NHS
Torbay and South Devon
NHS Foundation Trust

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

Annual Report and Accounts 2025/26

One Devon

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

FOREWORD BY THE CHAIRMAN AND CHIEF EXECUTIVE

Welcome to our Annual Report for 2025/26.

This has been a year of continued pressure for health and care services, alongside important progress and clear choices about the future of care for the people we serve. Across Torbay and South Devon, demand for services continues to grow, driven by an ageing population, increasing complexity of need and the reality that some of our communities experience significant deprivation and poorer health outcomes, alongside wider pressures on the NHS workforce and finances. Against this backdrop, our priority has remained consistent: to provide safe, high-quality care while making the changes needed to sustain services for the long term.

You will see both our challenges and our achievements reflected in this report. During the year, colleagues across our organisation and our partnerships supported care in people’s homes, communities and hospitals, alongside sustained efforts to improve access and reduce waiting times. We also continued to invest in our estate and infrastructure, including progress on the redevelopment of our Emergency Department and improvements to our theatres and diagnostic facilities.

A significant focus this year has been preparing for the future. This has included extensive work to introduce Epic, our new electronic patient record, which went live shortly after the end of the financial year. This is a major step forward in how we share information, improve safety and join up care across our services. Our focus now is on supporting colleagues to embed new ways of working so that the benefits are fully realised for patients and teams.

Alongside this, we have taken the time to listen - to our colleagues, our governors, our partners and the communities we serve. These conversations have been central to the refresh of our organisational strategy, which was approved shortly after year end. Our strategy sets out a clear direction for the next five years, grounded in the reality of the challenges we face and shaped by what people have told us matters most: improving access, strengthening care closer to home, making better use of digital technology and supporting people to live well.

Importantly, this work has not just been about setting ambition, but about making choices. We know we must live within our means while continuing to improve care. That requires honest conversations, strong partnerships and a shared focus on what will make the biggest difference for our communities.

We have also seen important changes during the year in how services are organised locally, including decisions about adult social care arrangements and the future delivery of children’s services. These are significant transitions and throughout we have focused on maintaining continuity of care and supporting our colleagues through change.

None of this would be possible without our people. Every day, more than 6,500 colleagues and our volunteers demonstrate professionalism, compassion and resilience in the face of ongoing pressures. We are deeply grateful for their commitment and for the continued support of our governors, partners, charities and local communities.

As we look ahead, we do so with a clear sense of both challenge and opportunity. The environment we are operating in remains uncertain and demanding, but we now have a refreshed strategy, strengthened partnerships and important foundations in place for change.

Our focus for 2026/27 will be on turning that strategy into practical, meaningful improvements for patients, colleagues and communities — embedding new models of care, supporting our workforce and continuing to improve access and outcomes. We will do this with realism about the challenges we face and with confidence in the strength, commitment and capability of our people.

Martin Beaman
Chairman
25 June 2026

Joe Teape
Chief Executive
25 June 2026

A personal message from our Chief Executive:

In April we said farewell to Professor Chris Balch who left us after two years as our Chair and seven years as a Non-Executive Director. He will be missed and we are grateful for his years of service and for his leadership of our transformation work for both our new hospital programme and our electronic patient record.

INTRODUCTION, PURPOSE AND HISTORY

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

Our vision is to support every person, family and community we serve to live well. This sits at the heart of our organisational strategy and reflects the opportunities and challenges facing our communities and our local health and care system.

Torbay and South Devon is a place people are proud to live and work. It is also a place where levels of deprivation are, in some places, some of the highest in the country, where more people are living longer with complex needs and where demand for care continues to grow. At the same time, the NHS is operating within tight financial limits, workforce shortages and an ageing estate. This context shapes the decisions we take and how we focus our efforts.

During 2025/26, alongside delivering care every day, we spent time listening to colleagues, governors, partners, people who use our services and local communities. These conversations helped us understand what matters most to people, where services feel stretched and where change is needed to ensure care remains safe, joined-up and sustainable.

What we heard locally reflects the wider national direction of travel for health and care: shifting more care from hospitals into communities, making better use of digital technology and placing greater emphasis on prevention and supporting people to stay well.

Together this local insight and national context has shaped the choices we made during the year - where we prioritised investment, how services have begun to change and how we are planning for the future.

One of the clearest examples of this in practice during the year was the launch of The Harbour, our new community frailty service. The Harbour brings together specialist teams to provide holistic assessment, urgent care and diagnostics for older people living with frailty, working closely with community services and our frailty virtual ward.

Although it's only been active for a few months it is demonstrating a very positive impact with increasing numbers of people supported to receive timely care without the need for a hospital admission, helping them remain independent and closer to home wherever possible. The Harbour shows how services can be organised around people's lives, while also easing pressure on acute care.

Across the year, we continued to deliver care in people's homes, in neighbourhood and community settings, and in our hospitals, supporting hundreds of thousands of face-to-face contacts with local people. We also continued to expand access to care without the need for hospital visits, including through remote monitoring and online appointments where appropriate.

While more care is increasingly provided in communities, our hospitals continue to play a vital role. During 2025/26, we made significant progress on the redevelopment of Torbay Hospital's Emergency Department, opening the first two phases of a £14.2 million investment, while beginning work on the refurbishment of day surgery theatres and the expansion of our OMFS department.

Strong foundations in our communities

Our work is built on strong primary and community services rooted in place. During the year, we completed the refurbishment of St Edmunds Community Healthcare Centre and celebrated 50 years of Castle Circus Health Centre (both in Torquay), Both the refurbishment and the anniversary provided an opportunity to recognise the vital role that trusted, accessible neighbourhood services play in prevention, continuity of care and long-term relationships with patients.

Managing change responsibly

2025/26 was a year of significant transition. Following several months of engagement and discussion by and within the Board, on 26 March 2026 the Board agreed to serve notice on the existing Section 75 Partnership Agreement for adult social care in Torbay, recognising that the current arrangements were no longer appropriate to meet the challenges ahead. This was a difficult but necessary decision, taken to enable future models of care that are sustainable, clear in their responsibilities and better able to respond to changing need, while continuing to work closely with partners on prevention and support.

We also worked with system partners to support the transition of Children and Family Health Devon to a single lead provider. Throughout the year, our focus was on maintaining continuity of care for children, young people and families, and supporting colleagues through organisational change as responsibilities transferred to Devon Partnership NHS Trust.

Preparing for the future

Alongside service delivery and change, we invested time in preparing for future improvements. During the year, extensive work was undertaken to prepare for the introduction of Epic, our new electronic patient record system, which went live shortly after the end of the financial year. Preparation focused on training, readiness and ensuring the foundations were in place to support safer, more joined-up care across hospital and community services.

Torbay Hospital also remained part of the national New Hospital Programme. While national timescales have continued to move, we have continued to explore every available funding route to address estate challenges in the meantime, recognising the importance of safe, resilient facilities for patients and colleagues now.

Our people and communities

Everything we do depends on the commitment, skill and compassion of our people. We employ over 6,500 colleagues across hospital, community and neighbourhood services and are proud to be a major local employer in the area. Through partnerships with schools, colleges and universities, we continue to develop skills, training and career opportunities that support both our workforce and our communities. Volunteers also play an important role, supporting patient experience and working alongside our teams and partner charities.

Many of our volunteers support patients at some of the most important moments in their care and recovery, and their contribution is deeply valued by both patients and colleagues. We currently have a total of 419 active volunteers comprising of 119 senior (over 70) and 50 youth volunteers (16-25). There were 151 leavers during the financial year and a further 32 people currently going through their recruitment checks and training.

There are approximately 108 people volunteering for charities – Torbay Hospital and Lifecare Radio, Torbay and Newton Abbot League of Friends, the Rotary Club, Snug, Care Homes and Volunteering in Health, all of which are included in the total figure of 419 active volunteers. The total number that volunteered with us in 2025/26 was 570 and the volunteering service arranged and attended 215 interviews. We had 153 new starters and 79 reviews were completed.

29,336 hours were recorded for the year, 10 volunteers gained employment in the community and 2 gained employment with us.

Looking ahead

As we move into 2026/27, our focus will be on building on the foundations laid over the past year and supporting our services, teams and partners through the next phase of change.

A central priority for the year ahead will be the delivery plan of our new five-year strategy which was approved shortly after year end. Our strategy sets out clear ambitions for how we will care for our communities, support our people and work differently as a trust and as part of the wider system.

Implementation will begin in earnest in 2026/27, with an emphasis on turning strategy into practical, meaningful change for patients, colleagues and partners – as set out below.

Over the summer, we will also be holding a series of community conversations to share our strategy, listen to local perspectives and continue shaping our plans alongside the people and communities we serve. These conversations reflect our commitment to openness, partnership and place-based working and will help ensure our strategy remains rooted in lived experience.

Alongside this, we will continue embedding new ways of working, including neighbourhood-based care for people living with frailty, further improvements in urgent and emergency care following the first phase of the Emergency Department redevelopment, and supporting colleagues as Epic becomes part of everyday practice across both hospital and community services. Learning, stabilisation and support for our colleagues will remain central to this work.

We will continue to work closely with partners as adult social care and children’s services arrangements evolve, keeping continuity of care, prevention and support for people and colleagues at the forefront. At the same time, we will manage the challenges of an ageing estate, while planning responsibly for the longer term.

Against a challenging and uncertain national context, the year ahead will require focus, realism and collaboration. We remain acutely aware of our responsibility to the 300,000 people who rely on our services and to our 6,500 colleagues who deliver care, support and leadership every day. The choices we make, and the pace and care with which we make them, must reflect that responsibility - balancing ambition with compassion and change with stability - so that we continue to provide safe, high-quality care while creating a workplace where our people feel supported to do their best work.

Turning our strategy into action

Our strategy sets a clear direction for the next five years, grounded in what we have heard from our communities, our people and our partners and shaped by the challenges we face.

At its heart is a simple, shared ambition: to support every person, family and community we serve to live well.

To deliver this, we are focusing on five clear shifts in how care works - our signature moves - which describe what will be different in practice for people, communities and our teams.

Our signature moves

Living well in our neighbourhoods
Working with communities to make care easy to reach and part of everyday life.

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

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

Smart use of technology for better care
Using digital tools and new approaches to make care more personal, connected and easier to access.

Caring, skilled people ready for tomorrow
Creating a great place to work, supporting people to be their best, and building an agile, inclusive workforce for the future.

What this means for our communities

Together, these moves describe a clear shift in how care is designed and delivered - strengthening support in neighbourhoods, ensuring hospital care is focused where it adds most value and improving how services connect.

They also reflect the choices we need to make. We cannot do everything and progress will depend on focusing our efforts where they will have the greatest impact for the people and communities we serve.

Delivering change in a realistic way

We know that change at this scale will take time. The pressures we face are real and progress will not always be linear. But this approach gives us a clear direction and a shared focus - aligning our efforts and supporting practical change over time.

Each of these moves connects immediate improvements with longer-term change, helping us build a more sustainable and joined-up model of care over time.

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
- Shrublands House, Morgan Avenue, Torquay, TQ2 5RS
- 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

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

We are proud to be part of the NHS and deeply rooted in its values. These values shape how we work with each other, how we care for patients, and how we serve our communities across Torbay and South Devon.

The NHS Constitution values were developed by patients, the public and NHS staff together, and they give us a shared understanding of what matters most. They guide our day-to-day decisions and provide common ground for working well together at every level of the NHS.

These values are:

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

Our commitment to our people

We fully recognise that the experience of our people and the experience of our patients are closely connected. When our people feel supported, listened to and valued, they are better able to provide safe, compassionate and high-quality care.

We continue to support an inclusive and representative workplace, including through our staff networks, which help bring lived experience into how we support our people and shape our services.

The NHS People Promise gives us a national framework for how we care for each other at work, and we use it as a practical guide for the culture we want to create. It sets out seven areas that matter to our people:

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

We know that when our people feel supported, patients receive better care. That's why we continue to focus on creating an environment where colleagues feel valued, listened to and able to do their best work. Our approach to wellbeing looks at the whole person - supporting mental, physical and emotional health through practical support such as counselling, flexible working and a range of wellbeing initiatives. Just as importantly, we make space for honest conversations and regular feedback, so people feel heard and part of something shared.

At the heart of this is how we lead. We are committed to compassionate leadership - leaders who listen, who understand the pressures their teams face, and who create a culture where people feel safe to speak up, share ideas and ask for help. This kind of environment not only supports individual wellbeing, it also helps our teams to work better together and continue improving the care we provide.

We also take time to recognise and celebrate our people. Our quarterly and annual People Awards reflect the values we stand for, recognising colleagues who show compassion, teamwork and excellence - and who make a real difference for patients and for each other.

Working in partnership

Our vision – to support every person, family and community we serve to live well can only be achieved through strong partnerships. We work closely with our Local Care Partnerships and across the wider Integrated Care System, alongside health and care organisations across Devon, Cornwall and the Isles of Scilly.

At a local level, we have well-established relationships with GPs and primary care teams, including pharmacists, opticians and dentists, as well as voluntary, community and social enterprise organisations and independent sector partners who support care at home and in care settings.

We also work closely with local, regional and national education partners, including universities, colleges and schools, to support the future workforce for health and care. Through high-quality clinical placements, apprenticeships and outreach in our communities, we help people from a wide range of backgrounds to start, develop and build their careers with us. Working together, we are strengthening "grow your own" pathways and widening access to opportunities, so that more people can see a future in health and care and feel supported to take that next step.

We also work closely with Devon County Council, Torbay Council and local businesses to address the wider factors that influence health and wellbeing. As an anchor institution, we take seriously our role in supporting our local communities, using our influence, skills and resources responsibly and for the greatest benefit. Our commitment to community wealth building, formalised through a memorandum of understanding, reflects this long-term approach.

We recognise the ongoing challenge of strengthening our own organisation while working collaboratively across the system to improve health and wellbeing. Our strategy for 2026-31 sets out our commitment to doing both - caring for our people and delivering high-quality services locally, while working in partnership to support better outcomes for communities across Devon.

Key partnerships include:

- working 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 and the South West Peninsula Board 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
- continuing to work with Devon County Council and Torbay Council (who commission our adult social care services in Torbay)
- our wholly owned subsidiary (SDH Developments Limited) providing an on-site pharmaceutical dispensary at Torbay Hospital
- being 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
- being a 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 population
- being 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.

The Integrated Care System for Devon

During 2025/26, the strategic direction for health and care across Devon was shaped by the national vision set out in *Fit for the Future: 10-Year Health Plan for England*. This plan reinforced the NHS's founding principles while setting a clear ambition to modernise services through innovation, technology, and new models of care that improve access, outcomes, and patient choice.

In response, NHS Devon strengthened its commitment to system-wide transformation, working through the One Devon Partnership to deliver a more integrated, outcome-focused approach to health and care. This collaboration between NHS organisations, local authorities, and the voluntary sector has been central to aligning priorities and resources across the system.

Over the past year, the system has increasingly oriented itself around the emerging NHS Devon Health and Care Strategy (2026–2031), published in October 2025, with early progress reflecting three core strategic shifts:

- From treatment to prevention – expanding early intervention, improving management of long-term conditions, and prioritising action to reduce health inequalities.
- From hospital-centred care to neighbourhood care – strengthening integrated neighbourhood teams to deliver more joined-up care closer to home, reducing reliance on acute services where appropriate.
- From analogue to digital services – accelerating the adoption of digital solutions to improve access, enhance communication, and support safer information sharing across organisations.

These shifts have been supported by a clear set of commissioning intentions focused on keeping people well in their communities, improving access to timely specialist care, and targeting improvements in priority areas.

Shaped by the priorities in the NHS 10 Year Plan and extensive engagement with local communities, over the next five years, we will transform how services are planned and delivered across Devon by focusing on delivering the One Plan for Devon.

The One Plan for Devon sets out the overall direction for how health and care services in Devon will need to evolve over the next five years to meet growing demand, workforce pressures, and the needs of an ageing population.

At the same time, the plan recognises the financial reality facing the NHS: we must live within our means. Therefore, we must look more towards prevention and supporting people to stay well.

For acute providers, this has marked the beginning of a transition toward a different role within the system—one that remains critical for delivering specialist and urgent care, while increasingly working in partnership to support prevention, reduce avoidable admissions, and enable earlier discharge.

Early impacts of this strategic direction are being seen through strengthened system collaboration, a growing emphasis on out-of-hospital care pathways and continued focus on improving waiting times and patient flow.

While demand pressures remain significant, the direction of travel is clear: to create a more sustainable, responsive, and patient-centred system that improves outcomes and supports people in Devon to live healthier, more independent lives.

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 2026 and provides commentary on relevant post year-end matters.

Chief Executive's statement on performance

We continue to face significant challenges in meeting operational performance targets across urgent and emergency care, planned care, cancer services and diagnostics, in line with the position across the NHS. During the year, attendances at our Emergency Department increased by 5.8%, including an 11% rise in ambulance conveyances. We also saw continued growth in demand across other services, with planned care referrals increasing by 3.6%, urgent suspected cancer referrals by 3.3% and diagnostic requests by 12% compared to the previous year. These pressures were compounded by industrial action and seasonal demand.

Despite this, we have seen improvement in a number of areas. In urgent and emergency care, we implemented our response to the Ambulance Timely Handover Process, resulting in a 51% improvement in ambulance handover times compared to the previous year. Alongside this, we opened the first phases of our Emergency Department redevelopment, increasing waiting and ambulatory capacity and improving the environment for patients and colleagues. We remain focused on continuing this progress and improving performance against national standards.

In planned care, we have made significant progress in reducing waiting times for patients. We have consistently ranked among the top 25 trusts nationally for referral to treatment performance, and we remain committed to further reducing waits, particularly for those who have been waiting longest. This work is supported by close collaboration with our system partners, alongside a continued focus on productivity and making best use of our existing resources while building capacity where needed.

We have experienced greater challenges in cancer care and diagnostics. While we have worked hard to improve performance against national cancer standards, and have made progress in recovery, we have not achieved the level of improvement we expected in diagnostic waiting times. We recognise the impact this has on patients and families, and have robust plans in place to improve performance, particularly in the early part of 2026/27.

Our ability to respond to these pressures continues to depend on strong partnership working. Our Families and Community services, including Children and Family Health Devon, demonstrate the strength of this approach, with teams working together across organisational boundaries to support people and communities more effectively.

As set out in our foreword, we have also taken time this year to listen and to plan for the future. Our refreshed strategy, approved shortly after year end, provides a clear direction for the next five years, grounded in the reality of the demand, performance and finance pressures. It sets out how we will improve access, strengthen care closer to home, make better use of digital technology and support people to live well. Our approach to performance is closely aligned with these priorities - focusing not only on recovery, but on building services that are sustainable for the long term. These priorities are now being taken forward through our five signature moves - the practical changes that will shape how care is delivered for people, communities and our teams.

The Board has maintained strong oversight of performance throughout the year. An integrated performance report has been considered at each Board meeting, supported by detailed review through Executive, Care Group and Committee structures. In particular, the Finance and Performance Committee, People Committee and Quality Assurance Committee have provided detailed scrutiny of performance, risks and improvement actions. At each quarter end, the Board has formally confirmed the position against key performance metrics to NHS England.

Looking ahead, the scale of the challenge remains clear. Demand across our services continues to grow, and the environment in which we operate remains complex and constrained. Our focus for the coming year will be on continuing to improve access and performance, particularly in urgent care, diagnostics and cancer services, while maintaining safety and quality.

We will do this by building on the progress we have made this year, working closely with our partners and supporting our colleagues as we embed new ways of working, including our electronic patient record. Above all, we remain committed to providing care that is safe, compassionate and responsive for the people and communities we serve.

We have experienced challenges in achieving our performance targets in cancer care and diagnostics this year. We have worked hard to recover our cancer performance to meet the national standards for faster diagnosis and referral to treatment. We have not been able to meet our expected performance improvements for diagnostic waiting times this year but we have robust plans in place to make improvements within Q1 of 2026/2027.

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 2025-26

This year was shaped by sustained pressure on health and care services, alongside a shared determination to continue delivering care that is safe, compassionate and increasingly joined-up for the people of Torbay and South Devon.

Across our communities, teams supported more people to manage their health, recover from illness and remain independent closer to home. Community nursing, intermediate care and adult social care colleagues worked alongside primary care, voluntary organisations and carers to help people avoid unnecessary hospital stays and to support timely, safe discharge when hospital care was needed. In Paignton, Jack Sears Rehabilitation Centre marked its first year in operation, supporting hundreds of people to rebuild confidence, mobility and independence following illness or injury, enabling many to return home who would otherwise have required longer stays in hospital.

This year also saw the launch of The Harbour, our community frailty service, bringing together specialist assessment, treatment and advice for older people in a non-acute setting. From its opening, The Harbour has played an important role in supporting people living with frailty to receive the right care at the right time, helping to reduce pressure on hospital services while keeping care focused on independence, dignity and quality of life.

Within our hospitals, colleagues continued to deliver acute and specialist care under intense demand. Teams made progress in improving access and reducing waiting times in a number of specialties, while maintaining a strong focus on safety and quality. Our endoscopy services achieved full accreditation, providing assurance to patients and carers that care meets national standards. Investment also progressed in key parts of the hospital estate, including the redevelopment of the Emergency Department and modernisation of theatres, improving both patient experience and the working environment for colleagues.

Specialist services continued to innovate and contribute to national learning. This included leading work on immersive virtual reality therapy to support people living with chronic pain, offering alternatives to medication through guided movement and wellbeing approaches. Our clinical teams also played a central role in research, including a major breast cancer study that will help build evidence to improve diagnosis and treatment for future patients.

Earlier diagnosis and prevention remained a priority throughout the year. We supported the introduction of local lung cancer screening, helping to identify disease earlier in people at greatest risk, when treatment is more effective. We also marked 20 years of bowel cancer screening, reflecting on the impact this programme has had in saving lives through early detection, supported by skilled screening, diagnostic and clinical teams.

Providing care that is truly joined-up depends on strong relationships across services. Our adult social care services in Torbay and Children and Family Health Devon both received Good ratings from the Care Quality Commission, recognising the commitment of colleagues to partnership working, safeguarding and high-quality, compassionate support for adults, children and families across Devon.

This year marked a significant step forward in digital transformation. Colleagues across clinical, operational and corporate teams prepared intensively for the introduction of the One Devon shared electronic patient record, bringing together information that had previously sat across multiple systems. This work focused on redesigning pathways and supporting staff to work more safely and efficiently together, rather than simply introducing new technology. Alongside this, the MyCare patient portal began to give people easier access to their information and appointments, while the MyRecovery app supported people to manage their recovery and rehabilitation beyond the hospital setting. Behind the scenes, new technologies such as automated pharmacy dispensing were introduced to improve safety and efficiency, freeing up for patient care.

Throughout the year, we also took time to reflect, listen and plan for the future. We undertook a refresh of our organisational strategy, shaped by engagement with colleagues, partners and communities, to set a clearer direction in the context of financial challenge, rising demand and the changing needs of our population. This work has provided a stronger foundation for prioritisation and improvement in the years ahead.

None of this would be possible without our people. Around 6,500 NHS colleagues across Torbay and South Devon continued to deliver care with professionalism, compassion and resilience. We invested in learning and development, including new local routes into nursing through our partnership with the Open University, helping people train and progress without leaving the communities they serve. Colleagues were recognised through our People Awards, and by the continued contribution of volunteers, whose time and kindness add real value to patient experience.

We also recognised the deep connections between our services and the communities we serve. This included the creation of an organ donor memorial, providing a dedicated space to honour donors and acknowledge the generosity of families whose gifts transform and save lives.

Across everything we delivered this year, a consistent theme emerged: people working together differently to respond to changing needs. Whether supporting recovery at home, delivering complex care in hospital, advancing research, introducing screening programmes or laying the foundations for digital and organisational change, our focus remained on providing safe, high-quality care for the people of Torbay and South Devon, now and for the future.

Our challenges and risk profile

We continue to face a number of significant challenges that shape our risk profile. These are driven by our financial position, the condition of our estate and digital infrastructure, increasing demand and delays in access to services, and the ongoing pressure on our colleagues. We also have a distinctive role in providing Adult Social Care and Continuing Healthcare for our population, which brings additional financial and operational risk not held by other organisations in the South West.

We manage these risks through our Board Assurance Framework, which aligns closely to our strategy and sets out our key objectives, principal risks and the actions in place to mitigate them. This is supported by our corporate risk register and regular review across our Board and committees, ensuring we have a clear and consistent view of where there are risks to delivery and where further assurance is required.

The most significant areas of challenge we continue to manage are:

- financial sustainability – delivering a challenging financial plan, including significant savings and productivity improvements, while maintaining safe, high-quality and personalised care
- operational performance and access – reducing waiting times and improving access to services across urgent care, planned care, diagnostics and cancer pathways, while meeting national performance expectations
- our people capacity and wellbeing – managing recruitment and retention challenges in key specialties and supporting colleagues in the context of sustained operational pressure, fatigue and burnout
- estate and infrastructure – maintaining and improving our estate and digital environment within the capital resources available, ensuring they remain safe, resilient and fit for the future

- transformation and delivery capacity – ensuring we have the leadership and organisational capacity to deliver the scale of change required, alongside day-to-day operational pressures
- our people costs and sustainability – reducing reliance on temporary staffing while maintaining safe staffing levels and managing affordability
- culture, inclusion and staff experience – continuing to strengthen a culture where people feel safe, supported and able to thrive, including addressing inequalities in workplace experience for colleagues from diverse backgrounds

We also recognise the importance of creating space for learning and development, ensuring our people and leaders are supported to grow and adapt as our services evolve.

Our approach reflects the balance we must strike between addressing immediate operational pressures and delivering longer-term change set out in our strategy. We remain focused on strengthening our organisation while working in partnership with others to improve outcomes for the people and communities we serve.

PERFORMANCE ANALYSIS

Financial position

Our financial position continues to be challenging, reflecting both the wider NHS context and the specific responsibilities we hold locally. The financial framework in 2025/26 remained largely consistent with the previous year, with block funding arrangements in place, adjusted for delivery against elective recovery targets.

