Royal Berkshire NHS Foundation Trust

Annual Report and Accounts 2025 – 2026

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Chief Executive's Report

As an organisation nearing its 200th year at the heart of the community, the Trust is well-practiced in responding to and recovering from the challenges that come our way. In fact, it has been something of a constant theme over the last several years. However, amidst it all, our incredible team of thousands – staff and volunteers – have shown such resilience, that not only have we recovered and responded, in many areas we are leading the way and showing others, nationally and internationally, what's possible.

Thanks to the hard work and dedication of colleagues, we have seen positive performance across many areas of work including Emergency pathways and Cancer targets that remain above or on course to meet the success measures we set ourselves. We have also been the highest performing District General Hospital for our elective performance, and, as part of the national NHS Oversight Framework dashboard in the national published league tables, we have been ranked the 6th best acute trust, 28 out of 134 (Quarter 3 2025/26) based on our average score, with only trusts in segment 1 ranking better.

We know that demands on our services are shifting and in many places increasing – challenging us to work differently. Our refreshed Trust strategy, developed with colleagues from across the organisation, stakeholders, patients, and members of the wider community, sets the direction for the next five years to meet needs locally, with the NHS 10 Year Plan at its foundation. We are now moving into implementation, with an emphasis on building effective local partnerships with community and mental health services, primary care, local government and the voluntary sector to improve the co-ordination of care. The strategy is informed by our continuous improvement approach, Improving Together, which supports teams throughout the organisation to drive positive improvements in their own work. Our 'Live Lab' approach is allowing us to export and share our experience of the difference the Improving Together methodology can make to delivery of services to other NHS organisations across the country.

As a learning organisation we know that delivering the highest quality care for all stems from listening, learning, and acting transparently to the feedback our patients give us. Over the course of the last 12 months, we have had the privilege of regularly hearing patient stories at Public Board. A theme that runs through many of them is that patients, families, and carers are the best co-ordinators of their own care – and that high quality care depends on listening and responding to them. Whilst we have a strong and lasting foundation in place through our Call 4 Concern approach, we continue to push ourselves to improve and will continue to do so. The Trust has taken a zero-tolerance approach to corridor care and this is reflected in improvements in ambulance handover times, patients receiving care through Same Day Emergency Care (SDEC) pathways and increasing use of the discharge lounge to improve flow through the hospital.

Our positive results in the CQC National Maternity Survey also shows a strong ethos of listening, with 96% of those asked feeling they were involved in decisions about their care during labour and birth, and 95% feeling they got the advice they needed during telephone triage with our midwives. These results are something to be rightly proud of, and I know the team are looking at areas where they can improve the experience for their service users even further.

Making the Trust a positive place to work and supporting our people to thrive continues to be a priority. The results of the latest NHS Staff Survey rank us as the top acute trust in England across 16 areas. These include: 'I look forward to going to work'. 'I am satisfied that the organisation values my work', 'My organisation takes positive action to support health and wellbeing ', and 'I am able to make improvements happen in my area of work'. One area we know there is more to do on is violence and aggression. We now have a joint initiative in place

with Thames Valley Police to support staff who become victims of crime while doing their job, the first initiative of its kind within the Thames Valley region.

We also continue to build on our health and wellbeing offer with a new project launched in February 2026 to reach colleagues with risk factors related to diabetes and workplace stress, helping them to access the preventative support they need. In terms of growing and supporting talent our Global Majority Aspiring Senior Leadership Programme continues to strive for leadership that is representative of our wider workforce and career development opportunities that are equitable and accessible. We also continue to develop and thrive as an undergraduate place of learning building on our existing offer with our first full cohort from Brunel University joining us during the last 12 months.

In the world of research, we continue to partner for impact, recruiting 3,182 participants into 89 National Institute for Health and Care Research (NIHR)-supported research studies across a range of specialisms, expanding research for all and keeping our eyes on the horizon. We are proactively sharing our learning outside of the Trust, with Gastroenterology and Hepatology colleagues publishing a research study looking back on 700 patients over a 10-year period to show clear benefits of taking a proactive approach to identifying people living with chronic Hepatitis B. Working with the University of Reading, Professor Toni Chan is exploring how AI can be used to triage patients, shrinking the gap from diagnosis to treatment – something that is already paying dividends for patients with Axial spondyloarthritis, with diagnosis times cut from eight years to one. Colleagues in our Stroke team are at the forefront of research into the potential of Artificial Intelligence (AI), recently co-authoring the largest global study of its kind that showed that use of technology can reduce the time to access treatment by more than an hour.

Over and above our core work, we have had much to celebrate over the last 12 months, with colleagues noted for their achievements externally. Our Renal team were recognised by the Health Service Journal for their Kidney Essentials web-based hub, providing information to patients with chronic kidney disease in multiple languages. The Trust as a whole was also recognised by the Thames Valley Chamber of Commerce as their ‘Employer of the Year’. Over the last 12 months we’ve also played host to a number of high profile visits, including senior government and system leaders and international peer organisations.

A crucial part of our success is the culture we have as an organisation and spirit of the people who make up our teams. Whilst much of the work taking place to support colleagues is peer-initiated and led, for example, the range of staff networks we have, this is supplemented by others that are core to how we do things. For example, our Staff Psychologist continues to support teams across the organisation to understand the mental health impacts of the experiences they deal with, putting in place practical tools to help them cope. Our Royal Berks Charity continues to fund a wide range of projects, equipment, and services designed to support patients, families and staff when they need it most. Charity funding has helped deliver new incubators for Buscot Ward, strengthening care for our smallest and most vulnerable babies. In addition, the Charity has funded the installation of AED (Automatic External Defibrillator) cabinets across the hospital to improve safety in emergency situations. The Charity has also continued to fund vital services, including a bereavement nurse specialist to offer compassionate support to families, ongoing provision of the Citizens Advice Bureau for colleagues, and rest spaces for colleagues including our Single Point of Access team.

Our financial position remains a significant challenge. We are responding with determination, drawing on our value of Resourcefulness and our Improving Together approach, to meet our financial commitments and build a more stable foundation for the Trust. We launched a new Financial Improvement Plan in April 2026, and this will be central to our efforts in the year

ahead. Demonstrating effective stewardship of public money is not just a requirement, it is how we protect the investments in care and staff wellbeing that matter most to our communities. With the knowledge that we will remain in our existing estate for the foreseeable future, we are building a sustainable environment together by maximising our current estate, whilst getting ready for our new hospital. This includes opening the doors of our £11.7m elective surgical hub, the Frederick Potts Unit; bringing on-stream our new £4.8m on-site Urgent Care Centre, equipped to see 100 patients a day; developing our digital capability by investing in a multi-million pound data centre; advancing cancer therapy through upgrading our radiotherapy LINAC equipment; and a £3m investment to extend the capacity for our emergency services. Construction has started on a new MRI unit at West Berkshire Community Hospital, enabling neighbourhood healthcare, closer to home.

The end of 2025/26 represented a watershed moment in the Trust's leadership as well. Steve McManus announced his departure in late 2025 and I took over as Chief Executive in May 2026. During the year, the Trust Board also welcomed Paul da Gama as Chief People Officer, Frances Khatcherian as Chief Finance Officer, and Umesh Jetha as Non-Executive Director.

We know Steve would want us to share that he is incredibly proud of the progress we have made over his near decade of being part of the Royal Berks team, knowing that the Trust will continue to put our patients at the heart of all we do, look for opportunities to reach out and share our expertise with others, and innovate to meet the needs of the community we serve in the years to come.

Signed

James Blythe
Chief Executive Officer **Date: 1 July 2026**

Performance Report: Overview

About the Royal Berkshire Foundation Trust

The Trust is the main provider of hospital services for the people of Reading, Newbury, Henley, Wokingham and the surrounding villages of Berkshire West and South Oxfordshire. We deliver care from a network of facilities across the area including facilities in Bracknell, Henley-on-Thames, Thatcham and Windsor (See figure 1 below).

Figure 1: Principal Service delivery locations

The Trust provides a full range of local hospital services, for a catchment area of just over 600,000 people. In addition, we provide specialist Cancer, Cardiology and Renal services that serve a wider population of up to one million.

Current Position & Operating Context

The NHS is operating under sustained pressure, with rising demand, an aging population, and increased regulatory requirements. The total population in Berkshire West is expected to increase by 8% by 2040 with an ageing population growing at a higher rate compared to the national average; the population over 65 is expected to grow by 70% by 2037. Across the former Buckinghamshire Oxfordshire & Berkshire Integrated Care System (BOB ICS) footprint (now Thames Valley ICS since April 2026), 50% of the population has one or more long term condition and requires ongoing treatment and care and the demand for health services is expected to exceed the capacity in diagnostics and several specialities without further development. The Trust continues to recover its performance following the pandemic and industrial action. Despite strong performance against the National Oversight Framework (NOF), currently ranked 28 out of 134 and would be placed in Segment 1 were it not for its deficit position, constitutional standards across Urgent & Emergency Care (UEC), elective, and cancer pathways are not yet being consistently achieved. Furthermore, whilst the Trust benchmarks

well on efficiency and productivity metrics (11% more efficient than the national average), it continues to face challenges with both its headline and underlying deficit positions.

Our Trust Strategy

At the Royal Berkshire NHS Foundation Trust, our vision remains “Working together to provide outstanding care for our community.’’ In 2025 we started the journey to refresh our Trust Strategy, with meaningful engagement at the heart of our approach. Our Trust Strategy therefore reflects the views, values, and priorities of more than 2500 patients, community, staff, volunteers and partner organisations who shared their time, energy and ideas.

The Trust’s strategy for 2025 - 2030 is anchored in the three 10-year plan shifts from treatment to prevention, hospital to community, and analogue to digital and has been developed with significant engagement with our patients, staff and partners.

It is structured around an overarching mission of working together to provide outstanding care for our community, and five strategic objectives:

1. Delivering the highest quality of care
2. Supporting our people to thrive
3. Partnering for impact
4. Driving improvement and enabling innovation
5. Building a sustainable future

Each of these are supported by multiple priorities and a range of enabling activities to drive our progress. These are underpinned by a set of strategic metrics and targets derived by ongoing work in continuous quality improvement. Together with our CARE values, this framework will support us in delivering our strategy and in achieving our mission. The refreshed objectives and their underpinning priorities are shown below in Table 1.

Table 1: Our Trust Strategy 2025-2030 strategic objectives and underpinning priorities

Strategic Objective	Underpinning priorities
Delivering the highest quality of care for all	• Person-centred and personalised care • Communication that works for everyone • Increasing accessibility of all our services • Addressing health inequalities • Improving patient experience and comfort • Listening, learning, and acting on feedback transparently
Supporting our people to thrive	• Health and Wellbeing • Growing and supporting talent • Education, development, and training • Preparing our workforce for tomorrow • Strengthening our role as a community anchor
Partnering for Impact	• Partnering for prevention • Neighbourhood healthcare, closer to home • Patients as partners, both in their care and in health service design • Unlocking commercial, academic, and industry partnerships
Driving improvement and enabling innovation	• Strengthening the foundations for a smarter, and more connected future • Leveraging data and insights to drive excellence • Building on our Improving Together success

	• Making innovation easier and more accessible for all our staff • Innovating to improve patient experience before, during and after our care • Expanding research for all and keeping our eyes on the horizon
Building a sustainable future together	• Planning for the long-term to achieve financial sustainability • Maximising our current estates, whilst getting ready for our new hospital • Evolving future-forward clinical support services • Collaborating across our Thames Valley Acute Provider Collaborative • Protecting our environment

Our strategic objectives are regularly measured on and reported via our Integrated Performance Report (IPR) using a range of metrics that are listed below. Alongside the strategic metrics identified below, each metric has 3-5 associated insight metrics as well as 110 watch metrics in the wider report.

Strategic Objectives and their Strategic Metrics:

Delivering the highest quality of care for all

- Person-centred care: I was listened to, well informed & involved in decisions about my care (Family & Friends Test (FFT) response)
- Learning from incidents to reduce harm: Patient safety incidents per 1000 bed days

Supporting our people to thrive

- Prioritising staff safety: Avoidable absence in days per month

Partnering for Impact

- Working together: Performance against 4-hour Emergency Pathway target
- Improve waiting times: 62-day cancer standard performance
- Maximising elective activity: <18 week Referral To Treatment (RTT) standard achievement

Driving improvement and enabling innovation

- Digitally enabling our patients: % of patients accessing patient portal / NHS app
- Royal Berks @ Home: Percentage of total inpatients cared for in virtual hospital

Building a sustainable future together

- Living within our means: Cash position (£)
- Increasing efficiency: Productivity growth (activity/whole time equivalent)

Progress against our previous Trust Strategy (Our Strategy: Improving Together) in 2025-26

The Trust has made good progress towards delivering our five strategic priorities and the Trust Strategy: Improving Together in 2025-26. The Trust has seen a number of achievements which has included:

Delivering the highest quality of care for all

- Successfully embedded our new e-Triage app, helping to reduce patient waiting times and improve access to care.
- Broke ground on a new MRI diagnostic centre at West Berkshire Community Hospital, which will enhance local diagnostic capacity.

- Secured funding for new incubators for Buscot Ward, strengthening care for our smallest and most vulnerable babies. Installed of AED (Automatic External Defibrillator) cabinets across the hospital to improve emergency safety.
- Welcomed a brand-new Neurophysiology service, already delivering substantial benefits for patients by reducing wait times and supporting faster diagnosis and treatment.
- Developed & launched a new service to screen patients at risk of developing lung disease to offer early intervention and improve clinical outcomes.

Supporting our people to thrive

- Heard from more than 4,000 colleagues through the NHS Staff Survey, achieving some of our strongest results to date and ranking as the top acute Trust in England across 16 areas.
- Established a staff diabetes prevention programme, providing access to appointments, support and onward referrals where needed.
- Partnered with Thames Valley Police to introduce a direct reporting line for staff experiencing abuse, mirroring the robust approach used to support police officers facing violence and aggression.
- Launched the Trust's inaugural Black History Month Conference, creating space for learning, reflection and celebration.
- Introduced a new health rota system for medical staff to improve staff experience and create efficiencies in HR processes.

Partnering for Impact

- Hosted a joint workshop between the Trust and Primary Care's clinical leaders to develop a joint approach to delivering the 10-year health plan.
- Founded Live Lab, the Trust's own innovative consultancy service developed to support partner organisations by providing them with the Trust's high-quality improvement approach and Improving Together programme. It fosters collaboration, learning, and development across NHS organisations.
- Launched a renewed partnership with the University of Reading, following a review, setting out how we will work together with our academic partners going forward.

Driving improvement and enabling innovation

- Continued our Improving Together roll out at pace with 42% of the organisation's teams trained in Continuous Quality Improvement (not including those that have completed the e-learning).
- Carried out Rapid Process Improvement Workshops across four specialities, improving work processes, eliminating waste and enhancing efficiency.
- Played a leading national role in the use of AI to improve outcomes for stroke patients, contributing to the largest study of its kind in the country.
- Launched the 'Alertive' clinical communication platform, replacing the outdated bleep system with a modern, role based digital solution. This has addressed longstanding safety risks by enabling auditable, role to role messaging, faster response times and improved information sharing, significantly strengthening clinical safety across the Trust.

Building a sustainable future together

- Invested c.£16m to open a new purpose-built Urology hub, the Frederick Potts Unit, creating additional elective space and expanding procedural and diagnostic capacity across multiple specialties.
- Delivered the Diagnostic Demand Optimisation project, reducing unnecessary pathology testing of patients to improve patient experience, staff time, financial efficiency and environmental sustainability.

- Improved Physiotherapy booking processes so patients are now asked to confirm whether they require an appointment before it is scheduled, leading to a reduction in Did Not Attend (DNA) rates.

Our Partnerships

The Trust appreciates that to best support patients we need to work in partnership with other agencies.

Accordingly, we have continued to build on years of close partnership with our key local stakeholders through work with the local Berkshire West Place-Based Partnership and regional Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (now Thames Valley ICS as of April 2026), BOB Acute Provider Collaborative (now Thames Valley APC), Thames Valley Cancer Alliance and Berkshire & Surrey Pathology Services (BSPS). These networks provide an opportunity for the Trust to work in new ways to improve care whilst delivering a more efficient service. We work collectively with these partners to agree priorities and ambitions for our local health system through the Joint Forward Plan and Place-based strategy and have actively supported making progress against these.

We partner with Frimley Health NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust to deliver improvement programmes through the Acute Provider Collaborative. In 2025/26 we implemented a fracture prevention service that has already benefited nearly 200 patients by getting them on the right treatment and prevent them from experiencing a fracture. This will save the trusts over £1m that can be redirected to frontline care. In 2026/27 we are bringing together the clinical and operational teams to look at opportunities for improving patient outcomes and experience in Neurology and Dermatology services. We are also working with our system partners to co-develop a planned care strategy. This will support the aims of the NHS ten-year plan to ensure that care is delivered in the right place, by the right clinician.

Further, we are working with Berkshire West Primary Care Alliance (BWPCA) and Berkshire Healthcare Foundation Trust (BHFT) to set out a sustainable model for neighbourhood health teams as set out in the NHS 10-year health plan and ICB commissioning intentions.
We continue collaborating with the Thames Valley Cancer Alliance to place specific focus on improving diagnostics and cancer waiting times.

Risks

Like many NHS organisations, the Trust faces a set of interconnected challenges: responding to the evolving needs of our population, recovering services, addressing workforce fatigue, maintaining ageing infrastructure, and sustaining our financial position. These are not new risks, but they remain live and significant.

Our focus for 2026/27 is clear, meeting national and regional performance objectives, delivering our financial plan in year and reducing our financial run rate to sustainable levels, and continuing to improve the care we provide. Achieving this will depend on several factors outside our direct control, including demand through emergency pathways, inflationary pressures, the resources made available by NHS England, and referral rates from Primary Care. We are clear on these dependencies and are planning accordingly.

There is significant risk from growth in non-elective activity and considerable further work will be needed with our system partners to minimise this. Specifically, if ED attendances continue to rise, if call before convey rates do not increase, and if No Criteria To Reside (NCTR) numbers remain high, with continued sub-optimal occupancy rates in community hospitals, there is a

significant risk that additional staffing will be required, at premium rates, which will risk budget overspend.

The Trust currently occupies a portfolio of buildings, with some having been opened in 1839 that have a range of issues associated with them, which impacts on quality and costs and cannot be effectively redesigned and efficiently used to provide health services in the 21st century. The Trust's estate related challenges have been recognised and the estate redevelopment has been included in the Government's New Hospitals Programme. However, with a delay to building work commencing on a new hospital until 2037 a strategic approach to tackling the maintenance backlog on the current site will be required urgently. Further, ensuring we have sufficient cyber-security and resilience will remain a risk.

Overview: Going Concern

These financial statements have been prepared on a going concern basis. In accordance with the Department of Health & Social Care (DHSC) Group Accounting Manual, that interprets and adapts IAS 1 *Presentation of Financial Statements* for the public sector context, the Trust's going concern assessment is based on the anticipated continuation of the provision of its services rather than on the availability of finance. The Directors have no reason to believe that the services currently provided by the Trust will cease to be provided, and they have identified no material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern.

In reaching this conclusion, the Directors have reviewed the Trust's financial position and future cashflows in detail. The Trust enters 2026/27 with a clearer financial picture than a year ago, while recognising that significant challenges remain. For the year ended 31 March 2026 the Trust reported an adjusted deficit of £4.5m, £3.3m better than planned, and closed the year with a cash position of £27.2m, an improvement of £9.8m on the position as at 31 March 2025. These results reflect the considerable effort made across the organisation to manage resources carefully while continuing to deliver high quality care.

As set out in Note 28, during 2025/26 the Trust identified a material prior period error relating to the over-recognition of accrued income from NHS England Specialised Commissioning in the year ended 31 March 2025, and the comparative figures have been restated to correct it. The Directors have considered the effect of this restatement on the going concern assessment. The correction relates to income that had not been earned and to a corresponding accrued income balance that was not subsequently received in cash. Therefore, it has no impact on the Trust's cash position, its future cashflows, or its current year reported financial performance, and is reflected as a reduction in retained earnings brought forward. As described in Note 28, the Trust has begun strengthening the control environment for income recognition and year-end accruals to reduce the risk of recurrence.

The Directors' assessment takes account of the environment in which the Trust operates. Factors outside the Trust's direct control, including inflationary cost pressures, the pace of public sector reform, demand through emergency pathways, and the level of resources made available nationally for recovery, all have a bearing on the Trust's financial trajectory. The Trust's planning assumptions reflect these factors, and the Trust continues to work collaboratively across the system to manage their impact. Underpinning the going concern conclusion is the certainty of Patient Care Income secured through the block contract arrangements with Thames Valley ICB, that provide funding certainty for the majority of the Trust's Patient Care Activity within the national NHS England funding structure, together with the Trust's continued engagement with NHS England within that structure.

The Trust's business and capital planning arrangements ensure that all categories of cost and risk are considered as part of the decision-making process. The Trust has set an internally

funded capital plan of £35.9m for 2026/27 (2025/26: £26m), for which prioritisation has been finalised. Demand on the capital plan continues to exceed the funds available and the Directors recognise that the continued rationing of capital expenditure creates pressure, particularly in repairs and maintenance, with an associated risk to services that are heavily dependent on equipment operating beyond its economic life. The Trust's prioritisation process seeks to strike the right balance between protecting income-generating services, managing infrastructure and clinical risk, and maintaining overall financial discipline.

Having considered the Trust's financial performance, cash position, future cashflows and the wider operating environment, and on the basis of the continued provision of the Trust's services, the Directors are satisfied that it is appropriate to adopt the going concern basis in preparing these financial statements, and they have identified no material uncertainty in doing so.

Performance analysis

For 2025/26 the Trust has continued to focus on safe delivery of services and appropriate prioritisation of patients as we balance the need to reduce waiting times and improve services, against a backdrop of increasing demand and on the day challenges. Actions taken throughout the year have sought to optimise processes throughout the patient pathway, focusing on both the reduction of backlog and the removal of inefficiencies early in patient pathways. This approach is supporting the Trust to make small improvements against performance standards but lays the ground for more sustainable service delivery and waiting times. As we look to 2026/27 the Trust will continue to focus on challenges early in the patient pathway e.g. first outpatient waiting times which have driven long elective waiting times and will continue to work closely with colleagues across the integrated care board (ICB) to identify demand reduction and flow efficiency opportunities across the non-elective pathway.

- Performance against ED 4-hour (95%) standard remains challenged (<80%), largely driven by sustained increased levels of demand through the department and more recently complicated as a result of significant winter pressures. Whilst performance against the standard remains challenged, this is comparable with local benchmark organisations and meeting our expected trajectory. During 2024/25 the Trust opened the first phase of our co-located Urgent Care Centre, which has been expanded through 25/26. This is expected to support improvement to the Trust's overall performance against the 4-hour standard.
- The Trust has continued to experience long delays within the emergency department, with c. 2.5% of patients waiting a total time of 12 hours from arrival. Work within our Same Day Emergency Care (SDEC) and Single Point of Access (SPOA), combined with early discharge and a focus on improving out of hospital flow, in particular to community setting care, are a daily focus for the Trust. We are clear that improvement in timely discharge will be required to make meaningful improvement to flow through the UEC pathway.
- The 2025/26 elective programme has continued to focus on maintaining a low number of long waits across the Referral to Treatment performance (RTT) standard whilst addressing extended waits to first outpatient, which is understood to be the primary driver of long waits for the Trust. Through a combination of validation, improved triaging and advice processes, and operational focus on the individual stages of treatment, the RTT Patient Tracking List (PTL) has exceeded the expected trajectory.
- Performance against the headline RTT standard (92% <18 weeks) was reported as 83% at the end of March 26. This compares with 75% March 25, and 57% in April 2022. The PTL size remains slightly higher than pre-pandemic level. However, this is expected to be addressed through a profile left shift in waiting times aligned

to improved triage and shorter 1st Outpatient Appointment (OPA) waiting times.

- The Trust has zero pathways waiting above 104 and 78 weeks and has maintained a low number of pathways >65 weeks throughout the year. The Trust is currently reporting zero >65 weeks and whilst we expect to continue to have a small number of these pathways they will be kept to a minimum.
- The number of >52-week waits is currently below 40. This is down from 100 in January 2024. We expect this number to be maintained through the early part of next year and begin to reduce as we continue to focus on removing the causes of long waits, in particular long waits to first Outpatient Appointment.
- The Trust has seen success from taking a two-pronged approach to reducing the overall waiting list size and profile, focusing on the treatment of the longest waits whilst also increasing outpatient capacity in order to clear backlog within the early stages of a patient's pathway. Reducing the time to assessment and decision making is considered to be the most effective approach to managing risk within the waiting list and is driving the Trust towards a sustainable recovery.
- The Diagnostic Monitoring (DM01 – 99%) standard remains below target. However, improvements made through 2024/25 have been maintained.
- Of particular note, Endoscopy modalities have made significant improvements to both the number of very long waits (>13 weeks) through backlog reduction as well as overall improvement to minimise the number waiting beyond 6 weeks. MRI and non-obstetric ultrasound have experienced challenges through the latter part of 2025/26 but demonstrated signs of recovery towards the end of the year.
- The Trust has seen a continuation of increased demand in referral numbers on the Two Week Wait (2WW) Cancer Pathway (c.8%) that has driven delays across the 14 day 2WW, diagnostics and overall 62 day treatment standards. As a result, our cancer performance has been impacted in these areas. However, the Trust remains ahead of our submitted performance trajectory for 2025/26.
- The Trust is meeting the 28 Day Faster Diagnosis and 31 Day Treatment cancer standards that are considered to be good indicators of providing safe and timely care for patients with a confirmed diagnosis of cancer.
- Work is continuing across challenged services (Colorectal, Gynaecology and Urology) to progress pathway level improvement which are expected to improve the diagnostic phase of the cancer pathway. This is expected to reduce the number of non-cancer patients on the PTL and improve waiting times for patients with a cancer diagnosis. Progress will continue through 2026/27.
- In 2025/26 the Trust continues to balance the need to work within a challenging environment and elective recovery as we seek to optimize our digital estate to go further faster with our recovery aims. Risk management, patient safety and patient/staff experience will be key drivers to recovery against the national elective access standards.
- Within the ED pathway specifically, the Trust will continue to drive improvement though the use of Same Day Emergency Care (SDEC) models, increasing the use and utilisation of the new co-located Urgent Care Centre and maximizing the estate to support both the 4-hour standard and ambulance handover standards.
- Within the routine elective pathways, we will continue to focus on balance reducing the backlog whilst bearing down on waiting times and optimizing each stage of the pathways.
- The enhanced referral and triage process (eTriage) has been rolled out within the Trust. We are already seeing improvements in use of Advice & Guidance (A&G), patients directed straight to test and the use of eTriage to aid in improving productive use of capacity and resource across the first outpatient stage of treatment.
- These tools will continue evolve through 2026/27 and provide a stable base to build from and enable both traditional performance recovery but also the implementation

of improved processes and transformation opportunity.

- Work within the cancer pathway will focus on maintaining stability in the waiting list and good performance against key cancer pathways. This will be balanced against work, through collaboration with others within the Integrated Care Partnership (ICP), Integrated Care System (ICS) and Thames Valley Cancer Alliance (TVCA) to work towards parity of performance across the region.

Performance Analysis: National Access Standards

- Across each of the national access standards the primary risk to delivery remains capacity, physical workforce availability as well as the funding arrangements for additional capacity.

- At the beginning of 2026/27 the Trust remains challenged in its ability to adhere to the national access standards. Throughout 2025/26 the Trust has attempted to focus on a reduction of waiting times at individual stages of treatment. A theme that will continue in 2026/27, with particular focus on first assessment waiting times in both the elective and non-elective pathways as well as waits for diagnostic procedures.

- Table 1. National Access Standards

		National Standards	RBFT 2023/24	RBFT 2024/25	RBFT 2025/26
Referral to Treatment (RTT)	% of Incomplete Pathways within 18 weeks from referral	*92%*	83%	75%	84%
Diagnostic Monitoring (DM01)	% of service users waiting less than 6 weeks from referral for a diagnostic test	*99%*	80%	92%	86.8%
Emergency Department (ED)	% of ED attendances admitted or discharged within 4 hours of arrival (combined)	*95%*	65.7%	64%	77%
Cancer – Core Access	% of service users referred with suspected cancer from a GP waiting no more than two weeks for first appointment	*93%*	71.7%	78.9%	88.8%
	% of service users referred urgently with breast symptoms (where cancer is not initially suspected) waiting no more than two weeks for first appointment	*93%*	96.9%	99.8%	91.9%

	% of service users waiting no more than one month (31 days) from decision to treat to treatment for all cancers	*96%*	93.9%	93.1%	95.7%
	% of service users referred with suspected cancer from a GP waiting no more than two months (62 days) from referral to first definitive treatment for cancer.	*85%*	67.9%	73.3%	74.6%
	% of service users waiting no more than two months (62 days) from referral from an NHS screening service to first definitive treatment for cancer	*90%*	73.3%	74.7%	76.3%
	% of service users waiting no more than one month (31 days) – Surgery	*94%*	96.34%	86.3%	90.6%
	% of service users waiting no more than one month (31 days) – Radiotherapy	*94%*	94.46%	88.2%	74.2%

Financial Performance

Overview
The Trust group, comprising the Trust, its wholly owned subsidiary and the Royal Berks Charity, reported an in-year deficit of £13.11m for 2025/26, compared with a restated deficit of £43.29m in 2024/25 — a year-on-year improvement of £30.17m.

The reported position is best understood by reference to the key elements that drove it:

- **Prior period restatement.** The 2024/25 comparator has been restated for a material prior period adjustment relating to the over-recognition of commissioner income (net £12.94m), which reduced retained earnings brought forward and had no impact on the current year deficit. Because the restatement worsens the prior year comparator, part of the year-on-year improvement reflects the correction of that prior-period error rather than underlying in-year progress.

- **Non-recurrent financial support.** The 2025/26 position benefited from non-recurrent support, including £6.045m of revenue support PDC funding received in January 2026 and Deficit Support Funding (DSF) of £16.53m. Excluding non-recurrent support, the Trust's underlying deficit was £33.9m.

- **Underlying delivery.** The remainder of the improvement reflects delivery against the Trust's financial plan, national funding arrangements, and continued operational effort to manage costs and increase activity.

Accordingly, while the reported deficit has reduced significantly year on year, this should be read in the context of both the prior year restatement and the benefit of in-year non-recurrent financial support

Summary Financial Results

The table below sets out the key financial results for 2025/26 compared to the prior year:

£m	2025/26	2024/25 (restated)*	Variance £m
Income	714.48	660.95	53.53
Pay	(442.84)	(417.74)	(25.10)
Non-Pay excluding impairments	(228.21)	(229.34)	1.13
Total Expenses	(671.05)	(647.08)	(23.97)
EBITDA	**43.43**	**13.87**	**29.56**
Depreciation/Amortisation	(35.14)	(35.78)	0.64
Impairments including reversals	(11.19)	(11.93)	0.74
PDC Dividend	(9.66)	(9.39)	(0.27)
Net Interest Receivable	0.42	1.17	(0.75)
Other non-operating expenses incl. loss on disposal	(0.97)	(1.22)	0.25
Reported (deficit) for the period	**(13.11)**	**(43.28)**	**30.17**

*stated as explained in note 29 to the financial statements on page 63

Total income from patient care activities and other operating income reached £714.48m, an increase of £53.53m (8.1%) on the restated prior year figure of £660.95m. NHS Commissioner income was received under the Aligned Payment and Incentive contract, which includes both fixed and variable elements, a departure from the full block contract that had been in place in 2023/24. Included within income is £25.2m of national funding towards employer pension contributions and £0.93m to cover clinicians' pension liabilities.

The pay bill increased by £25.1m (6.0%) from £417.74m in 2024/25 to £442.84m in 2025/26. This increase reflects the growth in workforce to support rising activity demands across both elective recovery and non-elective pathways. Workforce growth has been purposeful and directly linked to income generation, and the Trust continues to manage its establishment carefully to ensure pay costs remain proportionate to activity.

