NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Annual Report and Accounts

2025 - 2026

Communities Matter

Creating stronger, healthier, happier communities.

Bridgewater Community Healthcare NHS Foundation Trust

Annual Report and Accounts 2025-26

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

Contents

1. Statement from Chair and Chief Executive

It is our privilege to present the final Annual Report and Accounts for Bridgewater Community Healthcare NHS Foundation Trust (BCH), marking the conclusion of a proud and impactful chapter in our organisation's 15-year history.

The 2025-26 year has been unlike any other. It has been a year defined not only by our continued dedication to patient care, but by the solid foundation setting that will shape the future of community and hospital services across our region for years to come.

At the time of writing, government approval was formally received for BCH and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) to legally come together as one organisation. Named North Cheshire and Mersey NHS Foundation Trust (NCM), our newly integrated trust will officially launch on 1 April 2026. This represents one of the most significant developments in the local NHS landscape for more than a decade, and it will create new opportunities to strengthen the way we deliver care for the people and communities we serve.

While this transition marks the closing of one chapter, it also opens the door to an ambitious and exciting future.

Since its formation in 2011, BCH has consistently demonstrated the value and impact of high-quality community healthcare. Over the years, our colleagues have delivered compassionate, person-centred services to hundreds of thousands of patients across Cheshire, Merseyside and Greater Manchester, often supporting people at their most vulnerable.

From the early years of establishing a new community trust, through the challenges of rising demand, system reform and a global pandemic, our teams have shown remarkable resilience, professionalism and heart. The Trust's role in helping people remain well at home, preventing unnecessary hospital admissions, and bringing care closer to where people live will remain an enduring part of its legacy.

There is much to be proud of. Our services have evolved, our partnerships have strengthened, and our commitment to inclusive, community-based care has remained unwavering. This final Annual Report highlights just a fraction of the exceptional work happening across our teams every day - work that has changed lives, supported families and ensured our communities receive safe, accessible and effective care.

Throughout 2025-26, our focus has been two-fold: maintaining the highest standards of care while preparing for integration with WHH.

We have seen continued investment in key community pathways; strengthened collaborative working with our acute partners; further expansion of neighbourhood-based services; and a shared commitment to delivering seamless, person-centred care.

Colleagues across BCH have approached integration with professionalism, flexibility and an openness to doing things differently. Their willingness to embrace change, while remaining steadfast in their commitment to patients, has been a source of immense pride.

Looking ahead as NCM, the formation of this integrated organisation provides a powerful opportunity to reimagine how community and hospital services can work together. By bringing our expertise, our workforce and our shared values into one unified organisation, we will be better equipped to deliver truly integrated care - care that ensures people only tell their story once, that supports independence at home, and that responds to the real needs of our communities.

We will build on the very best of BCH and WHH. We will create a more seamless experience for patients, provide greater support and development opportunities for staff, and ensure community services are central within the wider health and care system.

As we prepare for this transition, we want to offer our heartfelt thanks to every colleague, executive director, non-executive director, governor, volunteer and partner who has contributed to Bridgewater's success over - not just the past 12-months - but the past 15 years.

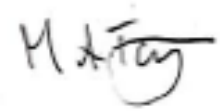
Your dedication, compassion and resilience have been the driving force of this organisation. You have embodied our values, supported one another through immense challenges, and put patients at the centre of everything you do.

The name, Bridgewater Community Healthcare NHS Foundation Trust, may be ending, but its spirit, its people and its impact will now live on within North Cheshire and Mersey NHS Foundation Trust. The work that matters most - the support we provide to patients, families and communities - will continue, strengthened by the opportunities which lie ahead.

With our very best wishes and sincere gratitude,

Nikhil Khashu

CHIEF EXECUTIVE OFFICER



Martyn Taylor

CHAIR

2. Performance Report

2.1 Overview of Performance

The purpose of the overview is to give a short summary to provide sufficient information to understand our organisation, its purpose and the key risks to the achievement of its objectives and how it has performed during the year.

Chief Executive's statement

This year marks an extraordinary moment in the history of Bridgewater Community Healthcare NHS Foundation Trust. As we publish this final Annual Report, we do so with a deep sense of pride - not only in what we have achieved over the past 12 months, but in everything this organisation has contributed to our communities since 2011. It has been a year defined by continuity and change: delivering safe, compassionate care every day, while preparing for one of the most significant organisational transitions our local NHS has seen in more than a decade.

Government approval has now confirmed that Bridgewater Community Healthcare NHS Foundation Trust (BCH) and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) will formally unite to become North Cheshire and Mersey NHS Foundation Trust (NCM) on 1 April 2026. This decision reflects the strength, quality and ambition of our services and provides a powerful opportunity to reshape how community and hospital care work together in ways that will truly benefit the people we serve.

Throughout this period of preparation, our colleagues have remained unwavering in their commitment to patients, families and communities. Their professionalism, adaptability and compassion have been the foundation on which this transition has been built. I want to express my heartfelt thanks to every member of staff for the dignity and focus with which they have navigated this year. I would also like to acknowledge the support of our Chair, Martyn Taylor, and both our executive and non-executive directors, whose leadership has been instrumental in guiding us through this final chapter.

Alongside integration planning, 2025-26 has been a year of remarkable achievement. Our services have continued to receive recognition locally, regionally and nationally. Highlights include the Urgent Community Response team being named Warrington's Health Hero - an award that reflects exceptional multidisciplinary working and the real impact made in helping people stay safely at home. We celebrated our nursing, dental and allied health professional colleagues, whose commitment to compassionate, inclusive and person-centred care has been recognised through awards, media features and sector-wide accolades.

We were particularly proud to see our Making Flexible Work initiative showcased at the national NHS Staff Experience Conference, reinforcing our commitment to staff experience and wellbeing. The reaccreditation of our 0–19 teams by the UNICEF UK Baby Friendly Initiative demonstrated our continued focus on evidence-based, family-centred practice; while national recognition for our Intermediate Care and Frailty Services highlighted the strength of our clinical partnerships and innovation in supporting people at home.