Our adjusted financial plan for 2025/26 was to deliver a deficit of £8.0m, supported by £30.8m of non-recurrent deficit funding. This plan excluded the net cost of donated income and expenditure, as well as the impact of the year-end revaluation of buildings and land. Delivering it required a significant savings programme, alongside a continued focus on managing inflationary pressures and the cost of goods and services.

During the year, we delivered savings of £41.6m, exceeding our original target. However, ongoing cost pressures and the withdrawal of £15.4m of deficit support funding had a material impact. As a result, we ended the year with an underlying deficit of approximately £22.4m, on a comparable basis to our plan and excluding the net cost of donated income and expenditure, Private Finance Initiative (PFI) remeasurement and the impact of the revaluation of buildings and land.

When these accounting adjustments are included - including donated income and expenditure, PFI remeasurement and impairments arising from the revaluation of land and buildings - our total reported revenue deficit for the year was approximately £33.7m, as set out in the financial statements.

Looking ahead, our financial environment for 2026/27 remains challenging. We are planning to deliver a breakeven position alongside a substantial savings programme totaling £54.4m, which will require continued focus on managing cost pressures, improving productivity and making best use of the resources available to us.

As set out in our strategy, this reinforces the importance of making clear choices about how we use our resources — focusing on improving access, strengthening care closer to home, and investing in the areas that will have the greatest impact for our communities over the longer term. Delivering financial sustainability alongside these priorities will remain a key focus for the year ahead.

Going concern

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

In line with International Accounting Standard (IAS) 1, the Board has considered our organisation's ability to continue to operate into the foreseeable future. For NHS organisations, this assessment is based on the expectation that services will continue to be provided within the public sector.

Having considered this, the Board is satisfied that the services we provide will continue and that there is a reasonable expectation that we will remain a going concern. The financial statements have therefore been prepared on this basis, in line with HM Treasury guidance.

Operational performance

Trajectories for 2025/26

Looking ahead, we have set clear and ambitious trajectories in line with national operational planning guidance. These reflect both the scale of the challenge we face and our commitment to improving access and outcomes for the people we serve.

Our priorities are to:

- achieve a four-hour Urgent and Emergency Care (UEC) performance rate of 82% by March 2027
- reduce the number of people waiting over 52 weeks for elective treatment by March 2027
- improve referral to treatment (RTT) performance so that 73.7% of people waiting less than 18 weeks by March 2027
- increase cancer performance to 80.75% of people treated within 62 days of urgent referral and 80.8% receiving a diagnosis within 28 days of referral
- improve diagnostic waiting times so that 84.5% of people receive tests within six weeks by March 2027.

These trajectories are central to delivery our strategy - improving access to care, reducing waits and ensuring people receive timely diagnosis and treatment.

Urgent and emergency care performance

We assess urgent and emergency care performance through a range of measures that reflect both access and quality. While the national four-hour standard remains an important benchmark, it is only one part of a wider picture.

We also focus on key indicators such as ambulance handover delays, urgent community response (UCR), delayed discharges and length of stay. Together, these provide a more complete view of how well our urgent and emergency care pathways are working for people.

During 2025/26, we did not meet our internal trajectory or national expectations for the four-hour standard. However, we have seen improvement compared to the previous year, particularly in reducing ambulance handover delays. This reflects sustained effort by teams across our organisation and with our partners to improve flow through our hospitals and into the community.

We have been actively supported through a national improvement programme, with regular engagement with NHS England, the Regional Support Programme and the Emergency Care Improvement Support Team. This has helped us to strengthen our plans and delivery, and our progress has been recognised, with our combined urgent and emergency care measures ranking among the top 10 most improved trusts nationally between quarter one and quarter three.

Despite this progress, we know there is more to do. Reducing waiting times in urgent and emergency care remains a priority, and we continue to focus on improving both performance and experience for patients.

Partnership working is central to this. Throughout the year, we have worked closely with colleagues across our Devon system, including commissioners, ambulance services, mental health, primary care, adult social care and children's services, to improve flow and ensure people receive care in the right place.

We have also continued to strengthen care outside of hospital. Working with our community and intermediate care teams, we are developing new ways to support people closer to home, helping to avoid unnecessary hospital admissions and improve recovery.

At the same time, we recognise the constraints of our physical estate, including the capacity of our emergency departments and hospital beds. In response, we are focusing on ensuring that hospital care is reserved for those who need it most, while supporting timely discharge for those who are ready to leave.

We continue to maintain low levels of patients remaining in hospital without a medical reason to stay, supported by strong discharge processes and close working with partners. This is an important part of improving flow through our hospitals and ensuring beds are available for those who need them most.

Together, these actions reflect our ongoing commitment to improving urgent and emergency care — not only in terms of performance standards, but in the quality and experience of care for the people we serve.

Maternity performance

Maternity assurance metrics are based on the required reporting as set out by NHS England Perinatal Quality Oversight Model (2025) 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 2025/26 was 1,725 This is an increase from 2024/25 of 53 births. Nationally, there has been a slight rise in births.

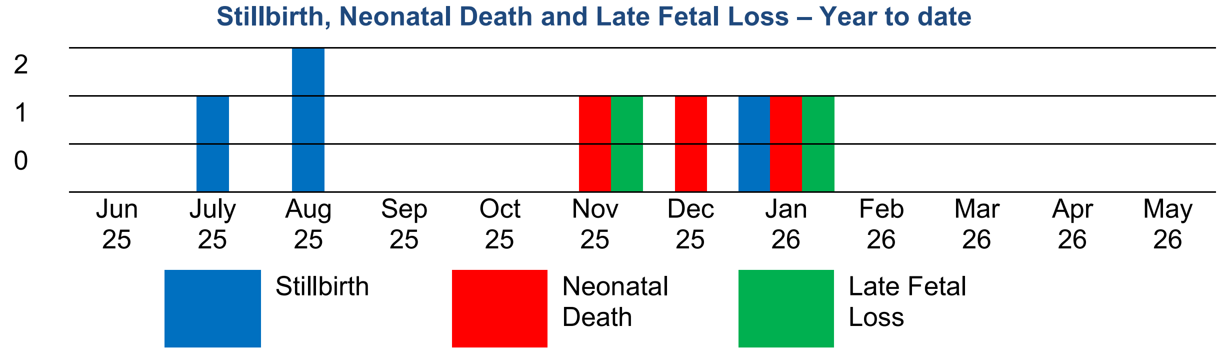
There continues to be an increasing complexity associated with pregnancy and birth due to several factors. These include demographics, health inequalities as well as being related to the standards that underpin safe care. There is also an increased requirement for operative/obstetric intervention during the birth process which impacts on the resources and capacity of the services. Fewer women are choosing to birth outside of a hospital setting due to the increased complexity described. There has also been a rise in women choosing to birth outside of recommended guidance.

Maternity and Neonatal Safety Improvement (MatNeo Improvement Support team)

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 programme has now transitioned into a six-month targeted support from an improvement team. Work includes co-production of a maternity and neonatal improvement plan as well as focus on governance , culture and leadership.

Perinatal Mortality Rate

The graph below shows the perinatal mortality detail for 2025/26. The service recorded five stillbirths, two late fetal loss and five neonatal deaths in 2025/26.



Smoking rates at time of delivery

The Smokefree Pregnancy Team continues to play a vital role in supporting women to quit smoking, contributing to a reduction in smoking at the time of delivery to 4% in the last financial year. This represents a significant improvement from 5.5% the previous year and reflects a consistent downward trend since 2019/20. The team continues to deliver the National Smoking in Pregnancy Incentive Scheme and has recently expanded its offer to include support for significant others. This initiative provides up to £500 in financial incentives, directly benefiting families—particularly those in more deprived communities where smoking rates are higher—and reinforcing our commitment to reducing health inequalities and improving outcomes for mothers and babies.

Performance for Planned Care

Cancer care

Demand for cancer services continues to increase. This year we received 23,380 Urgent Suspected Cancer (USC) referrals, a 2.4% increase on the previous year, equivalent to around 47 additional referrals each month. This reflects the growing demand for timely diagnosis and treatment across our communities.

Despite this sustained increase in referrals, we have continued to improve performance against national Cancer Waiting Time (CWT) standards, supporting faster access to diagnosis and treatment for local people.

We have consistently met or exceeded key national cancer standards set out in the NHS Operational Planning Guidance for this year:

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

  79.4% achieved in March 2025, with an annual average of 78.9%, above the national target of 77%

  This means more people are receiving a clear diagnosis, or having cancer ruled out, within 28 days of referral

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

  73.8% achieved in March 2025, with an annual average of 75.0%, above the national target of 70%

  This reflects continued progress in ensuring people begin their treatment as quickly as possible following urgent referral

These improvements demonstrate the sustained focus of our teams on early diagnosis and timely treatment, which are critical to improving outcomes for people.

Referral to Treatment (RTT) and long waits

Demand for planned care has also continued to grow with 126,200 referrals received this year, an increase of 5.3% compared to the previous year.

Despite this, we have made good progress in reducing the number of people waiting longer for treatment. During the year:

- The number of people waiting over 18 weeks reduced from 13,462 to 12,937
- The number waiting over 52 weeks reduced significantly from 1,764 to 931

We have also achieved important milestones in reducing the longest waits:

- no one waiting over 104 weeks
- fewer than 10 people waiting over 78 weeks
- continued progress in reducing 65-week waits, with 145 people remaining at the end of March 2025
- a substantial reduction in 52-week waits over the year.

This progress reflects a sustained focus on improving access and addressing the backlog built up in previous years.

Investment in our facilities has also supported this improvement. The completion of two additional day surgery theatres, including a dedicated eye theatre, has increased capacity and reduced reliance on costly additional sessions. This is enabling us to treat more people more efficiently and continue reducing long waits.

Alongside this, we have seen significant progress in specialities such as ophthalmology, particularly in reducing waits for cataract surgery.

While we have made clear progress, we know that challenges remain. Demand continues to grow and maintaining improvements in waiting times will require sustained focus.

As set out in our strategy, our approach is to continue improving access through a combination of increased capacity, better use of our existing resources, and new ways of delivering care. This includes strengthening day surgery, improving productivity and working more closely with partners to ensure patients are seen in the right place at the right time.

Recent investment and service improvement are already supporting this. The ongoing refurbishment of our theatre facilities is increasing capacity and enabling more efficient use of theatre time, while reducing reliance on additional sessions. Our day case theatres, including ophthalmology, have achieved Getting It Right First Time (GIRFT) accreditation, recognising the quality and efficiency of our clinical pathways and supporting continued improvement in patient outcomes and productivity.

Our focus remains on building on this progress — reducing waits further, improving the experience of care, and ensuring more people receive timely diagnosis and treatment.

Diagnostic performance

During 2025/26, our diagnostic performance did not meet the required standards or trajectories, despite delivering more tests overall.

We have seen improvements in some areas, but these have been offset by increased demand and pressures in others, particularly in non-obstetric ultrasound, flexible cystoscopy and DEXA scanning.

We have a clear recovery plan in place and will be focusing on improving performance across these modalities during 2026/27, building on the progress already made.

We have continued to work closely with the Community Diagnostic Centre in Torquay, which has increased overall capacity across CT, MRI, ultrasound, plain film and echocardiography. Together, we have refined the mix of diagnostics offered so it better reflects the needs of our population.

Children and Family Health Devon (CFHD)

Children and Family Health Devon (CFHD) supports children, young people and their families across Devon. It brings together physical health, mental health and developmental services so that children can access joined-up care, working closely with families, schools and local partners to provide early help, support wellbeing and improve long-term health outcomes.

A Care Quality Commission (CQC) inspection in November 2024 rated the service as Good across all domains, including safety, effectiveness, responsiveness, caring and leadership.

Overall, services are safe, well run and delivering what they are intended to, despite ongoing pressures. These pressures are well understood, regularly reviewed and managed through established governance arrangements.

Many pathways are performing well, with children and young people being seen within expected timescales across services such as community nursing, physiotherapy, children’s wellbeing support, urgent care and services for children in care. Where waiting times are longer than they should be - particularly in some mental health pathways and neurodiversity assessments - clear recovery plans are in place and progress is being closely monitored.

This is beginning to deliver improvement. Performance in the Mood, Emotions and Relationships (MERs) pathway has improved significantly compared to earlier in the year, with children, young people and families now being offered assessment appointments within the 18-week standard. Work is also underway to prepare for the introduction of the national four-week standard for mental health services.

We have continued to strengthen earlier and more accessible support. The introduction of the Balanced System® for speech, language and communication has improved early intervention, reduced delays and made it easier for families to access support by working more closely with schools, early years settings and partners.

We have also taken significant action to reduce waiting times for autism assessments by working with NHS partners, local authorities and approved independent providers to increase capacity. This approach is helping more children to be seen sooner, while ensuring diagnoses are recognised across education, SEND and EHCP processes, improving the experience for families.

Demand for support related to special educational needs and disabilities (SEND) remains high and continues to be one of our most significant challenges. Requests for Education, Health and Care Plans (EHCPs) are increasing, including for children not previously known to health services. We are working with partners to reduce delays in providing health advice for EHCPs and to improve coordination across the system, recognising that progress depends on collective action across health, education and local government.

We are also responding to national developments, including the SEND reform white paper, which emphasises earlier, more consistent support and closer partnership working.

The quality and safety of services continue to be monitored closely. Assurance is positive overall, with improvements in areas such as safeguarding and staff supervision. Some risks remain, including ensuring timely access to urgent mental health support and addressing constraints in buildings and estate.

Following a detailed review of how services are delivered, we worked closely with system partners throughout the year to plan and implement a transition to a single provider model. From 01 April 2026, services transferred to a single provider, with Devon Partnership NHS Trust (DPT) becoming the lead provider for the remainder of the contract period. This model is intended to improve coordination, reduce duplication and support more consistent care and experience for children, families and staff. Throughout the year, our focus has been on ensuring the transition was safe and well managed, maintaining service continuity and supporting colleagues through change. Partnership working will remain central as the new model is embedded.

Our people remain central to delivering these services. The overall position is stable, with a reduction in vacancy rates to 9% as at January 2026 and continued recruitment underway. While pressures remain in some areas, particularly mental health and urgent care, training and supervision are strong and teams continue to demonstrate commitment and resilience.

We have also strengthened our communications and engagement with children, families and staff. Increased use of digital channels has made it easier to access information and support, particularly in areas of highest demand such as neurodiversity, speech and language, and mental health. Campaigns such as Children’s Mental Health Awareness Week have helped amplify young people’s voices, reduce stigma and encourage early access to support.

From a financial perspective, services are operating within available budgets, with a continued focus on reinvesting efficiencies into frontline services to improve access and outcomes.

Overall, CFHD services are providing appropriate and safe care for children and families. While demand, staffing and funding pressures remain, these are well understood and openly reported. Continued partnership working will be critical to sustaining progress and improving access to services.

Our priorities for the year ahead reflect both the pressures we face and the needs of our communities:

- reducing waiting times, particularly for neurodiversity assessments, SEND-related services and mental health pathways
- strengthening early intervention and prevention, so children and families receive support sooner
- improving support for children with SEND through more joined-up working with councils, schools and partners
- supporting and developing our people, ensuring services are safely staffed and colleagues feel supported
- delivering recovery plans for mental health and neurodiversity services in a realistic and sustainable way
- making best use of available resources to support frontline services and reduce waiting times
- maintaining a strong focus on safety, including safeguarding and access to urgent mental health support
- improving openness and transparency about performance
- embedding the single provider model, ensuring services remain stable and focused on outcomes for children and families.

Quality goals and patient care

Quality Priorities 2025/2026

For the year 2025/26 we retained our four quality and patient safety goals which reflect our continued focus on embedding and sustaining the improvements achieved in the previous year. These goals remain at the heart of our ambition to improve the quality of care provided to our patients.

We also shared 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 2025/26 are displayed in the table below and our progress is discussed.

Quality goal 2024/25	**Quality priority 2025/26**
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 emergency and elective care delays Safe transition to EPR
Deliver what matters most to our people	Embedding PSIRF via engaging patients, their families and our colleagues in safety reviews and investigations Progressing a restorative just learning culture
Reduce health inequalities	Seek, identify and address health care inequalities Focus on Equality Impact Assessments (EQIA)

Quality goals	**Seek out and reduce harm**	**Excellence in clinical outcomes**	**Deliver what matters most to our people**	**Reducing health inequalities**
Improvement priorities	Sepsis	Reducing emergency and elective care delays	PSIRF: JLC and engaging patients, their families and staff in safety review	Seek, identify and address health care inequalities
	Safeguarding (MCA/DOLS)	Transition to EPR		Equality, Quality Impact Assessment

Progress against quality priorities 2025/26

Quality priority	**Progress**	**Plan**
Improve identification and management of sepsis	• developed a single trust-wide sepsis policy • embedded a trust-wide training and education programme introduction and roll out • agreed data collection for ongoing monitoring of compliance • improvement actions to support recognition and compliance of the sepsis care bundle • 2025-sepsis dashboard for all areas launched	Continue work to monitor sepsis trends and improvement work- step down as a quality priority for 2026/27
Strengthen the quality of our mental capacity assessments (MCA)	• delivered targeted Mental Capacity Act (MCA) training to ward teams to strengthen assessment quality • provided direct support to services where Deprivation of Liberty Safeguards (DoLS) are in place to improve MCA reviews • strengthened oversight and application	This area will remain a priority for clinical teams supported by our safeguarding leads.

<table>
<tr><td></td><td>of restrictive practices across clinical areas
• improved consistency and quality of mental capacity assessments through focused support and assurance
• developed an MCA app as part of a resource pack to support colleagues</td><td></td></tr>
<tr><td>Safe transition to EPR</td><td>• successfully transitioned to the One Devon electronic patient record (Epic) in April 2026
• embedded clinical leadership engagement to support safe transition and adoption
• strengthened focus on patient safety and quality throughout EPR implementation
• enabled more consistent, data-informed care through the new EPR
• positioned EPR as a key enabler of clinical quality, safety and productivity improvements</td><td>Continue to embed and support colleagues in the transition to Epic to ensure safety and quality benefits are realised.</td></tr>
<tr><td>Reducing elective and emergency care delays</td><td>• reduced delays across the emergency care pathway to improve patient safety and quality
• delivered improvements across urgent and emergency care performance
• reduced ambulance handover delays
• improved performance against national elective waiting time standards

<table><tr><th></th><th>March 25</th><th>March 26</th></tr><tr><td>78 weeks</td><td>7</td><td>7</td></tr><tr><td>65 weeks</td><td>141</td><td>47</td></tr><tr><td>52 weeks</td><td>931</td><td>600</td></tr></table></td><td>This improvement work has a significant impact on the quality and safety of patient care and will remain a core focus for our organisation.</td></tr>
<tr><td>Listening to our people</td><td>• strengthened involvement of patients, families and colleagues in safety investigations and complaints
• increased engagement in learning from incidents, with a focus on openness and inclusion
• recognised the need to further improve consistency in how people are involved
• developed a trust-wide Restorative, Just and Learning Culture (RJLC) programme
• established a clear policy and governance framework to support a fair and consistent approach to learning from incidents and concerns</td><td>This work will remain a focus and continue as a quality priority in the year ahead.</td></tr>
<tr><td>Reducing health inequalities</td><td>• worked with care groups to identify and address health inequalities across our population
• agreed to adopt the One Devon South Local Care Partnership strategy to tackle health inequalities
• aligned our approach with system partners to support consistent</td><td>Reducing Healthcare inequalities remains a core focus for our organisation, this is supported by a robust EQIA process and will continue as business as usual.</td></tr>
</table>

	delivery of the strategy • committed to sharing and embedding the strategy across our organisation	
Embedding Equality Impact Assessment (EQIA)	• reviewed and strengthened our Equality Quality Impact Assessment (EQIA) process • embedded EQIA into organisational change and cost improvement processes • ensured decisions are informed by impacts on quality (safety, effectiveness and experience) and health inequalities • introduced a panel approach to strengthen review and oversight of EQIAs	This process is now successfully embedded into our change processes. To continue as business as usual

Our progress against these priorities is discussed in more detail in our 2025/26 Quality Account.

Our quality priorities for 2026/27 are:

	Quality Priority
1	Ending corridor care by improving patient flow and safety in acute and community services and strengthening neighbourhood care
2	Improving engagement with our communities and workforce through listening, learning and a just culture, to support continuous improvement in quality and safety
3	Using digital technology and neighbourhood-based care to improve continuity, safety and people's ability to live well at home and avoid unnecessary hospital care

COVID-19 and flu immunisation programme

During autumn and winter 2025/26, we delivered our COVID-19 and flu vaccination programme through a combination of our Vaccination Hub, drop-in clinics and roving vaccinators, making it as easy as possible for colleagues to access their vaccination around their working day.

Overall, 58% of our colleagues chose to be vaccinated, the highest level across Devon and around 10 percentage points above the national average. Uptake increased across key professional groups, including medical, nursing and allied health colleagues, compared to the previous year.

For COVID-19, the national programme focused on a smaller number of eligible groups. Within this, we supported colleagues who were immunosuppressed, with 132 colleagues receiving the vaccination.

Together, this work has helped protect our colleagues and the people we care for and supports our wider focus on keeping services safe and resilient during periods of increased seasonal pressure.

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. This year we have met the standard of 90% of the waiting list being validated. In 2026/2027 we will be updating our access policy in line with the new national guidance on single point of access

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.

We have put in place improvement boards for urgent and emergency care (UEC) and planned care (elective) performance with cancer and diagnostics being included within the elective board. In addition to this, specific oversight forums have been held when required for areas of focus such as UEC demand, implementation of the ambulance timely handover process, improving corridor care and cancer recovery.

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

The outcome of the NHS England / Integrated Care Board EPRR core standards assessment for 2025 in relation to our organisational responsibilities as a category 1 responder under the Civil Contingencies Act (2004) was presented to the Executive Committee in September 2025 and to the Audit and Risk Committee in April 2026. The outcome of the review was that we were deemed fully compliant against 51 of the 62 core standards, with the remaining 11 graded as partially compliant. No standards were rated as non-compliant. This resulted in an overall rating of 'partially compliant'. It should be noted that this reflects a reduction in the number of standards rated 'fully compliant' from last year which was a conscious decision taken by us to rate several business continuity related standards as partially rather than fully compliant. This allows for a greater focus on business continuity as an overarching organisational requirement.

In addition to the core standards assessment, we 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 SWASFT site visit took place on 18 August 2025 and consisted of a review of CBRN documentation, a visit to the Torbay Hospital's decontamination unit and the

Emergency Department where SWASFT staff spoke with colleagues on duty. We were fully compliant in 11 of 12 standards, with one standard partially compliant and an action to investigate the capability of the eRostering system to clearly display trained staff who are on shift at any time.

EPRR incidents

During the 2025/26 year we did not declare any major incidents and the only external major incidents we participated in related to the discovery of unexploded bombs elsewhere in Devon which had a minimal impact on our services. There were two critical incidents, both of which related to pressure, patient flow and moving into Operational Pressures Escalation Levels (OPEL) 4. Both of these were in January 2026 at the height of winter pressures:

No.	Critical Incident	Date/Duration
1	Capacity/Operational pressures	05/01/26 – 09/01/26
2	Capacity/Operational pressures	14/01/26 – 15/01/26

In addition to these two critical incidents we responded to several Business Continuity Incidents which are outlined below:

No.	Business Continuity Incident	Date/Duration
1	Hot Water Leak affecting Labs, Pharmacy and Fracture Clinic	17/04/25
2	Liquidation of NRS Healthcare	01/08/25-09/04/26
3	Absconding mental health patient from Salus Ward (DPT unit)	04/11/25
4	Heraeus Medical bone cement supply chain disruption	19/02/26-26/02/26
5	Stryker cyber attack supply chain disruption	12/03/26-23/04/26

EPRR risk register

There are five risks under EPRR currently open on our risk register. Following review during the 2025 core standards process community risks will be considered and where appropriate added to our risk register under EPRR.

EPRR training

Our training this year has focussed on the ongoing Emergency Department Major Incident and Decontamination training, JESIP training for members of the on-call team and evacuation simulation training for ward teams in the tower block and in the intensive care unit at Torbay Hospital. Evacuation training for inpatient areas is a rolling programme to ensure as many colleagues as possible are trained in, and aware of, evacuation procedures.

Epic go-live and business continuity arrangements

The EPRR team were heavily involved in the run-up to the Epic go-live over the Easter bank holiday weekend with a member of the team attending the Gold and Silver meetings throughout. While the Epic go-live was not declared an incident, command and control arrangements were put in place to ensure issues could be escalated and resolved in a timely manner.

Working closely with the EPR Information Officers, the EPRR team played a significant role in the roll out of business continuity arrangements for Epic, including the rollout of BCA laptops and red folders to all departments across Torbay Hospital and community sites.

EPRR Exercises

This year the following internal exercises have been delivered:

- major incident (incident coordination centre) tabletop exercises on 25 April 2025 and 07 May 2025 – reviewing and testing action cards for members of the on-call team
- tower block ward evacuation tabletop exercise 23 December 2025 – testing plans and arrangements for a vertical evacuation from the Torbay Hospital tower block
- intensive care unit evacuation tabletop exercise 09 February 2026 – tabletop exercise with senior nursing and medical staff in advance of simulation exercises planned for all teams over a rolling 12 month period
- lockdown exercise in maternity 03 February 2026 – physically testing arrangements for a lockdown in maternity in the event of an attempted abduction
- intensive care unit evacuation simulation 05 March 2026 – the first of five simulation exercises testing progressive horizontal evacuation

We also actively participated in the following external exercises:

- Exercise Solaris 20 May 2025 – Devon, Cornwall and Isles of Scilly (IoS) Local Resilience Forum (LRF) pandemic influenza exercise in preparation for the national pandemic flu exercise (Exercise Pegasus)
- Exercise Dante 04 June 2025 – Devon ICB heatwave exercise
- NHS England (South West) Winter Plan exercise 10 September 2025
- Exercise Pegasus 22 September 2025 – testing the Devon, Cornwall and IoS LRF element of the national pandemic influenza exercise
- Operation Charron 06 November 2025 – contaminated fatalities desktop exercise led by UK Disaster Victim Identification on behalf of the local coroner and Devon and Cornwall Police

Health Inequalities

Our approach

We are committed to reducing health inequalities across Torbay and South Devon, ensuring that everyone can access high-quality care, have a positive experience, and achieve the best possible outcomes.