Non-pay costs (excluding depreciation, amortisation and impairments) decreased slightly by £2.0m to £227.3m, a reduction of 0.9% demonstrating the continued discipline applied through our efficiency programme. Within this:

- Drugs costs, including those funded through NHS England pass-through funding, increased by 6.4% to £75.15m (£70.62m in 2024/25), reflecting both activity growth and inflationary pressures on medicines.
- Premises costs increased by 5.7% to £30.77m (£29.12m in 2024/25), driven in part by rising utility costs.
- Clinical Negligence Scheme costs increased by 6.2% to £25.16m (£23.69m in 2024/25), following the annual reassessment of scheme liabilities by NHS Resolution.
- Clinical supplies and services reduced by 3.4% to £53.33m (£55.22m in 2024/25), reflecting the impact of efficiency initiatives.
- Establishment expenses increased by 35.9% to £3.37m (£2.48m in 2024/25).

Efficiency Programme

A deficit budget was set for 2025/26, incorporating a challenging efficiency savings target of £40.60m.
The Trust met its efficiency savings target in full, delivering £40.60m against the £40.60m planned. Of this, £37.47m was secured through recurrent and in-year scheme delivery, with the balance of £3.13m met through non-recurrent measures within the programme. While the target was therefore achieved, the proportion delivered non-recurrently was higher than planned, which limited the underlying improvement in the financial position and increases the recurrent savings requirement carried into 2026/27.
In recognition of the delivery challenge, a dedicated internal turnaround team was established, led by the Chief People Officer as Director of Turnaround. The team operated alongside Business As Usual activity and worked with Care Groups and Corporate Directorates to identify and implement both cost improvement and transformation initiatives. Delivery was monitored through the Efficiency and Productivity Committee, with strengthened governance and escalation processes introduced during the year, and the approach has now been embedded within normal financial management processes.
The 2026/27 efficiency target has been set at £43.70m — higher than both the 2025/26 target and the level of recurrent delivery achieved in-year. Combined with the reliance on non-recurrent delivery in 2025/26, this makes the 2026/27 programme materially more demanding and requires a decisive shift towards recurrent, sustainable savings. Work is already underway to load the 2026/27 workforce budget to ESR, identify recurrent opportunities, and reinforce grip and control over the non-pay budget.

Capital Expenditure

The Trust recognised £45.40m of capital expenditure in 2025/26 (£59.31m in 2024/25), including additions recognised as leases under IFRS 16. Capital investment was focused on three priority areas: Estates infrastructure, Medical Equipment, and Digital Data and Technology (DDaT), including intangible assets.

Of total capital spend, £19.30m was externally funded through Public Dividend Capital (PDC) from the Department of Health and Social Care, with the remainder funded internally. The tables below set out the principal schemes within each funding category.

Externally Funded (PDC) Capital Schemes

PDC Funded Schemes	£m
UEC: Other UEC Schemes	3.42
Cancer LINAC Replacement	2.35
Estates Safety: Other Schemes	4.41
Estates Safety: Phase II Maternity	3.95
Digital Diagnostic / Estate Safety Phase III	3.53
Total PDC Funded	**19.26**

Internally Funded Capital Schemes (selected)

Internally Funded Schemes	£m
Backlog Maintenance – Estate Programme	11.96
IT – Cybersecurity, Infrastructure/Networking	7.14
Equipment – Clinical Theatres & Critical Care	7.01

For 2026/27, the Trust has set a capital plan of £35.9m (£26m in 2025/26), prioritised to protect clinical services, address safety-critical infrastructure requirements, and manage the risks associated with equipment beyond its economic life. Demand on the capital plan continues to exceed available funds and continued rationing of capital spending creates pressure — particularly in repairs and maintenance. The Executive prioritisation process seeks to balance the protection of income-generating services, the management of infrastructure risk, and overall financial discipline.

Cashflow and Financial Position

The Group's liquidity position, as reported, improved during the year. Cash and cash equivalents at 31 March 2026 were £30.42m, compared with £13.52m at 31 March 2025. The principal driver of the closing position was capital expenditure incurred but not yet due for payment, with closing capital creditors of £21.23m largely settled in April and May 2026; the underlying liquidity position was therefore tighter than the closing balance suggests. The Cash to Net Asset ratio at 31 March 2026 was 0.096:1 (31 March 2025: 0.046:1), reflecting the same year-end timing position. The Trust will need to maintain the rigorous liquidity management processes established in 2025/26 to ensure financial resilience throughout 2026/27.
The Trust's principal assets are the land and buildings from which services are provided to patients. A revaluation of the Trust estate during the year resulted in an increase in asset value of £16.8m.
At the year end the Trust held one loan of £24m, from the Independent Trust Financing Facility, taken out to finance the development of the Royal Berkshire Bracknell Healthspace. The loan continues to be repaid, with £1.46m outstanding at 31 March 2026 (31 March 2025: £3.0m).

Going Concern

The Directors have reviewed the Trust's financial position and future cashflows in detail and are satisfied that the Trust has adequate resources to continue operating for the foreseeable future. The accounts have accordingly been prepared on a going concern basis, with no material uncertainty identified.

This conclusion reflects both the certainty of Patient Care Income secured through block contract arrangements with Thames Valley ICS and the Trust's ongoing engagement with NHS England within the national funding structure. NHS Commissioner income includes fixed and variable elements which provide a stable foundation for planning. The Trust's business and capital planning arrangements ensure that all types of cost and risk are considered as part of the decision-making process.

We are clear about the environment in which we operate. Factors outside our direct control including inflationary cost pressures, the pace of public sector reform, demand through emergency pathways, and the level of resources made available nationally for recovery all have a bearing on our financial trajectory. Our planning assumptions take these into account, and we continue to work collaboratively across the system to manage their impact.

Financial Risk Management

Principal Risks and Uncertainties

The Trust manages risk through its Board Assurance Framework (BAF), which aligns principal risks to the Trust's five strategic objectives and is reviewed regularly by the relevant Board sub-committees and by the Board. The BAF sets out the Board's risk appetite for each objective, the key controls in place, gaps in assurance, and the actions being taken to address them. The principal risks during 2025/26, and how they have moved through the year, are summarised below.

Quality of care (Strategic Objective 1). The Trust carries risks that material lapses in the quality or accessibility of care could result in failure to meet regulatory standards, and that clinical and quality ambitions may not be delivered at the intended pace. The Board maintains a low appetite for risks compromising patient safety or CQC compliance. These risks are mitigated through the CQC programme, the Improving Together continuous improvement approach, clinical audit and the quality reporting framework. Risks to delivery of access standards remained a live pressure during the year, mitigated through the elective activity plan, patient flow programme and performance reviews.

Workforce (Strategic Objective 2). Failure to recruit and retain a competent workforce, or to uphold the Trust's values, presents a risk to delivery of all strategic objectives. These risks are managed through the People Strategy, recruitment and retention programmes, and the staff health and wellbeing strategy, with the pace of improvement across the equality, diversity and inclusion agenda recognised as a continuing area of focus.

Partnerships and system working (Strategic Objective 3). The Trust depends on Place and system partners delivering operationally, and on Berkshire West Place and Thames Valley ICS plans delivering the envisaged improvements in care and value; failure in either presents a risk to constitutional standards, NOF position, and the Trust's own performance. These risks are mitigated through active executive and Board-level engagement in system governance, including the Trust's leadership of the Acute Provider Collaborative.

Improvement, innovation and digital (Strategic Objective 4). Risks arise if the Trust does not invest sufficiently in its digital environment or fails to realise benefits and commercial advantage from transformation and digital investment, with a consequent risk to income and efficiency delivery. These are managed through the digital strategy, the transformation and turnaround

programmes, and benefits oversight through the Finance and Investment and Efficiency and Productivity Committees.

Financial sustainability (Strategic Objective 5). Financial sustainability is a principal risk for the Trust, and the Board has been explicit that the current level of financial risk is above its stated risk appetite. The Trust set a deficit budget for 2025/26 and delivered an adjusted deficit of £4.5m, £3.3m better than plan. However, this position relied on a high proportion of non-recurrent efficiency delivery and on non-recurrent financial support, which limits the underlying improvement and increases the challenge in 2026/27, where a higher efficiency target of £43.70m has been set.
During the year the Trust also identified a material prior period error in the recognition of commissioner income, arising from weaknesses in the control environment for income recognition and year-end accruals (see Note 28 and the Annual Governance Statement); this is a new risk identified in-year, being mitigated through a programme of remedial action to strengthen controls. Related gaps in assurance identified through the BAF include oversight of income delivery at care group level and, following new NHSE guidance on Strengthening Financial Management, the strengthening of non-pay controls and financial recovery governance.
The Trust's estate and infrastructure risks — including backlog maintenance, critical infrastructure risks and the constrained capital position — also fall within this objective and present a risk to service continuity where assets operate beyond their economic life. These risks are managed through the financial recovery plan, strengthened financial controls and reporting, the capital prioritisation process, and the Trust's longer-term estate and New Hospital strategy. Actions are in place to reduce financial risk towards the Board's stated appetite over time.

Outlook

The Board recognises that financial risk in particular is expected to remain elevated in 2026/27, given the higher efficiency requirement, the unwind of non-recurrent support, and continued capital constraint. The Trust's forward plans reflect these risks, with mitigation focused on improving the recurrent quality of efficiency delivery, strengthening financial controls, and maintaining rigorous liquidity and capital management.

Task force on climate-related financial disclosures (TFCD)

NHS England’s NHS Foundation Trust Annual Reporting Manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies. This stems from HM Treasury’s TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

In 2025/26 the Chief Finance Officer held executive responsibility for the Trust’s Net Zero targets and Green Plan, providing Board-level accountability for delivery and governance. From 2026/27, this responsibility transfers to the Chief Strategy Officer reflecting the Trust’s decision to embed environmental sustainability at the heart of its long-term strategic leadership.

The Trust has established a robust governance structure to oversee its progress on climate-related issues and the delivery of its Net Zero Carbon (NZC) and Green Plans. Climate performance is reported quarterly to the Executive Management Committee (EMC), which includes care group, operational and executive membership, ensuring accountability at the most senior operational level. Significant risks and material deviations from plan are escalated to the

Finance and Investment Committee (ensuring non-executive oversight of the Trust's environmental commitments.

During 2025/26, the Trust has made significant progress in developing the data infrastructure and performance metrics required to underpin robust sustainability reporting. The Integrated Performance Report (IPR), reviewed at every Finance and Investment Committee and Board of Directors meeting, ensures that Board members maintain ongoing oversight of the Trust's most material environmental risks and performance indicators. A dedicated sustainability dashboard, enabling quarterly monitoring of progress against the Green Plan, is now in development and will further strengthen the Trust's reporting capability in 2026/27.

The Trust's Board Assurance Framework (BAF) formally assigns oversight of Net Zero Carbon and Green Plan delivery to the Finance and Investment Committee. This encompasses scrutiny of resource allocation decisions, budget planning and in-year carbon reduction performance. Environmental sustainability and carbon reduction are a core strategic priority within the Trust's Our Trust Strategy 2025–2030, under the 'building a sustainable future together' objective, ensuring that net zero ambitions are integrated into the Trust's overall planning and performance management.

The Trust has continued to play an active and influential role across its system partnerships. As Health lead on the Reading Climate Change Partnership Board and a member of the Thames Valley ICB Net Zero Carbon Board, the Trust contributes directly to coordinated, system-wide climate action across Berkshire and beyond, working alongside Greener NHS Southeast. During the year, collaboration with the University of Reading has advanced materially: the Trust is now participating in joint research projects focused specifically on how NHS services can achieve net zero and is facilitating deeper connections with the New Hospital Programme to embed net zero ambitions within our future estate. A dedicated sustainability performance dashboard, enabling quarterly monitoring of progress against the Green Plan, is now in development. These partnerships reflect the Trust's commitment to leading on sustainability, not simply responding to national requirements.

Within the Trust, day-to-day sustainability work is driven by an active network of Carbon Champions embedded across clinical and corporate teams, supported by a dedicated project team. This structure ensures that environmental sustainability is not a function of a single team but a shared organisational responsibility. During 2025/26 these groups have progressed a range of improvements across energy, waste, travel and procurement — with further initiatives planned as part of the refreshed Green Plan.

A comprehensive review of the Trust's sustainability performance was presented to the Trust Board in 2025/26, providing non-executive oversight of delivery against the Green Plan and informing the development of the refreshed plan for the period ahead.

The Trust has not been able to fully meet all TCFD disclosure requirements in the current reporting period due to the significant capacity pressures faced this year. The organisation is managing a challenging financial position, with a strong focus on delivering cash-releasing savings, maintaining liquidity, and addressing underlying deficit and efficiency requirements. This has required prioritisation of immediate financial recovery and statutory operational targets over further development of complex, resource-intensive climate risk modelling and reporting processes. The Trust currently has limited dedicated capacity and specialist expertise to fully develop and embed detailed processes for identifying, assessing, and managing climate-related risks, or to undertake comprehensive scenario analysis. As such, while governance arrangements and foundational work are in place, the Trust has not yet been able to complete the more advanced TCFD disclosures covering end-to-end risk management. This will be addressed in the financial year 2026/27, alongside our refreshed Green Plan.

Environmental Impact and Sustainability in 2025/26

The Trust has delivered meaningful reductions in several key emission sources during the Green Plan period. Electricity-related emissions have fallen significantly as both the national grid continues to decarbonise through increased wind, solar and renewable generation, and the Trust has actively reduced its grid consumption. Fleet vehicle emissions have also reduced through a smaller fleet size and transition to cleaner vehicles. The completion of the de-steam project has delivered measurable reductions in gas consumption across the energy centre heating circuits — a concrete infrastructure improvement with lasting impact on our carbon footprint.

The partial increase in emissions between 2023 and 2024/25 is primarily attributable to a single exceptional and non-recurring event: the North Block generator hall flood at the Royal Berkshire Hospital, which required the hire of diesel generators to maintain power supply to the north side of the site for a period of four months. This significantly increased gas consumption across the Combined Heat and Power (CHP) and wider estate during that period. A separate increase in inhaler-related emissions has also been recorded, in line with a pattern seen across many NHS trusts. Excluding these factors, the underlying trajectory of the Trust's carbon performance remains consistent with its longer-term reduction. Steps to reduce inhaler emissions including increasing the proportion of dry powder inhalers prescribed are incorporated into the refreshed Green Plan.

The Trust is refreshing its Green Plan to cover the period ahead, aligning its ambition and trajectory with the national NHS net zero target framework — scope 1, 2 and 3 emissions to net zero by 2040 and 2045 respectively. This refresh reflects both the evolution of national policy and the Trust's own performance review, and will set out a credible, costed set of actions across energy, fleet, procurement, travel and clinical practice. The updated plan will be presented to the Board and published in 2026/27, with progress monitored through the new quarterly sustainability dashboard.

Health Inequalities

The Trust continues to deliver a range of health inequalities and health prevention programmes and align these to our strategies, programmes and priorities. As part of a Health Promoting Hospital, the refreshed Trust Strategy reflected addressing health inequalities throughout, including a dedicated commitment in 'delivering the highest quality of care for all'.

Public Health Consultant

The Trust is partnering with West Berkshire Council and Reading Borough Council to bring additional public health expertise into the arena. West Berkshire Council has recruited a Service Lead, Consultant in Public Health and Reading Borough Council has recruited a Consultant Public Health (Health Intelligence & Healthcare Public Health) in and each of these roles has one day allocated to the Trust. The consultants will provide 1-day support to deliver the Trust's ambitions around preventative medicine and provide healthcare public health advice. Next steps include developing a full portfolio of work with the consultants upon their arrival.

Meet PEET (Patient Experience Engagement Team)

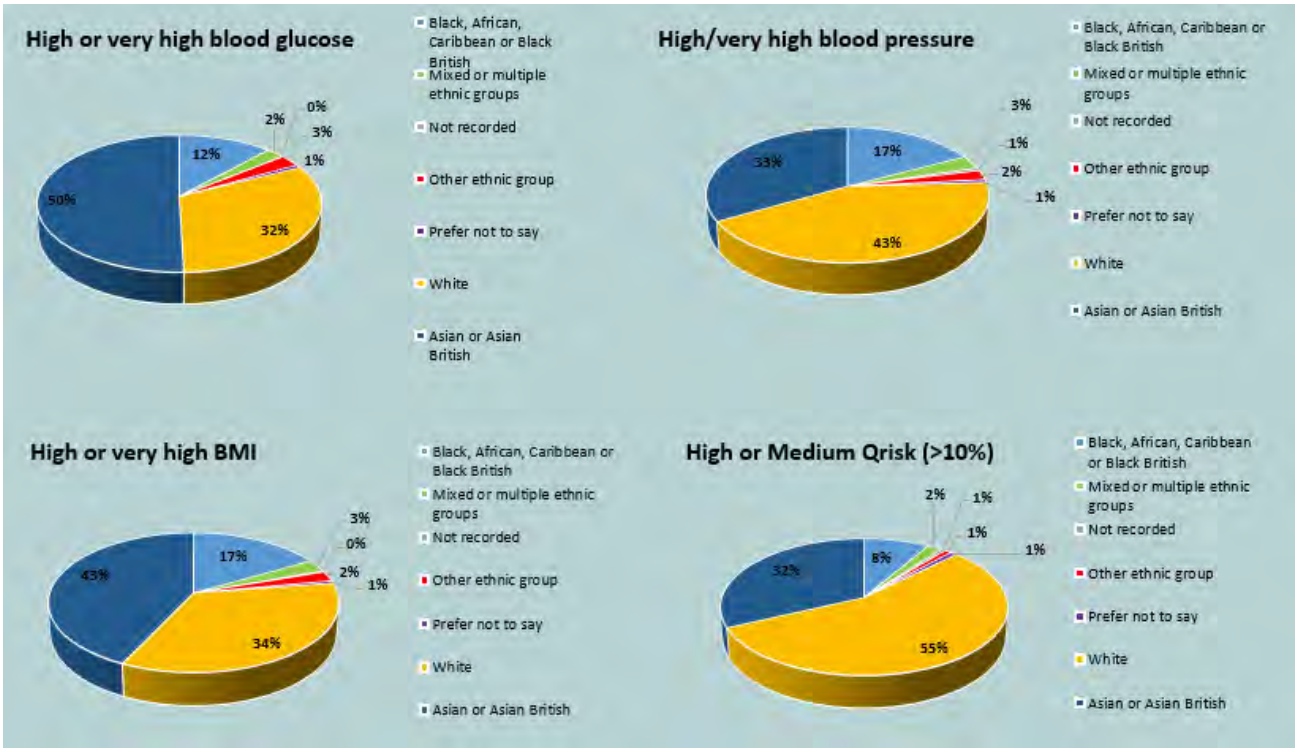
Following the success of the first phase of the Community Wellness Outreach programme, funding was extended to June 2026 meaning Meet PEET continues to focus on this pilot. The programme is an initiative funded by Thames Valley ICB which aims to reduce health inequalities for the most vulnerable communities across our region. In Reading, Meet PEET is working in partnership with Reading Voluntary Action (RVA) to deliver health checks and support through social prescribing in over 40 locations across the community. Meet PEET's nurses have conducted over 4800 full health checks from January 2024 to April 2026. As a result, they

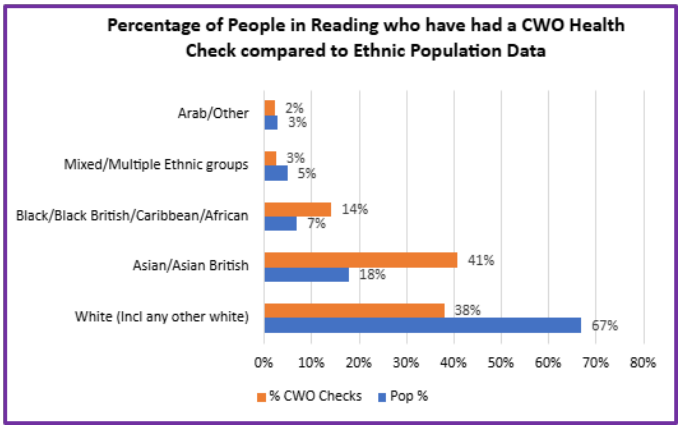
have identified and helped people deal with or prevent a large number of current and future health issues.

An improvement to the service this year is that the vast majority of results are sent to the patient's GP on the day via EMIS, thereby improving ongoing care where needed. Conditions identified during the checks to date show 69% very high/high body mass index (BMI), 21% very high/high blood pressure, and 21% with high blood glucose levels (a pre-indicator of diabetes) and 6% with a high risk score, indicating potential cardiovascular risk factors.

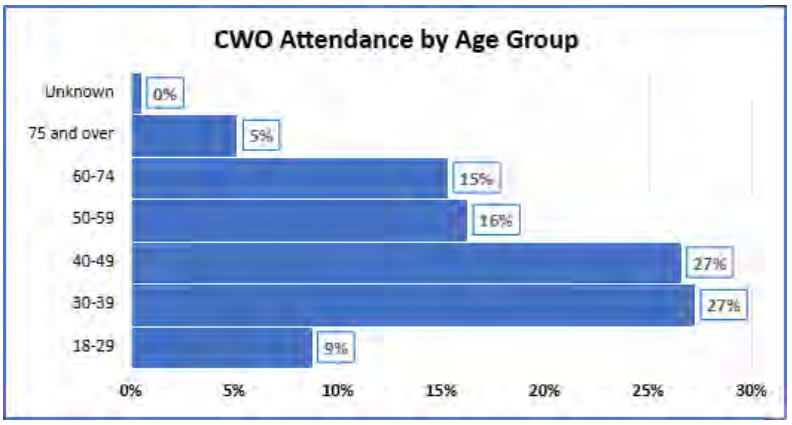
The team have maintained strong engagement with ethnically diverse groups, with 60% of people attending being from ethnically diverse backgrounds, with 40% being from Asian/Black backgrounds, who have a higher risk of developing cardiovascular disease and diabetes.

Results breakdown by Ethnicity





The NHS health checks in this project are also available to all adults. As a result, over a quarter of them have been on those in the age group 30-39. This is helping with early identification of health concerns, many of which can be addressed through lifestyle changes.



In addition to the community sessions organised by RVA as part of their role in the project, the Meet PEET team have worked hard to source additional venues by developing new and existing community contacts to ensure our priority cohorts have ample opportunity to receive the offer. As a result of this effort we have been able to take the Community Wellness Outreach programme to schools for the parents and carers of children on the Trust's Junior Carers programme; provide support to those using food pantries around Reading (in conjunction with several churches); work with Change Grow Live to provide checks to their clients with substance misuse issues; and offer checks at Faith Christian Group's drop-in for those who are homeless or insecurely housed, to name a few.

As the project nears its end, Meet PEET will look to build on these links to ensure our community engagement continues.

Wider Meet PEET initiatives:

The Junior Carers programme offers 8–10-year-olds from schools in areas of deprivation opportunities to become heath ambassadors and receive sessions on health promotion topics as well as careers in the health sector. This year the programme is being delivered to three schools, as well as an additional school focusing particularly on children with Special Educational Needs. The programme was highlighted as a flagship initiative in a recently published Government Schools and Health Framework called "Co-Creating Healthy Futures" produced by paper by the Windsor Academy Trust. This highlights the powerful potential of partnerships between schools and the health sector.

The Trust's Youth Forum engages with young people, aged 15 to 24. It gives them an opportunity to have a voice in the work of the Trust and to represent the voices of other young people. In return, the Forum organisers offer them insight into how the Trust works, with hands-on activities such as CPR training and trying out equipment with Clinical Engineering, and talks from, for example, Finance, and the DKMS service. The members have contributed to the refresh of the Children and Young People's strategy, as well as the Trust's overall strategy refresh. They have taken part in Building Berkshire Together (whilst still active), annual PLACE surveys and helped engage with patients and the public at the Community Wellness Outreach (CWO) Project events. They have recorded sessions for the hospital radio, and one member continues to volunteer there every week. They offer feedback and question processes, which can open up opportunities for them to be involved in improvement works, for example, the Martha's Rule steering group.

The team also continue their wider engagement work with particular community groups. For example, they are organising a large engagement session with the Gurkhas with the Audiology team to look at hearing loss. This was identified as an issue as part of the health checks in the CWO project we have been doing with this particular group.

Health bus

The Trust is working closely with the Berkshire Healthcare Foundation Trust (BHFT) clinical team to organise joint events using their health bus out in the local community. This has enabled health checks and other screening to be taken out to the places it is most required.

Translation and interpreting services

In 2025, the Trust arranged 16,004 bookings of interpreters. Of those, 10,470 were face to face to face (65%), 3,986 were telephone (25%) and 1,548 were video appointments (10%). Planned Care Group and Urgent Care Group are the biggest users of interpreters, with each using interpreter services over 6,500 times each. In Planned Care Group the majority of these are face to face bookings, whilst in Urgent Care the split is more even across all three modalities.

The top language requests across all services in 2025 were: Nepalese, Cantonese, Polish, Urdu, Arabic, Punjabi, Romanian, Portuguese, Bengali and Mandarin, replacing Turkish in 2024. 471 of the total language bookings were for British Sign Language to support deaf patients.

The Trust and Word360 continue to work to improve patient experience and reduce costs through a digital first approach. Over 2025, the Trust spent over £250,000 on interpreter services, but we continue to look for ways to reduce this. For example, the Royal Berks Charity has funded the purchase of an additional 16 Wordskii on Wheels (WoWs), following a successful trial of 4 devices. These are screens that can be used for video appointments in departments and will be rolled out later in the year.

Deaf Awareness

The Trust has partnered with Total Communications (who provide our British Sign Language interpreters) to provide staff with information about communicating with people who are Deaf. This training includes communication methods; terminology; technology; fingerspelling; some basic signs; and links to British Sign Language information.

Feedback from the course includes: “I *learnt loads from this session. Well worth attending if you haven't already*”; *“I have had the pleasure of going to this and I thoroughly loved every minute of it*” and “*This is a really good workshop and a great way to improve our patient and carer experience if they have any hearing impairments*”.

Accessible Information Standards (AIS)

Following the implementation of the Accessible Information Standard (AIS) in Electronic Patient Record (EPR) in April 2024, there is a continued drive to record patients as having an accessible information requirement. This subsequently will improve care and reduce complaints.

The Trust has reviewed and updated their website with the support of Healthwatch to ensure we meet the needs of our community. The updated accessibility page will have simple links to enable those with an accessibility need to access Trust support easily.

Smoking Cessation Project

The adult smoking cessation service has been rolled out through the Trust since August 2024. The Royal Berkshire Hospital signed the SmokeFree Site Pledge in January 2025. The team

have Tobacco Dependency Advisors offering staff monthly clinics for smoking cessation support and highlight the service at Trust induction.

Since August 2024 to August 2025 the inpatient hospital Tobacco Dependency Advisors have offered smoking cessation support to 528 patients. On discharge 67% of patients seen have taken up the offer of community smoking cessation support via SmokeFree Berkshire.

Going forward the team want to increase their support for all adult inpatient smokers. To achieve this, they plan to continue to highlight the need for smoking status to be recorded on EPR for every patient and will get their Tobacco Dependency Advisors.

Forces and veterans

This year the Trust has been reaccredited with its Veteran Aware status for the third year in a row, recognising the work the Trust does to support patients, staff and visitors who are part of the Armed Forces community and who may experience health inequalities. In June, the Trust re-signed its Armed Forces Covenant in a special ceremony at Brock Barracks. Since then, the Trust has received recognition for the work it does to support Armed Forces staff and their families by being awarded Gold in the Armed Forces Employer Recognition Scheme.

Gypsy, Roma and Traveller communities

This year we have been working with the Margaret Clitherow Trust (MCT) who were founded in partnership with, and for the benefit of, Gypsy, Roma and Traveller communities. MCT believe that everyone should be treated with dignity and justice, and it is possible for our Gypsy, Roma and Traveller communities to be part of a society where this is realised.

"Traveller people have the worst outcomes of any ethnic group across a huge range of areas, including education, health, … services fail to differentiate between different groups who have different needs. … This failure has led to services that are ill-equipped to support Gypsy, Roma and Traveller people to use services that they need."
Woman and Equalities Select Committee, House of Commons, 2019

MCT Chaplains have been working with the Trust Chaplains to enable them to support these families better when they are admitted into the organisation and the Meet PEET team to start facilitating conversations around health checks in their communities.

Carers

This year a Protocol for the Identification and Support of Carers has been developed to build on the previous work creating a Carers status flag on our Electronic Patient Record system. The Carers Lead has provided a number of bespoke training sessions, as well as two dedicated Managers' Training Seminars, focused on Carers' rights and supporting staff with caring responsibilities. The partnership with Age UK Berkshire has continued to enable weekly visits to the Trust and our Carers Lead has continued to attend carers' events across the region to raise awareness. The Carers Lead provides support to carers of patients with complex needs, engaging with Multidisciplinary Teams (MDTs) and outreach teams, as well as supporting staff with caring responsibilities. In 2025, the Staff Carers Network grew and now has over 125 members.

Care Group specific inequalities initiatives

The Trust's community-focused outreach services continue to expand significantly across all care groups, with strong emphasis on accessibility, early detection, and reducing health inequalities. The Sexual Health Service has strengthened its presence across Reading, Wokingham and West Berkshire through extended clinic hours, satellite clinics, same-day appointments for vulnerable groups, online testing and specialist outreach, including use of a well-received mobile van and high-engagement social media campaigns.

Maternity services have enhanced inclusivity by appointing new roles focused on community engagement and personalised support, expanding interpreter access through Wordski on Wheels, launching nationally recognised easy-read materials, and working collaboratively with community groups to address specific perinatal concerns affecting Black African women. Further work is planned in 2026/27 to address risk factors in maternity care particularly affecting specific communities, drawing on perinatal mortality and other data trends observed in 2025/26.

Across our Planned Care Group, major screening and outreach programmes have delivered high impact results. Community Liver Health Checks have performed over 5,000 scans with important diagnoses identified, while Viral Hepatitis screening, supported by mobile and home-visiting models, has led to successful treatment outcomes and expanded detection across Berkshire. Additional initiatives such as latent TB screening for asylum seekers, lung cancer screening through Primary Care Networks (PCNs), and targeted cervical screening outreach have further enhanced early diagnosis and engagement with underserved groups.

Overall, these programmes collectively demonstrate a strong organisational commitment to proactive, inclusive, community-focused healthcare.

Social, Community, Anti-bribery and Human Rights Issues

The Trust's Human Resources (HR) and Local Counter Fraud Policy covers our response to risks of bribery and corruption. The Audit and Risk Committee is responsible for monitoring compliance with the HR and Local Counter Fraud Policy.

The Trust's Equity of Opportunity and Diversity Policy covers human rights issues i.e., how it is illegal to discriminate against people with protected characteristics. The policy sets out the key roles and responsibilities and how staff can raise a concern about human rights issues. The policy outlines that all employees undertake mandatory training on equality, diversity and human rights. The Trust monitors compliance with human rights issues through the collation and review of appropriate data.

Important events since balance sheet date

There have been no material events after the reporting dates which require disclosure.

Overseas operations

The Trust has no overseas operations.

James Blythe
Chief Executive Officer **Date: 1 July 2026**

Accountability Report

Directors' Report

The Board of Directors of the Trust is a combined board which is comprised of both Executive (paid staff) and Non-Executive (appointed external) Directors. The Board of Directors of the Royal Berkshire Hospital Foundation Trust as at 31 March 2026 comprised of the following Executive Directors:

Name	Designation
Mr Steve McManus	Chief Executive
Mr Paul da Gama	Chief People Officer
Mr Dom Hardy	Chief Operating Officer
Dr Janet Lippett	Chief Medical Officer
Mrs Frances Khatcherian	Chief Finance Officer
Mrs Katie Prichard-Thomas	Chief Nursing Officer
Mr Andrew Statham	Chief Strategy Officer

The Board also comprised of the following Non-Executive Directors as at 31 March 2026:

Name	Designation	Appointed
Mr Oke Eleazu	Chair of the Trust	April 2025
Mrs Helen Mackenzie	Non-Executive Director	January 2019
Mr Mike McEnaney	Senior Independent Director, Non-Executive Director	October 2023
Professor Parveen Yaqoob	Non-Executive Director	January 2023
Mr Mike O'Donovan	Non-Executive Director	November 2023
Dr Minoo Irani	Non-Executive Director	September 2024
Ms. Catherine McLaughlin	Non-Executive Director	July 2024
Mr. Umesh Jetha	Non-Executive Director	July 2025

The following were also Board directors during the 2025/26 financial year:

- Bal Bahia: Non-Executive Director (01 April 2025 – 30 April 2025), Resigned
- Nicky Lloyd: Chief Finance Officer (01 April 2025 – 30 June 2025), Resigned
- Helen Troalen: interim Chief Finance Officer (23 June 2025 – 27 February 2026), Interim
- Don Fairley: Chief People Officer (01 April 2025 – 31 December 2025), Resigned

The Board of Directors is responsible for:

- providing leadership to the organisation within a framework of prudent and effective controls
- sponsoring the appropriate culture, setting strategic direction, ensuring management capacity and capability, and monitoring and managing performance

- safeguarding values and ensuring the organisation's obligations to its key stakeholders are met
- facilitating the understanding on the part of governors of the role of the Board and the systems supporting its oversight of the Trust
- taking account of the NHS Constitution in all aspects of its work.

