Open University to offer local people the opportunity to study and train to become a nurse. Our first recruitment campaign resulted in 25 people applying to study for their nursing degree, without the need to commute to university and with us guaranteeing all clinical placements across our acute and community settings. The aim of this partnership is to attract people to nursing who

have previously been unable to pursue it due to family commitments or personal circumstances.

We celebrated the achievements of over 300 of our amazing people at our annual people celebration event in May. We recognised the winners of our core our people awards as well as the winners of the DAISY Award for nurses and midwives, the primrose award for health care support workers, the My manager cares that I'm a carer support award and awards that recognise specialty, specialist and associate specialist (SAS) doctors, resident doctors and Allied Health Professionals.

As well as celebrating those who had won awards during the previous year, Dr Freddie Sweeting and the breast care unit were named the winners of the prestigious individual and team Our People's Choice awards respectively, which members of the public voted for in their thousands. The awards recognise the compassion, kindness and hard work of people who go above and beyond to provide exceptional care.

Young Devon was crowned the winner of the People Partner award, which is given once a year to colleagues from partner organisations who make a difference to people who use Torbay and South Devon NHS services or their carers.

The Charity Champion Award was also presented to Jane Read, Gill Walach and Cheryl MacKinnon who, between them had raised more than £20,000 for the Torbay and South Devon NHS Charity on top of their busy day jobs.

In July we unveiled our new 'wall of fame' at Torbay Hospital which recognises our award-winning colleagues.

We have increased the number of mealtime companions who are supporting our patients by 400% in the past year. Our mealtime companions are volunteers who help out at breakfast, lunch and dinner time, offering practical help to make sure people are able to eat their meals. They also provide social support by talking and listening to people to help their mental health and wellbeing, which plays a huge benefit in people's recovery.

Improving access to specialist services through partnerships across Devon

We officially opened the new Torbay and South Devon Community Diagnostic Centre (CDC) in Market Street, Torquay, in November, giving thousands of people in the area access to faster diagnosis and treatment for a range of conditions including cancer, heart and lung disease. The partnership between ourselves and InHealth, the UK's largest specialist provider of diagnostic solutions, is helping to speed up treatment, reduce waiting lists and give people access to tests in the town centre rather than visiting Torbay Hospital, allowing teams there to focus on more complex and urgent and emergency care and reducing the chance of appointments being postponed at times of high demand. More than 40,000 diagnostic tests are expected to be carried out during the centre's next 12 months.

In partnership with Torbay Council and Pendennis (an independent care provider) we opened the Jack Sears Rehabilitation Centre in Paignton. The focus of Jack Sears is on supporting an active recovery for all individuals with recent changes to their health needs to support with regaining independence and returning home swiftly.

The rehabilitation support is provided by our staff and comprises of a therapy lead, an assistant practitioner, physiotherapist, occupational therapist and our discharge coordinator who are based at the unit. They work alongside the Jack Sears care team

and manager, and this maintains a consistent staff group and continuity for the people in being treated in Jack Sears which helps achieve the best outcomes possible. In addition, the community nursing team support Jack Sears, alongside dietician and pharmacy support and the local GP practices.

We have formally signed a contract for an Electronic Patient Record (EPR) with Epic, along with our system partners at University Hospitals Plymouth NHS Trust. The signing of the contracts signifies a major step forward by all three acute NHS trusts in Devon and by investing in a system from the same supplier we will be making the most of digital advances. Royal Devon University Hospital patients have already been experiencing the benefits of the Epic electronic patient record. Having a single digital record for each patient improves the visibility of information between medical teams, which helps to improve safety and quality of care. This same digital record also offers patients better access to information about their own care through MY CARE, a digital platform for patients, which was introduced for East Devon in 2020 and for North Devon in 2022.

All three trusts are now working closely with Epic with a planned go live date for us in spring 2026 with University Hospitals Plymouth following in Summer 2026. As the Devon rollout takes place, additional functionality will be made available in the Royal Devon University Hospital system too, which will improve the overall system for all three trusts.

Improving financial value and environmental sustainability

We welcome the announcement that Torbay Hospital remains in the New Hospital Programme, which will now see our main construction timetable starting between 2033 and 2035.

We would like to thank everyone who has supported us as we made the case for investment into Torbay Hospital. While we wait for the new hospital construction, we will be exploring all other funding avenues available to manage our estates issues. We remain committed to working together with our staff, patients and local people to deliver the modern hospital that our Torbay and South Devon communities deserve and need.

Our Emergency Department at Torbay Hospital is benefitting from a £14.2 million capital investment which will increase capacity and help reduce the time people are waiting for urgent and emergency care. We are using the additional capital funding to build a new wrap-around extension for the Emergency Department, using modern methods of construction for speed and efficiencies.

The development is allowing us to create a new space for our Same Day Emergency Care Unit (SDEC) and support capacity and flow improvements throughout our existing emergency pathway. It will also create a new dedicated triage area for people in crisis who need mental health support.

We will be able to significantly improve the environment in our waiting areas which will make the whole experience better for people who need our services, who will also benefit from new digital triage and enhanced digital infrastructure ready for our Electronic Patient Record implementation.

A project run by our Electronic Patient Record team focusing on digital literacy and inclusion has been shortlisted in the prestigious Health Services Journal (HSJ) digital awards 2025. A four-month survey ran last year and more than 550 responses were received from staff from a range of clinical and non-clinical roles, with varied levels of

experience and from across the acute and community sites.

The project is shortlisted in the digital literacy, education and upskilling category of the awards. Digital transformation isn't just about systems and processes, it's about people, their struggles and silent worries regarding technology. Our project aims to remove that stigma by providing tailored, evidence-based support that meets people where they are, empowering them to learn without fear or judgment. This isn't just about digital literacy; it's about inclusion, confidence, and ensuring that no one is left behind in the NHS's journey toward digital excellence.

The research revealed that most staff have a good level of digital skills, but there are gaps in areas such as cybersecurity, accessibility features, and electronic-health tools. Digital confidence tends to decrease with age, years of service and seniority in banding, while training preferences vary significantly by levels of experience.

The team plans to run the survey again to make sure that it can track improvements and focus on getting more responses from under-represented minority groups and those in frontline roles.

Our new partnership with South West Blood Bikes has resulted in more than 350 deliveries with volunteers covering thousands of miles across Torbay and South Devon to support our patients and services. They are assisting with medicine deliveries and couriering samples to and from laboratories as well as vital blood deliveries and donor human breast milk for premature babies.

PERFORMANCE ANALYSIS

Financial position

The financial framework in 2024/25 remained largely unchanged from 2023/24 with the Trust receiving block funding from commissioners adjusted for performance against delivery of the elective recovery targets.

Our adjusted financial plan for 2024/25, which included £34.0m of non-recurrent deficit funding, but excluded the net cost of donated income, expenditure and the impact of the year end buildings and land revaluation, was to produce a deficit of £13.6m. Delivering this plan required us to produce savings of circa £39.9m whilst minimising the impact of inflation on the cost of goods and supplies that we purchase from third parties.

Actual savings delivered during 2024/25 totaled £27.9m, but cost pressures have been substantial and consequently we ended the year with a deficit of circa £33.5m (excluding the net cost of donated income, expenditure, Private Finance Initiative (PFI) remeasurement and the impact of the revaluation of Buildings and Land).

Inclusive of the net impact of donated income and expenditure transactions, PFI remeasurement as well as impairments caused through the revaluation of Land and Buildings, our total revenue deficit for the year totaled circa £48.7m as set out in Financial Statements.

Our financial environment for 2025/26 remains challenging, with a planned adjusted deficit of £8.0m to be delivered. This deficit is after the receipt of £65.1m of non-recurrent funding including deficit support funding and after the delivery of a substantial savings programme totaling £41.5m. Continued focus will be required to contain cost pressures. We will be required to reduce the underlying planned deficit in 2026/27 and in subsequent years through further savings programmes.

Going concern

Our financial statements have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires the Board to assess, as part of the account's preparation process, our organisation's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the trust without transfer of its services to another entity within the public sector.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Operational performance

New Facilities for Surgery

February 2024 saw two new theatres opened at Torbay Hospital. One dedicated for eye surgery with the capacity to treat 3,000 additional patients a year, and the other a dedicated day surgery theatre expanding capacity in our highly successful day surgery unit. The new day surgery theatre can treat 1,500 patients a year. Focussed on quality of care, this investment in our theatres allows patients to return home the same day and is reducing waiting times for patients. Routine cataract surgery waiting times have greatly reduced with wait to surgery down to two weeks for simple cases, and six weeks to be seen and diagnosed in outpatients. This is a huge benefit to our patients and through further repatriation of work from the Independent Sector will subsequently help the Trust's overall financial position.

Pathology and Radiology Services

In January 2024 the Pathology Service embarked on a seven-month project to replace the Laboratory Management System (LMS) – this was the first step on the journey towards a new EPR – Epic. The project was delivered at significant pace and was the fastest deployment globally of the project. This project ran alongside the implementation of ICE (Integrated Clinical Environment) Order Communications which allows full electronic ordering of diagnostic tests both within the acute and primary care sectors which were previously paper based.

Community Diagnostic Centre (CDC) Opens

2024 also saw the official opening of the CDC in Torbay, this facility gives much needed additional capacity and easier access for all imaging – MRI (magnetic resonance imaging), CT (computerised tomography), X-Ray, non-obstetric ultrasound, as well as echo cardiology, respiratory testing and phlebotomy.

Performance Challenges in 2024/25

Trajectories for 2025/26

Looking ahead to the next financial year, we have set ambitious targets in line with the operational planning guidance:

- achieve a four-hour Urgent and Emergency Care (UEC) performance rate of 78% by March 2026.

- Reduce the number of patients waiting over 52 weeks to less than 1% of total waiting list by March 2026.
- Increase performance for cancer treatment to 75% for treatment within 62 days of urgent referral and 80% of patients to be given their diagnosis within 28 days of referral.
- Improve diagnostic waiting times towards 95% of people receive diagnostics within six weeks by March 2026.

These trajectories underscore our commitment to continuous improvement and the delivery of high-quality healthcare services to our communities. We remain focused on achieving these goals through strategic initiatives and operational excellence.

Urgent and emergency care performance

Performance and quality of care are evaluated through a comprehensive set of metrics, with a key focus on the national benchmark known as the four-hour standard. This measures the time patients spend in the emergency department before being admitted to a hospital bed or discharged, providing a crucial indicator of both performance and experience. However, our assessment of performance extends beyond this headline metric to encompass a broader range of key indicators.

In addition to the four-hour standard, our metrics include, among others, ambulance handover delays, urgent community response (UCR), instances of delayed discharge from hospital beds and prolonged lengths of stay. Together, these metrics offer a more comprehensive view of the performance of our urgent and emergency care pathways.

During 2024/25, while our performance in meeting the national four-hour standard fell short, we have seen noticeable improvements towards the end of the year with a significant step change in performance in four-hour waiting times and reduced ambulance handover times. We have actively engaged in a recovery program under national oversight, involving regular meetings with NHS England support from Regional Support Programme (RSP) and Emergency Care Improvement Support Team (ECIST) to support our plans, progress, and actions.

Throughout 2024/5, we have collaborated on improvement programs with our Devon system partners. This collaboration includes engagement with commissioners, ambulance services, mental health teams, primary care providers, adult social care and children's services.

We have continued to seek opportunities to innovate across the Integrated care Model. Working closely with our intermediate care and community teams, we have targeted improvements specifically aimed at enhancing urgent and emergency care pathways in the community setting.

Recognising the limitations of our physical environments (within emergency departments and hospital acute bed capacities), our focus has been on exploring and supporting all viable alternatives to hospital referrals. Furthermore, we have implemented improvements to ensure that only people truly in need of hospital care remain in hospital. We continue to have one of the lowest rates of patients remaining in a hospital bed with “No medical Criteria To Reside” with established efficient and robust discharge processes for people with complex ongoing care needs. These efforts collectively reinforce our commitment to optimising outcomes and experiences for people within the urgent and emergency care setting.

Performance in urgent and emergency care in 2024/5

Torbay and South Devon NHS Foundation Trust

RAG rated against monthly Operational Plan trajectory	Target March 2026	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)		3217	3667	2846	3249	2488	2248	1576	3330	4343	3275	3108	2532	1625	1268	806
Average handover time (mins)	45 mins			93	102	83	71	56	106	139	109	95	84	62	47	35
Total average time in ED (hours/minutes)		06:39	06:33	06:04	06:00	05:43	05:34	05:25	06:20	06:44	06:18	06:17	06:20	05:53	05:26	04:58
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0	836	861	722	800	672	588	525	779	979	854	793	818	677	615	415
UEC 4-hour target (RAG against local trajectory to national target)	78%	63.2%	65.7%	67.7%	71.6%	70.8%	70.3%	70.7%	65.5%	68.7%	67.3%	65.0%	66.7%	68.8%	70.1%	72.8%
% patient discharges pre-noon	33%	23.3%	24.0%	22.3%	22.1%	21.3%	19.4%	18.9%	20.8%	21.5%	22.3%	20.4%	19.9%	21.2%	22.6%	22.4%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	4.9%	4.8%	4.9%	5.6%	7.8%	6.5%	6.0%	6.9%	5.9%	9.5%	6.6%	8.3%	9.1%	7.4%	8.1%

We have experienced a significant increase in demand, with an increase in emergency department attendances (5.3%) and the number of people requiring hospital admission (3.5%) since 2023/24, a trend consistent with national peers.

One of the major challenges we have faced has been managing ambulance handover delays. To address this, our teams have collaborated closely with the ambulance service, implementing enhanced care co-ordination escalation when waits increase. This includes ensuring appropriate prioritisation and timely escalation of cases, optimising the flow of patients to match daily demand patterns thereby reducing variation in service provision to better align with system capacity.

Looking ahead to 2025/26, our strategy builds upon these efforts and build capacity for Same Day Emergency Care (SDEC) for patients who require extended assessment and specialist intervention, but do not necessarily need full hospital admission, and virtual ward. These initiatives are pivotal in improving overall performance and managing the increase in demand for urgent care services.

Summary of performance in urgent and emergency care

We have seen a rise in urgent care referrals with further developments underway to optimise out of hospital care and avoid people needing to attend our emergency department. Our teams have made significant improvements on pathways of care with SDEC and virtual ward, resulting in improved patient experience and reducing risk of potential harm.

Our performance on ‘No Criteria To Reside’ across the year has remained strong and has been close to, if not exceeding, the national target. Overall average length of stay in amongst the best performance not only in Devon but in the southwest region. There is much more to do to continue and accelerate these improvements in the next year building on the progress made over the last twelve months.

Maternity performance

Maternity assurance metrics are based on the required reporting as set out by NHS England Perinatal Quality Surveillance Model (2020) and three year delivery plan (2023).

They are also based on the requirements set out in the maternity incentive scheme (MIS) as part of the clinical negligence scheme for trusts (CNST) via our maternity and governance and quality group. Metrics are shared via quality and safety assurance groups within the organisation and are visible at Trust board level.

Birth rate

The number of births for 2024/25 was 1,672 This is a reduction from 2023/24 when it was 1760 and reduction in birth rate is a national trend.

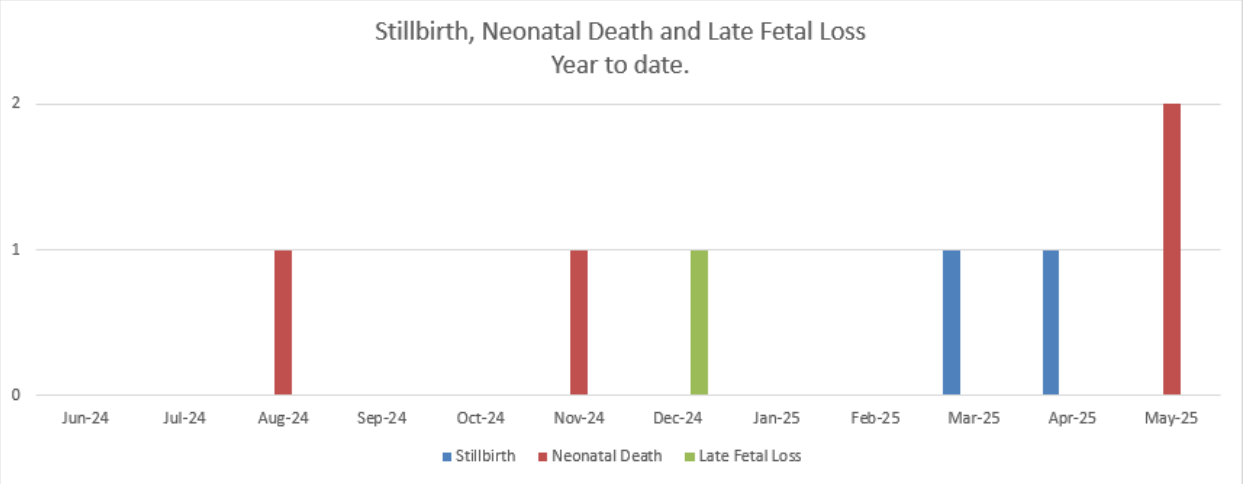
There continues to be an increasing complexity associated with pregnancy and birth due to several factors. These include demographics, health inequalities as well as being related to the standards that underpin safe care. There is also an increased requirement for operative/obstetric intervention during the birth process which impacts on the resources and capacity of the services.

Maternity Safety Support Programme

The maternity service was entered onto the Maternity Safety Support Programme (MSSP) in July 2024. This is a national support programme that is in place to provide intensive support and oversight into maternity services where concerns have been identified. The service was entered due to the Devon system inclusion in the national recovery support process. A national improvement advisor is working with the perinatal team to co-produce a maternity and neonatal improvement plan as well as outlining the exit criteria that will enable progression through the programme

Perinatal Mortality Rate

The graph below shows the perinatal mortality detail for 2024/25. The service recorded three stillbirths, one late fetal loss and two neonatal deaths in 2024/25.



Smoking rates at time of delivery

Continuing progress has been made against the reduction in smoking at time of delivery. The 2024/25 annual rate is 5.5 % which is below the national ambition of 6% for the first time. The team produced a video in which women shared their story around the successes in quitting. We are also participants in the national smoke free pregnancy incentive scheme.

These achievements highlight our ongoing dedication to advancing maternity care, embracing best practices, and prioritising the health and wellbeing of expectant mothers and their babies. As we continue to navigate evolving trends and challenges in maternal healthcare, our commitment to excellence remains unwavering.

Performance for Planned Care

Cancer care

In 2024/25, Torbay and South Devon received 23,380 Urgent Suspected Cancer (USC) referrals, representing a 2.4% increase compared to last year. This rise equates to approximately 47 additional referrals each month, reflecting the growing demand for timely cancer diagnostics and care.

Despite this sustained increase in referrals, the Trust has continued to improve performance against national Cancer Waiting Time (CWT) standards, ensuring that patients receive faster access to diagnostic and treatment pathways.

We are pleased to report that the Trust has consistently met or exceeded the key national cancer standards outlined in the 2024/25 NHS Operational Planning Guidance:

- **28-Day Faster Diagnosis Standard (FDS)**

  In March 2025, the Trust achieved 79.4%, with an annual average of 78.9%, exceeding the national target of 77%. This standard ensures that patients receive a definitive diagnosis (either ruling cancer in or out) within 28 days of referral.

- **62-Day Referral to Treatment Standard**

  In March 2025, performance reached 73.8%, with an annual average of 75.0%, again exceeding the national target of 70%. This standard measures the percentage of patients who start their first definitive treatment for cancer within 62 days of an urgent GP referral.

Referral to Treatment (RTT) and long waits

In 2024/25 Torbay and South Devon received 126,200 referrals up from 119,900 (5.3% increase) the previous year.

Overall a reduction in the number of long waits for elective care has been achieved with the number of patients waiting over 18 weeks reducing from 13,462 to 12,937 and those over 52 weeks from 1,764 to 931.

The completion of two new and additional New Day Surgery theatres, with one being an additional dedicated eye theatre has enabled increase in capacity and less reliance on expensive weekend sessions to support meeting increasing demand and to reduce the backlog in long waits.

Achievement against the key metrics surrounding the longest waits in 2024/25 include:

- having no one waiting over 104 weeks for RTT
- reducing the number of people waiting over 78 weeks to less than 10
- improving performance in reducing the number of people waiting over 65 weeks, with only 145 people exceeding this threshold at the end of March 2025
- reducing the number of people waiting over 52 weeks from 1,791 end of March 2024 to 931 at end of March 2025.
- significant strides have been made in ophthalmology, against cataract waiting times and notably in reducing the backlog of glaucoma follow up cases.

Torbay and South Devon NHS NHS Foundation Trust															
RAG rated against monthly Operational Plan trajectory	Target March 2026	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA															
Elective recovery															
RTT 104 week wait incomplete pathway	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	125	58	99	70	16	16	11	17	10	6	0	12	14	7
RTT 65 week wait incomplete pathway	0	695	470	423	416	382	353	368	285	242	239	229	204	215	141
RTT 52 week wait incomplete pathway	268	1985	1817	1796	1661	1615	1703	1761	1651	1451	1276	1265	1238	1209	931
Patient waits over 2.5 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Faster Diagnosis Standard - % of GP referred patients diagnosed within 28 days	80%	80.9%	78.4%	78.1%	77.1%	81.1%	80.2%	79.0%	80.1%	78.4%	71.5%	82.1%	75.6%	83.1%	79.2%
Number of patients waiting longer than 62 days for treatment	138	112	83	104	96	91	87	90	85	78	77	110	95	94	111

Diagnostic performance

In October 2024 the Community Diagnostic Centre (CDC) opened in Torquay town centre. This development has increased overall capacity across CT/ MRI /Ultrasound/ Plain film and echocardiograph. The opening of CDC has meant that the frequency of mobile CT and MRI can be reduced and will support reduction in waiting times over the coming year for routine diagnostic tests.

In February the installation of a new CT scanner commenced.

Children and Family Health Devon (CFHD)

Our focus within CFHD is to deliver a patient centred, multi-pathway approach, which brings together the clinical tools and workforce to provide an accessible, safe, patient-centred service. We launched a new website to reflect this model and an integrated patient record system is now in place.

During 2024/25 CFHD successfully concluded a consultation and estates optimisation project to co-locate service delivery in one site at Evergreen in Exeter. Additionally, CFHD acquired additional clinical and administrative space in Tiverton at Oaklands Court to support co-location of services on the basis that this estates model supports the integrated care model.

We have improved waiting times in many pathways (eating disorders, children in care and mental health) and we have completed more review health assessments for children in care within the statutory timeframe. Capacity, activity and demand work has taken place to ensure activity standards for each clinical pathway to improve timely access.

Among the long-term plan deliverables for mental health, urgent referrals for eating disorder are now seen within seven days with 100% compliance. The national access target measures the number of children within the year who have attended one appointment within an NHS funded service to address their mental health condition. The target for CFHD in 2024/25 was 11,801 and the services achieved 13,215.

SEND (special educational needs and disability) action plan targets have improved. Submission of advice for education health and care plans has improved from 45% to 91% within the six-week statutory timeframe.

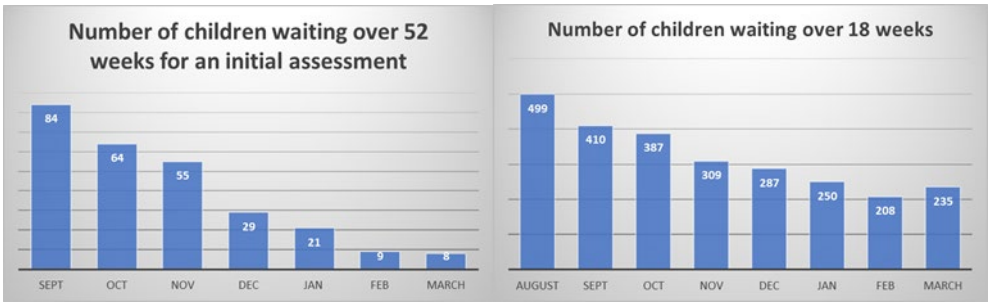
Review of the CFHD specification with our commissioners is complete, with four areas where the limitations of the pathway led us to jointly agree that we needed to instigate a harm review to identify the extent of the impact on children (end of life care, rehabilitation, speech and language therapy access and early years interventions). These are now complete and workstreams to develop system-wide integrated pathways are being led by our commissioners.

Objectives and progress for 2024/25 include:

- Recruitment and retention strategy alongside workforce planning

  Vacancy rates continue to reduce, now sitting at 11% across CFHD (equating to 71.63 whole time equivalents (WTE)); it was 16.5% vacancy rate in February 2024. The Mood, Emotions and Relationships (MER), Urgent Care and Neurodiversity pathways are experiencing the highest vacancies. Active recruitment remains ongoing across all areas.

- Capacity, activity and demand work to optimise access and continue to reduce waiting times.
- There has been noticeable improvements evidenced in MERS Mental Health. Over 52 week waits and over 18 week waits for initial assessment has significantly reduced as demonstrated below. Additionally, waits for intervention have been steadily reducing since July 2024.



- Trajectory reporting has been optimised across Speech and Language, Occupational Therapy and Neurodiversity to better inform and pathway delivery and maximise capacity to meet ever increasing demands
- Continued SEND improvement aligned to SEND strategy in Devon and Torbay
- CFHD strategy for digital and estates
- Development of CFHD clinical recording standards now that we have an integrated patient care record

Quality goals and patient care

Our Quality Account for 2024/2025 expands on our strategic commitment to delivering improved, personalised, patient care. We have retained our four quality and patient safety goals reflecting our continued focus on embedding and sustaining the improvements achieved in the previous year.

Under each quality goal sat several clinical priorities, our quality priorities for 2024/2025 were:

Quality goal 2024/25	Quality priority 2024/25
Continuously seek out and reduce harm	Improve identification and management of sepsis Strengthen the quality of our mental capacity assessments (MCA)
Excellence in outcomes	Reducing falls and harm sustained from falls Reducing emergency and elective care delays
Deliver what matters most to our people	Listening to our people
Reduce Health Inequalities	Seek, identify and address health care inequalities

A summary of our progress and performance against these goals is provided below, with a more detailed analysis available in our Quality Account 2024/2025.

Progress against quality priorities 2024/25

Quality Priority	Progress	Plan
Improve identification and management of sepsis	Against our target of 100% compliance with the sepsis bundle, our emergency department achieved an average of 97% compliance. Despite on-going pressures, 96% of patients received antibiotics within 60 minutes, demonstrating strong performance under challenging circumstances	Continue as a quality priority in 2025/26 to embed and roll out to other high-risk areas
Strengthen the quality of our mental capacity assessments (MCA)	Our safeguarding adult/mental health capacity (MCA) leads have worked to improve the quality of our mental capacity assessments by providing additional training and support for staff, visiting ward areas and improving the process to enable a more holistic assessment. An audit undertaken in February 2025 highlighted areas of improvement and also areas requiring further work.	Continue as a quality priority for 2025/26 with work to develop a standard operating procedure for staff. An action plan will be worked through over the next year
Falls Reduction	Trust renewed its commitments to reduce the number of patients who fall within our care and the level of harm experienced if patients do fall. Over 350 staff have been trained in falls prevention. We have continued to embed the fall safe audit, including visual assessment, lying and standing blood pressure and to audit compliance against this. We have seen a reduction in patients who fall and sustained a fractured neck of femur, this is evidence of improved safety. This work remains high profile and ongoing and will continue as business as usual	Work will continue as business as usual. To be stood down as a quality priority

<table>
<tr>
<td>Reducing elective and emergency care delays</td>
<td>Over the past 12 months we have continued our focus on reducing delay across our emergency care pathway to improve patient safety and quality of care. Our Trust has demonstrated significant and measurable improvements across Urgent and Emergency Care (UEC). Our progress is reflected nationally as being one of the top 10 most improved Trusts in the country for three key measures.

<u>Elective care</u> we have made significant progress in meeting national targets for waiting times which is seen in the table below:

<table>
<tr><th></th><th>April 24</th><th>April 25</th></tr>
<tr><td>52 weeks</td><td>1796</td><td>914</td></tr>
<tr><td>65 weeks</td><td>423</td><td>145</td></tr>
<tr><td>78 weeks</td><td>99</td><td>4</td></tr>
</table>

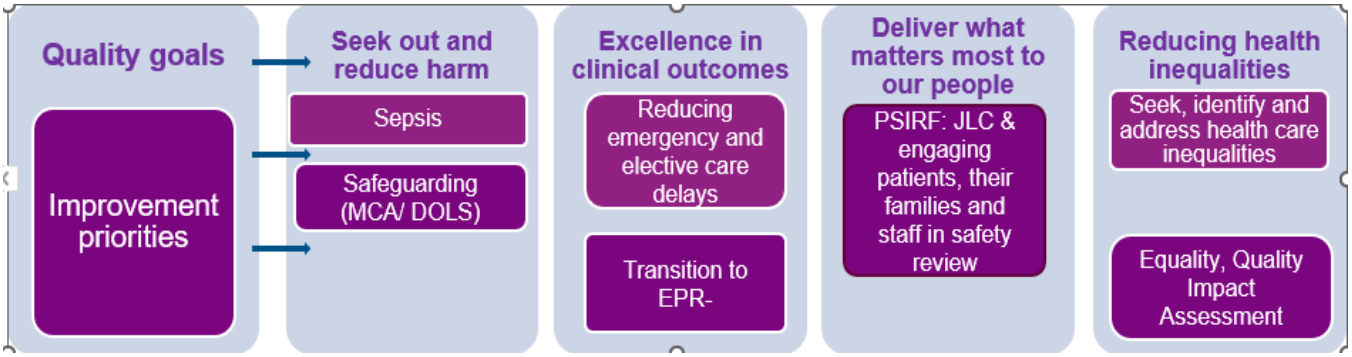
We have met the national waiting time targets for patients with suspected cancer and those who require onward treatment including:
28-day Faster Diagnosis Standard: 79.2% (target was 77%)
62-day treatment standard: 73.2% (target was 70%)</td>
<td>This improvement work has a significant impact on the quality and safety of patient care and will remain a quality priority for 25/26.</td>
</tr>
<tr>
<td>Listening to our People</td>
<td>We committed to strengthening our engagement with patients, their families and staff when reviewing safety incidents or responding to complaints. We have made progress in engaging patients, their families and staff in safety investigations, however we recognise that there is more to be done.</td>
<td>This work will continue as a quality priority be ongoing for the year ahead and will support the Trust to embed the Patient Safety Incident Response Framework (PSIRF)</td>
</tr>
<tr>
<td>Reducing health inequalities</td>
<td>We asked each of our four care groups to identify their priority for reducing health care inequalities based on their identified and diverse needs. This work is ongoing with a pilot underway in planned care to prioritise patient appointments based on an inequality scoring matrix. CFHD has commenced a pilot to enable people with a learning disability to be prioritised for therapy intervention.</td>
<td>Reducing Healthcare inequalities will remain a quality priority for 25/26.</td>
</tr>
</table>

We have revised our Quality priorities to align with the quality goals and this is shown below. Progress against these goals and priorities will be monitored and discussed within Care groups and Quality meetings throughout the coming year.

Quality Priorities 2025/2026

Our quality goals for the year 2025/26 will have not changed as they remain at the heart of ambition to improve quality of care for our patients. We have agreed additional quality priorities for this year including our commitment to ensure that quality and safety is integral to our transition to an electronic patient record (EPR) and that a robust equality quality impact assessment (EQIA) is completed for any proposed change which may affect services.

Our quality goals and priorities for the year ahead are displayed in the table below.



These priorities are discussed in more detail in the annual Quality Account 2024/25 and progress against these priorities will be further explored in the 2025/26 Quality Account.

COVID-19 and flu immunisation programme

In the autumn vaccination programme 2024/25 for flu and COVID-19 for NHS staff, 43.97% of our people took up the offer of vaccination. Medical and dental colleagues were the most vaccinated group at 58.16%. 31.75% of our staff received both Covid and Flu vaccinations; 11.41% flu only and 0.81% covid only

A low vaccination rate was evident across NHS England with NHS Acute Trusts recording 38.7% uptake of flu vaccine for 2024/25 a decrease of 5.5% on the previous year.

FURTHER PERFORMANCE ANALYSIS

National standards

This performance overview provides information about how we have performed against agreed operational objectives during the year.

Equality of service delivery

We maintain our approach to equality of service delivery by adhering to strict chronological booking processes in accordance with clinical prioritisation. We have a process of contacting people by telephone, as well as letter, to agree appointment dates and follow-up appointments when initial contact with people is unsuccessful. A rolling programme of clinical review and validation of longest waits is in place to identify and act as a safety net should an individual's condition change, or they fail to engage with offered appointments.

The Devon System is working together to ensure equitable waits are achieved and is supporting mutual aid across providers and access to the Nightingale Hospital Exeter as a system resource to support additional capacity for diagnostics, orthopaedic, and ophthalmology treatments under the One Devon Elective pilot.

Assurance and performance monitoring

Weekly assurance meetings are held with operational leads and the care group directors reporting to the Chief Operating Officer. These meetings are in addition to the monthly care group governance meetings where performance is reviewed following each care group's governance process.

Emergency Preparedness, Resilience and Response (EPRR) NHS England EPRR Assurance

On 19 January 2025 the Board of Directors received and approved the outcome of the NHS England / Integrated Care Board EPRR core standards assessment for 2024 in relation to the Trust's responsibilities as a category 1 responder under the Civil Contingencies Act (2004). Assurance was provided that against the 66 standards the Trust scored 62 fully compliant standards and four partially compliant standards, resulting in an overall rating of substantially compliant. An action plan was developed and approved by the Board to address the standards rated as partially complaint.

In addition to the core standards assessment, the Trust participated in an external audit from South Western Ambulance Service NHS Foundation Trust (SWASFT) in relation to the Chemical, Biological, Radiological and Nuclear (CBRN) capability audit. The audit consisted of a review of the CBRN documentation and SWASFT staff observing the delivery of CBRN training, as well as a review of the decontamination setup outside the Emergency Department. The Trust were fully compliant with the CBRN standards but SWASFT noted two minor areas for improvement on the CBRN equipment checklist, one of which was completed and the other relates to wastewater runoff.

EPRR incidents

During the 2024/25 year the Trust did not declare or participate in any Major Incidents. There were nine Critical Incidents, six of which were due to pressure, patient flow and moving into Operational Pressures Escalation Levels (OPEL) 4. The dates of these incidents, along with details of the other three Critical Incidents, are shown in the table below:

No.	Critical Incident	Date/Duration
1	Capacity/Operational pressures	29/04/24
2	Hazardous Material (HazMat)	14/07/24
3	Capacity/Operational pressures	13/11/24
4	Capacity/Operational pressures	19/11/24 - 21/11/24
5	Capacity/Operational pressures	26/11/24 - 29/11/24
6	Head and Neck portacabin RTI	27/11/24
7	Capacity/Operational pressures	03/01/25 - 08/01/25
8	Capacity/Operational pressures	28/01/25
9	Security Incident (threat of violence to Security Guard)	26/03/25

Debriefs were held and reports were written for the HazMat and Head and Neck portacabin road traffic incidents. Seven business continuity incidents were also recorded in the period, six of which were recorded through the Datix Cloud IQ incident

reporting system and debriefs for these incidents were held to identify lessons. The Business Continuity Incidents were:

No.	Business Continuity Incident	Date/Duration
1	Global IT problems	19/07/24
2	Symphony outage	18/08/24 - 19/08/24
3	National Grid power outages	02/10/24
4	IT issues affecting various platforms	07/10/24
5	Symphony outage	06/01/25
6	Loss of power	26/01/25
7	Level 2 Evacuation	07/03/25

EPRR risk register

There are currently five EPRR risks open on the Trust's risk register. These risks are in the process of being reviewed to assist in mitigating organisational and community risk. This review of the risk register then will aid the work plan for the EPRR team in the coming year.

EPRR training

The aim for 2024/25 was to deliver more than 75% of training to key roles across the Trust. In the period the EPRR team have delivered the following training courses:

Course name	Number of roles which completed the course	Number of roles required to complete the course	Percentage
Strategic command (Principles of Health Command)	10	12	83.3%
Tactical command	6	21	28.6%
Emergency Department Major Incident and Decontamination	50	91	54.9%
Switchboard Incident Notification	10	16	62.5%
4x4 Training	20	21	95.2%
Total	96	161	59.6%

On 10 July 2024 the EPRR team visited Dorset County Hospital to observe Dorset County Hospital NHS Foundation Trust's CBRN training. This visit was used to benchmark against best practice**.**

EPRR Exercises

Exercise Hera was an internal exercise which took place on 20 June 2024, bringing together participants from the Emergency Department, Decontamination Volunteers, and Security Officers. The exercise was designed to test practical understanding of the CBRN/HazMat plan and its associated action cards. Several key lessons were identified during the exercise, contributing to improved staff awareness and supporting the ongoing development of the plan.

During the period the Trust supported three system-wide exercises designed to enhance multi-agency preparedness and response:

- Exercise Pathologia took place on 25 April 2024 and tested NHS Devon's

response to a large-scale cyber-attack impacting NHS providers across the system, including Primary Care. It focused on enhancing participants' understanding of how different parts of the NHS would coordinate their response during a prolonged digital disruption. The exercise also explored the practical application of business continuity plans and the activation of mutual aid arrangements, identifying how services could be maintained or supported across the system in the event of a widespread cyber incident.

- An Aircraft Post-Crash Incident Management (APCIM) tabletop exercise was held on 9 October 2024 at RNAS Culdrose. This exercise was delivered by the Royal Navy and brought together key stakeholders to explore and test the multi-agency plans and coordinated response that would be activated in the event of an aviation incident.
- Exercise Ultravox was delivered on 4 March 2025 at County Hall in Exeter and was based on a real-world incident involving a contaminated batch of synthetic opioids in Devon, which resulted in a surge of casualties presenting to providers in North Devon. The tabletop exercise provided a valuable opportunity to explore how such an incident would be managed collaboratively and to identify lessons that will strengthen our preparedness for future events of this nature.

Health Inequalities

Introduction

Good quality, robust data enables the NHS to understand more about the populations it serves.

The duty to report health inequalities information is set out in the NHS England statement on information on health inequalities and aims to encourage better quality data and demonstrate the extent to which NHS organisations are able to identify groups that are at risk of poor access to healthcare, poor experiences of healthcare services, or outcomes from it, and deliver targeted action to reduce healthcare inequalities.

Background

Health inequalities are systematic, unfair and avoidable differences in health across the population, and between different groups within society. They arise because of differences in the conditions in which we are born, grow, live, work and age. The current UK 'cost-of-living crisis' is further worsening the socio-economic inequalities that drive many health disparities.

Many factors combine to affect the health of individuals and communities, such as where we live, the state of our environment, our income and education level, and our relationships with friends and family. It is estimated that only 20% of health inequalities relate directly to health service provision1 and it is these other wider determinants of health that have a far greater impact on health.

NHS providers have a key role – as a care provider, partner and anchor institution - in preventing or reducing ill health, to keep people better supported in their own communities, to address inequalities in access, experience and outcomes and use the levers we have at our disposal to influence the wider determinants of health alongside our partners.

[1] "It is estimated that only 20% of health outcomes result from clinical interventions with the remaining 80% driven by wider determinants of health, such as lifestyle choices, social networks and environmental factors" (Reducing health inequalities: system, scale and sustainability – Public Health England, 2017)

Our Duties

NHS England's statement on information on health inequalities published in November 2023 underlines that the Health and Care Act 2022 places a range of health inequalities duties on the NHS including provider trusts. It also outlines the powers available to NHS organisations to collect, analyse and publish information on health inequalities.

The purpose of the duty to report information on health inequalities is to encourage NHS bodies to use the data to shape and monitor improvement activity. The statement is intended to help drive improvement in the provision of good quality services and in reducing healthcare inequalities, helping to ensure equitable access, experience and outcomes for all. The statement also incentivises collaboration between NHS bodies on information collection and analysis to better understand the health and wellbeing needs of their local communities.

In publishing relevant data and analysis, we have sought to exercise its functions in accordance with the NHS England statement on health inequalities.

Our health inequalities strategy

We recognise that to truly have a significant and sustainable impact on reducing health and healthcare inequalities we need to work in partnership and collaboration with our local stakeholders across our 'place' (the geographical area of Torbay and South Devon, covered by the South Local Care Partnership (LCP), which has developed a strategy to reduce health inequalities at place. At the time of writing this report, the strategy is going through the governance processes to enable us to adopt this for the organisation.

Health inequalities data sources

Good quality, qualitative and quantitative data is key to all our efforts to tackle health inequalities. Data enables us to know more about the populations we serve, understand their experience in their own words and helps guide our efforts to ensure equitable access, positive experience and optimal outcomes.

The main categories of data which are accessed to support activities to tackle health inequalities:

- population health data national data platforms (the Foundry)
- local data capabilities
- partner data (i.e. housing, police, primary care)
- neighbourhood-level qualitative data/personal experience data.

We will take steps to understand the lived experience of people who are impacted by health inequalities. It is only by listening to the lived experience that services can understand how they must adapt their provision models to mitigate disadvantage and deprivation.

A key element of our work as a provider of healthcare services concerns access, completeness and transparency of our data. We are committed to improving the use of data and information as part of our emerging health inequalities strategy and commit to using data and insights to develop a deeper understanding of the extent and nature of health inequalities within populations.

The aim is to ensure that all relevant datasets we use incorporate, as standard, data relevant to ethnicity and deprivation as a way of driving service improvement on access, experience and outcomes.

NHS England statement on information on health inequalities data reporting and analysis

The following section sets out the data and information that NHS England's statement on information on health inequalities requires Foundation Trusts to publish in their Annual Report to help understand and improve health access, experience and outcomes.

Elective activity recovery – pre-pandemic (2019/20) vs current activity levels (2024/2025)

This data compares the current numbers of patients routinely accessing elective procedures with activity levels from before the pandemic. The levels of activity give an indication as to whether any previous unmet need is now being met, and if provision is being accessed in the same way by everyone.

Total numbers

Total elective activity				Change	
Age category	2019/20	2023/24	2024/25	N	%
Under 18s - Elective admissions	1,521	1,622	1,831	310	20%
18 and over - Elective admissions	39,956	38,722	42,170	2,214	6%

Source: our business intelligence team

Ethnicity

The data shows that there are higher percentages of under 18s from a minority ethnic group than in over 18s and over, accessing elective care.

It is important to note that data for minority ethnic groups in Devon is based upon comparatively smaller groups of patients which can generate unreliable analyses.