The practical impact of integration continues to flourish. In dermatology, closer collaboration has enabled a more patient-focused service at the Halton Health Hub in Runcorn Shopping City. Since April 2025, the service has supported over 2,600 patients and delivered more than 700 surgical procedures, helping to ensure timely diagnosis and treatment and a positive experience for people on the cancer pathway.

These achievements are a testament to the expertise and dedication of our workforce - and to

the values that have shaped BCH from the beginning. They also reflect our commitment to tackling health inequalities, strengthening neighbourhood models of care and listening closely to the voices of patients, families and carers.

As we move into the next phase of our journey, our focus remains clear. The creation of North Cheshire and Mersey NHS Foundation Trust provides a unique opportunity to build a more integrated, responsive and person-centred health and care system. By bringing community and hospital services together, we can reduce fragmentation, improve continuity and ensure people only need to tell their story once. Most importantly, we can strengthen the services that help people remain independent, well and supported at home.

The name Bridgewater may be coming to an end, but its legacy - our culture, our people and our belief in the importance of community healthcare - will continue at the heart of NCM.

To every colleague, partner, governor and volunteer: thank you. It has been a privilege to lead this organisation, and I am immensely proud of everything we have achieved together. The future is bright, and together we will continue to shape it for the communities we serve.

Nikhil Khashu

Chief Executive Officer

Profile of the Trust

Bridgewater Community Healthcare NHS Foundation Trust (Bridgewater) is a leading provider of community health services and specialised dental care in the North West of England.

Bridgewater Community Healthcare NHS Trust was established in April 2011. On 1 November 2014, the organisation was awarded NHS Foundation Trust status and changed its name to Bridgewater Community Healthcare NHS Foundation Trust.

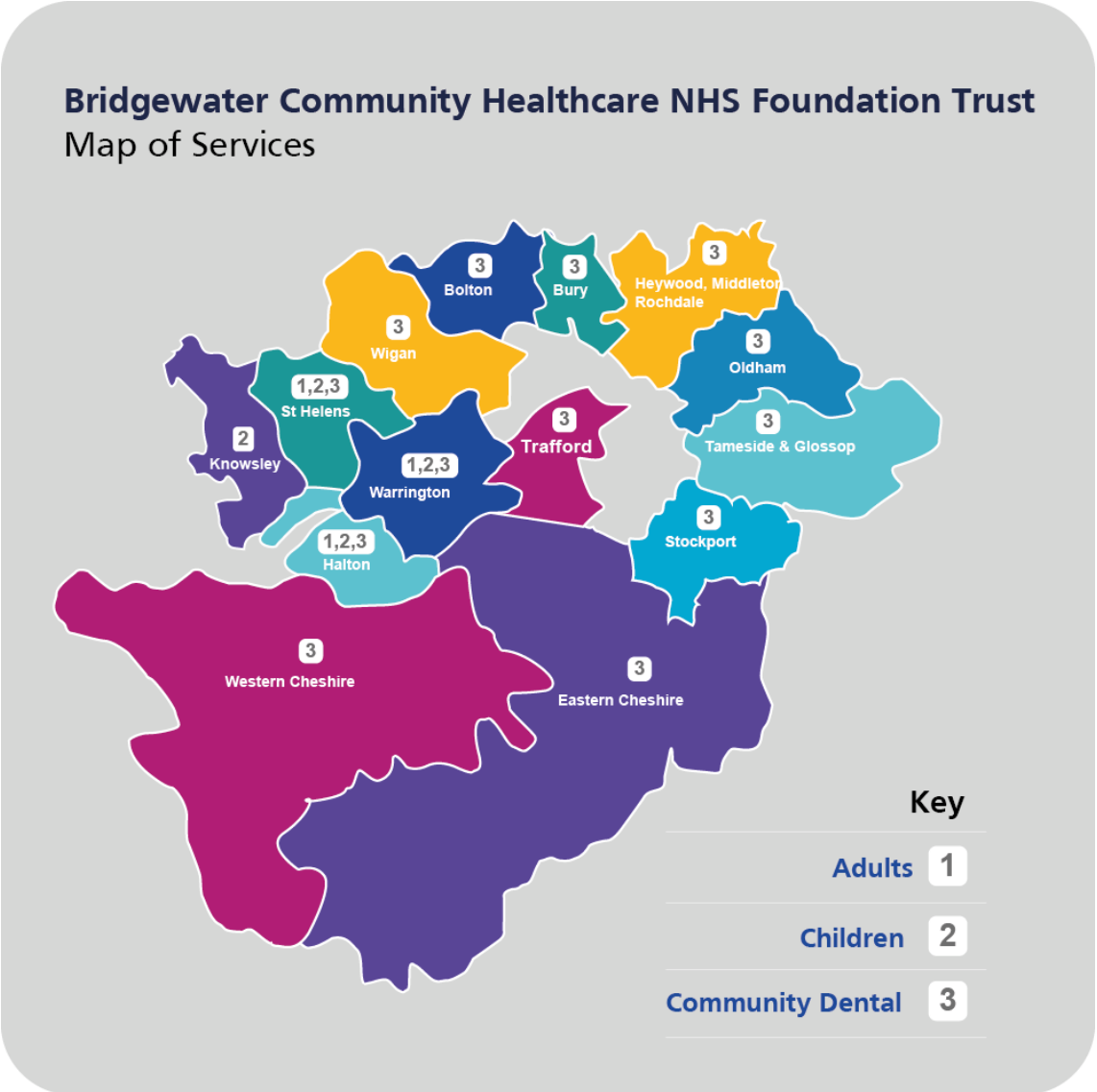
The Trust is part of the Cheshire & Merseyside Integrated Care System (ICS), place-based partnerships and Provider Collaboratives which deliver joined up approaches to improve health and care outcomes.