The Board carries out the role envisaged within the NHS Foundation Trust Code of Governance, namely that it provides active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed. The Chair meets with Non-Executive directors on a weekly basis.

As such, the Board:

- is responsible for ensuring compliance with the terms of authorisation, constitution, mandatory guidance issued by NHSE, relevant statutory requirements and contractual obligations

- sets the strategic aims, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance

- as a whole is responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health and Social Care, the CQC, and other relevant NHS bodies. The Board ensures that the Trust exercises its functions effectively, efficiently and economically

- sets the Trust's overall culture, values and standards of conduct and ensures that its obligations to the public, its members, patients and other stakeholders are understood and met.

The role of Board Directors is set out in the Board Charter of Expectations which is set on the Nolan Principles. All of our Board of Directors meet the standards of the 'Fit and proper persons requirement'.

The Trust's Constitution specifies that Non-Executive Directors are appointed for three year term of office. If a Non-Executive Director has held office for more than four years, any further appointment shall be for a term of one year. Appointments can be terminated in accordance with the NHS England (NHSE) Code of Governance for NHS Provider Trusts (the Code).

The following Non-Executive Directors are considered independent as none have served more than six years in post: Parveen Yaqoob, Mike McEnaney, Mike O'Donovan, Catherine McLaughlin, Minoo Irani and Umesh Jetha.

In January 2026, the Trust assessed itself against the provisions of the NHS Code of Governance on a 'comply or explain' basis and recognising that the provisions set out best practice recommendations rather than mandatory conditions.

In relation to provision B2.6. which states that the independence of Non-Executive Directors may be impaired if they serve a term of office longer than six years, the Trust considered that it had deviated from the provision in relation to the extension of the term of office for non-executive director, Helen Mackenzie. The rationale and disclosures are set out below.

Helen Mackenzie, Deputy Trust Chair and Chair of the Quality Committee has served in excess of six years as a Non-Executive Director of the Trust. Her continuation in the role followed processes set out in the Trust's Constitution and was considered by the Governor Nominations & Remunerations Committee and approved by the Council of Governors. In each case, Helen Mackenzie's significant and specialised expertise in quality and safety matters and her continued high standard of performance was considered and balanced against the risk of incurring a vacant Chair position in the Quality Committee and the loss of a non-executive member of the Audit & Risk Committee. The Trust departed from the recommendations of the provision to preserve the robust leadership of the Quality Committee, to retain specialist input at the Quality Committee and maintain the stability of the Board, particularly with the impending change of the Chair of the Trust.

Helen Mackenzie was then re-elected for one further year with her term of office due to end in January 2027. However, she will be leaving the Trust at the end of July 2026.

Board Member Biographies

Chair of the Trust: Oke Eleazu
Oke joined the Trust in April 2025. A qualified accountant, he's held a variety of senior leadership roles including at Prudential, Sainsburys and Bupa. An experienced non-executive director, Oke has been on the board of Hyde and Bromford housing providers and the Institute of Customer Service. After stepping down as UK CEO of ManyPets, Oke's passion for improving diversity, equity and inclusion led to him launching a start-up social enterprise, Elevate Colour, to improve representation of people of colour in business leadership roles. Oke is the host of Race to the Top podcast, where he interviews successful leaders of colour.

Chief Executive Officer: Steve McManus
Steve joined the Trust in January 2017 having previously occupied Board level roles as Chief Operating Officer (COO) at University Hospital Southampton, COO/Deputy CEO at Imperial Healthcare and Managing Director at Basildon and Thurrock University Teaching Hospital. In 2016 Steve was selected as part of the first cohort on the NHS Leadership Academy's national Aspiring Chief Executive Programme. In August 2020 Steve was seconded to NHS Test & Trace taking on key national roles during the Covid pandemic leading the Contain and Trace services. In 2022 Steve took on an 8 month role leading the Buckinghamshire Oxfordshire Berkshire West Integrated Care system as interim Chief Executive returning to the Trust in 2023. Steve regularly contributes across a range of healthcare topics both nationally and internationally particularly regarding patient safety, healthcare technology and leadership development. Steve left the organisation on 17 May 2026.

Chief Executive Officer: James Blythe
James joined the Trust on 18 May 2026 as Chief Executive Officer. James joined the NHS via the NHS Management Training Scheme in 2004, starting his career at the Royal Berkshire Hospital. After time in a variety of consulting, operational and policy roles, he was Director of Commissioning for Surrey Downs Clinical Commissioning Group, Managing Director of Merton and Wandsworth CCGs and Managing Director of Epsom and St Helier University Hospitals from 2022. In September 2025 he was appointed Interim Group Chief Executive across St George's and Epsom and St Helier. James is passionate about cross-system working and in his previous role combined acute hospital leadership with a system leadership role for the Integrated Care Board and executive lead of a major elective orthopaedic hub. James holds a Postgraduate Diploma in Healthcare Leadership and Management.

Chief Medical Officer: Dr Janet Lippett
Janet was appointed Chief Medical Officer in 2019 and with executive colleagues led the Trust's response to the Covid-19 Pandemic. In 2022, Janet held an 8-month interim role as Acting Chief Executive she is also the Executive Lead for our partnership with the University of

Reading. Qualifying as a doctor at St Georges Hospital, London in 1999 she joined RBFT in 2007 as a Consultant Geriatrician establishing a successful Orthogeriatric Service.
Moving into management in 2010; as a Clinical Director and then as Care Group Director for Networked Care; Janet works with system partners to ensure high quality care across the community.

Chief Nursing Officer: Katie Prichard-Thomas
After undertaking the Deputy Chief Nurse at Hampshire Hospitals NHS Foundation Trust, Katie joined the Trust in October 2023. After graduating as a Registered Nurse in 2001, Katie began her nursing career at University Hospital Southampton Foundation Trust, specialising in respiratory care, acute medicine, and older person's medicine. Katie joined Hampshire Hospitals NHS Foundation Trust in 2018 as Divisional Chief Nurse, in 2020 she was promoted to Deputy Chief Nurse. Katie holds an MSc in Leadership & Management in Healthcare and is a Florence Nightingale Foundation Scholar, she is passionate about coaching teams to deliver high quality safe patient care.

Chief Finance Officer: Frances Khatcherian
Frances Khatcherian joined the Trust in 2026 as Chief Finance Officer.
Prior to joining the Trust, Frances was Chief Finance Officer at Hertfordshire Community NHS Trust, where she led the organisation's financial strategy, financial planning and oversight of financial performance. In addition to her finance responsibilities, she also had executive oversight of the Trust's digital function, supporting programmes focused on digital transformation, automation and improving patient pathways. Frances has held a number of senior finance leadership roles across NHS provider organisations and has experience working closely with system partners to support financial sustainability and service transformation. Frances is a qualified accountant with over 20 years' experience working in NHS finance.

Chief Operating Officer: Dom Hardy
Dom Hardy joined the Trust in December 2019 as Chief Operating Officer. Previously he held the position of Director of Primary Care and System Transformation at NHS England and Improvement. Dom's previous roles at NHS England include Director of Commissioning Operations for Wessex and Regional Assurance and Delivery Director for the South of England. Prior to that, he held posts in central Government, with PricewaterhouseCoopers, and in South Central Strategic Health Authority.

Chief People Officer: Paul da Gama
Paul Da Gama joined the Trust in January 2026 as Chief People Officer.
Prior to joining the Royal Berkshire NHS Foundation Trust, Paul was Workforce Improvement Programme Director at NHS Employers, where he led the design and delivery of major national programmes to improve the working lives of Resident Doctors. Paul has previously served as Chief People Officer at St George's, Epsom and St Helier University Hospitals NHS Healthcare Group, West Hertfordshire Teaching Hospitals NHS Trust, and Hinchingbrooke Hospital. Before joining the NHS, Paul held senior HR leadership roles with the Royal Mail Group and spent 10 years with HSBC. Paul began his career as a teacher.

Chief Strategy Officer: Andrew Statham
Andrew is the Chief Strategy Officer for Royal Berkshire NHS Foundation Trust. Andrew is responsible for Strategy, Planning, Improving Together, Communications and Building Berkshire Together – our new hospital programme. He has over 15 years' experience working within the NHS and the wider healthcare sector. Before joining our Trust, Andrew spent time as a Director within a Healthcare consultancy, and as a Civil Servant at the Cabinet Office and Department for Work and Pensions. Andrew studied Economics in both the UK and Massachusetts.

Non-Executive Director, Parveen Yaqoob
Parveen Yaqoob is Deputy Vice-Chancellor at the University of Reading and works across a broad portfolio, leading on the University's research strategy. She leads on the strategic partnership between the University and the Trust and brings experience of developing and supporting health-related education, research and innovation. Parveen has served on a number of national and international research funding panels, particularly in the area of diet and health, and is a member of the Board of Directors of Advance HE, chairing its Equality, Diversity and Inclusion Committee. She was appointed OBE for services to higher education in 2022.

Non-Executive Director, Helen Mackenzie
Helen Mackenzie joined the Trust as a clinical Non-Executive Director in January 2019.
Prior to this she was Executive Director of Nursing with Berkshire Healthcare NHS Foundation Trust, the main provider of NHS mental health and community services in Berkshire.
Helen qualified as a nurse in 1979 and has held various clinical and managerial roles in the provision and commissioning of local NHS services.

Non-Executive Director, Mike McEnaney
Mike is a highly experienced board director having held finance director positions in both the private sector and the NHS. He has had a broad range of responsibilities, including Finance, HR, IT and Estates, at a number of high-profile organisations including, Honda manufacturing, Avis car rental and at Oxford Health NHS Foundation Trust until 2022. Mike is a Non-Executive Director and audit committee chair with South Central Ambulance Services NHS Foundation Trust, a Non-Executive Director and Audit & Risk Committee chair with Royal Berkshire NHS Foundation Trust, a trustee of an Academy of schools and an audit committee member at Oxford Brookes University.

Non-Executive Director: Mike O'Donovan
Mike spent 30 years in the consumer healthcare industry holding managing director positions in the UK and overseas as well as global corporate roles. He left industry to become chief executive of the Multiple Sclerosis Society. He has held a range of non-executive chair, director and trustee positions including founding co-chair of National Voices, the leading patient service user advocacy group, member of the management board of the European Medicines Agency, chair of two NHS Trusts and board member of Frimley Health NHS Foundation Trust. Mike is a Trustee of Younger People With Dementia

Non-Executive Director: Catherine McLaughlin
Catherine is a nurse who specialised in paediatrics and community nursing. She has extensive health service experience, spanning a variety of settings including acute hospitals, community providers, commissioning groups and most recently as CEO of a Hospice. She has worked at the Department of Health with the Performance Improvement Team for Emergency Care and led several transformation programmes across the NHS in England and Ireland.

Non-Executive Director: Minoo Irani
Minoo joined the Trust as clinical Non-Executive Director in September 2024. Before joining the Trust Minoo worked as Consultant Community Paediatrician in Berkshire for over 20 years and has held several leadership roles leading up to Executive Medical Director in Berkshire Healthcare for 9 years. His other roles in the healthcare system have included a mental health partner member on the Thames Valley ICB Board and partner member on the Board of the Health Innovation Network. He has a Masters in Health Management from Imperial College Business School and professional clinical qualifications from the United Kingdom, India and the United States.

Non-Executive Director: Umesh Jetha
Umesh joined the Trust in July 2025, bringing over 17 years of executive leadership in digital transformation, enterprise strategy, and consumer financial services. He has led complex

modernisation programmes across Aviva, Nationwide, Barclays, and Visa, shaping board-level strategies that deliver operational efficiency, stakeholder trust, and commercial impact. With deep expertise in customer data, agile delivery, and governance, Umesh applies a forward-thinking, values-driven approach that combines strategic clarity with practical innovation. His leadership reflects a commitment to advancing digital, technology, and data capabilities that support inclusive healthcare and measurable outcomes.

Board Engagement with the Council and Members

The Board takes active steps to ensure it interacts appropriately with the Council of Governors. The Board has agreed protocols in respect of communication with the Council and to help discharge its statutory duties. Non-Executive Directors and the Chief Executive attend Council of Governors meetings which are held four times a year. Other Executive Directors are also invited to provide updates on specific topics. Non-Executive Directors attend the Governors Assurance Committee to provide updates from Board Committees to governors. Direct engagement with members takes place at the Trust's Annual General Meeting where a review of the year and forward plans are delivered and there is an open question and answer session. The Council of Governor meetings are also open for the public to attend and have the opportunity to raise questions.

Review of Board Performance

The Trust was inspected by the CQC in July 2019 and was rated as 'good' overall. Executive Board members are also appraised on an individual basis. KPMG conducted a Well-Led review in 2025/26 which was presented to the Board in May 2026.

Board attendance 1 April 2025 – 31 March 2026

	Board	Quality	Charity	Nominations and Remuneration	Finance and Investment	Audit and Risk	Council of Governors *	People Committee
Mr Oke Eleazu	13/14	2/5	2/5	8/9	10/11	4/8	7/7	2/4
Mr Steve McManus^	14/14	3/5	0/5	1/9	10/11	2/8	3/7	3/4
Mr Paul da Gama	3/4			4/4			1/3	1/1
Mr Dom Hardy	13/14	4/5			10/11		0/7	
Dr Janet Lippett^^	13/14	5/5	3/5		6/11		0/7	3/4
Mrs Frances Khatcherian	1/1				1/1	1/1	0/1	
Mrs Katie Prichard-Thomas	11/14	4/5			5/11	6/8	0/7	4/4
Mr Mike O'Donovan	13/14			7/9	11/11	8/8	2/7	
Mrs Helen Mackenzie	13/14	5/5		9/9		8/8	3/7	
Prof. Parveen Yaqoob	11/14	4/5		6/9			2/7	3/4

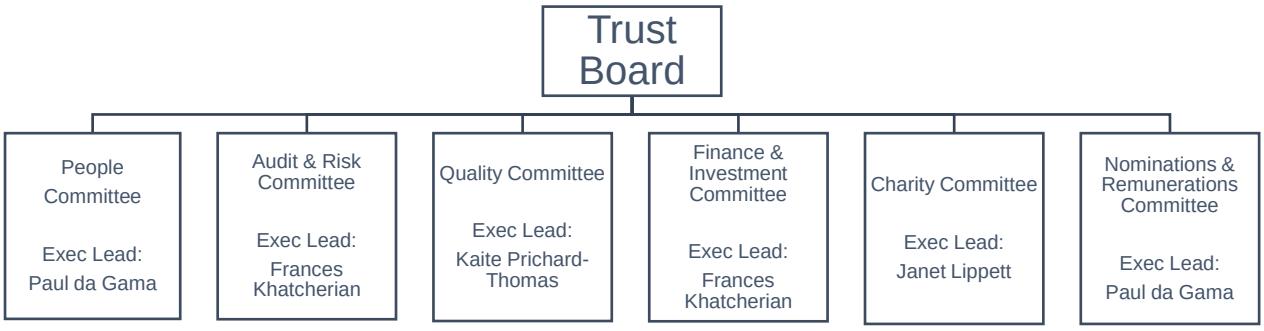
Mr Mike McEnaney	10/14			9/9	10/11	8/8	2/7	
Ms Catherine McLaughlin	13/14	1/1	5/5	9/9	10/11		1/7	3/4
Dr Minocher Irani	12/14	5/5	4/5	9/9			3/7	4/4
Mr Andrew Statham	14/14				10/11		2/7	
Mr Umesh Jetha	8/10		2/3	7/8		2/4	1/5	
Mrs Helen Troalen	9/10				8/8	4/4	1/4	
Mrs Nicky Lloyd	3/4				1/2	2/2	0/2	
Mr Don Fairley	9/10			5/5			0/4	2/2
Mr Bal Bahia	2/2						0/1	

^ For nominations business only
^^ Either Chief Medical Officer or Chief Nursing Officer required to attend Finance and Investment Committee
The Chief Executive and the Chair are only required to attend 50% of all the Board Committee meetings.

* The Council of Governors meets at least on a quarterly basis with additional special meetings scheduled as required.

Board Committees

The formal committee structure of the Board is shown below.



The main roles of each committee and group are as follows:

Audit & Risk Committee

Chair	Mr Mike McEnaney
Members	Mrs Helen Mackenzie Mr Mike O'Donovan Mr Umesh Jetha

The Committee oversees risk and audit issues within the Trust. It reviews the effectiveness of financial systems for internal control and reporting and reports to the Board of Directors on the levels of assurance. It is responsible for ensuring and monitoring the regular review of risks

identified against the board assurance framework and corporate risk register in order to embed risk management within the organisation.

The NHS Foundation Trust Code of Governance (the Code) provision D.2.1 requires the membership of the Audit & Risk Committee to comprise of a minimum of three independent non-executive directors.

The Audit and Risk Committee report

The Trust Board has delegated authority to the Audit & Risk Committee, a non-executive committee of the Trust Board, to review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial non-clinical internal controls, which supports the achievement of the Trust's objectives.

The Committee does not have executive powers. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

In addition, the Committee is required to satisfy itself that the Trust has adequate arrangements for countering fraud, for managing security of resources and has to review arrangements by which staff of the Trust may raise concerns via the Trust's Whistle Blowing policy.

The Audit & Risk Committee consists of not less than three Non-Executive Directors members supported by professional advisors with Trust attendance provided by the Chief Finance Officer. The Chief Executive Officer attends to discuss with the Committee the process for assurance that supports the Annual Governance Statement. Executive leads will be invited to attend the meeting when a high risk rated report has been submitted to the Committee. The Committee meets privately with the Trust's Internal and External Auditors at least once a year. Additional private meetings are held as and when required.

During 2025/26 the Audit & Risk Committee has satisfied itself that the findings within assurance reports and other studies relating to the Trust, are drawn to its attention by the Board or by management. Any reports instigated by NHS England, the Care Quality Commission and other professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.) would be reviewed by this Committee under their Terms of Reference.

The Committee conducts an annual review of its effectiveness with its terms of reference and submits any findings and proposals for changes to the Board of Directors for consideration and prepares an annual report each year. The 2025/26 review was carried out in January 2026 and presented to the Board on 25 March 2026.

Financial reporting

The Committee reviewed the Trust's accounts and Annual Governance Statement and how these are positioned within the wider Annual Report. To assist with this review, the Committee considered reports from management and from the internal and external auditors to assist the consideration of:

- the quality and acceptability of accounting policies, including their compliance with accounting standards
- key judgements made in preparation of the financial statements
- compliance with legal and regulatory requirements
- the clarity of disclosures and their compliance with relevant reporting requirements

- whether the Annual Report as a whole is fair, balanced and understandable and provides the information necessary to assess the Trust's performance and strategy.

The Committee reviewed the content of the 2025/26 annual report and accounts and advised the Board that, in its view, taken as a whole:

- it is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy;
- it is consistent with the draft Annual Governance Statement, Head of Internal Audit Opinion and feedback received from the external auditors

Significant financial judgments and reporting for 2025/26

The Committee considered several areas where significant financial judgments were made which have influenced the financial statements. The Committee identified, through discussion with both management and the external auditor, the key risks of misstatement within the Trust's financial statements. Discussions took place when the external auditor's audit plan was reviewed, and again at the conclusion of the audit, and the Committee also discussed these risks with management during the year. Set out below is a summary of how the Committee satisfied itself that these risks of misstatement had been appropriately addressed.

Valuation of land, buildings and dwellings, and intangible assets

The Committee reviewed reports from management explaining the basis of valuations and the consideration of any revaluation or impairment and considered the external auditor's views on the accounting treatment of these assets. The valuers assumed no abnormal ground conditions affecting the normal functioning of the Trust estate and valued on the basis of existing conditions. Following the geological investigation on the main hospital site, the Trust accepted the recommendation to inspect all structures visually on a periodic basis and to undertake targeted ground investigations only should deterioration be observed. The valuers confirmed no measurable impact on their valuation as a result, as the Trust has not altered the current or future use of the buildings nor undertaken corrective work to manage the geological risks.

The Committee also considered the estimated useful lives applied to property, plant and equipment. These are based on common, widely used assumptions for each asset type, except where specialist information is available from professional bodies, and are reviewed regularly as part of the assessment of whether assets have been impaired. The range extends from four years for IT software to up to 140 years for buildings (excluding dwellings).

The Committee is satisfied that the valuation of these assets, and the useful lives applied, are consistent with management's intention and in line with applicable accounting standards.

Capitalisation of assets

The Committee reviewed information provided by management on the judgments relating to costs capitalised, including the use of vesting certificates at year end, and considered the external auditor's views on the accounting treatment of these transactions and the associated value for money considerations. The Committee is satisfied that the treatment of these assets within the financial statements is consistent with management's intention and applicable accounting standards.

Prior year adjustment

The Committee gave particular attention to a material prior period adjustment relating to the over-recognition of accrued commissioner income in the year ended 31 March 2025. The Committee reviewed management's analysis of the matter and the basis on which it was treated as a prior period error under IAS 8, rather than as a change in accounting estimate,

and considered the external auditor's view, the auditor having confirmed it was satisfied with the evidence supporting error treatment.

The Committee considered the basis of the error: income had been recognised on the basis of expected billing values that were not reconciled to the actual usage, prior-approval and contract information available to the Trust at the reporting date, such that the income recognised was not supported by the information available when the 2024/25 financial statements were authorised for issue.

The Committee is satisfied that the matter has been appropriately identified, treated in accordance with IAS 8 and the DHSC Group Accounting Manual, and adequately disclosed in the financial statements.

Control environment and finance function improvement plan

The Committee recognised that the prior period adjustment arose from weaknesses in the control environment for income recognition and year-end accruals, and that the external auditor identified a significant weakness in the Trust's financial sustainability and control arrangements. The Committee considered this matter carefully, both in its own right and in the context of the value the Trust places on accuracy and professional integrity in its financial reporting.

The Committee reviewed management's response and the remedial action underway. This includes strengthening the controls over income recognition and year-end accruals — improving reconciliation to supporting data, documentation, oversight and escalation — and the wider finance function improvement plan. Oversight of financial sustainability and recovery is provided through the Financial Improvement Programme Committee, a fortnightly committee chaired by the Chief Executive and reporting monthly to the Finance and Investment Committee and the Board. The Committee also noted the Trust's review of its arrangements against the NHSE guidance on Strengthening Financial Management, including the strengthening of non-pay controls and financial recovery governance.

The Committee will continue to monitor delivery of the remedial actions and the finance function improvement plan during 2026/27 and is satisfied that management has acknowledged the weaknesses openly and has a credible programme of action in place to address them.

External audit

The Trust’s External Auditor for the period 2025/26 were:

Deloitte LLP
1 New Street Square
London
EC4A 3BZ
United Kingdom

Deloitte LLP has served as external auditor to the Trust since 2022. The financial year 2025/26 is Deloitte’s final year as auditor. Following a competitive tender process, Ernst & Young LLP has been appointed as external auditor for the Trust, commencing with the 2026/27 financial year.

Audit and non-audit fees are set, monitored and reviewed throughout the year and are included in note 4.2 of the accounts. In the event that any non-audit services were provided, the Committee would consider whether these services might result in any impairment of the auditor objectivity and independence.

During the year, the Audit & Risk Committee reviewed the external audit plan for the 2025/26 period. As part of the discussion at this meeting the Committee reviewed key risk areas highlighted by external audit in relation to the valuation of assets and recognition of capital expenditure.

During the Audit & Risk Committee meeting on the 22 June 2026 the Committee reviewed the 2025/26 financial statements and Deloitte's ISA260 Audit Highlights memorandum prepared as part of its audit of the Group and Trust financial statements. Following this, the Committee recommended to the Board that it approve the Annual Report and Financial Statements for the period ending 31 March 2026.

Over the course of the year, they have delivered a range of reports to the Committee. These included:

- Their Audit Plan for the period
- Progress update reports on the delivery of their audit work
- Technical update reports highlighting NHS FT and health sector issues of relevance for the Committee
- ISA 260 Audit Highlights Memorandum reports following their audit of the Group financial statements, and the financial statements of HFMS Limited and the Royal Berks Charity.

Deloitte's remuneration for the group audit was £303k excluding VAT for the period 1 April 2025 to 31 March 2026 (£294k 2024/25). See Note 5.2 of Financial Statements for further details.

The liability limits were agreed for 2025/26:

- Product Liability – up to £0.5m (2024/25 £0.5m)
- Professional Indemnity – up to £5m (2024/25 up to £5m).

Internal auditor details

The Trust's Internal Auditors for 2025/26 were:

KPMG LLP
15 Canada Square
London
E14 5GL

KPMG LLP were appointed as Internal Auditors to the Trust effective from 1 April 2022. This service covers both financial and non-financial audits according to a risk-based plan agreed with the Audit Committee. The Internal Auditors submitted a number of audit outcome and progress reports to the Committee including:

- Their audit plan for the period
- Progress update reports on the delivery of their reports
- Data Protection & Security Toolkit
- Cerner Modules Surgery and Anesthetics
- Cyber Security
- Cyber Security Governance & Human Factors
- Operational Risk Maturity
- Annual Contracting Review
- Financial Controls
- Maintenance

- Pathology
- Integrated Performance Report (IPR) Data Quality

KPMG's remuneration was £115k including advisory services and provision of internal audit services for the period 1 April 2025 to 31 March 2026.

Internal controls

Through the internal audit plan the Committee reviews the financial and risk controls in the Trust and their effectiveness. In addition, during the year the Committee also looked at the controls specifically relating to data quality, estate and the patient environment, information governance and major projects. Action plans were put in place to address minor issues in operating processes.

Fraud detection processes and whistle-blowing arrangements

BDO LLP were appointed as counter-fraud service providers to the Trust effective from 1 April 2022. BDO support the Trust to implement the NHS Counter Fraud strategy within the organisation and to investigate professionally, any suspicions of fraud, bribery or human rights issues that may arise. BDO provides fraud awareness training, carries out reviews of areas at risk of fraud and investigates any reported frauds including any disclosed via the Trust's Whistle Blowing policy.
The Committee reviewed the levels of fraud and theft reported and detected and the arrangements in place to prevent, minimise and detect fraud and bribery. No significant fraud was uncovered in the past year.

Other areas reviewed

In addition to the above the Committee will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This includes, but is not limited to, receiving updates on the Corporate Risk Register and the Board Assurance Framework and the review of risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the CQC Standards).

In addition the Committee also reviews the underlying assurance processes that indicate the degree of the achievement of corporate objectives along with the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. Whilst ensuring that the policies for ensuring compliance with relevant regulatory, legal and code of conduct meet all requirements. During 2025/26 regular updates were provided to the Committee on the Freedom to Speak Up Guardian arrangements at the Trust.

Charity Committee
The Royal Berks Charity (Royal Berks NHS Foundation Trust Charity Fund Registration Number 1052720) is governed by trustees acting through the Charity Committee. They are responsible for the overall management of charitable funds. A governor from the Council of Governors, staff member and patient representative are members of the Committee.

Quality Committee
The Committee gives detailed consideration to all components of the quality of care provided by the trust including clinical effectiveness, patient safety and patient experience.

Finance & Investment Committee
The Committee gives detailed consideration to operational, finance, estates, investment and Digital, Data and Technology. It advises the Executive and Board on issues to achieve the best value for money and use of resources. It seeks to ensure that agreed strategies for finance, estates and IT are developed, implemented, monitored and reviewed.

People Committee
The Committee develops and oversees the delivery of the People Strategy and gives detailed consideration to workforce issues.

Board Register of Interests

The Foundation Trust has published on its website the Board Register of Interests which details any company directorships and other significant interests held by directors which may conflict with their management responsibilities. Additionally, Directors are not permitted to hold simultaneously, positions of Director and Governor of any NHS Trust in accordance with conditions set out in the Trust Governance Handbook. The Register can be accessed at: Our Board of Directors - Royal Berkshire NHS Foundation Trust or from the Trust Secretary by email: foundation.trust@royalberkshire.nhs.uk.

The Trust also operates a Declarations of Interest, Gifts and Hospitality Policy which requires all Board Members and decision-making staff to make annual declarations on the Trust Register of Interests. The Trust Register of Interests is available on the Trust website at: Royal Berkshire NHS Foundation Trust (mydeclarations.co.uk) or from the Trust Secretary by email: foundation.trust@royalberkshire.nhs.uk.

Engaging the staff and public: Trust Membership

Members of the Trust elect governors to the Council. Other governors are appointed by key partners such as local authorities, the University of Reading and local charity groups. The Council of Governors hold the Non-Executive directors (NEDs), individually and collectively, to account for the performance of the Board of Directors. The Board of Directors comprises both Non-Executive and Executive Directors that lead the organisation and manage the key financial and strategic issues. On behalf of the Board, the Chief Executive and other senior staff, manage the Trust on a day to day basis.

The majority of governors on the Council are publicly elected by public members of the Trust. The Council of Governors appoint the Non-Executive Directors who have a voting majority on the Board. All Board members and governors meet the ‘fit and proper person test’ as described in our provider licence.

Council of Governors

The nominated Lead Governor is Dr Sunila Lobo.

The Council of Governors have two key duties which are:

- To hold the Non-Executive Directors to account for the performance of the Board
- Representing the interests of members and the public.

Other duties include:

- Approving the appointment of the Chief Executive

- Appointing and, if appropriate, removing the Chair and Non-Executive Directors
- Appointing the Trust's external auditors
- Approving amendments to the Trust's Constitution.

The Council of Governors meets on a quarterly basis. The Council of Governors is representative of the Trust's constituencies and is of average size in comparison with similar sized trusts. The Council composition is reviewed by the Council of Governors every three years. The roles and responsibilities of the Council of Governors are set out in the Trust Governance Handbook.

The Trust's Governance Handbook sets out the process for managing disagreements between the Council of Governors and the Board of Directors in the event that they should arise. In situations where any conflict arises, the decision of the Chair shall normally be the final. However, there may be circumstances where the Chair feels unable to decide owing to a conflict of interest. In such a situation, the Chair will initiate an independent review to investigate and make recommendations. Normally this will be achieved by inviting the Chair of another NHS Foundation Trust to conduct the review, and the choice of individual will be agreed by both the Council and Board.