Under 18s - Elective admissions	2019/20	2023/24	2024/25	Change
White	96%	86%	84%	-12%
Minority Ethnic Group	4%	6%	9%	5%
Unknown Ethnicity	0%	7%	7%	6%
18 and over - Elective admissions	**2019/20**	**2023/24**	**2024/25**	**Change**
White	97%	95%	94%	-3%
Minority Ethnic Group	3%	5%	6%	3%
Unknown Ethnicity	0%	0%	0%	0%

Index of Multiple Deprivation (IMD): Under 18 years of age

	(Most deprived)			IMD Decile					(Least deprived)	
Under 18 years old	1	2	3	4	5	6	7	8	9	10	Uncoded
2019/20	10%	9%	15%	12%	12%	17%	12%	5%	5%	2%	1%
2023/24	10%	10%	15%	9%	13%	14%	11%	6%	7%	3%	2%
2024/25	10%	8%	15%	11%	16%	14%	11%	6%	6%	3%	2%
Difference (2019-20 / 2024-25)	0%	-1%	1%	-1%	4%	-3%	-1%	1%	1%	0%	1%

The data shows that for under 18s, those living in the most deprived areas there has been a slight decline in those accessing elective care in IMD2. On the whole there is little change from a pre-pandemic position to 2024/25

Index of Multiple Deprivation (IMD): 18 years and over

The data shows that for over 18s there is has not been a significant change of elective activity in the most deprived IMDs compared to the least deprived IMDs.

	(Most deprived)			IMD Decile					(Least deprived)		
18 years and over	1	2	3	4	5	6	7	8	9	10	Uncoded
2019/20	7%	7%	14%	12%	11%	16%	14%	7%	8%	3%	1%
2023/24	7%	7%	14%	11%	11%	16%	13%	7%	9%	4%	1%
2024/25	8%	7%	14%	11%	11%	17%	13%	7%	8%	3%	1%
Difference (2019-20 / 2024-25)	0%	0%	0%	-1%	0%	1%	-1%	0%	0%	0%	0%

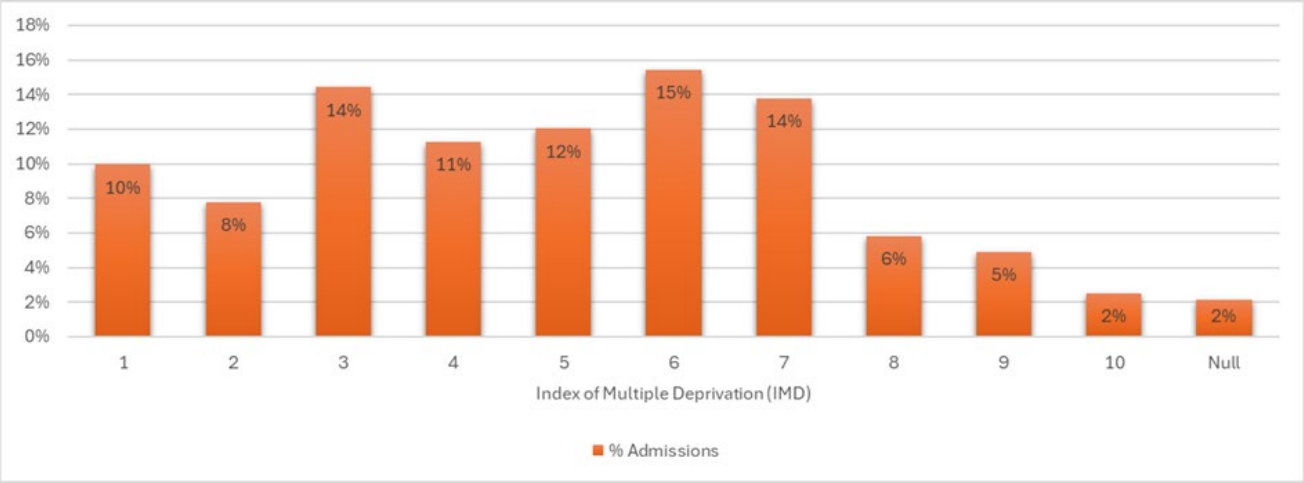
Urgent and emergency care: emergency admissions for under 18 years of age (2024/25)

Ethnicity and urgent care admissions

Emergency admissions for under 18s is in line with demographic ethnicity in Devon with the majority of our emergency admissions being White British (88%) with minority ethnic groups and other accounting for 4.5 %. However, of note is a high proportion of unrecorded ethnic category codes which account for nearly half of all non-white British recorded admissions.

Index of Multiple Deprivation (IMD)

The chart below shows a slightly atypical distribution of emergency admissions across all IMD profiles with people from the most deprived deciles (1 through 5) accounting for 55% of admissions in 2024/25.



Smoking cessation in secondary care: Acute and Maternity settings

We have a fully implemented Treating Tobacco Dependence (TTD) service in the maternity unit. The service follows the tobacco dependence treatment delivery model for maternity services and is delivered fully in-house. This is a significant achievement which meets the requirements NHS long term plan.

We have a Treating Tobacco Dependence (TTD) service for Acute Inpatients, but this does not cover 100% of inpatients due to budgetary restraints. The service is fully implemented within the available funding.

Smoking during pregnancy

	No of referrals	No of quitters	Quit success %	Smoking at time of delivery
2023/24	326	132	40%	8.1%
2024/25	303	110	36%	5.2%

Oral health in children

Oral health is an important measure of health inequalities as the rate of dental caries-related tooth extraction (avoidable tooth decay) for children and young people living in the most deprived communities is nearly 3.5 times that of those living in the most affluent communities.

Tooth decay is still the most common reason for hospital admissions in children aged between six and 10 years and requires trusts to collate data on children aged 10 and under admitted as inpatients for caries related tooth extraction.

In 2024/25 we had 232 admissions for caries related inpatient admissions for children under ten. The majority of cases involved multiple extractions, with patients from the most deprived deciles (1 through 5) accounting for 68% of admissions in 2024/25.

Tackling poor oral health in children and young people is a priority for partners across Devon

What are we doing to improve?

A working party across the Integrated Care System of Devon is looking at improving the access to dental services.

The Public Health Teams that support the population that we serve are divided into Torbay and South Devon and the teams have different activities to support the promotion of good oral hygiene work

Torbay

Across the Torbay geography health visitors give out dental packs (containing toothpaste, brushes and a timer, so that they know how long to brush for) alongside weaning advice at the 12-16 week contact. Targeted families will receive further dental packs and health promotion advice at the one and 2.3 year developmental reviews.

Also across the Torbay geography there is the 'Big Brush Club' Big Brush Club for primary school reception children.

The Special Care Dental Service in Torbay will see children and young people who are subject to a child protection plan for dental care concerns.

South Devon

From a Devon Public Health Nursing point of view oral hygiene is threaded through all their mandated contacts and is covered one to one in discussion with parents at that point. In addition to this they offer the First Dental Steps hygiene project to all families. Funding has been provided by NHS England to purchase dental packs which contain a baby toothbrush, fluoride toothpaste, a free flow beaker and some information to provide to families.

These packs are provided to families when they attend for their child's one year developmental review. These are given alongside a discussion around oral hygiene meaning they can access preventative advice and be signposted to how to locate a

local dentist. In some cases, where criteria are met, a referral may be indicated to the community dental team which the Public Health Nursing team take forward so that the family can access more specialist advice.

Devon have recently relaunched a scheme for three- to five-year-olds called the Big Brush Club which is being rolled out to all Devon Primary Schools who have an early years nursery, pre-school, or reception class.

Child and Family Health Devon Services focussing on children and young people living with learning disabilities

The pathways within the specialist learning disability team (early intervention and health) look at all the of the health needs of the young person, look to see if they have a dentist in place and if they do not, the team makes a referral to the specialist dental service. The team also undertake specific work with young people around oral hygiene for those with sensory processing difficulties, including developing easy read resources, visuals and developing personalised desensitisation plans alongside partners e.g. schools.

For children and young people requiring specialist dental service treatment under general anaesthetic the specialist dental team work closely with the Learning Disability team to prepare and support the young person and their families.

Torbay Hospital Specific Services

When children and young people attend the hospital dental service, they submit a Paediatric Liaison referral to the Paediatric Liaison Team, based at Torbay Hospital. At the point of contact the dental service provides the care giver with oral hygiene promotion advice and guidance as a form of secondary prevention. The Paediatric Liaison Team share the information with accompanying analysis and recommendations, with the 0-19 team (for Torbay or Devon depending on where the person lives), the GP and also Children's Services, if the child or young person is open to an allocated social worker or the early help service.

Together this focus on improving children and young people's dental health will support the drive to reduce health inequalities, and the prevention agenda from a very early age.

Digital inequalities and health Inequalities

Digital technologies have the potential to revolutionise the way care is delivered, making health and care services more accessible, flexible, person-centred, and providing a better experience for patients and our people while also improving efficiency. However, digital exclusion in health and care often overlaps with other forms of social exclusion and disadvantage, exacerbating existing health inequalities.

Digital exclusion refers to the lack of access, skills, and capabilities needed to engage with devices or digital services that help people participate in society. In healthcare, additional factors that are not relevant to other online interactions can contribute to digital exclusion. As more services are delivered online through websites, apps, email, and SMS, and online becomes the preferred means of contact, digitally this creates a higher risk of exclusion for some people. Conversely, improving digital inclusion means that everyone, regardless of their socioeconomic status, age, or geographic location, is equally able to engage with all public services, including health and care services.

We work with a range of partners to ensure that digital technologies are developed in an inclusive, service user focused way, meeting the needs of the diverse communities

we care for, engaging with them to understand their needs and preferences in doing so.

One way we promote inclusion is through our partnership with the national digital inclusion network, via their library services. This new partnership will provide access to free technology and data, to reach digitally excluded people across Torbay and South Devon, helping to reduce the digital divide and supporting the population to flourish and be able to access technology, information, and healthcare in ways that matter to them. By providing access to digital devices and training in digital skills, we can help to empower individuals to take control of their health and wellbeing and to engage more effectively with health and care services.

Conclusion

This is the third year NHS organisations have been requested to publish health inequalities information in their annual reports. It is anticipated that the requirements set out in the statement and benefits of a longer standing data set will evolve over time with more indicators being included from next year. We recognise, and the data set supports, that we serve a population with high levels of deprivation, an ageing population, are a holiday destination (serving a larger population in summer months) and therefore have specific challenges. We design our services to manage these challenges and focus provision as our population requires.

We have reported health inequalities and ethnicity data on our waiting lists quarterly to our Board of Directors via the agreed governance route helping to strengthen our approach to reporting and using health inequalities data to identify and tackle health inequalities across the populations we serve.

Financial Performance

During 2024/25 our income was circa £706million (excluding donated elements and central pension contribution) compared to £681million in 2023/24; this was derived primarily from the provision of clinical activities; however, as an integrated care organisation we also receive income for the provision of community services, children's services and adult social care through block contract income streams received via NHS Devon Integrated Care Board and Torbay Council respectively. This income is supplemented by other funding streams provided for education, training as well as other income generation activities.

In securing income for acute service provision, financial emphasis is placed on earned elective recovery income to reduce waiting lists on planned care pathways, in line with national strategic intent.

Excluding the pension contribution, which is funded centrally, planned income is forecast to increase by circa £30m in 2025/26, compared to actual income received in 2024/25, but this is inclusive of non-recurrent income totaling £65.1m. This, coupled with the impact of savings delivered non-recurrently in 2024/25 totalling circa £21.7m and significant inflationary cost pressures on consumables and care services provided by the Independent (out of hospital) Sector, we are forecasting a deficit of £8.0m during 2025/26, after an in year planned savings target of £41.5m.

Value for Money

To help demonstrate value for money, we use benchmarking information such as the NHS productivity metrics. For procurement of non-pay related items, we have a procurement strategy which maximises value using national contracts and through collaboration with other NHS bodies in the Peninsula Purchasing and Supply Alliance.

Under the National Audit Office ('NAO') Code for 2024/25, our external auditor, Grant Thornton LLP, have issued an Auditor's Annual Report providing a commentary on the Trust's arrangements to secure Value for Money.

Capital developments during the last year

During 2024/25 we continued to invest in our facilities and equipment and carried out capital projects, including recognition of in-year Right of Use Assets additions, totaling £35.3 million. We also received charitable donations totaling £0.5 million.

Part of our capital expenditure has been supported by the Public Dividend Capital received from the Department of Health and Social Care and through other sources of financing such as leases with both commercial providers and public sector organisations.

With specific regard to our estate we delivered £14.8m of capital investment in 2024/25, this included infrastructure, improvements and repairs alongside new builds and remodelling. Highlights included delivery of phase 1 of the Emergency Department expansion / refurbishment scheme and the purchase of Dawlish Hospital from the PFI operator. Phase 2 and completion of the Emergency Department expansion / refurbishment will take place in 2025/26.

Significant investment also took place in the Trust's new Electronic Patient Record (EPR) IT application. The sum invested in 2024/25 totaled £10.7m. Further substantial investment in EPR will take place in 2025/6.

Cashflow

Our cash position has decreased, from a starting point at 01 April 2024 of £41.3m, to a sum of £26.7m at 31 March 2025, a movement of £14.6m. The decrease in cash balance has primarily been driven by the Trust's adjusted deficit control total position of £33.5m exceeding the Revenue Public Dividend Capital (PDC) drawn down in the year to support that deficit position. The sum of Revenue PDC drawn down in year totaled £12.7m, a difference of £20.8m in comparison with the adjusted deficit control total position. There is a cost to drawing down PDC to both HM Treasury and to the Trust and consequently, PDC cash funding is not drawn down ahead of need.

During 2025/26, we will continue to maintain detailed cashflow forecasts to assist with cash planning with the introduction of cash being managed at Integrated Care System level with NHS England oversight.

Financial framework

Being licensed as an NHS Foundation Trust means that we are more accountable to its local public and patients. With effect from 01 April 2016, Monitor became part of NHS England. Since that date the financial framework of NHS Foundation Trusts and NHS (non Foundation) Trusts have become more aligned.

As noted in Part II of the annual report, our financial performance continues to be monitored by NHS England.

Accounting framework

As an NHS Foundation Trust, we apply accounting policies compliant with the Department of Health and Social Care's (DHSC) Group Accounting Manual (GAM). The DHSC GAM includes mandatory accounting guidance for DHSC group bodies completing statutory annual reports and accounts. These group bodies include

clinical commissioning groups, NHS trusts, NHS foundation trusts and arm's length bodies.

The GAM is approved by the HM Treasury Financial Reporting Advisory Board.

Accounting policies

Accounting policies for pensions and other retirement benefits are set out in a note to the full accounts (note 1.8) and details of senior employees' remuneration are given in the Remuneration Report.

Charitable funds

Torbay and South Devon NHS Charitable Fund is a registered charity (number 1052232), established to hold charitable donations given to our Trust. Its working name is Torbay and South Devon NHS Charity. Donations are received from individuals and organisations and are independent of the monies provided to us by the government. During 2023/24 the Board of Directors approved a five-year fundraising strategy for the charity.

Based upon the most up to date figures (subject to audit), in 2024/25 the charity received donations and legacies totaling £389,000.

Donations have been used to purchase numerous items of medical and other equipment, as well as supporting the training and development of our people and the welfare of our service users. Full details can be found in our Torbay and South Devon NHS Charity Annual Report and Accounts, which we produce in our role as corporate trustee. Link here

Environmental matters and the impact on the environment and task force on climate-related disclosures

In 2020, the NHS became the world's first health system to commit to reaching net zero emissions. The Delivering a Net Zero National Health Service report set out the scale of ambition. The Health and Care Act 2022 reinforced this commitment, placing new duties on integrated care boards (ICBs), NHS trusts and foundation trusts to consider statutory emissions and environmental targets in their decisions.

In 2021 we produced our first three year plan green plan (2022-2025) showing its commitment to the NHS net-zero targets to reduce direct carbon emissions by 2040. This remains a key strategic focus and is influenced heavily by our green plan and the work being undertaken by our sustainability and wellbeing group. We are currently working on its green plan refresh for the next 3 years (2025 – 2028).

Climate change and environmental instability present a significant risk to health in our communities. As a publicly funded organisation, with a responsibility for the provision of healthcare, we take seriously our obligations to our environment and our responsibilities in relation to decarbonisation, habitat conservation and carbon footprint reduction.

Our commitment to net-zero directly controlled carbon emissions by 2040 remains a key strategic focus and is influenced heavily by our green plan and the work being undertaken by our sustainability and wellbeing group.

Our green plan defines our commitment to environmental sustainability with a primary focus on how we will drive towards our net zero target. The key outcomes include:

- ensuring we are aligned to the NHS-wide ambition, and that of the Devon system for Devon to become the world's first healthcare system to reach net zero carbon emission

- prioritising interventions which improve the quality of healthcare we deliver, while also tackling greenhouse gas emissions and broader sustainability challenges
- defining our strategic approach in such a way that we make the right sustainability decisions first time.

We have made satisfactory progress over the last 12 months against our actions and commitments to decarbonisation, sustainable development, and achievement of national objectives and these continue to be key priorities for us.

Through our green plan, we are focusing on the following areas to achieve net zero carbon

- how we manage our existing buildings in the context of energy use and decarbonisation
- how we build new buildings that are net zero carbon in their construction and operation
- how we manage our consumption of water
- how we manage our waste streams
- how we support and develop sustainable travel and transport for patients, our people and visitors, encouraging sustainable travel modes where appropriate
- how we manage the reduction of our carbon footprint relating to anaesthetic gases and other pharmaceutical products
- how we innovate to provide net zero carbon healthcare embracing new working practices and digital enablers
- how we work with our supply chain to reduce, minimise and eventually decarbonise
- how we encourage and develop biodiversity across our green spaces for the benefit of patients, our people and visitors
- how we adapt to ensure we meet the challenges that will arise from climate change.

Our achievements this year include:

Keep cup initiative

We continue to provide keep me cups for removing the use of wax-finished cardboard cups in hot beverage outlets on the acute site, instead issuing our people with a re-usable takeaway cup and encouraging non-staff members to either rent or buy a reusable takeaway cup, or ‘drink in’ using crockery cups and mugs.

Volatile Anaesthetic gases

Following the successful eradication of desflurane, one of the most detrimental gases used in theatres, we have a planned process in place for the reduction of nitrous oxide decommissioning piped outlets by end of July 2025.

Electric bike loan scheme

Supporting active travel employees continue to take advantage of this scheme. The free loan of electric bike allows them to cycle to and from work, negating the need to drive and reducing the amount single mode vehicle journeys therefore, reducing carbon emissions.

EV Vehicles and EV Chargers

Over the last 12 months we have seen our green fleet expand further with the introduction of four zero emission electric vehicles and electric charging stations. This is

supporting our commitment to decarbonise its fleet in line with NHS Net zero travel and transport strategy.

Healthy travel event

Regular sustainable travel events continue promoting our cycle to work scheme, discounted bus travel scheme, walk to work information, personalised travel plan service, staff travel survey and the electric bike loan scheme.

PV Solar Farm

Collaborating with local authority to develop large-scale solar PV farm to be built adjacent to Torbay Hospital.

Biodiversity

Enhancing the natural environment on all our sites and utilising our significant green footprint to improve conditions for wildlife and make outdoor space more enjoyable for colleagues, patients, and the local communities remains a priority for us.

We continue to enhance our green spaces, and both our acute and community sites continue to benefit from biodiversity initiatives including bee and bug hotels, wildflower meadows, pollinator patches, bird and bat boxes, woodland walk, and sensory and tree trails.

From July 2023 through to January 2025, Devon Wildlife Trust have undertaken a series of ecological surveys of the acute site to establish the work we are required to undertake to achieve the prestigious biodiversity benchmark, which is a standard that certifies and celebrates the management of landholdings for nature and wildlife.

The final report recognises and commends the biodiversity initiatives already implemented by us and has made a series of recommendations for implementation.

These recommendations continue to be implemented however there are some obstacles in place. Local council restrictions (tree preservation orders) prevent us from modifying some of our trees in line with the recommendations, while planned capital projects prevent others.

BREEAM Compliant Construction

BREEAM is the Building Research Establishment Environmental Assessment methodology and is followed by us in the construction of any new buildings. BREEAM encourages the construction of buildings in an environmentally efficient way which has resulted in innovations such as the installation of solar panels in our newly constructed buildings and units such as Dartmouth Health and Wellbeing Centre, our endoscopy expansion and new theatres for day surgery and eye surgery.

Waste Management and Quantitative Environmental Impact

The Trust takes a robust approach to reducing the adverse environmental impact of waste disposal through the implementation of effective controls, to improve segregation of our waste to minimise incineration and increase recycling.

The average disposal rates per waste stream for 2024/2025 are outlined below:

- Total tonnage of all waste streams – 1732.6
- Percentage of total waste tonnage recycled – 33%
- Percentage of total waste tonnage sent to landfill – 0%
- Percentage of total waste tonnage of general waste to energy – 23%

- Percentage of total waste tonnage of clinical offensive waste – 22%
- Percentage of total waste tonnage of clinical non-burn waste – 13%
- Percentage of total waste tonnage of clinical burn waste – 10%

All of the above metrics are within the acceptable range for compliance.

Priorities for 2025/26

Our environmental and sustainability priorities for the next year are:

- Decommissioning of all nitrous oxide outlets in all the anaesthetic rooms and theatres
- Improve waste segregation throughout the Trust to achieve the targets of the national NHS clinical waste strategy by 2026
- Progress with the our heat decarbonisation plan and source funding streams to support its implementation
- Attainment of the biodiversity benchmark
- To continue to source grants for funding for innovative products to support net zero journey such as volatile capture in our ‘high volatile use’ theatres.

These priorities will be led by our workplace team, accountable to our sustainability and wellbeing group, and will form the basis of the sustainability update to the Board of Directors in 2025.

Social and community issues

We are clear about our leadership role in our local health and care system. As an anchor institution we are deeply connected to our local area and we use our influence, skills and resources to benefit the communities we serve.

We recognise we have a particular responsibility to help our children and young people start well in life, giving them a good foundation of health and wellbeing that will protect them against later ill-health, while also supporting their education, training and future job prospects.

We are working with our community partners to reduce the inequalities experienced by local people. We recognise the impact on employment on long term health outcomes and are committed to providing meaningful, flexible employment for local people as well as work experience and volunteering opportunities. Through the Torbay Advice Network supported pathway, local people in receipt of adult social care receive additional support to obtain and maintain employment through advice and guidance with reasonable adjustments and an access to work scheme.

We have developed several new initiatives to support employment within our local community. This includes an alliance with our local further education provider, South Devon College, to develop pathways into health and care careers. During the year we launched our new health care support worker scheme to support people into much needed roles and began working in partnership with the job centre on the volunteer to career programme which supports people through volunteering into secure employment. We also joined the T levels scheme for 16-18 year olds and expanded our placement opportunities with the first cohort of industrial placements offered this year.

We have shared our apprenticeship levy with Devon Partnership Trust and a number smaller employers in Torbay and South Devon to allow them to support employees to undertake apprenticeship programmes. We continue to develop new relationships and explore levy sharing opportunities. We are developing a new work experience online

platform to give everyone the opportunity to see what our local career opportunities. We are also working with private, voluntary and independent sector partners across Torbay and South Devon to broaden our reciprocal placements offer to help improve career prospects across the whole health and care sector.

We also recognise the impact of housing, education, environment, debt and many other factors on the health and wellbeing of our people and will continue to work closely with our communities and in partnership with others to support making life better for all. We are proud signatories of the Torbay Community Wealth Building Memorandum of Understanding. Through close collaboration with our partners; Torbay Council, South Devon College, and local leaders in the Voluntary, Community, and Social Enterprise (VCSE) sectors, our commitment extends from purchasing decisions to fostering local job creation. By harnessing our collective influence, we aspire to bring about positive change that directly benefits the local community.

In addition, our people support many health-related groups in both a business and voluntary capacity. We support and enable our people to play a full part in the community, for example by acting as governors for schools and colleges.

Anti-bribery and human rights issues

Our internal processes ensure consistency with our zero-tolerance approach to bribery and we work closely with our Local Counter Fraud Specialist (LCFS) to raise awareness of our policies and procedures through local induction sessions and bespoke training. We have continued to use the management database system to support our compliance with NHS England guidance on managing conflicts of interest. We have continued to run awareness campaigns to remind our people of the requirement to comply with NHS England guidance and the Bribery Act 2010.

We encourage anyone with a concern to speak out and report concerns through our governance processes and our policies and procedures.

Our people can raise concerns through internal channels, either via the Freedom to Speak Up Guardians (FTSU) or the LCFS. The FTSU and LCFS report regularly to the Board and the Audit and Risk Committee, respectively and the FTSU line management is direct to the Chief Executive. The FTSU Guardian has a standing invitation to the Board Sub-Committee with responsibility for workforce, staffing and wellbeing – the People Committee - and is a regular attendee.

As an organisation we recognise the benefits of ethical procurement and professional training. We endorse membership of the Chartered Institute of Procurement and Supply for our professional buying team. This includes the adoption of the Institute's code of conduct, which is also included within our Standing Orders and Standards of Business Conduct. We encourage best practice within our supply chain by ensuring we are compliant with legislation. We also encourage our suppliers and contractors working on our behalf to challenge unethical behaviour and promote a 'speak up' culture.

We have a Counter Fraud, Bribery and Corruption policy which deals with the specific issues in the title. Our policies relating to conflicts of interest, gifts and hospitality and our disciplinary policy link to Counter Fraud. Additionally, appropriate policies are reviewed throughout the year for fraud resilience and, where applicable, are updated to protect our organisation from economic crime and wrongdoing. A process is in place to ensure that none of our policies have an adverse or discriminatory effect on patients and our people.

Modern Slavery Act 2015

We have a Board approved anti-slavery and human trafficking statement, which is published on our website. We are playing a leading role in the development of a Devon and Torbay modern slavery adult victims referral pathway protocol and the formulation of the memorandum of understanding between statutory agencies within the anti-slavery partnership.

The Trust fully supports and is committed to the government's objectives to eradicate modern slavery and human trafficking, ensuring that no modern slavery or human trafficking takes place in any part of our organisation or our supply chain.

The Home Office's Statutory Guidance on Modern Slavery (2021) (https://www.gov.uk/government/publications/modern-slavery-how-to-identify-and-support-victims) is intended for staff in England and Wales within public authorities who may encounter potential victims of modern slavery and/ or who are involved in supporting victims.

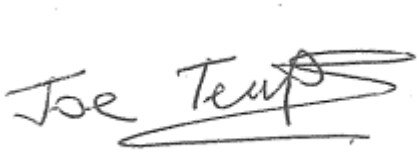
The Home Office states that these individuals and organisations must have regard to the statutory guidance, with a view to developing a more consistent response to modern slavery victims to ensure they are identified and receive the available and appropriate support.

In furtherance of our commitment to human rights issues and in accordance with the Modern Slavery Act 2015, the Trust has a published Modern Slavery and Human Trafficking Policy Statement, which can be found on the Trust website: https://www.torbayandsouthdevon.nhs.uk/uploads/slavery-and-human-trafficking-statement.pdf

No instances of modern slavery have been identified in our operations or supply chains during the 2024/2025 financial year, nor have any been identified at the time of reporting (June 2025).

Important events since the end of the financial year

There are no important events since the end of the financial year to report. This concludes the performance report, overview, risk and analysis section of the annual report.



Joe Teape
Chief Executive
25 June 2025

PART II – ACCOUNTABILITY REPORT

Directors' Report

The directors are responsible for the preparation of the financial statements in accordance with Department of Health and Social Care Group Accounting Manual and that the account gives a true and fair view. The directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess our performance, business model and strategy.

The Foundation Trust Board of Directors

Our Board of Directors ('the Board') has collective responsibility for the exercise of all our powers. The general duty of the Board and of each director individually, is to act with a view to promoting the success of the organisation to maximise the benefits for the members of the organisation and for the public. Directors are jointly and severally responsible for all the decisions of the Board.

The Board of an NHS Foundation Trust is accountable for the stewardship of the organisation, our services, resources, our people, and assets. The arrangements established by a Board must be compliant with the legal and regulatory framework, protect and serve the interests of stakeholders, specify standards of quality and performance, support the achievement of organisational objectives, monitor performance, and ensure an appropriate system of risk management and internal control.

Our constitution specifies that the Board of Directors shall comprise a non-executive Chairman; other non-executive directors; and executive directors.

To ensure the balance and effectiveness of the Board, our constitution further requires that:

- one of the Executive Directors shall be the Chief Executive
- the Chief Executive shall be the Accounting Officer
- one of the Executive Directors shall be the Chief Finance Officer
- one of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)
- one of the Executive Directors shall be a registered nurse or a registered midwife
- the non-executive directors and Chairman together shall be greater than the total number of executive directors
- the validity of any act of the organisation is not affected by any vacancy among the directors or by any defect in the appointment of any director

Appointments to the Board both of executive and non-executive directors in the reporting period meant that the Board was fully constituted.

The Board is accountable to stakeholders for discharging its general duties and is responsible for organising and directing the affairs of our organisation and our services in a manner that will promote success and is consistent with good corporate governance practice, and, for ensuring that in carrying out our duties, we meet our legal and regulatory requirements. In doing so, the Board of Directors ensures that our organisation maintains compliance with its terms of authorisation and other statutory obligations.

The Board reserves some responsibilities to itself, delegating others to the Chief Executive and other executive directors or committees of directors. Those matters reserved to the Board are set out as a formal schedule which includes approval of:

- our long-term objectives and financial strategy
- annual operating and capital budgets
- changes to our senior management structure
- the Board's overall 'risk appetite'
- our financial results and any significant changes to accounting practices or policies
- changes to our capital and estate structure
- conducting an annual review of the effectiveness of internal control arrangements
- setting the corporate governance structure of its Board and Committees
- ensuring the Well-Led framework is central to the Board's oversight and assurance, utilising it within the Board's annual effectiveness review

Our Board of Directors delegates responsibility to the Chief Executive to:

- enact the strategic direction of the Board of Directors
- manage risk
- achieve organisational compliance with the legal and regulatory framework
- achieve organisational objectives
- achieve specified standards of quality and performance
- operate within, generate, and capture evidence of the system of internal control

Board of Directors – disqualification

The following may not become or continue as a member of our Board of Directors:

- a person who has been adjudged bankrupt or whose estate has been sequestrated and who (in either case) has not been discharged
- a person who has made a composition or arrangement with, or granted a Foundation Trust deed for his creditors and who has not been discharged in respect of it
- a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him
- a person who falls within the further grounds for disqualification as described in our constitution
- a person excluded from eligibility in accordance with the NHS Standard Form Licence Conditions, as issued from time to time.

Composition of the Board of Directors

Our Board of Directors as at 31 March 2025 is shown below:

Non-Executive Directors	Executive Directors
Chris Balch – Chairman Martin Beaman – Non-Executive Director and Vice Chair Liz Edwards-Smith – Non-Executive Director Mark Greaves – Non-Executive Director Paul Richards – Non- Executive Director and Senior Independent Director Chris Saxby – Non-Executive Director Robin Sutton – Non-Executive Director Siân Walker-McAllister – Non-Executive Director Robert Williams – Non-Executive Director	Joe Teape – Chief Executive Adel Jones – Deputy Chief Executive/Chief Strategy and Transformation Officer (subsequently Chief Operating Officer) Mark Brice – Chief Finance Officer Anne Cholmondeley – Interim Chief People Officer Catherine (Kate) Lissett – Chief Medical Officer Nicola McMinn – Chief Nurse

Note: Our Board has one non-voting Associate Non-Executive Director: Mr Ashish Ghadiali and one non-voting Executive Director: Mrs Emily Long, Director of Corporate Governance and Trust Secretary.

Since the year-end there has been the following changes to Board membership: Mr Simon Tapley was appointed as Interim Chief Strategy and Planning Officer on 22 April 2025, Ms Adel Jones took on the role of Chief Operating Officer with effect from 21 February 2025 and Mr Robin Sutton stood down at the end of his term of office on 31 April 2025

The gender balance of the Board as at 31 March 2025 was:

	Female	Male
Non-Executive Directors	2	7
Executive Directors	4	2

Biographies of the members of the Board are provided in Appendix A.

Directors' interests

Members of the Board of Directors are required to disclose details of company directorships or other material interests which may conflict with their role and management responsibilities at our organisation. At each meeting of the Board of Directors, a standing agenda item also requires all executive directors and non-executive directors to make known any interest in relation to the agenda and any changes to their declared interests. There are no interests which may conflict with their management responsibilities as per the requirements of the Code of Governance for NHS Provider Trusts. The Chairman has no other significant commitments that affect his ability to carry out his duties to the full and was able to allow sufficient time to undertake those duties.

The Chief Executive's Office maintains a register of interests and is available on our website or by contacting the Trust Secretary at the address given in Appendix B – Further information and contact details.

No political donations were made or received by the organisation in the reporting period.

Independence of the Non-Executive Directors

Our Board of Directors has assessed the independence of the non-executive directors and considers all current non-executive directors to be independent in that there are no relationships or circumstances that are likely to affect their judgement as evidenced through their declarations of interest, previous employment, or tenure.

Committees of the Board of Directors

The Board has established the 'statutory' committees required by the NHS Act 2006 and our constitution. The Non-Executive Nominations and Remuneration Committee and the Audit and Risk Committee each discharge the duties set out in our constitution and their terms of reference.

The Board has chosen to deploy additional 'designated' Committees to augment its monitoring, scrutiny, and oversight functions, particularly with respect to quality and financial risk management. These are the Quality Assurance Committee, the Finance and Performance Committee, the People Committee and the Building a Brighter Future Committee. Separately, the Torbay and South Devon Charity is chaired through a management Committee, known as the Charity Committee.

The role, functions and summary activities of the Board's Committees are described below:

Audit and Risk Committee: The Committee has responsibility for reviewing the effectiveness of the framework in place for the identification and management of risks and associated controls, corporate governance and assurance frameworks. In delivering its remit the committee reviewed and received the following:

Reviewed:

- Board Assurance Framework and Corporate Risk Register, with appropriate challenge to the proposed controls and risk scoring
- draft Annual Governance Statement
- draft annual accounts, draft annual report and draft quality report and recommended them for approval to the Trust Board
- specific Internal Audit reports and proposed actions for those areas identified with limited assurance (with the relevant Executive Director present when required) and monitored the follow-up of outstanding actions
- effectiveness of Internal and External Audits and Local Counter Fraud Service
- accounting policies, judgements and material estimates of the Trust and made appropriate recommendations to the Trust Board
- external Audit reports and the Annual Audit Letter, including progress on implementation of recommendations and any corrected or uncorrected misstatements in the accounts
- Clinical Audit Plan and Framework

The Committee also:

- received reports on progress against local counter fraud, internal and external audit plans
- agreed the external audit annual fee and work plan
- agreed the internal audit and local counter fraud annual work plans
- received reports on losses and special payments; waivers; adult social care debt relating to service user contributions to care; fit and proper persons compliance; senior information risk officer annual report; and treasury report.

Quality Assurance Committee: The Committee provides assurance to the Board that there is continuous and measurable improvement in the quality of services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care and ensures that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.

In delivering its remit the committee reviewed and received the following: Reviewed:

- variances against quality and operational performance standards
- the Trust's compliance with the CQC essential standards of quality and safety and review of any specific CQC surveys
- assurance of high-quality care provision and compliance with national and local guidelines, standards and requirements
- submissions to national bodies and make recommendations for sign-off by the Trust Board
- annual assurance reports as appropriate
- findings of quality related Internal Audit reports
- information from national clinical audits where the Trust was identified as an outlier or a potential outlier
- reports from invited service reviews and external visits
- reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken
- the Board Assurance Framework and Corporate Risk Register in relation to those risks within the scope of the Committee

The Committee also:

- monitored quality of clinical and social care services provided by the Trust
- monitored delivery of the Trust's clinical strategy
- ensured there was a robust Equality and Quality Impact Assessment process
- oversaw the development of the Quality Account
- ensured the Trust learnt from national and local reviews and inspections and implemented all necessary recommendations to improve the quality of care.
- oversaw how all quality risks were managed across the Trust
- promoted an open culture in which incident and risk reporting was encouraged and supported as part of the delivery of safe and effective healthcare
- sought assurance on the process for reviewing and reporting complaints, adverse events and serious incidents and sharing the learning from these
- sought assurance against compliance with national clinical standards including NICE guidelines/guidance and any rationale for non or partial compliance
- oversaw any procedural, policy or strategy document which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with any key national standards and best practice
- established an annual work plan
- produced an annual report against delivery of the terms of reference of the committee.
- undertook an annual review of the Committee's effectiveness
- approved and oversaw delivery of the Clinical Audit Plan
- undertook deep dives into: falls prevention; Patient Safety Incident Response Framework; mixed sex mitigation on Surgical Receiving Unit; health inequalities; and Nephrology.

Finance and Performance Committee

The Committee:

- oversees, co-ordinates reviews and assesses the financial and performance management arrangements; including monitoring the delivery of the NHS Long Term plan and supporting Annual Plan decisions on investment and business cases
- provides the Board with an independent and objective review of, and assurances, in relation to significant financial and performance risks which may impact on the financial viability and sustainability of the Trust
- provides detailed scrutiny of financial and performance matters in order to provide assurance and raise concerns (if appropriate) to the Board of Directors
- assess and identify risks within the finance and performance portfolio and escalating this as appropriate
- makes recommendations, as appropriate, on financial and performance matters to the Board of Directors
- determines those matters delegated to the Committee in accordance with the Scheme of Delegation and Standing Financial Instructions as set out in the Trust's Standing Orders
- oversees the development of the Trust's medium term financial strategy
- maintains a watching brief over the strategic direction of the Devon ICS as informed by relevant national policy, and informing the Board of such

In delivering its remit the committee reviewed and received the following: Received:

- financial plan for 2024/25
- progress reports in regard to the development of the Annual Plan
- financial performance reports at each meeting
- year-end financial out-turn prior to being reported to Board
- progress reports against the Trust's Cost Improvement Plan
- assurance on our treasury management arrangements
- information on adult social care debt relating to service user contributions to care
- progress reports on the capital expenditure and performance against plan
- reports on the Devon Integrated Care System Medium Term Financial Plan
- reports on business and operational planning for 2024/25
- National Cost Collection Index Report
- Annual Strategic Agreement
- outcome of the Estates Return Information Collection (ERIC) exercise
- regular estates capital and highlight reports (responsibility for estates was passed to the Building a Brighter Future Committee towards the end of the financial year)
- regular workplace and compliance group reports
- business cases for approval in accordance with the Trust's scheme of delegation and where appropriate recommended approval by the Board
- Board Assurance Framework and risks in relation to those risks pertaining to the scope of the committee

The committee also:

- recommended to the Board approval of our capital and operational plans
- undertook the following deep dives: Productivity Opportunities – Overview of Model Hospital
- reviewed our capital programme
- reviewed financial performance of our business divisions.

- reviewed the performance section of the integrated performance report at each meeting
- sought assurance on demand and capacity issues and compliance with national standards
- reviewed performance against the National Oversight Framework criteria
- reviewed performance against the Trust's Financial Improvement Plan
- reviewed Adult Social Care performance
- approved the Winter Plan
- reviewed and approved a number of business cases and other reports including: Jack Sears Reablement facility; Establishment of NHS Devon Procurement Services; Emergency Department; Teignmouth Health and Wellbeing Centre; 0-19 Services; Adult Social Care – Single Handed Care; One Devon Shared Service; Disposal of Surplus Property and Land; Inflationary Uplifts Options Appraisal; Prioritisation of New Services Development Scheme 2024/25; UEC Recovery Plan Portfolio; Planned Care Improvement Portfolio; Healthcare Support Workers Rebanding; Competitive Tender for a Renewables Power Purchase Agreement; Productivity Opportunities Overview of a Model Hospital; Risk to Staff in Vulnerable Structures on Trust Site; and Section 75 Recovery Plan.
- developed a committee workplan for the year
- undertook a committee effectiveness self-assessment

People Committee: The committee provides assurance to the Board on the quality and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust.

- Difficulties recruiting to critical posts means there is an increase in services with high risks with staffing factors
- A need for more robust strategic business and workforce planning to support the Trust in identifying the workforce needed for the future
- Capacity to deliver services impacted by industrial action
- Operational pressures result in increased time in high escalation impacting on workload pressures, wellbeing of staff and ability to attend professional and mandatory training
- Unclear career pathways and talent management impacts on retention, wellbeing and development of workforce
- Absence and turnover increasing use of bank and agency staff, which impacts on the Trust's financial position and team health and effectiveness.
- Improvements required to ensure our leaders and managers have the skills to enable them to fulfil their roles within an unprecedented and challenging environment.
- A need to better align workforce and financial data to support financial and workforce planning.

Actions taken to mitigate the above include: use of interims and agency staff (following a robust approvals process); appointment of Strategic Workforce Planner (funding supported through the New Hospitals Programme); introduction of co-created leadership framework; industrial action planning; a process to support staff to attend training at times of high escalation; and a number of programmes of work to support organisational reshaping and budget setting resulting in more accurate vacancy data.

Building a Brighter Future Committee: The committee provides assurance to the Board regarding the processes, procedures and management of the strategic transformation and partnership functions that support the overall delivery of the Trust strategy.

- In delivering its remit the committee reviewed and received the following: strategic objective contained in the Board Assurance Framework
- risks attached to achieving the strategic objective, including deep dives of individual risks at each meeting
- progress of the Digital Workstream, EPR procurement and Digital Strategy
- revised expenditure profile information for seed funding
- progress reports and updates on timelines, finance, project status, project resourcing etc
- reports on capital planning; development of the site enabling business case; estates infrastructure; challenges facing the Trust's estate; estate utilisation and opportunities; multi story parking hub and park and ride feasibility; and development of the community estate.
- updates on the development of the site enabling business case and feedback from national Cohort 4 meetings, as pertained the National Hospital Programme
- updates on progress in respect of the Clinical Strategy, Trust Strategy and Health and Care Strategy
- sought assurance on the Trust's approach to potential digital risks
- report on Master Planning review
- governance reports from those Groups with reporting responsibilities to the Committee

Non-Executive Directors' Nomination and Remuneration Committee: The committee considers and reviews current and future requirements applicable to:

- strategic portfolio changes relevant to the posts covered by the committee's remit
- the performance of and the setting of salaries, terms of service and allowances for the posts covered by the committee's remit
- senior management succession planning arrangements and talent management process;
- senior managerial competence relating to leadership capability
- allowances as may be payable to Foundation Trust Governors.
- oversee the process for the nomination of the Chief Executive for approval by the Board (and ratification by the Council of Governors)
- To oversee the process for the appointment of other executive directors, associate directors and company secretary
- Lead the process for the identification and nomination of the chair of all Board committees and Board post holders, ie senior independent director and deputy chair

In delivering its remit the committee reviewed and received the following:

- the performance development reviews of executive directors, associate directors and defined senior managers
- kept up to date with relevant national and local developments
- informed the committee of changes, both local and national, which may impact on the committee

- proactively sought best practice and bring to the attention of the committee
- reviewed remuneration policies, including having oversight of those applicable to our people employed on very senior manager terms and conditions
- considered proposals for changes in terms and conditions of employment
- considered any matter relating to the continuation in office of any executive director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their employment contract
- considered any in-year variations of salaries and terms and conditions of employment of executive directors and senior managers who are subject to the annual review process carried out by the committee
- oversaw the process for the nomination of the Chief Executive for approval by the Board (and ratification by the Council of Governors)
- oversaw the process for the appointment of executive directors

The external auditor (Grant Thornton LLP) has not provided any additional non-audit services during the period.