During 2025-26 Bridgewater provided community adult and children's nursing and therapy services in Halton, Warrington and St Helens.

It also provided specialist community dental services across a larger geographic footprint in the North West covering many towns in the Cheshire & Merseyside and Greater Manchester regions.

The Trust is also the provider of Drive Ability North West in partnership with Drive Mobility and the Department for Transport.

Below is a map of the services provided by the Trust and where they are sited.



In 2025, the Trust embarked upon an ambitious programme of integration with colleagues at Warrington & Halton Hospitals NHS FT.

The Better Care Together programme builds upon the strengths of the two respective organisations, and its central tenet is to develop an organisation that works better by integrating the care and support provided within the community and acute sector.

By coming together, it is anticipated that we will deliver new models of care, with the continued involvement of a wide range of partner and voices, including primary care, local authorities and people with lived experience.

The integration programme represents an exciting opportunity to really make things better for our patients and our staff, whilst making our services stronger and more resilient.

One of the key developments in our journey was the appointment of a joint Chief Executive, Nikhil Khashu in November 2024.

Following this appointment the respective Boards of both organisations have approved the appointments of a joint Chief Operating Officer, joint Medical Director and joint Chief Nurse.

The process of integration has been supported by a robust and far-reaching communications and engagement programme. Regular briefings for staff are provided, and a dedicated internet and intranet site has been created to ensure staff, patients, public and stakeholders have access to the very latest developments.

“Better Care Together: A Case for Change”, found on Bridgewater’s Trust website, outlines the benefits of the two organisations coming together as a single organisation for our patient, staff and commissioners.

Warrington Adults

Our Warrington Adults’ Services has a large team of community nurses supported by specialised nurses, therapists and community matrons. We work with system partners across Warrington to provide an urgent community response service and frailty virtual ward. We deliver multi-disciplinary services which include:

- responding to urgent care needs and therapy needs as part of an integrated intermediate tier health and care offer
- intermediate care beds
- nursing care within care homes
- equipment services
- wheelchair services
- acquired brain injury and neuropsychology
- podiatry
- musculoskeletal and orthopaedic clinical assessment
- dermatology
- district nurses

Halton and St Helens Adults

Our Halton Adults’ Services is comprised of a large team of community nurses supported by specialist nurses, therapists and community matrons. We work with system partners across Halton and Warrington to provide an urgent community response service and frailty virtual

ward. We deliver a multi-disciplinary neuro rehabilitation service, stroke and heart failure services within Halton supporting our local community to promote self-care and the prevention of ill health and support the reduction of unavoidable admissions to our acute partners.

Our urgent treatment centre in Widnes is the focal point for many community-based services, with clear connections to our own services and those of our local partners. We also deliver wheelchair services, infection prevention and control services, equipment services, podiatry and speech and language services.

The Drive Ability North West service, delivered in partnership with Drive Mobility and the Department for Transport, provides services across the north west of England, supporting people with assisted driving, accessibility and independent living.

Children's Services

The Trust offers a range of universal and specialist children's community services in Halton and Warrington, with a small number extending into Knowsley, St Helens, Frodsham and Helsby.

The Trust retained the Halton 0-19 Service, Healthy Child Programme Contract for 2025 - 2030 through a successful Direct Award Contract process with Halton Borough Council.

The universal services delivered include

- Health Visiting
- Infant Feeding
- School Nursing
- Oral Health Promotion
- Hearing Screening in schools

Our universal services work closely with partners in place to ensure all parents and carers are able to give their children the best start in life through early identification and early help.

The specialist services delivered include:

- Family Nurse Partnership
- Paediatric Diagnostic Audiology
- Paediatric Occupational Therapy
- Paediatric Physiotherapy
- Paediatric Speech and Language Therapy
- Paediatric Bladder and Bowel
- Children's Community Nursing
- Community Paediatric Medical Service
- Neurodevelopmental Diagnostic Assessment
- Post diagnostic support from the Specialist Nursing Teams

Our specialist services work with partners in place to ensure all children and young people have timely access to high quality, specialist health treatment and support as required.

The Trust secured the Halton Universal, Targeted and Specialist Speech and Language

Service Contract from 1st April 2026 through a successful Direct Award Contract process with Halton Borough Council/ Halton Place ICB.

Specialised Dental Services

The North West Community Dental Service currently provides NHS dental services to a combined population of over two million people, who live across Cheshire, Merseyside and Greater Manchester.

We provide specialised dental care on referral to people of all ages, with disabilities and other needs which make it impossible for them to access treatment from an NHS family dentist (General Dental Practice). We also are commissioned to provide a specialist oral surgery service and intravenous service for anxious adults in Cheshire and Merseyside.

The majority of our services are delivered across 18 clinics within Greater Manchester and Cheshire and Merseyside, close to where our patients live but we also offer a domiciliary service to those patients that can't leave their homes As a provider of mainstream and specialist care, our role is to focus on providing cost effective NHS care.

Staff Headcount

On 31 March 2026, the headcount of our staff was 1530, and the whole time equivalent (WTE) was 1274.73. All staff are Staff Members of our Foundation Trust unless they opt out.

Operating Income

Our income for the year ended 31 March 2026 totalled £106.1m (2024-25: £107.6m) and included:

ICB and NHS England	£85.7m (2024-25 £84.9m)
Local authorities	£15.9m (2024-25 £16.4m)
Education and Training (including Health Education England)	£1.5m (2024-25 £1.9m)
Other NHS Providers	£1.7m (2024-25 £2.2m)
Other sources	£1.2m (2024-25 £2.2m)

The income for the provision of goods and services for the purposes of the health service in England is greater than our income for the provision of goods and services for any other purposes. (As per section 43(2a) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)).