Governors for the Royal Berkshire NHS Foundation Trust

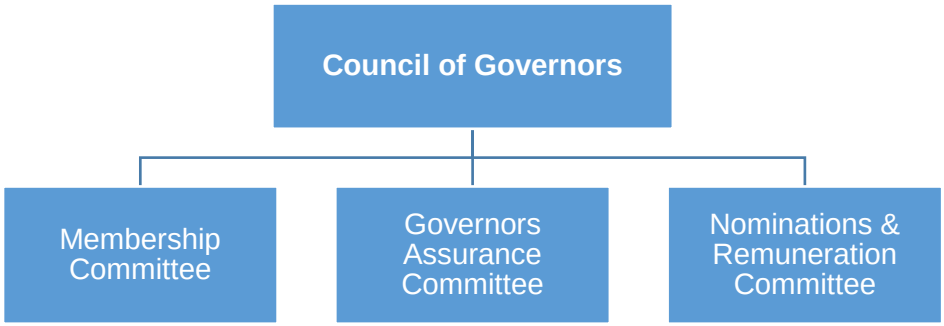
The list of Governors for the Royal Berkshire NHS Foundation Trust is maintained by the Trust Secretary. The latest list can be found on the Trust's website. The list of Governors for the Royal Berkshire NHS Foundation Trust and attendance as at 31 March 2026 was as follows:

Name	Constituency	Term of Office	Actual/ Possible
Mr. Tony Page	Reading	2028	5/7
Mr. Jonathan Barker	Reading	2026	5/7
Mr. Paul Williams	Reading	2026	7/7
Ms. Sunila Lobo	Reading	2026	4/7
Ms. Joycee Rebelo	Reading	2026	3/7
Mr. Clive Jones	Wokingham	2027	3/7
Ms. Maria Norville	Wokingham	2026	5/7
Mr. Benedict Krauze	Wokingham	2027	6/7
Ms. Terri Walsh	Wokingham	2027	6/7
Mr. Andrew Peters	East Berkshire & Borders	2027	2/7
Mr. Yaman Islim	East Berkshire & Borders	2026	3/7
Mrs. Clare Stafford	West Berkshire & Borders	2027	4/7
Mrs. Alice Gostomski	West Berkshire & Borders	2028	1/7
Mr. Martyn Cooper	West Berkshire & Borders	2028	5/7
Mr. William Murdoch	Southern Oxfordshire	2027	0/7
Mr. Richard Havelock	Volunteer Governor	2028	6/7
Mr. Madan Uprety	Staff: Health Care Assistant/Ancillary	2027	1/7
Ms. Jessica Grierson	Staff: Admin/Management	2027	1/7
Mr. Tom Duncan	Staff: Medical/Dental	2026	5/7
Rev. Joshua Wilson	Staff: Allied Health Professionals/Scientific	2026	2/7
Ms. Sarah Lupai	Staff: Nursing/Midwifery	2027	2/7
Vacant	Youth Governor	2025	-
Vacant	Appointed by Integrated Care Board	2025	-

Councillor Patrick Clark	Appointed by West Berkshire Council	2026	1/7
Mr. Darren Browne	Appointed by Autism Berkshire	2026	0/7
Councillor David Stevens	Appointed by Reading Borough Council	2026	3/7
Mr. Adrian Mather	Appointed by Wokingham Borough Council	2026	2/7
Dr. Paul Jenkins	Appointed by University of Reading	2026	3/7

Notes:
Governors are elected by members of the relevant constituency unless stated otherwise.
Declarations of interest made by Governors are available on the Trust website.
Changes to the Council during the year are set out on page 45

Governors work to influence the Trust and have an impact in several informal and formal ways. The formal 'committee structure' of the Council is shown below.



The main roles of each group are as follows:

Governors Assurance Committee
The Chair is currently Tom Duncan, Staff Governor, Medical & Dental. The Committee receives updates from Non-Executive Directors who highlight significant matters of interest or concern and the Board's response and provide an overview of key issues discussed at Board Sub-Committees. The Committee keeps under review a range of assurance information submitted to the Board. The format of the Governors Assurance Committee has created an open and transparent environment for governors to discharge their duty of holding the Non-Executive Directors to account for the performance of the Board. The Chief Executive attends all Council of Governors meetings and other directors attend when required.

Membership Committee
The Chair is currently Richard Havelock, Volunteer Governor. The Committee develops policy, implements agreed proposals and keeps under review, the Trust approach to engaging with the membership community.

The Committee also:

- recommends appropriate relationships and methods of communicating between Governors and the membership
- develop, implement and review, annually, a membership strategy for the Trust and to prepare an annual report for the Council and the Annual General Meeting with regard to the steps taken to secure representative membership, the progress of the membership strategy and any changes to the membership strategy
- keep under review the membership of the Trust to ensure that the actual membership is representative of those eligible to be members of each constituency

- consider any disputes concerning membership of a constituency, right to membership of the Trust and the conduct of individual governors
- seek the views of members and the public on material issues being discussed by the Trust and to conduct arrangements for collecting and reviewing views of members and the public on key issues and their experience of the Trust in general
- recommend objectives to the Council of Governors which are achievable and within the resources available
- keep under review the implementation of the objectives
- oversee the annual evaluation of the Council and its performance and to recommend any subsequent action
- recommend a governor training and annual development programme
- make recommendations to the Council on how it interacts with members and the public on Trust strategy and feedback their views to the Council.

Council Nominations & Remuneration Committee

The Nominations and Remuneration Committee is chaired by the Lead Governor and considers the salaries and appointments of the Non-Executive Directors of the Board. Further information on the role of the Council of Governors Nominations and Remunerations Committee is available on page 63.

Changes to the Council of Governors

The following were also governors during the year:

- Dora Abbi: post retired September 2025
- John Bagshaw: post retired September 2025
- Miranda Walcott: post retired February 2026

Governor representation of members' views is discussed at Governor's Membership Committee and at Council of Governors meetings. The Council of Governors were engaged on the Trust's operating plan, and the refresh of the Trust Strategy, including its objectives and priorities during 2025/26.

Trust Membership

This section sets out who is eligible to become a member of the Trust, our current membership numbers and our strategy and targets for recruiting new members. Our members can stand as governors, and are responsible for electing our governors.

Membership is an expression of public support for the Trust. Members have the opportunity to become involved in a number of areas including:

- being invited to Membership events, including the Annual General Meeting and information seminars
- voting in the election of representatives to the Council of Governors
- being able to stand for election to the Council of Governors
- receiving discounts on a wide range of goods and services by registering on the www.healthservicediscounts.com website
- receiving regular information about the Trust, including our magazine, Pulse
- being consulted, for example, on how the provision of services could be improved by completing surveys

- attending Membership Committee and Council of Governor meetings where Members can have the opportunity to ask questions and meet the Council of Governors.

Recruitment of Members

The Trust has a simple process for becoming a Member via an online application on its website and Membership application form which is made available at Membership events and within the hospital. Governors are encouraged to help with the recruitment of Members by engaging with Members of the public who may also be part of other groups outside of their role as Governors.

Eligibility

Membership is open to three main groups:
(a) Public, including patients and carers
- People living within the five constituencies
- People aged 16 and over.

(b) Staff employed by the Trust
- All staff on a permanent contract or a contract of 12 months or more
- All staff who are not already public members.

(c) Volunteers of the Trust
- All volunteers

Categories of staff membership:

- Medical and dental staff
- Nursing and midwifery staff
- Allied health professions and scientific and technical staff
- Healthcare support workers (all disciplines) and ancillary staff
- Administrative, clerical and management staff.

Boundaries of public membership

Reading	All the electoral wards in Reading Borough Council (unitary authority) area
West Berkshire and borders	All the electoral wards in West Berkshire Council (unitary authority) area. Electoral wards from the Basingstoke and Deane Borough Council area of North Hampshire including: Baughurst, Burghclere, Calleva, East Woodhay, Highclere and Bourne, Kingsclere, Pamber, Tadley North and Tadley South The following electoral ward from Test Valley Borough Council area of North Hampshire: Bourne Valley
East Berkshire and borders	All the electoral wards in Bracknell Forest Borough Council (unitary authority) area.

	All the electoral wards in Slough Borough Council (unitary authority) area. All the electoral wards in the Royal Borough of Windsor and Maidenhead (unitary authority) area. The following electoral wards from South Bucks District Council area: Burnham, Beeches, Burnham Church, Burnham Lent Rise, Dorney and Burnham South, Farnham, Royal, Iver Heath, Iver Village and Rickings Park, Stoke Poges, Taplow, Wexham and Iver West.
Southern Oxfordshire	The following electoral wards from South Oxfordshire District Council area: Chiltern Woods, Cholsey and Wallingford South, Crowmarsh, Didcot All Saints, Didcot Ladygrove, Didcot Northbourne, Didcot Park, Goring, Hagbourne, Henley North, Henley South, Shiplake, Sonning Common, Wallingford North and Woodcote.
Wokingham	All electoral wards in Wokingham Borough Council (unitary authority) area

Current membership

At 31 March 2026 our public membership stood at 3,674 and our total membership at 10,839. Membership is under-represented in younger age groups with under-representation remaining until the 30+ age groups. Members in the age 60 years and above category are the mostly highly represented. The Trust held an Annual General Meeting in September 2025. The Trust membership remains in line with the average foundation trust membership.

Constituency	Public	% of public membership
East Berkshire and Borders	833	21.46%
Reading	1050	27.05%
Southern Oxfordshire	177	4.56%
West Berkshire and Borders	600	15.45%
Wokingham	901	23.21%
Out of Trust Area	23	5.95%
Not Specified	90	2.32%
Total	**3674**	

Governors' Register of Interests

The Council of Governors' Register of Interests is reviewed throughout the year. Any enquiries about the Governors' Register of Interests should be made to the Trust Secretary, Corporate Governance Department, Royal Berkshire Hospital, London Road, Reading RG1 5AN or by email to foundation.trust@royalberkshire.nhs.uk.

Contacting the members of the Council of Governors

The public are able to contact a member of the Council of Governors through the Corporate Governance Department by writing to the Trust Secretary, Corporate Governance Department, Royal Berkshire Hospital, London Road, Reading RG1 5AN or by email to foundation.trust@royalberkshire.nhs.uk.

Membership Strategy

We recognise membership to be an important part of being a Foundation Trust. An engaged and representative membership enables the Trust to be responsive to the local communities it serves, gauge local views and priorities to help shape the development of services and guides the work we do. Our membership strategy was refreshed during 2025/26 and aimed to maintain and develop a Membership that is representative of the Constituencies that the Trust serves by:

- Increasing membership promotion and attendance
- Improving the quality of engagement and communication with Members
- Encouraging engagement and provide opportunities for staff and volunteers

Directors' responsibility for the Annual Report and Accounts

The Board of Directors takes the responsibility for preparing the Annual Report and Accounts of the Trust. The Directors consider that the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, public, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

NHS Well-Led Framework

Throughout the year, the Trust continued to build on the actions taken in 2024/25 to strengthen compliance with the framework. To maintain a well-led organisation the Trust is aware of the requirement to carry out an external review every three years to five years in accordance with the NHSE Well-led Framework. KPMG completed an external well-led assessment in 2025/26and the draft report was submitted to the Board in March 2026 with the final report and recommendation submitted to the Board in May 2026. The Trust uses the well-led framework to inform its governance processes, which are described in the Annual Governance Statement that starts on page 83.

Actions taken during the course of 2025/26 included, but were not limited to:

- the review and updating of the Trust's quality priorities
- patient care activities and stakeholder relations - Our Quality Account provides a detailed report on what the Trust is doing to develop its services, engage with our stakeholders and improve patient care. The Quality Account is due to be published in June 2026 and will be available on our website.
- the review of the Quality Governance Structure and the addition of a Corporate Governance item to all Care Group Leadership meetings with assigned members of the Corporate Governance team to attend and advise on all board governance processes
- the continued development of the Integrated Performance Report. Further information on the governance structure that supports the organisation can be found in the Annual Governance Statement of this Annual Report

- the review and approval of Freedom to Speak Up Guardian arrangements in the Trust by the Audit & Risk Committee and review of various staff fora by the Quality and People Committees
- the recruitment of a new member of the Audit & Risk Committee which resulted in Committee achieving compliance with provision D.2.1 of the NHS Foundation Trust Code of Governance. This provision requires a membership of at least three independent Non-Executive Directors who have not served in excess of six years.

Better Payment Practice Code

The Trust is required to pay all trade creditors in accordance with the Better Payment Practice Code (BPPC), with a target of paying 95% of all trade creditors within 30 days of receipt of goods or a valid invoice, unless other payment terms have been agreed.

Performance against this target has improved considerably over the three-year period, as shown in the table below. By number of invoices, overall compliance reached 88.01% in 2025/26, compared to 76.25% in 2024/25 and 59.25% in 2023/24. By value, 78.67% of invoices were paid within target. While we remain below the 95% target, the trend is strongly positive and work is ongoing to further improve our payment processes and system controls.

Non-NHS invoice compliance by number improved to 91.38%, while NHS invoice compliance by number was 62.29%. We are committed to improving NHS-to-NHS payment performance in 2026/27.

The Trust paid interest of £11k in 2025/26 (2024/25: £23k) to discharge liability relating to non-payment within the 30-day period.

	31/03/2026 Number	31/03/2026 £'000	31/03/2025 Number	31/03/2025 £'000	31/03/2024 Number	31/03/2024 £'000
Non-NHS						
Total bills paid	82,909	216,839	79,891	210,669	83,772	225,338
Paid within target	75,763	173,182	60,621	147,501	50,433	138,434
Target achieved	91.38%	79.87%	75.88%	70.02%	60.20%	61.43%
NHS						
Total bills paid	10,850	115,372	13,932	96,631	9,305	102,378
Paid within target	6,758	88,164	10,917	80,991	4,714	72,572
Target achieved	62.29%	76.42%	78.36%	83.81%	50.66%	70.89%
Total						
Total bills paid	93,759	332,211	93,823	307,300	93,077	327,717
Paid within target	82,521	261,346	71,538	228,492	55,147	211,008
Target achieved	88.01%	78.67%	76.25%	74.35%	59.25%	64.39%

Charitable Funds

The Trust is supported by the Royal Berks Charity (RBC), which makes charitable grants to the Trust, often contributing to capital projects. Under IAS 27, the Trust, as Corporate Trustee of the Charity, consolidates the financial statements of the Charity into these Financial Statements.

The Royal Berks Charity prepares its own separate financial statements, which are submitted to the Charity Commission.

The Trust did not make any political or charitable donations during the period 1 April 2025 to 31 March 2026.

Looking Ahead

Our planning for 2026/27 targets a breakeven position. Initial planning returns have demonstrated this is achievable, and we continue to work with Thames Valley ICB to ensure funding is utilised effectively across the system. This will require continued financial discipline, delivery of our efficiency commitments, and active management of the risks outlined in this report.

Demonstrating effective stewardship of public money is fundamental to everything we do. It is what enables us to protect and grow the investments in care and staff that define this Trust, and it underpins our ability to serve our communities well into the future.

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 the auditor is unaware; and

- 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 the auditor is aware of that information

Income Disclosures Required by Section 43(2A) of the NHS Act 2006

Details of the performance of the Trust, including the results achieved during 2025/26 can be found in the performance analysis section above.

There is no impact of other income received by the Trust on its provision of goods and services for the purposes of the health service in England.

The Trust has met the requirement as per Section 43(2A) of the NHS Act 2006 that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Remuneration Report

Annual Statement on Remuneration

The Board Nominations and Remuneration Committee agreed a 3.25% pay increase for all Very Senior Managers (VSM) backdated to 1 April 2025 in line with the VSM Pay Framework. The payment was processed in August 2025. The Chief Medical Officer received a 4% increase in line with the Medical and Dental pay ward.

The Chief Operating Officer continues to receive an additional responsibility allowance for management of Digital Data and Technology (DDaT). The amount has increased to £17,471 per annum.

The Chief People Officer continued to receive a 10% responsibility allowance for undertaking the role of Turnaround Director in addition to the Chief People Officer role through to September 2025.

Senior Managers' Remuneration Policy

Attracting and retaining talented directors and senior managers is essential for the successful delivery of the Trust's strategy and objectives within an increasingly competitive marketplace. The remuneration policy is designed with that in mind. The Trust undertakes benchmarking to set senior manager remuneration levels and looks to be in the top quartile for pay.

The table on page 52 shows the remuneration package for senior managers (Executive Directors) including pension related benefits. The remuneration package for senior managers is decided in line with Trust policy and the VSM Pay Framework. The salary paid is inclusive of any overtime or allowances. The table shows the salary/fees paid to Non-Executive Directors. No additional fees or other items, that could be considered to be remuneration in nature, are paid to the Non-Executive Directors. The Trust is satisfied, having undertaken benchmarking, that the salaries of its executives, including those earning above £170k per annum, are in line with trusts of a similar size.

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'. For the purpose of reporting senior manager's remuneration in the table (below) and the pension benefits table this has taken to mean those Executive Directors holding voting rights on the board and also the Trust's Non-Executive Directors.

The senior manager's salary is payment for delivering the Executive Director role and for delivering the short and long-term strategic objectives of the Trust. Each Executive Director post is paid a spot salary. The salaries are reviewed on an annual basis when a decision is made whether to implement a pay award.

Service contracts obligations disclosure

A contract for service is in place for any senior managers obtained via temporary, agency or contractor arrangements. The contract for service details the standard terms of business. The Trust will outline separately any specific obligations e.g. key deliverables. There are no further disclosures.

Policy on payments for loss of office

The notice period for Executive Directors is currently six months. A month is classed as four weeks. The notice period for other personnel in senior positions is three months. Payment for loss of office (redundancy) would be in line with national terms and conditions of employment (Agenda for Change) and (Medical and Dental).

Payment for any other type of loss of office would be made in line with contractual requirements and appropriate authorisation would be obtained as outlined in the Trust's Severance Protocol. The main components of the payment for loss of office would be unused annual leave and payment in lieu of notice.

Statement of consideration of employment conditions elsewhere in the foundation trust

Most Trust employees are employed on national terms and conditions of employment. The Trust has a very small number of staff on spot salaries. VSM on spot salaries received a 3.25% increase in August 2025 which was backdated to April 2025. This was in line with the national VSM pay award. The Trust also has a small number of staff who are not on national terms and conditions of employment as they were Transfer of Undertakings (Protection of Employment) regulations (TUPE'd) into the Trust. All staff have been given the opportunity to move across on national terms and conditions.

The Terms of Reference for the Nominations and Remuneration Committee makes reference to working with parties before making appointments to ensure searches for candidates is undertaken in light of equality legislation and best practice

Annual report on Remuneration

Salary and pension entitlements 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'. For the purpose of reporting senior manager's remuneration in the table (below) and the pension benefits table (Table C) this has been taken to mean those Executive Directors holding voting rights on the Board and also the Trusts' Non-Executive Directors.

Single total figure of remuneration table

The "Remuneration" section of this report has been subject to audit.
The pension related benefits for those Directors who have been in post for only part of the year have been calculated on a pro-rated basis to reflect that periodicity.

This section of the report includes information subject to audit

Name and Title	Year to 31 March 2026		
	Salary and fees Bands of £5,000 £000	Pension related benefits Bands of £2,500 £000	Total Bands of £5,000 £000
EXECUTIVE DIRECTORS **Steve McManus** [1] Chief Executive Officer	235 - 240	27.5 - 30	265 - 270
Janet Lippett [2] Chief Medical Officer	250 - 255	7.5 - 10	260 - 265
Nicky Lloyd (to 30 June 2025) [3 and 3a] Chief Finance Officer	40 - 45	5 - 7.5	45 - 50
Helen Troalen (from 23 June 2025) [4] Acting Chief Finance Officer	125 -130	25 - 27.5	155 - 160
Frances Khatcherian (from 1 March 2026) [5] Chief Finance Officer	10 - 15	2.5 - 5	15 - 20
Dominic Hardy Chief Operating Officer	195 - 200	205 - 207.5	400 - 405
Katie Prichard-Thomas Chief Nursing Officer	150 - 155	92.5 - 95	245 - 250

Don Fairley (to 30 November 2025) [6] Chief People Officer	115 - 120	0 - 2.5	115 - 120
Suzanne Emerson-Dam (from 1 December 2025 to 30 December 2025) [7] Acting Chief People Officer	10 - 15	5 - 7.5	15 - 20
Paul Da Gama (from 1 January 2026) [8] Chief People Officer	40 - 45	15 - 17.5	55 - 60
Andrew Statham Chief Strategy Officer	155 - 160	42.5 - 45	200 - 205
NON-EXECUTIVE DIRECTORS			
Oke Eleazu - Chair	45 - 50	0	45 - 50
Balbinder Bahia (to 30 April 2025)	0 - 5	0	0 - 5
Minocher Irani	15 - 20	0	15 - 20
Catherine McLaughlin	15 - 20	0	15 - 20
Helen Mackenzie	15 - 20	0	15 - 20
Michael McEnaney	15 - 20	0	15 - 20
Michael O'Donovan	15 - 20	0	15 - 20
Umesh Jetha (from 1 July 2025)	10 - 15	0	10 - 15
Parveen Yaqoob	15 - 20	0	15 - 20

1. Steve McManus opted out of the pension scheme on 1 July 2021. Payments in lieu of pension contributions have been included in the pension related benefits.

2. Janet Lippett has maintained clinical duties throughout the financial year 2025/26 and the remuneration for clinical duties alone is in the banding of £10,000 - £15,000. She opted out of the pension scheme on 1 June 2025 and rejoined on 1 November 2025.

3. Nicky Lloyd opted out of the pension scheme on 1 November 2024. Payments in lieu of pension contributions have been included in the pension related benefits.

3a In addition to salary payments up to 30 June 2026, an additional payment for loss of office of £99k was made to Nicky Lloyd in lieu of notice following voluntary resignation and is in line with contractual arrangements.

4. Helen Troalen was seconded from The Shrewsbury and Telford Hospital NHS Trust from 23 June 2025 to 31 March 2026. Salary costs during that period were recharged to the Trust. The pay shown in the Remuneration table is this Trust's share of her salary. In total, across both Trusts, remuneration was banded as £'000 165-170, all pension related benefits as £'000 35-37.5 and total £'000 200-205.

5. Frances Khatcherian was appointed as Chief Finance Officer on 1 March 2026.

6. Don Fairley left the Trust on 30 November 2025 and now is in receipt of pensions.

7. Suzanne Emerson-Dam (Deputy Chief People Officer) was in post Acting Chief People Officer from 1 December 2025 to 31 December 2025. She was full time during that month.

8. Paul Da Gama was appointed as Chief People Officer on 1 March 2026

Posts occupied by more than one person during the year From To

Chief Finance Officer		
Nicky Lloyd (Chief Finance Officer)	01 Apr 25	30 Jun 25
Helen Troalen (Acting Chief Finance Officer)	23 Jun 25	31 Mar 26
Frances Khatcherian (Chief Finance Officer)	01 Mar 26	31 Mar 26
Chief People Officer		
Don Fairley (Chief People Officer)	01 Apr 25	30 Nov 25
Suzanne Emerson-Dam (Acting Chief People Officer)	01 Dec 25	30 Dec 25
Paul Da Gama ((Chief People Officer)	01 Jan 26	31 Mar 26

Name and Title	Year to 31 March 2025		
	Salary and fees	**Pension related benefits**	**Total**
	Bands of £5,000	**Bands of £2,500**	**Bands of £5,000**
	£000	**£000**	**£000**
EXECUTIVE DIRECTORS			
Steve McManus [1] Chief Executive Officer	230 - 235	27.5 - 30	260 - 265
Janet Lippett [2] Chief Medical Officer	245 - 250	0	245 - 250
Nicky Lloyd [3] Chief Finance Officer	170 - 175	55 - 57.5	225 - 230
Dominic Hardy [5] Chief Operating Officer	175 - 180	350 - 352.50	525 - 530
Katie Prichard-Thomas Chief Nursing Officer	145 - 150	77.5 - 80	220 - 225
Don Fairley [6] Chief People Officer	170 - 175	212.5 - 215	380 - 385
Andrew Statham (from 1 July 2024) [4] Chief Strategy Officer	115 - 120	30 - 32.5	145 - 150
NON-EXECUTIVE DIRECTORS			
Graham Sims - Chairman	45 - 50	0	45 - 50
Balbinder Bahia	15 - 20	0	15 - 20
Minocher Irani (from 1 September 2024)	5 - 10	0	5 - 10

Catherine McLaughlin (from 1 July 2024)	10 - 15	0	10 - 15
Helen Mackenzie	15 - 20	0	15 - 20
Michael McEnaney	15 - 20	0	15 - 20
Michael O'Donovan	15 - 20	0	15 - 20
Parveen Yaqoob	15 - 20	0	15 - 20
Priya Hunt (to 30 September 2024)	5 - 10	0	5 - 10

1. Steve McManus opted out of the pension scheme on 1 July 2021. Payments in lieu of pension contributions have been included in the pension related benefits.

2. Janet Lippett has maintained clinical duties throughout the financial year 2024/25 and the remuneration for clinical duties alone is in the banding of £10,000 - £15,000.

3. Nicky Lloyd opted out of the pension scheme on 1 February 2024, rejoining in the financial year 2024/25 and opted out on 1 November 2024.

4. Andrew Statham joined the executive directors board from 1 July 2024. The salary in the table above is for the period 1 July 2024 to 31 March 2025.
5. Dominic Hardy opted out of the pension scheme on 1 December 2023 and rejoining in the financial year 2024/25. This has contributed to the increase in pension related benefits.

6. Don Fairley opted out of the pension scheme on 1 November 2023 and rejoining in the financial year 2024/25.This has contributed to the increase in pension 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 excludes increase due to inflation or any increase or decrease due to a transfer of pension rights. The value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provided further information on the pension benefits accruing to the individual.

None of the directors received any benefits in kind, annual performance related bonuses or long-term performance related bonuses.

Total Pension Entitlement 2025/26

Name and Title	Real increase in pension at pension age (Bands of £2,500)	Real increase in pension lump sum at pension age (Bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (Bands of £5,000)	Total accrued pension at pension age at 31 March 2025 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (Bands of £5,000)	Cash equivalent transfer value at 31 March 2026	Cash equivalent transfer value at 31 March 2025	Real increase in cash equivalent transfer value
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Executive Directors									
Steve McManus [1] Chief Executive Officer	0	0	0	0	0	0	0	0	0
Janet Lippett [2] Chief Medical Officer	0 - 2.5	0	70 - 75	65 - 70	170 - 175	170 - 175	1,526	1,471	20
Nicky Lloyd (to 30 June 2025) [3] Chief Finance Officer	0	0	0	40 - 45	0	0	0	720	0
Helen Troalen (from 23 June 2025) [4] Acting Chief Finance Officer	0 - 2.5	0	50 - 55	45 - 50	115 - 120	115 - 120	1,006	940	18
Frances Khatcherian (from 1 March 2026) [5] Chief Finance Officer	0 - 2.5	0	20 - 25	0	0	0	284	241	2
Dominic Hardy Chief Operating Officer	10 - 12.5	20 - 22.5	60 - 65	50 - 55	155 - 160	135 - 140	1,354	1,112	198
Katie Prichard-Thomas Chief Nursing Officer	5 - 7.5	5 - 7.5	45 - 50	40 - 45	105 - 110	100 - 105	888	778	80
Don Fairley (to 30 November 2025) [6] Chief People Officer	0	0	65 - 70	70 - 75	170 - 175	200 - 205	0	118	0
Suzanne Emerson-Dam (from 1 December 2025 to 30 December 2025) [7] Acting Chief People Officer	0 - 2.5	0 - 2.5	50 - 55	45 - 50	125 - 130	115 - 120	1,162	1,036	0
Paul Da Gama (from 1 January 2026) Chief People Officer	0 - 2.5	0	35 - 40	35 - 40	0	0	623	549	11
Andrew Statham [4] Chief Strategy Officer	2.5 - 5	0	20 - 25	20 - 25	0	0	304	257	24

1. Steve McManus opted out of the pension scheme with effect from 1 July 2021. Not in pension for whole year 2025/26.

2. Janet Lippett opted out of the pension scheme on 1 June 2025 and opted back in 1 November 2025.

3. Nicky Lloyd opted out of the pension scheme on 1 November 2024.

4. Helen Troalen was on seconded from The Shrewsbury and Telford Hospital NHS Trust and was not on this Trust's payroll. Salary and Pension information were provided by her employing Trust. Figures shown for "Real increase in pension at pension age", "Real increase in pension lump sum at pension age" and "Real increase in CETV" have been calculated on a pro rata basis for that period.

5. Frances Khatcherian joined on 1 March 2026. An automatic Greenbury calculation for the 2025/26 tax year has already been completed in the NHS Pension system at the request of the member's previous employer. In accordance with NHS Pension Scheme rules, only one Greenbury calculation is undertaken per member per tax year; therefore, no further calculation has been carried out for this period. Figures shown for "Real increase in pension at pension age", "Real increase in pension lump sum at pension age" and "Real increase in CETV" have been calculated on a pro rata basis for that period.

6. Don Fairley left the Trust on 30 November 2025. NHS Pensions is unable to provide a CETV figure as he is now in receipt of NHS Pension Scheme benefits.

7. Suzanne Emerson-Dam (Acting Chief People Officer) was in executive post from 01/12/2025 to 31/12/2025. Figures shown for "Real increase in pension at pension age", "Real increase in pension lump sum at pension age" and "Real increase in CETV" have been calculated on a pro rata basis between these two dates.

Where the calculation results in a negative figure zero is submitted
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 excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.
This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Total Pension Entitlement 2024/25

Name and Title	Real increase in pension at age 60 Bands of £2500	Real increase in pension lump sum at age 60 Bands of £2500	Total accrued pension at age 60 at 31 March 2025 Bands of £5000	Total accrued pension at age 60 at 31 March 2024 Bands of £5000	Lump sum at age 60 at 31 March 2025 Bands of £5000	Lump sum at age 60 at 31 March 2024 Bands of £5000	Cash equivalent transfer value at 31 March 2025	Cash equivalent transfer value at 31 March 2024	Real increase in cash equivalent transfer value
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Executive Directors									
Steve McManus [1]	0	0	0	0	0	0	0	0	0

Chief Executive Officer									
Janet Lippett Chief Medical Officer	0 - 2.5	0	65 - 70	60 - 65	170 - 175	165 - 170	1,471	1,354	0
Nicky Lloyd [2] Chief Finance Officer	2.5 - 5	0	40 - 45	30 - 35	0	0	720	621	44
Dominic Hardy Chief Operating Officer	15 - 17.5	40 - 42.5	50 - 55	30 - 35	135 - 140	85 - 90	1,112	775	264
Katie Prichard-Thomas Chief Nursing Officer	2.5 - 5	5 - 7.5	40 - 45	30 - 35	100 - 105	85 - 90	778	651	67
Don Fairley [3] Chief People Officer	10 - 12.5	20 - 22.5	70 - 75	55 - 60	200 - 205	160 - 165	118	1,512	0
Andrew Statham [4] Chief Strategy Officer	0 - 2.5	0	20 - 25	10 - 15	0	0	257	0	12

Notes

1.Steve McManus opted out of the pension scheme with effect from 1 July 2021. Not in pension for whole year 2024/25

2. Nicky Lloyd opted out of the pension scheme on 1 November 2024.

3. Don Fairley reached normal retirement age for 1995 scheme this year, which is why the CETV for 1995 section is now zero

4. Andrew Statham joined the executive directors board from 1 July 2024.

Where the calculation results in a negative figure zero is submitted

Fair Pay Disclosure

This section of the report has been subject to audit

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.

	Year to 31 March 2026	Year to 31 March 2025
Band of Highest Paid Director's Total Remuneration - £000	**265 - 270**	**260 - 265**
Median Ratio	**6.41**	**6.38**

	Year to 31 March 2026	Year to 31 March 2025
a) Percentage change in respect of Highest Paid Director	**3.25%**	**-4.69%**
b) Percentage change in respect of employees of the entity	**3.96%**	**7.35%**

The banded remuneration of the highest-paid director in the organisation in the financial year 2025/26 was £265k – 270k (2024/25: £260k – 265k). This is a change between years of 3.25% increase (2024/25: -4.69% decrease).

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

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £20k to £311k (2024/25: £19k to £329k). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 3.96% (2024/25: 7.35%). Two employees received remuneration in excess of the highest-paid director in 2024/25 (2023/24: Nine). These were medical consultants, comprising one substantive employee and one agency staff member. Their higher remuneration reflected the nature of their clinical roles, including additional hours worked, on-call payments and enhancements alongside their basic salary.

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	25th percentile	Median	75th percentile
Salary component of total remuneration (£)	**31,049**	**41,713**	**54,710**
Total remuneration (£)	**31,049**	**41,713**	**54,710**
Pay ratio information	**8.62**	**6.41**	**4.89**

2024-25	25th percentile	Median	75th percentile
Salary component of total remuneration (£)	**30,226**	**40,877**	**52,809**
Total remuneration (£)	**30,226**	**40,877**	**52,809**
Pay ratio information	**8.68**	**6.42**	**4.97**

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

The highest paid director's remuneration was 6.41 times (2024/25 - 6.42) the median remuneration of the workforce including medical consultants' remuneration, which was £41,713 (2024-25- £40,877). Fair pay calculations include agency and other temporary employees covering staff vacancies but exclude consultancy services. Agency fees are excluded from the remuneration.

The calculation is based on staff in post as at 31 March 2026 and reflects the annualised salary inclusive of any additional payments such as overtime and enhancements. For temporary staff the calculation is based on individuals covering vacant posts during March 2026 with figures annualised.

This represents a change in methodology from previous years, when bank and agency remuneration was calculated using average estimates due limitations in data availability.