Over the past year, we have strengthened how we identify, understand and respond to inequalities, supported by improved data, clearer governance and closer working with our partners.

We focus on three key questions:

- who is not accessing care as we would expect
- who is having a poorer experience or outcome
- where this is linked to wider disadvantage, such as deprivation, age or digital exclusion

This provides a clear framework for understanding variation and taking targeted action.

We combine quantitative data with insight from lived experience to build a fuller picture of the communities we serve and how services are experienced.

We know that only a small proportion of health inequalities are driven by healthcare itself, with wider factors such as income, education and housing having the greatest impact. This is why our approach focuses not only on access to services, but also on working with partners to address the wider determinants of health.

We have prepared this section in line with the NHS England statement on information on health inequalities. We use this information to understand variation in access, experience and outcomes, and to take targeted action. This forms part of our routine reporting to Board and supports decision-making across our organisation.

Understanding our population

The communities we serve have distinct characteristics, including an older population, areas of significant deprivation, and relatively small but growing minority ethnic communities, particularly among children and young people.

These factors shape patterns of health need and access to services. In some areas, inequalities may be less visible due to small population sizes, but this does not mean they are absent. We are therefore focused on improving the quality and completeness of our data so that we can identify variation confidently and respond appropriately.

Key insights

Elective care

We have seen a strong recovery in elective activity, with more people accessing planned care than before the pandemic. This includes a significant increase in activity for children and young people, with admissions rising by 36% compared to pre-pandemic levels, suggesting that previously unmet need is now being addressed.

Among adults, activity has also increased, with a 7% rise over the same period, reflecting sustained recovery across our services.

While overall volumes have increased, patterns of access across deprivation groups have remained largely unchanged. Among adults in particular, there has been no significant shift in the distribution of activity between more and less deprived communities.

This tells us that increasing activity alone is not enough - without targeted action, recovery risks maintaining rather than reducing inequality.

Ethnicity data shows a gradual increase in the proportion of patients from minority ethnic backgrounds accessing elective care, particularly among children and young people. However, small population sizes mean these changes should be interpreted with care, and continued monitoring is needed.

Urgent and emergency care

Among children and young people, emergency admissions are significantly higher in the most deprived areas compared to the wider Devon population.

This reinforces the strong link between deprivation and unplanned healthcare use, and highlights the need to focus earlier in the pathway—strengthening prevention, early intervention and support within communities to reduce avoidable hospital use.

Smoking in pregnancy and acute care

We have continued to make sustained progress in reducing smoking in pregnancy, with smoking at the time of delivery falling from 8.1% in 2023/24 to 4.1% in 2025/26.

This is important as smoking is a key driver of poorer outcomes for mothers and babies and is more prevalent in more deprived communities.

Our work to support people admitted to hospital to stop smoking is also showing improvement, with increasing engagement and quit rates despite constrained resources. This demonstrates the impact of a consistent, evidence-based approach.

Oral health in children

Oral health remains one of the clearest indicators of inequality.

Children from more deprived communities are significantly more likely to require hospital treatment for tooth decay, and most admissions continue to come from these areas. Activity has increased compared to the previous year, with over 300 children requiring treatment in 2025/26, suggesting growing need.

This highlights the importance of early prevention and coordinated support for children and families.

Digital access

As digital services become a more central part of how people access care, there is a risk that some groups are less able to benefit.

In our communities, digital exclusion is linked to age, rurality, income and confidence using technology. Without targeted support, this can limit access and widen existing inequalities.

What we are doing

We are working with our partners across Devon to take a more targeted and coordinated approach to reducing health inequalities. This includes strengthening prevention, improving access to services, and focusing support on communities with the greatest need.

For children and families, we are working across health, education and community services to promote early intervention. This includes oral health promotion, support for families who need additional help, and more coordinated pathways for children with additional needs.

We are embedding health inequalities into our service planning and improvement work, ensuring that decisions are informed by data on access, experience and outcomes across different population groups.

Through our neighbourhood approach, we are developing more local, integrated support to help people stay well in their communities and reduce avoidable hospital use.

As digital services become more central to how people access care, we are taking steps to ensure that no one is left behind. The introduction of our electronic patient record and patient portal creates new opportunities for people to manage their care more easily, but also brings a responsibility to ensure people can use these services confidently.

In response, we are providing practical support, including digital volunteers and on-site assistance, and working with partners to improve access to devices, connectivity and community-based support. Alongside this, we are investing in digital skills for our colleagues so they can support patients and use digital tools effectively in their roles.

We are using these measures to track variation over time, understand what is making a difference, and adapt our approach where inequalities persist.

Looking ahead

We have made progress in strengthening how we understand and respond to health inequalities, supported by improved data and closer partnership working.

We know there is more to do. Our focus will be on continuing to improve data quality, deepen our understanding of lived experience, and use this insight to take targeted action.

We will continue to embed this insight in routine Board reporting and decision-making, and evaluate whether our actions are making a measurable difference for the communities we serve.

Above all, we will continue to focus on reducing inequalities in access, experience and outcomes—so that everyone in our community can benefit from care that is fair, effective and shaped around their needs.

Financial Performance

During 2025-26 our income was £785m compared to £729m in 2024/25; this was derived primarily from the provision of acute patient care services; however, as an integrated care organisation we have also received 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. The Trust also recognises income in respect of education and training and 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.

The Trust is reporting a deficit of £34m for 2025-26, adjusted to £22m deficit for financial performance monitoring, which excludes the impacts of impairments and other technical accounting adjustments. This outturn position is £14m adverse to plan, with the variance relating to a shortfall in planned income. The Trust plan included £31m of Deficit Support Funding (DSF) but only £15m was received in respect of quarters 1-2 of the financial year, with DSF income withheld from all Devon ICS organisations for quarters 3-4. This was withheld due to the system failing to deliver their plan in year.

The Trust has set a balanced financial plan for 2026-27. The Trust financial plan for 2026-27 reflects an expected reduction in funding of £19m relating to the transfer of the Children and Family Health Devon (CFHD) contract to Devon Partnership NHS Trust with effect from 1st April 2026, reducing planned income and associated spend by £41m, offset with other increases in funding for demand and inflationary pressures. The Trust plans to deliver a breakeven financial position in 2026-27 includes non-recurrent DSF of £58m and achievement of savings target of £54m.

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 and joint working with other Devon providers as part of the One Devon Procurement Service.

Under the National Audit Office ('NAO') Code for 2025/26, our external auditor, Grant Thornton LLP, have issued an Auditor's Annual Report providing a commentary on our arrangements to secure Value for Money.

Capital developments during the last year

During 2025/26 we continued to invest in our facilities, equipment, and digital infrastructure, delivering a total capital programme of £76.9 million, including in-year Right of Use Asset additions. We also benefited from £0.8 million of charitable donations to support improvements for the people and communities we serve.

Our capital investment is supported through a combination of Public Dividend Capital from the Department of Health and Social Care, alongside other sources of financing including leases with both commercial providers and public sector partners.

Investment in our estate totalled £42.4 million during the year. This has enabled us to address critical infrastructure risks, tackle backlog maintenance, and invest in new and refurbished spaces to support high-quality care. Key schemes delivered during the year included upgrades to elective theatres, expansion of urgent and emergency care capacity, oral and maxillofacial remodelling works, relocation and remodelling of surgical admissions, and essential high and low voltage substation works.

Alongside our estate programme, we made a significant investment in our new electronic patient record. Total investment in 2025/26 was £24.4 million, reflecting the scale and importance of this transformation. Our One Devon electronic patient record went live on 01 April 2026, marking a major step forward in how we support joined-up, high-quality care across our services and with partners.

Investment in the programme is expected to reduce to around £8 million in 2026/27, reflecting the transition from implementation to ongoing optimisation, with funding met through operational capital allocations.

Cashflow

Our cash position has increased, from a starting point at 01 April 2025 of £26.7m, to a sum of £35.5m at 31 March 2026, a movement of £8.8m. The increase in cash balance has been primarily driven by an increase in creditors of £8m compared to the position as at 01 April 2025.

The sum of Revenue Public Dividend Capital (PDC) drawn down in year totaled £23.4m compared to £12.7m in 2024/25. The increased draw was due to the withdrawal of Deficit Support Funding of £15.4m. There is a cost to drawing down PDC to both HM Treasury and to us and consequently, PDC cash funding is not drawn down ahead of need.

During 2026/27, 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 organisation. 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.

Based upon the most up to date figures (subject to audit), in 2025/26 our Charity received donations and legacies totalling £390k.

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 people who use our services. 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 and are published on the Charity Commission's website.

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

During 2025/26 we continued to embed sustainability, carbon reduction and climate resilience across our services, aligning our approach with national policy and our wider purpose of supporting people and communities to live well.

We refreshed our Green Plan, originally published in 2022, to reflect updated NHS England guidance set out in *Delivering a Net Zero National Health Service* (February 2025). The updated plan was approved by our Board in July 2025 and published in September 2025. The updated Green Plan sets out how we will contribute to the NHS ambition to reach net zero for the NHS Carbon Footprint by 2040 and Carbon Footprint Plus by 2045, alongside clear interim milestones. It also reflects the duties set out in the Health and Care Act 2022, ensuring that environmental considerations are embedded in planning and decision-making.

A structured gap analysis was undertaken to assess our existing plan against the latest requirements. This will strengthen our approach in a number of areas, including governance, reporting, resilience and delivery:

- strengthening governance arrangements, with the Chief Operating Officer/Deputy Chief Executive designated as the Senior Responsible Owner for sustainability
- revising the Sustainability and Wellbeing Group, including Non-Executive Director leadership and broader senior representation
- updating our carbon emissions baseline and reporting to demonstrate progress since 2022
- beginning a Climate Change Risk Assessment to better understand and plan for the impacts of severe weather and longer-term climate change
- expanding training and development, including carbon literacy and Greener NHS education for colleagues
- taking forward further action on biodiversity, digital innovation and reducing emissions from anaesthetic gases and pharmaceuticals

An NHS Devon & NHS Cornwall & Isles of Scilly Green Plan 2025 – 2030 has also been published and sets out a bold course to achieving net zero. Through uniting our communities, health systems and local partners in a shared commitment to climate resilience and environmental stewardship. This joined up approach will get us ready in creating a healthier, more sustainable future for all. The Green Plan is accessible through this link: NHS Devon and NHS Cornwall and the Isles of Scilly Green Plan 2025-2030 - One Devon

Our focus areas

Our work is structured around key priority areas that support delivery of our Green Plan and the NHS net zero ambition:

- decarbonising our estate and improving energy efficiency
- designing new buildings to net zero carbon standards
- reducing water consumption
- improving waste management and recycling
- supporting sustainable travel for patients, colleagues and visitors
- reducing emissions from anaesthetic gases and medicines
- using digital technology to enable lower-carbon models of care
- reducing emissions across our supply chain
- enhancing biodiversity across our sites
- strengthening climate resilience.

Our progress this year

During the year we made practical progress across a number of areas:

We introduced a single plated patient food system on our acute site, reducing food and packaging waste while improving patient experience. All containers are recyclable and returned for reuse, with plans to extend this approach to our community hospitals.

We expanded our “Keep Me Cup” scheme to reduce disposable cup use, encouraging colleagues and visitors to use reusable options.

Following the removal of desflurane, we decommissioned piped nitrous oxide infrastructure in July 2025, reducing emissions from anaesthetic gases in line with national guidance.

We continued to promote sustainable travel, including a popular e-bike loan scheme and wider engagement activity supporting walking, cycling and public transport options.

We expanded our electric vehicle fleet and charging infrastructure, supporting the transition to lower-carbon transport.

We worked with local authority partners to progress plans for a solar photovoltaic (PV) farm to support future renewable energy generation.

Across our sites, we have continued to enhance green spaces and biodiversity through initiatives such as wildflower meadows, pollinator habitats, and woodland and sensory trails.

All new developments continue to be designed to BREEAM standards, including our Emergency Department extension, helping to improve energy performance and reduce environmental impact.

We have also maintained a strong focus on waste management, improving segregation to reduce incineration and increase recycling. During 2025/26:

- total waste generated was 1,692.51 tonnes
- 33% of waste was recycled
- 0% was sent to landfill
- the remaining waste was managed through energy recovery and clinical waste streams (percentage of total waste tonnage of general waste to energy – 22%; percentage of total waste tonnage of clinical offensive waste – 23%; percentage of total waste tonnage of clinical non-burn waste – 12.5%; percentage of total waste tonnage of clinical burn waste – 8.46%)

All metrics remained within expected compliance ranges.

Priorities for 2026/27

Looking ahead, we will continue to build on this progress, with a focus on:

- further improving waste segregation in line with NHS Clinical Waste Strategy targets
- strengthening our capacity by recruiting an Energy and Decarbonisation Manager
- achieving Biodiversity Benchmark accreditation
- securing external funding to support innovation, including technologies to reduce emissions from anaesthetic gases

This work will continue to be led by our Estates and Facilities teams, with oversight through our Sustainability and Wellbeing Group and regular reporting to the Board.

Social and community issues

As one of the largest employers in Torbay and South Devon, we recognise the responsibility we carry in our local health and care system and in the wider life of our communities. As an anchor institution, we are deeply rooted in place, and we use our influence, resources and relationships to contribute to long-term health, opportunity and wellbeing.

This responsibility is particularly important for children and young people. Supporting people to start well in life - through good health, education, skills and early access to opportunity - is a vital part of improving outcomes later in life. Over the past year, we have continued to strengthen pathways into health and care careers, working closely with education and employment partners to widen access and raise aspiration.

During the year, we continued our work with South Devon College, developing clearer routes into health and care roles through T Levels, placements and vocational pathways. We welcome industrial placement students and are part of the T Levels scheme for 16–18-year-olds, helping young people gain real experience of working in health and care. We continued our healthcare support worker scheme, supporting people into roles that are critical to our services while providing training, confidence and progression opportunities.

We continued to develop our approach to work experience and volunteering, including partnership working with Jobcentre Plus through the volunteer-to-career programme. This builds on our wider commitment to creating inclusive routes into work and we were proud this year to receive the NHS England Silver Award for Work Experience, recognising the quality and accessibility of the opportunities we offer to local people.

We also recognise the strong link between good work and good health. In partnership with community and voluntary sector organisations, including the Torbay Advice Network, we have supported adults in receipt of social care to access and sustain employment, with practical advice, reasonable adjustments and access-to-work support.

As part of our commitment to strengthening employment in our wider community, we share our apprenticeship levy with Devon Partnership Trust and smaller local employers, helping them to support staff to undertake apprenticeship programmes. We continue to explore further levy-sharing arrangements and to develop our online work-experience platform, widening awareness of career opportunities across the health and care sector.

Our role as an anchor institution also extends to how we spend, commission and partner. We are proud signatories of the Torbay Community Wealth Building Memorandum of Understanding, working alongside Torbay Council, South Devon College and local VCSE partners to support local jobs, skills and supply chains. This includes aligning our purchasing decisions with our commitment to place and using our collective influence to support inclusive economic growth.

Beyond formal programmes, many of our colleagues contribute directly to community life - supporting local health groups, volunteering their time and acting as governors for schools and colleges. We actively support and value this wider contribution, recognising that strong communities and strong public services depend on people being able to play an active role where they live.

We also recognise that health is shaped by more than care alone. Housing, education, environment, income and debt all influence people's ability to live well. We will continue to work alongside our communities and partners to address these wider determinants of health and to play our part in making Torbay and South Devon a better place to live and work.

Anti-bribery and human rights issues

We have a zero-tolerance approach to bribery, fraud and corruption, supported by clear policies, strong governance and a culture that encourages people to speak up.

We work closely with our Local Counter Fraud Specialist (LCFS) to raise awareness of our policies and procedures through induction, targeted training and ongoing communications. We continue to support compliance with NHS requirements, including the management of conflicts of interest, through the use of our central management system and regular awareness campaigns.

We encourage anyone with a concern to speak up. Colleagues can raise issues through a range of internal routes, including our Freedom to Speak Up Guardians or the LCFS. The Freedom to Speak Up function reports directly to the Chief Executive and provides regular updates to the Board, while counter fraud activity is reported through the Audit and Risk Committee. The Freedom to Speak Up Guardian is also a regular attendee at the People Committee, strengthening oversight of workforce and wellbeing matters.

We expect the same high standards of integrity across our supply chain. We promote ethical procurement practice and support professional standards through membership of the Chartered Institute of Procurement and Supply. This includes adherence to its code of conduct, which is reflected in our Standing Orders and Standards of Business Conduct. We also expect our suppliers and contractors to promote a culture of openness and challenge, and to act where they see unethical behaviour.

Our Counter Fraud, Bribery and Corruption Policy sets out our approach in detail, supported by related policies on conflicts of interest, gifts and hospitality, and disciplinary processes. These are reviewed regularly to ensure they remain effective and support our resilience to fraud and economic crime.

We are also committed to ensuring that our policies and practices respect human rights and do not have an adverse or discriminatory impact on the people and communities we serve or on our colleagues.

Modern Slavery Act 2015

We have a Board approved anti-slavery and human trafficking statement, which is published on our website.

We fully supports and are 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 colleagues 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, we have published Modern Slavery and Human Trafficking Policy Statement, which can be found on our 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 2025/26 financial year, nor have any been identified at the time of reporting (June 2026).

Important events since the end of the financial year

Since 31 March 2026, we have gone live with our One Devon Electronic Patient Record (EPR), marking a significant milestone in our digital transformation programme. Delivered in partnership with NHS organisations across Devon, the EPR provides a single, shared patient record to support joined-up care and access to information for colleagues involved in a person's care.

The go-live followed an extensive period of system build, testing and colleague training to support a safe and well-managed transition. During the initial period of operation, enhanced support arrangements have been in place across clinical and operational services to maintain patient safety and service continuity.

As a major transformation programme, the EPR is intended to support improvements over time, including information sharing and timely access to patient records. We will continue to monitor system performance and impact through its established governance and assurance processes.

This represents the only material event since the end of the financial year.

This concludes the performance report, overview, risk and analysis section of the annual report.

Joe Teape

Joe Teape
Chief Executive
25 June 2026

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 accounts give 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 2026 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 Ashish Ghadiali – Non-Executive Director Mark Greaves – Non-Executive Director Paul Richards – Non- Executive Director and Senior Independent Director Chris Saxby – Non-Executive Director Robert Williams – Non-Executive Director	Joe Teape – Chief Executive Adel Jones – Deputy Chief Executive/Chief Operating Officer James Corrigan – Chief Finance Officer Catherine (Kate) Lissett – Chief Medical Officer Nicola McMinn – Chief Nurse Jess Piper – Chief People Officer Simon Tapley – Chief Strategy and Planning Officer

Note: Our Board has 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: Chris Balch left the organisation on 30 April 2026 and was replaced by Martin Beaman. Adel Jones left the organisation on 04 May 2026 and Robert Williams left on 08 May 2026. Adel was replaced as Chief Operating Officer by Sam Wadham-Sharpe on an interim basis on 05 May 2026.

The gender balance of the Board as at 31 March 2026 was:

	Female	Male
Non-Executive Directors	1	7
Executive Directors	4	3

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.

In January 2026, the Quality Assurance, Finance and Performance, People and Building a Brighter Future Committees were stood down and replaced by the Quality and People and Finance and Operations Committees.

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 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; PSIRF Benchmarking; clinical audit forward plan; freedom to speak up guardian; cyber security; information governance; deprivation of liberty protocol; head and neck portacabin road traffic collision update; 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:

- results of Inpatient Nurse Safer Staffing Review
- Adult Social Care performance
- the Quality Report for Healthcare and performance
- Equality and Quality Impact Assessments
- BAF objectives within the Committee's remit

Received:

- regular Perinatal Governance Reports
- the Adult Social Care Local Account
- the Clinical Audit Forward Plan
- the Annual Fitness to Practice Report
- Maternity and Neonatal Staffing updates
- update on Martha's Rule implementation
- the Children and Family Health Devon Governance Report
- feedback following annual review of the Committee's effectiveness
- the following annual reports: Infection and Prevention; Mortuary; Safeguarding Children; Patient Safety Incidents; Patient Experience; Research and Development; Safeguarding Adults; Clinical Audit; and Medicines Optimisation Annual Report

The Committee also:

- gained assurance on delivery of the CQC Action Plan
- considered health inequalities performance
- gained assurance through the Mortality Safety Scorecard
- gained assurance around the Trust's compliance with its CQC Registration
- considered the results of the CQC NHS Adult Inpatient Survey
- considered relevant Internal Audit Reports

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:
- finance reports
- service line report progress reports
- Children and Family Health Devon integrated governance reports
- digital updates
- operational performance reports
- NHS Devon ICS governance review update
- National Cost Collection Index
- business planning updates
- Treasury report
- review of Adult Social Care performance and transformation
- Adult Social Care debt
- feedback from annual self-assessment exercise
- deep dives: trauma and orthopaedics; planned care; families and community; and surgical
- the following business cases: Contract Award Strategic Design Partner Capital Developments; Replacement Automated Dispensing System; Patient Transport Service; Frailty Service; Peninsula Pathology Target Operating Model Programme; and Money Transmission Memorandum of Understanding

Reviewed:
- annual plan
- capital spend and planning
- disposal of surplus property
- insurance renewal proposals
- Tower risk reports
- Electronic Patient Record progress
- cyber assurance
- Independent Sector uplift
- updated financial procedures
- Devon System Financial Risk Management
- Our Plan for Better Care
- cash Management
- Jack Sears' Performance
- Medium Term Financial Plan
- Cost Improvement Programme
- post Implementation reviews

- winter plan
- financial forecast
- relevant Internal Audit reports
- BAF objectives within the Committee’s remit

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 our organisation. In delivering its remit the Committee reviewed and received the following:

- noted difficulties delivering the 2025/26 Workforce Plan and limited impact of workforce controls
- continued work to align workforce and financial data
- delivery of People Digital Programme
- establishment of staff networks
- establishment of Cultural Insights Review Group and alignment with PSIRF and restorative just and learning culture
- received positive GMC National Training Survey
- received feedback on Staff Survey
- discussed cultural issues impacting the organisation
- reviewed achievement review performance
- impact of People Promise
- received regular performance reports
- received regular staff stories
- reviewed Guardian of Safe Working Hours feedback
- reviewed work of the Resident Doctor Ten Point Plan working group
- requirement to ensure people policies were up to date
- received WRES and WDES Action Plan
- reviewed BAF objectives within the Committee’s remit
- undertook an annual self-assessment exercise

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 organisational strategy. In delivering its remit the Committee reviewed and received the following:

- digital updates
- estates capital updates
- estates infrastructure updates
- improvement and innovation progress updates
- strategic partnership progress updates
- Electronic Patient Record progress
- Tower Assessment report
- multi storey parking hub report
- community estate strategy
- draft capital development strategy
- ERIC return
- relevant Internal Audit reports

- acceleration of digital innovation briefing
- following business cases: Surgical Admissions relocation; Ophthalmology lanes; Oral Maxillo-facial service expansion and remodelling; and Day Surgery Theatre and replacement of Air Handling
- NHP close report
- Green Plan refresh
- Teignmouth Community Hospital update
- BAF objectives within the Committee's remit
- undertook an annual self-assessment exercise

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)
- 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 in 2025/2026 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 organisation, 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
- considered proposals for executive restructure
- considered proposal for a mutually agreed resignation scheme
- oversaw the process for the appointment of four executive directors
- undertook a self-assessment exercise

The committee took advice, legal guidance and support from the Chief People Officer, who attends meetings in an advisory capacity. This input ensured that relevant matters were considered consistently and in line with agreed policy, regulatory expectations and good governance practice. Our governance arrangements also supported oversight of how the organisation promotes and sustains a diverse Board, including through inclusive and transparent appointment processes, consideration of Board composition and succession planning, and ensuring that recruitment and selection decisions are fair, objective and aligned to the Trust's values, statutory responsibilities and commitment to representing the communities it serves. The Committee ensured oversight of how the Board supports and reflects a diverse workforce, promoting inclusive practice, and ensuring that workforce-related decisions are fair, equitable and aligned to the Trust's values and statutory responsibilities. Where further development or action was identified, this was agreed, tracked and reviewed through the appropriate governance routes to provide assurance that progress is maintained and risks were effectively managed.

Finance and Operations Committee: The Committee provides assurance to the Board on financial performance, management and transformation; operational performance, productivity and sustainability; performance of the organisation in delivering the current financial and operational plan in year; and recommends the draft annual (financial and operational) plan as well as any relevant strategies for implementation, for approval to the Board of Directors. In delivering its remit the Committee reviewed and received the following:

Reviewed:

- financial and operational performance
- capital spend and planning
- Electronic Patient Record progress
- service line reporting
- BAF objectives within the Committee's remit

Quality and People Committee: The Committee provides assurance to the Board on the quality of care, ensuring systems are in place to achieve high standards and comply with regulations like the CQC framework; giving due consideration to the experience of those who use our services; and all people related matters, including workforce strategy, staff engagement, health and wellbeing, and equality, diversity, and inclusion (EDI).; and recommend the draft annual (financial and operational) plan as pertains to quality, safety and people, as well as any relevant strategies for implementation, for approval to the Board of Directors. In delivering its remit the Committee reviewed and received the following:

Reviewed:

- Adult Social Care
- health inequalities
- Maternity and Neonatal staffing
- 72 hour standards and 7 day working
- mortality
- quality and workforce performance
- BAF objectives within the Committee's remit

Received:

- external regulation oversight
- resuscitation annual report
- people services strategy and future model updates
- quarterly National Staff PULSE survey
- culture plan progress
- restorative just and learning culture plan
- cultural insights review group
- appraisal update
- CQC NHS patient experience survey
- Agenda for Change Job Evaluation Band 5-6 for Registered Nurses
- combined gender, ethnicity, disability pay gap report
- safer staffing report
- working lives of Resident Doctors
- CFHD integrated governance report
- relevant Internal Audit reports

And undertook a stroke deep dive.

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 and effective framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk;

- assurances received are sufficiently accurate, reliable, and comprehensive to meet the Accounting Officer's needs, are appropriately aligned to the organisation's Board Assurance Framework, and provide reasonable assurance;

- governance, risk management and internal control arrangements within the organisation include areas of good practice alongside areas where further improvement is required;

- financial controls are sufficient to provide reasonable assurance against material misstatement or loss; and

- the quality of both internal audit and external audit over the past year has met all the organisation's requirements.