The Trust has utilised operating income received to fund the cost of services provided along with essential investments to support key service developments. (As per section 43 (3a) of the NHS Act 2006 (as amended by the Health and Social Care Act 2021))

Our Mission and Strategy

Where people live matters. Communities matter.

As a community health care provider, Bridgewater Community Healthcare NHS Foundation Trust is an integral provider of the services delivered in the community. We support people to remain in their own home with their loved ones for longer, improving their health and wellbeing outcomes.

We see the impact of health inequalities across our communities and the demands these place across all our services. Our caring and professional staff respond to these needs, always going the extra mile to help and support the people they care for.

The new Health & Care Act, and the formation of Integrated Care Systems (ICSs), which are focused on places and local communities, set out the framework and the vision for the delivery of truly integrated care around a person-tailored and personalised to their needs and providing support for their families, in their own home and community. Therefore, protecting resources in hospitals and specialist services for when care at home can no longer be provided.

Achieving this person-focused, holistic care requires a committed and focused partnership approach and a shift in mindset. The drive to do things differently and the ability to challenge each other as partners in place and hold each other to account will help us collectively make a difference to the people we have in our care.

As a community provider, we are determined to improve equity in health outcomes with our partners to maximise the health, wellbeing, and prosperity of communities. We are challenging the traditional notion that an NHS provider only treats the ill, ambitiously moving this focus towards the delivery of planned and preventative care in the services we provide. Across our service portfolio, we already play a huge role in offering expert clinical care, and we will create additional capacity in our services by maximising the use of technology and delivering service transformation so that we can significantly contribute to preventing poor health, whilst improving and creating health and wellbeing.

Our mission statement is:

"We will improve health, health equity, wellbeing and prosperity across local communities, by providing person-centred care in collaboration with our partners."

We have an incredibly diverse portfolio of services with a vast reach across and into the heart of our communities. Whilst every service has its own range of national, regional and local priorities and must do's, our Trust Strategic Objectives are cross-cutting and apply to every

service.

Our Strategic Objectives have been developed to ensure they help drive delivery of our mission, provide clear goals and measurable steps for each directorate and service, and describe how they will, collectively, enable our services and our staff to thrive.

Our six Strategic Objectives are:

1. **Quality** - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
2. **Health Equity** - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.
3. **Staff** - We will ensure the Trust is a great place to work for our staff.
4. **Resources** - We will ensure that we use our resources in a sustainable and effective way.
5. **Diversity, Equality and Inclusion** - We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.
6. **Partnerships** - We will be a committed, respected and valued partner as we work in close collaboration in place and across the system to deliver the best possible care and positive impact in local communities.

Wrapping around our mission and objectives, we are building on our approach to engagement. At the heart of the collaboration between the NHS and its partners, the voices of the patient, communities and staff must be heard and embedded. Not as a one off, periodically undertaken task, but in the true spirit of co-production to shape and influence how improve the health and wellbeing of local communities.

We are working to improve healthcare for our communities and have embarked on a process of integration with Warrington and Halton Hospitals NHS Foundation Trust. Since 2024, we have been moving towards working as one to ensure our healthcare system is sustainable for the future. This includes establishing a formal partnership to deliver greater integration of community and hospital services with shared leadership and governance arrangements. These changes will help us develop new models of care with more care delivered at home and in the community and designed in partnership with a wide range of partners and voices, including primary care, local authorities and people with lived experience of health services.

Working towards integration will help partners better co-ordinate the use of public facilities across our boroughs to help us deliver more care in community settings, where safe to do so. This will include providing more care from homes but also clinics, health centres and health hubs. We have already worked in collaboration with Warrington and Halton Hospitals NHS Foundation Trust and local authorities, by successfully introducing this approach with recent developments including Halton Health Hub (located in Shopping City, Runcorn) and the Living Well Hub (located in Warrington town centre), enabling our staff to deliver more services in the community.

These developments will create the best conditions for staff to provide excellent patient care, in an environment where people want to be cared for and where people want to work. They will also support us to innovate, address health inequalities and deliver a green and sustainable future.

Communities matter.

Our role is to develop stronger, healthier and happier communities.

Influences and risks

From 1 April 2026 the Trust will be acquired by Warrington and Halton Hospitals NHS Foundation Trust (WHH) and will become North Cheshire and Mersey NHS Foundation Trust (NCM). The Trust will be exposed to many external influences and risks which will change and drive the way services are delivered in years to come.

Close monitoring and review will be needed and will be undertaken at a Trust level to ensure alignment to local system changes and health policy.

The analysis below illustrates the key external influencing factors and risks:

Political	• The Integrated Care System (ICS) and place-based infrastructure and commissioning arrangements • Increased financial challenges for the entire system • Potential lack of coordination across the system when setting commissioning strategies • Patient choice and NHS Constitution • Impact of integration with, and across, local partners and Provider Collaboratives
Economic	• The current cost of living crisis, for the people we serve and our staff • Risk to sustained transformation programmes within current resources • Continued impact of reduced funding and ambitious Cost Improvement Programme (CIP) • Increasing demands e.g. increased acuity of patients' conditions, ageing population and long-term conditions • Reduction in services from system partners due to budgetary pressure and challenges • Current industrial action being witnessed across many UK sectors
Sociological	• Demographic changes and impact i.e. ageing population and health inequalities across local communities • Global pandemic which highlighted health disparities and complex access issues across different ethnic communities • People with increasing dependency on services for their long-term health and social care needs • Varied levels of deprivation across all boroughs and local neighbourhoods • Increased emphasis on community based preventative healthcare / self-management and health creation • Increased choice for where care is received e.g. in community, at home etc. • Growing culture of assertive consumerism with increasing expectation