Audit and Risk Committee Chair's opinion and report

In support of the Chief Executive's responsibilities as Accounting Officer for the Foundation Trust, the Audit and Risk Committee has examined the adequacy of systems of governance, risk management and internal control within the organisation, from information supplied, and formed the opinion that:

- there is a generally adequate framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk; noting the caveats within and breaches of the Accounting Officers statement On Significant internal control issues on page 101.
- assurances received are sufficiently accurate, reliable, and comprehensive to meet the Accounting Officer's needs and to provide reasonable assurance
- governance, risk management and internal control arrangements within the organisation include aspects of excellence as well as aspects in which ongoing attention to the control improvement is required
- financial controls are sufficient to provide reasonable assurance against material misstatement or loss
- the quality of both internal audit and external audit over the past year has met all the organisation's requirements.

The Committee discharged its role through the year as follows:

- we reviewed the establishment and maintenance of an effective system of governance, risk management and intern al control across the whole of the organisation's activities (both clinical and non-clinical)
- we ensured that there was an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee. The Committee reviewed and approved the internal audit plan, ensuring that it was consistent with the audit needs of the organisation as identified by the Assurance Framework. The audit plan was reviewed during the year to ensure it remained risk based

- we considered the major findings of internal audit's work (and management's response). The internal auditor had unrestricted access to the Chair of the Committee for confidential discussion
- we reviewed the work and findings of the external auditor and considered the implications and management's response to their work. The key audit matters related to: ISA 240 revenue risk, valuation of land and buildings, management over-ride of controls, completeness of expenditure risk and, financial sustainability in respect of the organisation's arrangements for securing economy, efficiency and effectiveness in its use of resources. The external auditor had unrestricted access to the Chair of the Committee for confidential discussion
- we reviewed the Annual Report and financial statements before submission to the Board
- we ensured the Standing Financial Instructions and Standing Orders were maintained and kept up to date, with an annual review of instances where exceptions to the rules were made we reviewed the findings of other significant assurance functions, both internal and external to the organisation, and considered the implications to the governance of the organisation.

Enhanced quality governance reporting

The Board was satisfied during the year that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information), the organisation had, and will keep in place, effective leadership arrangements for monitoring and continually improving the quality of health and social care, including:

- ensuring required standards are achieved (internal and external)
- investigating and acting on substandard performance
- planning and managing continuous improvement
- identifying, sharing, and ensuring delivery of best-practice
- identifying and managing risks to quality of care

This encompasses an assurance that due consideration was given to the quality implications of plans (including service redesigns, service developments and cost improvement plans), in the form of quality and equality impact assessments, and that processes are in place to monitor their ongoing impact on quality and take subsequent action, as necessary, to ensure quality is maintained.

The Annual Governance Statement provides further information.

Membership and attendance at Board and Committee meetings

The Board of Directors discharged its duties during 2024/25 in eleven meetings, and through the work of its committees. The Chairman of the Board submitted a report to the Council of Governors (CoG) at each meeting, highlighting any matters requiring disclosure to the Council.

The table overleaf shows the membership and attendance of voting board members who attend meetings of the Board and Board Committees during the year.

2024-25	Board of Directors	Council of Governors	Non-Executive Director Nominations and Remuneration Committee	Audit Committee	Quality Assurance Committee	Finance, and Performance Committee	People Committee	Building a Brighter Future Committee
Number of meetings	11	5	15	6	7	11	5	11
Richard Ibbotson	C 2 (2)	C 1(1)	C 0 (0)	-	-	-	-	-
Chris Balch	C 11(11)	C 5 (5)	C 15 (15)	1 (2)	-	2 (2)	-	C 2(2)
Martin Beaman	11 (11)	3 (5)	7 (7)	6 (6)	C 7(7)	-	-	-
Richard Crompton	5 (5)	0 (2)	3 (7)	4 (6)	-	C 5 (5)	-	3 (5)
Liz Edwards-Smith	5 (6)	2 (3)	-	-	-	-	1 (2)	-
David Feindouno	2 (4)	0 (2)	-	-	-	-	-	-
Ashish Ghadiali	4 (6)	0 (2)	-	-	-	-	-	-
Mark Greaves	3 (3)	1 (1)	-	-	0 (1)	-	-	-
Barbara Gregory	0 (1)	0 (1)	-	-	-	-	-	-
Vikki Matthews	8 (9)	1 (4)	9 (13)	-	4 (6)	-	C 4 (4)	-
Paul Richards	9 (11)	4 (5)	15 (15)	4 (6)	-	C 9 (9)	2 (3)	11 (11)
Chris Saxby	4 (6)	2 (3)	-	-	-	3 (3)	1 (1)	3 (3)
Robin Sutton	11 (11)	3 (5)	-	C 6 (6)	-	11 (11)	-	-
Siân Walker-McAllister	9 (11)	3 (5)	0 (1)	0 (0)	7 (7)	-	C 4 (5)	-
Robert Williams	10 (11)	1 (5)	-	3 (4)		-	-	C 9(9)
Liz Davenport	7 (8)	2 (4)	8 (10)	-	-	-	-	-
Joe Teape	1 (1)	0 (0)	1 (1)	-	-	-	-	-
Bill Shields	2 (2)	0 (1)	1 (3)	-	-	-	-	-
Mark Brice	7 (11)	0 (5)	-	5 (6)	-	9 (11)	-	3 (11)
Arun Chandran	6 (11)	0 (5)	-	-	6 (6)	6 (9)	3 (4)	-
Anne Cholmondeley	3 (3)	0 (1)	2 (3)	-	1 (2)	-	1 (1)	-
Adel Jones	10 (11)	2 (5)	-	-	1 (1)	9 (11)	0 (1)	8 (11)
Catherine (Kate) Lissett	10 (11)	0 (5)	-	-	6 (7)	7 (9)	3 (4)	6 (9)
Emily Long	9 (11)	4 (5)	12 (15)	6 (6)	5 (7)	8 (11)	4 (5)	4 (11)
Nicola McMinn	9 (11)	2 (5)	-	4 (6)	6 (7)	6 (9)	3 (4)	-
Michelle Westwood	8 (8)	0 (4)	10 (12)	-	3 (5)	-	2 (4)	8 (10)
Joanne Watson	8 (10)	-	-	-	-	-	-	-

Notes:
Richard Ibbotson retired on 31/05/2024
Richard Crompton resigned on 02/10/2024
Barbara Gregory resigned on 22/05/2024
Liz Edwards-Smith was appointed as a non-executive director on 21/10/2024
Ashish Ghadiali was appointed as a non-executive director on 21/10/2024
Mark Greaves was appointed as a non-executive director on 01/01/2025
Chris Saxby was appointed as a non-executive director on 21/10/2024
Vikki Matthews resigned on 31.01.2025
Joe Teape was appointed on 3/3/2025 and assumed executive duties as Chief Executive on 10/03/2025
Liz Davenport retired on 31/12/2024
Joanne Watson resigned as an executive on 26/02/2025
Michelle Westwood resigned on 15/01/2025
Anne Cholmondeley was appointed as Interim Chief People Officer on 06/01/2025 and assumed executive duties on 16/01/25
David Feindouno was appointed on 21/10/2024 and resigned on 20/02/2025
Bill Shields was appointed as the Interim Chief Executive from 01/01/2025 to 07/03/2025

Figures in brackets indicate the number of meetings the individual could be expected to attend by their membership of the Board or Committee. A dash indicates that the individual was not a member. 'C' denotes the Chair of the Board or Committee.

Performance of the Board and Board Committees

Members of the Board are subject to on-going and regular performance appraisal. The Chief Executive appraises individual executive directors. Non-executive directors and the Chief Executive are appraised by the Chairman. The Chairman was appraised by the Senior Independent Director for 2024/25 in accordance with the guidance issued by NHS England's 'Framework for conducting annual appraisals of NHS provider chairs'.

The outcome of these appraisal processes was presented to the Governors' Nominations and Appointments Committee and confirmed with the Council of Governors. Confirmation of the process undertaken in respect of the Chairman's appraisal has been submitted to NHS England in accordance with the aforementioned guidance.

The Board of Directors undertakes a regular self-assessment of its performance to establish whether it has adequately and effectively discharged its role, functions, and duties.

For the reporting period, the Board's performance, considering the role, function, and work of the Board Committees, was of the requisite standard. The Board believes that it is balanced and complete in its composition and appropriate to the requirements of the organisation. This was attributed to the comprehensive annual cycle of reporting, a robust Board assurance framework and risk register, and a development plan undertaken under the guidance of the Chairman and Trust Secretary.

The findings of the internal audit, combined with the Head of Internal Audit Opinion set out in the Annual Governance Statement, support the Board's conclusion.

Similar assessment exercises were undertaken for each of the committees of the Board, all of which were considered to have fully discharged the duties set out in their terms of reference.

The Council of Governors

The Council of Governors is responsible for discharging the general duties set out in legislation which are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- to represent the interests of the members of the organisation as a whole and the interests of the public.
- The Council of Governors discharged its statutory duties as set in the Code of Governance for NHS Provider Trusts supported through its sub-committees and working groups.

It remains the responsibility of the Board of Directors to design and implement the organisational strategy. The Council of Governors and the Board of Directors communicate principally through the Chairman who is the formal conduit and Chairman of the two bodies. Informally the Council of Governors also hold Priorities and Governor Only Meetings. The Chair attends both meetings and Governors receive presentations of topics of interest at Priorities meetings to help deepen their understanding of the Trust and services provided.

The Board of Directors may request the Chairman to seek the views of the Council of Governors on any matters it may determine. Communications and consultations between the Council of Governors and the Board include, but are not limited to the following topics:

- our annual plan
- the Board's strategic proposals
- clinical and service priorities
- proposals for new capital developments
- engagement of our membership and the public.

The Board of Directors presents the Annual Accounts, Annual Report and Auditor's Report to the Council of Governors.

Detailed information on the composition of our Council of Governors can be found in the tables below and overleaf.

Public constituencies			
Name	**Constituency**	**Tenure**	**CoG Attendance**
Paul Allen	South Hams	Elected – 01 March 2024	0 (2)
Val Browning	South Hams	Elected - 01 March 2023	5 (5)
Dave Cawley	South Hams	Re-elected – 01 March 2025	4 (5)
Julie Spinks	South Hams	Elected – 01 March 2025	0 (0)
Eileen Engelmann	Teignbridge	Re-elected – 01 March 2025	4 (5)
Annie Hall	Teignbridge	Re-elected – 01 March 2022	2 (5)
Michael James	Teignbridge	Re-elected – 01 March 2022	0 (2)
Michael Joyce	Teignbridge	Elected – 01 March 2025	0 (0)
James Osben	Teignbridge	Elected – 01 March 2025	0 (0)
Alison MacGregor	Teignbridge	Elected – 01 March 2025	0 (0)
Geoff King	Teignbridge	Elected – 01 March 2025	0 (0)
John Smith	Teignbridge	Re-elected – 01 March 2022	1 (5)
Andrew Postlethwaite	Teignbridge	Elected – 01 March 2023	5 (5)
James Hartley	Teignbridge	Elected – 01 March 2023	2 (5)
Loveday Densham	Torbay	Re-elected – 01 March 2025	5 (5)
John Kiddey	Torbay	Re-elected – 01 March 2025	5 (5)
Peter Milford	Torbay	Elected – 01 March 2022	2 (2)
Alison Ramon	Torbay	Elected – 01 March 2023	5 (5)
Andrew Stilliard	Torbay	Re-elected – 01 March 2023	5 (5)
Lee Thomas	Torbay	Elected – 01 March 2023	2 (5)
Vincent Williams	Torbay	Elected – 01 March 2024	4 (5)
Mike James – stood down 30 August 2024 Paul Allen – stood down 04 November 2024 Annie Hall – end of term 28 February 2025 John Smith – end of term 28 February 2025 Peter Milford – stood down 23 September 2024			

Staff-elected governors (staff constituency)			
Name	**Class**	**Tenure**	**CoG Attendance**
Sal Aziz	Children and Family Health Devon	Re-elected - 01 March 2024	4 (5)
Matt Giles	Planned Care and Surgery	Re-elected - 01 March 2024	4 (5)
Yvonne Paulucy	Professional Support Services	Elected – 01 March 2024	4 (5)
Jonathan Shribman	Medical and Urgent Care	Re-elected – 01 March 2024 (previously governor for South Hams and Plymouth for one term and served one year of second term as staff governor)	3 (4)
Radia Woodbridge	Families and Communities	Re-elected - 01 March 2024	3 (5)
Matt Giles – stood down 14 March 2025 Jonathan Shribman – stood down 31 January 2025			
Appointed governors (partner organisations)			
Name	**Organisation**	**Tenure**	**CoG Attendance**
Karen Barry	Devon Integrated Care Board	Appointed – 05 June 2024	2 (4)
Joanna Bowtell	University of Exeter Medical School	Appointed - 02 October 2023	4 (5)
Clare McAdam	South Hams District Council	Appointed - 01 March 2023	0 (5)
Hilary Milner	Devon Carers	Appointed - 01 March 2023	3 (5)
John Nutley	Teignbridge Council	Appointed - 01 June 2023	2 (5)
Ron Peart	Devon County Council	Appointed – 09 April 2024	2 (5)
David Thomas	Torbay Council	Appointed – 25 March 2025	0 (0)
Hayley Tranter	Torbay Council	Appointed - 07 February 2024	2 (5)
Jo Turl	Devon Integrated Care Board	Appointed – 03 July 2023	0 (0)
Louise Winfield	Plymouth University Peninsula Schools of Medicine and Dentistry	Appointed - 01 March 2023	4 (5)
Ged Yardy	South Hams District Council	Appointed - 25 May 2023	3 (5)
Jo Turl – stood down 19 April 2024 Hilary Milner – stood down 6 February 2025 Clare McAdam – stood down 24 March 2025 Hayley Tranter – stood down 24 March 2025			

Governor elections

In order to refresh the Council of Governors and bring a diverse range of views into our organisation, elections are held every year. These elections are held in the various geographical or staff constituencies as set out in our constitution. During this year, the following elections were held with each member being offered a three-year term of office.

Constituency	Candidate	Result	Voting %
South Hams	Dave Cawley	Elected	35.4
South Hams	Julie Spinks	Elected	43.8
Teignbridge	Eileen Englemann	Elected	16.8
Teignbridge	Geoff King	Elected	16.8
Teignbridge	Michael Joyce	Elected	14.6
Teignbridge	Alison MacGregor	Elected	16.8
Teignbridge	James Osben	Elected	16.8
Torbay	John Kiddey	Elected Unopposed	

Governors' interests

Governors are required to disclose details of company directorships or other material interests which may conflict with their role as governors. Our membership office maintains a register of interests which is published on our website.

Committees of the Council of Governors

The Council of Governors has appointed one standing Committee and one working group. Further information on these can be found below:

Governor Nominations and Remuneration Committee

The committee considers and reviews current and future requirements applicable to the evaluation of the performance of the Chair and Non-Executives.

In fulfilling this role the committee will make reference to the Code of Governance for NHS Provider Trusts; Monitor Governor Statutory Duties Guide; and NHS England Chair and NED Appraisal Framework; and the remuneration, allowances and other terms and conditions of the Chairperson and Non-Executives; and determining and directing the process for recruitment, re-appointment or removal of the office of Chairperson and other Non-Executive Directors.

In delivering its remit the Committee:

- led appointment process for new non-executive directors
- made recommendations to the Council of Governors on the re-appointment of non-executive directors whose terms of office came to an end in the reporting year
- reviewed non-executive director succession planning
- received feedback on the output of the Chairman and non-executive director appraisals.
- received assurance on the non-executive director portfolio

Membership Committee

The Committee supports governors in fulfilling their statutory duty to represent the interests of our members and the public, specifically in relation to feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them.

In delivering its remit the Committee:

- received updates from the Working with Us Panel
- received feedback from Feedback and Engagement Group
- led on the arrangements for the Annual Members Meeting
- put in place arrangements for Medicine for Members events to take place
- focused on improvements to Membership Engagement
- Undertook a members' survey

Membership and meetings of the Council of Governors

Membership is free and aims to give local people and our people a greater influence over how our services are provided and developed. It also helps us to work much more closely with local people and the people who use our services. Our members have the chance to find out more about the hospitals, our community services, the way they are run and the challenges they face, and furthermore, help us work with local people to

improve the care and experience of patients and their carers'.

We had 14,629 members as at 31 March 2025, split between 7,340 public members and 7,289 staff members. The public constituencies of South Hams, Teignbridge, Torbay and Rest of the South West Peninsula comprised 878 members, 2,724 members, 3,724 members and 14 members, respectively. Public membership is open to people aged 14 or over and who live within our defined membership area. Our people are eligible for membership provided that they hold a permanent contract of employment with us or they have been employed by us on a temporary contract of 12 months or longer.

The Council of Governors met on a total of five occasions during 2024/25. An Annual Members' Meeting was held at which the Annual Report was presented to the governors by the Board.

Performance of the Council of Governors

The Council of Governors is required to undertake a regular self-assessment of its performance year to establish whether it has adequately and effectively discharged its role, functions, and duties during the preceding year. These activities supported the function of the Council and Governors.

NHS oversight framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

1. objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access, and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)
2. additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its license conditions.

Segmentation

On 22 November 2022, it was confirmed that we had been placed into segment 4 (from segment 3) and would therefore receive further bespoke mandated support. The reason for the segment 4 rating was our underlying financial deficit and operational performance improvement requirements.

In response to our segment rating we are developing a series of timebound and measurable performance obligations to exit segment 4. These have been agreed with ICB Devon and NHS England. Progress against the exit criteria is being regularly scrutinised through our governance processes and reported monthly to the system improvement and assurance group.

This segmentation information is the trust's position. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

Well Led

The Trust has due regard to the CQC well-led framework in arriving at its overall evaluation of our performance, internal controls and board assurance framework. The principles within the framework also underpin our strategy and approach to risk management and are utilised to review our Board and committee effectiveness. Greater detail of our approach with regard to clinical services can be found within our Quality Account 2024/25 and more broadly within this Annual Report; notably within the Performance Report and Governance Statements; which explore both our performance and governance framework more broadly.

During the reporting period 2024/25, we underwent CQC inspections on Louisa Cary ward, Children and Families Health Devon and Radiotherapy inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The IRMER report is not published on the CQC website and is primarily aimed at professionals in the radiology community, to share learning and improve compliance with IR(ME)R.

The reports for both Louisa Cary and CFHD are due to be published Spring 2025.

An action plan was produced in November 2024 for Louisa Cary immediately following inspection. Of the 38 identified sub actions, 25 have been completed (65.8%) and the remaining 13 have revised completion targets.

The Well-Led inspection action plan from the 2023 inspection is now at 80% completion and continues to be overseen by the CQC Quality Assurance Group, which reports to the Quality Assurance Committee, which reports into the Board.

The action plan relating to the planned maternity inspection in December 2023 remains in progress with 57% having been completed. The existing actions are being incorporated with the Maternity Safety Support Programme (MSSP). . Due this being part of the national CQC Maternity programme, whilst many improvements were noted by the CQC, our Maternity rating remained at requires improvement.

We continued to work in close partnership with the CQC, via our regular planned monthly CQC meetings, as well as via the quarterly engagement meetings. These meetings have executive involvement and are a good vehicle for open discussion and sharing between ourselves and the CQC.

Patient Care

We are aware of the obligation to ensure that patients are supported to receive personalised care and are offered choice and control over their care choices and pathways. We are committed to providing personalised care for all our people. We have established a person-centered care group, which is jointly chaired by the Head of Personalised Care and the Deputy Chief Allied Health Professional, that reports into our feedback and engagement committee. To support this priority we have taken the following steps:
Our nursing and therapy assessment include specific reference to 'What matters to you'
We conduct a regular audit of our approach to person centred care on our wards, using questions agreed with our local population. Our results (including direct patient

feedback) show an improving picture of staff using ‘What matters to you’ in planning patient care.
We continue to promote a range of options to support self-management approaches including our Health Connect Coaching programme (which received a NHS parliamentary award in 2023), digital education options and the HOPE (help overcoming problems effectively) programme
In the coming year we are increasing the focus of involving carers as part of our approach to Triangle of Care.

Stakeholder relations

In addition to the collaborative working previously described, we engage directly with other stakeholders including our patients, service users, carers, families, and the public to understand, listen and where possible adapt or change the services we offer and recognise the value of their ideas about these how services can be developed and improved.

Our Board of Directors recognises the importance of understanding the experiences of people who use our services and continues its commitment to receive a story regularly at Board meetings.

With such a large public membership, this allows the organisation to harness and utilise the experience of our members, who provide us with knowledgeable information. Our governors attend our Board sub-committees as observers and patient representatives also attend important groups such as the patient feedback and engagement group, quality improvement group and mortality surveillance group, so that we can better understand the experiences and needs of people who use our services.

Information and feedback are received from many quarters including national surveys and local surveys. We also receive valuable ideas and suggestions from well-established patient pathways, social media and our patient and service user groups.

We also work with external organisations such as Healthwatch and seAp (a charity providing independent and confidential advocacy services), both of which help us hear the voices of people who use our services more clearly. We are committed to working in partnership to improve how we listen to, and use, people’s experiences to improve our services.

During the past year, we have worked together with system partners to listen to the voices of local people and communities and help shape both the national 10-year health plan for England and our local plans. As part of the wider system work, in Torbay and South Devon we ran three workshops for staff and volunteers, an engagement session for our governors, bespoke sessions for carers, autism ambassadors and our Teignmouth community stakeholder group as well as two public workshops. We worked with Healthwatch Torbay, Devon and Plymouth to provide opportunities to give feedback through postcards and a telephone line. We shared the Devon online survey through all our channels. Across Devon we achieved 3,137 pieces of individual feedback.

Other disclosures

Fees and charges (income generation)

Costs associated with fees and charges we levied are set out in note 7 to the annual accounts.

Income disclosures required by Section 43(2A) of the NHS Act 2006

As disclosed in the Foundation Trust's annual accounts, we comply with the need to ensure that income from the provision of goods and services for health services in England is greater than our income from the provision of goods and services for any other purpose; Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

The other income that we receive either fully covers the cost of those services or for income generating activities, profit is directly reinvested into the provision of health and social care.

Cost allocation and charging guidance

We have complied with the cost allocation and charging guidance issued by HM Treasury and its regulators, NHS England.

Better payment code of practice

The Better Payment Practice Code requires us to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

No payments were made during the year (2023/24: £Nil) under the Late Payment of Commercial Debts (Interest) Act 1998.

	2024/25		2023/24	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	150,409	367,880	136,813	339,156
Total Non-NHS trade invoices paid within target	123,585	301,693	112,146	274,820
Percentage of Non-NHS trade invoices paid within target	82%	82%	82%	81%
Total NHS trade invoices paid in the year	1,649	42,991	1,535	28,033
Total NHS trade invoices paid within target	1,016	36,324	1,071	19,573
Percentage of NHS trade invoices paid within target	62%	85%	70%	70%

Counter fraud policies and procedures

We have a clear strategy for tackling fraud, corruption and bribery. This is documented in our counter fraud, bribery and corruption policy which details responsibilities and how to report suspicions of fraud, bribery or corruption.

We have a lead accredited Local Counter Fraud Specialist (LCFS) via consortium arrangements with Audit South West (ASW) Assurance. In addition, we have a number of nominated support personnel from within the consortium that are able to support the organisation as required. The LCFS ensures risks are mitigated and systems are resilient to fraud, corruption and bribery. An annual counter fraud work plan is reviewed and approved by the Audit and Risk Committee which is aligned to the NHS Counter

Fraud Authority strategy.

The Chief Executive and Chief Finance Officer and the Audit and Risk Committee oversee the work of the LCFS. Reports on progress with delivery together with outlines of referrals received and investigations are regularly provided to the Audit and Risk Committee. The LCFS also highlights to the Committee any issues that have arisen so that appropriate action can be taken.

The program of counter fraud work was delivered in 2024/25 addressing all components of the Government Functional Standard GovS 013: Counter Fraud with an overall rating of Green. The LCFS develops and maintains key relationships across the organisation and this, coupled with the work undertaken by the LCFS, has resulted in the development of a strong anti-fraud culture.

Cost allocation and charging guidance

The Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury and its regulators, NHS Improvement and NHS England.

Accessible Information Standard

Making health and social care information accessible

From 01 August 2016 onwards, all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

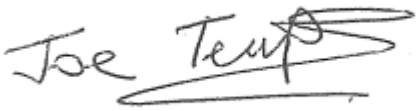
Healthwatch in Devon, Plymouth, and Torbay is the independent consumer champion for health and social care services, ensuring the voice of the community is used to influence and improve services for local people. They worked with the local deaf community and undertook an independent review of NHS services across Devon to ascertain how accessible their services were to them. They provided recommendations and suggestions for improvement and in response an action plan is being developed which will entail collaboration with the deaf community and other key partners.

Statement as to Disclosure to Auditors (s418)

The Board of Directors reports that for everyone who is a director at the time this report is approved:

- as far as the director is aware, there is no relevant audit information of which our auditor is unaware
- the director has taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that our auditor is aware of that information.
- ‘Relevant audit information’ means information needed by our auditor in connection with preparing their report. A director is regarded as having taken all the steps that they ought to have taken as a director to do the things mentioned above, and:
- made such enquiries of their fellow directors and of the corporation’s auditors for that purpose
- taken such other steps (if any) for that purpose, as are required by their duty as a director of the company to exercise reasonable care, skill, and diligence.

The directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the organisation's performance, business model and strategy.



Joe Teape
Chief Executive
25 June 2025

PART III – REMUNERATION REPORT

Salary and pension entitlements of senior managers as at 31 March 2025 (audited information)

	2023-24						2024-25					
	Salary	Expense Payments (taxable)	Annual Performance Pay and Bonuses	Long-term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense Payments (taxable)*	Annual Performance Pay and Bonuses	Long-term Performance Pay and Bonuses	All Pension Related Benefits**	Total
Name and Title	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Mrs L Davenport Chief Executive (retired 31/12/2024)	210-215	0	0	0	0	210-215	165-170	0	0	0	0	165-170
/Mr J Teape Chief Executive (appointed 10 March 2025)							10-15	300	0	0	2.5-5	15-20
Mr W Shields Interim Chief Executive (01/01/2025 to 07/03/2025)							35-40	0	0	0	0	35-40
Ms A Jones Director of Transformation and Partnerships/latterly Chief Operating Officer	135-140	600	0	0	2.5-5	135-140	140-145	900	0	0	32.5-35	175-180
Dr J Watson Health and Care Strategy Director (Resigned from executive duties on 26/02/2025)	195-200	0	0	0	0	195-200	160-165	0	0	0	0	160-165
Mrs E Long Director of Corporate Governance and Trust Secretary	110-115	0	0	0	25-27.5	140-145	120-125	0	0	0	30-32.5	150-155
Mr MH Brice Chief Financial Officer	100-105	0	0	0	25-27.5	125-130	155-160	0	0	0	42.5-45	200-205

	2023-24						2024-25					
	Salary	Expense Payments (taxable)	Annual Performance Pay and Bonuses	Long-term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense Payments (taxable)*	Annual Performance Pay and Bonuses	Long-term Performance Pay and Bonuses	All Pension Related Benefits**	Total
Name and Title	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Dr M Westwood Chief People Officer (resigned 15/01/2025)	125-130	0	0	0	32.5-35	155-160	100-105	0	0	0	65-67.5	165-170
Mr AP Chandran Chief Operating Officer	50-55	0	0	0	42.5-45	95-100	110-115	0	0	0	100-102.5	215-220
Dr CA Lissett Chief Medical Officer	40-45	0	0	0	2.5-5	45-50	190-195	0	0	0	432.5-435	625-630
Mrs N McMinn Chief Nurse	25-30	0	0	0	32.5-35	60-65	125-130	0	0	0	142.5-145	270-275
Ms A Cholmondeley Interim Chief People Officer (appointed 16 January 2025)							25-30	0	0	0	5-7.5	30-35
Mr D Stacey Chief Finance Officer and Deputy Chief Executive (left 31/7/23)	55-60	200	0	0	27.5-30	85-90						
Mr I Currie Executive Medical Director (left 31/12/23)	125-130	0	0	0	0	125-130						
Ms D Kelly Chief Nurse (left 31/12/23)	95-100	2800	0	0	0	100-105						
Mr J Scott Interim Chief	210-215	0	0	0	0	210-215						

Operating Officer (left 26/10/23)												

	2023-24						2024-25					
	Salary	Expense Payments (taxable)	Annual Performance Pay and Bonuses	Long-term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense Payments (taxable)*	Annual Performance Pay and Bonuses	Long-term Performance Pay and Bonuses	All Pension Related Benefits	Total
Sir R Ibbotson Non-Executive Chairman (retired 31/05/2024)	50-55	0	0	0		50-55	5-10	300	0	0		5-10
Mr R Sutton Non-Executive Director	15-20	0	0	0		15-20	15-20	0	0	0		15-20
Mr P Richards Non-Executive Director	10-15	0	0	0		10-15	10-15	0	0	0		10-15
Mrs V Matthews Non-Executive Director (resigned 31/01/2025)	10-15	0	0	0		10-15	10-15	0	0	0		10-15
Prof C Balch Non-Executive Chairman	15-20	0	0	0		15-20	45-50	0	0	0		45-50
Mr R Crompton Non-Executive Director (resigned 02/10/2024)	10-15	0	0	0		10-15	5-10	0	0	0		5-10
Ms S Walker-McAllister Non-Executive Director	15-20	0	0	0		15-20	15-20	0	0	0		15-20
Dr M Beaman Non-Executive Director	5-10	0	0	0		5-10	10-15	0	0	0		10-15
Mrs BE Gregory Non-Executive Director (resigned 22/05/2024)	5-10	0	0	0		5-10	0-5	0	0	0		0-5

Mr R Williams Non-Executive Director	0-5	0	0	0		0-5	10-15	0	0	0		10-15

	2023-24						2024-25					
	Salary	Expense Payments (taxable)	Annual Performance Pay and Bonuses	Long-term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense Payments (taxable)*	Annual Performance Pay and Bonuses	Long-term Performance Pay and Bonuses	All Pension Related Benefits	Total
Mr M Greaves Non-Executive Director (appointed 01/01/2025)							0-5	0	0	0		0-5
Mr A Ghadiali Non-Executive Director (appointed 21/10/2024)							0-5	0	0	0		0-5
Mrs E Edwards-Smith Non-Executive Director (appointed 21/10/2024)							5-10	0	0	0		5-10
Mr C Saxby Non-Executive Director (appointed 21/10/2024)							5-10	0	0	0		5-10
Mr D Feindouno Non-Executive Director (appointed 21/10/2024, left 20/03/2025)							0-5	0	0	0		0-5
Mrs J Lyttle Non-Executive Director and Senior Independent Director (left 30/9/23)	5-10	0	0	0	0	5-10						
Dr P Aitken Associate Non-Executive Director (appointed 1/1/23, left 26/7/23)	0-5	0	0	0	0	0-5						

Notes:

Sir R Ibbotson retired on 31/05/2024

Mrs V Matthews resigned on 31/01/2025

Mr RPd Crompton resigned on 02/10/2024

Mrs BE Gregory resigned on 22/05/2024

Mrs E Edwards-Smith was appointed as a non-executive director on 21/10/2024

Mr A Ghadiali was appointed as a non-executive director on 21/10/2024

Mr M Greaves was appointed as a non-executive director on 01/01/2025

Mr C Saxby was appointed as a non-executive director on 21/10/2024

Mr J Teape was appointed on 3/3/2025 but assumed executive duties as Chief Executive on 10/03/2025

Ms E Davenport retired on 31/12/2024

Dr J Watson resigned as an executive on 26/02/2025
Dr M Westwood resigned on 15/01/2025
Ms A Cholmondeley was appointed as Interim Chief People Officer on 06/01/2025 but assumed executive duties on 16/01/25
Mr D Feindouno was appointed on 21/10/2024 and left on 20/02/2025
Mr W Shields was appointed as the Interim Chief Executive from 01/01/2025 to 07/03/2025. Mr Shields had a substantive role with Devon ICB and his costs were recharged from the ICB to the Trust.
Mr A Chandran ceased executive duties on 14/01/2025
Mr David Killoran was employed by TSDFT as an Interim Finance Director in 2019-2021 and subsequently provided services to the trust in the financial year 2024-2025 via a limited company, DKA Consulting Limited.
Dr J Watson's remuneration includes clinical, operational and Trust Board duties (£87k of salary in respect of clinical services).
*The taxable benefits are for travel expenses or salary sacrifice benefits subject to income tax. None of the Directors received any annual or long-term performance-related benefits.
**The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase is due to inflation or any increase or decrease due to a transfer of pension rights. The value derived does not represent any amount that will be received by the individual. It is a calculation intended to estimate the benefit a member of the pension could provide. The pension benefits table provides further information on the pension benefits accruing to the individual.

Pension benefits as at 31st March 2025 (audited information)

	Real increase in pension	Real increase in pension lump sum	Total accrued pension at pension age	Lump sum at pension age related to accrued pension	Cash Equivalent Transfer Value	Real Increase	Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	at pension age	at pension age	at 31 March 2025	at 31 March 2025	at 1 April 2024	in Cash Equivalent Transfer Value	at 31 March 2025	
Name and title	(bands of	(bands of	(bands of	(bands of				(to nearest
	£2,500)	£2,500)	£5,000)	£5,000)				£100)
Mrs L Davenport Chief Executive (retired 31/12/2025)	0	0	100-105	265-270	2390	0	191	0
Mr J Teape Chief Executive (appointed 10 March 2025)	0-2.5	0	75-80	200-205	1607	4	1801	0
Ms A Jones Director of Transformation and Partnerships/latterly Chief Operating Officer	2.5-5	0	45-50	120-125	923	32	1034	0
Dr J Watson Health and Care Strategy Director (resigned from executive duties on 26/02/2025)	0	0	65-70	185-190	1,655	0	1,720	0
Mrs E Long Director of Corporate Governance and Trust Secretary	0-2.5	0	5-10	0	54	13	86	0
Mr MH Brice Chief Financial Officer	2.5-5	0	60-65	75-80	1150	52	1,299	0
Dr M Westwood Chief People Officer (resigned 15/01/2025)	2.5-5	0	5-10	0	41	36	94	0
Mr AP Chandran Chief Operating Officer	5-7.5	7.5-10	45-50	110-115	760	98	953	0

Dr CA Lissett Chief Medical Officer	20-22.5	50-52.5	75-80	200-205	1225	465	1805	0
Mrs N McMinn Interim Chief Nurse	5-7.5	12.5-15	55-60	150-155	1,106	162	1,358	0
Ms A Cholmondeley Interim Chief People Officer (appointed 16 January 2025)	0-2.5	0-2.5	20-25	60-65	447	11	493	0

As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued because of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2005/06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member because of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV – this reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0 per cent to 2.8 per cent. This rate affects the calculation of CETV figures in this report.

NHS Pensions have enacted changes to benefits in the NHS 2015 Scheme due to the McCloud remedy. The benefits and related CETVs disclosed have been calculated in line with the remedy, with pensionable membership calculated in the legacy scheme for those with pre 2012 NHS Pension membership.

Annual Statement on Remuneration

There have been no changes to the remuneration policy for senior managers during the year.

For executive directors there are no arrangements relating to termination payments other than the application of employment contract law. No termination payments have been made to either present or past senior managers within 2024/25.

The non-executive directors Nomination and Remuneration Committee (the committee), whose function it is to decide pay for Executive Directors conduct a review of executive salaries each year.

During the year ending 31 March 2025, six senior managers (two substantive Chief Executives and one Interim Chief Executive, Chief Finance

Officer, Medical Director, Health and Care Strategy) were paid more than £150,000.

The steps outlined above provides the Non-Executive Nominations and Remuneration Committee with assurance that the remuneration level is reasonable and linked appropriately to the weight of the role based on accountability, job responsibilities and the knowledge and skills required for each of those positions.

Remuneration is set in accordance with NHS Agenda for Change for all our people other than doctors and directors. Pay and conditions of service for doctors is agreed nationally.

Senior managers' remuneration policy

The remuneration package for senior managers consists of the following factors:

Item	Rationale
Salary	Our strategy and business planning process set the key business objectives of our organisation which are delivered by the senior managers. This success measure is one of the ways in which the senior managers' performance is monitored. Senior managers' remuneration is based on market rates and there are no automatic salary rises. To ensure that the pay and terms of service offered by the organisation are both reasonable and competitive, comparisons are made between the scale and scope of responsibilities of our senior managers and those of employees holding similar roles in other organisations. A report is prepared for the Non-Executive Nominations and Remuneration Committee, which makes these comparisons between our remuneration rates for senior managers and market rates, as required. The base salaries of executive directors in post at the start of the policy period and who remain in the same role throughout the policy period will not usually be increased by a higher percentage than the maximum incremental uplift applicable to the highest paid staff on Agenda for Change. The only exceptions are where an executive director has been appointed at below market level to reflect experience. Senior managers are paid spot level salaries rather than on an incremental scale and may collectively receive an annual uplift in salary in line with '*Guidance on pay for very senior managers'* issued by NHS England. All senior managers' remuneration is subject to satisfactory performance of duties in line with their employment. There is no performance related pay so senior managers receive one hundred per cent of their salary subject to the relevant deductions.
Taxable benefits	The Non-Executive Nominations and Remuneration Committee agree any taxable benefit. This forms part of the recruitment and retention of senior managers by ensuring that we remain competitive. There is no maximum amount payable.
Pension	Standard pension arrangements are in place. This forms part of the recruitment and retention of senior managers by ensuring that we remain competitive There is no maximum amount payable.
Bonus	There is no bonus scheme for any senior manager, however bonus payments may be made on a discretionary basis subject to approval by the Non-Executive Nominations and Remuneration Committee. All other staff, except the senior management team at Torbay Pharmaceuticals, are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally.
Other	Individual items such as lease cars are not offered as part of a remuneration package. Board level directors may, however, put forward an individual request in respect of such items. Senior managers' terms and conditions eg holidays, pensions, sick pay are in accordance with Agenda for Change terms and conditions.

Senior manager's objectives and performance

Senior managers meet annually with the Chief Executive to agree core and individual performance objectives and subsequently meet with the Chief Executive monthly to discuss the progress made towards the targets set. A formal interim progress review is held six months after the objectives are set, a final review of performance and achievement of objectives is held at the end of the year, when objectives for the following year are also discussed and agreed.

The Chief Executive's performance is appraised using the same system, but their performance objectives are agreed with and monitored by the Chairman. This process was designed to ensure that clearly defined and measurable performance objectives are agreed, and progress towards these objectives is regularly and openly monitored, both formally and informally.

The Chief Executive presents an assurance report to the Non-Executive Directors Nomination and Remuneration committee each year outlining the appraisal process undertaken. The committee also receives a summary report on the performance of each of the executive directors and associate directors and a recommendation in respect of any proposed changes to remuneration levels. The Chairman adheres to the same process in regard to the Chief Executive.

Remuneration of executive directors and other employees

When setting remuneration levels for the executive directors, the Nominations and Remuneration Committee considers the prevailing market conditions, the competitive environment (in particular through comparison with the remuneration of executives at other Foundation Trusts of a similar size and complexity) and the positioning and relativities of pay and employment conditions across the broader organisational workforce.

In particular, the Nominations and Remuneration Committee considers the recommendations of the NHS Pay Review Body and the Review Body on Doctors' and Dentists' Remuneration as reflecting most closely the economic environment encountered by Executive Directors. We do not consult more widely with employees on such senior managers' remuneration matters.

Annual Report on remuneration Service contracts

The following table shows for each person who was an Executive or Associate Director or Non-Executive Director as at 31 March 2025, the commencement date for their current position and the term of service agreement or contract for services and details of notice periods.

Director	Status	Contract start date	Contract term (years)	Unexpired term as at July 2025	Notice period by the organisation	Notice period by the director
Mr J Teape	Executive Board member	Commenced 03.03.2025 took on accountable officer duties 10.03.2025	Indefinite term	Not applicable	Three months	Three months
Mr M Brice	Executive Board member	Commenced 01.06.2023 took on executive duties 01.08.2023	Indefinite term	Not applicable	Three months	Three months
Mr A Chandran	Executive Board member	06.11.2023	Indefinite term	Not applicable	Three months	Three months
Ms A Cholmondeley	Executive Board member	06.01.2025	Fixed Term Contract	>1 month	Three months	Three months
Mrs A Jones	Executive Board member	22.07.2019	Indefinite term	Not applicable	Three months	Three months
Dr C Lissett	Executive Board member	01.01.2024	Indefinite term	Not applicable	Three months	Three months
Mrs E Long	Executive Board member and Trust Secretary (non-voting)	01.11.2021	Indefinite term	Not applicable	Three months	Three months
Ms N McMinn	Executive Board member	01.01.2024	Indefinite term	Not applicable	Three months	Three months
Prof C Balch	Non-Executive Board Member	14.04.2022	2 years	10 months	Three months	Three months
Mr M Beaman	Non-Executive Board Member	01.11.2023	3 years	1 year 4 months	Three months	Three months
Ms L Edwards-Smith	Non-Executive Board Member	21.10.2024	3 years	2 years 3 months	Three months	Three months
Mr A Ghadiali	Associate Non-Executive Board Member (non-voting)	21.10.2024	3 years	2 years 3 months	Three months	Three months
Mr M Greaves	Non-Executive Board Member	01.01.2025	3 years	2 years 6 months	Three months	Three months
Mr P Richards	Non-Executive Board Member	13.11.2020	1 year	4 months	Three months	Three months
Mr C Saxby	Non-Executive Board Member	21.10.2024	3 years	2 years 3 months		
Mr R Sutton	Non-Executive Board Member	01.05.2022	1 year	Contract ended April 2025	Three months	Three months
Mrs S Walker-McAllister	Non-Executive Board Member	01.09.2022	3 years	2 months	Three months	Three months
Mr R Williams	Non-Executive Board Member	01.11.2023	3 years	1 years and 4 months	Three months	Three months

Notes:
Professor Balch appointed as Chair wef 01.05.2024, having served 5 years and one month as a non-executive director
Unless noted above, these officers have been in post throughout 2024/25

Service contracts

As described above, senior managers' contracts are open-ended (permanent) contracts. Non-executive directors serve terms of three years, up to a maximum of six years. The Council of Governors will consider and set terms of office for non-executive directors beyond that point that meet the needs of the organisation, taking into account NHS England guidance and the Code of Governance for NHS Provider Trusts. Terms beyond that point should be set on an annual basis. Further details about the terms of office of each individual non-executive director can be found in the director's report within this annual report and accounts.