The Committee noted the Head of Internal Audit Opinion for the year, which provided satisfactory assurance over the organisation's framework of governance, risk management and control.

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 internal control across the whole of the organisation's activities (both clinical and non-clinical) with particular focus on key risks including financial sustainability and workforce pressures;
- 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 organisation's arrangements for counter fraud, bribery and corruption, including reports from the Local Counter Fraud Specialist;
- 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, including review and approval of changes ; and
- 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.

Membership and attendance at Board and Committee meetings

The Board of Directors discharged its duties during 2025/26 in seven 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.

2025-26	Board of Directors	Non-Executive Director Nominations and Remuneration Committee	Audit and Risk Committee	Quality Assurance Committee	Finance, and Performance Committee	People Committee	Building a Brighter Future Committee	Finance and Operations Committee	Quality and People Committee
Number of meetings	7	14	6	4	9	5	4	3	3
Chris Balch	C 7 (7)	C 14 (14)	-	-	-	-	-	-	-
Martin Beaman	7 (7)	12 (14)	6 (6)	C 4(4)	-	-	-	-	C 3(3)
Liz Edwards-Smith	7 (7)	5 (7)	2 (2)	1 (1)	3 (3)	C 4(5)	-	-	3 (3)
Ashish Ghadiali	5 (5)	-	-	0 (1)	-	2 (2)	-	-	2 (3)
Mark Greaves	5 (7)	-	C 5 (5)	1 (3)	2 (2)	-	-	3 (3)	-
Paul Richards	6 (7)	12 (14)	5 (6)	-	C 9 (9)	-	3 (4)	3 (3)	-
Chris Saxby	5 (7)	-	-	-	9 (9)	4 (5)	4 (4)	3 (3)	3 (3)
Robin Sutton	0 (0)	-	C 1 (1)	-	2 (2)	-	-	-	-
Siân Walker-McAllister	1 (2)	2 (7)	4 (4)	2 (2)	-	3 (3)	-	-	-
Robert Williams	6 (7)	-	5 (6)	-	-	-	C 4(4)	C 3 (3)	-
Joe Teape	7 (7)	14 (14)	-	-	-	-	-	-	-
Mark Brice	2 (2)	-	4 (4)	-	6 (6)	-	1 (2)	-	-
Arun Chandran	0 (0)	-	-	0 (0)	0 (0)	-	0 (0)	-	-
Anne Cholmondeley	0 (1)	1 (5)	-	-	-	1 (2)		-	-
James Corrigan	5 (5)	-	2 (3)	-	4 (4)	-	0 (2)	2 (3)	-
Adel Jones	6 (7)	-	-	1 (4)	7 (9)	3 (5)	3 (4)	1 (3)	1 (3)
Catherine (Kate) Lissett	7 (7)	-		2 (4)	-	3 (5)	-	-	3 (3)
Nicola McMinn	4 (7)	-	5 (6)	4 (4)	-	-	-	-	2 (3)
Jess Piper	2 (2)	-	-	-	-	-	-	-	-
Simon Tapley	7 (7)	-	-	-	6 (9)	-	3 (3)	2 (3)	-

Notes:
Arun Chandran resigned on 14.07.25 (relinquished executive duties wef 14.01.25)
Anne Cholmondeley resigned on 23.07.25 (relinquished executive duties wef 27.6.25)
Mark Brice resigned on 12.09.25 (relinquished executive duties wef 03.08.25)
Robin Sutton resigned on 31.04.25

Siân Walker-McAllister resigned on 31.08.25
Ashish Ghadiali became a substantive Non-Executive Director wef 01.09.25
Simon Tapley was appointed on 22.04.25 (interim) and 15.09.25 (substantive)
James Corrigan was appointed on 04.08.25 (interim) and 22.12.25 (substantive)
Jess Piper was appointed on 02.03.26
Wef from 01 January 2026 Quality Assurance, Finance and Performance, People and Building a Brighter Committees were stood down and replaced by Finance and Operations and Quality and People Committees.

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 2025/26 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 organisation and the services it provides.

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**
Val Browning	South Hams	Elected - 01 March 2023	4 (4)
Dave Cawley	South Hams	Re-elected – 01 March 2025	4 (4)
Julie Spinks	South Hams	Elected – 01 March 2025	3 (4)
Eileen Engelmann	Teignbridge	Re-elected – 01 March 2025	4 (4)
James Hartley	Teignbridge	Elected – 01 March 2023	1 (2)
Michael Joyce	Teignbridge	Elected – 01 March 2025	4 (4)
Geoff King	Teignbridge	Elected – 01 March 2025	1 (2)
Sue Knott	Teignbridge	Elected – 01 March 2026	0 (0)
Alison MacGregor	Teignbridge	Elected – 01 March 2025	1 (2)
Jake O'Donovan	Teignbridge	Elected – 01 March 2026	0 (0)
James Osben	Teignbridge	Elected – 01 March 2025	2 (4)
Andrew Postlethwaite	Teignbridge	Re-elected – 01 March 2026	2 (4)
Sally Allen-Gerard	Torbay	Elected – 01 March 2026	0 (0)
Mike Blakeley	Torbay	Elected – 01 March 2026	0 (0)
Susie Colley	Torbay	Elected – 01 March 2026	0 (0)
Loveday Densham	Torbay	Re-elected – 01 March 2025	3 (4)
John Kiddey	Torbay	Re-elected – 01 March 2025	2 (2)
Alison Ramon	Torbay	Elected – 01 March 2023	3 (4)
Andrew Stilliard	Torbay	Re-elected – 01 March	4 (4)

		2026	
Lee Thomas	Torbay	Re-elected – 01 March 2026	4 (4)
Vincent Williams	Torbay	Elected – 01 March 2024	2 (4)
Geoff King – stood down 19.06.25 John Kiddey – stood down 22.08.25 James Hartley – stood down 28.08.25 Alison MacGregor – stood down 01.10.25 Val Browning – stood down 11.02.26 Alison Ramon – end of term 28.02.26			

Staff-elected governors (staff constituency)			
Name	**Class**	**Tenure**	**CoG Attendance**
Sal Aziz	Children and Family Health Devon	Re-elected 01 March 2024	1 (2)
Olivia Bath	Planned Care & Surgery	Elected 01 March 2026	0 (0)
Maroria Oroko	Medical & Urgent Care	Elected 01 March 2026	0 (0)
Yvonne Paulucy	Professional Support Services	Elected 01 March 2024	0 (2)
Vicki Payne-Cater	Professional Support Services	Elected 01 March 2026	0 (0)
Radia Woodbridge	Families and Communities	Re-elected 01 March 2024	3 (4)
Sal Aziz – stood down 30.05.25 Yvonne Paulucy – stood down 23.10.25			
Appointed governors (partner organisations)			
Name	**Organisation**	**Tenure**	**CoG Attendance**
Sarah Adams	Devon Partnership Trust	Appointed 22 April 2025	3 (3)
Karen Barry	Devon Integrated Care Board	Appointed 05 June 2024	1 (3)
Joanna Bowtell	University of Exeter Medical School	Appointed 01 October 2023	3 (4)
Richard Keeling	Devon County Council	Appointed 24 June 2025	2 (3)
Alison Meadows	Devon/Torbay Carers	Appointed 22 May 2025	2 (3)
John Nutley	Teignbridge Council	Appointed 31 May 2023	2 (2)
Ron Peart	Devon County Council	Appointed 09 April 2024	0 (0)
David Thomas	Torbay Council	Appointed 25 March 2025	3 (4)
Louise Winfield	Plymouth University Peninsula Schools of Medicine and Dentistry	Appointed 01 March 2023	3 (4)
Ged Yardy	South Hams District Council	Appointed 24 May 2023	4 (4)
Ron Peart – stood down 07.05.25			

Since the end of the financial year Sally Allen-Gerard and Susie Colley stood down from their roles. Sue Knott also had to stand down as she moved to a location outside of the constituency to which she was elected to stand. The Trust will be running an additional election process in the summer to recruit to vacant governor positions.

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, elections were held with each member being offered a three-year term of office.

Constituency	Candidate	Result	Voting %
Teignbridge	Sue Knott	Elected unopposed	
Teignbridge	Jake O'Donovan	Elected unopposed	
Teignbridge	Andrew Postlethwaite	Elected unopposed	
Torbay	Sally Allen-Gerard	Elected unopposed	
Torbay	Mike Blakeley	Elected unopposed	
Torbay	Susie Colley	Elected unopposed	
Torbay	Andrew Stilliard	Elected unopposed	
Torbay	Lee Thomas	Elected unopposed	
Staff	Olivia Bath	Elected	75%
Staff	Maroria Oroko	Elected unopposed	
Staff	Vicki Payne-Cater	Elected	70%

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. The full Terms of Reference are available on the Trust website at Corporate documents - Torbay and South Devon NHS Foundation Trust.

In delivering its remit during 2025/2026 the Committee:

- 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
- appointed one substantive Non-Executive Director, previously having been an associate NED with the Trust.
- ran processes to appoint a new Chair and new Non-Executive Directors, although these colleagues did not commence in post until after the start of the new financial year. In respect of the Chair, following approval gained from NHSE Region an internal appointment was made. The new Non-Executives Directors were appointed following an external recruitment process, led by the Trust.

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 our organisation, our vision and our performance to members and the public and the stakeholder organisations that either elected or appointed them.

In delivering its remit the Committee:

- 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
- considered ways to promote Governor elections

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 14,603 members as at 31 March 2025, split between 7,223 public members and 7,380 staff members. The public constituencies of South Hams, Teignbridge, Torbay and Rest of the South West Peninsula comprised 862 members, 2,665 members, 3,680 members and 16 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 four occasions during 2025/26. 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 2025/26 sets out a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, supporting public accountability for performance and informing how NHS England works with systems and providers to support improvement.

For 2025/26, providers are assessed against a focused set of metrics aligned to the national priorities and operational planning guidance for the year. Based on performance against those metrics, providers are placed into one of four core segments, with segment 1 representing organisations with the narrowest range of challenges and segment 4 those with the broadest range of challenges. The most challenged providers may receive intensive, tailored improvement support through segment 5.

- providers are scored against a defined set of delivery, quality and financial metrics set out in the NHS Oversight Framework 2025/26 methodology
- individual metric scores are consolidated into an overall segment, and NHS England also considers organisational capability when determining the nature and intensity of improvement support

Under the 2025/26 methodology, segmentation is derived through an automated process. An organisation's segment guides the intensity of oversight and support, and providers with an underlying financial deficit cannot be allocated to a segment better than 3.

Trust Segmentation and Recovery Support

As we entered the 2025/26 financial year, we remained in Segment 4 and continued to receive bespoke mandated support. This segmentation reflected our underlying financial deficit and the need for improvement in operational performance.

In response, we developed and delivered a series of time-bound and measurable performance actions, agreed with NHS England, to support its exit from the Recovery Support Programme.

In March 2026, we received formal notification that we had successfully exited the Recovery Support Programme and had been moved to Segment 3.

This segmentation position reflects our status as at April 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website. NHS England » Segmentation and league tables

Well Led

The Council of Governors, Board, Committees and services are kept under regular review to assess whether they are well led in accordance with NHS England's Well-Led Framework. Annual effectiveness reviews of our governance arrangements are undertaken with reference to this framework. These reviews consider the extent to which governance arrangements support delivery of our organisational strategy, including effective and compassionate leadership, shared direction and culture, partnership working, responsiveness to stakeholders, sustainability and continuous improvement.

We also have due regard to the Care Quality Commission's well-led framework in reaching our overall assessment of performance, internal controls and the Board Assurance Framework. The principles of the framework underpin our strategy, approach to risk management and review of Board and Committee effectiveness.

In July 2025, the Board commissioned an external developmental well-led review to support the further refinement of our leadership priorities. The findings and recommendations arising from this review were incorporated into the Integrated Improvement Plan, enabling the Board to maintain oversight of implementation and progress. Actions were progressed during 2025/26 and will continue into 2026/27 to support sustained and embedded improvement.

The Audit Committee has delegated responsibility for oversight of our system of internal control, supported by the Trust's internal audit partner, Audit South West.

We continue to work closely with the CQC through regular monthly and quarterly engagement meetings. These meetings, which included executive representation, provided an important forum for open discussion, ongoing engagement and the sharing of information between our organisation and the CQC.

Further detail regarding our approach to clinical services is set out in the Quality Account 2025/26.

Person centred care

We remain committed to providing personalised care for all our people. This work is overseen by a person-centred care group, which is jointly chaired by the Head of Personalised Care and the Deputy Chief Allied Health Professional. Over the past year we have taken the following steps:

We continue to conduct regular audits of our approach to person centred care on our wards, including reviewing documentation, and surveying patients and carers. As we move to our electronic patient record (EPR) this data review will be brought into regular quality monitoring. We also have an opportunity with the EPR to review other measures of person-centred care such as recording preferred place of death in advanced care planning.

Over the past year there has been a particular focus on improving engagement with family members and carers. All ward areas now have carers boxes and ready access to carer lanyards to assist with identification of those in caring roles. We are proud there was a greater than 5% improvement in our results with the CQC inpatient survey around engaging with carers around hospital discharge. We have also focused on increased use of the Defence Welfare Medical Service (DWMS) for current Armed Forces personnel, veterans and their families, and this is now embedded in our nursing documentation.

We continue to promote a range of options to support self-management approaches including our Health Connect Coaching programme, digital education options and the HOPE (help overcoming problems effectively) programme. We are in the process of enabling our communities to access MyCare - the patient facing element of our EPR which will enable patients to manage their appointments, access their test results and share their information with proxies if they wish this, further strengthening our support of self management.

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 described elsewhere in this report, we engage directly with patients, service users, carers, families and the wider public to understand their experiences, listen to their views and, where possible, improve the services we provide. We value the ideas people share with us about how services can be developed and improved.

Our Board of Directors recognises the importance of understanding the lived experience of people who use our services and continues its commitment to hear a patient or carer story regularly at Board meetings.

As a Foundation Trust with a large public membership, we are able to draw on the knowledge and experience of our members. Governors attend Board sub-committees as observers, and patient representatives also attend key groups including the patient feedback and engagement group, quality improvement group and mortality surveillance group. This helps us better understand the experiences and needs of people who use our services.

Information and feedback are gathered from a wide range of sources, including national and local surveys. We also receive valuable ideas and suggestions through established patient pathways, social media, and our patient and service user groups.

We work closely with external organisations such as Healthwatch and seAp (a charity providing independent and confidential advocacy services), which help ensure we hear a wide range of voices. We are committed to working in partnership to strengthen how we listen to, and make use of, people's experiences to inform service improvement.

During the year, we carried out focused engagement to support the development of our refreshed organisational strategy. We worked with colleagues, governors and partners through existing meetings and development sessions, including Board and executive discussions, care group sessions and a dedicated workshop with governors. These conversations helped us understand whether the overall direction felt right, where greater clarity was needed and what might make delivery harder in practice.

We also invited colleagues, patients, carers and members of the public to share their views through a survey. People told us what matters most to them, what they think needs to change, and what they want us to focus on in the years ahead. The survey was shared through our internal and external channels and local media, with support from organisations such as Healthwatch.

What we heard through this engagement was considered alongside existing insight, including staff survey results, Freedom to Speak Up themes, complaints and patient feedback. Together, this helped shape the final strategy, ensuring it reflects the realities faced by our colleagues, patients and communities and is clear about priorities for the future.

Other disclosures

Fees and charges (income generation)

Costs associated with fees and charges 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 (2024/25: £Nil) under the Late Payment of Commercial Debts (Interest) Act 1998.

	2025/26		2024/25	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	146,563	421,823	150,409	367,880
Total Non-NHS trade invoices paid within target	136,800	386,213	123,585	301,693
Percentage of Non-NHS trade invoices paid within target	93%	92%	82%	82%
Total NHS trade invoices paid in the year	1,597	51,881	1,649	42,991
Total NHS trade invoices paid within target	1,199	35,399	1,016	36,324
Percentage of NHS trade invoices paid within target	75%	68%	62%	85%

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 2025/26 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

We have complied with the cost allocation and charging guidance issued by HM Treasury, as set out in Managing Public Money and interpreted through the Department of Health and Social Care Group Accounting Manual.

Accessible Information Standard

Making health and social care information accessible

This year, we continued to strengthen how we meet the Accessible Information Standard, helping people receive information in ways they can understand, with the right support where they need it. This is an important part of how we provide personalised, equitable care and reduce barriers for people with additional communication needs.

National expectations were refreshed during the year, placing greater emphasis not only on identifying, recording, flagging and meeting people’s needs, but also on routinely reviewing them and strengthening how organisations assess their own performance and report progress.

Locally, we have continued to build this into our wider focus on personalised care, equity and inclusion. We have maintained arrangements to record communication needs within patient records, ensured access to interpretation and translation services, and kept a clear focus on providing information in ways people can understand and use.

As we prepared for our new electronic patient record, we also reviewed how communication needs are captured and made visible to colleagues. While there is more to do, this work is helping us improve consistency and reduce the risk that people’s needs are missed.

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 2026

PART III – REMUNERATION REPORT

Salary and pension entitlements of senior managers as at 31 March 2026 (audited information)

	2024-25						2025-26					
	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)
Mr J Teape Chief Executive (appointed 10 March 2025)	10-15	300	0	0	2.5-5	15-20	215-220	3300	0	0	55-57.5	270-275
Dr CA Lissett Chief Medical Officer	190-195	0	0	0	432.5-435	625-630	190-195	0	0	0	65-67.5	260-265
Ms A Jones Director of Transformation and Partnerships/latterly Chief Operating Officer	140-145	900	0	0	32.5-35	175-180	140-145	1400	0	0	20-22.5	160-165
Mrs E Long Director of Corporate Governance and Trust Secretary	120-125	0	0	0	30-32.5	150-155	125-130	500	0	0	42.5-45	170-175
Mrs N McMinn Chief Nurse	125-130	0	0	0	142.5-145	270-275	130-135	1400	0	0	32.5-35	160-165
Mr MH Brice Chief Financial Officer (Ceased executive duties on 03/08/2025 and retired on 14/09/2025)	155-160	0	0	0	42.5-45	200-205	50-55	0	0	0	0	50-55
Mr J Corrigan Chief Finance Officer (Commenced executive duties 04/08/2025 and appointed to substantive role 22/12/2025)							100-105	0	0	0	0	100-105

	2024-25						2025-26					
	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 J Piper Chief People Officer (Commenced executive duties 16/06/2025 and appointed to substantive role 02/03/2026)							85-90	2700	0	0	45-47.5	135-140
Mr S Tapley Chief Strategy and Planning Officer (Commenced executive duties 22/04/2025 and appointed to substantive role 15/09/2025)							145-150	0	0	0	15-17.5	165-170
Ms A Cholmondeley Interim Chief People Officer (Ceased executive duties on 27/06/2025 and resigned on 23/07/2025)	25-30	0	0	0	5-7.5	30-35	30-35	0	0	0	7.5-10	35-40
Mrs L Davenport Chief Executive (retired 31/12/2024)	165-170	0	0	0	0	165-170						
Mr W Shields Interim Chief Executive (01/01/2025 to 07/03/2025)	35-40	0	0	0	0	35-40						
Dr J Watson Health and Care Strategy Director (Resigned from executive duties on 26/02/2025)	160-165	0	0	0	0	160-165						
Mr AP Chandran	100-105	0	0	0	100-102.5	215-220						

Chief Operating Officer												
Dr M Westwood Chief People Officer (resigned 15/01/2025)	100-105	0	0	0	65-67.5	165-170						

	2024-25						**2025-26**					
	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**
	(bands of	(to nearest	(bands of	(bands of	(bands of £2,500)	(bands of	(bands of	(to nearest	(bands of	(bands of	(bands of	(bands of
Name and Title	£5,000)	£100)	£5,000)	£5,000)		£5,000)	£5,000)	£100)	£5,000)	£5,000)	£2,500)	£5,000)
Mr R Sutton Non-Executive Director	15-20	0	0	0		15-20	0-5	0	0	0		0-5
Mr P Richards Non-Executive Director	10-15	0	0	0		10-15	15-20	0	0	0		15-20
Prof C Balch Non-Executive Director (appointed 21/10/2024)	45-50	0	0	0		45-50	50-55	100	0	0		50-55
Ms S Walker-McAllister Non-Executive Director	15-20	0	0	0		15-20	5-10	0	0	0		5-10
Dr M Beaman Non-Executive Director	10-15	0	0	0		10-15	10-15	0	0	0		10-15
Mr R Williams Non-Executive Director	10-15	0	0	0		10-15	10-15	0	0	0		10-15
Mr M Greaves Non-Executive Director (appointed 01/01/2025)	0-5	0	0	0		0-5	15-20	0	0	0		15-20
Mr A Ghadiali Non-Executive Director (appointed 21/10/2024)	0-5	0	0	0		0-5	10-15	0	0	0		10-15

Mrs E Edwards-Smith Non-Executive Director (appointed 21/10/2024)	5-10	0	0	0		5-10	10-15	0	0	0		10-15
Mr C Saxby Non-Executive Director (appointed 21/10/2024)	5-10	0	0	0		5-10	10-15	0	0	0		10-15

	2024-25						2025-26					
	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
Mrs V Matthews Non-Executive Director (resigned 31/01/2025)	10-15	0	0	0		10-15						
Sir R Ibbotson Non-Executive Chairman (retired 31/05/2024)	5-10	300	0	0		5-10						
Mrs BE Gregory Non-Executive Director (resigned 22/05/2024)	0-5	0	0	0		0-5						
Mr R Crompton Non-Executive Director (resigned 02/10/2024)	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						

Notes:
Mr R Sutton resigned on 30/04/2025
Ms S Walker-McAllister resigned on 31/08/2025
Mr MH Brice retired on 14/09/2025 but ceased executive duties on 03/08/2025
Ms A Cholmondeley resigned on 23/07/2025 but ceased executive duties on 27/06/2025
Mr J Corrigan commenced executive duties on 04/8/2025 and appointed to substantive role on 22/12/2025. He opted out of the NHS pension scheme on 1 Aug 2024.
Mrs J Piper commenced executive duties on 16/6/2025 and appointed to substantive role on 02/03/2026
Mr S Tapley commenced executive duties on 22/04/2025 and appointed to substantive role 15/09/2025
Mr AP Chandran left the Trust on the 14/07/2025 but ceased executive duties as Chief Operating Officer on 14/01/2025. He was paid £51k in 2025-26.

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 31 March 2026 (audited information)

	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2026	Lump sum at pension age related to accrued pension at 31 March 2026	Cash Equivalent Transfer Value at 1 April 2025	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employers Contribution to Stakeholder Pension
Name and title	**(bands of £2,500)**	**(bands of £2,500)**	**(bands of £5,000)**	**(bands of £5,000)**				**(to nearest £100)**
Mr J Teape Chief Executive (appointed 10 March 2025)	2.5-5	0	80-85	205-210	1801	69	1927	0
Ms A Jones Chief Operating Officer	0-2.5	0	50-55	120-125	1034	23	1093	0
Dr CA Lissett Chief Medical Officer	2.5-5	2.5-5	80-85	210-215	1805	81	1949	0
Mrs E Long Director of Corporate Governance and Trust Secretary	2.5-5	0	5-10	0	86	23	119	0
Mrs N McMinn Chief Nursing Officer	0-2.5	0	60-65	150-155	1,358	45	1,443	0
Mr S Tapley Chief Strategy and Planning Officer (Commenced executive duties 22/04/2025 and appointed to substantive Role 15/09/2025)	0-2.5	0	65-70	170-175	1491	24	1561	0
Mr MH Brice Chief Financial Officer	0	0	0	0	1299	0	0	0
Ms A Cholmondeley Interim Chief People Officer (appointed 16 January 2025)	0-2.5	0	20-25	60-65	493	11	521	0
Mrs J Piper Chief People Officer (Commenced executive duties 16/06/2025 and appointed to substantive role 02/03/2026)	0-2.5	5-7.5	20-25	55-60	356	47	424	0

Pension benefits are provided through the NHS Pension Scheme, which is an unfunded, defined benefit scheme.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of pension benefits accrued by a member at a given point in time. The benefits valued include the member's accrued pension and any contingent spouse's pension payable from the scheme. The CETV represents the value of pension benefits accrued through total membership of the scheme and is not limited to service in a senior capacity to which the disclosure applies.

The real increase in CETV represents the increase that is funded by the employer and excludes the increase arising from inflation and employee contributions. Movements in CETV may be influenced by factors other than changes in pensionable pay, including changes to actuarial assumptions and discount rates determined by HM Treasury.

Pension benefits and associated CETVs have been calculated in line with the NHS Pension Scheme McCloud remedy, applying the statutory remedy approach to affected members.

As non-executive directors do not receive pensionable remuneration, there are no pension disclosures in respect of non-executive directors

Annual Statement on Remuneration

There have been no changes to the remuneration policy for senior managers during the year ended 31 March 2026.

The Non-Executive Directors' Nomination and Remuneration Committee is responsible for determining the remuneration and terms of service of Executive Directors. During the year, the Committee undertook its annual review of executive remuneration and satisfied itself that remuneration levels were appropriate, proportionate and aligned to the scale, responsibility and accountability of each role.

During the year ended 31 March 2026, four senior managers (Chief Executive, Chief Medical Officer, Chief Finance Officer & Chief Strategy & Planning Officer) were paid remuneration in excess of £150,000.

For Executive Directors, there are no arrangements relating to termination payments other than those arising from the application of employment contract law. No termination or loss of office payments were made to either current or former senior managers during the year.