The revised methodology provides better alignment with NHS guidance on fair pay disclosure and improves the accuracy, transparency and year-on-year consistency of the information.

Expenses paid to Directors and Governors

The table below lists the total of reimbursable expenses paid to Directors and Governors

	Year to 31 March 2026		Year to 31 March 2025
Directors	**6,319**		**2,327**
Governors	**0**		**0**

Of the amount stated in respect of Directors expenses £68 was paid to Non-Executive Directors (2024/25 £947).

During the year, inclusive of non-executives, there were 20 Directors in post (2024/25,16). Of these 8 received expenses payments (2024/25, 6).

Additionally, there were 26 governors in post during the year (2024/25, 28) of which none were paid expenses (2024/25, 0).

Staff Exit Packages

Severance Payments 2025/26

Exit packages agreed during the year has been subject to audit.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	27	27
£10,000 - £25,000	3	14	17
£25,001 - £50,000	2	5	7
£50,001 - £100,000	1	4	5
£100,000 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
Total number of exit packages by type	**6**	**50**	**56**
Total resource cost (£'000)	**£183**	**£754**	**£937**

Exit packages: non-compulsory departure payments

	Agreements Number	Total value of Agreements
		£'000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	15	431
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	34	313
Exit payments following Employment Tribunals or court orders	1	10
Non- contractual payments requiring HMT / ***DHSC*** approval *	0	0
Total:	**50**	**754**
Of which: non contractual payments requiring HMT / ***DHSC*** approval made to individuals where the payment value was more than 12 months of their annual salary		

A payment for loss of office of £99k was made to Nicky Lloyd (Chief Finance Officer) in the form of a payment in lieu of notice following voluntary resignation and is in line with contractual arrangements. This is included in the non -compulsory departure payment in the table above.

Severance Payments for 2024-25

The "Severance Payments" section of this report has been subject to audit.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
			£'000
<£10,000	1	16	17
£10,000 - £25,000	5	1	6
£25,001 - £50,000	1	0	1
£50,001 - £100,000	0	1	1
£100,000 - £150,000	0	1	1
£150,001 - £200,000	0	0	0
Total number of exit packages by type	**7**	**19**	**26**
Total resource cost			

Exit packages: non-compulsory departure payments

	Agreements Number	Total value of Agreements
		£'000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	2	153
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	18	97
Exit payments following Employment Tribunals or court orders	0	0
Non- contractual payments requiring HMT / ***DHSC*** approval *	0	0
Total:	**20**	**250**
Of which: non contractual payments requiring HMT / ***DHSC*** approval made to individuals where the payment value was more than 12 months of their annual salary		

Service contracts

Details of the Non-Executive Directors' service contracts are detailed below.

Name	Designation	Date Appointed	End of Term of Office
Mr Oke Eleazu	Chair of the Trust	April 2025	March 2028
Dr Bal Bahia	Non-Executive Director	April 2019	April 2025
Mrs Helen Mackenzie	Non-Executive Director	January 2019	January 2027
Prof Parveen Yaqoob	Non-Executive Director	January 2023	March 2026
Mr Mike McEnaney	Non-Executive Director	October 2023	September 2026
Mr Mike O'Donovan	Non-Executive Director	November 2023	October 2026
Mrs Catherine McLaughlin	Non-Executive Director	July 2024	June 2027
Dr Minoo Irani	Non-Executive Director	September 2024	August 2027
Mr Umesh Jetha	Non-Executive Director	July 2025	July 2028

The notice period for Non-Executive Directors is one month.

Board and Council Nominations and Remunerations Committees

The Trust has a Board Nominations and Remunerations Committee and a Council of Governors Nominations and Remuneration Committee. The purpose and composition of each are described below.

Board Nominations & Remuneration Committee

The Committee oversees a formal, rigorous and transparent procedure for the appointment of the Chief Executive and the other Board Executive Directors. It advises and makes recommendations to the Board on Executive and senior management remuneration and remuneration policy. The Chief People Officer provides advice or services to the Nominations & Remuneration Committee.

The Nominations & Remuneration Committee uses the following survey guidance:

- NHS England Benchmarking Data
- Salary surveys conducted by NHS Providers.

Membership	Mr Oke Eleazu (Chair) Mrs Helen Mackenzie Professor Parveen Yaqoob Mr Mike O'Donovan Mr Mike McEnaney Ms. Catherine McLaughlin Dr Minoo Irani Mr Umesh Jetha (from July 2025)

Board attendance at Nominations and Remuneration Committees are shown on page 35.

Responsibilities

The Nominations & Remuneration Committee consists of all Non-Executive Directors and the Chief Executive attends for nominations business only.

Council of Governors Nominations and Remunerations Committee

Membership of the Governors Nominations and Remunerations Committee comprises any Governor wishing to serve.

Remuneration duties

The Committee will make recommendations to the Council of Governors on the following:

- To develop, seeking the advice and recommendations of the Chief Executive, mechanisms to ensure that the Committee and the Council in general is informed of the up to date position on Non-Executive Director remuneration in the public and private sectors, in particular the practice in Foundation Trusts

- To recommend an overall remuneration and terms of service policy for the Non-Executive Directors, taking into account the advice of the Chair of the Trust (other than in respect of their own remuneration), Chief Executive and external advisors to the Committee.

- To recommend levels and terms of service for individual Non-Executive Directors, taking into account the overall policy established by the Trust.

Nomination duties

The Committee will make recommendations to the Council of Governors on the following:

- To establish and keep under review a policy for the composition of Non-Executive Directors, which takes account of the strategic needs of the Trust and the balance of the Board, and the membership strategy

- To consider the skills and experience required in any Non-Executive Director appointment

- To identify appropriate candidates for appointment as Non-Executive Directors with guidance from the Chief People Officer as required and appropriate

- To establish and keep under annual review a policy for the composition of the Council of Governors, which takes account of the membership strategy (the Trust also reviews constituency boundaries on a three yearly basis)

- To oversee the process for the appraisal of the Chair of the Trust and Non-Executive Directors as set out in the protocol agreed between the Board of Directors and Council of Governors

- To keep under review the protocol for the appraisal of the Chair of the Trust and Non-Executive Directors

- Act on behalf of the Council in the arrangements agreed with the Board for the appointment of a Chief Executive

- To keep under review the structure, size and composition of the Board and make recommendations where appropriate

- Keep under review the protocol for the appointment of a Chief Executive.

The Committee reviews these terms of reference annually, making recommendations to the Council of Governors as appropriate.

Board re-appointment process

The process agreed by the Council of Governors, with the support of the Board of Directors, for the re-appointment of Non-Executive Directors is as follows:

a) The reappointment of a Non-Executive Director is considered by the Council's Nominations and Remuneration Committee, which will make a recommendation to the full Council

b) The following information is submitted to the meeting at which the re-appointment is considered:

- A summary of the individual's last three years' appraisals, submitted by the Chair of the Trust. In the case of the re-appointment of the Chair, this information will be submitted to the Committee by the Senior Independent Director

- A summary of the individual's attendance at Board and committee meetings since their appointment (or previous three years if appointed for four years or more)

- An assessment, provided by the Chair of the Trust (or Senior Independent Director in the case of the re-appointment of the Chair), of the balance of skills of the Non-Executive team on the Board and the individual's contribution to this

- As background information to the discussion, the Committee will be provided with the Charter of Expectations, which sets out the skills required from, and the expectations of, Board members, and any employment advice from the Director of Workforce

- A statement by the individual seeking reappointment.

c) The Nominations Committee are entitled to request any further information that they deem necessary to be able to make a recommendation to the Board. Independent external advisers are not permitted to be a member or have a vote on the nominations committee (s) as per the terms of the Trust Governance Handbook.

Signed

James Blythe
Chief Executive Officer **Date: 1 July 2026**

Staff Report

Information on staff turnover can be found via the following link to the NHS Digital publishing service: NHS Workforce Statistics - January 2026 - NHS England Digital Figures are updated monthly.

The Staff Report provides an analysis of staff costs by staff group. The analysis is broken down by those permanently employed and others, which includes agency workers and staff employed through the bank service.

This table has been subject to audit

Staff WTE	Permanent WTE 2025/26	Other WTE 2025/26	Permanent WTE 2024/25	Other WTE 2024/25
Medical and dental	426	467	398	466
Administration & Estates	1,118	70	1,090	91
Healthcare assistants and other support staff	1,213	117	1,175	21
Nursing, midwifery and health visiting staff	2,028	154	2,006	303
Scientific, therapeutic and technical staff	626	37	603	55
Healthcare science staff	175	19	168	33
Total Average Numbers	5,586	864	5,440	969

Staff Headcount

Status	Female	Male
Director	3	4
Employee	5,244	1,654
Senior Manager*	9	5
Grand Total	5,256	1,663

* The Senior Manager definition methodology in previous years has been based on an ESR role (including staff in bands 6-8a) which does not meet the definition used in the annual report manual.

Sickness Absence Data

Cumulative Absence Full Time Equivalent (FTE)	FTE (days)	Cumulative Available (FTE days)	Cumulative % Absence Rate (FTE)
	82,972	2,243,426	3.70%

The Trust's expenditure on consultancy during 2025/26 was £1,514k (£1,805k 2024/25).

A total of 29 HR policies were reviewed and ratified during 2025/26. Three of the policies specifically relate to medical and dental staff. All the other policies apply to all staff within the Trust. The Recruitment and Selection Policy provides full and fair consideration to applications for employment made by disabled persons, having regard to their aptitudes and abilities.

The Trust has a Human Resources and Local Counter Fraud Policy that covers counter fraud, corruption and bribery. The policy was last updated in July 2024.

Occupational Health (OH) have experienced a number of challenges in the past year and in particular with staffing in the team. The OH Consultant retired in November 2025 and the department now utilise the services of an existing OH consultant who provides clinics on an almost weekly basis. At present this appears to be meeting the demand for the more complex OH Consultant level cases. The new OH consultant also delivers our Ionising Radiation regulation medicals in line with our statutory requirements as an employer.

There was a planned retirement in the OH nursing team at the end of this financial year. Recruitment to this post has been challenging due to the specialist nature of OH specialty. However, we have now recently recruited and anticipate the new staff member joining in the coming weeks. Whilst this new recruit will provide improved capacity the overall OH capacity remains below our normal levels due to an unexpected ongoing absence in the team.

OH has continued to deliver just under 1300 appointments for management referral initial appointments during 2025/26. However, over the past year OH have seen a 17% increase in the number of management referrals received to OH and when compared to pre COVID level there is an 80% increase in the number of management referrals since 2020-21. The combination of increased referrals, absence in the OH nursing staff and difficulty to recruit has resulted in waiting times for OH increasing to approximately 8 weeks. To address this a number of priority referral slots have been created and any referrals triaged as urgent are given priority for appointments.

OH provide a detailed report to managers after every management referral appointment which includes independent advice on the staff members fitness for work whilst maintaining the staff members medical confidentiality. The number of staff seen for self-referrals has remained stable at 67, self-referral appointments are only for staff who want to discuss their health and work where no advice is required to managers post appointment.

In light of the rising number of management referral OH have liaised with Employee Relations and the People and Change Partners to provide training sessions for managers on when and how to utilise OH referrals. This has helped to further clarify for managers when they do and do not require OH input into their management of staff.

During 2025/26 the OH team processed over 1700 pre placement questionnaire for individuals who were offered post at the Trust, similar to the previous year. Off these OH identified 21% (364 individuals) who required a health assessment with an OH nurse advisor to assess their fitness for the post offered. Following the OH assessment advice is given to managers on how to support individuals in their new roles whilst also maintaining the prospective staff members medical confidentiality.

OH continue to provide regular work related vaccinations (786 appointments) and blood test (479 appointments) to staff and these appointments are all available within the 2 weeks target.

The number of needlestick, sharps, body fluid exposure injuries reported was up from 163 in 2024/25 to 179 in 2025/26 although none of these were confirmed a Reporting of Injuries,

Diseases and Dangerous Occurrences Regulations (RIDDOR) and therefore reportable with exposure to a known infectious blood borne virus.

OH completed the statutory skin and respiratory health surveillance for 2025 with Control of Substances Hazardous to Health (COSHH) reports sent to the department managers in line with our statutory requirements.

OH also work very closely with Infection Control in managing any incidents where staff may be exposed to communicable diseases ensuring appropriate action is taken to safeguard any staff who may have been exposed at work.

The Staff Physiotherapy Service continued to provide a comprehensive and responsive service to staff experiencing musculoskeletal (MSK) problems. Over the past year, more than 575 staff members were seen, with a total of 1,573 appointments delivered. Of those seen, 248 staff (43%) were offered an appointment within the two-week KPI target, while 57% were seen outside the target timeframe. This reflects both the increasing demand for MSK support and the challenges associated with operating as a single-handed service.

As a stand-alone service, the Staff Physiotherapy Service also provides a steroid injection clinic, enabling staff to access essential interventions without needing to attend their GP during working hours or wait extended periods for MSK-CSS appointments. This approach not only supports staff wellbeing but also reduces time away from work and contributes to improved service continuity across departments.

In addition to clinical care, the service delivers targeted teaching sessions to departments with high MSK-related sickness absence and to teams requesting support as part of their health and wellbeing initiatives. These sessions promote early intervention, improve MSK awareness, and equip staff with practical strategies to manage symptoms and prevent recurrence.

Despite these pressures, the service continues to demonstrate significant positive impact. Staff consistently report high levels of satisfaction with the care received, and feedback highlights the value of timely assessment, treatment, and advice. The continued demand for the service demonstrates its importance within the organisation.

The vaccination Centre has had a successful year maintaining service levels and expanding services. Changes in vaccine recommendations meant COVID vaccinations were no longer universally offered to staff, which led to an overall reduction in vaccinations given to 8000 from 10,000 last year. This extra capacity has allowed diversification into other areas. The highlight of the year was the department being recognised by HRH the Prince Of Wales, for support given to staff during the COVID pandemic. Peers and patients have also recognised the service provided and support given with an average friends and family patient score over the year of 99.4, with particular praise for a friendly and informative service.

Following the discontinuation of DrDoctor the vaccination centre worked closely with the projects teams from DDaT to integrate a new booking system with Swiftqueue. This has seen some improvements in functionality and efficiency, such as automatic appointment reminders, friends and family questionnaires and patient rebooking or cancellation.

The department continues to maintain its strong performance in staff seasonal FLU vaccinations, seeing a 5% increase in uptake to 55% of front-line workers. This is higher than the national average of 47.9%. COVID vaccinations were offered to all staff and volunteers at higher risk in line with government guidance. Staff were offered seasonal vaccinations by a range of delivery models, including pre-bookable clinics, walk in’s, roving and outreach across all Trust sites.

The staff travel vaccination service was launched in July 2025, offering our expert travel advice and vaccinations to staff and relatives to complement our staff health and wellbeing offering. To date we have treated 55 staff and administered 98 vaccines to staff and their family going on holiday.

The Staff Health and Wellbeing (H&WB) team developed and further enhanced the support services offered to staff during 2025/26 and have been pivotal in supporting the organisation retain our place as a top acute Trust for taking positive action on H&WB for the second consecutive year, as reported in the NHS Staff Survey.

The Oasis staff health and wellbeing centre remains as the focal point for all H&WB activities, with just under 4,000 different staff visiting the centre at least once, and approximately 40,000 cumulative visits recorded in 2025/26. As well as continuing to offer a range of alternative therapies and staff support sessions with external organisations such as Smoke Free Life Berkshire and Citizens Advice, the Oasis hosted a number of engagement and recognition events in 2025/26, including our now annual cultural celebration event as well as the Rainbow Day Nursery 'graduation' ceremony and numerous staff team building events and retirement celebrations.

Our Staff health checks+ project continued in 2025/26. The emerging theme from health check data continues to be diabetes risk amongst staff. Amongst the cohort of staff identified with at least one health issue, 76% were at risk of diabetes.

To help address this concern we were proud to be one of only 29 NHS Trusts to be awarded an external grant through phase 1 of the NHS Charities Together Workforce Wellbeing Programme. We used this funding to launch a new Staff Preventative Health Programme in January, initially funded to the end of 2026/27. This programme has initially focussed on diabetes prevention, with 136 diabetes prevention health checks completed in the first two months since launch and 15 staff being directly referred for further care through existing national services. As well as continuing with diabetes checks, the Staff Preventative Health Programme will further develop into supporting with management of work-related stress in 2026/27.

The Trust's Staff Psychological Support Service (SPSS) is well established in its third year. The Clinical Lead Psychologist strives to engage with colleagues at all levels and disciplines offering high quality psychologically informed support. The support offered includes; bespoke department reflective sessions where staff have a protected space to consider the psychological impact of their roles on their mental wellbeing, often discovering insights or learning new emotional regulation skills. The SPSS also offers Post Event Team Reflections (PETRs) in order to complement debriefing post incident and Trauma Risk Management (TRiM) sessions.

The Clinical Lead Psychologist has ongoing interactions with regional and national staff support services adding to the growing framework for staff psychological support.

The Trust has seen a reduction in turnover during 2025/26 from 9.30% in April 2025 to 8.61% in March 2026. The Trust has consistently overachieved against the target of 13% for 2025/26.

The Trust meets with employee representatives on a regular basis, through the Joint Staff Consultative Committee and the Joint Local Negotiating Committee (as required). These mechanisms enable the views of employees to be considered when decisions are made which are likely to affect their interests. We also use these mechanisms to brief staff on the Trust's performance against various key metrics.

The Trust's latest Equality reports, including our Gender Pay Gap; Workforce Race Equality and Workforce Disability Equality Standard reports can be found on our website at:

Equality and Diversity - Royal Berkshire NHS Foundation Trust.

The Trust's Gender Pay Gap report can also be found at the Cabinet Office website: Royal Berkshire NHS Foundation Trust - Gender pay gap service

In terms of our strategic direction across the Equality, Diversity and Inclusion agenda, ongoing delivery of our People Strategy (2023-2027) continues to set out our ambitions in pursuit of our goal to be the best and most inclusive place to work in the NHS. Based on our strategic and operational priorities, key areas of focus over the next 12 months will include:

- Our leadership structures are becoming more diverse, but we need to continue focus to drive the pace of improvement
- We remain concerned about the unacceptable levels of abuse and discrimination from patients, service users and members of the public that our staff are subjected to
- Delivering increased an enhanced pathways into employment for young people in our community and develop support and employment offers that flex in accordance with life stages and priorities.

The Trust has an Equity of Opportunity and Diversity Policy, which sets out a range of provisions in key areas including Recruitment and Selection; Reasonable Adjustments; Training and Development; Raising Concerns, Equality Objectives. And Equality Impact Assessments. This policy is complemented by additional stand-alone policies in a range of areas including Recruitment and Selection and Dignity at Work Policy.

In pursuit of our strategic and operational priorities a wide range of actions have been delivered in 2025/26 as we continue to drive forward the EDI agenda at the Trust. Some highlights from our work include:

- Our 'Up the Anti' campaign – a trust wide programme of work to drive forward an Anti-Discrimination culture at the RBFT – has connected with over 1000 colleagues in educational interventions to elevate the agenda and inform improvements.
- Our Annual 'Cultural Awareness Day' attracted over 600 colleagues to celebrate diversity across the Trust.
- Our Staff Networks and Forums continue to grow and lead a range of inclusion centred events including Reading Pride; International Women's Day; Black History Month celebrations
- Continually evolving education and training offer including Oliver McGowan Learning Disability and Awareness Training; LGBQ+ and Trans Awareness; Neurodiversity; Menopause support
- By the end of February 2026, nearly 24% of our Senior Leadership community at Band 8a+ were from Global Majority backgrounds, a 4% in year improvement in representation.

Representative Leadership

Our latest Workforce Race Equality Standard (WRES) data as of 31.03.26, reports that 21% of Trust Board members are from BAME backgrounds. This compares to a 43% overall organisational BAME representation. The differential between BAME workforce composition and BAME board composition is 22%.

The % of BAME staff in all senior Agenda For Change (AfC) Bands 8a - 9 and Very Senior Managers (VSM) positions at the Trust is 23.8%. This represents a 3.4% growth from March

2025 (our biggest ever in-year growth). As of March 2026, there are 102 Global Majority colleagues in senior AfC bands compared to 84 in 2025, 67 in 2023 and 19 in 2017. This increasing senior level representation takes place in the context of overall increasing representation of Global Majority colleagues across the Trust's workforce. As of March 2026 – 43% of the organisation are colleagues from Global Majority backgrounds (a 3% increase from 2025). National NHS Average representation is 31%.

36% of the Trust Board are female compared to organisation wide female composition of 76%.

Staff experience and engagement

Our commitment to delivering an excellent staff experience and high levels of engagement is reflected in our strong 2025 NHS Staff Survey Results, where our overall results ranked us amongst the very best acute Trusts in the Country. Ongoing delivery of our People Strategy 2023-2027 provides our strategic roadmap for the period ahead and sets out a broad range of actions and improvement priorities to deliver on our ongoing to vision to become the best and most inclusive place to work in the NHS.

NHS staff survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions were aligned to the seven elements of the NHS 'People Promise' and retained the two previous themes of 'engagement' and 'morale'. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are based on a score out of 10 (with 1 being the worst and 10 the best)

The response rate for the 2025/26 survey among trust staff was 62% (our best ever response rate) compared to 57% in 2024/25. The National Average for the Benchmark group in 25/26 was 47%. Scores for each indicator together with that of the survey benchmarking group (Acute and Acute & Community Trusts) are presented below.

Indicators ('People Promise' elements and themes)	**2025/26**		**2024/25**		**2023/24**	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	7.68	7.28	7.58	7.21	7.53	7.24
We are recognised and rewarded	6.29	5.87	6.22	5.92	6.18	5.94
We each have a voice that counts	7.12	6.60	7.09	6.67	7.08	6.70
We are safe and healthy	6.43	6.07	6.36	6.09	6.33	6.06
We are always learning	6.08	5.57	6.02	5.64	5.89	5.61
We work flexibly	6.57	6.22	6.51	6.24	6.42	6.20
We are a team	7.14	6.75	7.08	6.74	7.01	6.75
Staff engagement	7.34	6.74	7.35	6.84	7.30	6.91
Morale	6.26	5.84	6.20	5.93	6.20	5.91

The Trust 2025 NHS Staff Survey Performance evidences strong in year improvement and an exceptionally strong benchmarked position.

Performance across 8 of the 9 People Promise themes improved, with one evidencing fractional deterioration. Trust performance in the People Promise Themes of 'We each have a voice that counts' and 'We are the Team' is the best in the Country. Trust performance in all themes is significantly above the National Average and up amongst the very best acute performers.

Future priorities and targets

Whilst our in-year performance and benchmarked position has further improved in year, it is still the case that a continued and deliberate focus on delivering an excellent staff experience is required to deliver on our aspiration to be the best place to work in the NHS.

In the year ahead, our key Trust wide areas of focus will include (1) Unacceptable levels of violence, abuse and discrimination our staff experience from patients, relatives and members of the public (2) Continued emphasis on opportunities to develop careers and progress within the organisation and (3) Actions to ensure high motivation and morale in the context of ongoing operational challenges ahead.

A Trust level thematic improvement plan on a page has been developed. However, the key vehicle for continuous improvement will be local development plans developed and delivered by local leaders and managers through engagement with their staff on the key areas 'that matter'.

Monitoring of the 2025/6 Trust level improvement plan will be overseen by the People Committee and other forums such as the Executive Management Committee and Care Group Performance Review meetings. Local improvement plans will be monitored through local performance and governance structures.

Reporting high paid off-payroll arrangements

The Trust monitors, on a monthly basis, the reliance on off-payroll engagements by reviewing engagement costs more than £245 per day

Highly-paid off-payroll worker engagements as of 31 March 2026 earning £245 per day or greater

No. of existing arrangements as of 31 March 2026	38
Of which:	
Number that have existed for less than one year at time of reporting	3
Number that have existed for between one and two years at time of reporting	5
Number that have existed for between two and three years at time of reporting	8
Number that have existed for between three and four years at time of reporting	9
Number that have existed for four or more years at time of reporting	13

The Trust can confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual pays the right amount of tax and, where necessary, that assurance is being sought.

All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2026, for more than £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2025	409
Of which:	
Not subject to off-payroll legislation	
Subject to off-payroll legislation and determined as in-scope for IR35	409
Subject to off-payroll legislation and determined as out-of-scope for 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

The Trust has not engaged any individual without including contractual clauses allowing the Trust to see assurance as to their tax obligations.

For any off-payroll engagement 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 financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	0

Signed

James Blythe
Chief Executive Officer **Date: 1 July 2026**

NHS Foundation Trust Code of Governance

The Trust keeps its governance arrangements under regular review, including membership of Board committees, their terms of reference and Board performance assessments. The NHS Code of Governance, most recently revised in April 2026, is based on the principles of the UK Corporate Governance Code.

The Trust has assessed itself against the provisions of the NHS Code of Governance on a 'comply or explain' basis. In the few cases where the Trust has diverged from the recommended practice set out in the Code of Governance, it has made appropriate disclosures in this Annual Report and has provided explanations as to how its practices are consistent with the principle to which the provision in the NHS Code of Governance relates.

In March 2026, the Board carried out an assessment of its compliance with the NHS Foundation Trust Code of Governance and areas of non-compliance were reviewed by the Audit & Risk Committee. The Board noted that in each case, appropriate grounds for deviation from the code were duly considered and that all appropriate governance processes had been followed. The Trust offers the following disclosures in respect to the Code:

- Provision B2.5. This provision states that the Chair of the Audit & Risk Committee should not, ideally, hold one of the following positions: Deputy Trust Chair, Vice-Chair or Senior Independent Director (SID). Throughout the reporting period 1 April 2025 - 31 March 2026, the Chair of the Audit & Risk Committee has also held the position of Senior Independent Director. The Code does not explicitly prohibit the same individual from holding both posts and the current appointment was duly considered by the Governor Nominations and Remuneration Committee and approved by the Council of Governors. The Governors did not raise any objections or concerns.

- Provision B2.6. This provision notes that the independence of a non-executive director who has served more than six years in post may be impaired due to their length of service. The Trust's Constitution specifies that NEDs are appointed for three year terms of office. If a NED has held office for more than four years, any further appointment shall be for a term of one year. One Non-Executive director has service more than six years and an extension for a further one year term of office was approved by the Council of Governors Nominations & Remunerations Committee and approved by the Council.

- Provision C4.5 This provision notes that NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders. The format for NED appraisals published by NHS England has had feedback due to the complexity and Trusts were advised that a revised template would be issued in the future. Therefore, the Trust used its original template during 2025/26.

- Provision C4.2 The Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the Trust. Going forward, to achieve compliance with this provision, the Trust Secretary will discuss with the Chair of the Trust the need to conduct a Board skills audit.

Overall, the Board declares, that it is largely compliant with the majority of the provisions of the Code of Governance, that any deviations have been reasonably explained and disclosed as required.

Code Provision	Summary of Requirement	Location in Annual Report
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Statement of CEO and Chair Performance Analysis
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 annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Staff Report
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 with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Performance Overview
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior	Directors' Report Remunerations Report Board Register of Interests: Our Board of Directors - Royal Berkshire NHS Foundation Trust.

	employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Directors' Report
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors	Directors' Report
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	Staff Report
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Directors' Report

C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Directors' Report
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, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Director's Report
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served the gender balance of senior management and their direct reports.	Directors' Report Staff Report
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Directors' Report
D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee	Performance Analysis Accountability Report

	considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	
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, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Directors' Report
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Performance Overview Annual Governance Statement
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Annual Governance Statement
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the	Performance Analysis

	public sector. As a result, material uncertainties over going concern are expected to be rare.	
E 2.3	Where a trust releases an executive director, e.g. 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.	Remunerations Report – not applicable
Appendix B, para 2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Directors' Report
Appendix B, para 2.14	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Directors' Report
Appendix B, para 2.15	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Directors' Report.
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2) (aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. *Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). **As inserted by section 151 (6) of the Health and Social Care Act 2012).	The scenario did not present itself in 2025/26.

NHS Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to 1 of 5 'segments'. Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

- Its segment derived from scored metrics under 5 performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
- considering financial override which may limit a segment to be no better than 3
- contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality)
- capability assessments which consider the organisation's leadership and governance.

The Trust's position as at 31 March 2026 is in segment 3. It is ranked 34 out of 134 in acute trusts.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: NHS England » Segmentation and league tables

Statement of the Chief Executive's responsibilities as the Accounting Officer of the Royal Berkshire 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 Royal Berkshire 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 the Royal Berkshire 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 Officers Memorandum.

Signed

James Blythe
Chief Executive Officer **Date: 1 July 2026**

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 Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer's Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Royal Berkshire NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Royal Berkshire NHS Foundation Trust for the year ended 31 March 2026 and up to the date of the approval of the annual report and accounts.

Capacity to handle risk

The Trust has effective mechanisms in place to manage risk, in accordance with its risk management policy and strategy, supported by the Audit and Risk Committee, which has Board accountability.

The Board of Directors has overall responsibility for the management of risk within the Trust.

As Chief Executive, I am directly accountable to the Board of Directors in relation to the performance of the Trust. The operational authority and responsibility for risk management has been delegated for implementation to individual Directors (as set out below) who are supported by their own teams.

- Chief Finance Officer– financial, purchasing, business development and information governance
- Chief Medical Officer – clinical governance
- Chief Operating Officer – clinical services and objectives delivery
- Chief Nursing Officer– patient safety, patient experience, infection control, safeguarding, assurance, litigation and for the development and oversight of the Trust's strategic risk management processes, with support being provided by the Head of Risk for the Corporate Risk Register and the Trust Secretary for the Board Assurance Framework.
- Chief People Officer – human resources and organisational development and health and safety (during 2025/26)
- Chief Strategy Officer -organisational transformation and continuous improvement, capital developments
- Chief Digital Information Officer (reporting to the Chief Operating Officer) – IT infrastructure, security, support, data systems, hardware and software

- Director of Estates and Facilities (reporting to the Chief Strategy Officer) – the built environment, external estate, environment, travel, security and hotel support services

Risk management is embedded within the organisation in a variety of ways. It is included in all job descriptions and managers at all levels within the Trust have a responsibility to foster a culture of active risk management to improve operational performance and the safety of our patients and staff.

Each Directorate is responsible for maintaining and monitoring their own risk register, which contains key risks that can be escalated to their Care Board or Corporate equivalent risk register and ultimately, to the corporate risk register.

Trust employees are trained and supported to identify, assess and manage risks appropriate to their authority and duties. All those joining the Trust receive information, awareness and signposting on the induction day and then triennially through mandated refresher training. Additionally, Trust staff can access further information and guidance from the Risk Management Team and the Trust intranet.

The Trust seeks to learn from good practice internally through the monitoring of risks via the clinical and non-clinical governance structures, performance reports, audits, incident investigations, root cause analysis and safety programs and campaigns. Externally the Trust peer reviews its processes with other NHS organisations and implements guidance from the Institute of Risk Management and ISO 31000.

During 2025/26 the Trust's Board Assurance Framework process was included in the internal audit plan. The rating was 'significant assurance with minor improvement opportunities'

The Risk and Control Framework

Risk management can be guided by a framework, for successful implementation it requires collaboration, commitment, engagement and ownership from all staff within the organisation. The following documents highlight the advantages and encourage the identification and management of risk to improve the Trust's operational performance:

- **Risk Management Policy** – identifies the interlinking relationship of risks and the Trusts approach to risk management and provides the mechanism for identifying, assessing and monitoring risks
- **Board Assurance Framework** – provides a mechanism for the Trust Board to monitor strategic risks and their associated control assurance
- **Trust Risk Appetite Statement** – the Trust Board has identified the boundaries the organisation is willing to accept in pursuit of its objectives. The Trust recognises that the delivery of healthcare has inherent risks which cannot be removed and therefore seeks to mitigate and reduce its risk profile as far as is reasonably possible.
- **Centrally held electronic risk registers** – provides the Trust with the ability to monitor the escalation, de-escalation and reviewing of all its risks. Risks are reviewed at the Ward, Directorate, Care Group Management meeting and Trust Board levels

To facilitate a consistent approach to identifying, describing and managing risks, the Trust provides a grading matrix to ensure hazard, compliance, control and opportunity risks are consistently evaluated.

The work plan of the Board and its committees are aligned to ensure that there is independent and strategic focus on risks and assurance.