Remuneration Committee Memberships and Meetings

Membership and details of meetings attendance can be found at page 59 of this report.

We have established two committees responsible for the remuneration, appointments and nominations of directors. A description of the committee responsible for non-executive director remuneration can be found in the section 'Committees of the Council of Governors'. The Committee responsible for the remuneration of executive directors is described below.

With the "Committees of the Board of Directors" section of the Accountability report above we describe the role of the Non-Executive Nominations and Remuneration Committee in more detail, pages 48-50.

Chairman and Non-Executive Director remuneration

The Chairman's and non-executive Directors' remuneration is overseen by the Governors' Nominations and Remuneration Committee ('Committee') as outlined in the Accountability Report 'Committees of the Council of Governors' section.

The Committee makes recommendations to the Council of Governors on the non-executive directors' and Chairman's remuneration levels, noting the NHS England guidance as published from time to time. The Chairman and non-executive directors receive spot level remuneration but can claim reasonable expenses, for example travel expenses, as per other employees.

A review of remuneration levels applicable to Non-Executive Directors and the Chairman was undertaken during the year. The committee was cognisant of the new remuneration framework and took the decision to maintain current levels of remuneration. Some non-executive Directors receive an additional one-off responsibility allowance based on Board positions held. No uplift in responsibility allowances was made during 2024/25.

The remuneration package for the Chairman and other non-executive directors is made up of:

Item	Rationale
Remuneration	£51,000 per annum for the Non-Executive Chairman - three days per week
Remuneration	£13,500 per annum for all other Non-Executive Directors - three days per month
Remuneration	Additional responsibility allowance of £3,000 for the Chair of the Audit Committee
Remuneration	Additional responsibility allowance of £1,500 given to the Senior Independent Director (SID)
Remuneration	Additional responsibility allowance of £1,000 given to the Vice Chair
Expenses	Chairman and Non-Executive Director mileage rates are aligned with latest guidance: 56p per mile for the first 3,500 miles reducing to 20p per mile thereafter. All other expenses remain in line with organisational policy.

Governors' expenses

Governors may be reimbursed for legitimate expenses, incurred during their official duties, as governors of the Trust. During the financial year, Governors were paid expenses to reimburse costs incurred while attending meetings of the Foundation Trust and at external training and development events.

	31 March 2024	31 March 2025
Number of Governors in office	29	26
Number of Governors receiving expenses	4	2
Total expenses paid to Governors	£1009.85	£668.75

Fair pay multiple (audited information)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid Director in our Trust in the financial year 2024/25 was £220,000 - £225,000 (2023/24, £355,000 - £360,000). This was 6.2 times (2023/24, 10.9) the median remuneration of the workforce, which was £36,483 (2023/24, £32,617, previously reported as £34,581 the difference being due to the 23/24 figures previously not included an element of unsocial hours payment).

The decrease in ratio from 10.9 to 6.2 in 2024/25 is due to the reduction in salary for the highest paid director and an increase in the median employee salary. The highest paid director in 2024-25 was the Chief Executive Officer. The highest paid director in 2023-24 was the Interim Chief Operating Officer employed on a fixed-term contract. The interim contract ceased in 2023/24, and the post has been recruited substantively.

In 2024/25, 9 (2023/24, 0) employees received remuneration in excess of the highest-paid director. These staff were employed in senior medical roles.

For employees of the trust as a whole, remuneration ranged from £23,614 to £317,957 (2023/24, £22,383 - £355,266).

Total remuneration includes salary and non-consolidated performance-related pay. It does not include benefits-in-kind, severance payments, employer pension contributions and cash equivalent transfer value of pensions.

The median calculation is based on the full-time equivalent staff of the Foundation Trust at the reporting period end date on an annualised basis.

Fair pay multiple (audited information) – 25th and 75th Percentile

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

The percentage change in average employee remuneration (based on the total for all employees on an annualised basis divided by full-time equivalent number of employees) between years is 2%. The percentage change for the highest paid director between years is a reduction of 38%. The percentage change in average employee remuneration (based on the total for all employees on an annualised basis divided by full-time equivalent number of employees) Between 2022/23 to 2023/24 was 12 % and between 2023/24 to 2024/25, 2%. The percentage change for the highest director between 2022/23 to 2023/24 was a reduction of 1% and between 2023/24 to 2024/25 was a further reduction of 38%

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

	2024/25			2023/24		
	25th Percentile	Median	75th Percentile	25th Percentile	Median	75th Percentile
Salary component of pay	£25,917	£36,482	£48,508	£25,147	£32,617, previously reported as £34,581, the difference being due to the 23/24 figures previously not including an element of unsocial hours pay ments)	£43,500, previously reported as £44,787, the difference being due to the 23/24 figures previously not including an element of unsocial hours payments)
Total pay and benefits excluding pension	£25,917	£36,483	£48,508	£25,147	£32,617, previously reported as £34,581, as above	£43,500, previously reported as £44,787, as above
Total pay and benefits excluding pension: pay ratio for highest paid director	8.7:1	6.2:1	4.6:1	14.1:1	10.9:1	8.2:1

The above values include any unsocial pay premia, e.g. for working unsocial hours, that staff receive as part of their duties.

Definition of 'senior managers'

The definition of 'senior managers' is 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. This includes the Chief Executive, Chairman, executive, associate and non-executive directors. This definition covers all those who hold or have held office as Chairman, non-executive director, executive director, or associate director of the organisation during the reporting year. It is irrelevant that:

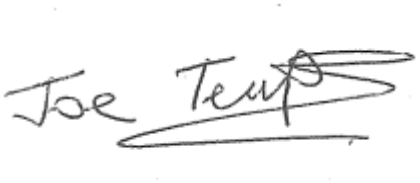
- an individual was not substantively appointed (holding office is sufficient, irrespective of defects in appointment)
- an individual's title as director included a prefix such as 'interim, acting, temporary or alternate'
- an individual was engaged via a corporate body, such as an agency, and payments were made to that corporate body rather than to the individual directly.

Policy on payment for loss of office for senior managers

Senior managers are employed on substantive contracts of employment and are employees of the organisation. Their contracts are open-ended employment contracts which can be terminated by either party by giving notice in accordance with their individual service contract.

Our normal disciplinary policy applies to senior managers, including the sanction of instant dismissal for gross misconduct. Our redundancy policy is consistent with the NHS redundancy terms for all our colleagues.

This concludes the Renumeration Report for 2024/25.



Joe Teape

Chief Executive
25 June 2025

PART IV – STAFF REPORT

Analysis of staff costs (audited information)

The Trust is required to provide an analysis of staff costs, in categories defined in the NHS Information Centre's Occupational Code Manual. This analysis distinguishes between 'permanently employed' and 'other staff'.

	2024/25			2023/24		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	296,408	288.596	7,812	279,382	278,603	779
Social security costs	28,204	28,204	-	27,154	27,154	-
Apprenticeship levy	1,433	1,433	-	1,377	1,377	-
Employer's contributions to NHS pensions	34,487	34,487	-	32,106	32,106	-
Pension cost – Employer contributions paid by NHS England on Trust's behalf (6.3%)	23,000	23,000	-	14,454	14,454	-
Pension cost - other	94	94	-	120	120	-
Temporary staff	9,144	-	9,144	16,521	-	16,521
Total staff costs	**392,770**	**375,814**	**16,956**	**371,114**	**353,814**	**17,300**
Of which: Costs capitalised as part of assets	3,820	3,820	-	3,708	3,708	-

We incurred £933,000 (2023/24 £711,000) in respect of other post-employment benefits, other employment benefits, or termination benefits. We did not second any staff in either year to other organisations, instead where staff were supplied to other organisations we generated an income from this service.

Analysis of worked full time equivalents (FTEs) (audited information)

We are required to provide an analysis of average staff numbers, in categories defined in the NHS Information Centre's Occupational Code Manual. This analysis distinguishes between 'permanently employed' and 'other' staff.

The average number of employees is calculated as the whole-time equivalent number of employees under contract of service in each month in the financial year, divided by the number of months in the financial year. The "contracted hours" method of calculating whole time equivalent number is used, that is, dividing the contracted hours of each employee by the standard working hours. Staff on outward secondment are not included in the average number of employees.

NHSI Staff Group	2024/25		
	Total	Of which permanently employed	Of which other
Medical and Dental	630	295	335
NHS Infrastructure Support	1823	1762	61
Registered Nursing, Midwifery and Health Visiting Staff	1456	1420	36
Registered/ Qualified Scientific, Therapeutic and Technical staff	934	914	20
Support to Clinical Staff	1381	1300	81
Total	6224	5691	533

* Figures as at 31 March 2025

Analysis of sickness absence

We continue to develop the overall health and wellbeing of our people and our management of sickness absence. The sickness absence rate for 2024/25 compared to the previous five years is shown below. As was the case in the previous financial year, absence related to COVID-19 was a key contributor to the levels of sickness witnessed in the year.

Year	12 month sickness	Average FTE	FTE days available	FTE days lost to sickness	Average sickness absence duration (FTE Days)
2019/20	4.45%	5,410	1,974,776	87,942	10
2020/21	4.02%	5,667	2,068,557	83,152	9
2021/22	5.02%	5,806	2,119,241	106,286	11.3
2022/23	5.27%	6,027	2,199,716	115,864	11.9
2023/24	4.95%	6,013	2,189,849	108,486	12.4
2024/25	5.00%	6,224	2,261625	112,802	12.4

Note: Source: from the Electronic Staff Record (ESR)

- period covered: April 2024 to March 2025 (Data as at 31 March 2025)
- data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year
- the number of Full-Time Equivalent (FTE) days available has been taken directly from ESR. This has been converted to an average FTE in the third column by dividing by 365
- the number of FTE days lost to sickness absence has been taken directly from ESR
- the average number of sick days per FTE has been estimated by dividing the FTE days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by average FTE.

Analysis of staff turnover

Information showing our staff turnover data can be accessed via the following link to the NHS Digital website NHS workforce statistics - NHS Digital

Staff policies and actions applied during the year

Key changes were made to our flexible working and carers' leave policies to ensure compliance with legislative changes. It was the intention to complete an overhaul of our core people policies in line with developing our just and learning culture, including resolution, sickness absence and disciplinary. Whilst the working group initially had momentum, a shift in priorities due to the financial position of the trust and impending collaboration work as part of the One Devon People Digital Project, the group was stood down to avoid duplication. In the meantime, a review will be conducted to update our policies and guidance to make them more user friendly for our workforce, pending a complete overhaul.

We continue to be committed to providing an inclusive environment for our patients, our people and visitors. We believe in providing equity in our services, in treating people fairly with respect and dignity and in valuing diversity both as a health and care services provider and as an employer.

Our diversity and inclusion policy sets out the responsibilities of the organisation, our people and people who use our services. We actively promote a culture that values difference and recognises that people from different backgrounds and experiences bring valuable knowledge and insights to the workplace and enhances the way we work. We strive to be inclusive, to value, respect and embed diversity in all areas across the organisation. This will support us to recruit and retain a diverse workforce that reflects the communities we serve. Our diversity and inclusion policy affords equal protection to those who access our services, ensuring people are involved in their care and our workforce, ensuring our people have fair and equal opportunity.

We are committed to compliance with the Equality Act 2010, and as part of the subsequent Public Sector Equality Duty, we are dedicated to:

- eliminating discrimination
- promoting equality of opportunity
- fostering good relations

All our policies continue to be subject to a rapid or full quality impact assessment which aims to tackle discrimination or disadvantage at the outset.

Employability activity supports those who may experience disadvantage to find sustainable employment through experience-based work placements. We support a range of people to develop their employability skills in a safe environment through our work experience programmes, traineeships if appropriate, apprenticeships and eventually through securing employment. We have created a stronger local network with the voluntary sector and the Department for Works and Pensions to work together on improving access to employment.

We have also joined the disability confident initiative (this replaced the √√ (2 ticks) scheme) and we are a disability committed employer who aims to progress to level two disability confident status.

One in three of our people are unpaid carers (source: National Staff Survey 2022) and during this year, we have enhanced our support for our colleagues who are juggling working with caring for a family member or friend. It is now firmly embedded within wellbeing with our wellbeing buddies receiving training in carer awareness. Access to support has been made simpler and managers who support our people who are carers have recently been recognised at our annual our people celebration event.

We continue to be a 'Mindful Employer', supporting health and wellbeing at work and this work continues to be reflected within our people promise. The plan is reflective of the national priorities, integrated care system and organisational priorities.

During the year our health and wellbeing programmes have focused on:

- successfully delivering our winter COVID and Flu vaccination programme and delivering the spring booster COVID programme
- we have been allocated monies via Charities Together to support our people's wellbeing and have delivered:
    - mental health training delivered to 121 of our managers via a local charity
    - the development and support of our wellbeing buddy community including mental health first aider training. We currently have over 200 active wellbeing buddies
    - provided the opportunity for 45 of our teams to bid for monies to support wellbeing activities in their teams
    - dedicated wellbeing week which focused on ‘looking after me’
    - following the review of wellbeing using the National Health and Wellbeing Framework diagnostic tool our priorities have been incorporated into the third element of our People Promise plan focusing on culture and inclusion

We have signed up to the Sexual Safety Charter and have committed to taking and enforcing a zero-tolerance to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace. There are ten commitments organisations are asked to implement by July 2024 and we are currently working towards achieving these. The National Staff Survey for the first time this year asked two questions relating to our staff experience of sexual misconduct and will provide and important benchmark on our progress

The commitments are as follows:

- We will actively work to eradicate sexual harassment and abuse in the workplace.
- We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
- We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
- We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
- We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
- We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
- We will ensure appropriate, specific, and clear training is in place.
- We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
- We will take all reports seriously and appropriate and timely action will be taken in all cases.
- We will capture and share data on prevalence and staff experience transparently.

We recognise that there may be times when our people experience episodes of poor health and wellbeing and this is reflected in our National Staff Survey results. We have policies in place to ensure our people get the support and guidance and reasonable adjustments they need to assist them through this difficult time. Our occupational health service is focused on the safety, health and wellbeing of our people, patients and visitors.

We offer a full range of occupational health services, which are available to all our people including the following:

- health promotion as well as health information and advice
- health surveillance for our people identified as ‘at risk
- workplace assessments

- immunisation programmes
- training and policy advice
- infection control including ‘needlestick hotline’
- baseline screening for new employees.

We have worked closely with our Clinical Health Psychology team to provide psychological support to our people who report being a victim of bullying, harassment, discrimination or violence.

Our corporate health and safety team moved into our workplace team (formerly known as estates and facilities management). In conjunction with our health and safety committee and with other relevant stakeholders and teams, our corporate health and safety team continue to develop a cultural improvement plan for organisational safety which focusses on training, individual accountability and improved reporting of hazards. In that spirit, additional learning is being rolled out across our Trust in the form of Institute of Safety and Health (IOSH) Managing Safely training for all line managers. National Examination Board in Occupational Safety and Health (NEBOS) environmental training has also been provided to key people across our services to enhance our environmental safety focus.

We manage health and safety through a series of steering groups and committees which are attended by clinical and non-clinical colleagues, as well as relevant external consultants and regulators. These include the health and safety committee, the fire safety group, the asbestos safety group and the water safety group.

The anonymous digital communication platform Work In Confidence provides our people with an alternative route to Speak Up. This enables our people to have a conversation with the Freedom to Speak Up Guardian without identifying themselves, this is proving successful and is being used both by individuals and teams. The platform is also being used to undertake anonymous surveys where concerns have been raised. This gives a temperature check and an opportunity for sharing experiences confidentially. The survey results are then shared with line managers and leadership to develop an appropriate action plan to help resolve the concerns. Proactive work to raise awareness through film, interactive platforms and face to face sessions continues as well as reactive work supporting both our people and managers in resolving concerns. The new national Freedom to Speak Up Policy has been launched alongside the new Patient Safety Incident Response Framework.

Whenever possible we continue to have an inclusivity representative on interview panels to ensure recruitment processes are inclusive. This also ensures we are growing a more inclusive and diverse future workforce and enabling the career progression for people from minority groups.

Through our continuously evolving people promise programme, we have undertaken significant engagement with people from under-represented groups in order to better understand what is needed to ensure a culture of inclusion and belonging. The themes identified from this work, together with the results of the staff survey and our CQC action plan, continued to inform our work for 2024/25; these included:

- we worked with our regional inclusion colleagues to bring together a week-long event of diverse talks and training sessions aimed at improving our regional and local work on inclusion
- we developed and launched our own interactive inclusion module with significant uptake from our workforce (over 5000 completions by April 2024)
- we launched our co-created compassionate leadership framework and associated development across the organisation, again with significant uptake and positive feedback
- In response to our CQC inspection outcome we launched a comprehensive plan aimed at meeting the needs of our people and the wider needs of our organisation
- we promote and raise awareness of Ramadan, Diwali and other celebrations through articles, videos and offering diverse foods in our restaurant
- we raised awareness through disability history month

- we celebrated a highly successful Black History Month; this year we worked in partnership with the Royal College of Nursing to co-produce a people event with regional speakers and successful attendance
- we raised awareness of race equality through daily challenges on key topics designed stimulate personal reflection own bias and privilege
- 29 of our people have completed our inaugural Black and Minority Ethnic (BME) Leadership programme with several achieving promotion during this time and a further two cohorts have been launched this year
- We started to develop and co-design a training framework for managers to raise cultural awareness to ensure smooth the transition for international colleagues into their new team. Our international colleagues have been pivotal in designing this with us

2024 National NHS staff survey

Staff engagement and experience

We know that the best way to care for people who use our services is to care for the people who deliver those services – our dedicated, talented, compassionate people.

Supporting them to live well is central to enabling us to deliver our purpose – to support the people of Torbay and South Devon to live well.

Research evidences a clear relationship between people feeling seen, heard and valued and individual and organisational outcome measures, such as absenteeism and turnover, patient satisfaction and mortality and safety measures, including infection rates.

The better we support and listen to our people, the better the outcomes and experience for people who use our services.

We have a range of well-established forums for our people to share their views and to engage with us including:

- Trust Talk – monthly briefing session from the executive team which is livestreamed, with opportunities for question and answers
- ‘Just Ask!’ noticeboard for people to ask questions or raise issues with the executive team
- staff surveys including the national annual staff survey and quarterly people pulse
- Freedom to Speak Up Guardian and champion network, anonymous platform
- joint consultations/negotiations with the Trade Unions
- wellbeing buddies
- staff governors.
- Learner councils and student forums

NHS staff survey (NSS)

The past 12 months have remained challenging as our health and social care services continue to experience significant pressure. We continue to be under considerable financial scrutiny, and the cost-of-living crisis continues impacting all of us to some extent. In August 24 we saw a number of race related riots across the country which significantly impacted our global majority staff. The annual staff survey provides an incredibly helpful insight into the experience of our people at work against this background.

The survey is aligned to the NHS people promise which is based on what our people say matter to them most. As such, the survey feedback is presented in the form of nine elements – the seven people promises, together with two additional elements: staff engagement and staff morale. Each element receives a score from 0 to 10, with 10 being the best score attainable.

In the 2024 NSS we saw a response rate of 39% rate for substantive colleagues which was a 1% increase compared to 2023. This compares to a median response rate of 49% for our benchmark group which was up 4%. We were significantly lower than both Devon Integrated Care System (ICS) and Southwest

Figure 1 – National Staff Survey Results – People Promise Elements vs average of benchmarking group.

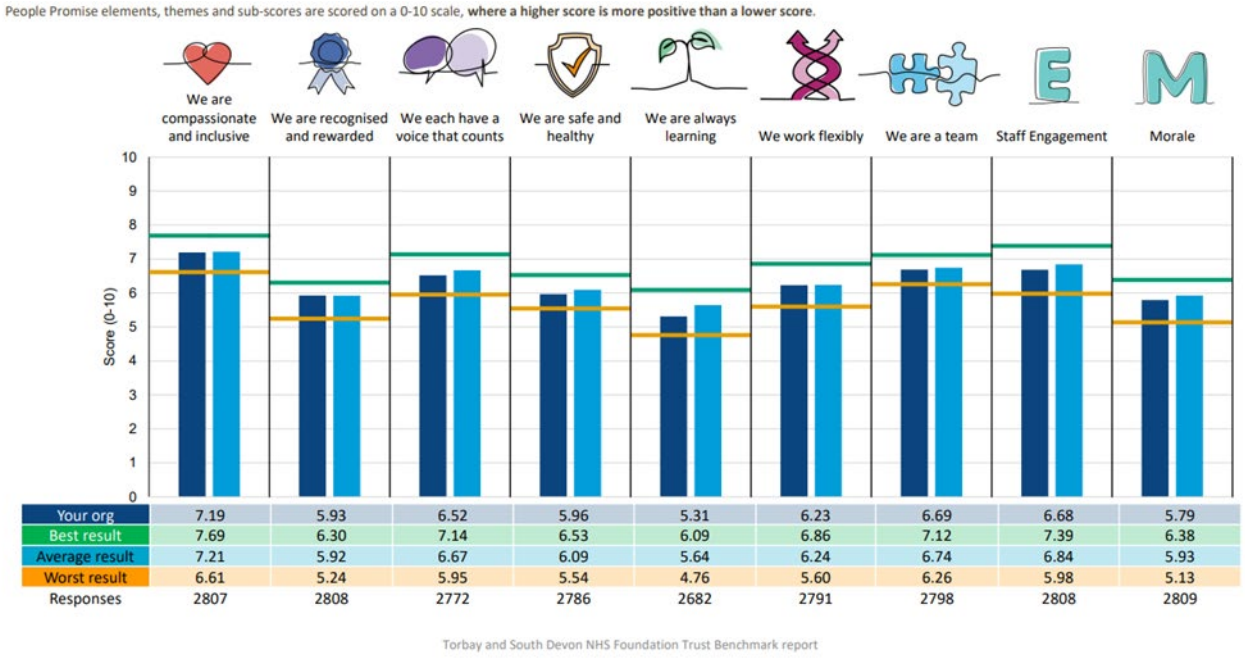


Figure 2- National Staff Survey results – People Promise Elements vs average for benchmarking group past 3 years

Indicators ('People Promise' elements and themes	2024/25		2023/24		2022/23	
	Trust score	benchmark group score	Trust score	benchmark group score	Trust score	benchmark group score
We are compassionate and inclusive	7.19	7.21	7.25	7.24	7.2	7.2
We are recognised and rewarded	5.93	5.92	5.92	5.94	5.8	5.7
We each have a voice that counts	6.52	6.67	6.60	6.70	6.6	6.6
We are safe and healthy	5.96	6.09	5.97	6.09	5.8	5.9
We are always learning	5.31	5.64	5.36	5.61	5.2	5.4
We work flexibly	6.23	6.24	6.24	6.20	6.1	6
We are a team	6.68	6.84	6.76	6.75	6.7	6.6
Staff engagement	6.68	6.84	6.74	6.91	6.7	6.8
Morale	5.79	5.93	5.81	5.91	5.6	5.7

As a Trust we have seen no notable improvements in any areas performing **marginally below or below the national average in six of the seven elements, and the two themes and equal in one.**

At a sub element level we perform most favourably in comparison to the national average in *diversity and equality*, *Inclusion, negative experiences* and *thinking about leaving*

The largest negative variances in comparison to the national average are *compassionate culture; health and safety climate; appraisals; advocacy and work pressure.*

Future priorities

Our People Priority: Delivering the People Promise in Challenging Times

At Torbay and South Devon NHS Foundation Trust, our commitment to building a safe, healthy and supportive working culture remains steadfast, even as we navigate one of the most challenging periods to date. In the face of continued financial and operational pressures, we have adapted our approach while continuing to deliver against the key elements of the NHS People Promise.

Our work is focused on three core priority areas:

- **Developing a compassionate leadership culture** where the principle of *'it starts with me'* is embedded across all levels of the organisation. This means creating an environment where everyone feels included, listened to with empathy and curiosity, and supported to act with courage.
- **Creating a sustainable workforce** capable of delivering our strategic goals. This includes investing in retention, supporting career development, and promoting staff wellbeing during times of uncertainty and change.
- **Embedding a culture of inclusion**, where diversity is celebrated, differences are valued, and every voice matters.

Despite the challenges, we are proud of the progress made - Our People Promise Ambassadors based in the following departments: Trauma and Orthopaedics, Maternity, Physiotherapy, and Dawlish Community Hospital – are leading the way in embedding the seven principles of the People Promise into everyday practice.

Their work is already having a measurable impact. For example:

- **Trauma and Orthopaedics** saw **a 4.65% decrease in turnover** and a **4.89% increase in staff stability.**
- **Physiotherapy** reported a **0.79% reduction in sickness absence.**
- **Maternity** showed improvements across multiple indicators: a **0.29% drop in turnover**, **6.30% increase in stability**, and **0.33% reduction in sickness absence.**
- **Dawlish Hospital** reported a **5.06% increase in workforce stability.**

These encouraging outcomes show that even in uncertain times, prioritising staff engagement and experience leads to real, positive change. Therefore, to support this work, we will continue to monitor progress via our workforce engagement dashboard, which tracks metrics such as staff retention, sickness absence, and staff experience, in addition with:

- Our *Compassionate Leadership Framework*, launched in September 2023, which has been well-received and is beginning to have some impact on team culture and leadership behaviours.
- Our *Culture Charter*, approved by the Board in early 2024, sets our shared values and behaviours and reinforces our collective responsibility for improving organisation culture.

- Over 5,000 colleagues have now completed our *Inclusion Training Module*, launched in January 2024, which is designed to enhance cultural awareness and improve inclusive practice across our workforce.

These encouraging outcomes highlight that even during periods of uncertainty, investing in staff engagement and experience leads to real and positive change. However, while we've seen measurable impact in areas such as turnover, stability, and sickness absence, our most recent 2024 National Staff Survey results remind us that there is still significant work to do.

The survey data reflects ongoing concerns among our workforce, and although we've made progress, we must not become complacent, there is a clear need to continue listening to our people, respond meaningfully, and act with purpose. Sustaining and building on this momentum requires collective effort across the organisation – with senior leaders setting the tone and leading by example.

The next phase of our People Promise journey must be driven by visible leadership, and only by working together can we ensure every member of our workforce feels valued, supported, and now more than ever, we know that looking after our people is not just the right thing to do, it is essential for delivering the high quality, compassionate care our patients and communities deserve

Diversity and inclusion

Diversity and inclusion is at the forefront of everything we do within the NHS. We are committed to building an organisation that puts people's wishes at the centre and removing the barriers that hinder our people and prevent them working to their full potential.

Our values reflect the NHS values and we embed these through our recruitment and appraisal processes. In addition, our people promise leads the way in which we treat all people whether our people or the public. Our people can be assured that they will continue to be supported and valued to carry out their duties effectively, ensuring that everyone counts.

Our 'embedding a culture of inclusion' programme of work is integral to the delivery of our people promise and is key to improving the experience of our people who are part of under-represented groups. We developed our priorities for the programme through in-depth engagement with our people. These include actions that will deliver the six high impact actions from the national Equality Diversity and Inclusion (EDI) Improvement Plan.

Workforce Disability Equality Standards (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality.

Making a difference for disabled staff

The WDES is important because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The WDES enables NHS organisations to better understand the experiences of their disabled staff and supports positive change for all staff by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

Nine of the 13 WDES metrics are taken from the National Staff Survey. The table below shows the Trust's performance against the WDES standard for the last two years and in comparison, to the national average. The broad headlines are:

- Disabled staff are less likely to be appointed from shortlisting and more likely to enter the formal capability process compared to non-disabled staff.

- There is a continued improvement in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public over the past 3 years. While this is encouraging it is important to note that disabled staff consistently report higher levels of negative experiences compared to their non-disabled colleagues.
- Disabled staff consistently report experiencing higher levels of bullying, harassment, or abuse from both managers and colleagues compared to non-disabled colleagues.
- While just under half of disabled staff who experienced negative behaviour reported it, this is only slightly higher than non-disabled staff and suggests ongoing challenges in creating psychologically safe reporting cultures.
- Disabled staff consistently report feeling more pressure from managers to work while unwell, indicating potential issues around presenteeism and a lack of reasonable adjustment awareness.
- Disabled staff are significantly less likely than non-disabled staff to believe the organisation provides equal opportunities for progression and promotion, with a declining trend.
- The percentage of disabled staff reporting that reasonable adjustments are made to support their work improved in 2023 but declined again in 2024 -highlighting inconsistency in support provision.

The WDES findings give a clear indication of the work needed to ensure our recruitment processes, capability processes and practice of reasonable adjustments are fair and inclusive, whilst also combating a culture of discrimination felt by our disabled staff.

Across all but two indicators show that disabled staff have a worse experience when compared to other staff in our organisation, this signals a need for a cultural shift in the experiences of our people.

Table: Trust's performance against the WDES standard for the last two years and in comparison, to the national average

Metric		Disabled 2023	Non-Disabled 2023	Disabled 2024	Non- Disabled 2024	Disability 2024 National
Percentage of staff experiencing harassment, bullying or abuse from: Patients/service users, their relatives or other members of the public in the last 12 months.	Positive	25.17%	22.53%	23.69%	21.52%	29.37%
Percentage of staff experiencing harassment, bullying or abuse from: Managers.	Negative	17.60%	7.97%	16.09%	9.17%	15.10%
Percentage of staff experiencing harassment, bullying or abuse from: Other colleagues.	Negative	23.84%	14.04%	26.15%	15.65%	25.24%
Percentage of staff saying they, or a colleague, reported harassment, bullying or abuse.	Positive	48.29%	47.86%	49.52%	48.67%	51.82%
Percentage of staff who believe that their organisation provides equal opportunities for career progression / promotion.	Negative	49.93%	59.00%	47.63%	55.06%	51.30%
Percentage of staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties.	Positive	26.99%	18.35%	26.67%	18.80%	26.85%
Percentage of staff satisfied with the extent to which their organisation values their work.	Positive	32.13%	42.71%	33.86%	43.09%	34.73%
Percentage of disabled staff who said their employer has made adequate adjustments to enable them to carry out their work.	Positive	78.41%	-	74.07%	-	-
Staff Engagement score (0-10).	Negative	6.4	6.9	6.3	6.8	6.4

Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) was introduced in 2015 to hold a mirror up to the NHS and spur action to close gaps in workplace inequalities between our global majority colleagues and white staff.

Four of the nine WRES indicators are taken from the national staff survey. The table below shows our performance against the WRES standard for the last two years and in comparison to the national average. The broad headlines are:

- Candidates from a global majority background are significantly less likely to be appointed than white candidates despite being shortlisted, indicating a recruitment inequality.
-
- Experience of bullying, harassment and abuse from patients has decreased both for our white and global majority staff, however global majority staff continue to report higher levels of harassment, bullying or abuse.
- The percentage of staff experiencing bullying, harassment and abuse from other staff members has increased this year both staff groups. An increase of 3.64% for global majority staff and 1.86% for white staff.
- The gap between white and global majority staff has narrowed to 4.36% in 2024, from 9.28% in 2023 – which is a positive sign. However, both groups remain below the levels reported in 2022, indicating overall declining confidence in progression opportunities.
- Global majority staff report discrimination from colleagues at over twice the rate of white staff – with a growing gap.

The WRES findings give a clear indication of the work needed to ensure our recruitment processes are fair and inclusive, whilst also combating a culture of discrimination felt by our staff from a global majority background.

Across all but two indicators show that staff from a Global Majority background have a worse experience when compared to white staff in our organisation, this signals a need for a cultural shift in the experiences of our people.

Indicator		Global Majority 2023	White 2023	Global Majority 2024	White 2024	Global Majority 2024 National
Percentage of staff experiencing harassment, bullying or abuse from patients / service users, their relatives or the public in the last 12 months.	Positive	29.07%	22.90%	27.88%	21.47%	28.27%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	Negative	20.35%	21.68%	23.99%	23.54%	24.78%
Percentage of staff believing that there are equal opportunities for career progression / promotion.	Positive	44.84%	54.12%	49.45%	53.81%	49.70%
Percentage of staff who in the last 12 months personally experienced discrimination from any of the following: Manager / team leader or other colleagues.	Negative	13.78%	6.73%	16.54%	8.00%	15.72%

Gender pay differential

Introduction

Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The data in this report is based on a snapshot taken on 31 March 2024.

Throughout this report, when data is labelled “2025” this refers to the year of publishing our gender pay gap report (data from 2024). Similarly, references to “2024” refer to this report, published in 2024, but using data from 2023.

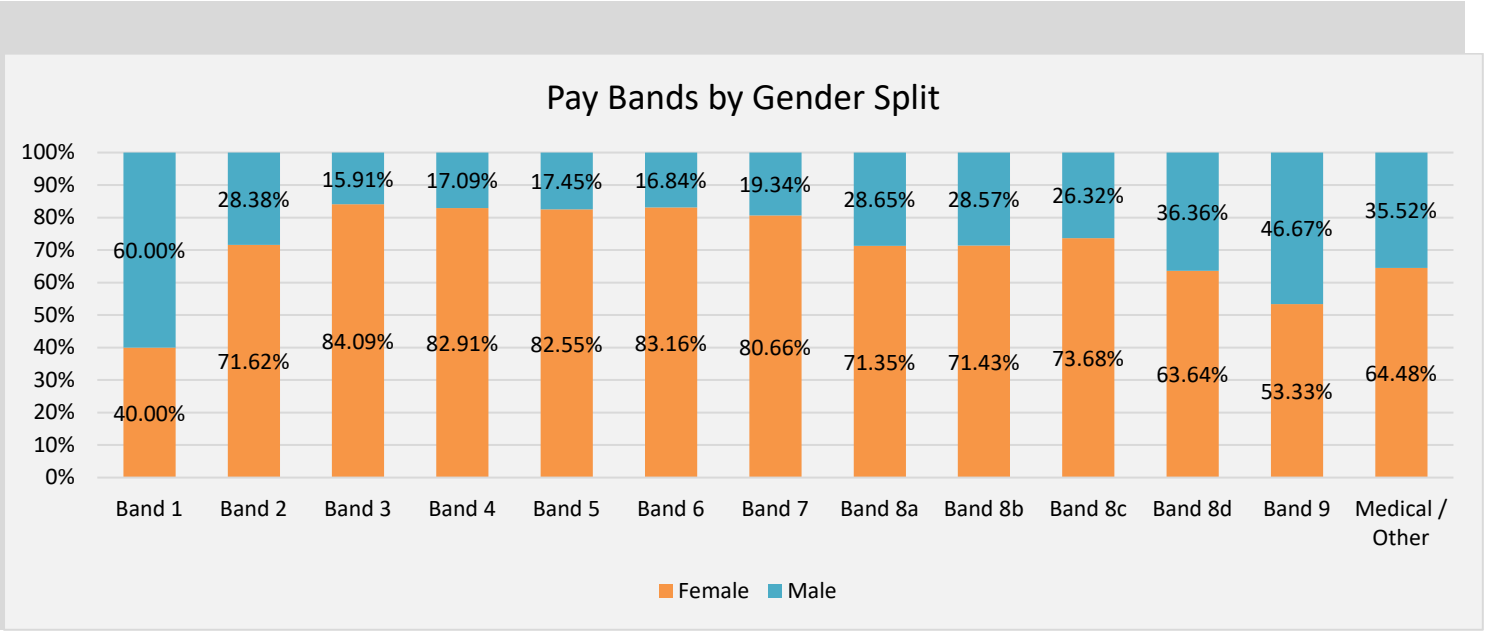
Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

Other than for medical and dental staff (doctors and dentists), Apprentices, Non-Executive Directors and Very Senior Managers (VSM), all other jobs are evaluated using the national Agenda for Change (AfC) job evaluation scheme. This process evaluates the job and not the post holder and makes no reference to gender or any other personal characteristics of existing or potential job holders. VSM’s include Executive Directors and a small number of other senior posts.

It should be noted that no bonuses are paid within the Trust as part of pay packages; however, for the purposes of the Gender Pay Gap report, Clinical Impact Awards payments, part of a national scheme are classified as a bonus.

The gender pay gap analysis below shows the difference in the average pay between all men and women in a workforce.

The current gender split for the overall workforce is 76.55% female and 23.45% male. The breakdown of proportion of females and males in each banding is as follows:



Average gender pay gap

Average gender pay gap as mean average (All applicable Foundation Trust staff)

	Male	Female	% difference
Mean hourly rate 2021	£19.58	£16.07	17.89%
Mean hourly rate 2022	£20.62	£16.79	18.54%
Mean hourly rate 2023	£21.11	£17.60	16.63%
Mean hourly rate 2024	**£22.71**	**£19.01**	**16.27%**

Average gender pay gap as median average (**a**ll applicable Foundation Trust staff)

	Male	Female	% difference
Median Hourly rate 2021	£14.58	£14.02	3.83%
Median Hourly rate 2022	£16.12	£14.92	7.43%
Median Hourly rate 2023	£16.63	£15.81	4.93%
Median Hourly rate 2024	**£17.69**	**£17.68**	**0.00%**

There has been significant improvement in narrowing the mean pay gap and eliminating median gap, however the remaining mean pay disparity indicates that men continue to earn more on average, likely due to higher paying roles.

The median gender pay gap has been eliminated (4.93% in 2023 to 0% in 2024) while the mean gender pay gap narrowed slightly from 16.63% to 16.27%. Consultants are a key focus for addressing the gender pay gap. Although the proportion of female consultants increased from 2024 significant inequalities in accessing these roles remain. There is a huge need for targeted actions to support female consultants and enhance their representation in this critical group.

Closing the Gender Pay Gap

The issues that surround the gender pay gap and its reporting can be complex, and the causes are a mix of work, family and societal influences. As an employer we can only influence those factors associated with work.

As a Trust, we welcome the introduction of gender pay gap reporting and are fully supportive of equality of opportunity within our workforce. We recognise that this data tells us that there is further work to be undertaken to achieve that equality of opportunity. However, we acknowledge that there could be greater representation in the senior clinical roles which drives the greatest variances in this report.

Additional information on our latest published Gender Pay Gap Report can be found on the website at Equality and Diversity- Torbay and South Devon NHS Foundation Trust. Further information as to gender pay can be found at: (https://gender-pay-gap.service.gov.uk/)

Relevant union officials

Number of employees who were relevant union officials during the relevant period	4
Full-time equivalent employee number	1.41

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1 – 50%	2
51% - 99%	1
100%	1

Percentage of pay bill spent on facility time

Total cost of facility time	£92,428.84
Total pay costs	£392,770,165.76
Percentage of the total pay bill spent on facility time, calculated as (total cost of facility time divided by total pay bill) x 100	0.024%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on trade union activities by relevant union officials during the relevant period + total paid facility time hours) x 100	100.00%

Consultancy costs

Expenditure on consultancy costs for 2024/25 was £116,000 compared with £551,000 for 2023/24.

Off-payroll report

PES (2018)13 requires the Foundation Trust to seek assurance from individuals working through off-payroll engagements, that all their tax obligations are being met. This is required for existing and new engagements that during the period between 1 April 2024 and 31 March 2025 cost more than £245 per day and were engaged for more than six months.

The Foundation Trust is required under the reporting requirements published by HM Treasury in relation to PES (2018)13, to report if it had any engagements which met the disclosure requirements. The Foundation Trust can confirm that it had no engagements requiring disclosure.

Off-payroll worker engagements as at 31 March 2025

Number of existing engagements as of 31 March 2025	
Of which…….	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two years and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

All off-payroll workers engaged at any point during the year ended 31 March 2025

Number of off-payroll workers engaged during the year ended 31 March 2025	
Of which…….	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Of which: Number of engagements that saw a change to IR35 status following review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'Board members and/or senior officials with significant responsibility' during the financial year. This figure must include both off-payroll and on- payroll engagements	0

Note: The Foundation Trust has a number of doctors who meet the financial criteria but have no significant financial responsibility and therefore fall outside of the scope of the reporting requirement.

Staff exit packages paid in year (audited information)

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally agreed arrangements or local arrangements for which Treasury approval was required.

	2024/25			2023/24		
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	37	37	-	28	28
£10,001 - £25,000	-	3	3	-	3	3
£25,001 - 50,000	-	-	-	-	-	-
£50,001 - £100,000	-	-	-	-	1	1
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-
Total number of exit packages by type	**-**	**40**	**40**	**-**	**32**	**32**
Total resource cost (£)	**£0**	**£166,000**	**£166,000**	**£0**	**£221,000**	**£221,000**

In addition to the above costs, £20,000 employer's National Insurance contributions were paid on the above.

Redundancy and other departure costs have been paid according to the provisions of the national Agenda for Change scheme where payment was made in lieu of notice, or the locally agreed Mutually Agreed Resignation Scheme (MARS) based on national guidance. Exit costs in this note are the full costs of departures agreed in the year.

Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Exit packages: other (non-compulsory) departure payments (audited information)

	2024/25			2023/24	
Agreements	Number	Value (£'000)		Number	Value (£'000)
Voluntary redundancies including early retirement contractual costs	-	-		1	75
Mutually agreed resignations (MARS) contractual costs	-	-		-	-
Early retirements in the efficiency of the service contractual costs	-	-		-	-
Contractual payments in lieu of notice	38	137		31	146
Exit payments following Employment Tribunals or court orders	-	-		-	-
Non-contractual payments requiring HMT approval	2	29		-	-
Total	40	**166**		**32**	**221**

*any non-contractual payments in lieu of notice are disclosed under “non-contractual payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and non-contractual payments in lieu of notice.