Remuneration for all staff other than doctors and directors is determined in accordance with national Agenda for Change arrangements. Pay and conditions of service for doctors are 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 managers' 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 Non-Executive Directors 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 Non-Executive Directors 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 2026, 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 2026	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 J Corrigan	Executive Board member	04.08.25 (interim) 22.12.25 (substantive)	Indefinite term	Not applicable	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
Ms J Piper	Executive Board member	02.03.26	Indefinite term	Not applicable	Three months	Three months
Mr S Tapley	Executive Board member	22.04.2025 (interim) 15.09.25 (substantive)	Indefinite term	Not applicable	Three months	Three months
Prof C Balch	Non-Executive Board Member	01.05.2024	Na	Tenure ended on 30.04.2026	Three months	Three months
Mr M Beaman	Non-Executive Board Member	01.11.2023	3 years	01.05.26 took on role of Chair for a 2 year period	Three months	Three months
Ms L Edwards-Smith	Non-Executive Board Member	21.10.2024	3 years	1 year 3 months	Three months	Three months
Mr A Ghadiali	Non-Executive Board Member	01.09.2025	3 years	2 years 2 months	Three months	Three months
Mr M Greaves	Non-Executive Board Member	01.01.2025	3 years	1 year 6 months	Three months	Three months
Mr P Richards	Non-Executive Board Member	12.11.2025	1 year	4 months	Three months	Three months
Mr C Saxby	Non-Executive Board Member	21.10.2024	3 years	1 year 3 months	Three months	Three months
Mr R Williams	Non-Executive Board Member	01.06.2024	3 years	Left the Trust on 08.05.2026	Three months	Three months

Notes:
Unless noted above, these officers have been in post throughout 2025/26

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 53 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 45 – 51.

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 2025/26.

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/four days per month
Remuneration	£10,000 per annum for all Associate Non-Executive Directors – three/four 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 21p 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 2025	31 March 2026
Number of Governors in office	26	28
Number of Governors receiving expenses	2	2
Total expenses paid to Governors	£668.75	£619.85

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 the financial year 2025/26 was £220,000 - £225,000 (2024/25, £220,000 - £225,000). This was 5.9 times (2024/25, 6.2) the median remuneration of the workforce, which was £37,796 (2024/25, £36,483).

The decrease in ratio from 6.2 to 5.9 in 2025/26 is due to an increase in the median employee pay salary. The highest paid director in 2025-26 was the Chief Executive Officer. The highest paid director in 2024-25 was also the Chief Executive Officer.

In 2025/26, eight (2024/25, nine) employees received remuneration in excess of the highest-paid director. These staff were employed in senior medical roles.

For employees of the organisation as a whole, remuneration ranged from £24,465 to £273,878 (2024/25, £23,614 - £317,957).

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 2024/25 and 2025/26 is –0.49%, while the percentage change between 2023/24 and 2024/25 was 2%. The highest paid director's remuneration between 2024/25 and 2025/26 has not changed, while the percentage change between 2023/24 and 2024/25 was 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.

	2025/26			2024/25		
	25th Percentile	Median	75th Percentile	25th Percentile	Median	75th Percentile
Salary component of pay	£27,738	£37,796	£48,234	£25,917	£36,482	£48,508)
Total pay and benefits excluding pension	£27,738	£37,796	£48,234	£25,917	£36,483	£48,508
Total pay and benefits excluding pension: pay ratio for highest paid director	8.0:1	5.9:1	4.6:1	8.7:1	6.2:1	4.6:1

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.

Payments for loss of office will be limited to contractual entitlements and will comply with NHS England approval processes and government guidance on special severance payments.

This concludes the Renumeration Report for 2025/26.

Joe Teape

Chief Executive
25 June 2026

PART IV – STAFF REPORT

Analysis of staff costs (audited information)

We are 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'.

	2025/26			2024/25		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	296,019	296,019	-	274,910	267,098	7,812
Social security costs	36,424	36,424	-	28,204	28,204	-
Apprenticeship levy	1,423	1,423	-	1,433	1,433	-
Employer's contributions to NHS pensions	35,836	35,836	-	34,487	34,487	-
Pension cost – Employer contributions paid by NHS England on Trust's behalf (6.3%)	23,568	23,568	-	23,000	23,000	-
Pension cost - other	47	47	-	94	94	-
Temporary staff	26,376	-	26,376	30,642	-	30,642
Total staff costs	**419,693**	**393,317**	**26,376**	**392,770**	**354,316**	**38,454**
Of which: Costs capitalised as part of assets	8,288	8,288	-	3,820	3,820	-

We incurred £34,000 (2024/25 £933,000) in respect of other post-employment benefits, other employment benefits, or termination benefits. We did not second any colleagues in either year to other organisations, instead where colleagues supported 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' colleagues.

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. Colleagues on outward secondment are not included in the average number of employees.

NHSE Staff Group	2025/26		
	Total	Of which permanently employed	Of which other
Medical and Dental	663	307	356
NHS Infrastructure Support	1794	1710	84
Registered Nursing, Midwifery and Health Visiting Staff	1495	1464	31
Registered/ Qualified Scientific, Therapeutic and Technical staff	921	899	22
Support to Clinical Staff	1393	1319	74
Total	6,266	5,699	567

* Figures as at 31 March 2026

Analysis of sickness absence

The sickness absence rate for 2025/26, compared with the previous five years, is shown below. Sickness absence in 2025/26 remains elevated at 5.17%, reflecting a sustained increase compared to pre-pandemic levels (4.02% in 2020/21) and a rise from 5.00% in 2024/25. This equates to 118,303 FTE days lost, the highest level across the six-year period, and represents a disproportionate increase relative to workforce growth. While average FTE has grown to 6,266, sickness days have increased at a much faster rate, indicating that the underlying attendance position has deteriorated rather than this being purely a function of a larger workforce.

Encouragingly, the average sickness absence duration has reduced slightly to 11.9 days, down from 12.4 days in the previous two years, which may indicate early signs of improvement in the management of longer-term absence. However, duration remains materially higher than earlier years, reinforcing that absence continues to be driven by more complex or longer-term conditions, with the highest prevalence seen in mental health and musculoskeletal cases.

Overall, the 2025/26 position points to a persistent and structural absence challenge, with both the rate and total volume of sickness remaining elevated. This continues to place sustained pressure on workforce capacity and operational resilience, despite marginal improvements in absence duration.

In response to the sustained rise in sickness absence, there has been a clear organisational focus on strengthening the health and wellbeing offer, with a particular emphasis on supporting staff to remain well in work rather than solely responding once absence occurs. This has included a renewed focus on early intervention, timely occupational health input, and the proactive use of reasonable adjustments, ensuring that colleagues with both physical and mental health needs are supported to continue working safely where possible.

Recognising that the highest levels of absence are driven by mental health and musculoskeletal conditions, targeted initiatives have been prioritised in these areas. This includes promoting access to wellbeing support services, enhancing line manager capability to have supportive wellbeing conversations, and embedding a more consistent approach to tailored workplace adjustments, such as flexible working, amended duties, and phased returns. These interventions are designed to both reduce the likelihood of absence and support earlier returns where absence does occur.

While the overall sickness position remains challenging, the reduction in average absence duration suggests that these approaches are beginning to have a positive impact in managing longer-term cases more effectively. Continued focus on prevention, early support, and sustaining staff in work will be key to improving attendance levels over time and mitigating the operational impact of absence.

Year	12 month sickness	Average FTE	FTE days available	FTE days lost to sickness	Average sickness absence duration (FTE days)
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	2,261,625	112,802	12.4
2025/26	5.17%	6,266	2,286,115	118,303	11.9

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

- period covered: April 2025 to March 2026 (Data as at 31 March 2026)
- 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

Over the past year, we have taken important steps to strengthen our culture, modernise our people policies and improve how we support our colleagues day to day.

A key focus has been embedding our Restorative, Just and Learning Culture, moving away from blame and towards a more open, fair and learning-focused approach. This includes creating the conditions for colleagues to feel safe to speak up, learn from experience and be supported when things go wrong.

To support this, we have developed a clear implementation plan and established a dedicated policy review group, bringing together colleagues from across our organisation to ensure our people policies are fair, accessible and aligned with national Just Culture principles.

Alongside this, we introduced the Cultural Insights Review Group (CIRG), which provides oversight of culture and colleague experience. CIRG brings together insight from across the organisation to identify themes, strengthen accountability and ensure that learning is understood and acted on consistently.

Key developments this year

- launch of the Cultural Insights Review Group (CIRG)
- progress in embedding our Restorative, Just and Learning Culture
- introduction of our Employee Virtual Assistant (EVA)
- strengthening of staff networks and colleague engagement
- commitment to the NHS Sexual Safety Charter

We have also made progress in modernising our people services. As part of the One Devon People Digital Programme, we introduced our Employee Virtual Assistant, giving colleagues a simpler way to access information, get support and track requests. This is an important step towards improving experience and releasing time back to patient care.

Creating an inclusive and supportive working environment remains a priority. We continue to promote equity, respect and dignity, supported by our diversity and inclusion policy and our wider culture work. Our policies are routinely reviewed to consider their impact and reduce the risk of disadvantage from the outset.

We have strengthened opportunities for people who may face barriers to employment through our work experience programmes, apprenticeships and partnerships with local organisations, helping more people access and sustain employment.

We have also taken steps to support colleagues with caring responsibilities, including improving access to support and building carer awareness into our wellbeing offer. More broadly, we continue to support health and wellbeing through occupational health services, psychological support and our commitment to being a Mindful Employer.

Alongside this, we have continued to strengthen how we support an inclusive and representative workplace. Our staff networks play an important role in this, creating space for colleagues to connect, share lived experience and shape how we improve services and working environments. These networks provide valuable insight into the experiences of our people and help to inform our approach to inclusion, wellbeing and reducing inequalities - both for our workforce and the communities we serve.

This includes networks supporting colleagues from global majority backgrounds, disabled colleagues, LGBTQ+ colleagues and others, each contributing to a more inclusive and supportive working environment.

During the year, we further developed our approach to engagement and inclusion, including targeted engagement with under-represented groups and the expansion of leadership and development opportunities in partnership with system colleagues

We have also committed to the NHS Sexual Safety Charter, reinforcing our zero-tolerance approach to unacceptable behaviours and continuing to strengthen how we prevent, report and respond to concerns.

Providing safe ways for colleagues to speak up remains a priority. Alongside our Freedom to Speak Up Guardian and network, we have expanded the use of anonymous channels, ensuring colleagues have a range of ways to raise concerns and that these are listened to and acted upon.

Taken together, this work is helping us build a more inclusive, compassionate and supportive working environment. While there is more to do, we are establishing stronger foundations for a culture where colleagues feel safe, valued and able to do their best work.

Staff engagement and experience

We know that the best way to care for the people who use our services is to care for the people who deliver them – our dedicated and compassionate colleagues.

Supporting our people to live well is central to our purpose of supporting every person, family and community we serve to live well. When colleagues feel seen, heard and valued, this is reflected in lower absence and turnover, and in better patient experience, safety and quality of care.

We continue to prioritise listening to and engaging with our colleagues through a range of established channels. These include Trust Talk, our monthly executive briefing, the 'Just Ask!' platform, surveys such as the National Staff Survey and quarterly Pulse surveys, our Freedom to Speak Up Guardian and network, partnership working with trade unions, wellbeing initiatives, staff governors, learner councils and our staff networks.

The past year has remained challenging. Health and social care services continue to operate under significant pressure, alongside financial constraints and the ongoing impact of the cost of living. During summer 2025, we also saw an increase in unacceptable comments and behaviours towards colleagues, particularly those from global majority backgrounds.

In response, we reinforced our expectations of respectful behaviour, strengthened support for colleagues who experience unacceptable behaviour and worked with teams to ensure concerns are identified and addressed quickly. We have also continued to prioritise inclusion and staff voice, so that colleagues feel confident to speak up and know they will be heard.

NHS National Staff Survey (NSS) 2025

The 2025 National Staff Survey provides important insight into how our colleagues are experiencing work at a time of continued pressure across our services.

The overall response rate was 35.55% (down from 39% in 2024). This means we need to do more to engage colleagues and ensure we are hearing from a broader and more representative range of voices, particularly those from under-represented groups.

Overall, the results show a broadly stable but fragile position, reflecting the wider national picture. While there have been small improvements in areas such as engagement, morale and aspects of inclusion and staff voice, there has been no significant shift in overall experience.

National Staff Survey results – People Promise/ Theme from previous year and compared to Sector

Indicators (People promise elements and themes) People Promise:	**2025/26**		**2024/25**		**2023/24**	
	Trust Score	**Benchmarking group score**	**Trust Score**	**Benchmarking group score**	**Trust Score**	**Benchmarking group score**
We are compassionate and inclusive	7.29	7.28	7.27	7.21	7.24	7.24
We are recognised and rewarded	5.96	5.87	5.92	5.92	5.93	5.94
We each have a voice that counts	6.53	6.60	6.50	6.67	6.59	6.70
We are safe and healthy	6.06	6.07	6.02	6.09	6.02	6.06
We are always learning	5.29	5.57	5.26	5.64	5.32	5.61
We work flexibly	6.36	6.22	6.23	6.24	6.27	6.20
We are a team	6.71	6.75	6.66	6.74	6.72	6.75
Staff engagement	6.68	6.74	6.66	6.84	6.73	6.91
Morale	5.80	5.84	5.79	5.93	5.83	5.91

Colleague experience continues to vary across services and roles. Work pressure remains the most consistent and significant challenge, alongside ongoing concerns relating to wellbeing, psychological safety, behavioural consistency, and experiences of bullying, harassment and discrimination.

We continue to see a mixed picture in our culture indicators. There have been some improvements in people feeling able to speak up and in how we respond as an organisation. However, this is balanced by slight declines in perceptions of compassionate culture and continued reports of negative experiences.

Our results also show that colleagues remain proud of the care they provide, but confidence in recommending us as a place to work is lower than comparable organisations.

We perform comparatively well in areas such as recognition and flexible working. However, we remain below benchmark in areas including health and wellbeing, safety, and opportunities for learning and development.

Health and wellbeing indicators highlight the sustained impact of workload pressures. Only 41% of colleagues report being able to meet their work demands on time, and around half report insufficient staffing. There has also been an increase in musculoskeletal concerns.

Taken together, these findings reinforce themes we already understand through our wider insight: that while colleagues take pride in their work, pressures remain high and experiences are not yet consistent across our organisation.

In response, we are strengthening our approach to listening and acting on feedback. The Cultural Insights Review Group (CIRG) will provide clear oversight of improvement activity, ensuring that action plans are meaningful, coordinated and delivered at pace across our services.

Our focus will be on continuing to listen to what colleagues tell us, responding in a visible and meaningful way and creating the conditions for a safer, more supportive and more consistent experience for everyone who works with us.

Future priorities

Our People Priorities

We know this is a difficult period for our colleagues as we continue to navigate financial and operational pressures. Our focus remains on supporting our people, strengthening our culture and staying true to the principles of the NHS people promise.

Our work is focused on five core priority areas:

- **health and wellbeing:** the health, care and wellbeing of our people are our top priority. Our people's health and wellbeing directly impacts retention, performance, productivity and innovation. It is integral to high quality patient care, improves performance, reduces cost and strengthens a positive culture at work. We will strengthen and enhance our wellbeing offer and implement preventative, proactive and consistent supportive measures that will mean that our people can stay well and have a more positive experience at work.
- **Fair, supportive and inclusive culture**: a fair, supportive and inclusive culture is a fundamental strategic driver to creating a great place to work and receive care. A just and learning culture supports wellbeing by creating a fair and supportive environment where people feel comfortable discussing their wellbeing, are able to ask for help and feel empowered to learn when things do not go as expected. Inclusion and engagement are vital for improving patient care, fostering a supportive working environment, tackling health inequalities and are key to people feeling valued, listened to and treated equally and fairly. We will improve our engagement through open and transparent communication and staff networks. Feedback will be acted upon, with a continuous cycle of learning and improvement. Everyone, regardless of their

background or differences, will be valued, respected and able to participate fully in how our organisation and workplaces develop.

- **management and leadership:** leadership development is a critical strategic priority for driving organisational performance, change and sustainability. Leadership and management development is a necessity for improving services and culture change. Leaders and managers are key to modelling our compassionate behaviours – we icnlude with care, we listen with genuine curiosity and we act with courage - which are integral to embed a just and learning culture of trust, inclusion and fairness across the organisation. compassionate, inclusive, and collective. A comprehensive management and leadership development programme will be implemented aligned to our organisational priorities and national frameworks. This will include opportunities to learn from each other as leaders, sharing of good practice and equitable access to training and development opportunities. Managers and leaders will feel more equipped and confident to undertake their roles and the organisational change ahead.
- **collaborating and working with partners:** successful collaboration and partnerships are a key enabler to addressing the workforce priorities and challenges across our organisation and the wider NHS in Devon and beyond. The workforce transformation required will be dependent on how organisations work together and with partners such as education providers, to develop the future workforce needed, including developing pathways for roles delivering neighbourhood and community care. For our people services this means moving to more digital delivery of services and transitioning to the national future of people services model. For us, our people services will pay a key role in working with colleagues to facilitate and support organisational change, while supporting and guiding people through the change pathway.
- **supporting people to develop and succeed:** skills and careers are a key priority for our people strategy because they underpin workforce transformation, sustainability and quality of care. With ongoing workforce shortages, the need to reduce reliance on temporary staffing and the changing shape of health care delivery, attracting and developing people and ensuring they have the right skills is vital. Committing to the development of our people will also support our culture through increasing motivation, value and morale. We will work with clinical colleagues and education partners in the development of a learning academy to facilitate the co-design of new training pathway models and develop the new and emerging skills required longer term. Ensuring people have equitable access to continued professional development will be key to improve retention and for the continuous development of our people as roles adapt and change to new ways of working.

Diversity and inclusion

We are committed to becoming a more inclusive organisation, where everyone feels valued, respected and able to contribute.

We know there is more to do to remove the barriers that can affect our colleagues and prevent people from working to their full potential. Over the past year, we have continued to focus on strengthening inclusion, improving experience and creating a culture where people feel supported.

Our values reflect those of the NHS and we continue to embed these through how we recruit, develop and support our colleagues. Our People Promise also sets out the standards we expect for how people are treated, both within our organisation and in the care we provide.

Our ‘Embedding a Culture of Inclusion’ programme plays an important role in this. It is focused on improving the experiences of colleagues from under-represented groups and is shaped by what our people have told us through engagement and feedback.

This has informed a clear set of priorities, including delivering the high impact actions set out in the national Equality, Diversity and Inclusion 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 colleagues

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 disabled colleagues and supports positive change for all colleagues by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

Nine of the 10 WDES metrics are taken from the National Staff Survey. The table below shows our performance against the WDES standard for the last two years and in comparison, to the national average. The broad headlines are:

- disabled colleagues are three times more likely to enter the formal capability process compared to non-disabled colleagues
- disabled colleagues consistently report experiencing higher levels of bullying, harassment, or abuse from managers, colleagues and patients/members of the public compared to non-disabled colleagues
- disabled colleagues are significantly less likely than non-disabled colleagues to believe the organisation provides equal opportunities for progression and promotion, with an increasing gap
- disabled colleagues consistently report feeling more pressure from managers to work while unwell, indicating potential issues around presenteeism.

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, while also combating a culture of discrimination felt by our disabled colleagues.

Some of our indicators show that disabled colleagues have a worse experience when compared to non- disabled colleagues in our organisation, this signals a need for a cultural shift in the experiences of our people.

Table: Performance against the WDES standard for the last two years and in comparison, to the national average

Metric		Disabled 2024	Non-Disabled 2024	Disabled 2025	Non- Disabled 2025	Disability 2025 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.	Negative	23.69%	21.52%	27.90%	19.20%	29.14%
Percentage of staff experiencing harassment, bullying or abuse from: Managers.	Negative	16.10%	9.20%	16.30%	8.20%	14.12%
Percentage of staff experiencing harassment, bullying or abuse from: Other colleagues.	Positive	26.10%	15.70%	22.90%	15.40%	24.45%
Percentage of staff saying they, or a colleague, reported harassment, bullying or abuse.	Positive	49.50%	47.80%	51.00%	48.60%	53.16%
Percentage of staff who believe that their organisation provides equal opportunities for career progression / promotion.	Positive	47.60%	55.10%	45.30%	54.90%	47.79%
Percentage of staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties.	Positive	26.70%	18.80%	25.10%	17.40%	27.19%
Percentage of staff satisfied with the extent to which their organisation values their work.	Negative	33.90%	43.10%	32.60%	43.60%	32.09%
Percentage of disabled staff who said their employer has made adequate adjustments to enable them to carry out their work.	Positive	74.10%	-	76.30%	-	73.65%
Staff Engagement score (0-10).	Positive	6.3	6.8	6.3	6.8	6.3

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 colleagues.

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:

- while recording completeness (97.6%) is relatively strong, the percentage of colleagues who have taken part in the annual staff survey means this gives a limited view. However, this remains a helpful indicator of the overall effectiveness of the inclusion work being undertaken, and organisational gaps remaining
- global majority staff are underrepresented in middle and senior non-clinical roles (especially Bands 5-7 and 8a-b). This was demonstrated in our Ethnicity Pay Gap reporting for the same period
- candidates from a global majority background are significantly less likely to be appointed than white candidates despite being shortlisted, indicating a recruitment inequality
- global majority staff continue to report higher levels of harassment and abuse from patients and the public than White staff.
- global majority colleagues are less likely to believe in equal opportunities for career progression compared to white colleagues

- global majority colleagues report discrimination from colleagues at over twice the rate of white colleagues
- Board-level global majority representation is low, creating a possible disconnect between workforce diversity and senior decision-making.

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

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

Indicator		Global Majority 2024	White 2024	Global Majority 2025	White 2025	Global Majority 2025 National
Percentage of staff experiencing harassment, bullying or abuse from patients / service users, their relatives or the public in the last 12 months.	Positive	27.90%	21.50%	22.20%	21.90%	28.98%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	Positive	24.00%	23.50%	21.10%	22.20%	24.06%
Percentage of staff believing that there are equal opportunities for career progression / promotion.	Negative	49.40%	53.80%	47.60%	53.00%	49.11%
Percentage of staff who in the last 12 months personally experienced discrimination from any of the following: Manager / team leader or other colleagues.	Negative	16.50%	8.00%	15.70%	7.40%	14.70%

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 “2026” this refers to the year of publishing our gender pay gap report (data from 2025). Similarly, references to “2025” refer to this report, published in 2024, but using data from 2024.

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. VSMs include Executive Directors and a small number of other senior posts.
It should be noted that no bonuses are paid 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 77.03% female and 22.97% 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 2025	£23.32	£18.99		
Mean hourly rate 2026	£25.01		£20.20	

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

	Male	Female	% difference
Median Hourly rate 2024	£17.68	£16.71	
Median Hourly rate 2025	£19.09	£18.49	

Between 2025 and 2026, average hourly pay increased for both male and female employees, with male pay rising slightly faster. As a result, the mean gender pay gap increased from 18.56% to 19.23%, while the median gap reduced from 5.49% to 3.13%, reflecting changes in pay distribution rather than unequal pay for the same roles. Our workforce remains predominantly female across all pay quartiles, with only modest shifts year on year. Small increases in female representation in middle and lower quartiles and minor changes in the top quartile were observed. In terms of bonus pay, a higher proportion of females received bonuses in 2026, while male bonus values decreased overall. This led to a reduction in the median bonus gap from 90.18% to 74.15%, although the mean bonus gap remained high at 67.57%.

We are pleased to note our gender pay gap remains significantly below the national average and industry standards. We continue to action plan to work towards eliminating any existing inequalities. It is suggested that action planning must include a review of applicants for consultants' posts and recommended that we review our current practices to ensure they are equitable.

The consultant body remain our critical staff group, for addressing our gender pay gap. Between 2025 and 2026, our consultant workforce grew from 269 to 289. While the number of female consultants increased slightly, their share of the total fell to 42.6%, reflecting a rise in male representation at senior medical roles. This shift contributes to the widening mean gender pay gap, as higher-paid roles have a greater impact on average pay, even though median pay remains relatively balanced for the majority of colleagues.

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/)

Consultancy costs

Expenditure on consultancy costs for 2025/26 was £108,000 compared with £116,000 for 2024/25.

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 2025 and 31 March 2026 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 2026

Number of existing engagements as of 31 March 2026	
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 2026

Number of off-payroll workers engaged during the year ended 31 March 2026	
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 2025 and 31 March 2026

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.

	2025/26			2024/25		
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	-	48	48	-	37	37
£10,001 - £25,000	-	11	11	-	3	3
£25,001 - 50,000	-	12	12	-	-	-
£50,001 - £100,000	-	7	7	-	-	-
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-
Total number of exit packages by type	**-**	**78**	**78**	**-**	**40**	**40**
Total resource cost (£)	**£0**	**£1,247,000**	**£1,247,000**	**£0**	**£166,000**	**£166,000**

In addition to the above costs, employer's National Insurance contributions were paid as appropriate 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 we have agreed early retirements, the additional costs are met by the organisation 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)

	2025/26		2024/25	
Agreements	**Number**	**Value (£'000)**	**Number**	**Value (£'000)**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	39	1021	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	38	150	38	137
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	1	76	2	29
Total	78	**1247**	40	**166**

*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 play an important role in building careers in health and care and widening participation across our local communities. They offer a practical and accessible route into employment, allowing people to earn while gaining valuable qualifications.

By supporting apprenticeships, we are investing in local talent and helping people achieve their career aspirations. This benefits not only the individual, but also strengthens our services and the communities we serve.

We currently support over 300 apprentices working across clinical, allied health and corporate roles. We continue to grow this each year, making full use of the apprenticeship levy to create more opportunities for local people.

Since 2017, we have supported more than 800 apprentices to complete their programmes and move into sustained roles with us. Many go on to further professional development, including degrees and postgraduate study, in areas such as nursing, occupational therapy, physiotherapy, radiography, healthcare science, engineering and leadership.

Apprenticeships are fully funded by us and provide an inclusive route into employment and progression, particularly for those who may not otherwise be able to access higher education. Programmes range from Level 2 through to postgraduate study.

As one of the largest employers in our area, we are committed to creating opportunities for everyone. Apprenticeships are an important part of this - helping us open our doors wider, support our existing colleagues to develop, and ensure that no one is left behind.

This concludes the Staff Report for 2025/26.