Public stakeholders are invited to the Trust Public Board where the corporate risk register is discussed and reviewed.

Organisational in Year Risks

The key risks to the delivery of the Trust's strategic objectives are identified in the Board Assurance Framework, with the key risks impacting on the operational performance being identified in the Corporate Risk Register.

The Corporate risks are reviewed at Integrated Risk Management Committee and updates provided to the Board sub-committees including People, Finance and Investment, Audit & Risk Committee, Quality Committee and Executive Management Committee. In addition, risks with specific focus (e.g. infection control or Safeguarding) are reviewed and discussed at the speciality committees including Health & Safety Committee, Infection Prevention and Control Committee, Fire Management and Assurance Group, Estates Management and Assurance Group.

At the end of 2025/26 the Trust identified the following as the key operational risks:

- **Fire Safety**

Due to ageing infrastructure and lack of ability to invest at the rate of deterioration in fire safety systems there are increased fire safety risks. Although these are operational they are obsolete and at high risk of failure. The requirements of the Building Safety Act 2022 mean that fire safety improvement works in Maternity are delayed by up to 12 months. It is currently taking up to 12 months for the Building Safety Regulator to approve projects after RIBA stage 4 plans have been submitted.

The risks are not currently fully mitigated and mitigations within operational control are in place with a focus on training, risk assessments and fire marshals.

A new Fire Safety Adviser was appointed in December 2025. Their initial risk review restates the known risk in Maternity Block, relating to lack of fire compartmentation and the likely loss of the building due to uncontrolled and rapid spread of fire, should a fire occur. As a result of the review a new corporate risk for Maternity Building was added in December 2025.

- **Maternity Block Fire Safety Risk**

Maternity Block is classified as a "high rise building" under the Building Safety Act 2022, as it is over 18m in height. The block was built in the1960's and whilst it met safety standards at the time, due to the age of the building, decades of refurbishment projects and alterations, along with recent changes in legislation, it now no longer meets basic fire safety standards.
The Trust received detailed reports which resulted in the fire safety risk in Maternity Block being added as a corporate risk.

The New Hospital Program deferral to a 2037 start date necessitates an urgent strategic shift towards a medium-to-long-term investment strategy for the existing estate

A Trust wide action plan is in place including replacement works, full building assessment of fire loads and relocation of clinical areas.

- **Management of Estates Infrastructure/Backlogged Maintenance**

The Trust's has an estate that has grown and developed over many years. For the Trust to deliver on its day to day business and strategic objectives, work is required across its estate to maintain the existing services, address a maintenance backlog and develop infrastructure to support the delivery of its strategic objectives. Current cash and Capital Dividend Expenditure Limit (CDEL) 'affordability does not enable the Trust to significantly mitigate this risk.

National Estates Safety Funding (Critical Infrastructure Risk (CIR) Funding) funding was awarded for) for 2025/26 to reduce backlog maintenance, and the Trust was successful in being awarded an additional £7m for CIR and those works are currently underway and a four year capital plan has been developed.

- **Risk of Cyber-Attack**

Cyber security incidents in the NHS can critically undermine patient care by compromising the confidentiality, integrity, and availability of vital information systems and data. The Trust has a risk of unauthorised access to medical records, inaccurate clinical information potentially compromising diagnosis and treatment decisions and impacting on care. Ensuring adherence to Data Security & Protection Toolkit (DSPT) standards and maintaining robust cyber defences is essential to safeguarding the seamless delivery of patient services and protecting the public's confidence in healthcare systems. The Trust will move to Windows 11 in 2026/27 by October 2026.

- **New Hospital**

The Building Berkshire Together (BBT) New Hospital Programme's planned construction start date has moved from the original target of May 2031 (programme initiation) to the revised date of January 2037 (programme initiation). This extended timeline increases the risk of political and funding uncertainties, with two potential government changes before construction begins. Shifts in political priorities could result in reduced or withdrawn funding, further delays, or even a complete halt to the programme. The risk reflects the increased exposure to external political and funding uncertainty arising from the extended programme timeline, which could impact the delivery, scope or viability of a key strategic investment for the Trust. It represents a critical enabler of the Trust's future estate and service model.

- **ED Capacity & Compliance**

The risk of the Emergency Department having insufficient capacity to treat high volume of patients within the 4hour quality standard target. Consequences include increased risk of harm to patients as well as reputational risk if the 78% standard is not met in March 2026. During 2025/26 the Trust achieved a more consistent performance and new frailty Same Day Emergency Care (SDEC) area was implemented.

The Board Assurance Framework

The Board Assurance Framework provides the mechanism for the Board to monitor risks, controls and the assurances that controls are effective. The Board recognises the importance of the Board Assurance Framework in mitigating the Trust's strategic risks. During 2025/26 the Board Assurance Framework was reviewed by the Board and sections reviewed by the relevant Board sub-committees.

The Board has identified the following strategic risks on the Board Assurance Framework:

- If we allow material lapses in the quality of care, including access to care, the Trust will not meet its regulatory standards for quality and safety

- If we do not deliver our clinical and quality ambitions at the intended pace we will lose opportunities to improve patient outcomes and experience

- If we do not recruit and retain a competent workforce we will fail to deliver on the Trust's strategic objectives

- If we fail to uphold our Values (CARE and Diversity & Inclusion) the Trust will not be an employer of choice or considered an exemplar organisation for staff

- If our partners at Place and System fail to deliver operationally there is a risk that the Trust will not deliver against NHS Constitutional standards

- If Berkshire West Place and Thames Valley ICS plans and programmes do not deliver the envisaged improvements in care and value, the Trust's financial and operational performance will be impacted

- If we do not realise the opportunities presented by our strategic partnership with University of Reading (UoR) we will not deliver on our education, training and research ambitions

- If we do not continue to invest in digital infrastructure and development we will not be able to deliver Our Strategy and our Clinical Services Strategy and we will face challenges in running a modern efficient healthcare service

- If we fail to realise benefits/secure commercial advantage from innovation and digital investments we will face income shortfalls and will not to be able to deliver our efficiency targets

- If the organisation does not generate sufficient cash to meet its day to day liquidity requirements and capital programme the organisation will fail

- If we do not robustly represent the organisation in national and regional and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System decision making, we will fail to secure sufficient income to deliver Improving Together and strategic objectives

- If we do not create and maintain a built environment suitable for current and future needs, we risk delivery of Our Strategy: Improving Together

- If we do not take action on sustainability agenda we risk impact on the Trust's reputation

- If we do not create and maintain a built environment suitable for current and future needs, we risk delivery of Our Trust Strategy

- If the Trust is not successful in converting the future promise of a new hospital and bring it to fruition sooner than 2040, we risk the ability to deliver on our mission over the long term

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. The register and Trust's Declarations of Interest, Gifts and Hospitality policy is available on the Trust website.

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights are complied with. The foundation trust has undertaken risk assessments and has plans in place which take account of the '*Delivering a Net Zero Health Service*' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

As of 31 March 2026, the Trust was fully compliant with the registration requirements of the Care Quality Commission (CQC) and did not have any regulatory notices from the CQC.

Compliance with the NHS Provider Licence Section 4 (Governance)

The NHS Provider Licence forms part of the oversight arrangements for the NHS and sets out the conditions that providers of NHS-funded healthcare services in England must meet to ensure it is working effectively for the benefit of patients.

Condition 4 relates to the governance arrangements of a Foundation Trust to enable the Board of Directors to effectively discharge its duties. The Trust has assessed its compliance against the provisions and is assured that it is compliant with the requirements.

In 2025/26, the Trust had the following processes in place which:

- enabled the Board to review and mitigate against risks and to monitor its strategic direction and progress in achieving agreed outcomes
- supported the Non-Executive Directors in their scrutiny and challenge of Executive management action
- maximised the value of Non-Executive Directors' time
- supported the Board's assessment of evidence to enable the Board to make evidence-based unitary decisions
- ensured the timely and accurate submission of information to relevant external stakeholders when required.

These processes are supported by five Board Sub-Committees: Audit & Risk, Finance & Investment, People, Quality and Charity. Each of these committees undertake an annual review of their performance, effectiveness and constitution, in accordance with their Terms of Reference. These annual reviews of effectiveness are submitted to the Board of Directors.

For the reporting period 1 April 2025 – 31 March 2026, the Board considered that it was largely compliant with the NHS Code of Governance and any deviations from the best practice recommendations were duly considered and outweighed the benefits of full compliance. The Board does not consider the nature of the deviations to impact on the Trust's overall compliance with Section 4 (Governance) of the NHS Provider Licence.

Compliance with Developing Workforce Safeguards recommendations

People Strategy 2023 – 2027

The Trust Board approved a new People Strategy in May 2023 that sets out the priorities and plans for 2023-2027. Building on the success of our first people strategy, the new strategy recognises that the things that were important in the first strategy, remain so. Our aim is to further grow our ambitions with regards to our workforce in pursuit of our aim to be one of the best places to work in the NHS.

This sentiment is encapsulated in the 5 Ambition Themes within the current strategy:

- **Experience**: a place where people want to work, stay and grow whose experience at work is ranked amongst the top 10% in the NHS;
- **Learning**: a place where everyone fulfils their potential, we work with our partners to deliver opportunities for people to learn and grow their skills;
- **Health and Wellbeing**: To enable all our people to live a healthy, active and fulfilling lives by investing in their wellbeing
- **Inclusion:** An inclusive culture that celebrates and drives the power of diversity as a source of strength
- **Future**: We enable our people and services to work differently and create a sustainable and flexible workforce to meet future service needs

Our operating environment remains challenging with ever increasing demands on our services and our people. Coupled with significant challenges in our external environment and their impacts on our people – it is more important than ever that we focus on how we support, develop, motivate and grow our staff. We recognise the need to continue and elevate our focus on 'experience at work' in its broadest sense as a fundamental enabler of driving retention, responding to evolving expectations and demands of work and nurturing our staff as part of the RBFT family.

Despite our good progress with regards to inclusion, to accelerate our improvements we recognise a need for sharper, more deliberate focus on EDI and we understand that our operating context requires further focus on staff Health and Wellbeing and Learning and Development. Our focus on the future recognises our need to respond to workforce supply, demand, productivity and transformation challenges through development, planning, innovation and partnerships in pursuit of the ambitions set out in the Trust Clinical Services Strategy.

People Committee

The Board People Committee is responsible for identifying and monitoring key risks to ensure that they are appropriately included in the Board Assurance Framework. The Committee monitor workforce metrics, review areas of concern and report issues and plans to address them to the Board. The Committee request and review reports and positive assurances from executives (directors and managers) on the overall arrangement for Human Resources, workforce planning and learning and development. The Committee is also responsible for the scrutiny of systems and controls to ensure statutory and regulatory standards regarding workforce are met. The Committee capture and review the views of staff via relevant staff engagement mechanisms and develop effective strategies to respond to feedback. The Committee also supports the development and implementation of the People strategy to ensure strategic priorities are being addressed.

Other workforce safeguards

The Trust also ensures compliance with workforce safeguards through the following:

- Workforce planning in line with predicted activity and financial resources
- Close monitoring of relevant workforce metrics to ensure the timely production of business cases and application of strategies to close potential workforce shortfalls
- Monitoring of workforce metrics to ensure safe staffing levels
- The development and implementation of People strategies and initiatives to support the recruitment and retention of staff
- The development and implementation of the Retention and Recruitment team to support new starts and carry out Stay Conversations at 4 and 8 months' post start in post

- A nominated Freedom to Speak Up Guardian (who reports in to the Audit & Risk Committee) to provide independent and confidential support to staff that want to raise concerns and to promote a culture in which staff feel safe to raise those concerns without fear of retribution
- A nominated Guardian of Safe Working (who reports in to the People Committee) to ensure that issues of compliance with safe working hours are addressed in line with junior doctor contracts
- Ongoing monitoring of training requirements via annual appraisals and revalidation, staff development review and Mandatory and Statutory Training reporting.
  E-rostering for nursing and medical staff to ensure optimum efficiency taking into account patient acuity.

As an employer with staff 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. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Emergency Preparedness, Resilience and Response

In line with its statutory obligations under the Civil Contingencies Act 2004, the Trust has in place arrangements for EPRR (Emergency Preparedness, Resilience and Response). We undertake joint emergency planning with healthcare partners, local authorities and other emergency services. This work is undertaken through regional and local forums such as the Thames Valley Local Health Resilience Partnership and the Berkshire Resilience Group.

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services. This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).

NHS England has published NHS Core Standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. Assessment against the Core Standards takes place annually and the Accountable Emergency Officer in each organisation is responsible for making sure these standards are met. The designated Accountable Emergency Officer for the Trust is the Chief Operating Officer.

The assurance process requires provider organisations to undertake a self-assessment and rate their compliance against 69 core standards relevant to their organisation type. These individual ratings will then inform the overall organisational rating of compliance and preparedness, which provider organisations are required to take to a public Trust Board meeting and also publish in their Annual Report.

For assurance purposes in 2025/26, the Trust was rated **fully compliant**. Out of the 62 core standards applicable to acute health trusts, the Trust was fully compliant with all 62 standards for a second consecutive year.

NHS England– EPRR Assurance Compliance Levels

To support a standardised approach to assessing an organisation's overall preparedness rating, NHS England and NHS Improvement have set the following criteria:

Organizational rating	Criteria
Fully compliant	The organisation is fully 100% compliant with 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

The EPRR team will continue 'horizon scanning' and maintaining the EPRR Risk Register, which is influenced by the National and Community Risk Registers, to support the Trust in its anticipation of and response to events and incidents which might affect delivery of essential services.

EPRR Statement of Compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

A letter from NHS England dated 1 July 2025 informed all NHS trusts of the assurance process for 2025/26.

The Trust's EPRR assurance compliance level is: **fully compliant.**

Review of economy, efficiency and effectiveness of the use of resources

The Trust applies its Improving Together Methodology as the principal means of securing economic, efficient and effective use of resources. This approach centres on the performance review cycle and is supported by the Efficiency and Productivity Committee, established in 2023/24, which provides structured oversight of our cost improvement and efficiency programmes.

Monthly performance review meetings with the Trust Executive assess performance against our breakthrough priorities and driver metrics. Where variation from expected performance is identified, remedial plans are agreed and tracked. These structures are being rolled out trust-

wide, ensuring a consistent approach to identifying and addressing variation, and enabling the organisation to recognise and spread best practice.

The Improving Together Programme underpins the development of the Integrated Performance Report, received by the Board of Directors. Internal Audit is directed towards areas of concern or identified scope for improvement, with findings and associated actions reported to the Audit and Risk Committee and the Executive Management Committee.

Long-term financial sustainability is recorded as a strategic risk on the Board Assurance Framework (Strategic Objective 5) and the Corporate Risk Register. The Trust's external auditors reported a significant weakness in the Trust's arrangements to secure financial sustainability in 2024/25, noting that the cost improvement programme was largely achieved through non-recurrent measures. We take this assessment seriously.

In response to the 2024/25 findings, the Efficiency and Productivity Committee provided direct oversight of the 2025/26 Efficiency Savings programme, with a particular focus on ensuring the robustness and recurrence of Cost Improvement Programmes. In parallel, the Internal Financial Turnaround programme worked to build a credible, deliverable and recurrent programme of work to reduce the cost base and support long-term financial sustainability. The improvements achieved in 2025/26 demonstrate the early impact of this approach.

However, the external auditors' significant weakness finding for 2025/26 highlights that financial pressures persist. While the Trust's submitted financial plan for 2026/27 shows an ambitious surplus position, significant challenges remain in achieving this. Arrangements are being refreshed and implemented to deliver the planned savings of £43.7m for 2026/27, including enhanced tracking and monitoring. The financial plan still requires £8.9m of non-deficit support funding to achieve this position. Furthermore, liquidity and funding remain critical concerns, with the Trust projecting a cash position of £1.6m at 31 March 2027. This underscores the continued significant financial pressure on the Trust, requiring both improved performance and additional funding to support operations. The Board remains committed to addressing these challenges through robust financial management and strategic planning.

To ensure economic, efficient, and effective use of resources, the Trust applies its Improving Together Methodology. The principal processes of this, centre on the performance review cycle, and is supplemented by the Efficiency and Productivity Committee that was established in 2023/24. Consideration is given at this Committee to economic, efficient, and effective use of resources as part of our plan to reduce the underlying deficit of the organisation.

The Performance Review Cycle includes monthly performance review meetings with the Trust Executive, in which performance is reviewed against each of our breakthrough priorities and driver metrics. Variation from expected performance is discussed and remedial plans agreed.

These structures form part of the overarching Improving Together Programme which is being rolled out trust wide. This Programme allows the organisation to recognize best practice and areas for improvement, and the roll-out ensures consistency in approach to identifying and developing solutions to variation from expected performance.

The Improving Together Methodology includes the development of the Integrated Performance Report, which the Board of Directors receives. Internal Audit is targeted at areas where we believe we have concerns or scope for improvement, and the findings and associated actions are reported back to the Audit and Risk Committee and Executive Management Committee which oversees delivery.

Information Governance

The Trust is committed to encouraging all staff to report all incidents and issues, and to proactively partake in the learning exercises as a result of these. This is irrespective of the severity of the issues – it is a community responsibility to engage and make improvements where possible. Over the last year, we have seen an increase in the number of reported issues and incidents showing that staff are engaged with this approach. Our commitment to improving the awareness of Information Governance has shown good results, and we look forward to building on this engagement in the future. In all instances where a report has been made, this report has been investigated and actions have been taken to prevent further occurrences.

During 2025-2026, the Trust reported one incident externally via the Data Security and Protection Toolkit. No further action was taken by the Information Commissioners Office (ICO) as appropriate processes had been followed by the Trust in terms of responding to this incident. The Trust is committed to performing learning exercises, and the wider staff community was informed of the findings where necessary. To date, the Trust has not been levied a fine, enforcement notice or undertaking for breaching data protection legislation or regulatory requirements.

The Trust obtained the 'Standards met' accreditation for its 2024-2025 Data Security and Protection Toolkit. Our 2025-2026 Data Security and Protection Toolkit baseline assessment was submitted on 19 December 2025. We are expected to attain the minimum standards set by NHSE for all 47 outcomes.

The Trust is also committed to ensuring that the requirement for Data Protection Impact Assessments (DPIAs) is fulfilled. DPIA's are a legal requirement and help to build an accurate record of information processing across the Trust and help inform multi-disciplinary decision making with regard to digitalisation and transformation. In 2025/26 as part of our Improving Together plan, we completed a review of our DPIA process that resulted in updating our template to explicitly include a section around the use of any artificial intelligence along with setting our DPIA turnaround timeframe to 10 working days. In 2025-2026 the Trust performed more than 127 of these assessments.

Data security and protection incidents are reported to the Information Governance Steering Group (IGSG) which is chaired by the Caldicott Guardian, and to which both the Data Protection Officer (DPO) and Senior Information Risk Owner (SIRO) attend. The IGSG helps to steer the efforts of training and compliance for Information Governance across the Trust.

Data Quality and Governance

In 2025/26 the Royal Berkshire NHS Foundation Trust took the following actions to improve Data Quality:

- The Data Quality team delivers comprehensive support to users across all modules of the Electronic Patient Record. Their responsibilities include overseeing data clean-up processes for operational, reporting, and information functions. The service resolves an average of 255 Data Quality tickets per month, consistently achieving the team's target Service Level Agreement (SLA).
- Overseeing and escalating compliance concerns related to the DQMI (Data Quality Maturity Index) national assessment.
- Monitoring and escalating compliance concerns on the Commissioning Data Sets Data Quality Dashboards.

- Collaborated with the Performance team to clean up waitlists. Ongoing monitoring and maintenance are in place, with user support and feedback ensuring improved waitlist data.
- Enhancing the visibility of DQ indicators and standards among senior management and the executive team by regularly presenting the Trust-level Data Assurance Framework dashboard at meetings for ongoing review, monitoring, and action.
- Responsible for overseeing and monitoring a suite of 40 Data Quality KPIs, proactively escalating issues, formulating corrective actions, and developing new KPIs as necessary.
- Audits were performed throughout the year, reviewed by the DQSG (Data Quality Steering Group) and DQAG (Data Quality and Assurance Group) recommendations made for areas of particular data quality concern.
- Collaboration with the Information team to maintain high data quality SUS (Secondary Uses Service) returns.
- Continuous support and improvement of Maternity Services Data Set (MSDS) in line with developments in national requirements throughout the year. 25/26 included working with the Maternity team in resolving data-related issues with Booking assessments.
- DQA Risks and Issues log maintained, reviewed and actioned by DQSG/DQAG.
- ISNs (Information Standard Notices) received from NHSE/Digital are collated, reported and monitored by DQSG/DQAG and escalated if necessary to DSG.
- Perform monthly data quality audits including Oracle's non-elective inpatient audit, Radiology Day Case capture, reviews of patients without NHS numbers, and inpatient length of stay assessments.
- Supported the Income Recovery Programme, with a focus on correct reporting of National Interim Clinical Imaging Procedures and activity capture for Interventional Radiology procedures.
- Review and update of Outpatient Outcomes M-pages in partnership with relevant services.
- Supported Medisoft to Medisight project with data catch-up initiatives.
- Conducted monitoring, analysis, and reporting of ethnicity data capture and Outpatient outcomes usage to services.
- Monitor, evaluate, and implement actions based on the Hospital Episode Statistics (HES) Data Quality Report.

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 and the Executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit & Risk and Quality Committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have been specifically informed on the effectiveness of the system of internal control and the validity of the Corporate Governance Statement by the:

- Trust Board: through the regular review, adoption and approval of the Trust Corporate Risk Register, the ‘Quality and Patient Safety reports’ and the ‘Integrated Performance reports’.
- Audit and Risk Committee: through internal and external audit, reviewing the adequacy of internal control systems designed to minimise risk. The Committee also ensures overall

co-ordination of risk management and monitors action plans to address risks identified in the Trust Corporate Risk Register.
- Quality Committee: ensuring the effective working of clinical governance, both corporately and at care group level, including clinical audit and risk management. It also reviews reports on the quality assurance process that demonstrate effectiveness and improvements in the quality and safety of our care for patients.

My review is also informed by the Internal Audit annual conclusion for 2025/26. Their annual conclusion covers four key components: Governance, Risk Management, Financial Reporting and Management, and Data Capture and Use by the organisation.

Based on the controls reviewed, the following conclusions were drawn:

- Governance: Amber-Red
- Risk Management: Amber-Green
- Financial Reporting and Management: Amber-Green
- Data Capture and Use by the organisation: Amber-Green

The 'Amber-Red' rating for Governance highlights areas where the effectiveness of control design and operation requires focused attention. Management has acknowledged these findings and has developed specific action plans to address the identified weaknesses in governance. These plans are being actively implemented and their progress is subject to ongoing monitoring by the Audit and Risk Committee to ensure continuous improvement in our control environment.

The Board is committed to quality governance and ensures that the combination of structures and processes at every level throughout the Trust support quality performance.

During 2025/26 the Trust had one Care Quality Commission (CQC) inspection - the Nuclear Medicine Department at the Royal Berkshire Hospital had a CQC Ionising Radiation (Medical Exposure) Regulations (IR[ME]R) inspection on 5 July 2025. On the basis that the Nuclear Medicine Department's Employer's Procedure was out-of-date and did not include a statutory IR(ME)R update, an Improvement Notice was issued by the CQC.

On 18 November 2025 the CQC informed the Trust that the evidence submitted had led to the CQC concluding that the Trust had complied with the conditions of the Improvement Notice and that the Improvement Notice would be closed. An on-site visit to the Nuclear Medicine Department took place on 2 March 2026 resulting in notification by the CQC that the inspection process was closed. IR[ME]R inspections are not given ratings, and the report is not published.

In terms of the Trust's engagement with CQC inspections of local authority partners, in March 2025, the Trust participated in a Joint Targeted Area Inspection focusing on unborn and children's experience who were victims of domestic abuse. The local authority was Reading Borough Children's services and included police, probation and all health services. In January 2026 the Trust took part in the Wokingham, Joint Local Area SEND Ofsted/CQC inspection of its services. We await the final report and continue to work with the partnership on improvements to our services.

The Trust continues to participate in quarterly engagement meetings with the CQC. The engagement meeting in February 2026 included focussed visit to departments within the children and young people's service at the Royal Berkshire Hospital site resulting in positive feed-back about the service.

The Trust continues to respond to enquiries raised by the CQC from additional intelligence streams such as Learning from Patient Safety Events (LFPSE) portals, the CQC public enquiry

function and general CQC enquires. In the period 1 April 2025 – 31 March 2026, the Royal Berkshire NHS Foundation Trust received 27 enquiries from the CQC. Within it the same period it proactively reported CQC notifications and issues of importance to the CQC.

The Quality Governance Committee is now fully established within the Trust's governance structure, with strong engagement from director-led subcommittees. Agreed reporting templates are consistently used, providing a clear and structured route for escalation. Matters are escalated via the Quality Committee and Executive Management Committee through a consolidated summary report, ensuring clear reporting lines and accountability. The effectiveness of clinical governance processes continues to be reviewed annually through the Trust's audit programme.

The Trust's workforce strategies include robust plans to ensure the Trust can manage short, medium and long-term workforce issues. The Trust is compliant with the recommendations made in the *Developing Workforce Safeguards*' (2018) in terms of establishment setting processes for nursing and Allied Healthcare Professional (AHP) workforce planning.

A bi-annual triangulated approach is utilised using the evidenced based workforce planning Safer Nursing Care Tool (SNCT 2013) for nursing with a similar approach for AHP's, using professional guidance where applicable. Daily staffing is managed using an Opel status framework with escalation from ward to board via a new workforce report. A system of red flag reporting which aligns to the NICE guidance 2014 is used to escalate any staffing concerns.

Conclusion

This report sets out an open and balanced reflection of the Trust's progress over the past year. The Board and Executive have a clear understanding of the issues facing the Trust and the work they must focus on during the 2025/26 financial year, including to address the risks to the Trust's financial sustainability.

There were no significant internal control issues that were identified during 2025/26.

Signed

James Blythe
Chief Executive Officer **Date: 1 July 2026**

Royal Berkshire NHS Foundation Trust

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

Royal Berkshire NHS Foundation Trust

Consolidated Financial Statements for the year ended 31 March 2026

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Independent auditor's report to the board of governors and board of directors of Royal Berkshire NHS Foundation Trust

Report on the audit of the financial statements

Opinion
In our opinion the financial statements of Royal Berkshire NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2026 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the group and foundation trust statements of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in equity;
- the group and foundation trust statements of cash flows; and
- the related notes 1 to 31.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

Basis for opinion
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern
In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the foundation trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of

irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

We considered the nature of the group and its control environment, and reviewed the group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit and local counter fraud about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

We obtained an understanding of the legal and regulatory framework that the group operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists, such as real estate and IT, regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud or non-compliance with laws and regulations in the following areas, and our specific procedures performed to address them are described below:

- determination of whether an expenditure is capital in nature: this determination is subjective. To address the risk of misstatement, we tested a sample of expenditure transactions to assess whether they meet the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure is recognised in the correct accounting period.
- recognition of accrued income: there is an inherent risk that revenue recorded, particularly for services yet to be settled by commissioners, may not be valid, accurate, or appropriately valued. This risk is heightened by the complex nature of NHS contracts, the reliance on estimates, the potential for disputes and the control environment in this area at the Trust. We tested accrued income on a sample basis and evaluated its compliance with relevant accounting requirements; we assessed mismatches reported within the agreement of balances process performed by NHS bodies.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006 in all material respects; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

In our audit report dated 30 June 2025 on the 2024/25 financial statements, we reported a significant weakness in the foundation trust's arrangements to secure financial sustainability. The significant weakness reported was in how the foundation trust identifies and manages risks to financial resilience such as from unplanned cost pressures, and plans to bridge its funding gaps and identify achievable savings. The Trust has made improvements against the prior-year recommendations, however, the weakness has not yet been fully addressed. Our recommendations for improvement included:

- Improve contract management procedures to prevent future unplanned shortfalls, including proactively monitoring, agreeing and finalising contractual arrangements early, regular reviews with the counterparties, and clear escalation pathways for addressing potential issues.
- Develop more accurate and detailed cost forecasts, incorporating realistic assumptions and contingency planning for unforeseen circumstances. Implement enhanced monitoring mechanisms to track actual costs against budget throughout the year, enabling timely intervention and corrective action.
- Develop a funding strategy to reduce reliance on short-term funding solutions and work towards developing a medium-term plan that shows that the Trust is self-sustainable, not requiring additional liquidity funding from other NHS bodies.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

As at the date of this audit report, we have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Royal Berkshire NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Royal Berkshire NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by

law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Stephen Turner

For and on behalf of Deloitte LLP

Appointed Auditor

London, United Kingdom

1 July 2026

FOREWORD TO THE CONSOLIDATED FINANCIAL STATEMENTS

Royal Berkshire NHS Foundation Trust

These consolidated financial statements for the year ended 31 March 2026, have been prepared by Royal Berkshire NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) of the National Health Service Act 2006.

Signed ……

James Blythe
Chief Executive Officer
1 July 2026

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2025/26	2024/25 Restated*	**2025/26**	2024/25 Restated*
	Note	**£000**	£000	**£000**	£000
Operating income from patient care activities	3	**667,496**	615,663	**667,496**	615,663
Other operating income	4	**47,083**	45,293	**46,789**	46,091
Operating expenses	6	**(717,475)**	(694,798)	**(716,222)**	(696,235)
Operating deficit from continuing operations		**(2,896)**	(33,842)	**(1,937)**	(34,481)
Finance income	10	**1,942**	2,135	**2,429**	2,686
Finance expenses	11	**(1,523)**	(966)	**(2,007)**	(1,588)
PDC dividends payable		**(9,659)**	(9,392)	**(9,659)**	(9,392)
Net finance costs		**(9,240)**	(8,223)	**(9,237)**	(8,294)
Other losses	12	**(213)**	(435)	**(213)**	(435)
Corporation tax expense		**(758)**	(788)	**-**	-
Deficit for the year		**(13,107)**	(43,288)	**(11,387)**	(43,210)
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	**(1,758)**	(1,024)	**(1,512)**	(1,327)
Revaluations		**3,353**	825	**3,206**	842
May be reclassified to income and expenditure when certain conditions are met:					
Fair value losses on financial assets mandated at fair value through OCI	18	**(3)**	-	**-**	-
Total other comprehensive income/(expense) for the period		**1,592**	**(199)**	**1,694**	**(485)**
Total comprehensive expense for the period		**(11,515)**	**(43,487)**	**(9,693)**	**(43,695)**

* Restated as per Note 29 Prior Period Adjustments

None of the other comprehensive income and expense would be reclassified to surplus and deficit.

All income and expenditure are derived from continuing operations.

The accompanying notes on pages 15 to 66 form part of these financial statements.