Technological	• New IT solutions: People powered technology e.g. telehealth / telemedicine • New and innovative technologies to drive and transform how care and services are accessed and / or delivered • Alignment and sharing of data and information across IT platforms, and between partners • Greater access to the internet, apps and remote assessment • Potential for a widening of the digital inclusion / exclusion divide • Availability of new drugs to support conditions and disease • Diagnostic / service capability i.e. opening up opportunities for delivery of more services / diagnostics outside the acute hospital sector • Innovation to support care delivery and staff mobilisation e.g. Electronic Patient Records (EPR), Virtual Wards and agile working • A hybrid approach to home / office working, security and reliability • Maintenance and replacement of hardware / communications network / software
Legal	• Future organisational legal status • Changes due to reversion to UK law • Regulatory environment i.e. regulatory checks, changing CQC approach, NICE guidelines, governance etc. • Potential future changes to staff terms and conditions • On-going changes to drug and equipment licencing between EU and UK
Environmental	• Estates, i.e. available estate to meet expectations and requirements • Green Plan and Carbon Reduction targets • Investment in smart buildings control systems • Corporate responsibility to environmental factors e.g. carbon footprint, recycling etc. • Focus on NHS Prevention Pledge and Anchor Institution status • Provision of sustainable care • Increasing estate and utility costs

Going Concern

These accounts have been prepared on a going concern basis.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

The Trust is also required to disclose material uncertainties in respect of events or conditions that may cast significant doubt upon the going concern ability of the Trust and the Trust does not consider that there are any such events or conditions requiring disclosure. However, details have been provided below in respect of future potential core activity changes.

The Secretary of State for Health and Social Care approved a transaction business case in March 2026 which had the following impact. On 1st April 2026, Bridgewater Community

Healthcare NHS Foundation Trust dissolved. All its assets and liabilities were acquired by Warrington and Halton Teaching Hospitals NHS Foundation Trust who subsequently renamed as North Cheshire and Mersey NHS Foundation Trust. Services at all trust sites continue but under the management of the new entity. This does not prevent the going concern basis for accounts being adopted and is not a material uncertainty over going concern.

The Trust has submitted a 2026-27 plan to both NHS Cheshire and Merseyside ICB and NHS England (NHSE) showing a break even position. The Board has approved the plan.

Having considered the uncertainties in the Trust's financial plans, the directors have determined that these are not material, and it remains appropriate to prepare these accounts on a going concern basis as per the statement below:

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

Service Improvement and Transformation - Key Achievements in 2025-26

Halton Adult Services

Widnes Urgent Treatment Centre

Since our first Patient Led Assessment of the Care Environment (PLACE) assessment in 2022 the service has been revisited annually by the PLACE team to re-assess its progress, ensuring our standards continue to be maintained and improved.

PLACE assessments give patients and local people the opportunity to tell services directly what they think of the environment and make recommendations for change. In this way, patients and local people can influence how the service is run and ultimately, improve the service for everyone.

The outcome of our most recent assessment, undertaken in October 2025, reported that patient assessors were happy with the environment of Widnes Urgent Treatment Centre (UTC) and were confident that a good level of patient care and experience is being delivered. Improvements made since the previous year were acknowledged, particularly enhanced external accessibility for wheelchair users. Areas for development were identified, including clearer and more accessible signage, the introduction of a dedicated quiet room for privacy and breastfeeding, and improvements to accessibility for people with hearing loss. Recommendations have been incorporated into an action plan for ongoing improvement.

Halton Urgent Community Response

Working in collaboration with Halton Borough Council and acute partners, our Urgent Community Response team continue to support people to get the care they need at home. This service receives a high volume of referrals and supports patients with high acuity to prevent unnecessary hospital admissions.

The service continues to work in close partnership with the Mental Health, Learning Disabilities, and community collaborative Urgent Community Response Project Group. This group focuses on implementation of key Cheshire and Merseyside workstreams including development of the Northwest Ambulance Service stack project, supporting category 3, 4 and 5 ambulance conveyance.

Community Nursing Teams

Work has continued in 2025-26 to develop community nursing. Services continue to deliver a high-quality service for patients whilst ensuring sustainability and resilience in the workforce.

Recruitment and retention of the nursing workforce have been key objectives of this piece of work, and our senior community nursing role continues to be embedded within the services. In 2026-27 work will continue to develop the community nursing model focusing on seamless pathways of care.

Drive Ability North West

The Drive Ability North West service continues to grow and develop having increased the number and partnerships of our outreach services. In 2025-26 the service moved to their new operational delivery base in St Helens and took on delivery of the Blue Badge (Disabled Persons' Parking) Scheme in Warrington.

Heart Failure

During 2025-26 our Heart Failure Nursing Team have collaborated with Widnes Primary Care Network (PCN) and system partners to develop an enhanced community service for people with heart failure within Halton.

An integrated multi-disciplinary hub for patients has been developed, reducing the structural challenges and inequalities across the healthcare system related to this condition.

Halton Palliative Care Team

Halton Palliative Care Team have continued to improve their relationships with local health care providers to achieve better outcomes for patients. A morning huddle has been set up with Halton Haven Hospice, Warrington Halton Specialist Palliative Care Team and Whiston Halton Specialist Palliative Care Team which has proved effective in more timely and appropriate admissions to the hospice and improved transfers for patients between the acute trust and primary care.

Halton Palliative Care Team have led Bridgewater community services in developing the Trust Palliative End of Life Care Strategy. The work has been a challenge for the service due to clinical demands but in undertaking the work, the team have developed closer relationships between community services, and the collaboration has produced positive strategies to improve patient experience and ensure the right services are involved at the right time.

Podiatry

Over the last twelve months, the Podiatry service in Halton has halved their waiting list whilst maintaining a significantly high number of referrals.

Halton Podiatry services have been undergoing a transformation to ensure that the resources which are available are delivered in the most efficient and effective way and directed at those with the highest clinical need. The team have developed a new needs-based eligibility criteria that is supported by evidence based best practice. These changes have maximised clinical capacity within the team and focused resources.

Wheelchairs

The team hold a current caseload of over 4000 clients across Halton and St Helens. Although there is a waiting list, children and palliative care patients do not have to wait and there no patients waiting over 18 weeks.