Joe Teape
Chief Executive
25 June 2026

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

Joe Teape
Chief Executive
25 June 2026

Statement of compliance with the NHS Foundation Trust Code of Governance

Torbay and South Devon NHS Foundation Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a 'comply or explain' basis. The Code of Governance, most recently revised in April 2023, is based on the principles of the UK Corporate Governance Code issued in 2012. There are other disclosures and statements (mandatory disclosures) that we are required to make, even where we are fully compliant. The mandatory disclosures have already been made within the main text of the Annual Report and page references are therefore provided below. NHS Foundation Trusts are required to provide (within their Annual Report) a specific set of disclosures in relation to the provisions within the Code of Governance.

We are compliant with these provisions and in compliance with the Code, a supporting explanation for each required provision is provided within the table below. The table also demonstrates how we have complied with the necessary aspects of the Foundation Trust Annual Reporting Manual (FT ARM).

For further information in relation to the way in which the Board of Directors operates, please refer to page 42.

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 organisation 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 which are available as part of our Board papers published on our website 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.	The Accountability report (page 42) highlights the Board's oversight of managing and monitoring culture.
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	The working in partnership statements on page 11 details how we engage with stakeholders and partners
Section B, 2.6	The Board of Directors should identify in the annual report each Non-Executive Director it considers to be independent.	We consider all of our 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 Further information can be found within our accountability report , starting on page 42.
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 42.
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 91.
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 77.

Section C, 2.8	Describe the process followed by the council of governors to appoint the Chair and Non-Executive Directors.	This can be found within our report, on page 57.
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 109.
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.	Information on Well Led is detailed on page 59.
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 report on page 49.
Section C, 5.15	Foundation Trust governors should canvass the opinion of 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 91.
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 report, starting on page 45.
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.	The Director's explanation of responsibility in relation to the preparation of the Annual Report and Accounts is detailed in the statement of the Chief Executive's responsibilities as the Accounting Officer of Torbay and South Devon NHS Foundation Trust (page 91).
Section D, 2.7	The Board of Directors should carry out a robust assessment of the trust's emerging and principal risks.	The Annual Governance Statement (page 95) details how the Board assess risks and details the our Assurance Framework including the Board Assurance Framework.
Section D, 2.8	The Board of Directors should monitor and report on the organisation's risk management and internal control systems.	Information on our risk management and internal control systems and how they review their effectiveness can be found in the Annual Governance Statement on page 91.
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	A statement on Going Concern can be found in the Annual Accounts on page 19.
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 report, starting on page 65.

Matters to be reported against on a comply or explain basis

We have no matters of deviation where an explanation is required to report for 2025/26.

Matters to be circulated for information

For the matters listed below the Code requires that we make particular information available to governors; even in the case that we are 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 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 organisation'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. The Terms of Reference 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 the organisation's policies, aims and objectives, while safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that Torbay and South Devon NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. In discharging these responsibilities, I have regard to the standards of governance expected of NHS foundation trusts, including the provider licence, the NHS Foundation Trust Code of Governance, relevant statutory guidance and the duties placed on the Board in relation to quality, safety, financial stewardship and operational performance.

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 provide reasonable, and not absolute, assurance of effectiveness. The system is based on an ongoing process designed to identify and prioritise the risks to the achievement of our objectives, to evaluate the likelihood and impact of those risks being realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place throughout the year ending 31 March 2026 and up to the date of approval of the Annual Report and Accounts.

Our control environment supports delivery of integrated health and care services across Torbay and South Devon and reflects the complexity of working across acute, community and social care pathways. The Board recognises that effective governance must support safe, compassionate and high-quality care, sustainable operational delivery, financial resilience, statutory compliance and strong partnership working across the local system. Our governance framework is therefore intended not only to secure compliance, but also to promote transparency, continuous improvement and timely escalation where risks or control weaknesses arise.

Accountability Framework and Internal Control

We have established an accountability framework which consists of clear internal control arrangements consisting of:

- standing orders
- standing financial instructions
- delegated authorities
- policies and procedures
- budgetary control
- business planning
- workforce governance
- procurement controls
- incident reporting
- safeguarding arrangements
- information governance controls
- cyber and digital oversight
- arrangements to secure compliance with statutory and regulatory requirements.

We also maintained arrangements for fraud prevention and detection through our counter fraud provision and by ensuring that concerns, incidents and near misses were reported, investigated and acted upon.

Risk Leadership and Risk Control Framework

The Board of Directors has the overall responsibility for risk management within our organisation. Terms of Reference for the Board's assurance-seeking committees also set out the responsibility of key meetings in the oversight of risk management. The specific responsibilities of each Board member, Care Group Leadership Teams, Risk Owners and all staff, are set out in our Risk Management Strategy and Policy.

We have maintained arrangements for identifying, evaluating and managing risk across all areas of its activity. Risks are managed through a framework that includes clear accountability, a corporate risk register, the Board Assurance Framework, local risk registers, defined escalation routes and regular review by management teams, committees and the Board. The framework is intended to ensure that principal risks are visible, appropriately owned and subject to mitigating action. Our full risk management policy and supporting documentation can be found on our website.

We have also appointed a Senior Independent Director, in line with the NHS Foundation Trust Code of Governance. The role of the Senior Independent Director is to be available to Governors and members (including staff) should they have any concerns that they feel unable to raise via normal channels of communication with the Chair, Chief Executive, or any other Board members, or where such communication remains unresolved or would be inappropriate.

Our principal risks during 2025/26 included pressures relating to urgent and emergency care performance, elective recovery, workforce supply and retention, quality and safety, financial sustainability, digital resilience, information governance, estate infrastructure and the delivery of strategic transformation in partnership with system colleagues. Further information is outlined in the following sections of this report.

Board Assurance Framework objectives (BAF)

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 is available as part of our Board papers published on our website here.

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.

During 2025/2026 the Trust has had no notifications from NHS England that a breach, or suspected breach, of our licence has occurred.

Care Quality Commission (CQC) Compliance

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
- reviewing assurances on the effective operation of controls
- receiving assurances provided by internal audit, 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.

Compliance with people strategies and 'developing workforce safeguards

Our People Promise and Plan continues to shape how we support our colleagues and develop our culture, aligned to the national People Promise.

Over the past year, strengthening leadership within our People and Education teams, including the appointment of a People Promise Manager and a Joint Head of Inclusion, Diversity and Equity, has enabled us to make more consistent progress. This has supported our ambitions to improve inclusion, increase engagement and continue building a positive, inclusive culture.

We have continued to align with national expectations while strengthening our local approach. This has included contributing to the People Promise Exemplar Programme, sharing learning and data nationally, and embedding a more consistent focus on colleague experience. This, in turn, supports retention and the quality of the care we provide.

We have also worked closely with our partners and NHS England to ensure our policies, processes and leadership development offer reflect our ongoing commitment to equity, inclusion and belonging.

Looking ahead, we will continue to build a working environment where our colleagues feel safe, healthy and supported. As part of this, we are developing a refreshed culture plan, which will sit within Our Plan for Better Care and set out our priorities for the years ahead.

These priorities include how we support our people to develop and grow, strengthen our approach to planning and deployment, and continue embedding a positive, inclusive culture across our organisation.

People priority programmes

Over the past year, we have made good progress in strengthening how we support our colleagues to thrive, develop their skills and build a positive culture. This work is helping us create a more sustainable and well-governed approach, underpinned by better insight, stronger leadership and a clearer focus on improvement as we prepare for organisational redesign.

Planning and supporting our people - we have strengthened how we manage and plan our staffing, with a focus on creating a more sustainable and financially responsible approach. This has included reducing our reliance on temporary staffing by improving our e-rostering capability and connecting planning more closely with financial controls.

We have also met national requirements for managing temporary staffing, strengthening compliance and governance. Improvements in e-rostering dashboards, alongside the continued rollout of medical rostering, are giving us better visibility and supporting more informed decision-making.

Close working between our planning, information, finance, performance and programme teams has also helped us take a more joined-up approach to operational planning, including stronger alignment between staffing and financial data.

During the year, we introduced a new integrated workforce performance report, bringing together our people, financial and operational service information in one place. This provides clearer insight into staffing levels, agency and temporary usage, pay, sickness, turnover and key employee relations indicators, helping us better understand risks and trends, strengthen oversight and support timely decision-making.

Strengthening our people and education teams - over the year, we have focused on building the foundations needed to strengthen capability and capacity within our People and Education teams.

This has included preparing for the directorate restructure, supported by a detailed review of current and future skills, redesign of key processes, and updates to our core people policies. We have also stabilised leadership, refined governance, and taken focused action to reduce employee relations and sickness absence cases.

Alongside this, clearer insight and directorate-level measures are providing stronger oversight and supporting continuous improvement. While further progress will be shaped by organisational redesign, this work has created a strong platform for a more efficient, skilled and strategically aligned function.

Culture, organisational development and leadership – we have also continued to invest in our culture, organisational development and leadership capability.

This has included a comprehensive review of cultural indicators to better understand the experiences of our colleagues, alongside improvements to how we listen and respond so people feel heard, valued and involved in shaping change. We have also strengthened our approach to reasonable adjustments, helping to create a more inclusive and supportive working environment.

A key milestone has been the launch of our Restorative, Just and Learning Culture programme, which is embedding a more compassionate, fair and learning-focused approach to how we work.

In parallel, we have expanded our leadership and management development offer, giving colleagues at all levels the skills and confidence to support their teams, build positive cultures and lead improvement.

Together, this work is helping us create a more open and supportive environment, where colleagues feel safe to speak up, leadership is stronger, and continuous learning is part of how we work every day.

Financial Compliance

Our cost base in 2025/26 continued to reflect the sustained pressures across health services, alongside a strong focus on recovering elective, diagnostic and cancer care. We have maintained targeted investment in safer staffing and, to support performance against national standards, have continued to use insourcing and outsourcing for some elective and diagnostic activity.

While we have seen a reduction over the year, we remain reliant on agency medical and nursing colleagues in a number of specialties where there are national workforce shortages.

A distinctive and ongoing pressure for us is within continuing healthcare and adult social care. We support a higher number of people in receipt of care, and at higher overall cost, than comparable organisations. This reflects both the needs of our population and areas where we are continuing to improve our processes. Continuing healthcare pressures are particularly evident in the number of people requiring support.

Our operational and financial plans for 2026/27 have been developed jointly with our partners and through the Board and have been subject to review by the Integrated Care Board and NHS England, both regionally and nationally. The Board has recognised the need to continue strengthening how we plan and deliver, supported by a clearer accountability framework and an enhanced programme management approach.

Looking ahead, the financial outlook remains challenging. There is a significant risk to delivering the level of financial improvement required, both within our organisation and across the wider Devon system. Our efficiency programme for 2026/27 is £50 million—greater than any we have delivered before—and will require us to redesign services at pace while continuing to provide safe, high-quality care.

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, attended and chaired by Executive Directors, to provide oversight of financial and operational performance
- 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 Operations 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.
- to ensure best value for money on non-pay contracts, we have recently established a One Devon Procurement Service to standardise products and services and obtain the best price for all partner organisations, as well as continued collaboration with other NHS bodies across the peninsula to maximise value through the NHS Peninsula Procurement and Supply Alliance.

Operational Compliance

As part of our performance improvement programmes for the year, we have developed and delivered detailed improvement plans with the support of our Improvement and Innovation team working closely with the clinical and operational teams. We have collaborating closely with partners such as the Emergency Care Improvement Support team (ECIST) and Getting It Right First Time (GIRFT) to support improvement in both urgent and emergency care (UEC) and planned care (elective) services. We actively participate in the regional UEC and elective Learning Improvement Networks, identifying best practice and sharing our improvement journey with other organisations. We were recognised by GIRFT as one of the most improved Trusts in the country for combined UEC performance between Q1 and Q3 of 2025/2026 and were the subject of two case studies focussing on our improved leadership culture and delivery of ambulance handover standards as part of the national UEC improvement cascades.

Looking ahead to the financial year 2026/2027, we will continue our focus on maintaining our improvements by delivering on the operational planning guidance and achieving set targets and trajectories. We have set ourselves an ambitious plan to continue to improve access to services for our population in line with national waiting time guidance including improvements in four-hour performance, RTT, Elective Long Waiters, Cancer and Diagnostics

We will continue our collaborative efforts with South Western Ambulance Service NHS Foundation Trust (SWAST) and other stakeholders are aimed at ensuring patients access the right services for urgent and emergency care, further developing our services such as the frailty unit, urgent treatment centre, same day emergency care (SDEC) and virtual wards.

We retain our commitment to improving access to cancer care, diagnostics, and elective services. By March 2027, our objectives include having no more than 1% of people waiting longer than 52 weeks and to have no one waiting beyond 65 weeks for planned care treatment, as well as achieving diagnostic and cancer performance in line with national guidance. Our plans have accounted for the expected levels of activity and performance expected in Q1 due to our implementation of our new electronic patient record. These reductions and associated recovery plans have been carefully modelled and agreed with NHS England to ensure they are deliverable.

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 and our Inclusion Steering Group). 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 completed climate-related risk assessments and developed a comprehensive Sustainable Development Management Plan incorporating the UK Climate Projections 2018 (UKCP18). This work ensures continued compliance with the Climate Change Act and associated adaptation reporting requirements. In the year ahead, we will continue to integrate climate resilience and sustainability actions into our operational and strategic planning, ensuring alignment with national NHS net zero commitments and strengthening our long-term environmental preparedness.

Compliance with information governance requirements

Continuous improvement and maintenance of good information governance standards is a key priority for us. This is reflected in our commitment to the national standards set out in the Data Security and Protection Toolkit (DSPT), completed annually.

The DSPT 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 we:

- have embedded good decision-making over compliance, and ownership of information risks at all levels of the organisation
- foster a culture of continuous improvement, understanding the effectiveness of its practices

- recognise 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 during 2025/26, is the Executive Board member who is familiar with information risks and provides the focus for the management of information risk at Board level. In April 2026 the SIRO role was transferred to the Chief Medical Officer.
- Caldicott Guardian, held by a Consultant for pain management and anaesthesia. The Caldicott Guardian is the senior person responsible for protecting the confidentiality of patient and service-user information, acting as conscience for the organisation on management of patient information.
- 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 position is held on an acting basis by the Associate Director of Legal Services.

Throughout the year we have identified areas for improvement and have made good steps in improving our compliance in key areas.

Recognising the growing utilisation of artificial intelligence (AI) technologies we have now developed a robust acceptable use of Artificial Intelligence technologies policy with guidance for colleagues and a two-pronged approval process. This policy development work has included establishing clear criteria for AI use, including data minimisation, fairness, and explainability. We have also integrated AI risk assessments into existing processes, with additional scrutiny for high-risk applications, and ensured compliance with all relevant regulations and best practice.

We implemented the Epic Electronic Patient Record (EPR) early April 2026. This marks the most significant digital transformation in the NHS' history in Devon and will improve clinical delivery of services enabling the right information to be available to the right people at the right time. Large scale governance works have been undertaken over the last 12 months to enable a safe implementation of the EPR.

Working closely with both technical and clinical teams to ensure data protection has been embedded into the systems lifecycle we have established formal cross organisation governance structures with Royal Devon University Healthcare NHS Foundation Trust and University Hospitals Plymouth NHS Trust. to support this, we have worked to ensure completion of multiple, component specific Data Protection Impact Assessments, joint data sharing agreements and controllership arrangements have also been entered into development of shared confidentiality and data sharing policies. Independent Data Protection Officer (DPO) assurance has been provided to Trust Boards and committees and comprehensive clinical safety management in line with national standards undertaken. These controls provide a risk based, proportionate framework for safe, lawful and transparent deployment, with defined conditions and ongoing post go-live assurance.

Additional digital transformation is also being undertaken in our Adult Social Care services, taking a phased approach, we have worked with our partners at Torbay Council to ensure joint governance arrangements are in place. We have undertaken the development and review of data sharing and processing agreements and addressing legacy system risks to facilitate the secure migration of records to the new system. Archiving the legacy system remains a significant challenge, with the complexity of segregating health and social care data.

To support the significant transformational projects, we have completed a comprehensive review of information governance structures within the Trust to ensure oversight of compliance. The review undertaken assessed the adequacy of current policies and procedures, the effectiveness of reporting and escalation mechanisms and alignment with statutory requirements and best practice standards. Findings indicated that while core structures remain fit for purpose, there is scope for further improvement, strengthening links between IG, clinical governance, and digital transformation teams. To support this, the Information Governance team now attend the Patient Safety Incident Review Group (PSIRG) on a quarterly basis and redeveloped two governance groups to monitor compliance.

Information Governance incidents and risks are recorded on our risk management system. These are monitored by the Information Governance team and the DPO who offers guidance and support for investigation, management, and resolution.

Summary reports and highlighted risks are discussed at Information Governance Operational Group (IGOG) and Risk Management Group. We have ensured that all significant information governance incidents reported to the Information Commissioners Office (ICO) have a formal root-cause analysis (aligned to the Patient Safety Incident Response Framework) undertaken, and are presented both at IGOG and PSIRG, when involving patient data. Incidents that score in line with regulated reporting requirements are reported to the ICO – see summary below:

ICO cases reported 2025/26:

As part of our Data Security and Protection Toolkit (DSPT) compliance we ensure all notifiable Information Governance breaches are reported to the ICO; each incident is investigated and reviewed at our IGOG, with learning shared through the Patient Safety Incident Response Group (where patient data is affected) and to the Audit Committee. Where an incident has been assessed as ‘likely’ to cause ‘harm or detriment to a living individual’ we engage in Duty of Candour processes to inform all affected persons unless it is deemed clinically unsafe to do so.

In 2025/26, we reported 10 ICO-notified incidents via the DSPT, covering inappropriate disclosures of information, insecure disposal of records, and inappropriate staff access to records. The ICO outcome of “no further action” was reported in most cases, providing assurance that when incidents do occur, appropriate reporting and investigation mechanisms are in place internally.

Case Reference	Incident Number	Case Summary	Investigation Findings & ICO Outcome
IC-375513-D7F2	DCIQ_INC-21734	The birthmother of an adopted child was contacted in error and confidential information disclosed.	Several checks and system limitations were missed that could have prevented the incident, including failure to verify referral details and use system links/alerts (notably the “do not disclose address” warning). ICO: No further action.
IC-378094-Q8G0	DCIQ_INC-22004	A small volume of confidential paper records was found fly-tipped by a local authority partner.	No evidence could be found as to who was responsible for this incident. An all-staff reminder was issued on the importance of confidential disposal. ICO: No further action.
IC-378171-K0N8	DCIQ_INC-21973	A Subject Access Request was released to the incorrect person due to an internal labelling error.	Additional care must be taken by all staff responsible for postal franking to ensure labelling matches the intended recipient. ICO: No further action.
IC-379823-R7P1	DCIQ_INC-21204	Confidential pathology records of a patient were inappropriately accessed by a staff member	Disciplinary action taken. ICO: No further action.

IC-406780-S2K3	**DCIQ_INC-25946**	**A staff member made posts on social media where confidential information was visible in the background.**	**Disciplinary action taken. ICO: No further action.**
IC-436357-H9S5	DCIQ_INC-29162	A confidential patient tracker was emailed to a patient in error.	The information that was intended for release (patient information leaflets) should be made available on the public website. This would have prevented the incident occurring. ICO: No further action.
IC-439539-P8X7	DCIQ_INC-29443	Safeguarding information regarding a patient was inappropriately shared with a local school.	Disciplinary action taken. ICO: No further action.
IC-444393-Q2RB	DCIQ_INC-30121	A member of staff disclosed details about a patient to a relative of that patient.	Investigation ongoing. ICO: No further action pending investigation outcomes.
IC-467078-Y5B8	DCIQ_INC-32692	An email containing pension details of 692 staff members was shared internally in error.	Investigation ongoing. ICO: No further action pending investigation outcomes.
IC-480734-B9W3	[redacted]	Two members of staff were identified as part of an audit to have inappropriately accessed patient information.	Investigation ongoing. ICO: No further action pending investigation outcomes.

ICO complaints received 2025/26:

These are complaints we have received from the ICO. Each case is reviewed and action taken, with the ICO provided with an outcome letter or the data subject contacted directly if requested.

In 2025/26, we received 11 ICO complaints, largely relating to late responses to Freedom of Information and Subject Access Requests. Additionally, complaints were received about an alleged inappropriate disclosure and a significant historic data breach. All cases were resolved by releasing the requested information and/or providing an outcome letter. The ICO concluded “no further action” in most cases, and a small number are pending ICO or internal investigation outcomes.

Case Reference	Case Summary	Investigation Findings & ICO Outcome
IC-373509-X9K3	A Freedom of Information Request was not responded to within the legislative timeframe.	All requested information was released. ICO: No further action.
IC-326952-L8B9	Allegation that a member of staff inappropriately disclosed information to Devon and Somerset Fire and Rescue Service. Additionally, a Freedom of Information Request was not responded to within the legislative timeframe.	No evidence of inappropriate disclosure of Trust material identified. All requested information was released under the Freedom of Information Act. ICO: No further action.
IC-391986-N2Z8	A Freedom of Information Request was not responded to within the legislative timeframe.	All requested information was released. ICO: No further action.
IC-354828-X0G4	A patient reported concerns regarding a data breach resulting in criminal behaviour. When the data subject complained to the organisation in 2021, we failed to take appropriate action.	Pending ICO outcome.
IC-408355-D2D1	A Subject Access Request was not responded to within the legislative timeframe.	All requested information was released. ICO: No further action.
IC-435933-F4B8	A Freedom of Information Request was not responded to within the legislative timeframe.	All requested information was released. ICO: No further action.
IC-451088-K8K6	A Freedom of Information Request was not responded to within the legislative timeframe.	All requested information was released. ICO: No further action.

IC-387992-Q8F9	A Subject Access Request is alleged to not confirm all requested information.	Investigation ongoing.
IC-464172-L0R1	A Freedom of Information Request was not responded to within the legislative timeframe.	All requested information was released. ICO: No further action.
IC-477882-T6Y0	A Freedom of Information Request was not responded to within the legislative timeframe.	All requested information was released.
IC-387623-T8D5	An affected person following a data breach made a complaint.	Appropriate disciplinary action was taken. ICO: No further action.

Key compliance areas:

We endeavour to maintain consistently high standards of compliance in key performance areas which are monitored by the Trust Board. These areas are:

- Compliance with requests made under the Data Protection Act 2018 and Access to Health Records Act 1990
- Compliance with requests made under the Freedom of Information Act 2000 and Environmental Information Regulations 2004

Latest figures show:

Subject Access Request compliance:

	Non-Compliant	Compliant	Non-Compliant (%)	Compliant (%)	Grand Total
2024/25	2001	155	92.81%	7.19%	**2156**
2025/26 Q1	225	296	43.19%	56.81%	**521**
2025/26 Q2	516	67	88.51%	11.49%	**583**
2025/26 Q3	280	246	53.23%	46.77%	**526**
2025/26 Q4	88	523*	14.40%	85.60%	**611**
Grand Total	**1109**	**1132**	**49.49%**	**50.51%**	**2241**

* includes active requests

At present we have a compliance rate for 2025/26 of 50.51%, this is below our key performance indicator of 85%+ compliance. We are committed to returning to consistent compliance with the Data Protection Act and achieving the 85%+ KPIs, however building a compliance of above 85% for the 2025/26 financial year period has not been achievable due to the challenges faced.

Work is underway to improve the resources available to this department and changes are being made to strengthen and streamline processes to ensure swift and safe disclosures of information.

Access to Health Records 1990 requests:

	Non-Compliant	Compliant	Non-Compliant (%)	Compliant (%)	Grand Total
2025/26 Q1	14	4	77.78%	22.22%	**18**
2025/26 Q2	8	13	38.10%	61.90%	**21**
2025/26 Q3	13	13	50.00%	50.00%	**26**
2025/26 Q4	2	38*	5.00%	95.00%	**40**
Grand Total	**37**	**68**	**35.24%**	**64.76%**	**105**

* includes active requests

The Access to Health Records Act 1990 provides a limited right of access to a deceased person's health records. For reporting purposes compliance with requests made under the Access to Health Records Act 1990 is measured based on the 40-day deadline.

At present we have a compliance rate for 2025/26 of 64.76%, this is below our key performance indicator of 85%+ compliance. Prioritisation of requests has meant we focus on requests made under other powers, such as those by Court Order or the Data Protection Act 2018, however during any requests, communication is maintained with the requestor to reduce avoidable delays, complaints, and risk.

Freedom of Information and Environmental Information Requests:

	Non-Compliant	Compliant	Non-Compliant (%)	Compliant (%)	Grand Total
2024/25	**171**	**554**	**23.78%**	**77.05%**	**725**
2025/26 Q1	152	26	85.39%	14.61%	**178**
2025/26 Q2	148	56	72.55%	27.45%	**204**
2025/26 Q3	178	16	85.17%	7.66%	**209**
2025/26 Q4	163	72*	69.36%	30.64%	**235**
Grand Total	**641**	**170**	**77.60%**	**20.58%**	**826**

At present we have a compliance rate for 2025/26 of 20.58%, this is significantly below our key performance indicator of 85%+ compliance.

The team have struggled in the past 12 months with capacity, impacted heavily by vacancies and needs to focus resources on transformation projects. Work is being undertaken to improve the compliance in this area and an improvement plan has been developed and will be monitored by the Audit Committee.

Summary

In summary, 2025/26 has been a year of significant progress for Information Governance within our organisation. The planned implementation of Epic, social care systems, and the introduction of a robust AI governance framework have strengthened organisational capacity to meet evolving regulatory and ethical demands. We do however recognise that compliance with requests in line with both the Data Protection Act 2018 and Freedom of Information Act 2000 have been impacted by resource capacities.

Looking ahead, priorities for 2026/27 include further integration of IG into digital transformation initiatives, continued refinement of AI oversight, and improving compliance on both SAR and FOI/EIR compliance. The Data Protection Officer and Information Governance team will continue to work closely with executive leadership and the board to ensure sustained compliance and to foster a culture of transparency and accountability.

Data Quality Compliance

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.

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 is required to meet national data quality standards. Regular review and audits are carried out.

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, clinical audit, the executive directors, the clinical leads and the Corporate Governance Team within the Trust that have responsibility for the development and maintenance of the internal control framework. I have also drawn on the performance information available to me along with comments made by the external auditors and the outputs from the Board commissioned Well Led review from which a plan to address weaknesses and ensure continuous improvement of the system has been put in place.