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025 Restated*	**31 March 2026**	31 March 2025 Restated*
	Note	**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	13	**13,704**	18,318	**13,704**	18,318
Property, plant and equipment	14	**334,290**	320,458	**296,290**	284,420
Right of use assets	15	**44,471**	50,114	**53,939**	61,493
Other investments / financial assets	18	**17**	20	**10,600**	10,600
Receivables	19	**1,836**	1,664	**17,061**	17,505
Total non-current assets		**394,318**	390,574	**391,594**	392,336
Current assets					
Inventories	17	**8,706**	8,215	**8,706**	8,215
Receivables	19	**35,039**	27,614	**38,754**	29,576
Cash and cash equivalents	20	**30,415**	13,518	**24,391**	7,056
Total current assets		**74,160**	49,347	**71,851**	44,847
Current liabilities					
Trade and other payables	21	**(97,289)**	(79,437)	**(94,980)**	(78,803)
Borrowings	23	**(9,555)**	(9,433)	**(12,890)**	(10,534)
Provisions	24	**(388)**	(4,170)	**(388)**	(4,170)
Other liabilities	22	**(5,949)**	(6,088)	**(5,949)**	(6,088)
Total current liabilities		**(113,181)**	(99,128)	**(114,207)**	(99,595)
Total assets less current liabilities		**355,296**	340,792	**349,238**	337,588
Non-current liabilities					
Trade and other payables	21	**(1,077)**	(969)	**-**	-
Borrowings	23	**(37,802)**	(44,334)	**(47,300)**	(58,400)
Provisions	24	**(919)**	(1,034)	**(919)**	(1,034)
Total non-current liabilities		**(39,798)**	(46,337)	**(48,219)**	(59,434)
Total assets employed		**315,498**	294,455	**301,019**	278,154
Financed by					
Public dividend capital		**300,321**	267,763	**300,321**	267,763
Revaluation reserve		**69,512**	69,943	**66,441**	66,775
Income and expenditure reserve		**(57,440)**	(46,342)	**(65,743)**	(56,384)
Charitable fund reserves	16	**3,105**	3,091	**-**	-
Total taxpayers' equity		**315,498**	294,455	**301,019**	278,154

* Restated as per Note 29 Prior Period Adjustments

The Financial Statements on pages 9 to 14 were approved by the Board on 24 June 2026 and signed on its behalf by

James Blythe
Chief Executive Officer
1 July 2026

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

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025- brought forward - Restated*	**267,763**	**69,943**	**(46,342)**	**3,091**	**294,455**
Surplus/(deficit) for the year	-	-	(14,125)	1,018	**(13,107)**
Other transfers between reserves	-	(2,038)	2,038	-	**-**
Impairments	-	(1,758)	-	-	**(1,758)**
Revaluations	-	3,365	-	-	**3,365**
Revaluations and impairments - charitable fund assets	-	-	-	(12)	**(12)**
Fair value losses on financial assets mandated at fair value through OCI	-	-	-	(3)	**(3)**
Public dividend capital received	32,558	-	-	-	**32,558**
Other reserve movements charitable fund consolidation adjustment	-	-	989	(989)	**-**
Taxpayers' and others' equity at 31 March 2026	**300,321**	**69,512**	**(57,440)**	**3,105**	**315,498**

* Restated as per Note 29 Prior Period Adjustments

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**250,806**	**72,336**	**(5,939)**	**3,782**	**320,985**
Surplus/(deficit) for the year (Restated*)	-	-	(43,921)	633	**(43,288)**
Other transfers between reserves	-	(2,114)	2,114	-	**-**
Impairments	-	(1,024)	-	-	**(1,024)**
Revaluations	-	851	-	-	**851**
Revaluations and impairments - charitable fund assets	-	-	-	(26)	**(26)**
Transfer to retained earnings on disposal of assets	-	(106)	106	-	**-**
Public dividend capital received	17,666	-	-	-	**17,666**
Public dividend capital repaid	(709)	-	-	-	**(709)**
Other reserve movements charitable fund consolidation adjustment	-	-	1,298	(1,298)	**-**
Taxpayers' and others' equity at 31 March 2025 - Restated*	**267,763**	**69,943**	**(46,342)**	**3,091**	**294,455**

* Restated as per Note 29 Prior Period Adjustments

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

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward - Restated*	**267,763**	**66,775**	**(56,384)**	**278,154**
Deficit for the year	-	-	(11,387)	**(11,387)**
Other transfers between reserves	-	(2,028)	2,028	**-**
Impairments	-	(1,512)	-	**(1,512)**
Revaluations	-	3,206	-	**3,206**
Public dividend capital received	32,558	-	-	**32,558**
Taxpayers' and others' equity at 31 March 2026	**300,321**	**66,441**	**(65,743)**	**301,019**

* Restated as per Note 29 Prior Period Adjustments

Trust Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**250,806**	**69,480**	**(15,394)**	**304,892**
Deficit for the year (Restated*)	-	-	(43,210)	**(43,210)**
Other transfers between reserves	-	(2,114)	2,114	**-**
Impairments	-	(1,327)	-	**(1,327)**
Revaluations	-	842	-	**842**
Transfer to retained earnings on disposal of assets	-	(106)	106	**-**
Public dividend capital received	17,666	-	-	**17,666**
Public dividend capital repaid	(709)	-	-	**(709)**
Taxpayers' and others' equity at 31 March 2025 - Restated*	**267,763**	**66,775**	**(56,384)**	**278,154**

* Restated as per Note 29 Prior Period Adjustments

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

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

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 1.3.

Statements of Cash Flows

		Group		Trust	
		2025/26	2024/25	**2025/26**	2024/25
	Note	**£000**	£000	**£000**	£000
			Restated*		Restated*
Cash flows from operating activities					
Operating deficit		**(2,896)**	(33,842)	**(1,937)**	(34,481)
Non-cash income and expense:					
Depreciation and amortisation	6	**35,141**	35,777	**36,085**	36,721
Net impairments	7	**11,187**	11,926	**9,086**	11,999
Income recognised in respect of capital donations	4	**(1,733)**	(35)	**(2,722)**	(834)
(Increase) / decrease in receivables and other assets		**(7,165)**	5,008	**(8,750)**	10,767
(Increase) / decrease in inventories		**(491)**	774	**(491)**	774
Increase / (decrease) in payables and other liabilities		**13,072**	(2,005)	**12,288**	(753)
Increase / (decrease) in provisions		**(3,907)**	2,525	**(3,907)**	2,525
Movements in charitable fund working capital		**(519)**	210	**-**	-
Tax paid		**(758)**	(804)	**-**	-
Other movements in operating cash flows		**(852)**	(609)	**-**	-
Net cash flows from operating activities		**41,079**	18,924	**39,652**	26,718
Cash flows from investing activities					
Interest received		**1,805**	1,945	**2,429**	2,686
Purchase of intangible assets		**(3,964)**	(2,902)	**(3,964)**	(2,902)
Purchase of PPE and investment property		**(35,567)**	(40,968)	**(31,508)**	(39,447)
Receipt of cash donations to purchase assets		**1,733**	-	**1,733**	-
Net cash flows used in investing activities		**(35,993)**	(41,925)	**(31,310)**	(39,663)
Cash flows from financing activities					
Public dividend capital received		**32,558**	17,666	**32,558**	17,666
Public dividend capital repaid		**-**	(709)	**-**	(709)
Movement on loans from DHSC		**(1,502)**	(1,502)	**(1,502)**	(1,502)
Capital element of lease liability repayments		**(8,072)**	(7,583)	**(10,406)**	(9,791)
Interest on loans		**(106)**	(170)	**(106)**	(171)
Other interest		**(11)**	(23)	**-**	(23)
Interest paid on lease liability repayments		**(1,414)**	(790)	**(1,909)**	(1,414)
PDC dividend (paid) / refunded		**(9,642)**	(9,180)	**(9,642)**	(9,180)
Net cash flows from / (used in) financing activities		**11,811**	(2,291)	**8,993**	(5,124)
Increase / (decrease) in cash and cash equivalents		**16,897**	(25,292)	**17,335**	(18,069)
Cash and cash equivalents at 1 April - brought forward		**13,518**	38,810	**7,056**	25,125
Cash and cash equivalents at 31 March	20	**30,415**	13,518	**24,391**	7,056

* Restated as per Note 29 Prior Period Adjustments

NOTES TO THE ACCOUNTS

1 Accounting policies and other information

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, intangible assets, inventories and certain financial assets and financial liabilities.

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 (FReM), defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

After reviewing the Trust's financial forecasts and cashflow projections for a period of at least 12 months from the date of approval of these financial statements, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future.

As set out in Note 29, during 2025/26 the Trust identified a material prior period error relating to the over-recognition of accrued income from commissioners in the year ended 31 March 2025, and the comparative figures have been restated to correct it. The Directors have considered the effect of this restatement on the going concern assessment. The correction relates to income that had not been earned and to corresponding accrued income balances that were not subsequently received in cash; it therefore has no impact on the Trust's cash position, its future cashflows, or its current year reported financial performance, and is reflected as a reduction in retained earnings brought forward. As described in Note 29, the Trust has begun strengthening the control environment for income recognition and year-end accruals to reduce the risk of recurrence.

The Group has net current liabilities of £39,021k (2024/25: net current liabilities restated £49,781k).

1.3 Consolidation

NHS Charitable Funds

The Trust is the Corporate Trustee to Royal Berkshire Charity NHS Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The Charity holds restricted and unrestricted funds of £484k and £3,271k respectively (2024/25: restricted £765k and unrestricted £2,976k). Included within unrestricted funds is £650k donated in 2023 by subsidiary, Healthcare Facilities Management Services Ltd (HFMS), which is eliminated on consolidation in the Group accounts.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Other subsidiary

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.

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.

These consolidated financial statements have been prepared incorporating the accounts of Healthcare Facilities Management Services Ltd (HFMS), a wholly owned subsidiary of Royal Berkshire NHS Foundation Trust, and Royal Berkshire NHS Foundation Trust Charity (the Charity).

HFMS provides fully managed healthcare facilities to the healthcare community. The company has two principal assets which are the Royal Berkshire Bracknell Healthspace at Brants Bridge in Bracknell and Princes House in Reading.

1.4 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 these 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.

Credit terms in relation to revenue from contracts with customers are 30 days other than for those NHS contract receivables that are on 15 day payment terms.

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 the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such 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 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.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

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.

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.

1.5 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 grant 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.

1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave 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

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Re-measurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.7 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.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will 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:
    a) individually have a cost of at least £5,000; or
    b) collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
    c) form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of Value added tax (VAT) where the VAT is recoverable by the entity.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. 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 economic 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 reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

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 Government Accounting Manual (GAM), impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income 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.

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 is shown in the table below:

	Min life	**Max life**
	Years	**Years**
Buildings, excluding dwellings	4	140
Plant & machinery	5	10
Transport equipment	5	5
Information technology	4	10
Furniture & fittings	5	10

All property plant and equipment are depreciated on a straight-line basis.

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38 Intangible Assets.

Software

Software which is integral to the operation of hardware, e.g. 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, e.g., 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.

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. All Trust's intangible assets are amortised on a straight-line basis applying useful life of the asset which ranges between 5 to 16 years.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

1.11 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.

1.12 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 Office of National Statistics (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 and financial liabilitites 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 and contract assets or assets measured at fair value through other comprehensive income, 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).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

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 the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

De-recognition

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.

1.13 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 lessee

Initial recognition and 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. 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.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Income.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset, the Trust applies a revised rate to the remaining lease liability.

Where existing leases are modified, the Trust must determine whether the arrangement constitutes a separate lease and apply the Standard accordingly.

The Trust as 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.

1.14 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 for 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 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 benefit 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 23.2 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.

1.15 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 24 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 24. 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.

1.16 Public dividend capital (PDC)

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 in the PDC dividend policy issued 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.

1.17 Value added tax

Most of the activities of the Trust are outside the scope of value added tax (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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation tax

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to HM Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year.

In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;

- Trading activities undertaken in-house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax; and

- Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50k per trading activity.

The Trust's subsidiary company is a trading company which is subjected to corporation tax at the rates applying at the reporting date. The tax amount included in the 2025/26 financial period is £758k (2024/25 £788k).

1.19 Research and development (R&D)

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to its technical feasibility and its resulting in a product or services that will eventually be brought into use; and
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure deferred is limited to the value of future benefits granted by the R&D funding organisation and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. It is re-valued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, the Trust discloses the total amount of R&D expenditure charged in the Statement of Comprehensive Income separately. However, where R&D activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed. Non-current assets acquired for use in R&D are amortised over the life of the associated project.

1.20 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.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

1.22 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, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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.

1.23 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.

1.24 Early adoption of standards, amendments and interpretations.

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

1.25 Standards, amendments and interpretations in issue but not yet effective or adopted.

The Department of Health and Social Care (DHSC) does not require the following Standards and Interpretations 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 £259,193k as at 31 March 2026.

1.26 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. Judgement involves management decisions in applying accounting policies, selecting methodologies, and interpreting standards. Unlike estimation, which deals with numerical uncertainty, judgement involves qualitative decisions.

There are no further critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies that have a significant effect on the amounts recognised in the financial statements:

1.27 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Land and building valuations

The Trust considers the revaluation of its land and buildings to be a material estimation made by management, based on professional advice given by the external valuer (Newmark Gerald Eve LLP), a regulated firm of

Chartered Surveyors. The valuation was prepared in accordance with the requirements of the RICS Valuation – Global Standards 2024 and the national standards and guidance set out in the UK national supplement (October 2023), the International Valuation Standards. The valuation was prepared to comply with IFRS, specifically with regard to IAS 16 Property, Plant and Equipment, Department of Health Group Manual for Accounts 2025/26 and to the Government Financial Reporting Manual (FReM) 2025-2026.

The valuation of the Trust's estate is based on a special assumption whereby HFMS, Charity and the Trust are amalgamated to provide the Trust with the freehold interest. The valuations of specialised properties were derived using the Depreciated Replacement Cost (DRC) method, with other in-use properties reported on an Existing Use Value basis.

The Trust works with its valuer to ensure that judgements are appropriate, but these judgements are inherently based on estimates of the application of market conditions, building costs and land values that are uncertain.

The carrying amount of the Trust's revalued land and buildings, including peppercorn land and buildings, is £259,193k (2024/25: £243,130k) for the year ended 31st March 2026.

The impact of any movement has been accounted for through the Statement of Comprehensive Income and Revaluation Reserves.

2 Operating Segments

IFRS 8 'Operating Segments' requires disclosure of the results of the significant operating segments. A business or operating segment is a group of assets and operations engaged in providing core or non-core services that are subject to risks and returns that are different from those of other business or operating segments. In line with the standard, based on the internally reported activities, the foundation trust identifies that all activity is healthcare related and a large majority of the foundation trust's revenue is received from within UK government departments.

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive is the Chief Operating Decision Maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed. As all decisions affecting the foundation trust's future direction and viability are made based on the overall total presented to the board, the foundation trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

3.1 Income from patient care activities (by nature)

	Group		Trust	
	2025/26	2024/25 Restated*	**2025/26**	2024/25 Restated*
	£000	£000	**£000**	£000
Acute services				
Income from commissioners under API contracts - variable element**	**146,181**	129,160	**146,181**	129,160
Income from commissioners under API contracts - fixed element**	**452,062**	422,094	**452,062**	422,094
High cost drugs income from commissioners	**39,027**	34,427	**39,027**	34,427
Other NHS clinical income	**3,221**	2,956	**3,221**	2,956
All services				-
Private patient income	**1,807**	2,152	**1,807**	2,152
National pay award central funding****	**-**	1,310	**-**	1,310
Additional pension contribution central funding***	**25,198**	23,564	**25,198**	23,564
Other clinical income	**-**	-	**-**	-
Total income from activities	**667,496**	615,663	**667,496**	615,663

* Restated as per Note 29 Prior Period Adjustments

**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.

3.2 Income from patient care activities (by source)

	Group		Trust	
	2025/26	2024/25 Restated*	**2025/26**	2024/25 Restated*
Income from patient care activities received from:	**£000**	£000	**£000**	£000
NHS England**	**70,910**	115,579	**70,910**	115,579
Integrated care boards	**586,021**	491,724	**586,021**	491,724
Other NHS providers	**746**	450	**746**	450
Local authorities	**2,570**	2,802	**2,570**	2,802
Non-NHS:				
- Private patients	**1,807**	2,152	**1,807**	2,152
- Overseas patients (chargeable to patient)	**1,972**	1,747	**1,972**	1,747
- Injury cost recovery scheme	**1,207**	843	**1,207**	843
- Other	**2,263**	366	**2,263**	366
Total income from activities	**667,496**	615,663	**667,496**	615,663

* Restated as per Note 29 Prior Period Adjustments

**Commissioning responsibility for certain specialised services (known as ‘delegated services’) was transferred in 2025/26 from NHSE to ICBs.

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

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Income recognised this year	**1,972**	1,747	**1,972**	1,747
Cash payments received in-year	**681**	690	**681**	690
Amounts written off in-year	**196**	825	**196**	825

4 Other operating income

	Group		Trust	
	2025/26	2024/25 Restated*	**2025/26**	2024/25 Restated*
	£000	£000	**£000**	£000
Research and development	**3,988**	3,482	**3,988**	3,482
Education and training	**20,791**	20,246	**20,791**	20,246
Non-patient care services to other bodies	**-**	252	**-**	252
Other income recognised in accordance with IFRS 15	**17,929**	19,081	**18,419**	20,061
Other operating income recognised in accordance with other standards:				
Education and training - notional income from apprenticeship	**869**	1,216	**869**	1,216
Receipt of capital grants and donations	**1,733**	35	**2,722**	834
Charitable fund incoming resources	**1,773**	981	**-**	-
Total other operating income	**47,083**	45,293	**46,789**	46,091

All income relates to continuing operations.

* Restated as per Note 29 Prior Period Adjustments

Other income recognised in accordance with IFRS 15 includes the following; grants and other funding £7,565k (2024/25: £5,024k); clinical services provided £5,591k (2024/25: £6,773k); non-clinical services recharged to other bodies £1,174k (2024/25: £1,299k); car parking £2,207k(2024/25: £1,796k) and catering £1,056k (2024/25: £994k).

5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	4,850	4,986

5.2 Transaction price allocated to remaining performance obligations

	2025/26	2024/25
	£000	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	4,711	4,850
Total revenue allocated to remaining performance obligations	**4,711**	4,850

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.

5.3 Income from activities arising from commissioner requested services

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:

	Group		**Trust**	
	2025/26	2024/25 Restated*	**2025/26**	2024/25 Restated*
	£000	£000	**£000**	£000
Income from services designated as commissioner requested services	**656,931**	606,759	**656,931**	606,759
Income from services not designated as commissioner requested services	**57,648**	54,197	**57,354**	54,995
Total	**714,579**	660,956	**714,285**	661,754

* Restated as per Note 29 Prior Period Adjustments

6.1 Operating expenses

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**6,314**	3,392	**6,314**	3,392
Purchase of healthcare from non-NHS and non-DHSC bodies	**13,306**	14,250	**12,061**	13,090
Staff and executive directors costs	**439,848**	414,913	**439,848**	414,913
Remuneration of non-executive directors	**174**	168	**174**	168
Supplies and services - clinical (excluding drugs costs)	**53,346**	55,223	**52,582**	54,420
Supplies and services - general	**7,196**	7,182	**7,182**	7,161
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**75,146**	70,620	**75,146**	70,620
Consultancy costs	**1,514**	1,805	**1,499**	1,791
Establishment	**3,374**	2,483	**3,358**	2,472
Premises	**30,879**	29,259	**34,495**	31,947
Transport (including patient travel)	**2,928**	3,485	**2,928**	3,485
Depreciation on property, plant and equipment and right of use assets	**26,968**	26,527	**27,912**	27,471
Amortisation on intangible assets	**8,173**	9,250	**8,173**	9,250
Net impairments	**11,187**	11,926	**9,086**	11,999
Movement in credit loss allowance: contract receivables / contract assets	**(540)**	736	**(521)**	877
Fees payable to the external auditor:				
audit services- statutory audit	**357**	431	**306**	382
Internal audit costs	**115**	171	**115**	171
Clinical negligence	**25,161**	23,693	**25,161**	23,693
Legal fees	**(137)**	932	**(136)**	931
Insurance (as a policy holder)	**398**	317	**352**	279
Research and development	**3,040**	2,800	**3,040**	2,800
Education and training	**3,269**	3,352	**3,269**	3,352
Variable lease payments not included in the liability	**370**	139	**370**	139
Redundancy	**54**	26	**54**	26
Car parking & security	**2,245**	2,111	**2,189**	2,059
Other NHS charitable fund resources expended	**871**	517	**-**	-
Other	**1,919**	9,090	**1,263**	9,345
Total	**717,475**	694,798	**716,222**	696,235
Of which:				
Related to continuing operations	717,475	694,798	716,222	696,235
Related to discontinued operations	-	-	-	-

6.2 External auditor remuneration

	Group		Trust	
	2025/26 £000	2024/25 £000	**2025/26 £000**	2024/25 £000
Fees paid to external auditor:				
Audit services - statutory audit	303	364	255	318
VAT payable	54	67	51	64
Total fees paid and payable to the Trust's external auditor including VAT	**357**	431	**306**	382

6.3 Limitation on auditor's liability (Group and Trust)

The Statutory Audit liability limits are:

- Audit Liability – £500k
- All other work – £500k

7 Impairment of assets

	Group		Trust	
	2025/26 £000	2024/25 £000	**2025/26 £000**	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:				
Abandonment of assets in course of construction	-	6,321	-	6,321
Changes in market price*	10,633	5,605	8,532	5,678
Other	554	-	554	-
Total net impairments charged to operating surplus / deficit	**11,187**	11,926	**9,086**	11,999
Impairments charged to the revaluation reserve	1,758	1,024	1,512	1,327
Total net impairments	**12,945**	12,950	**10,598**	13,326

*Impairments arising from changes in market values are determined based on the annual valuations performed by an independent professional valuer. An impairment is recognised where a reduction in an asset's valuation cannot be fully offset against a revaluation reserve balance, with the resulting loss charged to the Statement of Comprehensive Income.

For the year, total impairments amounted to £10,663m, of which £4,086k relates to the newly constructed Frederick Potts Urology Unit, which opened in 2025.

8.1 Employee benefits

	Group		Trust	
	2025/26 Total	2024/25 Total	**2025/26 Total**	2024/25 Total
	£000	£000	**£000**	£000
Salaries and wages	**318,369**	303,507	**318,369**	303,507
Social security costs	**41,686**	32,580	**41,686**	32,580
Apprenticeship levy	**1,550**	1,478	**1,550**	1,478
Employer's contributions to NHS pensions	**63,881**	59,645	**63,881**	59,645
Temporary staff (including agency)	**19,694**	22,357	**19,694**	22,357
Total gross staff costs	**445,180**	**419,567**	**445,180**	**419,567**
Of which				
Costs capitalised as part of assets	2,238	1,828	2,238	1,828

8.2 Retirements due to ill-health - Group & Trust

During 2025/26 there were 5 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £518k (£424k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

8.3 Directors' remuneration and other benefits - Group & Trust

The aggregate amounts payable to directors were:	**2025/26**	2024/25
	£000	£000
Salary	1,386	1,416
Employer's pension contributions	122	131
Total	**1,508**	1,547

The amounts shown reflect the cumulative salaries and employer pension contribution to executive and non-executive directors directly employed by the trust. It excludes employer national insurance contributions. No taxable benefits or performance related bonuses were paid during the year relating to 2025/26 financial year (£nil in 2024/25).

Further details of directors' remuneration can be found in the Remuneration Report.

9 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 2023, 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 at 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.

10 Finance income

Finance income represents interest received on assets and investments in the period.

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Interest on bank accounts	1,805	1,945	1,689	1,791
Interest on other investments / financial assets	-	-	740	895
NHS charitable fund investment income	137	190	-	-
Total finance income	**1,942**	2,135	**2,429**	2,686

The interest amount earned by the Trust included £740k (2024/25: £895k) interest receivable from the loan granted to its subsidiary. The other amounts were earned from working capital balances in interest bearing bank accounts and from investment in National Loan Funds.

11.1 Finance expenditure

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

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Interest expense:				
Interest on loans from the Department of Health and Social Care	88	151	88	151
Interest on lease obligations	1,414	790	1,910	1,412
Interest on late payment of commercial debt	11	23	-	23
Total interest expense	**1,513**	964	**1,998**	1,586
Unwinding of discount on provisions	10	2	9	2
Total finance costs	**1,523**	966	**2,007**	1,588

11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Amounts included within interest payable arising from claims made under this legislation	11	23	-	23

12 Other losses

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Losses on disposal of assets	(213)	(435)	(213)	(435)
Total losses on disposal of assets	**(213)**	(435)	**(213)**	(435)

13.1 Intangible assets - 2025/26

Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost at 1 April 2025 - brought forward	**79,147**	**-**	**79,147**
Additions	1,733	2,231	**3,964**
Reclassifications	149	-	**149**
Cost at 31 March 2026	**81,029**	**2,231**	**83,260**
Amortisation at 1 April 2025 - brought forward	**60,829**	**-**	**60,829**
Provided during the year	8,173	-	**8,173**
Impairments	554	-	**554**
Amortisation at 31 March 2026	**69,556**	**-**	**69,556**
Net book value at 31 March 2026	**11,473**	**2,231**	**13,704**
Net book value at 1 April 2025	**18,318**	**-**	**18,318**

13.2 Intangible assets - 2024/25

Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**76,139**	**77**	**76,216**
Additions	2,931	-	**2,931**
Reclassifications	77	(77)	**-**
Valuation / gross cost at 31 March 2025	**79,147**	**-**	**79,147**
Amortisation at 1 April 2024 - as previously stated	**51,579**	**-**	**51,579**
Provided during the year	9,250	-	**9,250**
Amortisation at 31 March 2025	**60,829**	**-**	**60,829**
Net book value at 31 March 2025	**18,318**	**-**	**18,318**
Net book value at 1 April 2024	**24,560**	**77**	**24,637**

13.3 Intangible assets - 2025/26

Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost at 1 April 2025 - brought forward	**78,991**	**-**	**78,991**
Additions	1,733	2,231	**3,964**
Reclassifications	149	-	**149**
Cost at 31 March 2026	**80,872**	**2,231**	**83,103**
Amortisation at 1 April 2025 - brought forward	**60,673**	**-**	**60,673**
Provided during the year	8,172	**-**	**8,172**
Impairments	554	**-**	**554**
Amortisation at 31 March 2026	**69,399**	**-**	**69,399**
Net book value at 31 March 2026	**11,473**	**2,231**	**13,704**
Net book value at 1 April 2025	**18,318**	**-**	**18,318**

13.4 Intangible assets - 2024/25

Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**75,983**	**77**	**76,060**
Additions	2,930	-	**2,930**
Reclassifications	77	(77)	**0**
Valuation / gross cost at 31 March 2025	**78,991**	**-**	**78,991**
Amortisation at 1 April 2024 - as previously stated	**51,423**	**-**	**51,423**
Provided during the year	9,250	-	**9,250**
Amortisation at 31 March 2025	**60,673**	**-**	**60,673**
Net book value at 31 March 2025	**18,318**	**-**	**18,318**
Net book value at 1 April 2024	**24,560**	**77**	**24,637**

14.1 Property, plant and equipment - 2025/26

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**22,843**	**223,718**	**33,585**	**82,049**	**92**	**45,377**	**3,549**	**294**	**411,507**
Additions	-	13,161	21,076	6,510	-	429	199	-	**41,375**
Impairments	-	(18,515)	-	-	-	-	-	(12)	**(18,527)**
Reversals of impairments	46	(202)	-	-	-	-	-	-	**(156)**
Revaluations	-	424	-	-	-	-	-	-	**424**
Reclassifications	-	21,514	(22,745)	930	-	152	-	-	**(149)**
Disposals / derecognition	-	-	-	(2,241)	-	(1)	-	-	**(2,242)**
Valuation/gross cost at 31 March 2026	**22,889**	**240,100**	**31,916**	**87,248**	**92**	**45,957**	**3,748**	**282**	**432,232**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**650**	**-**	**45,948**	**92**	**40,957**	**3,403**	**-**	**91,050**
Provided during the year	-	9,314	-	6,952	-	1,839	38	-	**18,143**
Impairments	-	(2,862)	-	-	-	-	-	-	**(2,862)**
Reversals of impairments	-	(3,418)	-	-	-	-	-	-	**(3,418)**
Revaluations	-	(2,941)	-	-	-	-	-	-	**(2,941)**
Disposals / derecognition	-	-	-	(2,029)	-	-	-	-	**(2,029)**
Accumulated depreciation at 31 March 2026	**-**	**743**	**-**	**50,871**	**92**	**42,796**	**3,441**	**-**	**97,943**
Net book value at 31 March 2026	**22,889**	**239,357**	**31,916**	**36,377**	**-**	**3,161**	**307**	**282**	**334,290**
Net book value at 1 April 2025	**22,843**	**223,068**	**33,585**	**36,101**	**-**	**4,420**	**146**	**294**	**320,458**

Of the £41,375k capital additions recognised during the year, £3,930k (9.5%) was delivered through vesting certificates at the financial year end.