Apprenticeships

Apprenticeships continue to be an important pathway into health and care careers and support widening participation across our local population and an ideal way for anyone to earn a wage while gaining a valuable qualification.

Employing and supporting apprentices helps all businesses and organisations employ local talented people and supporting career aspirations, benefiting the organisation, the person and the local community. Apprentices provide organisations such as the NHS with a motivated, talented, skilled and qualified workforce.

Being an apprentice provides opportunities to gain a nationally recognised qualification, develop professional skills, while earning a salary.

We currently employ almost 300 apprentices in many clinical, allied healthcare and business roles. The number of apprentice employees increases annually to ensure our organisation makes best use of the apprenticeship Levy opportunity.

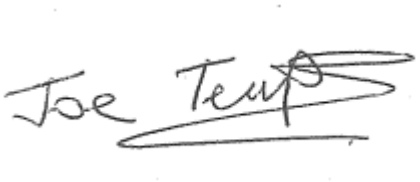
Since 2017 we have supported over 800 apprentices through their apprenticeship and into successful working roles. Some of our apprentices go on to achieve a Bachelor of Science (BSc) degree in their chosen career. This includes nurses, occupational therapists, physiotherapists, radiographers, healthcare science practitioners in cardiology, Respiratory and engineering, managers and senior leaders etc.

All apprenticeship training programmes are paid for by the employer organisation and enable those who may not be in a position to take on a student loan to achieve their career aspirations from a level 2 apprenticeship up to and beyond a MSc apprenticeship.

As the largest employer in the region, we truly value our people and use the resources available to us for the benefit of the employee and ensure that nobody is excluded, discriminated against, or left behind.

We are an inclusive organisation, and we continue to support as many people as possible into our organisation. Apprenticeship opportunities provide another respected route into our organisation as well as supporting the career aspirations of those who currently work with us.

This concludes the Staff Report for 2024/2025.



Joe Teape
Chief Executive
25 June 2025

PART V – GOVERNANCE STATEMENTS

Statement of the Chief Executive's responsibilities as the Accounting Officer of Torbay and South Devon NHS Foundation Trust:

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Torbay and South Devon NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Torbay and South Devon NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

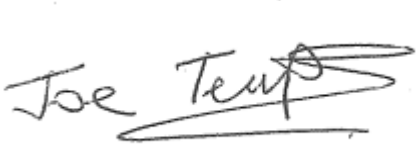
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Joe Teape
Chief Executive
25 June 2025

Our Governance framework

The Board of Directors and Council of Governors are committed to continuing to operate according to the highest corporate governance standards. To achieve this, the Board of Directors:

- meets monthly, or at an increased frequency when required, in order to discharge its duties effectively
- seeks and receives assurance that internal controls, systems and processes of good governance are maintained, with a view to measuring and monitoring the organisations productivity, effectiveness, efficiency and economy in the delivery of safe, quality services
- reviews operational performance against regulatory and contractual obligations, NOF segmentation and NOF4 exit criteria, operating plans and objectives.
- assures itself of the quality of services provided, with a view to testing the accessibility as well as safety of such services
- oversees and scrutinises the deployment of resources with a view to receiving assurance that resources are invested in a way that delivers optimal health outcome
- a culture of psychological safety is encouraged with a view to enabling all directors to constructively challenge each other (executive and non-executive), whilst maintaining and acknowledging their collective responsibility as a unitary Board
- Non-executive directors scrutinise the performance of the executive directors in meeting agreed goals and objectives and monitor the reporting of performance. If a Board member disagrees with a course of action it is minuted accordingly. The Chairman would then hold a meeting with the non-executive directors. If the concerns cannot be resolved this should be noted in the Board minutes
- Non-executive directors are appointed for a term of three years by the Council of Governors. The Council of Governors has the authority to appoint or remove the Chairman or the non-executive directors at a general meeting. Removal of the Chairman or another non-executive director requires the approval of three-quarters of the members of the Council of Governors
- Non-executive directors are determined by the Board to be independent on appointment
- operates a code of conduct that builds on our organisational values to reflect high standards of probity and responsibility
- a non-executive director holds the role of Senior Independent Director
- the Chairman ensures that the Board of Directors and the Council of Governors work together effectively and that directors and governors receive timely and clear information that is appropriate to carry out their duties
- the Chairman holds regular meetings with non-executive directors without the executive directors present
- no independent external adviser has been a member of or had a vote on the Committees responsible for the appointments or remuneration of executive or non-executive directors
- the Committee responsible for setting levels of remuneration for executive directors has delegated authority from the Board to do so
- independent professional advice is accessible to the non-executive directors and the trust secretary via the appointed independent external auditors and/or via external legal firms
- there is no full-time executive director that takes on more than one non-executive director role of another NHS Foundation Trust or another organisation of comparable size and complexity
- all Board meetings and Board committee meetings receive sufficient resources and support to undertake their duties
- a going concern report is undertaken annually
- effective mechanisms are in place to ensure co-operation with relevant third-party bodies

In accordance with the Code, our organisation is led by the Board of Directors who have joint and several responsibilities for the exercise of the powers of the Foundation Trust. Appointments to the Board both of executive and non-executive directors in the reporting period meant that the Board was fully constituted. The Board does not consider that its performance or balance was significantly impacted during any period of interim arrangements.

The information flows to the Board are overseen by the Chairman and supported by an appropriately qualified trust secretary, as defined by the Companies Act 2006, applying the criteria for a company secretary, as is best practice. The trust secretary is an experienced, dual qualified, Chartered Company Secretary and CILEX Lawyer.

The Council of Governors

- represents the interests of the organisation's members and partner organisations in the local health economy.
- has a code of conduct in place to ensure Governors adhere to our best interests and values
- holds the Board of Directors to account for their performance and receives appropriate information on a regular basis
- governors are consulted on the development of strategic plans and arrangements are in place for them to be consulted on any significant changes, if so required
- the Council of Governors meet on a regular basis in order for them to discharge their duties
- the governors elect a lead governor. As lead governor, the main function is to act as a point of contact with NHS England, the directors and governors continually update their skills, knowledge and familiarity with our organisation and our obligations, to fulfil their role on various boards and committees
- our constitution, which was refreshed in 2023 to ensure it is up to date with current law, is available on the website and outlines the clear policy and fair process for the removal from the Council of Governors of any governor who consistently and unjustifiably fails to attend the meetings of the Council of Governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties; this is supported by the Governor Engagement policy (for the escalation of serious concerns), the detail of which supplements the constitutional provisions
- the performance review process of the Chair and non-executive directors involves the governors, is conducted by the Senior Independent Director and in accordance with NHS England guidance. Each executive director's performance is reviewed by the Chief Executive. The Chairman reviews the performance of the Chief Executive
- the Committee responsible for setting remuneration of non-executive directors and the Chairman adhere to the NHS England guidance when reviewing levels of remuneration
- the Governor Nomination and Remuneration Committee holds responsibility for the appointment of the Chair and non-executive directors; it is comprised by a majority of governors.

Both the Board of Directors and Council of Governors

- the Chief Executive, supported by the Chairman and Trust Secretary, ensures that the Board of Directors and the Council of Governors act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Chairman contemplates a course of action involving a transaction which the Chief Executive considers infringes these requirements, the procedures set by NHS England for advising the Board and Council for recording and submitting objections to decisions will be followed. During the period there have been no occasions on which it has been necessary to apply the NHS England procedure
- our people are required to act in accordance with NHS standards and accepted standards of behaviour in public life (Nolan Principles).

We ensure compliance with the Fit and Proper Person (FPP) framework, as issued from time to time.

Statement of compliance with the NHS Foundation Trust Code of Governance

We have applied requirements of The Code of Governance for NHS Provider Trusts (the "Code"), as published and applicate for this financial year, as required. The Code replaced the former NHS Foundation Trust Code of Governance on 1 April 2023. The Code must be applied and reported on under three mechanisms: matters to be disclosed, matters to be assessed on a comply or explain basis and matters where information is to be circulated, typically to our Governors or Membership

These categories are utilised below to ensure that matters are properly reported on, as required, with a reference to the relevant pages of the report if the detail is not provided here.

Information relating to governance systems and processes is detailed in the Annual Report, and in particular the Annual Governance Statement. Details of the Constitution of the Board are given in the Accountability Report.

Matters to be disclosed

The Code requires the Trust to disclose certain matters, providing a supporting explanation within the annual report; even in the case that the Trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is provided to avoid unnecessary duplication.

Code provision	*Summary of requirement*	*Explanation, where required AND/OR location in annual report*
Section A, 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, commenting on the contribution of its strategy and governance in delivery both as a Trust and an ICS.	The Board receives performance reports at each meeting and Board sub-committees undertake detailed review, further information on this can be found on page 52. An assessment of our end of year performance position can be found within our performance report , starting on page 14.
Section A, 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action.	During 2024/25 the Board has taken active steps to promote and lead a learning and just culture, one way we have done this is through the deployment of Compassionate Leadership training. Further information can be found within our staff report, starting on page 84.
Section A, 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration	Collaboration, partnership and the delivery of the Triple Aim, as required by our licence is a cultural norm for the Trust and evidenced in our decision making through our standard form reporting cover sheet, requiring due consideration to be given and outlined, the BAF objectives set during the year and our daily operation as an integrated care organisation. Further information can be found within our governance report , starting on page 107.
Section B, 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent.	Following the implementation of the Code and provisions hitherto, the Trust considers all of its Non-Executive Directors to be independent; each was independent on appointment and is assessed as continuing to be so having applied the Fit and Proper Persons Declaration and considered any declarations of interest as they arose as well as undertaking the annual review process; overseen

		by Audit Committee. Whilst the Chair, Sir Richard Ibbotson served 10 years, in contrast with the presumption of independence the Trust Board assessed him as being so and that his continued appointment was in the best interests of the Trust at that time. Further information can be found within our accountability report , starting on page 49.
Section B, 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	This can be found within our accountability report , starting on page 49.
Section B, 2.17	State the roles and responsibilities of the council of governors.	This can be found within our governance report, starting on page 107.
Section C, 2.5	If an external consultancy is engaged, it should be identified in the annual report.	This can be found within our staff report, starting on page 84.
Section C, 2.5	Describe the process followed by the council of governors to appoint the chair and non-executive directors..	This can be found within our governance report, starting on page 107.
Section C, 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	This can be found within our Director biographies within Appendix A, starting on page 130.
Section C, 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years.	The last review was undertaken by Deloitte in 2021. At this time the Trust continues to implement actions arising from that review and the Well Led inspection, having made significant changes to its governance in 2023/24.
Section C, 4.13	The annual report should describe the work of the nominations committee(s) (including Board equality data)	This can be found within our staff report, starting on page 84.
Section C, 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, feeding back to Board of Directors.	This can be found within our governance report, starting on page 107.
Section D, 2.4	The annual report should include a summary of work undertake by the Audit Committee in the period.	This can be found within our staff report, starting on page 84.
Section D, 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable.	This can be found within our accountability report, starting on page 49.
Section D, 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks.	This can be found within our governance report, starting on page 107.
Section D, 2.8	The board of directors should monitor and report on the trust's risk management and internal control systems.	This can be found within our governance report, starting on page 107.
Section D, 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis .	This can be found in the performance report (page 14) and is acknowledged in the Chief Executive and Directors statements.

Section E, 2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	This can be found within our staff report, starting on page 84.

Matters to be reported against on a comply or explain basis

For the provisions listed below, the Code requires that the 'comply or explain' requirement be applied and that any deviation from the code be noted with an explanation of the reasons for the departure as well as how the alternative arrangements continue to reflect the principles of the code. Where deviation from a particular provision is intended to be limited in time, the explanation will indicate when the trust expects to conform to the provision. For the avoidance of doubt, only matters of deviation where an explanation is required will be reported for brevity.

Nothing to report for 2024/25.

Matters to be circulated for information

For the matters listed below the Code requires that the Trust make particular information available to governors; even in the case that the trust is compliant with the provision and explanation must be provided.

Code provision	***Summary of requirement***	***Explanation, where required AND/OR location in annual report***
Section C, 4.9	Council of Governors ("COG") agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.	Compliant. There are clear provisions within the Constitution, Code of Conduct and Governor Engagement Policy; all of which the COG were consulted upon and approved.
Section C, 5.7	The board of directors and council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties.	Compliant. This is assessed annually through the Board, Committee and COG effectiveness processes.
The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision.		
Section C, 2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	Compliant. There are clear provisions within the Constitution and model election rules which are appended.
The provisions listed below require information to be made **publicly available,** even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request.		
Section B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.	Compliant. There are clear provisions within the Constitution, Scheme of Delegation and relevant governance documentation which are available on our public website.
Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	Compliant. Board information alongside the declarations register and this annual report are available on our public website

Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors.	Compliant. are available on our public website

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that our organisation is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Torbay and South Devon NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Torbay and South Devon NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Risk management and our capacity to handle risk

As Accounting Officer, I have overall responsibility for ensuring that there are effective risk management and integrated governance systems in place within the organisation and these meet all statutory requirements and adhere to guidance issued by NHS England in respect of governance and risk management.

We have a risk management framework for managing risks across the organisation which is consistent with best practice and Department of Health and Social Care guidance; the framework is reviewed and endorsed by the Board of Directors. There is a clear, systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation.

The Board of Directors provides leadership on the overall governance agenda including risk management. It is supported by a number of sub-committees that undertake detailed work to scrutinise and review assurances on internal control. These include the Audit and Risk Committee, Quality Assurance Committee, People Committee, Building a Brighter Future Committee and the Finance and Performance Committee.

Executive governance undertaken within the scope of authority delegated to me as Chief Executive Officer and Accounting Officer; it is visible, strong and clear to ensure sound systems of internal control are maintained.

To support this and ensure visibility and accessibility of our internal control and decision making framework, our governance is aligned to Tiers, explained within our governance manual. We have four primary governance Tiers:

Tier 1: The Board of Directors and its Committees (Corporate Governance structure and legal structure); and meetings thereof.

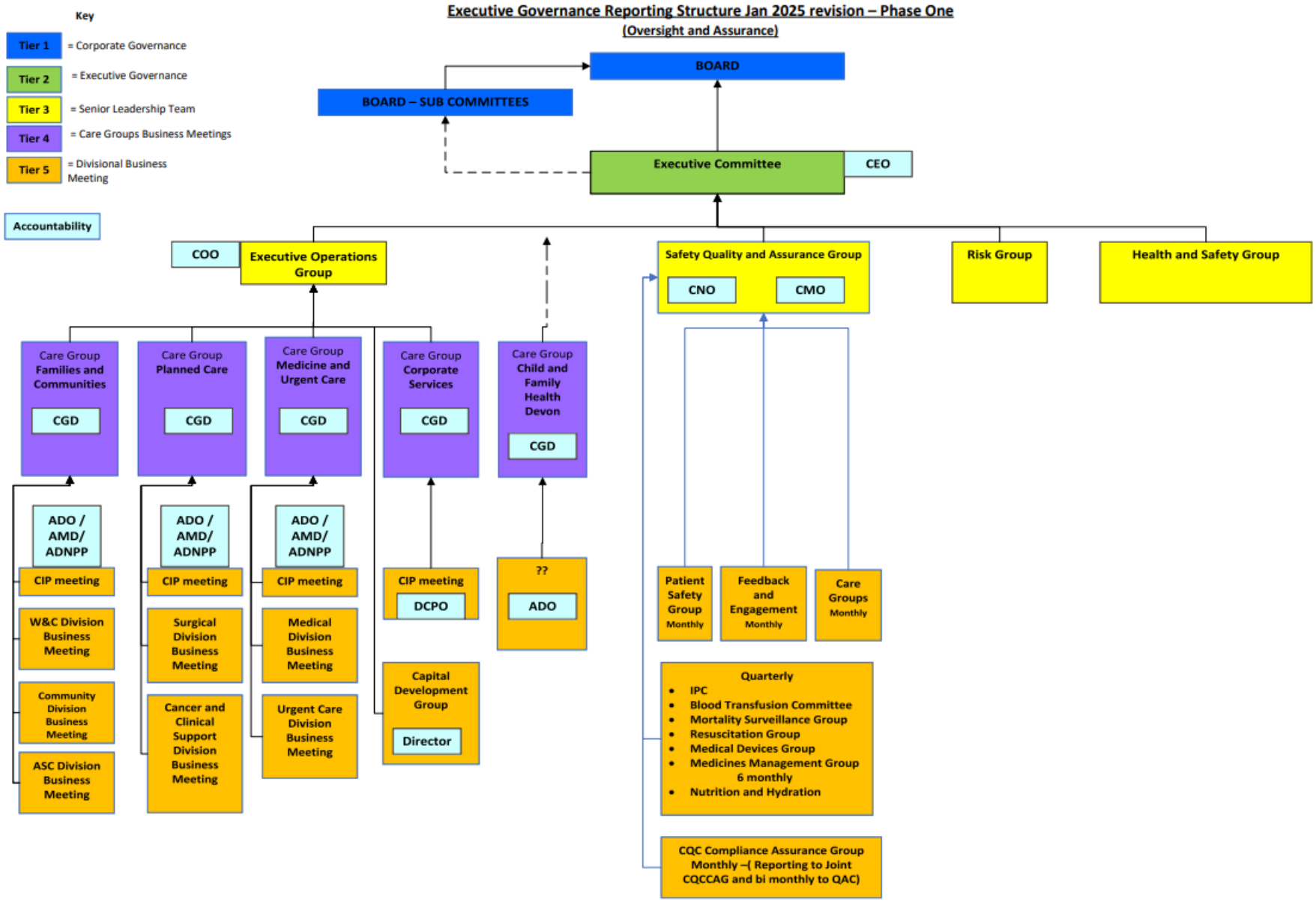
Tier 2: Executive Governance (Operational Governance), led by the Chief Executive as the most senior Executive within the Trust; and meetings thereof. Operating within the delegated authority of the Chief Executive.

Tier 3: Trust Senior leadership; and meetings thereof.

Tier 4: Care Group and functional leadership and meetings thereof. Reporting to Tier 3.

Tier 5: Any group or meeting reporting into Tier 4.

The Tiers operate in oversight and assurance terms, as well as performance management and oversight; this information flow structure is supported by our Executive accountability portfolio, which outlines line management and individual Executive portfolios. This structure has created clear accountability and reporting lines, with information flowing up to and down from the Executive Committee, who in turn report to the Board, strengthening ward to Board line of governance where information can flow up or down, as required. We further strengthened our operational governance this year with the creation of the Executive Operations Group, stepping down the previous performance oversight meeting, led by the Chief Operating Officer (established January 2025). This is shown in the diagram overleaf:


Executive Governance Reporting Structure Jan 2025 revision – Phase One
(Oversight and Assurance)
Key
Tier 1 = Corporate Governance
Tier 2 = Executive Governance
Tier 3 = Senior Leadership Team
Tier 4 = Care Groups Business Meetings
Tier 5 = Divisional Business Meeting
Accountability
BOARD
BOARD – SUB COMMITTEES
Executive Committee
CEO
COO
Executive Operations Group
Safety Quality and Assurance Group
CNO
CMO
Risk Group
Health and Safety Group
Care Group Families and Communities
CGD
Care Group Planned Care
CGD
Care Group Medicine and Urgent Care
CGD
Care Group Corporate Services
CGD
Care Group Child and Family Health Devon
CGD
ADO / AMD/ ADNPP
CIP meeting
W&C Division Business Meeting
Community Division Business Meeting
ASC Division Business Meeting
ADO / AMD/ ADNPP
CIP meeting
Surgical Division Business Meeting
Cancer and Clinical Support Division Business Meeting
ADO / AMD/ ADNPP
CIP meeting
Medical Division Business Meeting
Urgent Care Division Business Meeting
CIP meeting
DCPO
Capital Development Group
Director
??
ADO
Patient Safety Group Monthly
Feedback and Engagement Monthly
Care Groups Monthly
Quarterly
IPC
Blood Transfusion Committee
Mortality Surveillance Group
Resuscitation Group
Medical Devices Group
Medicines Management Group 6 monthly
Nutrition and Hydration
CQC Compliance Assurance Group Monthly –(Reporting to Joint CQCCAG and bi monthly to QAC)

During 2024/25 the risk group oversaw all risk management activities across the organisation to ensure that the correct strategy is adopted for managing operational risk, controls are present and effective, action plans are robust for these risks that are being actively managed and that high risks are scored appropriately; accountability for this however sits with the Executive Committee and ultimately Board and as such the Audit and Risk Committee have oversight of and monitor the efficacy of the internal control framework. The risk group is chaired on rotation by a member of the Senior Leadership Team, currently one of our Care Group Directors, allowing for peer review and recommendation onto the Executive Operations Group and Executive Committee. The introduction of the Organisational Risk Map, as seen in our public Board papers, enhances our approach to risk and triangulates operational risk with strategic risk and our risk appetite, to quantify the Trust's residual risk position, taking into account inherent risk and mitigating actions.

Established governance arrangements within our Care Groups also facilitate use to maintain effective risk management, with each maintaining risk registers and reporting accordingly. The Care Group Directors are responsible and accountable to the Chief Operating Officer for the quality of the services they manage and to ensure that any identified risks are placed on the relevant Care Group risk register, as well as escalating risks to Trust Management Group for oversight.

While the Chief Executive has overall responsibility for the management of risk, other members of the Executive team exercise lead responsibility for our principle risks as follows:

Strategic risk	Chief Executive
Clinical and quality risks	Chief Nurse/Chief Medical Officer
Financial risks	Chief Finance Officer
Workforce risks	Chief People Officer
Clinical staffing risks	Chief Nurse/Chief Medical Officer
Operational risks	Chief Operating Officer
Information management and technology risks	Chief Strategy and Transformation Officer
Governance, legal and regulatory compliance:	Chief Executive, supported by Executive Directors and Trust Secretary

All Board level directors are responsible for ensuring there are appropriate arrangements and systems in place to identify and assess risks and hazards, comply with internal policies and procedures, and statutory and external requirements and integrate functional risk management systems and develop the assurance framework. These responsibilities are supported operationally by care group directors.

Our people have responsibility for participation in the risk/patient safety management system, through:

- awareness of risk assessments which have been carried out in their place of work and to compliance with any control measures introduced by these risk assessments
- compliance with all legislation relevant to their role, including information governance requirements set locally by the organisation
- following all our policies and procedures
- reporting all adverse incidents and near misses via our incident reporting system
- attending regular training as required ensuring safe working practices
- awareness of our patient safety and risk management strategy
- knowing their limitations and seeking advice and assistance in a timely manner when relevant.

We recognise the importance of risk management being both well-defined and understood, as such we have developed a training programme to support implementation, principally delivered by the risk officer for our people. Executive directors and non-executive directors are provided with risk management development on an individual basis or collectively at Board development sessions.

We continue to maximise our opportunities to learn from other foundation trusts (particularly those who achieve outstanding CQC ratings), internal/external audit and continuous feedback is sought internally to ensure the systems and processes in place are fit for purpose. The findings are taken to the relevant executive lead and/or committee to ensure that any learning points are implemented. A wider distribution of learning points for our people is disseminated via staff briefings and bulletins.

In addition to the organisation reviewing all internally driven reports, we adopt an open approach to the learning derived from third party investigations and audits, and/or external reports. We have also adopted a pro-active approach to seeking independent reviews should concerns be raised of a significant magnitude. Furthermore, in addition to taking the integrated performance and quality report, the risk and Board assurance framework are taken in public Board, we remain cognisant of our duty to be open and transparent with the public as to delivery of services.

I have ensured that all risks of which I have become aware are reported to the Board of Directors. All new significant risks are escalated to the executive lead and reviewed and validated by the risk group. There is a regular review of risks on the Board assurance framework by the Board of Directors as a collective Board and at Board committee; the purpose of which is to scan the horizon for emergent threats and opportunities and consider the nature and timing of the response required to ensure the risk is kept under control. Risk and assurance is also discussed annually at Board development days.

An example of how risk management is incorporated into our core business is in relation to the integrated finance, performance, quality and people Board report. The monthly report to the Board of Directors provides commentary on performance and on key variances and improvements. The report is created by the outcomes and actions from various meetings, for example, the integrated governance group meetings and executive team weekly meetings. Each of the Board sub-committees also review the section appropriate to scope of their work at each of their meetings, for example the People Committee receive the people section of the integrated Board report.

Discussions have also been held throughout the year with Integrated Care System colleagues to ensure all key access targets are being managed from within available resource. There have been regular contract management meetings with our lead commissioners and councils.

Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit and Risk Committee and the internal audits undertaken annually on our Board Assurance Framework and risk reporting. Additional assurance on the effectiveness of the systems for ensuring clinical quality is given by the Quality Assurance Committee, supported by clinical audits and quality checking. The Board of Directors receives a report from the Chair of each of the Board sub-committees at each meeting. The Board of Directors also receives the Board assurance framework and risk register at each meeting.

The Board sets its risk appetite and tolerance annually when reviewing both the risk management framework and setting Board Assurance Framework objectives.

For further detail of our processes, our full risk management policy and supporting documentation can be found on our website here.

Board Assurance Framework objectives (BAF) and principal risks to their delivery

Our risk management framework is supported by a Board assurance framework (“BAF”), which is used to record strategic corporate objectives, risks to their achievement, key risk controls, sources of assurance and gaps in assurance to ensure effective risk management. At each Board of Directors meeting, papers are provided with a report summary sheet through which directors identify links to one or more corporate objectives and one or more overarching corporate level risks / themes.

The Board of Directors evaluates the BAF at each meeting alongside the risk reports, receiving relevant updates from Board committee chairs as to discussions that have taken place at their respective

meetings and any strategic risks to delivery of the BAF objectives or operating plan more broadly.

The BAF objectives for the period, together with commentary as to the principal risks to delivery are outlined below along with how they have been/are being managed and mitigated and how outcomes are being assessed.

BAF Reference 1: quality and patient experience – personalised care
Objective: to deliver high quality health and care services, achieving excellence in health and wellbeing for patients, facilitating their families, carers and local community to live well, enabling prevention as well as patient choice, where possible

Factors impacting delivery/opportunities

- pace and scale of change required to minimise harm and poor patient experience and meet NOF 4 exit criteria is a significant challenge
- setting out medium to long term plan for reconfiguration of services to meet risk/demand. Recovery and Restoration plan with agreed targets as set out in Performance framework and operating plan for Planned, Families and Community and Emergency Care
- ensure Care Group clinical governance frameworks are embedded and robustly monitored for effectiveness
- capacity and capability to monitor /interrogate business/clinical Intelligence data including workforce, operational performance, quality and safety immature and sub optimal
- inequities and inequalities in access resulting in increase in mortality and morbidity across Torbay and South Devon. Performance and operational resilience remained constrained with: delays in diagnostics and access to treatment - analysis of harm in key high-risk service areas shows an increase in harm in Ophthalmology, Urology, Cancer Services
- challenge in meeting recovery and restoration targets set out in the Operational Recovery Plan
- ability to maintain improved ambulance handovers whilst managing operational pressures
- long length of stay in the Emergency Department, particularly patients with complex mental health needs
- quality metrics reviewed to ensure appropriate focus on quality and ensure alignment with risks and NOF4 criteria.

BAF Reference 2: people
Objective: to build a culture where our people feel safe, healthy and supported

- Difficulties recruiting to critical posts means there is an increase in services with high risks with staffing factors.
- A need for more robust strategic business and workforce planning to support the Trust in identifying the workforce needed for the future.
- Capacity to deliver services impacted by industrial action
- Operational pressures result in increased time in high escalation impacting on workload pressures, wellbeing of staff and ability to attend professional and mandatory training
- Unclear career pathways and talent management impacts on retention, wellbeing and development of workforce
- Absence and turnover increasing use of bank and agency staff, which impacts on the Trust's financial position and team health and effectiveness.
- Improvements required to ensure our leaders and managers have the skills to enable them to fulfil their roles within an unprecedented and challenging environment.
- A need to better align workforce and financial data to support financial and workforce planning.

Actions taken to mitigate the above include: use of interims and agency staff (following a robust approvals process); appointment of Strategic Workforce Planner (funding supported through the New Hospitals Programme); introduction of co-created leadership framework; industrial action planning; a process to support staff to attend training at times of high escalation; and a number of programmes of work to support organisational reshaping and budget setting resulting in more accurate vacancy data.

BAF Reference 3: financial sustainability
Objective: to improve productivity to achieve financial sustainability, delivering the ICS five-year financial recovery plan: enabling appropriate investment in the delivery of outstanding care

- inflation outstrips funding available resulting in a deterioration in financial performance, managed through effective contract negotiation
- digital and physical environments are not fit for purpose, infrastructure risks are reduced through effective capital planning and prioritisation of available capital funding
- recruitment and retention are difficult for highly skilled clinical staff, managed through effective workforce planning and recruitment and retention initiatives
- failure to comply with best practice guidance such as GIRFT and model hospital, which is managed on an ongoing basis through constant review of benchmarking data to inform improvements in productivity and efficiency
- material differences between income and costs for specific services most notably adult social care. Work ongoing with partners to identify and implement recovery and transformation initiatives to reduce cost.
- non delivery of the cost improvement programme (CIP) in year has resulted in the implementation of more robust system and processes around CIP identification, delivery and assurance.
- failure to implement the identified actions from the external assurance report and internal audit report as regard to financial performance and internal control.
- pressures on operational services are monitored through Executive Operations Group where the financial impact is also considered in delivering elective and urgent care standards

BAF Reference 4: estates
Objective: providing a fit for purpose environment, where our people have the conditions to succeed and deliver excellent patient care

- the estate is heavily dilapidated with £62.3m of backlog reported to NHS England through the Estates Return Information Collection (ERIC) in 2024 (half is high and significant risk). This is the cost to remediate to an estates environment that is operationally safe, not the cost to fully modernise or meet current clinical or compliance standards. Real estimates of true capital needs can be between double and up to five times the return figure, depending on local site conditions and scope of ambition.
- insufficient engineering infrastructure capacity, capability and resilience to maintain activity and safe environments
- Insufficient capital to address and mitigate backlog maintenance risks
- inability to improve and reconfigure the estate due to significantly aged infrastructure and insufficient funding impacting the delivery of clinical activity, for which the New Hospital Programme was the long-term mitigation and has been delayed post-2030.
- Aging premises, requiring additional servicing and repair, impacted by lack of decant space and the necessity to work in live clinical environments which are operationally challenged.
- Premises infrastructure and layout not efficient for modern healthcare needs
- Reduction of capital allocations due to system wide top slices for schemes, the imposed capital penalties due to revenue financial performance, the impact of NOF 4.

To mitigate these risks the Trust has delivered 21 schemes as part of the capital programme to improve the infrastructure failures in the organisation and mitigate key risks, these include: steam main works, replacement CT scanner, medical gas duct enhancements, tower block remedial and window repairs, critical electrical infrastructure improvements. In addition, we have installed two new day surgery theatres and a new Endoscopy Unit with the support of external funding. We will continue to seek external funding to support the delivery of high quality and modern healthcare.

BAF Reference 5: operations and performance standards **Objective: to deliver levels of performance that are in line with our plans and national standards to ensure provision of safe, quality care; focusing on safe, quality services and articulation of performance against NOF4 exit criteria**
• increase in emergency and planned care demand • workforce shortages which require reliance on locums in key emergency and elective specialities • resilience in the care home and domiciliary care market • infection control outbreaks resulting in reduced bed capacity • insufficient estate of fit for purpose quality to improve productivity of urgent and emergency care and elective pathways • inadequate information and data analysis to enable effective planning • industrial action continues to impact electives and no-elective programmes
BAF Reference 6: digital and cyber resilience **Objective: to provide clinical and administrative IT systems, and supporting digital infrastructure, that efficiently and cost-effectively meets the Trust's clinical models of care and key business needs, supporting the confidentiality, integrity and availability (including resilience) requirements of a modern health and care provider delivering 24/7/365 services.**
• Successful approval of the electronic patient record (EPR) business case which will resolve a large proportion of information management and technology risks on implementation in April 2026 • Replacement of ICE OrderComms • Replacement of Laboratory Information System • Approval of the business case for contract management system for Adult Social Care, which will be implemented in April 2026 • Workforce challenges in the implementation of EPR and managing business as usual • potential for increase of licensing costs above inflation • inability to refresh IT hardware before it ceases to perform or becomes unsupported due to constraints in the capital programme • data centre upgrades required – business case has been approved • requirement to update software with patches can result in system failure • systems unavailable due to ransomware attacks • Internal Audit cyber security review highlighted a number of areas requiring improvement this is being managed through agreed action plan
BAF Reference 7: Building a Brighter Future (BBF) **Objective: to secure the innovation and transformation of the Trust's capital programmes; both infrastructure and digital, including but not limited to the Electronic Patient Record and New Hospital Plan; ensuring that such programmes meet the needs of the local population, communicates, and the peninsula system now and in the future.**
• uncertainty in the national funding availability within the New Hospital Programme which has now been confirmed and the Trust's position in the programme means that the new build will not be delivered pre-2030.
BAF Reference 8: Strategy and Transformation **Objective: to 'hard wire' continuous improvement into the way we work and execute the required change at pace in order to tackle clinical, operational and financial challenges enabling the organization to meet its strategic imperatives and navigate a route out of NOF 4 by meeting exit criteria**
• significant challenges in quality, safety, performance and financial improvement continue to require significant improvement programmes to be delivered at scale and at pace • Executive Committee and the Board have signed off an extensive plan (our plan for better care) with 19 improvement areas that align to NOF 4 exit and support the delivery of the 2025/26 plan • the requisite improvement resource is currently being identified and will be supported by Recovery Support Programme colleagues.

• adopting a whole organisation approach to continuous improvement is an integral enabler to the organisation sustaining improvement and more progress is needed to achieve this • the organisation is producing a new strategy that will provide clarity on key priority areas covering clinical, digital, estate, workforce and financial • no standardised or co-ordinated approach to leading improvement programmes across the Integrated Care System • A new EPR is being implemented and will mitigate some of the clinical system issues that have been in place for over a decade • Estate infrastructure is poor and does not enable significant levels of transformation at pace.
BAF Reference 9: Green Plan/Environmental **Objective: to deliver on our plans and commitments to environmental sustainability and decarbonization, as set out in the Trust's Green Plan**
• infrastructure across the estate is aged and not environmentally efficient • the existing infrastructure is aged to a point where assets cannot be easily added or replaced with environmentally efficient ones • sufficient focus and priority is not given to the implementation of our green plan as resource availability is limited and focussed on operational delivery and recovery.
BAF Reference 10: Equality, Diversity and Inclusion **Objective: to have an increased focus on equality, diversity and inclusion to address the increase in bullying and harassment across the organization. To develop and embed a culture of inclusion throughout the organisation.**
• lack of clear inclusive leadership/management expectations, accountability and development resulting in direct and indirect discrimination • an upward trend in equality, diversity and inclusion investigations and employment tribunals, increase in reports of bullying and harassment within our BAME colleagues and overall decline in experience for people with long term conditions (staff survey) suggests we do not have an inclusive culture in our Trust. This was highlighted in our CQC inspection 2023.
BAF Reference 11: Provision of community and care services delivered in partnership **Objective: to deliver community services and care through partnership which supports the population we serve to live well; notably the Children and Family Health Devon and Adult Social Care provision**
• community service provision challenged by workforce shortages and requires redesign • Children and Family Health Devon facing increased demand for specialist services including neurodiversity assessments which are contributing to long waiting times • Impact of provider model for Children and Family Health Devon leading to a lack of productivity for children's services • The pace of delivery of the Peninsula Acute Sustainability Programme and the lack of a Devon clinical strategy offers significant risk to the Trust

Financial, performance, people and quality risks

During 2024/25, we developed a series of improvement plans which supported our progress against the NOF 4 exit requirements as agreed with the Integrated Care System and NHS England Regional team. We have made notable progress in each area but have further to go. To that end and with the support of national and regional colleagues we have invoked further support during the year, refocussed on our financial and operational performance reporting and controls, improved assurance reporting to the Board and requested a developmental, independent, well led review to support our progress.

Capital funding risks

We reported a deficit in 2024/25 and have seen reduced levels of underlying EBITDA (earnings before interest, taxes, depreciation and amortization) over a number of years. This has significantly restricted the level of cash available for capital expenditure. As a result, we are reliant on external funding through public dividend capital to fund a proportion of our capital programme, such as essential repairs and replacements. NHS England also determines how much each NHS System can spend on capital each year, this expenditure cap similarly curtails how much the Trust can invest in service developmental capital necessary to further develop our care model, and further support productivity and service improvements.

We have successfully secured national funding through NHS England for a number of development schemes to supplement the NHS System caps. The Trust continues to pursue those opportunities. In January 2025 the Secretary of State for Health and Social Care provided an update on the outcome of the New Hospital Programme review in Parliament. Partial rebuild of Torbay Hospital remains within the programme due to our very poor condition estate and significant estates backlog maintenance, but it has been significantly delayed. The main construction timetable is now starting between 2033 and 2035. It should be noted until the new build is complete, we are carrying significant estate risks due to the failing estate and the constrained capital to manage this risk.

System cost pressures

The pressure in the 2024/25 cost base reflected increased pressure on health services in general, and the significant focus on elective, diagnostic and cancer recovery. We have also continued the targeted investment programme in safer staffing and have relied on in-sourcing and outsourcing of elective and diagnostic services to recover performance against national targets. We continue to depend on agency medical and nursing staff in a number of shortage areas.

Uniquely, and most significantly in our organisation, are pressures building in continuing health care and adult social care. The Trust benchmarks high for Adult Social Care both in terms of the number of people in receipt of care but also the cost of those people. This is due to process issues as well as our demographics. Continuing Healthcare benchmarks high for numbers of people.

The NHS Devon system-wide plans for 2025/26 have been developed in conjunction with our partners and through the Board. These have been subject to review and scrutiny by both the Integrated Care Board and NHS England (Regionally and Nationally). The Board has acknowledged that we must continue to develop our planning and delivery models. An enhanced accountability framework and programme management office supports this model.

The financial outlook is challenging and there is a significant risk to achieving the necessary level of financial improvement within our organisation and across the Integrated Care System for Devon. Our cost saving and efficiency programme in 2025/26 amounts to £41.5 million, a quantum never previously achieved, which will demand significant service redesign at pace.

Operational Plans

In the pursuit of excellence in healthcare delivery, we have forged robust quality improvement plans with the support of our Improvement and Innovation team working closely with the clinical and operational teams, collaborating closely with partners such as the Integrated Care Board, Emergency Care Improvement Support team (ECIST), and Intensive Support Team (IST). Together, we have embarked on a journey to benchmark our services against industry standards, identify best practices, and adapt evidence-based methodologies to enhance our performance against national access targets.

Looking ahead to the financial year 2025/26, we will continue our focus on translating these efforts into tangible results by aligning with the operational planning guidance and achieving set targets.

Specifically, we are dedicated to advancing our performance against the National Urgent and Emergency Care (UEC) standards, notably the 4-hour access standard and the 15-minute ambulance handover standard

Our collaborative efforts with South Western Ambulance Service NHS Foundation Trust (SWAST) and other stakeholders are aimed at improving access and leveraging virtual ward opportunities to further elevate our performance benchmarks.

Looking forward, our commitment remains resolute in advancing cancer care, diagnostics, and elective services. By March 2026, our objectives include having no more than 1% of patients waiting longer than 52 weeks and an elimination of patients waiting beyond 65 weeks for planned care treatment, achieving a diagnostic performance rate of 95% within six weeks, and ensuring that a standard of 75% is met for patients who are referred on an urgent cancer pathway receiving treatment within 62 days.

NHS England Provider Licence

The Board are responsible for oversight of and compliance with the NHS Standard Form Licence conditions, which, together with the updated cover page forms our provider licence of operation, as issued by NHS England, together (the “Licence”). The Licence sets out the operational standards and regulatory oversight parameters within which we must operate in the delivery of services, as directed by NHS England. The Board are able to report compliance with its Licence of registration, as issued by NHS England and remains cognisant of its responsibilities hitherto.

Care Quality Commission (CQC)

The Chief Nurse is responsible for ensuring compliance with our registration with the CQC. This is achieved by:

- reporting and keeping under review matters highlighted within inspections
- liaising with the CQC inspectors and senior clinicians and managers in response to any specific concerns raised by the CQC or by patients and members of the public
- engaging with the CQC inspectors in the inspection process and coordinating our response to inspections and any recommendations or actions that arise thereafter
- Updating the board on any changes to the CQC regulatory approach
- analysing trends from incident reporting, complaints and patient and staff surveys and sharing the learning from these across our services
- reviewing assurances on the effective operation of controls
- receiving assurances provided by internal audit and any clinical audit conclusions, which provide only limited assurance
- engaging with the CQC at the standard Quarterly Engagement meetings and Monthly relationship meetings
- a yearly report on the trust’s registration to Board

Care Quality Commission compliance declaration

We are fully compliant with the registration requirements of the Care Quality Commission and can provide the following regulated activities with no restrictions or conditions;

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Personal care
- Surgical procedures

- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury.
- Communication with stakeholders

Our communications and engagement team works in partnership with the feedback and engagement team and the membership office to ensure that there are sufficient and robust mechanisms in place to inform the public about, and involve them in, our work.

Together we are committed to ensuring that patients, carers, our people and the public are listened to and have the opportunity to feedback on their experiences while also raising concerns and asking questions about any of our current and future activities. We work closely with our partners in the Integrated Care System and any formal consultation is led by the Integrated Care System with our support and involvement as appropriate.

Our engagement and communications strategy aims to support meaningful conversations with our people and communities while our patient and service user experience of healthcare strategy helps us to hear and learn better from patient and carer experience.

Compliance with people strategies and 'developing workforce safeguards

Our People Promise and Plan has continued to drive our people and culture priorities, aligned to the national people promise principles. The appointment of a dedicated People Promise Manager and Equality, Diversity and Inclusion Lead and Associate Director of People enabled stronger delivery of strategic ambitions around improving inclusion, staff engagement, and cultural transformation.

We took proactive steps to ensure compliance with both the national strategy and local workforce governance frameworks, which included participation in the People Promise Exemplar Programme, contributing to national data and learning, and embedding a consistent approach to staff experience, thereby improving retention and the quality of patient care.

We continued to work collaboratively with system partners and NHS England to drive workforce transformation, ensuring our policies, processes, and leadership development offers were reviewed and updated to reflect our commitment to equity, inclusion and belonging.

In 2025/26 we will continue to build a culture at work where our people feel safe, healthy and supported. To achieve all the different components of the NHS people promise the organisation will develop a re-focussed culture plan which will now sit within 'Our Plan for Better Care' and which clearly sets out our priorities going forward. These priorities will focus on delivering our workforce plan, developing the workforce capability and capacity and embedding a re-focussed culture plan.