The Halton and St Helens Wheelchair Service have commenced a process of integration, and this will remain the focus for 2025-26. The aim of this integration workstream is to build sustainability and resilience within the services, sharing learning and maximising opportunities for development

Parkinson’s Disease Nurse

The Parkinson’s Disease (PD) nurse continues to provide an excellent service for patients in Halton who have been diagnosed with Parkinson’s or Parkinsonism. As a sole practitioner, they work in collaboration with PD UK, the Walton Centre and other local healthcare providers to ensure that a high-quality service is delivered to all.

Warrington Adult Services

Urgent Care Response (UCR)

The Warrington UCR service has been fundamental in supporting the Urgent and Emergency Care workstream to reduce hospital attendances and admission where necessary and support people in crisis within the wider community. The service strives to deliver care within 2 hours of receiving a call, aiming to prevent an unnecessary emergency department attendance and admission where clinically appropriate. The service has consistently achieved the 2 hours response target of 70% throughout the year.

The Clinical & Operational UCR model has been revised and improved. The model is an

evidence-based delivery model which is aligned with national, Cheshire & Mersey and local models, to reduce hospital admissions in the over 65 years target cohort in Warrington. Moving into 2026-27 the model from last year will be continued to be implemented, whilst continuing to focus on caring for patients in the community.

The UCR team have been working in partnership with North West Ambulance Service (NWAS) on a pilot to prevent unnecessary hospital admissions and attendance in patients who are deemed a category 3,4 or 5 call by NWAS call handlers and are UCR suitable. The NWAS CAS (Stack) project has been in operation since November 2025. NWAS will contact UCR prior to conveyance of patients identified as category 3, 4 or 5 to establish if the patient is suitable to be onboarded to UCR and be cared for in their own home or if they can be signposted to another suitable alternative service therefore preventing an admission to the Emergency Department.

Dermatology

The Dermatology team ended the year with zero patients waiting beyond the 65-week and 52-week targets. This represents a significant achievement and reflects the team's sustained focus on timely, high-quality patient care.

Podiatry

The podiatry team ended the year with zero patients waiting beyond the 52-week targets. This represents a significant achievement and reflects the team's sustained focus on timely, high-quality patient care.

Frailty Virtual Ward

The aim of the Frailty Virtual Ward is to provide 'hospital at home', patient-centred care to patients over 65 years with a frailty condition. The virtual ward currently onboards patients who reside within both nursing and residential care homes, with an additional step-down pathway that allows patients from the Frailty Assessment Unit to be stepped down to their own home.

Moving into 2026-27 a step-up pathway will be developed and implemented to onboard patients from their own homes into the virtual ward.

The Warrington Virtual Ward is currently open to a maximum of 20 beds. Bed occupancy has been challenging at times but has remained at approximately 60-70% filled.

The Warrington Frailty Virtual Ward is a partnership between Warrington & Halton Hospitals (WHH) and Bridgewater Community Healthcare Foundation Trust (BCH).

MADE (Multi-Agency Discharge Event)

The Warrington Directorate work closely in collaboration with system partners to support the MADE (Multi-Agency Discharge Event) held at WHH. The event is focused on collaborative working with health and social care.

- Identifying and removing barriers to ensure patients can be discharged from hospital in a timely manner
- Enhance cross-organisational working
- Expediate safe and appropriate discharges
- Support early facilitated discharge
- Improve patient flow

Several teams from the Warrington Directorate including Community Matron, Community Equipment Stores, Intravenous Team, Catheter Team, Urgent Care Response service,

Intermediate Care, Enhanced Care Home Support Service and District Nursing all play a fundamental part within the MADE events that are carried out throughout the year.

Specialised Dental Services

Following successful CQC registration we moved into our new Dental Hub in Altrincham on 6 May 2025, vacating 3 previous older clinics spread across Trafford.

We have continued to make significant capital investment in our clinics and surgery space within 2025-26 to replace dental chairs, inhalation sedation, x-ray, and decontamination equipment.

In Cheshire and Merseyside, our contracts have been extended to provide paediatric exodontia and special care services.

We continued to support and influence managed clinical leadership forums across both regional systems, focusing on paediatrics, special care, and oral surgery. We also hold internal network meetings for paediatrics, special care, and oral surgery, alongside professional dental nurse group meetings.

We maintain a high level of compliance across all clinical sites with infection prevention and control audits, and audits against Health Technical Memorandum 01-05 standards. We have introduced Quality Review Visits to our clinics as part of the wider Trust initiative.

We conducted the 2025-26 epidemiology surveys of adults in care homes across Cheshire and Merseyside and in eight boroughs of Greater Manchester (GM), and in 2026-27 we will focus on the oral health of 5 year olds. We provided two regional trainers to participate in conducting the survey and host national calibration events.

We collaborated with NHS England North West (NHSENW) to provide placements for six first-year and one second-year foundation dentists and supported an oral surgery specialist trainee in Cheshire and Merseyside.

Our in-house inhalation and intravenous sedation courses have been reaccredited by the Royal College of Surgeons, and we have continued to deliver these courses to our dental teams. We ran a sedation update course for all staff in September 2025.

In addition, a number of staff have been accredited to deliver ‘clinical holding’ training, which is being rolled out across all teams, thereby providing our teams with the skills they require to deliver treatments effectively and safely where appropriate.

We have continued to see a growing demand for paediatric dentistry and have reviewed our pathways with our partner hospital sites to ensure patients wait the shortest possible time for their treatment under general anaesthetic; we have opened up one of our Whiston theatre sessions and continue to maximise the 20 slots we have available at the Trafford Hub. We have been able to successfully allocate other pathways for children with additional needs to reduce their wait for treatment.