The Board of Directors, supported by the Audit and Risk Committee, has routinely reviewed the Trust's system of internal control and governance framework, together with the Trust's integrated approach to achieving compliance with the CQC fundamental standards. The Assurance Framework provides the Board of Directors with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. The Audit Committee has provided the Board of Directors with an independent and objective review of internal financial control within the Trust by reflecting on the Trust financial report to the Board of Directors.

There have been no significant controls gaps identified during 2025/26. The Board sub committees provide the Board of Directors with assurance reports at regular intervals and ensure compliance on governance issues are delivered and immediate action is taken should performance not be in line with the target set by the Board of Directors.

Any significant issues that emerge during the year are reported to the Board of Directors via the Trust governance and escalation processes with service improvement plans or Trustwide quality improvement plans. Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal audit standards. Where scope for improvement was found, recommendations were made, and appropriate action plans agreed with management. The Head of Internal Audit Opinion Statement has been received on the effectiveness of the system of internal control giving good assurance of an improving trajectory.

Conclusion

My overall opinion is that no significant internal control issues have been identified during 2025/26 and therefore assurance can be given that there is a generally sound system of internal control, which is supported by a plan for continuous improvements into 2026/2027, which is designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Joe Teape

Joe Teape
Chief Executive
25 June 2026

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.

Joe Teape
Chief Executive
25 June 2026

James Corrigan
Chief Finance Officer
25 June 2026

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. He will become the Trust's Chair on 1st May 2026 when Chris Balch stands down from the role. 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 and People Committee, and a member of the Audit and Risk, and Non-Executive Remuneration and Nominations Committees. Martin is the Trust's Non-Executive lead for maternity services and the Board Maternity Safety Champion.
Liz Edwards-Smith **Non-Executive Director** **Appointed: October 2024**	Liz joined us as a Non-Executive Director in October 2024. 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. Alongside this, Liz has held research fellow positions at Plymouth University focusing on how local coastal and rural community assets in South Devon and Torbay can support health and wellbeing. 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. Liz is a Fellow of the Chartered Management Institute, a member of the British Psychological Society 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 to co-create agency and wellbeing. Liz is Chair of the Board's Charity Committee and a member of the Audit and Risk, Non-Executive Nominations and Remuneration, and Quality and People Committees.
Ashish Ghadiali **Non-Executive Director** **Appointed: October 2025**	Ashish Ghadiali, Totnes 'Ashish joined us as an Associate Non-Executive Director in October 2024 and became a substantive Non-Executive Director in September 2025. 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 Chair of Newlyn Art Gallery and Exchange, and 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. Ashish is a member of the Board's Quality and People, and Charity Committees.
Mark Greaves **Non-Executive Director** **Appointed: January 2025**	Mark joined us as a 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. 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 owned by Plymouth City Council, North Somerset Council and Devon ICB. He also hosted a podcast series called Business Noodles and is a governor at Arts University Plymouth. Mark is Chair of the Board's Audit and Risk Committee and a member of the Finance and Operations Committee.
Paul Richards **Non- Executive Director** **Appointed: November 2017**	Paul Richards joined Torbay and South Devon NHS Foundation Trust as a Non-Executive Director in November 2017 and serves as the Trust's Senior Independent Director. Paul is a senior international healthcare leader with more than 30 years' experience in driving commercial growth, digital innovation, and large-scale transformation across global health markets. He has held senior executive roles within leading digital and health technology organisations, where he has led complex product portfolios, international service operations, and major technology programmes that have strengthened organisational competitiveness and accelerated the adoption of digital and clinical systems worldwide. He is recognised for bringing strong commercial discipline to innovation and for building high-impact partnerships across suppliers, governments, and healthcare systems. Paul has a particular interest in how advances in digital technology, health tech, and pharmaceuticals, combined with modern partnership models, can unlock value, support integrated care, reduce system friction, and improve patient outcomes. Paul is committed to improving health outcomes for the population of Devon, with a focus on enabling more joined-up, person-centred care across organisational boundaries. Alongside his Trust role, Paul serves as a Health Crown Representative, providing national commercial and strategic leadership across NHS England, the Department of Health and Social Care, and the Cabinet Office. He also chairs the One Devon Electronic Patient Record (EPR) Implementation Board, supporting system-wide integration and the delivery of shared digital infrastructure across the Devon health and care system. Paul chaired the Finance and Performance Committee until January 2026 and is now a member of the Board's Finance and Operations and Non-Executive Nominations and

	Remuneration Committees. Paul is also chair of the One Devon EPR Board, a joint programme across the Royal Devon University Healthcare NHS Foundation Trust , University Hospitals Plymouth NHS Trust, NHS Devon Integrated Care Board and Torbay and South Devon NHS Foundation Trust.
Chris Saxby **Non-Executive Director** **Appointed: October 2024**	Chris joined the Foundation Trust in October 2024, and is an experienced, executive and non-executive leader having undertaken senior roles within the defence, engineering, social support, and health sectors. A varied public, private, and third sector executive career has seen him serve in the Royal Navy, enjoy secondments to the UK civil service, manage strategic national infrastructure in New Zealand, and lead support to vulnerable young people across the UK's SW peninsula. As a non-executive, he held several governance leadership roles for the IMarEST, he is a past Chair of Devonport Services RFC, a former non-executive director of Careers England, and in NZ, was Vice Chair of the Defence Industry Association. Committed to the community; he is a graduate of Common Purpose, and currently Vice Chair at City College Plymouth, where he also chairs the Audit & Risk Committee. He has garnered a reputation for focussed delivery through compassionate leadership, transformational change with meaningful collaboration, and the consistent building of shareholder value. His principal skill sets revolve around strategic thinking, organisational planning, governance and assurance alignment, and promoting the voice of the people he serves. Chris is a passionate learner, recently completing the Institute of Directors' pathway to become a Chartered Director and Fellow of the IoD. Chris has also been a Chartered Engineer, a Fellow of the IMarEST, a Fellow of the RSA, and a Member of the APM. He is a graduate of the NHS Aspiring Chairs Talent Programme. Chris is a member of the Finance and Operations, and Quality and People Committees and is the Trust's Freedom to Speak Up Board Champion.
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 Finance and Operations Committee and a member of the Audit and Risk, and Charity Committees.

James Corrigan **Chief Finance Officer** **Appointed: May 2024 to interim post. Took up substantive position from December 2025**	James joined us in May 2024 as Interim Director of Operational Finance and stepped into the role of Interim Chief Finance Officer in August 2025. James was appointed as our Chief Finance Officer in December 2025. A Chartered Management Accountant, James brings over 28 years of NHS experience, having held senior finance positions across acute, tertiary, ambulance and mental health trusts—including Cambridge University Hospitals, Great Ormond Street Hospital, and London Ambulance Service. He has led financial recovery programmes in large acute trusts, working closely with managers and clinicians to deliver improvements in quality, safety, productivity and efficiency.
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**	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

position from September 2024	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.
Jess Piper **Chief People Officer** **Appointed: July 2025 to interim post. Took up substantive position from March 2026**	Jess has spent her entire career working in health and care, beginning on the frontline in social care before moving into a range of roles across community and acute hospital services. She joined us in 2005 and has since held a variety of senior operational and corporate roles. Over the past 15 years, Jess has worked at senior management and executive level across education, people services, quality and corporate services. Most recently, she served as Associate Director and then Deputy Director of People with responsibility for a broad portfolio of people services, including education, resourcing, culture, equality, diversity and inclusion, and workforce development. After covering the Chief People Officer role on an interim basis from summer 2025, Jess was appointed to the substantive Chief People Officer position in February 2026. Jess brings more than a decade of executive and senior leadership experience, with a particular specialism in people and human resources, multi-professional education, workforce development, and system-wide strategy. She has extensive experience of working across community and acute organisations at local, regional and national level, leading and influencing strategic change and transformation across NHS providers and integrated care systems. Jess is a Fellow of the Chartered Institute of Personnel and Development (CIPD) and holds postgraduate and master's-level qualifications in Business and Clinical Education. She is an experienced educator and has previously held Higher Education Academy accreditation, having designed, developed and approved academic curricula.
Simon Tapley **Chief Strategy and Planning Officer** **Appointed March 2025**	Born in Paignton, Simon joined the NHS in 1993 with one of our predecessor organisations, South Devon Healthcare Trust. After spending 10 years working within Internal Audit he joined Teignbridge Primary Care Trust. He has a wealth of commissioning and operational experience and was a senior commissioner in Devon for 20 years, with 12 of those years as an Executive. He was the Chief Executive Officer for Devon Clinical Commissioning Group throughout the COVID-19 pandemic. Simon has commissioned all areas including adult social care. Simon joined us in January 2024 as the Associate Director for health and social care giving a valuable insight to operations.

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 tsdft.dataprotection@nhs.net
To hear more
The public are invited to observe our Board of Directors meetings in public and are able to do so online. For further information on our meeting schedule or to register for the joining link for a meeting 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) contact us at 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.volunteerwithus@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 tsdft.dataprotection@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.workexperience@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 2026

Foreword to the accounts

Torbay and South Devon NHS Foundation Trust

These accounts, for the year ended 31 March 2026, 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 2026**

Consolidated Statement of Comprehensive Income

		Group	
		2025/26	**2024/25**
	Note	**£000**	**£000**
Operating income from patient care activities	3	738,899	686,169
Other operating income	4	46,457	43,116
Operating expenses	7,9	(811,675)	(771,881)
Operating deficit from continuing operations		**(26,319)**	**(42,596)**
Finance income	11	1,775	2,633
Finance expenses	12	(3,107)	(3,448)
PDC dividends payable		(5,950)	(5,053)
Net finance costs		**(7,282)**	**(5,868)**
Other losses	13	(98)	(243)
Corporation tax expense		(16)	(17)
Deficit for the year		**(33,715)**	**(48,724)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(4,588)	(5,238)
Revaluations	19	278	5,204
Total comprehensive expense for the year		**(38,025)**	**(48,758)**
Deficit for the period attributable to:			
Torbay and South Devon NHS Foundation Trust		(33,715)	(48,724)
TOTAL		**(33,715)**	**(48,724)**
Total comprehensive expense for the period attributable to:			
Torbay and South Devon NHS Foundation Trust		(38,025)	(48,758)
TOTAL		**(38,025)**	**(48,758)**

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	15	47,487	23,862	47,487	23,862
Property, plant and equipment	16	243,248	228,294	243,201	228,227
Right of use assets	20	13,496	12,679	13,496	12,679
Receivables	23	4,155	4,179	4,383	4,444
Total non-current assets		**308,386**	**269,014**	**308,567**	**269,212**
Current assets					
Inventories	22	7,481	6,966	6,592	6,072
Receivables	23	33,947	33,657	34,721	33,488
Non-current assets held for sale	25	400	1,895	400	1,895
Cash and cash equivalents	26	35,458	26,701	35,368	26,578
Total current assets		**77,286**	**69,219**	**77,081**	**68,033**
Current liabilities					
Trade and other payables	27	(85,223)	(77,395)	(86,253)	(77,398)
Borrowings	29	(5,801)	(6,083)	(5,801)	(6,083)
Provisions	30	(628)	(497)	(628)	(497)
Other liabilities	28	(9,329)	(11,100)	(9,329)	(11,100)
Total current liabilities		**(100,981)**	**(95,075)**	**(102,011)**	**(95,078)**
Total assets less current liabilities		**284,691**	**243,158**	**283,637**	**242,167**
Non-current liabilities					
Borrowings	29	(48,750)	(50,007)	(48,750)	(50,007)
Provisions	30	(3,733)	(4,119)	(3,733)	(4,119)
Total non-current liabilities		**(52,483)**	**(54,126)**	**(52,483)**	**(54,126)**
Total assets employed		**232,208**	**189,032**	**231,154**	**188,041**
Financed by					
Public dividend capital		359,541	278,340	359,541	278,340
Revaluation reserve		55,046	60,740	55,046	60,740
Income and expenditure reserve		(182,379)	(150,048)	(183,433)	(151,039)
Total taxpayers' equity		**232,208**	**189,032**	**231,154**	**188,041**

The notes on pages 126 to 185 form part of these accounts.

Name	**Joe Teape**
Position	**Chief Executive Officer**
Date	**25 June 2026**

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**278,340**	**60,740**	**(150,048)**	**189,032**
Deficit for the year	-	-	(33,715)	**(33,715)**
Impairments	-	(4,588)	-	**(4,588)**
Revaluations	-	278	-	**278**
Transfer to retained earnings on disposal of assets	-	(1,384)	1,384	**-**
Public dividend capital received	81,201	-	-	**81,201**
Taxpayers' and others' equity at 31 March 2026	**359,541**	**55,046**	**(182,379)**	**232,208**

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**

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**278,340**	**60,740**	**(151,039)**	**188,041**
Deficit for the year	-	-	(33,778)	**(33,778)**
Impairments	-	(4,588)	-	**(4,588)**
Revaluations	-	278	-	**278**
Transfer to retained earnings on disposal of assets	-	(1,384)	1,384	**-**
Public dividend capital received	81,201	-	-	**81,201**
Taxpayers' and others' equity at 31 March 2026	**359,541**	**55,046**	**(183,433)**	**231,154**

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 - property, plant and equipment	-	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**

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 operational capacity.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statements of Cash Flows

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating deficit		(26,319)	(42,596)	(26,383)	(42,656)
Non-cash income and expense:					
Depreciation and amortisation	7.1	23,835	21,955	23,814	21,934
Net impairments	8	10,882	14,094	10,882	14,094
Income recognised in respect of capital donations	4	(769)	(486)	(769)	(486)
(Increase) / decrease in receivables and other assets		(2,044)	2,022	(2,950)	2,379
(Increase) / decrease in inventories		(515)	19	(520)	227
Increase / (decrease) in payables and other liabilities		(8,865)	13,041	(7,872)	12,966
Increase / (decrease) in provisions		(360)	420	(360)	420
Tax (paid) / received		(22)	(7)	(22)	(17)
Net cash flows from / (used in) operating activities		**(4,177)**	**8,462**	**(4,180)**	**8,861**
Cash flows from investing activities					
Interest received		1,693	2,573	1,693	2,573
Purchase of intangible assets		(29,107)	(15,541)	(29,107)	(15,541)
Sales of intangible assets		1,656	-	1,656	-
Purchase of Plant, Property and Equipment		(30,478)	(26,964)	(30,478)	(26,964)
Sales of Plant, Property and Equipment		131	4	131	4
Receipt of cash donations to purchase assets		769	486	769	486
Prepayment of PFI capital contributions		-	-	-	-
Finance lease receipts (principal and interest)		187	160	187	160
Net cash flows from / (used in) investing activities		**(55,149)**	**(39,282)**	**(55,149)**	**(39,282)**
Cash flows from financing activities					
Public dividend capital received		81,201	30,351	81,201	30,351
Movement on loans from DHSC		(1,961)	(2,506)	(1,961)	(2,506)
Other capital receipts (*)		-	-	36	36
Capital element of lease liability repayments		(2,866)	(4,279)	(2,866)	(4,279)
Capital element of PFI, LIFT and other service concession payments		(1,354)	(452)	(1,354)	(452)
Interest on loans		(378)	(433)	(378)	(433)
Interest paid on lease liability repayments		(352)	(422)	(352)	(422)
Interest paid on PFI, LIFT and other service concession obligations		(1,435)	(1,441)	(1,435)	(1,441)
PDC dividend (paid) / refunded		(4,772)	(4,566)	(4,772)	(4,566)
Cash flows from (used in) other financing activities		-	-	-	
Net cash flows from / (used in) financing activities		**68,083**	**16,252**	**68,119**	**16,288**
Increase / (decrease) in cash and cash equivalents		**8,757**	**(14,568)**	**8,790**	**(14,133)**
Cash and cash equivalents at 1 April - brought forward		**26,701**	**41,269**	**26,578**	**40,711**
Cash and cash equivalents at 31 March	26	**35,458**	**26,701**	**35,368**	**26,578**

* - Other capital receipts for the Trust totalling £36k (2024/25 - £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 2025/26 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 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

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

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 and key sources of estimation uncertainty 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 18 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 2026 totals: £184,588k (31st March 2025: £189,469k). A variation of +/- 1% to the valuations provided by the valuer incorporated into the financial statements would result in a movement of +/- £1,846k (31st March 2025: £1,895k).

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.

Note 1.4 Consolidation

The Group financial statements consolidate the financial statements of the Trust and its subsidiary undertakings made up to 31 March 2026.

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 2025/26 and 2024/25 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.

The majority of the Trust's income for patient care from NHS England and Integrated Care Boards is received in fixed monthly payments, adjusted during the year to recognise any increases or reductions to contractual payments relating to activity that is variable under the terms of the API contract. Other Operating 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 (API) 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 with 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 operational capacity 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 operational capacity 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 operational capacity, 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 operational capacity 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 operational capacity 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 buildings held for operational use are measured at current value in existing use.
• Where an active market exists, valuation is based on market value for existing use.
• Where no active market exists, valuation is based on depreciated replacement cost using a modern equivalent asset approach.

Where current value in existing use is assessed for operational assets for which no active market exists, value is interpreted as the cost of replacing the asset's remaining operational capacity. This is measured using depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. The MEA approach reflects the replacement of the asset with a modern asset of equivalent capacity that meets the location requirements of the services provided. Where appropriate, assets have been valued on an alternative site basis where this meets service delivery 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 land and buildings are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors Valuation Global Standards. Land and buildings are measured at current value in existing use using appropriate valuation techniques. The most recent full physical revaluation took place in 2023/24 with a valuation date of 31 March 2024. Full physical revaluations follow a five year cycle. Values are updated in the intervening years using appropriate indices. Full desktop revaluations, with some physical inspection, took place in 2024/25 and 2025/26.

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 operational capacity 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 operational capacity 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.

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 operational capacity 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 initially 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 intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Intangible assets are held at cost less accumulated amortisation and impairment. In line with the FReM, intangible assets are not revalued. Impairment reviews take place where indicators of impairment exist. The recoverable amount reflects the asset's operational capacity and is used only to assess whether the carrying value is overstated. Where the recoverable amount is lower than the carrying value, an impairment is recognised in expenditure. Intangible assets under construction are reviewed for impairment annually, regardless of indicators.

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	**Max life**
	Years	**Years**
Software licences	3	14
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.

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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
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 2.95% in real terms (prior year: 2.40%).

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 2025/26.

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 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and 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.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £185,674k as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the operational capacity using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for some of its specialised buildings, meaning the replaced operational capacity may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore, the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £181,610k at 31 March 2026. The expected impact of applying the standard 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.

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)	**2025/26**	**2024/25**
	£000	**£000**
Acute services		
Income from commissioners under API contracts - variable element*	88,849	84,640
Income from commissioners under API contracts - fixed element*	369,886	321,755
High cost drugs income from commissioners	41,332	39,592
Other NHS clinical income	4,894	3,097
Community services		
Income from commissioners under API contracts*	111,467	109,231
Income from other sources (e.g. local authorities)	96,325	101,840
All services		
Private patient income	120	172
National pay award central funding***	-	1,049
Additional pension contribution central funding**	23,568	23,000
Other clinical income	2,458	1,793
Total income from activities	**738,899**	**686,169**

Due to guidance clarification in 2025-26, 2024-25 income for acute services has been reclassified to better reflect the classifications presented in 2025-26. The variable element has been increased from £14,045k to £84,640k and the fixed element has been decreased from £392,350k to £321,755.

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 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 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 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

	2025/26	2024/25
Income from patient care activities received from:	**£000**	**£000**
NHS England***	57,462	84,853
Integrated Care Boards***	581,426	497,918
Other NHS providers	2,458	3,096
Local authorities	82,206	81,081
Non-NHS: private patients	120	172
Non-NHS: overseas patients (chargeable to patient)	150	157
Injury cost recovery scheme	647	650
Non NHS: other	14,430	18,242
Total income from activities	**738,899**	**686,169**
Of which:		
Related to continuing operations	738,899	686,169
Related to discontinued operations	-	-

* NHS injury scheme income is subject to a provision for doubtful debts of 24.62% 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.

*** The reduction in income received from NHS England and increase in income received from Integrated Care Boards from 2024-25 relates primarily to the delegation of specialised commissioning activities, this contract is now held by Somerset ICB.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider) - Group

	2025/26	2024/25
	£000	£000
Income recognised this year	150	157
Cash payments received in-year	50	30
Amounts written off in-year	74	30

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	2,914	-	**2,914**	1,905	-	**1,905**
Education and training	19,310	1,527	**20,837**	18,458	1,440	**19,898**
Non-patient care services to other bodies	8,364		**8,364**	8,131		**8,131**
Receipt of capital grants and donations and peppercorn leases		769	**769**		486	**486**
Charitable and other contributions to expenditure		2,004	**2,004**		762	**762**
Revenue from operating leases		965	**965**		879	**879**
Other income	10,604	-	**10,604**	11,055	-	**11,055**
Total other operating income	**41,192**	**5,265**	**46,457**	**39,549**	**3,567**	**43,116**
Of which:						
Related to continuing operations			46,457			43,116
Related to discontinued operations			-			-

* Other income (recognised in accordance with IFRS 15) also includes £1.6m (2024/25 £1.9m) 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

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	11,100	7,077
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 2026	31 March 2025
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	9,329	11,100
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**9,329**	**11,100**

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:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	723,552	666,948
Income from services not designated as commissioner requested services	15,347	19,221
Total	**738,899**	**686,169**

Note 5.4 Profits and losses on disposal of property, plant and equipment - Group

During 2025/26 the Trust disposed of a number of Property, Plant and Equipment assets, the net loss of which was £98k (2024/25 net loss of £243k).

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)

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	965	879
Variable lease receipts / contingent rents	-	-
Total in-year operating lease income	**965**	**879**

Note 6.2 Future lease receipts (Group)

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	741	741
- later than one year and not later than two years	741	741
- later than two years and not later than three years	741	741
- later than three years and not later than four years	741	741
- later than four years and not later than five years	-	741
- later than five years	-	-
Total	**2,964**	**3,705**

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)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	26,699	24,858
Purchase of healthcare from non-NHS and non-DHSC bodies	65,057	64,468
Purchase of social care	116,578	110,624
Staff and executive directors costs	389,801	367,979
Remuneration of non-executive directors	171	189
Supplies and services - clinical (excluding drugs costs)	37,637	33,661
Supplies and services - general	7,645	6,911
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	52,128	49,893
Inventories written down	185	178
Consultancy costs	108	116
Establishment	2,806	2,708
Premises	26,203	25,237
Transport (including patient travel)	2,832	3,235
Depreciation on property, plant and equipment	18,844	18,617
Amortisation on intangible assets	4,991	3,338
Net impairments	10,882	14,094
Movement in credit loss allowance: contract receivables / contract assets	918	1,358
Increase/(decrease) in other provisions	219	792
Change in provisions discount rate(s)	(140)	14
Fees payable to the external auditor		
audit services- statutory audit	297	332
other auditor remuneration (external auditor only)	23	23
Internal audit costs	331	321
Clinical negligence	9,683	9,070
Legal fees	759	533
Insurance	42	33
Research and development	2,759	2,395
Education and training	20,746	23,295
Expenditure on short term leases	-	37
Expenditure on low value leases	192	233
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,426	881
Grossing up consortium arrangements	1,502	1,312
Other	10,351	5,146
Total	**811,675**	**771,881**
Of which:		
Related to continuing operations	811,675	771,881
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 2025/26 was £247k (2024/25 £247k). 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)

	2025/26	2024/25
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit of accounts of any associate of the trust	23	23
Total	**23**	**23**

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 (2025/26, £23k) VAT being recoverable.

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 8 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Abandonment of assets in course of construction	47	9,193
Changes in market price	10,835	4,896
Other	-	5
Total net impairments charged to operating surplus / deficit	**10,882**	**14,094**
Impairments charged to the revaluation reserve	4,588	5,238
Total net impairments	**15,470**	**19,332**

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 £47k

	2025/26	2024/25
	£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	10,835	4,896
	10,835	4,896

Year end revaluation: - The Trust commissioned the District Valuation Office in both 2025/26 and 2024/25 to provide an updated valuation of the Trust's properties as at 31st March 2026 and 31st March 2025 respectively. The exercises in 2025/26 and 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 £15,423k (2024/25 decrease of £4,935k). Of the decrease in value, £4,310k (2024/25 decrease, £34k) has been charged to the Trust's revaluation reserve and a net £10,835k has been charged (2024/25 £4,901k) to Operating Expenditure as an Impairment charge.

Note 9 Employee benefits (Group)

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	296,019	274,910
Social security costs	36,424	28,204
Apprenticeship levy	1,423	1,433
Employer's contributions to NHS pensions	59,404	57,487
Pension cost - other	47	94
Temporary staff (including agency)	26,376	30,642
Total gross staff costs	**419,693**	**392,770**
Recoveries in respect of seconded staff	-	-
Total staff costs	**419,693**	**392,770**
Of which		
Costs capitalised as part of assets	8,288	3,820

Following a review of staff cost classifications, £21,498k has been reclassified in the prior year from Salaries and Wages to Temporary Staff. This change reflects a more appropriate alignment of NHS Professionals expenditure with DHSC GAM definitions and improves the distinction between substantive and temporary staffing. There is no impact on total staff costs.

The employer contribution rate for NHS pensions is 20.6% (excluding the administrative charge). NHS providers pay contributions at the base rate, with the balance funded centrally by NHS England. The full employer pension cost is recognised within staff costs, with the corresponding funding recognised in income, resulting in no net impact on the Trust's surplus or deficit for the year.

Note 9.1 Retirements due to ill-health (Group)

During 2025/26 there were 3 early retirements from the trust agreed on the grounds of ill-health (STA0370 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £34k (£933k in 2024/25).

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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,693	2,574
Interest income on finance leases	82	59
Total finance income	**1,775**	**2,633**

Note 12.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	364	417
Interest on lease obligations	352	422
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	1,436	1,441
Remeasurement of the liability resulting from change in index or rate	850	1,096
Total interest expense	**3,002**	**3,376**
Unwinding of discount on provisions	105	72
Total finance costs	**3,107**	**3,448**

Note 13 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	51	4
Losses on disposal of assets	(149)	(247)
Gains / losses on disposal of charitable fund assets	-	-
Total gains / (losses) on disposal of assets	**(98)**	**(243)**

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 £33.7 million (2024/25: £48.7 million). The trust's total comprehensive income/(expense) for the period was £38.0 million (2024/25: £48.8 million).