'Our Plan for better Care' – People priority Programmes

Programme one – deliver our workforce plan and workforce transformation. This programme will ensure we can deliver a sustainable, workforce plan that delivers an efficient, agile and high performing workforce aligned to system and organisational priorities. This will be achieved through ensuring we have the right workforce, reducing our reliance on temporary staffing while maintaining quality and safety, and supporting service transformation projects.

Programme two will focus on building a high-performing, forward-thinking and values driven People and Education Directorate service, with the right capacity, skills, systems, and leadership to enable the organisation to deliver its strategic people priorities, meet regulatory expectations, and drive long-term workforce sustainability. We will do this by remodelling our structure and enhancing our skills and knowledge through development of our teams, which will enable us to work together effectively towards the delivery of our shared goals.

Programme three will oversee the development of our re-focussed culture plan and embed a culture where our people feel valued and supported and that continues to align to the principles of the People Promise. Included in this work will be a focus on our cultural insights, such as the staff survey, WRES and WDES report and Freedom to Speak Up Guardian insights and setting up a mechanism to proactively analyse, respond and action the required interventions for improvement. We will establish a staff engagement plan which is focussed on inclusion, staff experience, feedback, including refreshing our staff networks and Freedom to Speak Up Guardian process and support. We will review our wellbeing support, focussing on proactive and preventative interventions and ensure our commitment to people's development continues through undertaking a review of our learning and development programmes. We will all ensure that through this programme we continue celebrating our people through Our People Awards which are based on our people promise principles, recognising and rewarding our people for living our people promise and our values.

Delivering these priorities and measuring their impact will be achieved by monitoring our people dashboard, which represents key workforce metrics, including the experiences of our people, retention, sickness absence and turnover. Our Inclusion Module, aimed at increasing awareness of cultural differences and increasing cultural competence, launched in January 2024, continues to be part of our mandatory training. The collaboration of colleagues within our Workforce Planning and Information, Finance, Performance and Project Management Office teams continue to develop a much more joined up approach to supporting operational planning across the organisation, including developing data alignment.

The embedding of a strengthened governance framework will support the provision of evidenced-based assurance from ward to Board. The Board reviews the organisation's performance in the key areas of finance, activity, national targets, patient safety and quality and people in the form of an integrated quality dashboard. This includes the regular presentation of performance information against key quality, people and financial metrics to the Board and its committees. The people section contains information on monthly staff sickness as well as rolling 12-month sickness absence, staff turnover and use of temporary staffing, as well as performance against the annual staff survey. These are high level organisational metrics and data that we will continue to collate, review and analyse each month. These people metrics, together with quality and outcomes indicators and productivity measures form part of the Integrated Performance Report. A more detailed version of the workforce metrics (in the form of a People Dashboard) are reviewed by the People Committee, within the context of delivery of our people promise.

In terms of the wider context, we remain fully engaged with the Devon system workforce strategy, of which the focus is centered on developing a culture and structure that facilitates trust, involvement and innovation and local empowered decision making.

Compliance with 'Managing Conflicts of Interest in the NHS' guidance

We have published on our website, an up-to-date register of interests, including gifts and hospitality, for decision-making colleagues (as defined by us with reference to the guidance) within the past 12 months as required by the 'Managing Conflicts of Interest in the NHS' guidance published by NHS England.

Compliance with NHS pension scheme regulations

As an employer with our people entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Compliance with equality, diversity and human rights legislation

Control measures are in place to ensure that all our obligations under equality, diversity and human rights legislation are complied with.

We are committed to providing an inclusive and welcoming environment for all our people, patients, clients, service users, carers and families. We are striving to create a culture of inclusion for all.

A range of control measures are in place to ensure we comply with our obligations under equality, diversity and human rights legislation. Performance is monitored through the collection of statutory data and our people promise programme/CQC action plan, which report through the People Committee.

The Board of Directors receives reports on diversity and inclusion issues from the Chief Nurse (patient and service user updates) and the Chief People Officer (people updates through our people promise). These include any updates or changes in national mandates together with any risks or challenges.

Compliance with Climate Change Act and the adaptation reporting requirements

We have undertaken risk assessments and have a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). We ensure that our obligations under the Climate Change Act and the adaptation reporting requirements are complied with and in line with NHS net zero targets.

Review of economy, efficiency, effectiveness, and use of resources

Directors are responsible for putting in place proper arrangements to secure economy, efficiency, and effectiveness in our use of resources. We have established several processes to ensure the achievement of this. These include:

- clear processes for setting, agreeing, and implementing strategic objectives based on the needs of the local population, reflecting the priorities of key partners and the Department of Health and Social Care. This includes a strategy for patient, client, service users, carers, and public involvement as well as our governors and public members, providing a key focus for our engagement work within Torbay and South Devon. Established objectives are supported by quantifiable and measurable outcomes
- clear and effective arrangements for monitoring and reviewing performance which include a comprehensive and integrated performance dashboard used monthly in the performance management of health and social care services and reported to the Board of Directors. The integrated finance, performance, quality and people report details any variances in planned performance and key actions to resolve them
- there is also a performance management regime embedded throughout the organisation including weekly capacity review meetings, financial recovery planning meetings, executive reviews of services, budget reviews (undertaken monthly) and regular work to ensure data quality
- committees consider reports of external regulators and bodies, with improvement action plans developed and their implementation monitored where and as necessary
- through the Finance and Performance Committee we have arrangements for planning and managing financial and other resources in place. These are encompassed in the Scheme of Delegation and the Standing Financial Instructions
- we use other benchmarking tools such as the Model Health System productivity metrics to demonstrate the delivery of value for money and identify opportunities for improvement. We continue to develop our reference cost reporting data to ensure services are being provided as efficiently as possible. For procurement of non-pay related items, we have a clear procurement strategy and collaborate with other NHS bodies to maximise value through the NHS Peninsula Procurement and Supply Alliance.

Compliance with information governance requirements

Continuous improvement and maintenance of good information governance standards is a key priority for the Trust. This is reflected in the Trust's commitment to the national standards set out in the Data Security and Protection Toolkit (DSPT), completed annually.

The Data Security and Protection Toolkit is supplied by NHS England to support the performance monitoring of Information Governance. We submitted 'standards met' for 2024/25, agreed by external audit and expect to meet the same for 2025/26. Completion of DSPT demonstrates that the Trust:

- has embedded good decision-making over compliance, and ownership of information risks at all levels of the organisation
- fosters a culture of continuous improvement, understanding the effectiveness of its practices and moves beyond 'tick boxes'
- recognises and can respond to all new and existing threats to the confidentiality, integrity and availability of information required for operation of essential functions and services.

We have appointed key roles to support our commitment to data protection by design and default. These roles are the champions of appropriate data capture, processing, security and sharing by the organisation:

- Senior Information Risk Owner (SIRO), held by the Director of Corporate Governance and Trust Secretary is the Executive Board member who is familiar with information risks and provides the focus for the management of information risk at Board level.
- Caldicott Guardian, held by Consultant for pain management and Anaesthesia is the senior person responsible for protecting the confidentiality of patient and service-user information , acting as conscience for the Trust
- Data Protection Officer (DPO), held by Head of Information Governance, Data Protection, Freedom of Information and Records is the expert in data protection and reports to the most senior levels within the organisation on risks to the privacy of individuals, and threats to the organisation. This has recently transferred to the Trust's Legal Services

Throughout the year we have identified areas for improvement and have made good steps in improving our compliance in key areas. Work is ongoing to develop clear governance routes for the use of artificial intelligence and embed practices from cross-organisational sharing which respect the rights to confidentiality whilst sharing information required for clinical care.

Information Governance incidents and risks are recorded on our risk management system. These are monitored by the Information Governance team, and the DPO who offer guidance and support for investigation, management, and resolution.

Summary reports and highlighted risks are discussed at information governance steering group (IGSG) chaired by the SIRO. Incidents that score in line with regulated reporting requirements are reported to the ICO – see summary below:

ICO cases reported 2024/25:

These are cases the Trust has reported to the ICO via the DSPT; each incident is investigated and reviewed at the Trust's IGSG, with learning shared through the Patient Safety Incident Response Group (where patient data is affected). Where an incident has been assessed as 'likely' to cause 'harm or detriment to a living individual' the Trust engages in Duty of Candour processes to inform all affected persons unless it is deemed clinically unsafe to do so.

Datix ID	Case summary	Outcome	ICO recommendations / outcome
DCIQ_INC-8793	Information pertaining to a looked after child was shared inappropriately with a birth parent.	A working group has been established to review the process for managing the records of looked after and adopted children as we migrate to an electronic patient record. Policies for conducting '3 point patient ID checks' have been reviewed and amended. Meetings are ongoing with local authorities' partners to ensure there are appropriate notifications regarding looked after children.	No further action.
DCIQ_INC-8833	A complaint response was inappropriately enclosed with another person's response.	The process for disclosure of information has been reviewed and use of 'batch printing' emphasised as inappropriate.	No further action.
DCIQ_INC-7145	A third-party data processor was targeted in a cyber-attack and information exfiltrated to the 'dark web'	Case ongoing	Under investigation
DCIQ_INC-10214	A member of staff inappropriately accessed records relating to themselves and their children.	Managed as a disciplinary matter.	Pending disciplinary outcome
DCIQ_INC-15646	A member of staff inappropriately accessed clinical records of other persons.	Managed as a disciplinary matter.	Pending disciplinary outcome
DCIQ_INC-15143	Information relating to staff was uploaded to an unapproved web-based AI tool.	The Trust is developing an AI governance process to support staff make appropriate risk based decisions regarding the use of AI for non-clinical matters.	No further action.
DCIQ_INC-15890	Patient records were lost within the community.	Records were recreated following all reasonable steps to identify loss.	No further action.
DCIQ_INC-20946	Letters disclosed to patients regarding a change in services included other person's personal details in error.	Processes for batch printing letters were reviewed and reminders issued regarding checking all information prior to disclosure.	No further action.

ICO complaints received 2024/25:

These are complaints the Trust has received from the ICO; each case is reviewed and action taken, with the ICO provided an outcome letter or the data subject contacted directly if requested.

Case Ref	Case summary	Investigation findings	ICO recommendations / outcome
IC-295547-Q9H3	Incorrect application of s.40(2) in the response to a Freedom of Information Request.	S.40(2) was not appropriate to apply, the information should have been exempted under S.40(5) of the FOIA.	Staff responsible for applying Freedom of Information Act exemptions should ensure accurate application of exemptions in responses.
IC-326984-L6Y6	Incorrect application of s.40(2) in the response to a Freedom of Information Request	Exclusion of 'totals' was not appropriate; however this was disclosed prior to the ICO complaint being received.	No further action.
IC-327262-W5T4	A patient requested an audit of their clinical record which was not appropriately completed.	The clinical system did not have the required audit functionalities to audit records without naming both a specific patient and staff member.	Audit functionality for all clinical systems must meet the requirements set out in legislation.

		This has been taken forward with the system supplier.	
IC-316085-X7W8	A Subject Access Request did not include all information requested.	A full case review was conducted and all information disclosed with guidance of neighbouring organisations who may also hold information within scope.	When services transfer between organisations, clear Records Transfer Agreements should be drafted. Teams responsible for managing information assets should have clear records documented on the Trust's Information Asset Register.
IC-325328-J6P5	A Subject Access Request did not include all information requested or explain redactions / exemptions.	A full case review was conducted and all redactions agreed as appropriate. However, these should have been communicated with the requestor.	Change redaction procedures and document the rationale for exempting any information within a Subject Access Request.
IC-373509-X9K3	A Freedom of Information Request was not responded to within the legislative timeframe.	Complaint upheld.	No further action.
IC-329871-X3V5	A Subject Access Request was not responded to within the legislative timeframe and did not include all requested information.	Complaint upheld.	All staff attend mandatory training which is routinely tested and refreshed in relation to the handling of subject access request. All policies and procedures are up to date and reflect the current obligations placed on controllers and processors under the General Data Protection Regulation / Data Protection Act 2018 in respect of time frames for responding to Subject Access Reqeustss

Key compliance areas:

We maintain consistently high standards of compliance in key performance areas which are monitored by the Trust Board. Whilst we note compliance has dropped across Freedom of Information and Environmental Information Requests, action plans are ongoing to return to an acceptable compliance within six months.

Latest figures show:

Subject Access Request compliance:

	Breached %	Compliant %	Breached	Compliant	Grand Total
2024/25					
Grand Total	7.37%	92.63%	175	2116	2291

Access to Health Records 1990 requests:

	Breached %	Compliant %	Breached	Compliant	Grand Total
2024/25					
Grand Total	13.47%	86.53%	15	97	112

Freedom of Information & Environmental Information Requests:

	Breached %	Compliant %	Breached	Compliant	Requests received
2024/25					
Grand Total	24.06%	76.08%	173*	547	719

* includes ongoing cases

Data quality and governance

Performance dashboards are used across the organisational governance structures to give monthly oversight of key metrics covering quality, workforce, performance and finance. Each of the specialist areas has its own processes for assurance against data quality and reporting accuracy. Care Groups hold monthly performance, risk and assurance meetings to review progress against key targets. Any data variations or concerns raised are first checked with the business Intelligence team and Performance team. Performance escalations are taken as needed through our operational governance framework and our Executive Committee. Operational performance risks and highlights are reported to Board in the Chief Operating Officer's report along with the Integrated Performance Report.

External assurance is gained from a variety of sources to triangulate against data Quality and Performance. We review benchmarking to wider NHS Peers using tools including "model hospital", third-party benchmarking from "Telstra (Dr Foster)", 'Gooroo' Planner (referral to treatment data ('RTT') and NHS England performance benchmarking and performance reporting. These tools use data provided via our National data returns. These sources can be triangulated to in-house reports to provide assurance of data quality and reporting accuracy. A significant data quality exercise was undertaken by a collaboration of in house and consulting specialists to assess waiting lists, with a view to reducing numbers and improving RTT times.

Clinical coding is a key source of intelligence for us, creating an asset that is used as a key intelligence resource, and carries financial implications. Incident data and medical record audit data can be used to assess the quality of paper medical records. Clinical coding compliance is heavily audited and required to meet national data quality standards. Regular review and external audit are carried out.

In readiness for the upcoming implementation of Epic, the Trust's chosen EPR solution, the Trust will be recruiting to specific data quality posts to begin the work to create strong data quality framework. This work will align to system wide assurance across the Devon footprint. Initially data quality clerks will be appointed to the Information Governance team to support service user experience, with the view to later appoint analysts as the requirement is identified and resourced.

The current system working assurance is provided by the Data Engineering Team, who work closely with the Integrated Care Board and review National Data Quality reports to provide assurance against national submissions used for commissioning and contract income purposes.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, corporate and clinical audits as well as operational and governance reporting mechanisms, supported by the knowledge, capability and accountability of the executive managers and clinical leads, each of whom have responsibility for the development and maintenance of the internal control framework in their respective areas. I have also drawn on performance information available to me, as well as comments made by the external auditors in their management letter and other reports.

I have been advised on effectiveness of the system of internal control during the year by the Board, and its sub-committees: including the Audit and Risk Committee; Quality Assurance Committee; Finance and Performance Committee; Building a Brighter Future Committee and People Committee, and in addition the executive group and risk group. Where identified, weaknesses are addressed or a plan is put into place to mitigate them, so as to ensure continuous improvement of the system is in place.

Core documentation underpinning our system of internal control (including accountabilities and delegations) include but is not limited to: the Trust Licence and Constitution, committee terms of reference, matters reserved to the Board, standing orders, scheme of delegation and standing financial instructions as well as both corporate and operational policy, procedure guidelines and standard operational procedures.

The Board Assurance Framework, as a mechanism for monitoring strategic delivery in a risk-based way, provides me with evidence of the effectiveness of controls and that any gaps are being addressed with appropriate action. My review has also been informed by the major sources of assurance on which reliance has been placed during the year.

These sources include reviews carried out by our external auditor Grant Thornton LLP, Care Quality Commission, Internal Audit and the Health and Safety Executive.

The following Committees and groups are involved in maintaining and reviewing the effectiveness of the system of internal control:

- the Board of Directors has overall accountability for the governance arrangements, including the committee structure, and ensuring we adhere to our constitution and apply our standing orders, scheme of delegation and standing financial instructions correctly. The Chairs of each of the Board sub-committees present a report to the next available Board meeting for the purpose of providing assurance on matters within its terms of reference. Urgent matters if requiring escalation to the Board are reported by the Committee Chair in the intervening period. The Board has agreed, in conjunction with the Council of Governors, the strategic objectives for the organisation
- the executive directors have assessed the risks to their achievement, along with risk controls and assurance mechanisms. As part of this risk assessment process, gaps in controls and assurances have been highlighted. This information is incorporated in our Board Assurance Framework document reviewed regularly by the Board of Directors
- the Audit and Risk Committee is responsible for establishing an effective system of internal control and risk management and provides an independent assurance to the Board. The Committee takes an overview of our governance activity by reviewing the statement on internal effectiveness and Annual Governance Statement. Reports from the internal auditors and external auditor also provide assurance. The Committee also reviews on a regular basis, the risks that are described in the Board Assurance Framework. The Committee has oversight of and relies on the work of the risk group to monitor the risk management process and risk registers. The Committee has oversight of expressions of concerns and whistleblowing arrangements. The Audit and Risk Committee is chaired by a suitably qualified Non-Executive and membership comprises the Chairs of each of the Board Sub-Committees
- the Quality Assurance Committee provides the Board of Directors with assurances of clinical effectiveness through scrutiny of patient quality and safety, patient experience, medicines management and staffing. It monitors selected quality metrics and ensures the organisation has robust systems in place to learn from experience. It receives reports from specialist governance groups and Boards e.g. statutory safeguarding partnership boards; patient safety; and serious incidents and undertakes a deep-dive review into a service or specialty at each meeting. The Quality Assurance Committee is chaired by a Non-Executive Director and reports to the Board of Directors

- the Finance and Performance Committee oversees, co-ordinates, reviews and assesses our financial and performance arrangements, including monitoring the delivery of the NHS long-term plan and supporting annual plan decisions on investment and business cases. The Committee provides the Board with an independent and objective review of, and assurances, in relation to significant financial and performance risks which may impact on our financial viability and sustainability. It provides detailed scrutiny of financial and performance matters in order to provide assurance and raise concerns (if appropriate) to the Board of Directors. It also assesses and identifies risks within the finance and performance portfolio and escalates as appropriate. The Committee is chaired by a Non-Executive Director and reports to the Board of Directors
- the Building a Brighter Future Committee was established in 2020 for the purpose of providing assurance to the Board regarding the processes, procedures and management of the new hospital and digital programmes and to support the successful achievement of the programmes' investment objectives and realisation of the stated benefits. It also aims to assure the Board of the achievement of the objectives set out in the programmes, that approved projects are being effectively managed and controlled and confirm that projects are delivering the stated benefits, are value for money, and are ultimately affordable
- the risk group oversees the risk management process at operational level, ensuring that risks are managed and/or escalated in line with the risk management strategy. It promotes effective risk management and compliance and supports maintaining a dynamic Board Assurance Framework and risk management database where risks are registered. It also ensures local level responsibility and accountability and will challenge risk assessment and risk assurance arrangements in areas of our activity where robust controls are not evident in order to raise standards and ensure continuous improvement. The risk group is chaired by the a Care Group Director.

My review is also informed by the Head of Internal Audit Opinion which states that satisfactory assurance can be given that there is a sound system of internal control, designed to meet the organisations objectives, and controls are being applied consistently. Weaknesses in the design and/or inconsistent application of controls in some key areas put the achievement of particular objectives. One review, that of the Trust's Core Financial Systems, attracted a limited assurance, however this did not impact on the overall Head of Internal Audit Opinion and work is already taking place to action the recommendations identified as part of the review.

During the year, internal audit undertook 25 substantive reviews and a high-level assessment of our governance arrangements, all of which informed the Head of Internal Audit Opinion for 2023/24. Internal audit reports are received by the risk group for review and action and are presented to the Audit and Risk Committee for assurance. Action plans and progress are reported in detail to each subsequent Audit and Risk Committee meeting as part of internal audit's follow-up process. This process includes a programme of review of improvements in practice in response to limited assurance reviews by the Audit and Risk Committee, including presentation of the action plan to the Audit and Risk Committee by the Executive Lead Director. The internal auditor takes a risk-based approach to formulating the annual work plan for agreement with management prior to final approval by the Audit and Risk Committee.

External audit provides independent assurance on the Annual Accounts, Annual Report and the Annual Governance Statement.

Significant internal control issues

Gaps in internal control or assurance which arise during the year are identified in a multitude of ways as a result of the effectiveness of our internal controls; three principal ways that any such gaps are captured and reported are through the Board Assurance Framework, Risk Management Framework and audit, both internal and external. Such gaps are identified and corresponding actions are set and managed.

Notable matters which impacted on the effectiveness of our internal controls, during the year, were:

- that, following the external assurance report authored by Kaye Bentley in November 2024 which was commissioned by the Trust and the Integrated Care Board (ICB) for Devon, when we identified variance from our control total and which identified weaknesses in the application of our internal control framework and financial performance management, we *invited a developmental well-led review to be undertaken to test the effectiveness of the changes we have made. Whilst our system of internal control identified this variance and the necessary actions have been identified and begun to be implemented this has weakened the efficacy of our internal control framework .*
- that the Head of Internal Audit opinion report noted the following audits as having received Limited assurance: Care Group Governance; Emergency Preparedness, Resilience and Response - Post Incident Debriefs; Non-Pay Controls; Mental Capacity Act – Understanding and Application; Torbay Council Assurance – Deprivation of Liberty Safeguards; and Additional Payments however, corresponding actions have been taken; and
- a number of recommendations from the internal audit reports were not completed in a timely manner; and
- The cumulative effect of the aforementioned, together with the findings of the independent review of our financial systems, has led the Head of Internal Audit to provide a limited overall opinion for this financial year. It has however been recognised that in the first quarter of 2025/26 this position has improved significantly, with improvements being seen from month 9 of the 2024/25 financial year; these are reflected in the narrative around the Head of Internal Audit opinion.

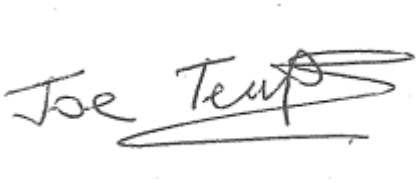
The aforementioned audits have been considered by the Audit and Risk Committee and detailed action plans have been identified. These are being reviewed and monitored during 2025/26 by the Audit and Risk Committee, with additional oversight from the relevant Board Sub-Committee, (reporting to the Board of directors). In addition, the Executive leads, as well as Team as a whole, are reviewing operational progress routinely.

Conclusion

In concluding my review on the overall system of internal control, I am assured that:

- the Board, Executive Directors, senior management and our people, have identified and are managing the risks we face, with escalation of risk events, an effective process for keeping risk scores up to date and flagging any risk and control concerns
- there is an appropriate risk management framework embedded in the organisation along with there being no major concerns from the undertaking of an effective programme of independent, risk-based monitoring
- our internal auditors and other independent assurance providers such as external auditors, have no major concerns from their risk focused programme of independent assurance.

My review therefore confirms that no significant internal control issues have been identified for the financial year ended 31 March 2025 and up to the date of approval of the annual report and accounts.



Joe Teape
Chief Executive
25 June 2025

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS OF TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

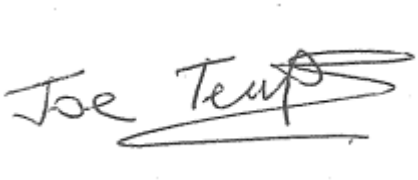
- apply on a consistent basis accounting policy laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above- mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

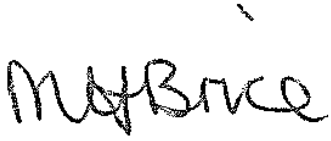
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board:



Joe Teape
Chief Executive
25 June 2025



Mark Brice
Chief Finance Officer
25 June 2025

Appendix A – Biographies of the Board of Directors as at 31 March 2025

Chris Balch **Non-Executive Director and Senior Independent Director** **Appointed: April 2019** **Chair: Appointed June 2024**	Chris joined us as a Non-Executive Director in April 2019 and took on the role of Chair in June 2024. Chris is Emeritus Professor of Planning at Plymouth University and is a chartered town planner and surveyor. He has held senior executive positions with an international property advisory company, latterly as managing director of DTZ UK and Ireland, and has extensive experience of providing consultancy advice to public and private sector clients specialising in the planning and delivery of major regeneration projects and programmes. He was chair of Basildon Renaissance Partnership, a member of the Council of Essex University, a director of Torbay Development Agency, a non-executive chairman of Hilson Moran (a consultancy specialising in the energy performance of complex buildings) and a member of the supervisory board of Ecorys BV (a European policy and research consultancy). He is a Board member of LiveWest housing association and is a trustee and vice-chair of South West Lakes Trust. His interest lies in tackling the under-performance of places and managing positive change within professional organisations and communities.
Joe Teape **Chief Executive** **Appointed: March 2025**	Joe joined us in March 2025 as our Chief Executive. Previously he was Chief Operating Officer at University Hospital Southampton NHS Foundation Trust from December 2019 to February 2025. Prior to 2019, he was Deputy Chief Executive and Director of Operations of a large health board in Wales which managed integrated services across three counties including four district general hospitals as well as mental health, learning disability and community services. Joe has worked in the NHS since 2001 and has also worked in a number of director roles across finance and strategy within provider acute trusts across the south west of England. Joe is passionate about providing leadership and support for all staff, whatever their profession, and contributing to excellent patient care. He is committed to open and ongoing engagement with the general public and often uses social media to engage with colleagues and with those who have an interest in healthcare.
Martin Beaman **Non-Executive Director and Vice-Chair** **Appointed: November 2023**	Martin joined us as a Non-Executive Director in November 2023 and took on the role of Vice-Chair in November 2024. Martin graduated in Medicine from King's College Hospital in London in 1979. He undertook his postgraduate training in London, the Midlands and Manchester before moving to Exeter as a Consultant Physician and Nephrologist. He was Clinical Director of Medicine (1995-2000) during which time he graduated with an MBA in Health Executive Management. Throughout his time in Exeter he provided care to patients with kidney disease living in Torbay and South Devon visiting both Torbay and Newton Abbot Hospital on a weekly basis for over 20 years. In 2000 he became an Associate Postgraduate Dean for Medical Education in the South West before being appointed in 2005 as the Inaugural Postgraduate Dean to the South West Peninsula Deanery. He subsequently became Dean for Postgraduate Medical Education in Bristol (Severn Deanery) in 2013. He retired in 2019 having been appointed as a Non-Executive Director to Devon Partnership NHS Trust (DPT) a few months earlier. He chaired the Quality Assurance Committee at DPT for just over four years. His NHS interests include quality of care, workforce development and clinical education. Martin is Chair of the Board's Quality Assurance Committee and a member of the Audit and Risk Committee.

Liz Edwards-Smith **Non-Executive Director** **Appointed: October 2024**	Liz joined us as a Non-Executive Director in October 2024. Liz is an experienced senior leader and people and change specialist who has worked for more than 20 years across the public and private sectors. She has supported organisations and teams to deliver large scale transformation programmes including digital and culture change. Following 14 years at Sema Group Plc, Schlumberger, Atos KPMG Consulting and Atos Consulting, Liz founded a micro-consultancy focusing on organisational and team development underpinned by evidence-based interventions. She is a qualified coach and Master Strengthscope Practitioner. An experienced Non-Executive Director and Trustee, she successfully guided transformation of Age UK Plymouth including collaboration with local government and health to establish a Short Term Care Centre providing step-up / step-down care as part of the city's health and social care system. Liz is a Fellow of the Chartered Management Institute with a position on the South West Regional Board, Co-Chair of the British Psychological Society South West Branch Committee and Trustee at Citizens Advice Plymouth. Her interests lie in the value of partnership working for wider societal benefit and the use of strengths-based models of care to co-create agency and wellbeing. Liz is Chair of the Charity Committee and a member of both People and Finance and Performance Committees.
Ashish Ghadiali **Associate Non-Executive Director** **Appointed: October 2024**	Ashish joined us as an Associate Non-Executive Director in October 2024. Ashish is a skilled builder of networks and partnerships who, over 20 years, has established a track record in developing innovative structures for change with social and environmental justice at their core. He is the founder/director of Radical Ecology, Lead Governor for Equality, Diversity and Inclusion at Exeter College, Founder and Co-Chair of the Black Atlantic Innovation Network at University College, London and Steering Committee Chair for the Arts and Humanities Research Council's programme, Early Career Research Fellowships in Cultural and Heritage Organisations. He is active as a volunteer youth worker at the Mount Wise Neighbourhood Centre in Devonport and as lead organiser of Diversity in Gardens, a regional network supporting access to nature for refugees and asylum seekers across South Devon. The strategic impact of his work addressing inequity and the global environmental crisis is internationally recognised. From 2020-2, he led on political strategy for the COP26 civil society coalition in the UK. Since 2022, as a Visiting Research Fellow at the University of Exeter, he has co-led the research and public engagement programme, Addressing the New Denialism and co-authored the 2023 study, Quantifying the human cost of global warming. He has curated public programmes and exhibitions for cultural institutions including Serpentine, the Southbank Centre and KARST. He has been a member of Devon County Council's Climate Task Force since 2023. A seasoned communicator, Ashish contributes regularly to The Guardian and The Observer newspapers. He has directed films for the BBC and the BFI and creates immersive film installations for public venues across South Devon including The Box in Plymouth, the Markethall in Devonport and the Royal Albert Memorial Museum in Exeter. His interest lies in nurturing a culture of cohesive community engagement across our catchment that puts clarity, integrity and care at the centre of the services we deliver.

Mark Greaves **Non-Executive Director** **Appointed: January 2025**	Mark joined us as an Associate Non-Executive Director in January 2025. Mark built a career as a Corporate Finance partner at PKF Francis Clark, where he was also responsible for developing their role in the international network PKF and leading an internal change programme based upon the digitalisation of the practice. His international duties included arranging trade visits to China and building closer links with Australian, European and American firms. Mark has more than 20 years of dedicated transaction experience and is highly regarded for his commercial approach and negotiation skills. He has advised on many high-profile deals such as the Management Buy Outs of Sutton Seeds and Dartington Crystal. He has a particular interest in media agencies and consumer branded businesses and advised on the sale of Dr Organic to Holland & Barrett. Mark now chairs the PKF UK & Ireland network of independent accounting firms as well as chairing the board at Delt Shared Services, a back office shared services business jointly owned by Plymouth City Council and Devon ICB. He also hosts a podcast series called Business Noodles and is a governor at Arts University Plymouth. Mark is Chair of the Audit and Risk Committee and a member of the Board's Quality Assurance Committee.
Paul Richards **Non- Executive Director** **Appointed: November 2017**	Paul joined us as a Non-Executive Director in November 2017. Paul's early career was in the NHS level leading on resource management, informatics, health tech and digital. Paul went on to lead international businesses and consult in the technology and digital solutions space with a variety of well-known, international consulting, product and services businesses such as IBM, McKesson, Tata Consulting Services, Allscripts and iSOFT. As a senior Director and Vice President, he has led large teams, with business and people across several continents and extensive experience of a range of national health and care systems world-wide. He has led on the development, implementation, and support of clinical and EPR systems, as well as commercial aspects of the business with P&L responsibility and has led on a wide range of merger, acquisition, and divestment work. Paul continues to have a wide range of business and health and care interests. Paul is our Senior Independent Director and is Chair of the Board's Finance and Performance Committee, and a member of the Building a Brighter Future and Audit and Risk Committees. Paul is also chair of the One Devon EPR Board, a joint programme across the Royal Devon University Healthcare Trust, University Hospitals Plymouth Trust, Devon Integrated Care Board and Torbay and South Devon Trust.
Robin Sutton **Non-Executive Director** **Appointed: May 2016** **Term of office ended April 2025**	Robin joined us as a Non-Executive Director in May 2016. Robin is a chartered accountant with more than 30 years' of financial experience gained at a senior level for both private and public enterprises in both executive and non-executive director roles, including at several multi-national organisations including Sifam, JDS Uniphase, CompAir Holman, Rolls-Royce PLC and Deloittes. Robin's interest in healthcare stems from a variety of different factors, ranging from consulting for Lowell General Hospital in Massachusetts to working with Novartis in developing ultrafast fibre laser technology for eye surgery. He has also been heavily involved with care services and social care covering a spectrum of services from meals on wheels, day care, supported living and residential care. Robin has local business interests in the care home industry and is the chair of Devon Care Homes Collaborative. Robin has also enjoyed completing an innovating in healthcare program with Harvard University with a team of like-minded people looking at smart phone applications in the field of dementia. Robin was chair of Torbay Pharmaceuticals and is a director of our subsidiary SDH Developments Limited.

Chris Saxby **Non-Executive Director** **Appointed: October 2024**	Chris joined us as a Non-Executive Director in October 2024. He has a wealth of engineering, leadership, governance, and executive experience. Chris is a chartered marine engineer and served in the Royal Navy from teenage apprentice to Captain with numerous appointments at sea and ashore across a 34-year career. Senior appointments focused on the delivery of projects in both research and development, and engineering support. He has held governance roles as Chairman of the Devon and Cornwall Joint Branch, Vice President of Council, and Vice Chairman of the Technical Leadership Board all within the Institute of Marine Engineering, Science and Technology (IMarEST) and he is a former Chairman of Devonport Services RFC. He joined Babcock in a strategy role before heading to New Zealand as the senior executive responsible for the company's marine and land operations there. Within NZ, he was the Vice Chairman of the NZ Defence Industry Association. On returning to the UK, he took the lead at CSW Group, a not-for-profit organisation focused on supporting less-advantaged young people across the south west region, especially those with special educational needs or disabilities, or with mental health issues. Maintaining his focus on and commitment to young people, he is a Governor at City College Plymouth. Chris is a graduate of Common Purpose, a Fellow of the IMarEST, a Fellow of the Royal Society for Arts, Manufactures and Commerce and a Member of the Institute of Directors, where he holds a Certificate in Company Direction. Now, a more passionate armchair sportsman; he attempts to maintain his fitness through the more sedate pastimes of cycling and walking his Old English Sheepdog, having outgrown his youthful obsessions for rugby and rowing. Chris is a member of the Building a Brighter Future, Finance and Performance and People Committees.
Siân Walker-McAllister **Non-Executive Director** **Appointed: September 2022**	Siân joined us as a Non-Executive Director in September 2022. Siân is an independent social care consultant, a registered social worker, and an associate of the Association of Directors of Adult Social Services. A former local authority director of health and social care, Siân has more than 40 years' experience of working in social care in London, Wales and across the south west. As a former housing association director Siân was responsible for the delivery of a wide range of commissioned social care services as well as supported housing in London and the south east, as well as in Devon. Alongside her role as a Non-Executive Director with us, Siân chairs two Safeguarding Boards in the south west and is an Executive Member and former co-chair of the National Safeguarding Adult Board Chairs' Network. Siân concluded two terms of office as a Commissioner for the Jersey Care Commission in 2023, with responsibility for regulating and inspecting health and social care. Siân has a wealth of experience of Non-Executive Director roles across a local authority, the NHS, housing associations, and the voluntary sector. Siân is driven by a passion for excellence, ensuring all services to vulnerable people are person-centred, easy to access and importantly promote independence, while ensuring people are safe. Siân is Chair of the Board's People Committee and a member of Charity and Quality Assurance Committees.

Robert Williams **Non-Executive Director** **Appointed: November 2023 as Associate, Substantive Non-Executive Director from June 2024**	Robert joined us as an associate Non-Executive Director in November 2023 and became a substantive non-executive Director in June 2024. Robert has spent most of his career in management consulting and advisory services to private and public sector organisations across the globe, specialising in business transformation and organisation change. His consulting experience fuelling his interest in healthcare and life sciences includes exposure to the UK NHS, US, Middle East and Australian healthcare systems. He continues to work with companies developing innovative, digitally-enabled capabilities that are transforming the way strategic change and transformation are delivered. A graduate in Occupational Psychology, Robert's early career was in HR management in the technology sector. Robert is Vice Chair of the Board of Trustee for Step One Charity supporting people across Devon facing challenges with their mental health, learning disabilities and neurodiversity. Robert is most proud of his work as former Chair of Governors for a large school for children with complex learning needs in Berkshire, during which time he led the funding, development and opening of a new, state-of-the-art school complex. He and his family support his son, a young adult with special needs. Robert is Chair of the Board's Building a Brighter Future Committee and a member of the Audit and Risk Committee, and the Charity Committee.
Mark Brice **Chief Finance Officer** **Appointed: June 2023 to interim post, took up substantive role from September 2024**	Mark joined us as our interim Chief Finance Officer in July 2023 and was appointed to the substantive position in September 2024. Mark is an incredibly experienced finance professional and has worked for the NHS at both a deputy and chief finance officer level and has a wealth of knowledge and expertise at both a regional and national level which is helping us take control of our finances. He has previously worked for the NHS in Devon and with several acute trusts in and around London including Hillingdon Hospitals NHS Foundation Trust, working with them on its NHS oversight framework (NOF 4) and again at University Hospitals Leicester NHS Trust (NOF 4).
Anne Cholmondeley **Interim Chief People Officer** **Appointed: January 2025**	Anne joined us as our interim Chief People Officer in January 2025. Anne is an experienced human resources and organisational development director with expertise in change management, improving performance and collaboration across organisations on shared programmes. Anne has worked in the NHS for more than twenty years, most recently at Dudley Integrated Health and Care NHS Trust.
Adel Jones **Deputy Chief Executive and Chief Operating Officer (from February 2025)** **Appointed: July 2019**	Adel is our Deputy CEO and Chief Operating Officer having joined the Trust in July 2019 as our Chief Strategy and Transformation Officer where she played a pivotal role in securing significant investment in infrastructure improvements and delivered major IT programmes. Adel has significant experience of large-scale transformational change across health and social care, operational leadership, quality improvement, digital transformation and workforce redesign. Adel was appointed as Deputy Chief Executive in 2023 and has recently taken up the position of Chief Operating Officer, with accountability for the safe and effective operational delivery of all health and community services, estates and facilities management, emergency planning and preparedness, performance management and information and quality improvement.
Dr Catherine (Kate) Lissett **Chief Medical Officer** **Appointed: January 2024**	Kate was appointed as our Chief Medical Officer in January 2024 and is responsible for the provision of high-quality, safe and effective care and providing medical input into shaping strategy as well as the Responsible Officer for the organisation. Kate joined us in 2006 as a Consultant in Diabetes and Endocrinology, having previously been Registrar in the Manchester region, working at a number of hospitals in Greater Manchester. During this time she also completed a qualification in Medical Education from Cardiff University. Prior to this, Kate completed a research Doctorate at the Christie Hospital in Manchester, and worked in Nottingham and Sheffield, having qualified in Medicine from Sheffield in 1993. Kate's leadership is motivated by a passion for equity and compassionate care and driven by this she has held a range of appointments in educational and leadership roles throughout her career.

Emily Long **Director of Corporate Governance and Trust Secretary** **Appointed: November 2021**	Emily joined us as Director of Corporate Governance and Trust Secretary in November 2021. Emily is a qualified Chartered Company Secretary and CILEX Lawyer (fellow of the Chartered Institute of Legal Executives), specialising in corporate law, corporate governance, sector regulation, organisational structure, stakeholder engagement and risk management. As an experienced dual qualified corporate services professional, Emily brings a wealth of experience having worked in this capacity since 2010 in a number of different sectors: including professional services, aerospace and defence, housing, marine and events. Most recently working for Leonardo, a large international aerospace and defence and supporting the review of their corporate governance, implementing a revised Board and Committee framework, supported by a new delegations protocol and adoption of a new Code of Governance, the Wates Principles.
Nicola McMinn **Chief Nurse** **Appointed: January 2024 to interim post. Took up substantive position from September 2024.**	Nicola was appointed as our interim Chief Nursing Officer in January 2024 and to the substantive position in September 2024. Nicola joined us in June 2021 as our Head of Nursing Workforce and was appointed to the Deputy Chief Nurse role in January 2022. Nicola is a Registered Nurse and Midwife and before joining us worked at the Royal Devon and Exeter Hospital as the Assistant Director of Nursing for Medicine and prior to that at the University Hospital Plymouth as the Head of Midwifery. As the Chief Nursing Officer, Nicola is responsible for providing professional leadership to all nursing, midwifery, and allied health professionals across the organisation. She also leads on the social care agenda in partnership with the Director of Adult Social Care. Nicola is the executive lead for ensuring CQC compliance and is responsible for the safety and quality of patient care ensuring patient experience is held at the forefront of care delivery. Nicola is committed to ensuring we deliver our vision of safe, patient centred care. She has ensured that people's experiences of care inform our work to improve services and provides compassionate clinical leadership in everything she does.