Children’s Services

<u>Halton and Warrington 0-19 Services: UNICEF UK Stage 3 Baby Friendly Initiative</u>

The services successfully achieved the UNICEF UK Stage 3 Baby Friendly Initiative (BFI) re accreditation award.

This prestigious recognition follows a rigorous two-day on-site assessment and highlights the services ongoing commitment to supporting families and giving every baby the best start in life.

The initiative is a nationally recognised programme that sets standards for supporting infant

feeding and parent-infant relationships. Achieving Stage 3 re-accreditation means that 0-19 teams have fully embedded stage 3 standards into everyday care, ensuring that families consistently receive high-quality, evidence-based support.

BFI-accredited services are proven to increase breastfeeding initiation and duration rates, which are vital for infant health and development. There are also significant health benefits for mothers. Achievement of these standards means local families are benefitting from the very best start.

The BFI assessment team described the results as “particularly impressive, given that the assessment is based on the implementation of new community standards.”

Warrington Therapies: Service Offer to 17-19 year olds

Warrington Occupational Therapy, Physiotherapy and Speech and Language Therapy Services secured additional funding to facilitate an extension to the teams offer to meet the needs of young people aged 17-19 years of age.

Halton 0-19 Years Service: Emotional Wellbeing Team

Halton 0-19 team have been working in partnership with the Halton Family Hubs Best Start in Life programme and have developed an Emotional Wellbeing multidisciplinary team that supports parents with mild to moderate mental health needs and parent-child relationships. This team have created a range of groups such as ‘Mindful Me’ and ‘Time for Me’ an ‘Neonatal Natters’ where parents / carers can come together in an informal and supportive environment to participate in therapeutic craft activities whilst their child is able to access on-site creche facilities. Feedback has been incredible with parents reporting a hugely positive impact.

The Family Hub’s ‘Best Start in Life’ programme has also enabled the 0-19 team to develop and deliver a range of one to one and group interventions such as the Lighthouse Parenting, Circle of Security group, video interactive guidance, targeted baby massage, and support the delivery of creative writing workshops all of which support the nurturing of secure and respectful parent-infant relationships.

The Emotional Wellbeing Team have created our ‘Perinatal Infant Mental Health (PIMH) Village’ and strengthened our links between services that provide mental health support for Halton. They have produced a strategy to support the multidisciplinary approach to supporting parental mental health and parent child attachment for our families, which includes a neonatal pathway and birth trauma pathway.

Halton 0-10 Service: Best Start Healthy Babies Family Hub and Healthy Child Programme Learning Exchange

Due to the challenges of staying up to date with rapid changes, the Halton 0-19 service alongside Family Hub colleagues, have developed a series of 30-minute ‘Best Start Healthy Babies Learning Exchange’ sessions, held weekly. These sessions provide an opportunity for partners to come together to hear about the latest developments and opportunities available in Halton. Each session features guest speakers who share updates on new initiatives and resources for families, with a particular focus on families with a preschool child. During March 2026, guest speakers included Dad Matters, Parenting Co-ordinator, Midwifery, and the local Health Improvement team.

Halton 0-19 Service: Better Start Conference, Blackpool

The team were invited to provide both a poster and a symposium presentation. The presentations were titled:

- Developing Integrated Pathways to Support Children’s Development in Halton

- A Partnership Approach and Start for Life: Evaluating a Collaborative Multidisciplinary Team (MDT) Approach to Perinatal Emotional Wellbeing.

Warrington 0-19 Service: Mandated Offer

The Warrington 0-19 team have been recognised by commissioners as one of the highest performing 0-19 Services in the North West and nationally, in terms of achieving the mandated core contacts in the Healthy Child Programme within target timeframes. A report from DHSC (2026) identifies that the Warrington service currently performs better than the average both across the Northwest region and England.

Warrington 0-19 Service: Work with the Department of Health and Social Care

Warrington 0-19 were selected as one of three local authority areas to take part in the Department of Health and Social Care (DHSC) research and deep dive on our Health Care Partnership delivery which was good news. The research focused on 'Healthy Babies' and how as a 0-19 service we have been able to increase and deliver on productivity, maintain KPIs and the delivery of a high quality as a borough that did not receive Family Hub funding.

As a result of this work, the DHSC and policy lab professionals attended our Warrington 0-19 Celebration Event to find out more regarding the service offered to Warrington families.

Following the event, positive feedback was received from those attending and we were asked to compile a Healthy Babies good practice case study. The DHSC fed back that they were "keen that they didn't just spotlight local authorities who have received Start for Life funding and was aware from the research workshop how much positive work there is going on in Warrington". Following this involvement with the DHSC, the Warrington 0-19 service were then invited to a 'Healthy Babies co-design workshop' in Leeds to take part and share best practice.

Warrington 0-19 Service: NHS Employers National Conference

The team were invited to participate in a film which opened the annual NHS Employers National Conference in November 2025 showcasing how the service had made flexible working work successfully, for both staff and service users. Retention of staff remains high, and staff identify that flexible working opportunities have contributed to this.

Children's Specialist Services: Neurodevelopmental Diagnostic Assessment Pathway

In June 2025, teams successfully completed Rapid Intervention project. The project enabled the team to triage, risk stratify and data transform every child referred for a neurodiverse assessment. The Trust has been the first in the Cheshire and Merseyside ICB region to fully complete this piece of work. This project has been recognised by the Trust and has been shortlisted for a Trust 'Thank You Award' and the outcome will be known at the event on 15th May 2026.

Warrington 0-19 Service: Oral Health

Warrington Oral Health Team were contacted by the Cheshire and Merseyside funded 'All Together Smiling' programme manager to help deliver training for partners across the region.

This request was made as the Warrington team have created a reputation for delivering a successful, long-standing supervised toothbrushing programme, with a track record of achieving outstanding results.

Warrington Speech and Language Therapy Service: Developmental Language Disorder Pathway

The team have developed and implemented a new Developmental Language Disorder (DLD) care pathway in accordance with latest evidence base. Staff have received training to build confidence diagnosing this disorder which affect approximately 7% of all school age children.