In 2025/26 the Group reported net deficit included surpluses generated by SDH Developments Ltd totalling £63k (2024/25 £65k). SDH Developments Ltd was a wholly owned Subsidiary of the Trust throughout the financial years 2024/25 and 2025/26.

Note 15.1 Intangible assets - 2025/26

Group and Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**23,613**	**15,856**	**39,469**
Transfers by absorption	-	-	**-**
Additions	1,048	27,639	**28,687**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Revaluations	-	-	**-**
Reclassifications	3,149	(3,226)	**(77)**
Transfers to / from assets held for sale	-	-	**-**
Disposals / derecognition	(1,872)	-	**(1,872)**
Valuation / gross cost at 31 March 2026	**25,938**	**40,269**	**66,207**
Amortisation at 1 April 2025 - brought forward	**15,607**	**-**	**15,607**
Provided during the year	4,985	-	**4,985**
Reclassifications	-	-	**-**
Transfers to / from assets held for sale	-	-	**-**
Disposals / derecognition	(1,872)	-	**(1,872)**
Amortisation at 31 March 2026	**18,720**	**-**	**18,720**
Net book value at 31 March 2026	**7,218**	**40,269**	**47,487**
Net book value at 1 April 2025	**8,006**	**15,856**	**23,862**

Note 15.2 Intangible assets - 2024/25

Group and Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024	**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	**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 16.1 Property, plant and equipment - 2025/26

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 2025 - brought forward	**7,420**	**176,890**	**4,352**	**15,446**	**45,171**	**814**	**14,209**	**835**	**265,137**
Additions	-	16,842	351	23,145	4,981	67	912	23	**46,321**
Impairments	-	(15,343)	(231)	(47)	-	-	-	-	**(15,621)**
Reversals of impairments	53	100	-	-	-	-	-	-	**153**
Revaluations	5	(6,911)	(217)	-	-	-	-	-	**(7,123)**
Reclassifications	-	3,761	9	(8,364)	2,074	17	2,415	165	**77**
Transfers to / from assets held for sale	(250)	-	-	-	-	-	-	-	**(250)**
Disposals / derecognition	-	-	-	-	(2,828)	(161)	(1,132)	(24)	**(4,145)**
Valuation/gross cost at 31 March 2026	**7,228**	**175,339**	**4,264**	**30,180**	**49,398**	**737**	**16,404**	**999**	**284,549**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**171**	**-**	**-**	**28,373**	**541**	**7,448**	**310**	**36,843**
Provided during the year	-	7,212	254	-	5,103	57	3,025	213	**15,864**
Revaluations	-	(7,147)	(254)	-	-	-	-	-	**(7,401)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,693)	(161)	(1,127)	(24)	**(4,005)**
Accumulated depreciation at 31 March 2026	**-**	**236**	**-**	**-**	**30,783**	**437**	**9,346**	**499**	**41,301**
Net book value at 31 March 2026	**7,228**	**175,103**	**4,264**	**30,180**	**18,615**	**300**	**7,058**	**500**	**243,248**
Net book value at 1 April 2025	**7,420**	**176,719**	**4,352**	**15,446**	**16,798**	**273**	**6,761**	**525**	**228,294**

Note 16.2 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	**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	**-**	**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 16.3 Property, plant and equipment financing - 31 March 2026

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	7,228	149,413	4,264	30,180	16,460	256	6,923	463	**215,187**
On-SoFP PFI contracts and other service concession arrangements	-	19,947	-	-	-	-	-	-	**19,947**
Owned - donated/granted	-	5,743	-	-	2,155	44	135	37	**8,114**
NBV total at 31 March 2026	**7,228**	**175,103**	**4,264**	**30,180**	**18,615**	**300**	**7,058**	**500**	**243,248**

Note 16.4 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 17.1 Property, plant and equipment - 2025/26

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 2025 - brought forward	**7,420**	**176,890**	**4,352**	**15,446**	**44,963**	**814**	**14,209**	**835**	**264,929**
Additions	-	16,842	351	23,145	4,981	67	912	23	**46,321**
Impairments	-	(15,343)	(231)	(47)	-	-	-	-	**(15,621)**
Reversals of impairments	53	100	-	-	-	-	-	-	**153**
Revaluations	5	(6,911)	(217)	-	-	-	-	-	**(7,123)**
Reclassifications	-	3,761	9	(8,364)	2,074	17	2,415	165	**77**
Transfers to / from assets held for sale	(250)	-	-	-	-	-	-	-	**(250)**
Disposals / derecognition	-	-	-	-	(2,828)	(161)	(1,132)	(24)	**(4,145)**
Valuation/gross cost at 31 March 2026	**7,228**	**175,339**	**4,264**	**30,180**	**49,190**	**737**	**16,404**	**999**	**284,341**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**171**	**-**	**-**	**28,232**	**541**	**7,448**	**310**	**36,702**
Provided during the year	-	7,212	254	-	5,083	57	3,025	213	**15,844**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(7,147)	(254)	-	-	-	-	-	**(7,401)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,693)	(161)	(1,127)	(24)	**(4,005)**
Accumulated depreciation at 31 March 2026	**-**	**236**	**-**	**-**	**30,622**	**437**	**9,346**	**499**	**41,140**
Net book value at 31 March 2026	**7,228**	**175,103**	**4,264**	**30,180**	**18,568**	**300**	**7,058**	**500**	**243,201**
Net book value at 1 April 2025	**7,420**	**176,719**	**4,352**	**15,446**	**16,731**	**273**	**6,761**	**525**	**228,227**

Note 17.2 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	**7,517**	**173,821**	**4,433**	**25,184**	**48,140**	**870**	**12,683**	**978**	**273,626**
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	**-**	**160**	**-**	**-**	**29,740**	**550**	**6,902**	**251**	**37,603**
Provided during the year	-	7,389	253	-	4,716	47	2,411	252	**15,068**
Revaluations	-	(7,344)	(253)	-	-	-	-	-	**(7,597)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
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 17.3 Property, plant and equipment financing - 31 March 2026

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	7,228	149,413	4,264	30,180	16,414	256	6,923	463	**215,141**
On-SoFP PFI contracts and other service concession arrangements	-	19,947	-	-	-	-	-	-	**19,947**
Owned - donated / granted	-	5,743	-	-	2,155	44	135	37	**8,114**
Total net book value at 31 March 2026	**7,228**	**175,103**	**4,264**	**30,180**	**18,569**	**300**	**7,058**	**500**	**243,202**

Note 17.4 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 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 2025/26 totalling £769k (2024/25: £486k). 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 2025/26, 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 2026. 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; land, buildings, and dwellings held for operational use were valued using depreciated replacement cost where no active market existed, and existing use value or open market value where an active market was available.

The overall net impact of the above revaluations has been to decrease the value of the Trust's Property, Plant and Equipment items by £15,423k (2024/25 decrease of £4,935k). Of this net decrease, a net expense of £10,835k has been charged against operating expenditure as an 'Impairment' (2024/25 £4,901k) and the balance of £(4,310k) (2024/25 £(34)k) has been taken to the revaluation reserve. The net movement of £(4,310k) to the revaluation reserve has been presented as an impairment of £(4,588)k and an upwards revaluation movement of £278k in line with the GAM's requirements, (2024/25 a net movement of £(34)k being an impairment of £(5,238)k and £5,204k 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 Note 24. These notes details information about leases for which the Trust is a lessee.

Note 20.1 Right of use assets - 2025/26

Group and Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Intangible assets	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**12,297**	**7,253**	**1,214**	**5,461**	**-**	**40**	**26,265**	**1,013**
Additions	3,185	22	785	-	15	-	**4,007**	37
Remeasurements of the lease liability	-	-	-	-	-	-	**-**	-
Impairments	(2)	-	-	-	-	-	**(2)**	-
Reversal of impairments	-	-	-	-	-	-	**-**	-
Revaluations	(15)	-	-	-	-	-	**(15)**	-
Reclassifications	-	-	-	-	-	-	**-**	-
Disposals / derecognition	(599)	(290)	(826)	(3,225)	-	-	**(4,940)**	(293)
Valuation/gross cost at 31 March 2026	**14,866**	**6,985**	**1,173**	**2,236**	**15**	**40**	**25,315**	**757**
Accumulated depreciation at 1 April 2025 - brought forward	**3,381**	**4,995**	**870**	**4,318**	**-**	**22**	**13,586**	**510**
Provided during the year	1,174	1,111	210	482	3	6	**2,986**	94
Revaluations	(15)	-	-	-	-	-	**(15)**	-
Disposals / derecognition	(432)	(275)	(806)	(3,225)	-	-	**(4,738)**	(126)
Accumulated depreciation at 31 March 2026	**4,108**	**5,831**	**274**	**1,575**	**3**	**28**	**11,819**	**478**
Net book value at 31 March 2026	**10,758**	**1,154**	**899**	**661**	**12**	**12**	**13,496**	**279**
Net book value at 1 April 2025	**8,916**	**2,258**	**344**	**1,143**	**-**	**18**	**12,679**	**503**

Net book value of right of use assets leased from other NHS providers	279
Net book value of right of use assets leased from other DHSC group bodies	-

Note 20.2 Right of use assets - 2024/25

Group and Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Intangible assets	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000	£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**
At start of period for new FTs	**-**	**-**	**-**	**-**		**-**	**-**	**-**
Provided during the year	1,197	1,094	208	1,029	-	6	**3,534**	114
Impairments	-	-	-	-	-	-	**-**	-
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 20.3 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	
	2025/26	**2024/25**
	£000	**£000**
Carrying value at 1 April	**15,161**	**18,892**
Lease additions	4,007	401
Lease liability remeasurements	-	147
Interest charge arising in year	352	422
Early terminations	(202)	-
Lease payments (cash outflows)	(3,218)	(4,701)
Other changes	-	-
Carrying value at 31 March	**16,100**	**15,161**

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 2026

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2026	**31 March 2026**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	3,084	75
- later than one year and not later than five years;	7,205	230
- later than five years.	9,427	-
Total gross future lease payments	**19,716**	**305**
Finance charges allocated to future periods	(3,616)	(18)
Net lease liabilities at 31 March 2026	**16,100**	**287**
Of which:		
Leased from other NHS providers		287
Leased from other DHSC group bodies		-

Note 20.5 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 finance lease liabilities at 31 March 2025	**15,161**	**487**
Of which:		
Leased from other NHS providers		487
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 2026.

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 2025/26 incorporates a subsidiary post-tax profit of £63k (2024/25 £65k). The subsidiary's gross and net assets at 31st March 2026 were £2,365k (31st March 2025 £2,269k) and £1,053k (31st March 2025 £986k) 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.

Note 22 Inventories

	Group		Trust	
	31 March 2026	**31 March 2025**	**31 March 2026**	**31 March 2025**
	£000	**£000**	**£000**	**£000**
Drugs	3,059	3,096	2,170	2,202
Consumables	3,981	3,385	3,981	3,385
Energy	43	30	43	30
Other	398	455	398	455
Total inventories	**7,481**	**6,966**	**6,592**	**6,072**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £63,702k (2024/25: £59,733k). Write-down of inventories recognised as expenses for the year were £185k (2024/25: £178k).

Note 23.1 Receivables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Contract receivables *	25,605	24,599	26,600	24,642
Allowance for impaired contract receivables / assets	(3,568)	(2,983)	(3,568)	(2,983)
Prepayments (non-PFI)	8,619	5,772	8,619	5,772
PFI lifecycle prepayments	-	740	-	740
Finance lease receivables	110	105	110	105
PDC dividend receivable	-	933	-	933
VAT receivable	3,113	4,087	2,855	3,875
Other receivables	68	404	105	404
Total current receivables	**33,947**	**33,657**	**34,721**	**33,488**
Non-current				
Contract receivables	981	818	981	818
Finance lease receivables	2,899	3,009	2,899	3,009
Clinician pension tax provision reimbursement funding from NHS England **	275	352	275	352
Other receivables	-	-	228	265
Total non-current receivables	**4,155**	**4,179**	**4,383**	**4,444**
Of which receivable from NHS and DHSC group bodies:				
Current	4,424	6,227	4,424	6,227
Non-current	500	589	500	589

* Contract receivables (IFRS15) : invoiced, includes Adult Social Care Debt of £15,213k (2024/25 £12,323k).

** 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 - 2025/26

	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 2025 - brought forward	**2,983**	**-**	**2,983**	**-**
New allowances arising	918	-	**918**	**-**
Utilisation of allowances (write offs)	(333)	-	**(333)**	**-**
Allowances as at 31 Mar 2026	**3,568**	**-**	**3,568**	**-**

Note 23.3 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	**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 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	
	2025/26	**2024/25**
	£000	**£000**
Finance lease receivables at 1 April	**3,114**	**3,215**
Additions	-	-
Interest arising (unwinding of discount)	82	59
Lease receipts (cash payments received)	(187)	(160)
Finance lease receivables at 31 March	**3,009**	**3,114**

Note 24.2 Finance lease receivables maturity analysis as at 31 March 2026

	Group and Trust	
	Total	Of which leased to DHSC group bodies:
	31 March 2026	**31 March 2026**
	£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;	186	19
later than two years and not later than three years;	163	19
later than three years and not later than four years;	151	19
later than four years and not later than five years;	151	19
later than five years.	4,184	892
Total future finance lease payments to be received	**5,021**	**987**
Estimated value of unguaranteed residual interest	-	-
Unearned interest income	(2,012)	(746)
Allowance for uncollectable lease payments	-	-
Net investment in lease (net lease receivable)	**3,009**	**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 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**
Unearned interest income	(2,095)	(765)
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 25 Non-current assets held for sale and assets in disposal groups

	Group and Trust	
	2025/26	**2024/25**
	£000	**£000**
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,895**	**1,865**
Assets classified as available for sale in the year	250	-
Assets sold in year	(1,745)	469
Impairment of assets held for sale	-	(439)
Assets no longer classified as held for sale, for reasons other than disposal by sale	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**400**	**1,895**

A vacant building remained unsold at 31st March 2026. These have a realistic prospect of sale within the next 12 months and are being actively marketed with a carrying value of £0.4m.

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	
	2025/26	**2024/25**	**2025/26**	**2024/25**
	£000	**£000**	**£000**	**£000**
At 1 April	**26,701**	**41,269**	**26,578**	**40,711**
Net change in year	8,757	(14,568)	8,790	(14,133)
At 31 March	**35,458**	**26,701**	**35,368**	**26,578**
Broken down into:				
Cash at commercial banks and in hand	102	177	12	54
Cash with the Government Banking Service	35,356	26,524	35,356	26,524
Total cash and cash equivalents as in SoFP	**35,458**	**26,701**	**35,368**	**26,578**

Note 27 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	17,715	24,239	18,773	23,349
Capital payables	19,549	4,866	19,549	4,866
Accruals	34,428	34,359	34,428	34,322
Social security costs	8,143	6,888	8,143	6,888
Other taxes payable	28	33	-	-
PDC dividend payable	245	-	245	-
Pension contributions payable	5,079	4,553	5,079	4,553
Other payables	36	2,457	36	3,420
Total current trade and other payables	**85,223**	**77,395**	**86,253**	**77,398**
Of which payables from NHS and DHSC group bodies:				
Current	8,696	11,105	8,696	11,105
Non-current	-	-	-	-

Note 28 Other liabilities

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Current		
Deferred income: contract liabilities	9,329	11,100
Total other current liabilities	**9,329**	**11,100**

Note 29.1 Borrowings

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Current		
Loans from DHSC	2,058	2,071
Lease liabilities	2,623	2,703
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,120	1,309
Total current borrowings	**5,801**	**6,083**
Non-current		
Loans from DHSC	11,957	13,919
Lease liabilities	13,477	12,458
Obligations under PFI, LIFT or other service concession contracts	23,316	23,630
Total non-current borrowings	**48,750**	**50,007**

Note 29.2 Reconciliation of liabilities arising from financing activities (Group and Trust)

Group and Trust - 2025/26	**Loans from DHSC**	**Lease liabilities**	**PFI and LIFT schemes**	**Total**
	£000	**£000**	**£000**	**£000**
Carrying value at 1 April 2025	**15,990**	**15,161**	**24,939**	**56,090**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,961)	(2,866)	(1,354)	**(6,181)**
Financing cash flows - payments of interest	(378)	(352)	(1,435)	**(2,165)**
Non-cash movements:				
Additions	-	4,007	-	**4,007**
Lease liability remeasurements	-	-	-	**-**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	850	**850**
Application of effective interest rate	364	352	1,436	**2,152**
Early terminations	-	(202)	-	**(202)**
Carrying value at 31 March 2026	**14,015**	**16,100**	**24,436**	**54,551**

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**

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 2026	**Interest Rate**	**Interest outstanding at 31st March 2026 and repayable within one year**	**Loan principal due within one year**	**Total current liability as at 31st March 2026**	**Loan principal repayments due after more than one year at 31 March 2026**	**Duration of Loan**	**Date of final loan repayment**	**Total outstanding at 31 March 2025**
	£000	**%**	**£000**	**£000**	**£000**	**£000**	**Years**	**£000**	**£000**
Loans for Capital Developments									
Backlog Maintenance 2011/12	2,737	3.41%	27	540	567	2,170	20	Dec 2030	3,282
Backlog Maintenance 2012/13	3,176	1.90%	2	527	529	2,647	20	Mar 2032	3,704
Critical Care Unit and Hospital Front Entrance	6,399	2.34%	54	706	760	5,639	20	Nov 2034	7,111
Linear Accelerator Bunker and associated enabling works	1,703	2.34%	14	188	202	1,501	20	Nov 2034	1,893
Sub-total; Capital loans	**14,015**		**97**	**1,961**	**2,058**	**11,957**			**15,990**

	31-Mar-26			31-Mar-25
	Total	**Interest**	**Principal**	**Total**
	£000	**£000**	**£000**	**£000**
of which payable within:				
- not later than one year;	**2,058**	**97**	**1,961**	**2,071**
- later than one year and not later than five years;	**7,846**	**0**	**7,846**	**7,847**
- later than five years.	**4,111**	**0**	**4,111**	**6,072**
	14,015			**15,990**

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 2025	**695**	**2,873**	**261**	**787**	**4,616**
Change in the discount rate	(9)	(131)	-	(21)	**(161)**
Arising during the year	48	55	184	-	**287**
Utilised during the year	(109)	(195)	(37)	(15)	**(356)**
Reversed unused	(68)	-	(20)	(60)	**(148)**
Unwinding of discount	20	85	-	18	**123**
At 31 March 2026	**577**	**2,687**	**388**	**709**	**4,361**
Expected timing of cash flows:					
- not later than one year;	79	146	388	15	**628**
- later than one year and not later than five years;	361	717	-	42	**1,120**
- later than five years.	137	1,824	-	652	**2,613**
Total	**577**	**2,687**	**388**	**709**	**4,361**

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 2027. 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 2026, £95,398k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Torbay and South Devon NHS Foundation Trust (31 March 2025: £95,193k).

Note 31 Contingent assets and liabilities

	Group and Trust	
	31 March 2026	**31 March 2025**
	£000	**£000**
Value of contingent liabilities		
NHS Resolution legal claims	(66)	(41)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(1,216)	(1,282)
Gross value of contingent liabilities	**(1,282)**	**(1,323)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(1,282)**	**(1,323)**
Net value of contingent assets	**(1,282)**	**(1,323)**

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 £66k (2024/25 £41k).

Employment tribunal and other related litigation

At 31 March 2026, there were 10 cases ongoing (31st March 25 - seven cases). As with 2024/25, it has not been possible to quantify the potential liability or assess the likelihood of a liability arising, and a contingent liability of £0 (2024/25: £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 2026 the potential liability would be £1.2m (31st March 2025: £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 2026	31 March 2025
	£000	£000
Property, plant and equipment	2,607	4,859
Intangible assets	2,941	5,417
Total	**5,548**	**10,276**

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 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Not later than 1 year	20,729	15,213	20,681	15,162
After 1 year and not later than 5 years	12,940	10,312	12,940	10,312
Paid thereafter	7,440	9,617	7,440	9,617
Total	**41,109**	**35,142**	**41,061**	**35,091**

Changes were made to the 31 March 2025 revenue commitments statement. The overall total remains unchanged. Amounts due after one year and amounts paid thereafter were rephased. This reflects EPIC commitments spread over several years.

Note 34 On-SoFP PFI, LIFT or other service concession arrangements

At 31st March 2026 and 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'. During 2024/25 the Trust had two PFI contracts for two Community Hospital facilities, Dawlish Community Hospital and Newton Abbot Community Hospital.

Newton Abbot Hospital

On 11th April 2007 Devon Primary Care Trust (now 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 2025/26 the unitary payment was £3,932k (2024/25 £3,799k). Newton Abbot Hospital has a value of £19,947k at 31st March 2026 (31st March 2025 £20,379k).

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 2026	31 March 2025
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**34,954**	**36,498**
Of which liabilities are due		
- not later than one year;	2,483	2,698
- later than one year and not later than five years;	10,136	10,202
- later than five years.	22,335	23,598
Finance charges allocated to future periods	(10,518)	(11,559)
Net PFI, LIFT or other service concession arrangement obligation	**24,436**	**24,939**
- not later than one year;	1,120	1,309
- later than one year and not later than five years;	5,410	5,334
- later than five years.	17,906	18,296

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 2026	31 March 2025
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**51,633**	**52,137**
Of which payments are due:		
- not later than one year;	4,061	3,801
- later than one year and not later than five years;	16,243	15,206
- later than five years.	31,329	33,130

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	
	2025/26	2024/25
	£000	£000
Unitary payment payable to service concession operator	**3,932**	**4,070**
Consisting of:		
- Interest charge	1,436	1,441
- Repayment of balance sheet obligation	1,354	452
- Service element and other charges to operating expenditure	435	558
- Capital lifecycle maintenance	382	565
- Revenue lifecycle maintenance	325	314
- 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	676	9
Total amount paid to service concession operator	**4,608**	**4,079**

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 and the Office of the Government Banking Service. 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; 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 was fixed and the service fee was 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). The PFI contract for Dawlish ceased during 2024/25.

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 2026	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	26,370	-	-	**26,370**
Cash and cash equivalents	35,458	-	-	**35,458**
Total at 31 March 2026	**61,828**	**-**	**-**	**61,828**

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**

Note 35.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	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	27,365	-	-	**27,365**
Other investments / financial assets	265	-	-	**265**
Cash and cash equivalents	35,368	-	-	**35,368**
Total at 31 March 2026	**62,998**	**-**	**-**	**62,998**

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**

Note 35.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	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	14,015	-	**14,015**
Obligations under leases	16,100	-	**16,100**
Obligations under PFI, LIFT and other service concessions	24,436	-	**24,436**
Trade and other payables excluding non financial liabilities	67,029	-	**67,029**
Total at 31 March 2026	**121,580**	**-**	**121,580**

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**

Note 35.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	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	14,015	-	**14,015**
Obligations under leases	16,100	-	**16,100**
Obligations under PFI, LIFT and other service concessions	24,436	-	**24,436**
Trade and other payables excluding non financial liabilities	68,087	-	**68,087**
Total at 31 March 2026	**122,638**	**-**	**122,638**

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**

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 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	74,886	70,826	75,944	70,781
In more than one year but not more than five years	26,008	25,377	26,008	25,377
In more than five years	36,067	38,953	36,067	38,953
Total	**136,961**	**135,156**	**138,019**	**135,111**

Note 36 Losses and special payments

	2025/26		2024/25	
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	7	9	16	4
Bad debts and claims abandoned	161	483	128	305
Total losses	**168**	**492**	**144**	**309**
Special payments				
Ex-gratia payments	16	10	17	29
Special severance payments	1	76	2	29
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**17**	**86**	**19**	**58**
Total losses and special payments	**185**	**578**	**163**	**367**
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 2025/26 and 2024/25 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	
	2025/26	2024/25	31st March 2026	31st March 2025
	£000	£000	£000	£000
Delt Shared Services Ltd	11	12	0	11
	11	**12**	**0**	**11**

	Expenditure		Payables	
	2025/26	2024/25	31st March 2026	31st March 2025
	£000	£000	£000	£000
Step one charity	196	145	10	0
Ogwell Grange Ltd	0	21	0	0
Delt Shared Services Ltd	76	54	0	0
	272	**220**	**10**	**0**

Non-consolidated Associates & Joint Ventures (Group and Trust)

	Income		Receivables	
	2025/26	2024/25	31st March 2026	31st March 2025
	£000	£000	£000	£000
SDH Innovations Partnership LLP	0	0	0	0
	0	**0**	**0**	**0**

	Expenditure		Payables	
	2025/26	2024/25	31st March 2026	31st March 2025
	£000	£000	£000	£000
SDH Innovations Partnership LLP	0	89	0	84
	0	**89**	**0**	**84**

In 2024-25 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.

SDH Innovations Partnership LLP was inactive in 2025-26 and is in the process of being dissolved.

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 £271k (2024/25: £334k) and capital of £76k (2024/25: £64k) from the charity. The charity had reserves of £1,851k at 31st March 2026 (31st March 2025: £1,723k) and recorded an increase in funds of £128k during the year ended 31st March 2026 (2024/25: decrease £45k). The balance of receivables due from the charity at 31st March 2026 was £79k (31st March 2025: £32k).

2024/25 revenue income of £334k received by the Trust from the charity has been restated (previously £646k).

Consolidated Subsidiary (Trust)

	Income		Receivables	
			31 March	31 March
	2025/26	2024/25	2026	2025
	£000	£000	£000	£000
SDH Developments Ltd	817	702	340	318

	Expenditure		Payables	
			31 March	31 March
	2025/26	2024/25	2026	2025
	£000	£000	£000	£000
SDH Developments Ltd	13,891	12,823	1,076	968

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 2025/26 and 2024/25.

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 Foundation Trust and the nature of the primary relationship are described below:

Devon Partnership NHS Trust	Principle sub-contractor to the provision of the Children's & Family Health Devon contract.
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 University Hospitals Plymouth NHS Trust	Provision of clinical, internal audit and other services to one another.
NHS Pension Scheme	Provision of post employment benefits to Staff and Directors of the Trust.