Appendix B – Further information and contact details

To see our annual reports and accounts
You can look on our website www.torbayandsouthdevon.nhs.uk or request a copy by writing to the Foundation Trust Office, Hengrave House, Torbay Hospital, Torquay, TQ2 7AA. Large print or other formats are available on request. To obtain additional information available under the Freedom of Information Act, refer to our public website at www.torbayandsouthdevon.nhs.uk For information not available on our public website, contact the Freedom of Information Office at Torbay Hospital on 01803 654868 or email dataprotection.tsdft@nhs.net
To hear more
The public are invited to attend our Public Board meetings in person or attend virtually. For further information on our meeting schedule or a virtual meeting invite please contact the Foundation Trust office on 01803 655705 or email tsdft.foundationtrust@nhs.net
To tell us what you think
About this annual report or our forward plans, contact the Communications Office on 01803 655744 or email tsdft.communicationsteam@nhs.net
To help us to improve
There are opportunities offered through our membership, patient involvement, our Torbay and South Devon NHS Charity or through our volunteers. Contact: Foundation Trust Office on 01803 655705 or email tsdft.foundationtrust@nhs.net Torbay and South Devon NHS Charity (Registered Charity No. 1052232) on 07557 481459 or tsdft.charity@nhs.net Visit our website at: https://charity.torbayandsouthdevon.nhs.uk/ The NHS across Torbay and South Devon benefits enormously from the work of hundreds of volunteers, giving practical support or fundraising. If you are interested in joining our volunteers, we would welcome your enquiry. Sincere thanks to the hundreds of volunteers who support Torbay Hospital and our community and adult social care services. Contact: Voluntary Services Coordinator on tsdft.voluntarysector@nhs.net To complain, seek advice or information about aspects of your care our Patient Advice and Liaison Service (PALS) / Feedback and Engagement Team may be able to assist. Contact: Telephone 01803 655838 | Free phone 0800 028 2037 | Email tsdft.feedback@nhs.net
To access your health records
An application form can be obtained for records held by Torbay and South Devon NHS Foundation Trust. You may be charged a fee. Contact: Data Protection Office on 01803 654868 or email dataprotection.tsdft@nhs.net
To find out about joining our team
Contact: Recruitment on 01803 654120 or email tsdft.workwithus@nhs.net For work experience placements: Contact: email tsdft.workwithus@nhs.net
For general (non-urgent) health queries
Contact NHS advice by telephone on 111

Torbay and South Devon NHS Foundation Trust

Annual accounts for the year ended 31 March 2025

Foreword to the accounts

Torbay and South Devon NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by Torbay and South Devon NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Joe Teape**
Job title **Chief Executive Officer**
Date **25 June 2025**

Consolidated Statement of Comprehensive Income

		Group	
		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	3	686,169	637,407
Other operating income	4	43,116	58,704
Operating expenses	7,9	(771,881)	(750,940)
Operating deficit from continuing operations		**(42,596)**	**(54,829)**
Finance income	11	2,633	2,383
Finance expenses	12	(3,448)	(5,720)
PDC dividends payable		(5,053)	(5,513)
Net finance costs		**(5,868)**	**(8,850)**
Other losses	13	(243)	(665)
Corporation tax expense		(17)	(104)
Deficit for the year		**(48,724)**	**(64,448)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(5,238)	(3,219)
Revaluations	19	5,204	4,542
Total comprehensive expense for the period		**(48,758)**	**(63,125)**
Deficit for the period attributable to:			
Torbay and South Devon NHS Foundation Trust		(48,724)	(64,448)
TOTAL		**(48,724)**	**(64,448)**
Total comprehensive expense for the period attributable to:			
Torbay and South Devon NHS Foundation Trust		(48,758)	(63,125)
TOTAL		**(48,758)**	**(63,125)**

Statements of Financial Position

		Group		Trust	
		31 March 2025	31 March 2024	31 March 2025	31 March 2024
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	15	23,862	13,856	23,862	13,856
Property, plant and equipment	16	228,294	236,111	228,227	236,023
Right of use assets	20	12,679	15,742	12,679	15,742
Receivables	23	4,179	4,237	4,444	4,539
Total non-current assets		**269,014**	**269,946**	**269,212**	**270,160**
Current assets					
Inventories	22	6,966	6,985	6,072	6,299
Receivables	23	33,657	35,469	33,488	35,343
Non-current assets held for sale	25	1,895	1,865	1,895	1,865
Cash and cash equivalents	26	26,701	41,269	26,578	40,711
Total current assets		**69,219**	**85,588**	**68,033**	**84,218**
Current liabilities					
Trade and other payables	27	(77,395)	(75,194)	(77,398)	(74,965)
Borrowings	29	(6,083)	(6,754)	(6,083)	(6,754)
Provisions	30	(497)	(445)	(497)	(445)
Other liabilities	28	(11,100)	(7,077)	(11,100)	(7,077)
Total current liabilities		**(95,075)**	**(89,470)**	**(95,078)**	**(89,241)**
Total assets less current liabilities		**243,158**	**266,064**	**242,167**	**265,137**
Non-current liabilities					
Borrowings	29	(50,007)	(54,946)	(50,007)	(54,946)
Provisions	30	(4,119)	(3,679)	(4,119)	(3,679)
Total non-current liabilities		**(54,126)**	**(58,625)**	**(54,126)**	**(58,625)**
Total assets employed		**189,032**	**207,439**	**188,041**	**206,512**
Financed by					
Public dividend capital		278,340	247,989	278,340	247,989
Revaluation reserve		60,740	61,334	60,740	61,334
Income and expenditure reserve		(150,048)	(101,884)	(151,039)	(102,811)
Total taxpayers' equity		**189,032**	**207,439**	**188,041**	**206,512**

The notes on pages 147 to 208 form part of these accounts.

Name **Joe Teape**
Position **Chief Executive Officer**
Date **25 June 2025**

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**247,989**	**61,334**	**(101,884)**	**207,439**
Deficit for the year	-	-	(48,724)	**(48,724)**
Impairments	-	(5,238)	-	**(5,238)**
Revaluations	-	5,204	-	**5,204**
Transfer to retained earnings on disposal of assets	-	(560)	560	**-**
Public dividend capital received	30,351	-	-	**30,351**
Taxpayers' and others' equity at 31 March 2025	**278,340**	**60,740**	**(150,048)**	**189,032**

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**195,614**	**62,093**	**(31,812)**	**225,895**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(7,706)	**(7,706)**
Deficit for the year	-	-	(64,448)	**(64,448)**
Impairments	-	(3,219)	-	**(3,219)**
Revaluations	-	4,542	-	**4,542**
Transfer to retained earnings on disposal of assets	-	(2,082)	2,082	**-**
Public dividend capital received	52,375	-	-	**52,375**
Taxpayers' and others' equity at 31 March 2024	**247,989**	**61,334**	**(101,884)**	**207,439**

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**247,989**	**61,334**	**(102,811)**	**206,512**
Deficit for the year	-	-	(48,788)	**(48,788)**
Impairments	-	(5,238)	-	**(5,238)**
Revaluations	-	5,204	-	**5,204**
Transfer to retained earnings on disposal of assets	-	(560)	560	**-**
Public dividend capital received	30,351	-	-	**30,351**
Taxpayers' and others' equity at 31 March 2025	**278,340**	**60,740**	**(151,039)**	**188,041**

Statement of Changes in Equity for the year ended 31 March 2024

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**195,614**	**62,093**	**(32,705)**	**225,002**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(7,706)	**(7,706)**
Deficit for the year	-	-	(64,482)	**(64,482)**
Impairments	-	(3,219)	-	**(3,219)**
Revaluations - property, plant and equipment	-	4,542	-	**4,542**
Transfer to retained earnings on disposal of assets	-	(2,082)	2,082	**-**
Public dividend capital received	52,375	-	-	**52,375**
Taxpayers' and others' equity at 31 March 2024	**247,989**	**61,334**	**(102,811)**	**206,512**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statements of Cash Flows

	Note	Group 2024/25 £000	Group 2023/24 £000	Trust 2024/25 £000	Trust 2023/24 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(42,596)	(54,829)	(42,656)	(54,890)
Non-cash income and expense:					
Depreciation and amortisation	7.1	21,955	20,363	21,934	20,342
Net impairments	8	14,094	35,665	14,094	35,665
Income recognised in respect of capital donations	4	(486)	(484)	(486)	(484)
(Increase) / decrease in receivables and other assets		2,022	4,842	2,379	4,857
(Increase) / decrease in inventories		19	6,474	227	6,473
Increase / (decrease) in payables and other liabilities		13,041	(6,478)	12,966	(6,957)
Increase / (decrease) in provisions		420	(1,057)	420	(1,057)
Tax (paid) / received		(7)	(119)	(17)	(97)
Net cash flows from / (used in) operating activities		**8,462**	**4,377**	**8,861**	**3,852**
Cash flows from investing activities					
Interest received		2,573	2,383	2,573	2,403
Purchase of intangible assets		(15,541)	(6,180)	(15,541)	(6,180)
Sales of intangible assets		-	2,628	-	2,628
Purchase of Plant, Property and Equipment		(26,964)	(43,131)	(26,964)	(43,131)
Sales of Plant, Property and Equipment		4	14,830	4	14,830
Receipt of cash donations to purchase assets		486	484	486	484
Prepayment of PFI capital contributions		-	-	-	-
Finance lease receipts (principal and interest)		160	97	160	97
Net cash flows from / (used in) investing activities		**(39,282)**	**(28,889)**	**(39,282)**	**(28,869)**
Cash flows from financing activities					
Public dividend capital received		30,351	52,375	30,351	52,375
Movement on loans from DHSC		(2,506)	(6,822)	(2,506)	(6,822)
Other capital receipts (*)		-	-	36	36
Capital element of lease liability repayments		(4,279)	(3,498)	(4,279)	(3,498)
Capital element of PFI, LIFT and other service concession payments		(452)	(1,789)	(452)	(1,789)
Interest on loans		(433)	(576)	(433)	(576)
Interest paid on lease liability repayments		(422)	(486)	(422)	(486)
Interest paid on PFI, LIFT and other service concession obligations		(1,441)	(1,491)	(1,441)	(1,491)
PDC dividend (paid) / refunded		(4,566)	(6,666)	(4,566)	(6,666)
Cash flows from (used in) other financing activities		-	-	-	
Net cash flows from / (used in) financing activities		**16,252**	**31,047**	**16,288**	**31,083**
Increase / (decrease) in cash and cash equivalents		**(14,568)**	**6,535**	**(14,133)**	**6,066**
Cash and cash equivalents at 1 April - brought forward		**41,269**	**34,734**	**40,711**	**34,645**
Cash and cash equivalents at 31 March	26	**26,701**	**41,269**	**26,578**	**40,711**

* - Other capital receipts for the Trust totalling £36k (2023/24 - £36k) represent the value of loan principal repayment received from the Trust's wholly owned subsidiary, SDH Developments Ltd

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Critical judgements in applying accounting policies
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision and future periods if the revision affects both current and future periods.

The critical accounting judgements, apart from those involving estimations (see below) and key sources of estimation uncertainty that management has made in the process of applying the trust accounting policies and that have a significant effect on the amounts recognised in the financial statements are detailed below:

Modern equivalent asset valuation of property - key sources of estimation uncertainty

As detailed in accounting policy note 1.11 'Property, plant and equipment - valuation', the Trust has applied a Modern Equivalent Asset approach to valuing its Land, Specialised buildings and Buildings excluding dwellings and Dwellings. The significant estimate being depreciated replacement value, using modern equivalent methodology - both on an alternative site basis and construction methodology. The result of this valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, is disclosed in note 19 to the financial statements. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets. For context, the total sum of the Land, Specialised buildings excluding dwellings and dwellings as at 31st March 2025 totals £189,469k (31st March 2024: £184,327k). A variation of +/- 1% to the valuations provided by the valuer incorporated into the financial statements would result in a movement of +/- £1,895k (31st March 2024: £1,843k).

Impairments and the estimated lives of assets - key sources of estimation uncertainty

As detailed in accounting policy notes 1.11 and 1.12, 'Property, Plant and Equipment - Measurement' and 'Intangibles - Measurement', the Trust is required to review property, plant and equipment and intangibles for impairments and the accuracy of estimated useful lives. In between formal valuations by qualified surveyors (property, plant and equipment - buildings and buildings excluding dwellings), management make judgements about the condition of assets and review their estimated lives. The Trust had previously been notified that would benefit from the Government's 'New Hospital Programme'. In January 2025 the Trust was notified that the new hospital will be significantly delayed, with the main construction timetable starting between 2033 and 2035. As a result of this the total spend incurred to date has been impaired as at 31st March 2025. This is set out in more detail in note 8.

Accounting for the disposal of Torbay Pharmaceuticals

In the prior year the Trust disposed of a commercial entity during the course of the year, namely a Pharmacy Manufacturing business. As a means of disposing of the commercial entity - Torbay Pharmaceuticals Ltd, a wholly owned limited company was specifically formed. Relevant net assets / liabilities were transferred to Torbay Pharmaceuticals Ltd from the Trust across the period 1st September 2023 through to 15th November 2023. Torbay Pharmaceuticals Ltd was wholly disposed of to a third party investor on 16th November 2023. A financial surplus of £444k was generated by Torbay Pharmaceuticals Ltd during the period 1st September 2023 through to the point of sale and the Trust also generated a small surplus on disposal of £130k. On the basis that Torbay Pharmaceutical Ltd was solely formed to achieve the sale, and the sale was realised in the prior year, the revenue income streams of Torbay Pharmaceutical Ltd, the income of assets held for sale, and the small surplus on sale, form part of the reported Group and Trust's retained Income and Expenditure reserve as at 31st March 2024.

Note 1.4 Consolidation

The Group financial statements consolidate the financial statements of the Trust and its subsidiary undertakings made up to 31 March 2025.

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. In accordance with the NHS Group Accounting Manual a separate income statement for the parent (the Trust) has not been prepared.

The amounts consolidated have been drawn from prepared but unaudited management accounting statements.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Trust is the Corporate Trustee of Torbay South Devon NHS Charitable Fund (Registered Charity 1052232). Under International Accounting Standards the Charitable Fund is considered to be a subsidiary of the Trust. The financial results of the Charity have not been consolidated into the Trust's Financial Statements. The reason for not consolidating is that it is not thought to be helpful to reader of the Trust accounts and the Trust has elected not to consolidate on the grounds of immateriality.

Note 1.5 Segmental Reporting

During 2024/25 and 2023/24 the Trust reported its financial results to the Trust's chief decision maker in line with 'Note 2 to the Financial Statements'.

Note 1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

A significant proportion of the Trusts Operating income is paid to the Trust as fixed block payments on a monthly basis. Invoices for variable income including means tested Adult Social Care contributions are raised after the performance obligations have been satisfied. Standard payment terms are 30 days after the date the invoice is raised.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Revenue from Education and training (excluding notional apprenticeship levy income)

The Trust receives income through contracts with Commissioners to deliver Education and Training services to its staff. The Trust recognises the income when performance obligations are satisfied. The income is recognised in line contract values.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.7 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.8 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
Past and present employees are covered by the provisions of the NHS Pension Schemes, details of which are set out in Note 10.

Note 1.9 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.10 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.11 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:
• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Valuations of the Land and non specialised buildings and specialised buildings are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The latest full revaluation of the Trust's specialised building was undertaken in 2023/24 with a prospective valuation date of 31 March 2024. Full physical valuations take place every 5 years.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition
In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement
Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Land (indefinite)	-	-
Buildings, excluding dwellings	6	70
Dwellings	36	48
Plant & machinery	2	25
Transport equipment	3	7
Information technology	2	15
Furniture & fittings	2	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.12 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner for operational use. They are subsequently valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use. An assessment is undertaken each year for any signs of Impairment that requires to be reflected in the asset's carrying value.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	3	13
Licences & trademarks	2	10

Note 1.13 Inventories

Inventories are valued at the lower of cost and net realisable value. The Trust has a number of separate stock control systems and consequently cost of inventories is measured by either using on a first in, first out (FIFO) method or the weighted average cost method.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Work in progress comprises goods in intermediate stages of production.

Note 1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.15 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust undertakes a regular review of its aged debt analysis to ensure that invoices are settled in a prompt manner and to ensure that any debts that show signs of being disputed are escalated appropriately. If as a consequence of an investigation the likelihood of debt recovery is remote, a provision for a potential credit loss is made. A provision for a credit loss for is applied to NHS Recovery Unit debts as advised by NHS England. The Trust also applies a provision for expected credit losses against its Adult Social Care debtors.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.16 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.
The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.
Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 1.7%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 30.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.18 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in Note 31 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 31, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.20 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.21 Corporation tax

The Trust is a Health Service Body within the meaning of s986 Corporation Taxes Act 2010. Accordingly it is not liable to corporation tax. The Trust is also exempt from tax on chargeable gains under S271(3) of Chargeable Gains Act 1992.

There is however a power of HM Treasury to submit an order to Parliament, which will dis-apply the corporation tax emption in relation to particular activities of a NHS Foundation Trust (s987 Corporation Taxes Act 2010). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities to be specified in the order which are not related to, the provision of healthcare, and where the profits there from exceed £50,000 per annum. Until the order is approved by Parliament, the trust has no corporation tax liability.

The Trust's subsidiaries company profits and losses are subject to Corporation tax, the costs and liability for which are disclosed in the Trust's consolidated financial statements.

Note 1.22 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.23 Foreign exchange

The functional and presentational currency of the trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Note 1.24 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts.

Note 1.25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.26 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.27 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:
•Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
•Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.
These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:
•A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
•Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.
The impact of applying these changes in future periods has not yet been assessed.

Note 2 Operating Segments

The Trust's Chief Operating Decision maker is the Board of Directors.

The Board of Directors functions as a corporate decision-making body. Executive Director and Non-executive Director are full and equal members. Their role as members of the Board of Directors is to consider the key strategic and governance issues facing the Trust in carrying out its statutory and other functions

In line with IFRS 8 'Operating Segments', the Trust uses three key factors in its identification of its reportable operating segments. The factors are that the reportable operating segment: -

* engages in activities from which it earns revenues and incurs expenses

* reports financial results which are regularly reviewed by the Trust's board of directors to make decisions about allocation of resources to the segment and assess its performance

* has discrete financial information.

In 2023/24 the Trust Board received monthly financial data relating to the Trust's activities as a whole with a separate analysis of the commercial element of the Trust's activities, namely Torbay Pharmaceuticals. The Trust's Statement of Financial Position data was presented as a whole with no separate analysis being provided for Torbay Pharmaceuticals. The data presented below is consistent with these principles.

Statement of Comprehensive Income for the year ended 31 March 2025

			Group	
	Total	Other Trust activities	Torbay Pharma-ceuticals *	Total
	24/25	23/24	23/24	23/24
	£000	£000	£000	£000
Operating income from patient care activities	686,169	637,190	217	637,407
Other operating income	43,116	44,219	14,485	58,704
Operating expenses **	(771,881)	(736,669)	(14,271)	(750,940)
Operating (deficit) / surplus from continuing operations	**(42,596)**	**(55,260)**	**431**	**(54,829)**
Finance income	2,633	2,375	8	2,383
Finance expenses	(3,448)	(5,666)	(54)	(5,720)
PDC dividends payable	(5,053)	(5,463)	(50)	(5,513)
Net finance costs	**(5,868)**	**(8,754)**	**(96)**	**(8,850)**
Other losses, net	(243)	(665)	0	(665)
Corporation tax expense	(17)	(6)	(98)	(104)
(Deficit) / surplus for the year from continuing operations	**(48,724)**	**(64,685)**	**237**	**(64,448)**
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Impairments	(5,238)	0	0	0
Revaluations	5,204	4,542	0	4,542
Total comprehensive expense for the year	**(48,758)**	**(60,143)**	**237**	**(59,906)**
(Deficit) / surplus for the period attributable to:				
Torbay and South Devon NHS Foundation Trust	(48,724)	(64,685)	237	(64,448)
TOTAL	**(48,724)**	**(64,685)**	**237**	**(64,448)**
Total comprehensive (expense) / income for the year attributable to:				
Torbay and South Devon NHS Foundation Trust	(48,758)	(63,362)	237	(63,125)
TOTAL	**(48,758)**	**(63,362)**	**237**	**(63,125)**

*** Torbay Pharmaceuticals.** Torbay Pharmaceuticals (TP) traded as part of the Trust for the period 1st April 2023 through to 31st August 2023. On 1st September 2023 TP traded through a new wholly owned subsidiary of the Trust, i.e. Torbay Pharmaceuticals Ltd. Torbay Pharmaceuticals Ltd was entirely sold to a third party by the Trust on 16th November 2023. The above financial results for 23/24 represents the trading position of TP during the whole period from 1st April 2023 through to 15th November 2023.

**** Operating Expenses, Impairments and Revaluations** - a proportion of the impairments in 23/24 charged to Operating Expenditure will relate to Torbay Pharmaceuticals. These were not reported separately to the Trust Board and consequently are included in the 'Other Trust activities' analysis above.

Note 3 Operating income from patient care activities - Group

All income from patient care activities relates to contract income recognised in line with accounting policy 1.6

Note 3.1 Income from patient care activities (by nature)	2024/25 £000	2023/24 £000
Acute services		
Income from commissioners under API contracts - variable element*	14,045	9,360
Income from commissioners under API contracts - fixed element*	392,350	375,727
High cost drugs income from commissioners	39,592	35,626
Other NHS clinical income	3,097	3,062
Community services		
Income from commissioners under API contracts*	109,231	111,624
Income from other sources (e.g. local authorities)	101,840	86,181
All services		
Private patient income	172	370
National pay award central funding***	1,049	209
Additional pension contribution central funding**	23,000	14,454
Other clinical income	1,793	794
Total income from activities	**686,169**	**637,407**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source) - Group

Income from patient care activities received from:	2024/25 £000	2023/24 £000
NHS England	84,853	69,277
Integrated care boards	497,918	478,957
Other NHS providers	3,096	3,062
Local authorities	81,081	69,465
Non-NHS: private patients	172	370
Non-NHS: overseas patients (chargeable to patient)	157	265
Injury cost recovery scheme	650	469
Non NHS: other	18,242	15,542
Total income from activities	**686,169**	**637,407**
Of which:		
Related to continuing operations	686,169	637,407
Related to discontinued operations	-	-

* NHS injury scheme income is subject to a provision for doubtful debts of 23.76% to reflect expected rates of collection.

** Non NHS Other Income is comprised mostly of Adult Social Care Client Contributions; Adult Social Care costs being means tested.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider) - Group

	2024/25	2023/24
	£000	£000
Income recognised this year	157	265
Cash payments received in-year	30	124
Amounts written off in-year	30	5

Note 4 Other operating income (Group)

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,905	-	**1,905**	1,940	-	**1,940**
Education and training	18,458	1,440	**19,898**	15,912	1,103	**17,015**
Non-patient care services to other bodies	8,131		**8,131**	9,387		**9,387**
Receipt of capital grants and donations and peppercorn leases		486	**486**		484	**484**
Charitable and other contributions to expenditure		762	**762**		777	**777**
Revenue from operating leases		879	**879**		832	**832**
Other income	11,055	-	**11,055**	28,269	-	**28,269**
Total other operating income	**39,549**	**3,567**	**43,116**	**55,508**	**3,196**	**58,704**
Of which:						
Related to continuing operations			43,116			58,704
Related to discontinued operations			-			-

* Other income in 23/24 (recognised in accordance with IFRS 15) included a part-year value of £14.5m of sales from the Trust's Pharmacy Manufacturing Unit, which was sold in 23/24 (see also note 25). Other income (recognised in accordance with IFRS 15) also includes £1.9m (2023/24 £1.8m) from hosting the Audit South West - Internal Audit Counter Fraud and Consultancy Services.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period - Group

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	7,077	8,015
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations - Group

	31 March 2025	31 March 2024
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	11,100	7,077
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**11,100**	**7,077**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services - Group

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	666,948	621,579
Income from services not designated as commissioner requested services	19,221	15,828
Total	**686,169**	**637,407**

Note 5.4 Profits and losses on disposal of property, plant and equipment - Group

During 2024/25 and 2023/24 the Trust disposed of a number of Property, Plant and Equipment items and Intangible assets, the net loss of which was £243k (2023/24 net loss of £665k).

Note 6 Operating leases - Torbay and South Devon NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Torbay and South Devon NHS Foundation Trust is the lessor.

Note 6.1 Operating leases income (Group)

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	879	832
Variable lease receipts / contingent rents	-	-
Total in-year operating lease income	**879**	**832**

Note 6.2 Future lease receipts (Group)

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	741	706
- later than one year and not later than two years	741	705
- later than two years and not later than three years	741	706
- later than three years and not later than four years	741	706
- later than four years and not later than five years	741	706
- later than five years	-	705
Total	**3,705**	**4,234**

The Trust has a lease agreement with Devon Partnership Trust (DPT) which was extended for a period of 10 years from 1st April 2020, which is set out in note 6.1 above. The lease income received in year and future minimum lease receipts due all relate to lease of buildings.

Note 7.1 Operating expenses (Group)

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	24,858	21,654
Purchase of healthcare from non-NHS and non-DHSC bodies	64,468	64,097
Purchase of social care	110,624	97,192
Staff and executive directors costs	367,979	350,022
Remuneration of non-executive directors	189	188
Supplies and services - clinical (excluding drugs costs)	33,661	34,359
Supplies and services - general	6,911	6,536
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	49,893	45,029
Inventories written down	178	127
Consultancy costs	116	551
Establishment	2,708	3,155
Premises	25,237	26,184
Transport (including patient travel)	3,235	3,880
Depreciation on property, plant and equipment	18,617	17,830
Amortisation on intangible assets	3,338	2,533
Net impairments	14,094	35,665
Movement in credit loss allowance: contract receivables / contract assets	1,358	435
Increase/(decrease) in other provisions	792	(515)
Change in provisions discount rate(s)	14	(212)
Fees payable to the external auditor		
audit services- statutory audit	332	298
other auditor remuneration (external auditor only)	23	26
Internal audit costs	321	335
Clinical negligence	9,070	8,990
Legal fees	533	371
Insurance	33	76
Research and development	2,395	2,082
Education and training	23,295	19,069
Expenditure on short term leases	37	46
Expenditure on low value leases	233	103
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	881	1,298
Grossing up consortium arrangements	1,312	1,274
Other	5,146	8,262
Total	**771,881**	**750,940**
Of which:		
Related to continuing operations	771,881	750,940
Related to discontinued operations	-	-

* **External Audit Fees.** The costs reported above relate to the audit of the Trust and Group reported position. Grant Thornton LLP are responsible for this element of the service. The fee for 2024/25 was £247k (2023/24 £248k) with an additional £31k being charged in 24/25 relating to 23/24 making a total charge within 24/25 of £278k, VAT being irrecoverable.

**** Internal Audit costs.** The costs reported above represent the pay costs of the Internal Audit and Counter Fraud services the Trust has received the benefit of during the financial years. The Trust is part of a Peninsular wide Internal Audit and Counter Fraud consortium, where resources are shared with other and recharged to other NHS organisations. For accounting purposes, Torbay and South Devon NHS Foundation Trust operates as the lead consortium member. The Trust employs a proportion of the Audit and Counter Fraud consortiums staff. The value of charges made to the Trust by other organisations is shown as a 'Grossing up consortium arrangements' cost in operating expenditure and the value of charges made by the Trust as Lead Consortium member is recorded on 'Other income' within Other Operating Income.

Note 7.2 Other auditor remuneration (Group)

	2024/25	2023/24
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit of accounts of any associate of the trust	23	26
Total	**23**	**26**

The costs reported above relates to the audit of one of the Trust's subsidiary company - SDH Developments Ltd. The audit of SDH Developments Ltd is undertaken by Bishop Fleming LLP. The fee charged for the subsidiary's audit was £23k (2023/24, £26k) VAT being recoverable. The Trust's other consolidated subsidiary during the year 2023/24 was Torbay Pharmaceuticals Ltd . Torbay Pharmaceuticals Ltd was formed in June 2023 and was sold to third party investors in November 2023. It is the responsibility of the new owners to arrange the audit of the first set of the financial statements and consequently, no audit fees are included above for Torbay Pharmaceuticals Ltd in 23/24 or 24/25.

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2,000k (2023/24: £2,000k).

Note 8 Impairment of assets (Group)

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	16
Abandonment of assets in course of construction	9,193	1,015
Changes in market price	4,896	34,634
Other	5	-
Total net impairments charged to operating surplus / deficit	**14,094**	**35,665**
Impairments charged to the revaluation reserve	5,238	3,219
Total net impairments	**19,332**	**38,884**

The Trust had previously been notified that would benefit from the Government's 'New Hospital Programme'. In January 2025 the Trust was notified that the new hospital will be significantly delayed, with the main construction timetable starting between 2033 and 2035. As a result of this the total spend incurred to date, totalling £9.2m, has been impaired as at 31st March 2025.

Abandonment of assets in the course of construction (Group)

As set out above, impairment resulting from abandonment of assets in the course of construction totalled £9,192k (2023/14: £1,015k).
The impairment charge in 2023/24 predominantly related to a decision to implement an alternative IM&T system that better aligns with the Trust's new Electronic Patient Record strategy. The implementation cost of the application written off in 23/24 was £754k. A further £237k of design fees associated with a prospective Clinical facility, that again no longer aligns with the Trust's strategy was written off in 23/24. The balance of write off costs during 2023/24 related to four minor schemes that total £24k.

	2024/25	2023/24
	£000	£000
Changes to market price (Group)		
Net impairments (credited) / charged to operating surplus resulting from:		
Year end revaluation of Trust's Land, Buildings and Dwelling assets, ROU assets and assets held for re-sale	4,896	15,508
Changes in the basis of the valuation - relating to the sale of an Asset	-	19,126
	4,896	34,634

Year end revaluation: - The Trust commissioned the District Valuation Office in both 2024/25 and 2023/24 to provide an updated valuation of the Trust's properties as at 31st March 2025 and 31st March 2024 respectively. The valuation exercise in 2023/24 involved a full physical site inspection. The exercise in 2024/25 consisted of partial site inspection, desktop reviews and also application of BCIS and local indexation factors. In line with accounting standards, the assets available for sale were valued at the lower of existing use value or alternative use value; assets surplus to requirements but available for sale were valued at the higher of existing use value or alternative use value; specialised building and dwelling assets in use were valued at depreciated replacement cost and non specialised building assets were valued at open market value. The review decreased the value of PPE Land, Buildings and Buildings excluding Dwellings, ROU assets and assets held for re-sale by a net £4,935k (2023/24 decrease of £14,185k). Of the decrease in value, £34k (2023/24 decrease, £1,323k) has been charged to the Trust's revaluation reserve and a net £4,901k has been charged (2023/24 £15,508k) to Operating Expenditure as an Impairment charge.

Changes in the basis of the valuation - relating to the sale of an asset: During 2023/24 the Trust disposed of a commercial asset, namely a Pharmacy Manufacturing Unit to a third party. As described in the 'Non-current Assets held for sale and assets in disposals group', note 25 of these Financial Statements, the Intangible and Property, Plant and Equipment assets associated with the Manufacturing Unit were classified as being held for sale as at 31st August 2023. Previously these assets were valued in line with IAS 38 (Intangible assets) and IAS16 (Property, Plant and Equipment) respectively as described in the Accounting Policies notes to the Accounts, namely notes 1.11 and 1.12 respectively. In line with IFRS5, the Trust continually assessed the open market value of the asset less estimated cost of sale. This exercise resulted in a net impairment charge of £19,048k in 2023/24. A further £78k impairment charge in 2023/24 was also processed against Right of Use Assets, note 20.1 to these financial statements. The sum of the net book value of Right of Use assets transferred to the purchaser of the manufacturing facility totalled £59k in 2023/24

Note 9 Employee benefits (Group)

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	296,408	279,382
Social security costs	28,204	27,154
Apprenticeship levy	1,433	1,377
Employer's contributions to NHS pensions	57,487	46,560
Pension cost - other	94	120
Temporary staff (including agency)	9,144	16,521
Total gross staff costs	**392,770**	**371,114**
Recoveries in respect of seconded staff	-	-
Total staff costs	**392,770**	**371,114**
Of which		
Costs capitalised as part of assets	3,820	3,708

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administrative charge) from 1 April 2019. From 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts

Note 9.1 Retirements due to ill-health (Group)

During 2024/25 there were 9 early retirements from the trust agreed on the grounds of ill-health (15 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £933k (£711k in 2023/24).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2024/25	2023/24
	£000	£000
Interest on bank accounts	2,574	2,383
Interest income on finance leases	59	-
Total finance income	**2,633**	**2,383**

Note 12.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	417	555
Interest on lease obligations	422	487
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	1,441	1,490
Remeasurement of the liability resulting from change in index or rate	1,096	3,090
Total interest expense	**3,376**	**5,622**
Unwinding of discount on provisions	72	98
Total finance costs	**3,448**	**5,720**

Note 13 Other gains / (losses) (Group)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	4	290
Losses on disposal of assets	(247)	(955)
Gains / losses on disposal of charitable fund assets	-	-
Total gains / (losses) on disposal of assets	**(243)**	**(665)**

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was £48.8 million (2023/24: £64.9 million). The trust's total comprehensive income/(expense) for the period was £48.8 million (2023/24: £63.6 million).

In 23/24, the Group reported net deficit included surpluses generated by Torbay Pharmaceuticals Ltd totalling £444k. Torbay Pharmaceuticals Ltd was a wholly owned company of the Trust between 23rd June 2023 and 15th November 2023. It commenced trading on 1st September 2023. During the period the period 1st September 2023 through to 15th November 2023, trading surpluses totalled £444k. Torbay Pharmaceutical Ltd was sold in full to a third party on 16th November 2023.
In 24/25 the Group reported net deficit included surpluses generated by SDH Developments Ltd totalling £65k (2023/24 £34k). SDH Developments Ltd was a wholly owned Subsidiary of the Trust throughout the financial years 2023/24 and 2024/25.

Note 15.1 Intangible assets - 2024/25

Group and Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**19,755**	**-**	**8,538**	**28,293**
Additions	2,251	-	11,935	**14,186**
Impairments	-	-	(776)	**(776)**
Reclassifications	3,799	-	(3,841)	**(42)**
Disposals / derecognition	(2,192)	-	-	**(2,192)**
Valuation / gross cost at 31 March 2025	**23,613**	**-**	**15,856**	**39,469**
Amortisation at 1 April 2024 - brought forward	**14,437**	**-**	**-**	**14,437**
Provided during the year	3,332	-	-	**3,332**
Disposals / derecognition	(2,162)	-	-	**(2,162)**
Amortisation at 31 March 2025	**15,607**	**-**	**-**	**15,607**
Net book value at 31 March 2025	**8,006**	**-**	**15,856**	**23,862**
Net book value at 1 April 2024	**5,318**	**-**	**8,538**	**13,856**

Note 15.2 Intangible assets - 2023/24

Group and Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	**17,642**	**2,086**	**9,699**	**29,427**
Additions	1,628	1	4,756	**6,385**
Impairments	(772)	-	-	**(772)**
Reclassifications	2,392	483	(2,875)	**-**
Transfers to / from assets held for sale	(1,046)	(2,570)	(3,042)	**(6,658)**
Disposals / derecognition	(89)	-	-	**(89)**
Valuation / gross cost at 31 March 2024	**19,755**	**-**	**8,538**	**28,293**
Amortisation at 1 April 2023	**12,735**	**88**	**-**	**12,823**
Provided during the year	2,288	239	-	**2,527**
Transfers to / from assets held for sale	(497)	(327)	-	**(824)**
Disposals / derecognition	(89)	-	-	**(89)**
Amortisation at 31 March 2024	**14,437**	**-**	**-**	**14,437**
Net book value at 31 March 2024	**5,318**	**-**	**8,538**	**13,856**
Net book value at 1 April 2023	**4,907**	**1,998**	**9,699**	**16,604**

Note 16.1 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**7,517**	**173,821**	**4,433**	**25,184**	**48,348**	**870**	**12,683**	**978**	**273,834**
Additions	-	6,841	-	11,595	2,116	-	188	12	**20,752**
Impairments	(244)	(10,947)	-	(8,422)	-	-	-	-	**(19,613)**
Reversals of impairments	-	1,516	-	-	-	-	-	-	**1,516**
Revaluations	2	(2,311)	(84)	-	-	-	-	-	**(2,393)**
Reclassifications	160	8,458	3	(12,820)	958	-	3,245	38	**42**
Transfers to / from assets held for sale	(15)	(470)	-	-	-	-	-	-	**(485)**
Disposals / derecognition	-	(18)	-	(91)	(6,251)	(56)	(1,907)	(193)	**(8,516)**
Valuation/gross cost at 31 March 2025	**7,420**	**176,890**	**4,352**	**15,446**	**45,171**	**814**	**14,209**	**835**	**265,137**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**160**	**-**	**-**	**29,860**	**550**	**6,902**	**251**	**37,723**
Provided during the year	-	7,389	253	-	4,737	47	2,411	252	**15,089**
Revaluations	-	(7,344)	(253)	-	-	-	-	-	**(7,597)**
Transfers to / from assets held for sale	-	(16)	-	-	-	-	-	-	**(16)**
Disposals / derecognition	-	(18)	-	-	(6,224)	(56)	(1,865)	(193)	**(8,356)**
Accumulated depreciation at 31 March 2025	**-**	**171**	**-**	**-**	**28,373**	**541**	**7,448**	**310**	**36,843**
Net book value at 31 March 2025	**7,420**	**176,719**	**4,352**	**15,446**	**16,798**	**273**	**6,761**	**525**	**228,294**
Net book value at 1 April 2024	**7,517**	**173,661**	**4,433**	**25,184**	**18,488**	**320**	**5,781**	**727**	**236,111**

Note 16.2 Property, plant and equipment - 2023/24

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	**8,075**	**179,203**	**4,467**	**38,919**	**54,054**	**772**	**16,808**	**824**	**303,122**
Additions	-	20,196	24	16,497	3,653	185	717	243	**41,515**
Impairments	(33)	(19,284)	-	(260)	-	-	-	-	**(19,577)**
Reversals of impairments	25	729	-	-	-	-	-	-	**754**
Revaluations	-	(2,522)	(137)	-	-	-	-	-	**(2,659)**
Reclassifications	-	10,777	79	(18,273)	3,792	36	3,552	37	**-**
Transfers to / from assets held for sale	(550)	(14,693)	-	(11,699)	(10,519)	-	(429)	(80)	**(37,970)**
Disposals / derecognition	-	(585)	-	-	(2,632)	(123)	(7,965)	(46)	**(11,351)**
Valuation/gross cost at 31 March 2024	**7,517**	**173,821**	**4,433**	**25,184**	**48,348**	**870**	**12,683**	**978**	**273,834**
Accumulated depreciation at 1 April 2023	**-**	**103**	**-**	**-**	**34,879**	**585**	**13,096**	**224**	**48,887**
Provided during the year	-	7,229	248	-	4,817	30	1,837	97	**14,258**
Revaluations	-	(6,953)	(248)	-	-	-	-	-	**(7,201)**
Transfers to / from assets held for sale	-	(215)	-	-	(7,263)	-	(243)	(24)	**(7,745)**
Disposals / derecognition	-	(4)	-	-	(2,573)	(65)	(7,788)	(46)	**(10,476)**
Accumulated depreciation at 31 March 2024	**-**	**160**	**-**	**-**	**29,860**	**550**	**6,902**	**251**	**37,723**
Net book value at 31 March 2024	**7,517**	**173,661**	**4,433**	**25,184**	**18,488**	**320**	**5,781**	**727**	**236,111**
Net book value at 1 April 2023	**8,075**	**179,100**	**4,467**	**38,919**	**19,175**	**187**	**3,712**	**600**	**254,235**

Note 16.3 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,420	150,193	4,352	15,446	14,806	267	6,688	496	**199,668**
On-SoFP PFI contracts and other service concession arrangements	-	20,379	-	-	-	-	-	-	**20,379**
Owned - donated/granted	-	6,147	-	-	1,992	6	73	29	**8,247**
NBV total at 31 March 2025	**7,420**	**176,719**	**4,352**	**15,446**	**16,798**	**273**	**6,761**	**525**	**228,294**

Note 16.4 Property, plant and equipment financing - 31 March 2024

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,517	146,891	4,433	25,184	16,298	313	5,682	727	**207,045**
On-SoFP PFI contracts and other service concession arrangements	-	20,486	-	-	-	-	-	-	**20,486**
Owned - donated/granted	-	6,284	-	-	2,190	7	99	-	**8,580**
NBV total at 31 March 2024	**7,517**	**173,661**	**4,433**	**25,184**	**18,488**	**320**	**5,781**	**727**	**236,111**

Note 17.1 Property, plant and equipment - 2024/25

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**7,517**	**173,821**	**4,433**	**25,184**	**48,140**	**870**	**12,683**	**978**	**273,626**
Transfers by absorption									**-**
Additions	-	6,841	-	11,595	2,116	-	188	12	**20,752**
Impairments	(244)	(10,947)	-	(8,422)	-	-	-	-	**(19,613)**
Reversals of impairments	-	1,516	-	-	-	-	-	-	**1,516**
Revaluations	2	(2,311)	(84)	-	-	-	-	-	**(2,393)**
Reclassifications	160	8,458	3	(12,820)	958	-	3,245	38	**42**
Transfers to / from assets held for sale	(15)	(470)	-	-	-	-	-	-	**(485)**
Disposals / derecognition	-	(18)	-	(91)	(6,251)	(56)	(1,907)	(193)	**(8,516)**
Valuation/gross cost at 31 March 2025	**7,420**	**176,890**	**4,352**	**15,446**	**44,963**	**814**	**14,209**	**835**	**264,929**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**160**	**-**	**-**	**29,740**	**550**	**6,902**	**251**	**37,603**
Provided during the year	-	7,389	253	-	4,716	47	2,411	252	**15,068**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(7,344)	(253)	-	-	-	-	-	**(7,597)**
Transfers to / from assets held for sale	-	(16)	-	-	-	-	-	-	**(16)**
Disposals / derecognition	-	(18)	-	-	(6,224)	(56)	(1,865)	(193)	**(8,356)**
Accumulated depreciation at 31 March 2025	**-**	**171**	**-**	**-**	**28,232**	**541**	**7,448**	**310**	**36,702**
Net book value at 31 March 2025	**7,420**	**176,719**	**4,352**	**15,446**	**16,731**	**273**	**6,761**	**525**	**228,227**
Net book value at 1 April 2024	**7,517**	**173,661**	**4,433**	**25,184**	**18,400**	**320**	**5,781**	**727**	**236,023**

Note 17.2 Property, plant and equipment - 2023/24

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	**8,075**	**179,203**	**4,467**	**38,919**	**53,846**	**772**	**16,808**	**824**	**302,914**
Additions	-	20,196	24	16,497	3,653	185	717	243	**41,515**
Impairments charged to Operating Expenditure	(33)	(16,065)	-	(260)	-	-	-	-	**(16,358)**
Impairments charged to the Revaluation Reserve	-	(3,219)	-	-	-	-	-	-	**(3,219)**
Reversals of impairments	25	729	-	-	-	-	-	-	**754**
Revaluations	-	(2,522)	(137)	-	-	-	-	-	**(2,659)**
Reclassifications	-	10,777	79	(18,273)	3,792	36	3,552	37	**-**
Transfers to/ from assets held for sale	(550)	(14,693)	-	(11,699)	(10,519)	-	(429)	(80)	**(37,970)**
Disposals / derecognition	-	(585)	-	-	(2,632)	(123)	(7,965)	(46)	**(11,351)**
Valuation/gross cost at 31 March 2024	**7,517**	**173,821**	**4,433**	**25,184**	**48,140**	**870**	**12,683**	**978**	**273,626**
Accumulated depreciation at 1 April 2023	**-**	**103**	**-**	**-**	**34,780**	**585**	**13,096**	**224**	**48,788**
Provided during the year	-	7,229	248	-	4,796	30	1,837	97	**14,237**
Revaluations	-	(6,953)	(248)	-	-	-	-	-	**(7,201)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	(215)	-	-	(7,263)	-	(243)	(24)	**(7,745)**
Disposals / derecognition	-	(4)	-	-	(2,573)	(65)	(7,788)	(46)	**(10,476)**
Accumulated depreciation at 31 March 2024	**-**	**160**	**-**	**-**	**29,740**	**550**	**6,902**	**251**	**37,603**
Net book value at 31 March 2024	**7,517**	**173,661**	**4,433**	**25,184**	**18,400**	**320**	**5,781**	**727**	**236,023**
Net book value at 1 April 2023	**8,075**	**179,100**	**4,467**	**38,919**	**19,066**	**187**	**3,712**	**600**	**254,126**

Note 17.3 Property, plant and equipment financing - 31 March 2025

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,420	150,193	4,352	15,446	14,739	267	6,688	496	**199,601**
On-SoFP PFI contracts and other service concession arrangements	-	20,379	-	-	-	-	-	-	**20,379**
Owned - donated / granted	-	6,147	-	-	1,992	6	73	29	**8,247**
Total net book value at 31 March 2025	**7,420**	**176,719**	**4,352**	**15,446**	**16,731**	**273**	**6,761**	**525**	**228,227**

Note 17.4 Property, plant and equipment financing - 31 March 2024

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,517	146,891	4,433	25,184	16,210	313	5,682	727	**206,957**
On-SoFP PFI contracts and other service concession arrangements	-	20,486	-	-	-	-	-	-	**20,486**
Owned - donated / granted	-	6,284	-	-	2,190	7	99	-	**8,580**
for COVID response	-	-	-	-	-	-	-	-	**-**
Total net book value at 31 March 2024	**7,517**	**173,661**	**4,433**	**25,184**	**18,400**	**320**	**5,781**	**727**	**236,023**

Note 18 Grants and Donations of property, plant and equipment and intangibles

The Trust has benefitted from the receipt of Granted and Charitable Donations of Property, Plant and Equipment during 2024/25 totalling £486k (2023/24: £484k). This principally related to generous donations from the Torbay League of Friends for the purchase of clinical equipment for Torbay Hospital. Generous donations were also received from other local Leagues of Friends and from other donors.