14.2 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**22,843**	**224,276**	**24,533**	**81,798**	**92**	**44,018**	**3,515**	**320**	**401,395**
Additions	-	6,572	25,541	3,859	-	149	34	-	**36,155**
Impairments	-	(10,804)	(6,321)	-	-	-	-	-	**(17,125)**
Reversals of impairments	-	1,107	-	-	-	-	-	-	**1,107**
Revaluations	-	(4,952)	-	-	-	-	-	(26)	**(4,978)**
Reclassifications	-	7,685	(10,168)	1,273	-	1,210	-	-	**-**
Disposals / derecognition	-	(166)	-	(4,881)	-	-	-	-	**(5,047)**
Valuation/gross cost at 31 March 2025	**22,843**	**223,718**	**33,585**	**82,049**	**92**	**45,377**	**3,549**	**294**	**411,507**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**563**	**-**	**43,842**	**90**	**38,067**	**3,370**	**-**	**85,932**
Provided during the year	-	8,968	-	6,724	2	2,890	33	-	**18,617**
Impairments	-	(784)	-	-	-	-	-	-	**(784)**
Reversals of impairments	-	(2,284)	-	-	-	-	-	-	**(2,284)**
Revaluations	-	(5,803)	-	-	-	-	-	-	**(5,803)**
Disposals / derecognition	-	(10)	-	(4,618)	-	-	-	-	**(4,628)**
Accumulated depreciation at 31 March 2025	**-**	**650**	**-**	**45,948**	**92**	**40,957**	**3,403**	**-**	**91,050**
Net book value at 31 March 2025	**22,843**	**223,068**	**33,585**	**36,101**	**-**	**4,420**	**146**	**294**	**320,458**
Net book value at 1 April 2024	**22,843**	**223,713**	**24,533**	**37,956**	**2**	**5,951**	**145**	**320**	**315,464**

14.3 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	22,889	236,025	31,705	33,544	-	3,138	267	282	**327,851**
Owned - donated/granted	-	3,332	211	2,833	-	23	40	-	**6,439**
NBV total at 31 March 2026	**22,889**	**239,357**	**31,916**	**36,377**	**-**	**3,161**	**307**	**282**	**334,290**

14.4 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	22,843	219,999	33,566	33,314	-	4,380	130	294	**314,527**
Owned - donated/granted	-	3,069	19	2,787	-	40	16	-	**5,931**
NBV total at 31 March 2025	**22,843**	**223,068**	**33,585**	**36,101**	**-**	**4,420**	**146**	**294**	**320,458**

14.5 Property, plant and equipment - 2025/26

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**19,703**	**192,848**	**32,058**	**80,411**	**44,835**	**3,531**	**373,386**
Additions	-	10,131	18,846	6,507	579	182	**36,245**
Impairments	-	(15,448)	-	-	-	-	**(15,448)**
Reversals of impairments	46	(201)	-	-	-	-	**(155)**
Revaluations	-	400	-	-	-	-	**400**
Reclassifications	-	21,374	(22,605)	930	152	-	**(149)**
Disposals / derecognition	-	-	-	(2,241)	(1)	-	**(2,242)**
Valuation/gross cost at 31 March 2026	**19,749**	**209,104**	**28,299**	**85,607**	**45,565**	**3,713**	**392,037**
Accumulated depreciation at 1 April 2025 - brought forward	-	**647**	-	**44,408**	**40,518**	**3,393**	**88,966**
Provided during the year	-	8,456	-	6,923	1,758	37	**17,174**
Impairments	-	(2,141)	-	-	-	-	**(2,141)**
Reversals of impairments	-	(3,417)	-	-	-	-	**(3,417)**
Revaluations	-	(2,806)	-	-	-	-	**(2,806)**
Disposals / derecognition	-	-	-	(2,029)	-	-	**(2,029)**
Accumulated depreciation at 31 March 2026	**-**	**739**	**-**	**49,302**	**42,276**	**3,430**	**95,747**
Net book value at 31 March 2026	**19,749**	**208,365**	**28,299**	**36,305**	**3,289**	**283**	**296,290**
Net book value at 1 April 2025	**19,703**	**192,201**	**32,058**	**36,003**	**4,317**	**138**	**284,420**

14.6 Property, plant and equipment - 2024/25

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2024 - brought forward	**19,703**	**192,941**	**24,534**	**80,160**	**43,476**	**3,496**	**364,310**
Additions	-	6,576	23,936	3,859	226	35	**34,632**
Impairments	-	(10,804)	(6,321)	-	-	-	**(17,125)**
Reversals of impairments	-	804	-	-	-	-	**804**
Revaluations	-	(4,188)	-	-	-	-	**(4,188)**
Reclassifications	-	7,685	(10,091)	1,273	1,133	-	**-**
Disposals / derecognition	-	(166)	-	(4,881)	-	-	**(5,047)**
Valuation/gross cost at 31 March 2025	**19,703**	**192,848**	**32,058**	**80,411**	**44,835**	**3,531**	**373,386**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**558**	**-**	**42,335**	**37,708**	**3,362**	**83,962**
Provided during the year	-	8,125	-	6,691	2,810	31	**17,657**
Impairments	-	(784)	-	-	-	-	**(784)**
Reversals of impairments	-	(2,212)	-	-	-	-	**(2,212)**
Revaluations	-	(5,030)	-	-	-	-	**(5,030)**
Disposals / derecognition	-	(10)	-	(4,618)	-	-	**(4,628)**
Accumulated depreciation at 31 March 2025	**-**	**647**	**-**	**44,408**	**40,518**	**3,393**	**88,965**
Net book value at 31 March 2025	**19,703**	**192,201**	**32,058**	**36,003**	**4,317**	**138**	**284,420**
Net book value at 1 April 2024	**19,703**	**192,383**	**24,534**	**37,826**	**5,768**	**134**	**280,348**

14.7 Property, plant and equipment financing - 31 March 2026

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	19,749	205,037	28,088	33,473	3,266	243	**289,856**
Owned - donated / granted	-	3,328	211	2,832	23	40	**6,434**
Total net book value at 31 March 2026	**19,749**	**208,365**	**28,299**	**36,305**	**3,289**	**283**	**296,290**

14.8 Property, plant and equipment financing - 31 March 2025

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	19,703	189,104	32,058	35,726	4,273	117	**280,981**
Owned - donated / granted	-	3,097	-	277	44	21	**3,439**
Total net book value at 31 March 2025	**19,703**	**192,201**	**32,058**	**36,003**	**4,317**	**138**	**284,420**

15.1 Right of use assets - 2025/26

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**57,298**	**15,452**	**72,750**	**33,708**
Additions	36	28	**64**	36
Remeasurements of the lease liability	1,838	1,280	**3,118**	1,717
Valuation/gross cost at 31 March 2026	**59,172**	**16,760**	**75,932**	**35,461**
Accumulated depreciation at 1 April 2025 - brought forward	**14,759**	**7,877**	**22,636**	**10,358**
Provided during the year	4,556	4,269	**8,825**	3,667
Accumulated depreciation at 31 March 2026	**19,315**	**12,146**	**31,461**	**14,025**
Net book value at 31 March 2026	**39,857**	**4,614**	**44,471**	**21,436**
Net book value at 1 April 2025	**42,539**	**7,575**	**50,114**	**23,350**
Net book value of right of use assets leased from other NHS providers				18,633
Net book value of right of use assets leased from other DHSC group bodies				2,803

15.2 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**44,302**	**12,354**	**56,656**	**32,964**
Additions	12,046	3,055	**15,101**	-
Remeasurements of the lease liability	950	43	**993**	744
Valuation/gross cost at 31 March 2025	**57,298**	**15,452**	**72,750**	**33,708**
Accumulated depreciation at 1 April 2024 - brought forward	**9,800**	**4,926**	**14,726**	**6,914**
Provided during the year	4,959	2,951	**7,910**	3,444
Accumulated depreciation at 31 March 2025	**14,759**	**7,877**	**22,636**	**10,358**
Net book value at 31 March 2025	**42,539**	**7,575**	**50,114**	**23,350**
Net book value at 1 April 2024	**34,502**	**7,428**	**41,930**	**26,050**
Net book value of right of use assets leased from other NHS providers				20,567
Net book value of right of use assets leased from other DHSC group bodies				2,783

15.3 Right of use assets - 2025/26

Trust	Property (land and buildings) £000	Plant & machinery £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2025 - brought forward	**74,497**	**15,453**	**89,950**	**33,708**
Additions	36	28	**64**	36
Remeasurements of the lease liability	1,839	1,279	**3,118**	1,717
Valuation/gross cost at 31 March 2026	**76,372**	**16,760**	**93,132**	**35,461**
Accumulated depreciation at 1 April 2025 - brought forward	20,580	7,877	**28,457**	10,358
Provided during the year	8,122	2,614	**10,736**	3,667
Accumulated depreciation at 31 March 2026	**28,702**	**10,491**	**39,193**	**14,025**
Net book value at 31 March 2026	**47,670**	**6,269**	**53,939**	**21,436**
Net book value at 1 April 2025	**53,917**	**7,576**	**61,493**	**23,350**

15.4 Right of use assets - 2024/25

Trust	Property (land and buildings) £000	Plant & machinery £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	**60,858**	**12,354**	**73,212**	**32,964**
Additions	12,046	3,055	**15,101**	-
Remeasurements of the lease liability	1,594	44	**1,638**	744
Valuation/gross cost at 31 March 2025	**74,497**	**15,453**	**89,950**	**67,416**
Accumulated depreciation at 1 April 2024 - brought forward	**13,718**	**4,926**	**18,644**	**6,914**
Provided during the year	6,862	2,951	**9,813**	3,444
Accumulated depreciation at 31 March 2025	**20,580**	**7,877**	**28,457**	**61,338**
				0
Net book value at 31 March 2025	**53,917**	**7,576**	**61,493**	**23,350**
Net book value at 1 April 2024	**47,139**	**7,428**	**54,568**	**26,050**

15.5 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 23.1.

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Carrying value at 1 April	**50,765**	42,254	**65,931**	58,985
Lease additions	64	15,101	64	15,101
Lease liability remeasurements	3,118	993	3,119	1,637
Interest charge arising in year	1,414	790	1,909	1,412
Lease payments (cash outflows)	(9,486)	(8,373)	(12,315)	(11,204)
Carrying value at 31 March	**45,875**	50,765	**58,708**	65,931

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 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

15.6 Maturity analysis of future lease payments at 31 March 2026

	Group		Trust	
	Total	leased from DHSC group bodies:	**Total**	leased from DHSC group bodies:
	31 March 2026	**31 March 2026**	**31 March 2026**	**31 March 2026**
	£000	**£000**	**£000**	**£000**
Undiscounted future lease payments payable in:				
- not later than one year;	9,949	3,930	12,779	3,930
- later than one year and not later than five years;	33,816	17,206	44,986	17,206
- later than five years.	6,130	256	6,130	256
Total gross future lease payments	**49,895**	**21,392**	**63,895**	**21,392**
Finance charges allocated to future periods	(4,020)	(666)	(5,187)	(666)
Net lease liabilities at 31 March 2026	**45,875**	**20,726**	**58,708**	**20,726**
Of which:				
Current	8,073	3,725	11,408	3,725
Non-Current	37,802	17,001	47,300	17,001

15.7 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000
Undiscounted future lease payments payable in:				
- not later than one year;	8,902	3,485	11,732	6,314
- later than one year and not later than five years;	16,060	6,970	21,719	12,629
- later than five years.	30,665	13,382	40,668	21,721
Total gross future lease payments	**55,627**	**23,837**	**74,119**	**40,664**
Finance charges allocated to future periods	(4,862)	(769)	(8,187)	(2,431)
Net finance lease liabilities at 31 March 2025	**50,765**	**23,068**	**65,932**	**38,233**
Of which:				
Current	7,895	3,280	8,996	5,615
Non-Current	42,870	19,788	56,937	32,618

15.8 Leases - other information

Extension options in respect of the Princes House and Bracknell Healthspace leases have not been included in the measurement of the lease liability, as the exercise of these options is not considered reasonably certain. If exercised, these options would give rise to additional lease payments with an estimated present value of approximately £60.8m, based on a 10-year extension period and discounted future lease payments.

16 Analysis of charitable fund reserves

	Group	
	31 March 2026	**31 March 2025**
	£000	**£000**
Unrestricted funds:		
Unrestricted income funds	2,621	2,326
Restricted funds:		
Endowment funds	36	38
Other restricted income funds	448	727
	3,105	**3,091**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

17 Inventories

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Drugs	1,682	1,591	1,682	1,591
Consumables	7,024	6,624	7,024	6,624
Total inventories	**8,706**	8,215	**8,706**	8,215

Inventories recognised in expenses for the year were £85,514k (2024/25: £87,331k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

18 Other investments / financial assets (non-current)

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Carrying value at 1 April - brought forward	**20**	20	**10,600**	10,600
Movement in fair value through OCI	(3)			
Carrying value at 31 March	**17**	20	**10,600**	10,600

Group's Investment relates to Charity - Chariguard Fund. The Trust's investment relates to investment in subsidiary - Healthcare Facilities Management Service Limited (HFMS).

HFMS is 100% wholly owned subsidiary of the Trust, providing healthcare facilities to healthcare providers. It is registered at Princes House, 73A London Road, Reading, Berkshire, RG1 5UZ.

The carrying value of the Trust's investment in the subsidiary HFMS is reviewed by the Trust on a regular basis by considering the forward financial projections of the Company and the open market value of the company's non-current assets. Following further review of the investment in the subsidiary, there are no indications of impairment.

The number and the value of shares held by the Trust in HFMS are stated below:

	31 March 2026	31 March 2025
Number of ordinary shares of £1 each held by the Trust	**15,000,100**	15,000,100
	£000	£000
Cost of ordinary shares held	**15,000**	15,000

19.1 Receivables

	Group		Trust	
	31 March 2026	31 March 2025 Restated*	**31 March 2026**	31 March 2025 Restated*
	£000	£000	**£000**	£000
Current				
Contract receivables	30,716	26,438	30,409	25,971
Allowance for impaired contract receivables	(5,173)	(6,054)	(5,149)	(6,011)
Prepayments	5,900	5,847	5,873	5,825
PDC dividend receivable	-	17	-	17
VAT receivable	1,408	490	1,712	850
Other receivables	1,605	742	1,629	419
Intercompany receivables - HFMS	-	-	3,663	1,890
Inter-company loans	-	-	616	616
NHS charitable funds receivables	583	134	-	-
Total current receivables	**35,039**	27,614	**38,754**	29,576
Non-current				
Contract receivables	1,231	859	1,231	859
Allowance for impaired contract receivables	(303)	(210)	(303)	(210)
Other receivables	908	1,015	902	1,009
Inter-company loans	-	-	15,230	15,848
Total non-current receivables	**1,836**	1,664	**17,061**	17,505
Of which receivable from NHS and DHSC group bodies:				
Current	17,573	26,386	17,573	26,386
Non-current	902	1,009	902	1,009

* Restated as per Note 29 Prior Period Adjustments

The Trust has existing loans with its subsidiary HFMS which has a final repayment date of 30 November 2058. The principal is £35,200k with an interest rate of 5% per annum and £9,358k with an interest rate of 3.5%. Amount outstanding over one year is £15,224k (2024/25: £15,841k), and £616k (2024/25: £616k) in the current receivables is the amount outstanding within one year.

Contract receivables non-invoiced (falling due after more than one year) represents costs that the Group is claiming from insurance companies for treating injuries from road traffic accidents, via the Injury Cost Recovery Scheme £1,231k (2024/25: £859k) which is expected to be recovered after 12 months; and included in the other receivables is £902k (2024/25 - £1,009k) clinician pension tax provision reimbursement funding from NHS England.

19.2 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	**6,264**	**-**	**6,221**	**-**
New allowances arising	(540)	-	(521)	-
Utilisation of allowances (write offs)	(248)	-	(247)	-
Allowances as at 31 Mar 2026	**5,476**	**-**	**5,452**	**-**

19.3 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 - as previously stated	**6,382**	**-**	**6,197**	**-**
New allowances arising	736	-	877	-
Utilisation of allowances (write offs)	(854)	-	(854)	-
Allowances as at 31 Mar 2025	**6,264**	**-**	**6,221**	**-**

19.4 Ageing of impaired financial assets

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Up to three months	885	566	679	566
In three to six months	241	143	241	143
Over six months	7,607	6,905	7,591	6,905
Total	**8,734**	7,615	**8,512**	7,615

19.5 Ageing of non-impaired financial assets past their due date

	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Up to three months	1,331	405	1,331	405
In three to six months	48	109	48	109
Over six months	1,170	1,576	1,170	1,576
Total	**2,550**	2,090	**2,550**	2,090

20 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	**13,518**	38,810	**7,056**	25,125
Net change in year	16,897	(25,292)	17,335	(18,069)
At 31 March	**30,415**	13,518	**24,391**	7,056
Broken down into:				
Cash at commercial banks and in hand	3,442	4,281	487	960
Cash with the Government Banking Service	26,973	9,237	23,904	6,096
Total cash and cash equivalents as in SoFP	**30,415**	13,518	**24,391**	7,056

21 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	21,212	11,547	20,513	10,979
Capital payables	21,233	16,414	20,164	16,414
Accruals	36,740	37,534	35,508	36,221
Receipts in advance and payments on account	2,929	210	2,929	-
Social security costs	9,158	7,951	9,158	7,951
Pension contributions payable	5,521	5,031	5,521	5,031
Other payables	180	364	180	364
NHS charitable funds: trade and other payables	316	386	-	-
Intercompany payable - HFMS	-	-	1,007	1,844
Total current trade and other payables	**97,289**	79,437	**94,980**	78,803
Non-current				
Other payables	1,077	969	-	-
Total non-current trade and other payables	**1,077**	969	**-**	**-**
Of which payables from NHS and DHSC group bodies:				
Current	18,574	11,375	18,574	11,375
Non-current	-	-	-	-

22 Other liabilities

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Current				
Deferred income: contract liabilities	4,711	4,850	4,711	4,850
Deferred grants	1,238	1,238	1,238	1,238
Total other current liabilities	**5,949**	6,088	**5,949**	6,088

23.1 Borrowings

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Current				
Loans from DHSC	1,482	1,538	1,482	1,538
Lease liabilities	8,073	7,895	11,408	8,996
Total current borrowings	**9,555**	9,433	**12,890**	10,534
Non-current				
Loans from DHSC	-	1,464	-	1,464
Lease liabilities	37,802	42,870	47,300	56,936
Total non-current borrowings	**37,802**	44,334	**47,300**	58,400

23.2 Reconciliation of liabilities arising from financing activities

Group - 2025/26	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2025	**3,002**	**50,765**	**53,767**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,502)	(8,072)	**(9,574)**
Financing cash flows - payments of interest	(106)	(1,414)	**(1,520)**
Non-cash movements:			
Additions	-	64	**64**
Lease liability remeasurements	-	3,118	**3,118**
Application of effective interest rate	88	1,414	**1,502**
Carrying value at 31 March 2026	**1,482**	**45,875**	**47,357**

Group - 2024/25	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**4,523**	**42,254**	**46,777**
Financing cash flows - payments and receipts of principal	(1,502)	(7,583)	**(9,085)**
Financing cash flows - payments of interest	(170)	(790)	**(960)**
Non-cash movements:			
Additions	-	15,101	**15,101**
Lease liability remeasurements	-	993	**993**
Application of effective interest rate	151	790	**941**
Carrying value at 31 March 2025	**3,002**	**50,765**	**53,767**

23.3 Reconciliation of liabilities arising from financing activities

Trust - 2025/26	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2025	**3,002**	**65,931**	**68,934**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,502)	(10,406)	**(11,908)**
Financing cash flows - payments of interest	(106)	(1,909)	**(2,015)**
Non-cash movements:			
Additions	-	64	**64**
Lease liability remeasurements	-	3,119	**3,119**
Application of effective interest rate	88	1,909	**1,997**
Carrying value at 31 March 2026	**1,482**	**58,708**	**60,190**

Trust - 2024/25	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**4,523**	**58,985**	**63,508**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,502)	(9,791)	**(11,294)**
Financing cash flows - payments of interest	(169)	(1,412)	**(1,581)**
Non-cash movements:			
Additions	-	15,101	**15,101**
Lease liability remeasurements	-	1,637	**1,637**
Application of effective interest rate	151	1,412	**1,563**
Carrying value at 31 March 2025	**3,002**	**65,931**	**68,934**

24.1 Provisions for liabilities and charges analysis (Group and Trust)

All provisions relate to the Trust and there are none in the subsidiary.

Group	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2025	**41**	**1,500**	**3,663**	**5,204**
Change in the discount rate	-	-	(71)	**(71)**
Arising during the year	8	-	-	**8**
Utilised during the year	(25)	(1,157)	(2,650)	**(3,832)**
Reversed unused	-	-	(71)	**(71)**
Unwinding of discount	10	-	59	**69**
At 31 March 2026	**34**	**343**	**930**	**1,307**
Expected timing of cash flows:				
- not later than one year;	17	343	28	**388**
- later than one year and not later than five years;	17	-	902	**919**
- later than five years.	-	-	-	**-**
Total	**34**	**343**	**930**	**1,307**

Pension - early departure cost

This relates to former NHS employees whose contract of employment was terminated prior to their normal retirement age, with the effect that the employing authority became responsible for making up any shortfall in pension contributions as a result of that termination up until the death of either the former employee or any remaining survivor. The provision is adjusted annually, taking into Government Actuarial Department changes to life expectancy for England and Wales and the applicable Treasury discount rate. Where the pension is no longer payable, then this is reversed unused.

Legal claims

This provison relates to legal claims made against the Trust that are not covered by NHS Resolution. At the start of the financial year the provision represented two ongoing legal claims. The commercial dispute is now settled and the provision of £1,157k has been utilised. The remaining balance is held in respect to ongoing employment-related case, which is expected to be concluded and the payment made within one year.

Other provisions

Closing balance £930k represents 2019/20 clinicians' pension reimbursement as mandated by NHS England. Provision is calculated using the latest available information in regards to actual uptake of the scheme combined with information on applications to join and discounting of future liabilities.

24.2 Clinical negligence liabilities

At 31 March 2026, £417,648k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal Berkshire NHS Foundation Trust (31 March 2025: £431,810k).

25 Contingent assets and liabilities

There were no material contingencies at the Statement of Financial Position date.

26 Contractual capital commitments

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	**31 March 2026 £000**	31 March 2025 £000
Property, plant and equipment	4,538	3,000	4,538	3,000
Total	**4,538**	3,000	**4,538**	3,000

27.1 Financial Instruments

A financial instrument is defined in IAS 32 Financial Instruments - Presentation and IFRS 9 Financial Instruments as a 'contract that gives rise to a financial asset of one Trust and a financial liability or equity instrument of another Trust'. NHS Foundation Trusts could have financial instruments under any area of the following Statement of Financial Position categories - investments, trade receivables (but not prepayments), cash at bank and in hand, trade payables (but not deferred income), loans and provisions.

Once financial assets and liabilities have been identified and recognised, they are initially measured at fair value. Subsequently, financial assets are measured at amortised cost or fair value through income and expenditure, depending on their classification and the business model for holding them. Financial liabilities are generally measured at amortised cost, except where they are required to be measured at fair value through income and expenditure. Fair value is the amount at which an asset can be exchanged, or liability settled, between knowledgeable, willing parties in an arms-length transaction.

IFRS 7 Financial Instruments – Disclosures requires a disclosure relating to the risks associated with financial instruments. These are defined below.

Market risk

This is the risk that the fair value or cash flows of a financial instrument will fluctuate because of changes in market prices. The Trust is exposed to minimal market risks.

Interest Rate Risk

All the Trust's financial assets and liabilities, with the exception of cash held in UK banks, carry a nil or fixed rate of interest. The Trust is not, therefore, exposed to significant interest rate risk.

Under IAS 32 and IAS 39 Public Dividend Capital is not a financial instrument. It continues to be classified within 'Taxpayers' Equity'.

The Trust had negligible foreign currency income and expenditure during the year.

The Trust is not aware of any other specific risks relating to individual instruments.

Liquidity risk

The Group's operating income is predominantly from contracts with local Integrated Care Boards, which are financed from resources voted annually by Parliament. The Group has minimised its exposure to any liquidity risks.

Credit risk

This is the risk that one party to a financial instrument will cause financial loss to another party by failing to discharge an obligation.

The majority of the Group's financial contracts are with other NHS bodies. As these entities are subject to the Better Payment Practice Code and are supported by taxpayer funding, the associated credit risk is considered to be low.

The policy reflects the position on the causes of debt, the implications of compliance and the need to identify trading counterparties correctly and the varied level of risk associated with them along with the requirement to maintain an adequate bad debt provision. The Trust maintains a bad debt provision rule set which is flexible and reflects the monthly aged debt position, however it also requires that a line by line review of items to be provided is carried out regularly. Specific credit loss allowances are provided for selected overseas and private patients. General credit loss allowances are provided based on ageing.

Trade debtors consist of high value transaction with NHS England and ICB commissioners under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health and local authorities under contractual terms, although, these are subject to individual negotiation. Other trade debtors include private and overseas patients, spread across diverse geographical areas. The maximum exposure of the Trust to credit risk is equal to the total trade and other receivables within Note 18.1

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss.

Overdue amounts owed by local commissioning bodies for clinical services will be pursued by the Trust's contracting team through monthly contract meetings with the commissioners. Escalation to the Group Financial Controller will be undertaken on a debt by debt basis if issues arise on the recovery of debt. If appropriate the Group Financial Controller will discuss with the equivalent individual that the NHS organisation concerned. Overdue amounts owed by non-NHS customers passed to the Trust's debt collection agency for recovery. In exceptional circumstances the Group Financial Controller may propose that the debt should be written-off.

All write-offs of bad debts require the approval of the Chief Finance Officer and are reported to the Audit and Risk Committee. Cash and cash equivalents are held within a combination of financial institutions (Government Banking Service and Lloyds Plc.) all of which have investment grade ratings.

27.2 Carrying values of financial assets

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Trade and other receivables excluding non financial assets	28,984	35,730	48,230	53,333
Other investments / financial assets	-	-	10,600	10,600
Cash and cash equivalents	27,168	9,834	24,391	7,056
Consolidated NHS Charitable fund financial assets	3,847	3,838	-	-
Total	**59,999**	49,402	**83,221**	70,989

All financial assets are held at amortised cost.

27.3 Carrying values of financial liabilities

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Loans from the Department of Health and Social Care	1,482	3,002	1,482	3,002
Obligations under leases	45,875	50,765	58,708	65,932
Trade and other payables excluding non financial liabilities	79,401	65,581	76,330	64,576
Total	**126,758**	119,348	**136,519**	133,511

All financial liabilites are held at amortised cost.

27.4 Fair values of financial assets and liabilities

Book values of the Trust's and Group's financial assets and liabilities are not considered to be materially different than their fair values and consequently the fair values have not been disclosed separately.

27.5 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	90,862	76,112	90,621	76,757
In more than one year but not more than five years	33,816	17,553	44,986	24,602
In more than five years	6,130	32,010	6,130	43,139
Total	**130,808**	125,675	**141,737**	144,498

28 Losses and special payments

Group and trust	2025/26 Total number of cases	2025/26 Total value of cases	2024/25 Total number of cases	2024/25 Total value of cases
	Number	**£000**	Number	£000
Losses				
Cash losses	2	-	-	-
Fruitless payments and constructive losses	6	-	-	-
Bad debts and claims abandoned	230	312	150	854
Stores losses and damage to property	4	21	4	1
Total losses	**242**	**333**	154	855
Special payments				
Compensation under court order or legally binding arbitration award	6	42	6	65
Ex-gratia payments	25	437	41	175
Total special payments	**31**	**479**	47	240
Total losses and special payments	**273**	**812**	201	1,095

The amounts quoted are reported on an accruals basis but exclude provisions for future losses.

There are no cases that were £300k or more in 2025/26 or 2024/25.

29 Prior period adjustments

During the year ended 31 March 2026, the Trust identified a number of errors involving the accrued income balance from commissioners in the year ended 31 March 2025. These errors, when examined in aggregate, were concluded to represent a material prior period error resulting in the overstatement of both Income and Accrued income by £12,943k.

The most significant of these errors related to the following:

Income from NHS England Specialised Commissioning in respect of high-cost drugs and devices are reimbursed on a pass-through basis such that revenue is earned only to the extent that actual usage is evidenced. Accrued income at 31 March 2025 was recognised on the basis of expected billing values and was not reconciled or later adjusted to reflect the actual usage data available from the Trust's own systems at that date.

Overstatement of Income from commissioners within the calculation of contract values for NHS England and Buckinghamshire, Oxfordshire and Berkshire West ICB. This was due to the incorrect treatment of specific income components, such as high-cost drugs and devices, within the overall contract value calculation.

Across these errors, the information necessary to determine the appropriate level of income was available when the 2024/25 financial statements were authorised for issue, and the level of income recognised was not supported by that information, leading to an improper measurement of revenue. The misstatement therefore arose from the failure to apply reliable information that was available at the reporting date, and not from new information or changed circumstances arising subsequently. Accordingly, it represents the correction of a prior period error in accordance with IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors, and not a change in accounting estimate.

The Trust assessed the error against both quantitative and qualitative materiality criteria. At £12,943k the misstatement exceeds the materiality threshold applied to the financial statements of £10,500k. In qualitative terms, the error is material because its correction changes the Trust's reported financial performance for 2024/25, moving the restated result to a deficit, and because it arises from an identified weakness in the control environment for income recognition. A misstatement that changes the reported result in this way is material by its nature, irrespective of amount, because it affects the view a reader would form of the Trust's financial performance and its delivery against plan. For these reasons the Trust concluded that correction within the current year was not appropriate and that restatement of the prior period comparatives under IAS 8 was required.

In accordance with IAS 8 and the DHSC Group Accounting Manual, the comparative figures have been restated to correct this error. If not corrected, the error would result in a material misstatement of both the prior year and current year reported financial performance. The adjustment has no impact on the current year deficit but reduces retained earnings brought forward.

Control environment
The Trust has undertaken an initial review of the control environment relating to income recognition and year-end accruals. This has identified areas where processes, documentation and oversight require strengthening. Further work is underway to ensure that controls and review processes are robust and consistently applied to prevent recurrence.

29 Prior period adjustments (cont.)

The table below presents retrospective restatement of Group financial statements and the notes:

		Group		
Financial statement / Note	**Line item**	**Disclosed £'000**	**Adjustment £'000**	**Restated £'000**
		31-Mar-25	**31-Mar-25**	**31-Mar-25**
Consolidated Statement of Comprehensive Income	Operating income from patient care activities	628,062	(12,399)	615,663
Consolidated Statement of Comprehensive Income	Other operating income	45,837	(544)	45,293
Statement of Financial Position	Receivables	40,557	(12,943)	27,614
Statement of Financial Position	Income and expenditure Reserve	(33,399)	(12,943)	(46,342)
Statement of Changes in Equity for the year ended 31 March 2025	Surplus/(deficit) for the year - Income and expenditure reserve	(30,978)	(12,943)	(43,921)
Statement of Changes in Equity for the year ended 31 March 2025	Taxpayers' and other's equity at 1 April 2025 - Income and expenditure reserve	(33,399)	(12,943)	(46,342)
Statement of Cash Flows	Operating deficit	(20,899)	(12,943)	(33,842)
Statement of Cash Flows	(Increase) / decrease in receivables and other assets	(7,935)	12,943	5,008
Note 3.1 Operating income from patient care activities	Income from commissioners under API contracts - variable element	132,300	(3,140)	129,160
Note 3.1 Operating income from patient care activities	Income from commissioners under API contracts - fixed element	428,898	(6,804)	422,094
Note 3.1 Operating income from patient care activities	High cost drugs income from commissioners	36,882	(2,455)	34,427
Note 3.2 Income from patient care activities (by source)	NHS England	120,770	(5,191)	115,579
Note 3.2 Income from patient care activities (by source)	Integrated care boards	498,932	(7,208)	491,724
Note 4 Other operating income	Other income recognised in accordance with IFRS 15	19,625	(544)	19,081
Note 5.3 Income from activities arising from commissioner requested services	Income from services designated as commissioner requested services	619,702	(12,943)	606,759
Note 19.1 Receivables	Contract receivables	39,381	(12,943)	26,438

29 Prior period adjustments (cont.)

The table below presents retrospective restatement of Trust financial statements and the notes:

		Trust		
Financial statement / Note	**Line item**	**Disclosed £'000**	**Adjustment £'000**	**Restated £'000**
		31-Mar-25	**31-Mar-25**	**31-Mar-25**
Consolidated Statement of Comprehensive Income	Operating income from patient care activities	628,062	(12,399)	615,663
Consolidated Statement of Comprehensive Income	Other operating income	46,635	(544)	46,091
Statement of Financial Position	Receivables	42,519	(12,943)	29,576
Statement of Financial Position	Income and expenditure Reserve	(43,441)	(12,943)	(56,384)
Statement of Changes in Equity for the year ended 31 March 2025	Surplus/(deficit) for the year - Income and expenditure reserve	(30,267)	(12,943)	(43,210)
Statement of Changes in Equity for the year ended 31 March 2025	Taxpayers' and other's equity at 1 April 2025 - Income and expenditure reserve	(43,441)	(12,943)	(56,384)
Statement of Cash Flows	Operating deficit	(21,538)	(12,943)	(34,481)
Statement of Cash Flows	(Increase) / decrease in receivables and other assets	(2,176)	12,943	10,767
Note 3.1 Operating income from patient care activities	Income from commissioners under API contracts - variable element	132,300	(3,140)	129,160
Note 3.1 Operating income from patient care activities	Income from commissioners under API contracts - fixed element	428,898	(6,804)	422,094
Note 3.1 Operating income from patient care activities	High cost drugs income from commissioners	36,882	(2,455)	34,427
Note 3.2 Income from patient care activities (by source)	NHS England	120,770	(5,191)	115,579
Note 3.2 Income from patient care activities (by source)	Integrated care boards	498,932	(7,208)	491,724
Note 4 Other operating income	Other income recognised in accordance with IFRS 15	20,605	(544)	20,061
Note 5.3 Income from activities arising from commissioner requested services	Income from services designated as commissioner requested services	619,702	(12,943)	606,759
Note 19.1 Receivables	Contract receivables	38,914	(12,943)	25,971

30 Events after the reporting date

There are no material events after the reporting period at 31 March 2026 (none reported in 2024/25).

31 Related parties

During the year none of the Trust Board members (who are key management personnel of the Trust) or parties related to them has undertaken any material transactions with Royal Berkshire NHS Foundation Trust other than receipt of salary.

During the year none of the Trust Board members (who are key management personnel of the Trust) received any form of short-term employee benefits; post-employment benefits; other long-term benefits; termination benefits or share-based payments in additional to the salary they receive other than accrued pension benefits, the details of which can be found on page 47 of the Remuneration Report.

Staff at the Royal Berkshire NHS Foundation Trust are part of the board of Healthcare Facilities Management Services Ltd and the Charity Committees of Royal Berkshire NHS Foundation Trust Charity. None of these staff receive any form of remuneration for these positions.
Where decision making affects one of the related parties the director of the Trust Board will declare an interest and recuse themselves from the meeting. In 2025/26 none of these related parties met the threshold for a Board decision.

During the year 2025/26, the Trust had a significant number of transactions with the Department and with other entities for which the Department is regarded as the parent. These entities are listed below. Though not required to be disclosed under IAS24, the Trust has elected to disclose the below information which readers of the accounts may find useful.

	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Providers				
Berkshire Healthcare NHS Foundation Trust	3,318	7,001	3,067	3,449
Frimley Health NHS Foundation Trust	1,296	455	4,528	7,195
Northumbria Healthcare NHS Foundation Trust	-	-	-	535
Oxford Health NHS Foundation Trust	17	6,881	30	709
Oxford University Hospitals NHS Foundation Trust	1,105	2,336	1,063	2,089
Buckinghamshire Healthcare NHS Trust	541	233	360	260
University Hospital Southampton NHS Foundation Trust	2,465	301	691	92
NHS Commissioners				
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	677	-	5	-
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	537,532	261	2,891	1,379
NHS Frimley ICB	42,701	-	153	1,825
NHS Hampshire and Isle of Wight ICB	2,270	-	-	-
NHS North West London ICB	967	-	2	-
NHS Somerset ICB	902	-	1	-
NHS Surrey Heartlands ICB	819	-	37	-
NHS England	66,575	-	4,256	885
Other NHS bodies				
NHS Resolution	-	25,161	5	3
NHS Property Services	-	1,902	1	483
Other Whole Government Account bodies				
HM Revenue & Customs	-	43,994	-	9,158
NHS Pension Scheme	-	63,881	-	5,521
NHS Blood and Transplant	29	2,128	4	83
NHS Professionals	-	17,890	-	2,904
Local Authorities				
Reading Borough Council	2,802	525	-	-