Note 19 Revaluations of property, plant and equipment

As described in note 8 to the Accounts 'Impairment of Assets', the Trust commissioned the District Valuation Office to undertake a revaluation during the course of 2023/24, namely:

Provision of a valuation for land and buildings that were surplus to Trust needs and were available for sale; provision of a valuation of land and building assets not currently available for sale and a valuation of land, and provision for buildings and dwellings in use as at 31st March 2025. In line with accounting standards, the assets available for sale were valued at the lower of existing use value or alternative use value; assets surplus to requirements but unavailable for sale were valued at the higher of existing use value or alternative use value; specialised building and dwelling assets in use were valued at depreciated replacement cost and non specialised building assets were valued at open market value.

The overall net impact of the above revaluations has been to decrease the value of the Trust's Property, Plant and Equipment items by £4,935k (2023/24 decrease of £14,185k). Of this net decrease, a net expense of £4,901k has been charged against operating expenditure as an 'Impairment' (2023/24 £15,508k) and the balance of £(34)k (2023/24 £1,323k) has been taken to the revaluation reserve. The net movement of £34k to the revaluation reserve has been presented as an impairment of £(5,238)k and an upwards revaluation movement of £5,204k in line with the GAM's requirements, (2023/24 a net movement of £1,323k being an impairment of £(3,219)k and £4,542k upwards revaluation movement).

Note 20 Leases - Torbay and South Devon NHS Foundation Trust as a lessee

Information about future lease payments receivable from lease arrangements classified as finance leases where the Torbay and South Devon NHS Foundation Trust is the lessor is set out in Notes 24 and 31. These notes details information about leases for which the Trust is a lessee.

Note 20.1 Right of use assets - 2024/25

Group and Trust	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Intangible assets £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	**11,998**	**7,335**	**1,104**	**5,461**	**40**	**25,938**	**1,013**
Additions	212	-	189	-	-	**401**	-
Remeasurements of the lease liability	147	-	-	-	-	**147**	-
Impairments	(20)	-	-	-	-	**(20)**	-
Revaluations	(40)	-	-	-	-	**(40)**	-
Disposals / derecognition	-	(82)	(79)	-	-	**(161)**	-
Valuation/gross cost at 31 March 2025	**12,297**	**7,253**	**1,214**	**5,461**	**40**	**26,265**	**1,013**
Accumulated depreciation at 1 April 2024 - brought forward	**2,224**	**3,926**	**741**	**3,289**	**16**	**10,196**	**396**
Provided during the year	1,197	1,094	208	1,029	6	**3,534**	114
Revaluations	(40)	-	-	-	-	**(40)**	-
Disposals / derecognition	-	(25)	(79)	-	-	**(104)**	-
Accumulated depreciation at 31 March 2025	**3,381**	**4,995**	**870**	**4,318**	**22**	**13,586**	**510**
Net book value at 31 March 2025	**8,916**	**2,258**	**344**	**1,143**	**18**	**12,679**	**503**
Net book value at 1 April 2024	**9,774**	**3,409**	**363**	**2,172**	**24**	**15,742**	**617**

Net book value of right of use assets leased from other NHS providers	503
Net book value of right of use assets leased from other DHSC group bodies	-

Note 20.2 Right of use assets - 2023/24

Group and Trust	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Intangible assets £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**14,312**	**7,761**	**920**	**5,677**	**40**	**28,710**	**1,008**
Additions	-	63	283	-	-	**346**	-
Remeasurements of the lease liability	666	-	-	-	-	**666**	5
Impairments	(153)	(78)	-	-	-	**(231)**	-
Disposals / derecognition	(2,827)	(411)	(99)	(216)	-	**(3,553)**	-
Valuation/gross cost at 31 March 2024	**11,998**	**7,335**	**1,104**	**5,461**	**40**	**25,938**	**1,013**
Accumulated depreciation at 1 April 2023 - brought forward	**1,076**	**2,907**	**597**	**2,355**	**10**	**6,945**	**147**
Provided during the year	1,154	1,138	198	1,082	6	**3,578**	249
Impairments	10	-	-	-	-	**10**	-
Disposals / derecognition	(16)	(119)	(54)	(148)	-	**(337)**	-
Accumulated depreciation at 31 March 2024	**2,224**	**3,926**	**741**	**3,289**	**16**	**10,196**	**396**
Net book value at 31 March 2024	**9,774**	**3,409**	**363**	**2,172**	**24**	**15,742**	**617**
Net book value at 1 April 2023	**13,236**	**4,854**	**323**	**3,322**	**30**	**21,765**	**861**

Net book value of right of use assets leased from other NHS providers	617
Net book value of right of use assets leased from other DHSC group bodies	-

Note 20.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 29.1.

	Group and Trust	
	2024/25	2023/24
	£000	£000
Carrying value at 1 April	**18,892**	**21,783**
Transfers by absorption	-	-
Lease additions	401	346
Lease liability remeasurements	147	666
Interest charge arising in year	422	487
Early terminations	-	(406)
Lease payments (cash outflows)	(4,701)	(3,984)
Other changes	-	-
Carrying value at 31 March	**15,161**	**18,892**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 20.4 Maturity analysis of future lease payments at 31 March 2025

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	3,023	110
- later than one year and not later than five years;	6,310	367
- later than five years.	8,958	36
Total gross future lease payments	**18,291**	**513**
Finance charges allocated to future periods	(3,130)	(26)
Net lease liabilities at 31 March 2025	**15,161**	**487**
Of which:		
Leased from other NHS providers		487
Leased from other DHSC group bodies		-

Note 20.5 Maturity analysis of future lease payments at 31 March 2024

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2024	**31 March 2024**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	3,813	110
- later than one year and not later than five years;	8,745	441
- later than five years.	9,916	109
Total gross future lease payments	**22,474**	**660**
Finance charges allocated to future periods	(3,582)	(34)
Net finance lease liabilities at 31 March 2024	**18,892**	**626**
Of which:		
Leased from other NHS providers		626
Leased from other DHSC group bodies		-

Note 21 Disclosure of interests in other entities

The Trust's principal subsidiary undertakings and investments as included in the consolidation as at the reporting date are set out in these financial statements.

The reporting date of the financial statements for the subsidiary is the same as for these group financial statements - 31 March 2025.

Investment in Subsidiary - SDH Developments Ltd

The Trust's wholly owned subsidiary company is registered in the UK, company no. 08385611 with a share capital comprising one share £1 owned by the Trust. The company commenced trading on 1st July 2013 as an Outpatients Dispensing service in Torbay Hospital and a significant proportion of the company's revenue is inter group trading with the Trust which is eliminated upon the consolidation of these group financial statements. The Group position for 2024/25 incorporates a subsidiary post-tax profit of £65k (2023/24 £34k). The subsidiary's gross and net assets at 31st March 2025 were £2,269k (2023/24 £2,161k) and £986k (2023/24 £927k) respectively. The management of the subsidiary company produce their own tax computations, supported with professional advice which due to ethical standards the auditors can no longer produce. There has been no significant change in the trading risks during the course of this year.

Prior Year - Realised Investment in Subsidiary - Torbay Pharmaceuticals Ltd

The Trust formed a new wholly owned subsidiary of the Trust during June 2023, Torbay Pharmaceuticals Ltd with a share capital comprising £1 owned by the Trust. The company is registered in the UK, company no. 14955659. The company commenced trading on 1st September 2023. The company was sold in its entirety by the Trust to a third party investor in the prior year, on 16th November 2023. Details of the sale are listed in note 25.1 to these financial statements.

Investments in associates and joint ventures outside of the government accounting boundary

During 2018/19 the Trust together with a Partner formed a LLP named 'SDH Innovations Partnership LLP'. The Trust holds a 50% equity stake in the business, namely share capital of £1 nominal value. The principal purpose of the LLP is a vehicle to support the development of new healthcare facilities with a Strategic Estates Partner. On the grounds of materiality the Trust has not consolidated the results of the LLP into these financial statements.

Note 22 Inventories

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Drugs	3,096	2,977	2,202	2,291
Consumables	3,385	3,633	3,385	3,633
Energy	30	45	30	45
Other	455	330	455	330
Total inventories	**6,966**	**6,985**	**6,072**	**6,299**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £59,733k (2023/24: £72,496k). Write-down of inventories recognised as expenses for the year were £178k (2023/24: £127k).

Of the inventories recognised in expense £17k related to Consumables donated from DHSC group bodies (2023/24 £73k). Write-down of inventories recognised as expenses for the year totalled £178k (2023/24: £127k). Of the write down of inventories recognised as expenses for the year £nil related to Consumables from DHSC group bodies (2023/24 £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £49k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 23.1 Receivables

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Current				
Contract receivables *	24,599	29,408	24,642	29,438
Allowance for impaired contract receivables / assets	(2,983)	(2,370)	(2,983)	(2,370)
Prepayments (non-PFI)	5,772	3,821	5,772	3,821
PFI lifecycle prepayments	740	-	740	-
Finance lease receivables	105	101	105	101
PDC dividend receivable	933	1,420	933	1,420
VAT receivable	4,087	2,613	3,875	2,457
Other receivables	404	476	404	476
Total current receivables	**33,657**	**35,469**	**33,488**	**35,343**
Non-current				
Contract receivables	818	672	818	672
Finance lease receivables	3,009	3,114	3,009	3,114
Clinician pension tax provision reimbursement funding from NHS England **	352	451	352	451
Other receivables	-	-	265	302
Total non-current receivables	**4,179**	**4,237**	**4,444**	**4,539**
Of which receivable from NHS and DHSC group bodies:				
Current	6,227	11,483	6,227	11,483
Non-current	589	693	589	693

* Contract receivables (IFRS15) : invoiced, includes Adult Social Care Debt of £12,323k (2023/24 £9,254k). The Pharmacy Manufacturing Unit was disposed of during 2023/24. Please refer to note 25 to these financial statements. In line with IFRS5, Non current Assets Held for Sale and Discontinued Operations, the value of the Trade debt associated with the Pharmacy Manufacturing Unit was sold to the purchaser at its carrying value at the point of sale.

** Clinician pension tax provision reimbursement funding from NHS England, relates to monies due to offset the potential liability the Trust is exposed to in underwriting the tax liabilities Clinicians are facing relating to increases in their Pensions above and above their Annual Allowances in respect of 2020/21. See note 30.1 to these financial statements for further analysis.

Note 23.2 Allowances for credit losses - 2024/25

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2024 - brought forward	**2,370**	**-**	**2,370**	**-**
New allowances arising	1,358	-	**1,358**	**-**
Utilisation of allowances (write offs)	(745)	-	**(745)**	**-**
Allowances as at 31 Mar 2025	**2,983**	**-**	**2,983**	**-**

Note 23.3 Allowances for credit losses - 2023/24

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2023	**2,503**	**-**	**2,503**	**-**
New allowances arising	493	-	**493**	**-**
Reversals of allowances	(58)	-	**(58)**	**-**
Utilisation of allowances (write offs)	(568)	-	**(568)**	**-**
Allowances as at 31 Mar 2024	**2,370**	**-**	**2,370**	**-**

Note 24 Finance leases (Torbay and South Devon NHS Foundation Trust as a lessor)

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the Torbay and South Devon NHS Foundation Trust is the lessor.

Note 24.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)

	Group and Trust	
	2024/25	**2023/24**
	£000	**£000**
Finance lease receivables at 1 April	**3,215**	**501**
Additions	-	2,811
Interest arising (unwinding of discount)	59	-
Lease receipts (cash payments received)	(160)	(97)
Finance lease receivables at 31 March	**3,114**	**3,215**

Note 24.2 Finance lease receivables maturity analysis as at 31 March 2025

	Group and Trust	
	Total	Of which leased to DHSC group bodies:
	31 March 2025	**31 March 2025**
	£000	**£000**
Undiscounted future lease receipts receivable in:		
not later than one year;	186	19
later than one year and not later than two years;	188	20
later than two years and not later than three years;	186	19
later than three years and not later than four years;	163	19
later than four years and not later than five years;	153	20
later than five years.	4,333	909
Total future finance lease payments to be received	**5,209**	**1,006**
Estimated value of unguaranteed residual interest	-	-
Unearned interest income	(2,095)	(765)
Allowance for uncollectable lease payments	-	-
Net investment in lease (net lease receivable)	**3,114**	**241**
of which:		
Leased to other NHS providers		241
Leased to other DHSC group bodies		-

Note 24.3 Finance lease receivables maturity analysis as at 31 March 2024

	Group and Trust	
	Total	Of which leased to DHSC group bodies:
	31 March 2024	**31 March 2024**
	£000	**£000**
Undiscounted future lease receipts receivable in:		
not later than one year;	186	19
later than one year and not later than two years;	188	20
later than two years and not later than three years;	186	19

later than three years and not later than four years;	188	20
later than four years and not later than five years;	163	19
later than five years.	4,543	948
Total future finance lease payments to be received	**5,454**	**1,045**
Unearned interest income	(2,239)	(803)
Net investment in lease (net lease receivable)	**3,215**	**242**
of which:		
Leased to other NHS providers		242
Leased to other DHSC group bodies		-

Note 25 Non-current assets held for sale and assets in disposal groups

	Group and Trust	
	2024/25	**2023/24**
	£000	**£000**
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,865**	**2,102**
Assets classified as available for sale in the year	469	36,459
Assets sold in year	-	(17,248)
Impairment of assets held for sale	(439)	(19,048)
Assets no longer classified as held for sale, for reasons other than disposal by sale	-	(400)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**1,895**	**1,865**

An area of land and two vacant buildings remained unsold at 31st March 2025. These have a realistic prospect of sale within the next 12 months and are being actively marketed with a carrying value of £1.2m (land) and £0.68m (buildings).

Included within the prior year figures is the transfer of the Intangible and Property, Plant and Equipment assets associated the Pharmacy Manufacturing basis, which was classified as being held for sale at 31st August 2023. Between September and November 2023, these assets were sold by the Trust to a wholly owned subsidiary of the Trust, namely Torbay Pharmaceuticals Ltd. Prior to the sale, the Intangible and Property Plant and Equipment assets associated with the Pharmaceuticals manufacturing business were revalued at fair value less anticipated cost of disposal in line with IFRS 5 - Non current assets held for sale and discontinued operations. This resulted in an impairment charge of £19,048k. A further impairment charge of £78k was reported against a Right of Use asset that was also transferred to Torbay Pharmacy Pharmaceuticals Ltd after the Trust had paid for legal title of those assets.

Included within the prior year figures is the disposal of Torbay Pharmaceuticals Ltd on 16th November 2023. Its trading activities up until that point in time are consolidated within the prior year financial statements. Total proceeds from the sale were £32,485k. Of this, £444k of this related to the operating profits Torbay Pharmaceuticals Ltd generated during the period 1st September 2023 through to 15th November 2023, £115k of the disposal proceeds were also used by the Trust to purchase legal title on those Right of Use assets that were transferred to Torbay Pharmaceuticals Ltd. The total proceeds also included a sum of £2,992k for the estimated cost of disposal.

Included within the prior year figures are total profits recognised on Assets Held for Sale during 2023/24 totalling £207k as reflected in note 13 to these financial statements. Of this sum, £77k related to the vacant Building excluding Dwelling and £130k related to the sale of the Pharmaceuticals manufacturing business.

Note 26 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
At 1 April	**41,269**	**34,734**	**40,711**	**34,645**
Net change in year	(14,568)	6,535	(14,133)	6,066
At 31 March	**26,701**	**41,269**	**26,578**	**40,711**
Broken down into:				
Cash at commercial banks and in hand	177	572	54	14
Cash with the Government Banking Service	26,524	40,697	26,524	40,697
Total cash and cash equivalents as in SoFP	**26,701**	**41,269**	**26,578**	**40,711**

Note 27 Trade and other payables

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Trade payables	24,239	11,823	23,349	11,823
Capital payables	4,866	11,693	4,866	11,693
Accruals	34,359	38,598	34,322	38,532
Social security costs	6,888	7,019	6,888	7,019
Other taxes payable	33	23	-	-
Pension contributions payable	4,553	4,559	4,553	4,559
Other payables	2,457	1,479	3,420	1,339
Total current trade and other payables	**77,395**	**75,194**	**77,398**	**74,965**
Of which payables from NHS and DHSC group bodies:				
Current	11,105	10,064	11,105	10,064
Non-current	-	-	-	-

Note 28 Other liabilities

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Current		
Deferred income: contract liabilities	11,100	7,077
Total other current liabilities	**11,100**	**7,077**

Note 29.1 Borrowings

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Current		
Loans from DHSC	2,071	2,633
Lease liabilities	2,703	3,685
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,309	436
Total current borrowings	**6,083**	**6,754**
Non-current		
Loans from DHSC	13,919	15,880
Lease liabilities	12,458	15,207
Obligations under PFI, LIFT or other service concession contracts	23,630	23,859
Total non-current borrowings	**50,007**	**54,946**

Note 29.2 Reconciliation of liabilities arising from financing activities (Group and Trust)

Group and Trust - 2024/25	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2024	**18,513**	**18,892**	**24,295**	**61,700**
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,506)	(4,279)	(452)	**(7,237)**
Financing cash flows - payments of interest	(433)	(422)	(1,441)	**(2,296)**
Non-cash movements:				
Additions	-	401	-	**401**
Lease liability remeasurements	-	147	-	**147**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	1,096	**1,096**
Application of effective interest rate	416	422	1,441	**2,279**
Early terminations	-	-	-	**-**
Carrying value at 31 March 2025	**15,990**	**15,161**	**24,939**	**56,090**

Group and Trust - 2023/24	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2023	**25,356**	**21,783**	**15,288**	**62,427**
Cash movements:				
Financing cash flows - payments and receipts of principal	(6,822)	(3,498)	(1,789)	**(12,109)**
Financing cash flows - payments of interest	(576)	(486)	(1,490)	**(2,552)**
Non-cash movements:				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	7,706	**7,706**
Additions	-	346	-	**346**
Lease liability remeasurements	-	666	-	**666**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	3,090	**3,090**
Application of effective interest rate	555	487	1,490	**2,532**
Early terminations	-	(406)	-	**(406)**
Carrying value at 31 March 2024	**18,513**	**18,892**	**24,295**	**61,700**

Note 29.3 Loans from DHSC (Group and Trust)

The interest rates and terms of the Loans from DHSC are as follows: -

	Group and Trust								
	Total principal and interest outstanding at 31 March 2025	Interest Rate	Interest outstanding at 31st March 2025 and repayable within one year	Loan principal due within one year	Total current liability as at 31st March 2025	Loan principal repayments due after more than one year at 31 March 2025	Duration of Loan	Date of final loan repayment	Total outstanding at 31 March 2024
	£000	%	£000	£000	£000	£000	Years	£000	£000
Loans for Capital Developments									
Backlog Maintenance 2011/12	3,282	3.41%	32	540	572	2,710	20	Dec 2030	3,828
Backlog Maintenance 2012/13	3,704	1.90%	3	527	530	3,174	20	Mar 2032	4,231
Critical Care Unit and Hospital Front Entrance	7,111	2.34%	60	706	766	6,345	20	Nov 2034	7,823
Linear Accelerator Bunker and associated enabling works	1,893	2.34%	16	188	204	1,689	20	Nov 2034	2,083
Replacement Linear Accelerator	0	1.66%	0	0	0	0	10	Nov 2024	334
Car Parking Facilities	0	1.66%	0	0	0	0	10	Nov 2024	214
Sub-total; Capital loans	**15,990**		**111**	**1,961**	**2,072**	**13,918**			**18,513**

	31 March 2025			31 March 2024
	Total	Interest	Principal	Total
	£000	£000	£000	£000
of which payable within:				
- not later than one year;	**2,071**	**111**	**1,960**	**2,633**
- later than one year and not later than five years;	**7,847**	**0**	**7,847**	**7,844**
- later than five years.	**6,072**	**0**	**6,072**	**8,036**
	15,990			**18,513**

Note 30.1 Provisions for liabilities and charges analysis (Group and Trust)

Group and Trust	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2024	**717**	**2,285**	**236**	**886**	**4,124**
Change in the discount rate	1	13	-	(78)	**(64)**
Arising during the year	97	732	96	(36)	**889**
Utilised during the year	(123)	(190)	(57)	(25)	**(395)**
Reversed unused	(14)	(22)	(14)	-	**(50)**
Unwinding of discount	17	55	-	40	**112**
At 31 March 2025	**695**	**2,873**	**261**	**787**	**4,616**
Expected timing of cash flows:					
- not later than one year;	88	144	261	4	**497**
- later than one year and not later than five years;	429	721	-	50	**1,200**
- later than five years.	178	2,008	-	733	**2,919**
Total	**695**	**2,873**	**261**	**787**	**4,616**

Pensions early departure costs has two components. The provision for early retirement and injury benefit payments to staff have been based on information from NHS Pensions. The principal uncertainty relating to this is the life expectancy of the beneficiaries.

Legal claims relates to personal injury claims received from employees and members of the public. These claims have been quantified according to the guidance received from the NHSLA and the relevant insurance companies. Due to the inherent uncertainty of this type of claim it has been assumed that any of the claims dealt with by the insurance companies will be settled and paid during the year ending 31 March 2026. The potential liability has been split into two parts with one part being provided for and the second part included in Contingencies at Note 31.

Other provisions includes 'Clinician Pension Tax reimbursement' relating to a potential liability that the Trust will face to underwrite the tax liability faced by clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in 2019/20 face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold. The Trust will make a contractually binding commitment to pay clinicians in this position a corresponding amount on retirement, ensuring that they are fully compensated in retirement for the effect in retirement. Due to the timescale for pension tax annual allowance (AA) charges and the scheme pays nominations, there is no data of the ‘actual’ nominations for the 2019-20 tax year available; the deadline for initial nomination is 31 July 2021, with the ability to make changes up to 31 July 2024. The Trust has recognised a provision liability in line with the estimate provided to the Trust by NHS England. The Trust's liability to these costs have been underwritten by NHS England and therefore a corresponding Receivable has been included in note 23 to these financial statements.

Note 30.2 Clinical negligence liabilities

At 31 March 2025, £95,193k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Torbay and South Devon NHS Foundation Trust (31 March 2024: £83,146k).

Note 31 Contingent assets and liabilities

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(41)	(70)
Other	(1,282)	(1,349)
Gross value of contingent liabilities	**(1,323)**	**(1,419)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(1,323)**	**(1,419)**
Net value of contingent assets	**-**	**-**

Personal Injury Claims

The Trust receives a number of personal injury claims from employees and members of the public. The NHS Resolution administer the scheme and provide details of the liability and likely value of claims. The value of the claims which have been assessed as being unlikely to succeed for which no provision has been made in the accounts is £41k (2023/24 £70k).

Employment tribunal and other related litigation

At 31 March 2025, there were seven cases ongoing (31st March 24 - two cases). As with 2023/24, it has not been possible to quantify the potential liability or assess the likelihood of a liability arising, and a contingent liability of £0 (2023/24: £0) is disclosed.

Centre for Health & Care Professions - South Devon College

The Trust entered into a lessor finance lease with South Devon College on 1st September 2017 to enable the College to use part of the Trust's Torbay Hospital Annexe site as an educational facility. The Secretary of State for Education loaned the College a sum of money to invest in the site. This external investment does not form part of the Trust's Statement of Financial Position, but the value of the Trust buildings now leased to the College have been classified in the Trust's accounts as a finance lease. The lease is for a 50 year period, with a break point at year 30. If during the course of the primary lease period (i.e. the first 30 years) South Devon College (or successor organisation) was to cease the delivery of education (for whatever reason), then the Trust would be obliged to pay a sum to the Secretary of State for the capital invested by the Department of Education. The potential sum payable diminishes over time but at 31st March 2025 the potential liability would be £1.3m (31st March 2024: £1.3m). No provision for this potential liability has been made, as the likelihood of this liability crystallising is considered remote.

Note 32 Contractual capital commitments

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	4,859	4,909
Intangible assets	5,417	287
Total	**10,276**	**5,196**

Note 33 Other financial commitments

The group / trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Not later than 1 year	35,142	4,300	35,091	4,255
After 1 year and not later than 5 years	-	-	-	-
Paid thereafter	-	-	-	-
Total	**35,142**	**4,300**	**35,091**	**4,255**

Note 34 On-SoFP PFI, LIFT or other service concession arrangements

At 31st March 2025 the Trust had one PFI contract for a Community Hospital facility at Newton Abbot Community Hospital. This contract met the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, and was therefore accounted for as 'on-Statement of Financial Position'. At 31st March 2024, the Trust had two PFI contracts for two Community Hospital facilities, Dawlish Community Hospital and Newton Abbot Community Hospital.

Dawlish Hospital

As a PFI arrangement, Dawlish Hospital has a value of £nil at 31st March 2025 (31st March 2024 £18k). The Trust purchased the remaining leasehold of Dawlish Community Hospital from the PFI Operator in June 2024. The value included within the accounts at June 2024 was £1.6m and the value at 31st March 2025 was £4.5m.

The Trust entered into an agreement under the Private Finance Initiative (PFI) arrangements for the construction of a new community hospital in Dawlish. The contract for the arrangement runs from 22nd June 1999 with a term of 25 years.
On 1 April 2002 this arrangement passed to Teignbridge Primary Care Trust (a predecessor body of NHS Devon ICB). On 1 April 2013 it passed to Torbay and Southern Devon Health and Care NHS Trust. On 1 October 2015 it returned to the Trust through the transfer of absorption of Torbay and Southern Devon Health and Care NHS Trust.

From the commencement of the contract a service fee of £241,000 was payable each year subject to indexation based upon RPI.

During 2024-25 the unitary payment was £271k (2023/24 £1,240k).

Arrangement - The contract is for the provision of services for maintenance, domestics and catering staff for the hospital. The ownership of the equipment and content rests with the Trust. The arrangement works on the principal of 'no hospital, no fee'. The provision of services is managed through service level agreements, which have measurable targets and are subject to regular monitoring.

Terms of Arrangement - The unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a Service fee which is subject to indexation based upon the movement in the 'Retail Prices Index (RPIX) All items, excluding mortgage interest payments'. Services are subject to market testing approximately every 5 years, and increases and decreases in costs from these regular market testing exercises are passed through to the Trust. At the end of the project term the Trust may allow the lease to expire with no compensation payable, or the parties may agree commercial terms for an extension of the agreement for a further 10 years, or have an option to acquire the leasehold interest and collapse the entire Lease structure by paying open market value for the land and buildings. In the event of re-financing of the PFI the Trust is entitled to receive half of the refinancing cash flow benefits. The Trust purchased the remaining leasehold of Dawlish Community Hospital from the PFI Operator in June 2024.

Newton Abbot Hospital

On 11th April 2007 Devon Primary Care Trust (now reconfigured and named NHS Devon CCG and then NHS Devon ICB) entered into an agreement under the Private Finance Initiative (PFI) arrangement for the construction of a new community hospital at Jetty Marsh, Newton Abbot. The capital value of the scheme was £21,980,000

The construction of the hospital was completed on 18th December 2008. From that date the unitary payment was £2,103,669 each year subject to annual RPI indexation movement for a period of 30 years. For the twelve month period in 2024/25 the unitary payment was £3,799k (2023/24 £3,635k). Newton Abbot Hospital has a value of £20,379k at 31st March 2025 (31st March 2024 £20,464k).

Arrangement - The contract is for the provision of maintenance services for this hospital. The ownership of the equipment between the parties is specified in the Agreement. The arrangement works on the basis of a reduction in the payments for failure to deliver to the agreed service levels. The provision of services is managed through service level agreements which have measurable targets and are subject to regular monitoring.

Terms of Arrangement - The unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a Service fee which is subject to indexation based upon the movement in the 'Retail Prices Index (RPI) All items'. At the end of the project term the Agreement will terminate with no compensation payable. In the event of re-financing of the PFI the Trust is entitled to receive half of the re-financing cash flow benefits.

Note 34.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the Statement of Financial Position:

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**36,498**	**36,724**
Of which liabilities are due		
- not later than one year;	2,698	1,807
- later than one year and not later than five years;	10,202	9,593
- later than five years.	23,598	25,324
Finance charges allocated to future periods	(11,559)	(12,429)
Net PFI, LIFT or other service concession arrangement obligation	**24,939**	**24,295**
- not later than one year;	1,309	436
- later than one year and not later than five years;	5,334	4,666
- later than five years.	18,296	19,193

Note 34.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**52,137**	**53,738**
Of which payments are due:		
- not later than one year;	3,801	3,884
- later than one year and not later than five years;	15,206	14,540
- later than five years.	33,130	35,314

Note 34.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust	
	2024/25	2023/24
	£000	£000
Unitary payment payable to service concession operator	**4,070**	**4,875**
Consisting of:		
- Interest charge	1,441	1,490
- Repayment of balance sheet obligation	452	1,789
- Service element and other charges to operating expenditure	558	901
- Capital lifecycle maintenance	565	313
- Revenue lifecycle maintenance	314	382
- Addition to lifecycle prepayment	740	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	9	987
Total amount paid to service concession operator	**4,079**	**5,862**

Note 35 Financial instruments

Note 35.1 Financial risk management

A financial instrument is a contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another enterprise.

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities.

The financial assets and liabilities of the Trust are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Credit risk

Credit risk is the possibility that other parties might fail to pay amounts due to the Trust. Credit risk arises from deposits with banks as well as credit exposures to the Trust's commissioners and other receivables. Surplus operating cash is only invested with UK based Clearing banks. The Trust's cash assets are held with National Westminster Bank plc, the Office of the Government Banking Service and Citibank only. An analysis of receivables and provision for impairment can be found in the trade and other receivables note.

Because of the continuing service provider relationship that the Trust has with local NHS commissioning bodies and the way those commissioning bodies are financed, the Trust is not exposed to the degree of credit risk faced by many other business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies.

Liquidity risk

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities.

The Trust's net operating costs are incurred largely under annual service agreements with local NHS commissioning bodies, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has secured Independent Trust Financing Facility (ITFF) Loans. These loans were used to enable the Trust to invest in replacement infrastructure of Torbay Hospital, namely investment in backlog maintenance; enabled the expansion of the Trusts Pharmacy Manufacturing Unit (PMU); construction of a new Critical Care Unit and Hospital Front Entrance; improvement of Car Parking Facilities and continuation of the Trust's Radiotherapy service. Interest on these loans are fixed.

During 2015/16 the Trust acquired two Private Finance Initiative (PFI) contracts, in respect of Newton Abbot and Dawlish community hospitals. Further details of the contracts are given in Note 34. The unitary payments for the Newton Abbot contract are subject to annual indexation in accordance with RPI (excluding mortgage interest payments). However, the associated risk is not judged to be significant, as these payments are equivalent to less than 1% of Trust turnover. With regard to the Dawlish contract, the availability fee is fixed and the service fee is subject to periodic market testing (meaning that the cost should be no greater than if the contract did not exist and the services were purchased externally).

Market Risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. The Trust's transactions are almost all undertaken in sterling and so it is not exposed to foreign exchange risk. It holds no significant investments other than short-term bank deposits. Other than cash balances, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cash flows are substantially independent of changes in market interest rates. Therefore, the Trust is not exposed to significant interest-rate risk.

Note 35.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	26,300	-	-	**26,300**
Cash and cash equivalents	26,701	-	-	**26,701**
Total at 31 March 2025	**53,001**	**-**	**-**	**53,001**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	31,852	-	-	**31,852**
Cash and cash equivalents	41,269	-	-	**41,269**
Total at 31 March 2024	**73,121**	**-**	**-**	**73,121**

Note 35.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	26,083	-	-	**26,083**
Other investments / financial assets	265	-	-	**265**
Cash and cash equivalents	26,578	-	-	**26,578**
Total at 31 March 2025	**52,926**	**-**	**-**	**52,926**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	31,882	-	-	**31,882**
Other investments / financial assets	302	-	-	**302**
Cash and cash equivalents	40,711	-	-	**40,711**
Total at 31 March 2024	**72,895**	**-**	**-**	**72,895**

Note 35.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	15,990	-	**15,990**
Obligations under leases	15,161	-	**15,161**
Obligations under PFI, LIFT and other service concessions	24,939	-	**24,939**
Trade and other payables excluding non financial liabilities	62,656	-	**62,656**
Total at 31 March 2025	**118,746**	**-**	**118,746**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	18,513	-	**18,513**
Obligations under leases	18,892	-	**18,892**
Obligations under PFI, LIFT and other service concessions	24,295	-	**24,295**
Trade and other payables excluding non financial liabilities	64,718	-	**64,718**
Total at 31 March 2024	**126,418**	**-**	**126,418**

Note 35.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	15,990	-	**15,990**
Obligations under leases	15,161	-	**15,161**
Obligations under PFI, LIFT and other service concessions	24,939	-	**24,939**
Trade and other payables excluding non financial liabilities	62,611	-	**62,611**
Total at 31 March 2025	**118,701**	**-**	**118,701**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	18,513	-	**18,513**
Obligations under leases	18,892	-	**18,892**
Obligations under PFI, LIFT and other service concessions	24,295	-	**24,295**
Trade and other payables excluding non financial liabilities	64,512	-	**64,512**
Total at 31 March 2024	**126,212**	**-**	**126,212**

Note 35.6 Fair values of financial assets and liabilities

The book value of assets and liabilities (excluding loans from the Department of Health and Social Care) due after 12 months is estimated to be the same as the fair value of the assets and liabilities.

The fair value of Loans from the Department of Health and Social Care should be classed as being held at Current Value. They are however currently reflected at Amortised Cost. The valuations of these loans are again estimated to be the fair value of these loans.

Note 35.7 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
In one year or less	70,826	73,405	70,781	73,199
In more than one year but not more than five years	25,377	27,400	25,377	27,400
In more than five years	38,953	43,780	38,953	43,780
Total	**135,156**	**144,585**	**135,111**	**144,379**

Note 36 Losses and special payments

	2024/25		2023/24	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	16	4	13	10
Bad debts and claims abandoned	128	305	212	594
Total losses	**144**	**309**	**225**	**604**
Special payments				
Ex-gratia payments	17	29	22	20
Special severance payments	2	29	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**19**	**58**	**22**	**20**
Total losses and special payments	**163**	**367**	**247**	**624**
Compensation payments received				

Note 37 Related parties

Torbay and South Devon NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. The Foundation Trust forms part of the Government's 'Whole Government Accounting' framework along with other NHS and Local Authority bodies. The Trust's parent is the Department of Health and Social Care and the ultimate parent is HM Government

Key Management (Group and Trust)

Key Management personnel - Key management includes directors, both executive and non-executive. The compensation paid or payable in aggregate to Key management for employment services is shown in the Annual Report and summarised in the Operating Expenditure note. None of the Key management personnel received an advance from the Trust. The Trust has not entered into any guarantees of any kind on behalf of Key management personnel. There were no amounts owing to Key management personnel at the beginning or end of the financial year.

During 2024/25 and 2023/24 the Trust transacted with related parties on whose Boards the Trust's non-executive directors and directors had similar chair or non-executive roles, or other interests. The value of transactions entered into were as follows:

	Income		Receivables	
			31st March	31st March
	2024/25	2023/24	2025	2024
	£000	£000	£000	£000
Delt Shared Services Ltd	12	0	11	0
	12	**0**	**11**	**0**

	Expenditure		Payables	
			31st March	31st March
	2024/25	2023/24	2025	2024
	£000	£000	£000	£000
Step one charity	145	0	0	0
Age UK Torbay	0	95	0	0
Ogwell Grange Ltd	21	15	0	0
Delt Shared Services Ltd	54	0	0	0
	220	**110**	**0**	**0**

Non-consolidated Associates & Joint Ventures (Group and Trust)

	Income		Receivables	
			31st March	31st March
	2024/25	2023/24	2025	2024
	£000	£000	£000	£000
SDH Innovations Partnership LLP	0	0	0	0
	0	**0**	**0**	**0**

	Expenditure		Payables	
			31 March	31 March
	2023/24	2022/23	2024	2023
	£000	£000	£000	£000
SDH Innovations Partnership LLP	89	788	84	45
	89	**788**	**84**	**45**

The transactions with SDH Innovations Partnership LLP mostly relate to the construction of Land excluding Dwellings projects. SDH Innovations Partnership LLP's registration is OC424178. Its registered office is, 9th Floor Cobalt Square, 83-85 Hagley Road, Birmingham, United Kingdom, B16 8QG.

Related Parties - Charity (Group and Trust)

The Trust also receives charitable contributions from a number of generous charitable and other bodies. These are principally channelled through Torbay and South Devon NHS Charitable Fund, for which the Foundation Trust is Corporate Trustee. The registered number of the charity is 1052232, the registered office is Regent House, Regent Close, Torquay TQ2 7AN. During the year, the Trust received revenue contributions of £646k (2023/24: £756k) and capital of £64k (2023/24: £66k) from the charity. The charity had reserves of £1,723k at 31st March 2025 (31st March 2024: £1,771k) and recorded an decrease in funds of £45k during the year ended 31st March 2025 (23/24: increase £272k). The balance of receivables due from the charity at 31st March 2025 was £32k (31st March 2024: £113k).

Consolidated Subsidiary (Trust)

	Income		Receivables	
			31 March	31 March
	2024/25	2023/24	2025	2024
	£000	£000	£000	£000
SDH Developments Ltd	702	571	318	37

	Expenditure		Payables	
			31 March	31 March
	2024/25	2023/24	2025	2024
	£000	£000	£000	£000
SDH Developments Ltd	12,823	11,773	968	666

SDH Developments Ltd is a company registered in the UK. Its registration number is 08385611 and its registered address is Regent House, Regent Close, Torquay, TQ2 7AN. The company was a wholly owned subsidiary of the Torbay and South Devon NHS Foundation Trust through out 2024/25 and 2023/24.

Related Parties - Whole Government Accounting (Group and Trust)

During the year Torbay and South Devon NHS Foundation Trust has had a number of material transactions with the Department of Health and Social Care (DHSC) and other entities for which DHSC is regarded as parent of those entities. Income from these DHSC entities are reported in either the Operating Income or the Other Operating Income note to these financial statements. Expenditure with these entities forms part of the Trust's Operating Expenditure note to these financial statements.

The DHSC Related Party transactions that are the most material in value to Torbay and South Devon NHS

Devon Partnership NHS Trust	Principle sub-contractor to the provision of the Children's & Family Health Devon contract
Health Education England	Provide income to the Trust to facilitate the delivery of training to healthcare staff
NHS Devon ICB	The Trust's main commissioner of patient care services.
NHS England	Main commissioner of specialised and high cost services provided by the Trust
NHS Resolution	Provision of litigation cover
Royal Devon United Hospitals Foundation Trust	Provision of clinical, internal audit and other services to one another
University Hospitals Plymouth NHS Trust	
NHS Pension Scheme	Provision of post employment benefits to Staff and Directors of the Trust

Independent auditor's report to the Council of Governors of Torbay and South Devon NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Torbay and South Devon NHS Foundation Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2025, which comprise the consolidated statement of comprehensive income, the statements of financial position, the consolidated statement of taxpayers equity, the statement of taxpayers equity, the statements of cash flow and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2025 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) (the 'Code of Audit Practice') approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the group's and the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and the Trust and the group's and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2024/25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the Accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2024/25, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of their services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance**,** but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the Audit and Risk committee, concerning the group's and the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Risk committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the group's and the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - high risk and unusual journals; and
  - management estimates including land and building valuations for indicators of management bias.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on high risk and unusual journals, including those journals processed by senior officers or those with super-user access rights as well as journals that contained other criteria that we determined presented a higher risk;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the significant accounting estimates related to land and buildings valuations. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.

- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the group and Trust audit team members included consideration of their:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the group and the Trust operates
  - understanding of the legal and regulatory requirements specific to the group and the Trust including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group's and the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation process, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The group's and the Trust's control environment, including the policies and procedures implemented by the group and the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter except on 24 June 2024 we reported a significant weakness in how the Trust plans and manages its resources to ensure it can deliver its services. This was in relation to how the Trust delivered its outturn position and the financial risk relating to delivering savings. We recommended the Trust takes a more proactive approach to its short-medium term financial planning to help achieve financial sustainability. This included:

- establishing a rigorous in-year process for identifying savings schemes, which focuses on recurrent savings and multi-year programmes to deliver realistic and achievable targets;
- developing a comprehensive approach to medium term financial planning;
- prioritising sustained improvement in its financial metrics, specifically in relation to its National Oversight Framework rating of 4.

The Trust has made limited progress in these areas and therefore the significant weakness remains in place for the year ended 31 March 2025.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Torbay and South Devon NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Julie Masci, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol
25 June 2025