The team have delivered a training programme for DLD to all mainstream schools.

Warrington Paediatric Bladder and Bowel Service: Toileting in Schools project

The service is working with families, young people and high schools across Warrington to make it easier for pupils to have access to a toilet during the school day.

A lack of access can affect learning, confidence, mental health and, for some children, the management of long-term health conditions. By improving access to toilets and encouraging children and young people to stay hydrated whilst in school the team hope to help pupils stay healthy, reach their full potential, and reduce the need for ongoing healthcare support as they grow older.

Next steps include speaking with schools, through focus groups and other activities, to understand the challenges they face. The team will also be creating tailored training for staff and gathering ongoing feedback from parents, carers and young people.

Going Digital

A number of teams across children's services are trialling Lyrebird, an ambient voice technology that records conversations during meetings and clinical consultations and generates a summary. This creates efficiency when documenting records and minutes of meetings etc and the intention is to implement this across clinical teams for record keeping purposes once any learning / training etc has been identified following the trial period.

Warrington and Halton 0-19 Services

A digital reception year health questionnaire process has been developed by the School Nursing Team, so that communication with families of children that are starting school is efficient and responsive. This approach has reduced costs in relation to printing, staff travel costs, and staff time and has received positive feedback form both parents and carers and school staff. In addition, the teams will begin sending result letters following the National Child Measurement Programme school visits digitally rather than by post. This will deliver cost savings on postage and reduce the time spent printing and posting.

Halton and Warrington Neurodevelopmental Nursing Teams: Patient booking system

The team have introduced a new on-line patient booking system for height, weight and blood pressure measurement appointments, where parent/carers can choose a date and time to best suit their own/child's schedules.

People and Organisation Development

- During the year, the Trust has continued to strengthen its approach to People and Organisation Development, underpinned by the People Operational Delivery (POD) infrastructure and oversight through the POD Council. This work aligns with the NHS People Promise and focuses on improving staff experience, engagement and inclusion, while supporting high-quality patient care.
- Delivery of the Trust's people priorities is informed by national NHS England frameworks and robust workforce intelligence, including sickness absence, turnover and staff survey data. The continued development of the Trust's People Dashboard has enhanced oversight and triangulation of workforce data, enabling more informed and evidence-based decision-making. This year also saw the introduction of a dedicated Equality, Diversity and Inclusion (EDI) dashboard, ensuring equity remains central to organisational decisions.
- The Trust continues to place strong emphasis on listening to and engaging with staff. Staff Networks play a vital role in supporting inclusion and amplifying staff voice,

representing colleagues from ethnically diverse backgrounds, those with disabilities, long-term conditions or neurodivergence, and those who identify with diverse gender and sexual identities. Additional networks support carers and colleagues experiencing menopause. Collaborative working has been further strengthened through the 'Networks in Common' approach with Warrington and Halton Teaching Hospitals NHS Foundation Trust.

- Progress has continued against the Trust's equality and inclusion priorities, with action plans in place and monitored across the Gender Pay Gap, Equality Delivery System, Workforce Disability Equality Standard and Workforce Race Equality Standard. This work is complemented by the Trust's commitment to the North West Black, Asian and Minority Ethnic Assembly Anti-Racist Framework and the NHS EDI Improvement Plan. External accreditations, including Disability Confident Leader status, the Navajo LGBT+ Charter Mark, Veteran Aware accreditation and Silver status in the Defence Employer Recognition Scheme, provide further assurance of the Trust's inclusive approach.
- Board and Executive-led engagement remains a key feature of the Trust's culture. 'Time to Talk' sessions continue to provide opportunities for direct dialogue with services, enabling senior leaders to understand staff experience and respond to feedback. The Trust's Health and Wellbeing offer has continued to expand, with initiatives tailored to workforce needs and informed by absence and wellbeing data. Targeted support has been provided to teams with higher absence levels, supported by partnership working where appropriate.
- The Trust has also strengthened its focus on safety and dignity at work. The Sexual Misconduct Policy has been embedded in support of the NHS England Sexual Safety Charter, alongside participation in the Cheshire and Merseyside Integrated Care Board Domestic Abuse and Sexual Safety Allies programme. Trained allies now operate across the Trust, providing visible and accessible support for staff.
- Investment in learning, development and career progression remains a priority. The Trust has continued to maximise the benefits of its Apprenticeship offer, with full utilisation of the Apprenticeship Levy. Significant progress has also been made in standardising job descriptions and competency frameworks, developed with clinical and staff input and aligned to newly released national Nursing and Midwifery profiles. This work supports transparency, consistency and clearer career pathways for staff.
- Flexible working continues to be actively promoted through the Making Flexible Work campaign, reinforcing the Trust's commitment to supporting diverse working patterns. The high level of applications received during the year reflects both staff demand and increasing managerial confidence, with the programme receiving national recognition and contributing to wider NHS learning.
- Overall, the Trust remains committed to creating a compassionate, inclusive and high-performing organisation, where staff feel valued, supported and able to develop, and where strong people practices continue to underpin safe and effective care.

Digital Services

- The Trust continued its planned digital enabling and infrastructure developments in line with its Digital Strategy during 2025-26.
- We continued the enablement of the option of patient facing digital services for our dental services including self-check in, electronic correspondence and questionnaires and improved our reporting capabilities.
- Digitised children's dental surveys across the Greater Manchester and Cheshire and

Mersey by replacing paper-based processes digital surveys. This improved data accuracy and turnaround times, reduced administrative burden, and enabled more efficient, secure collection and reporting of survey data.

- Reviewed and optimised clinical records templates with various clinical services.
- Enhanced access to the Cheshire and Merseyside Connecting Care Record service and our ability to share structured data.
- Completed the rollout of e-Prescribing to community pharmacies from Bridgewater services.
- Introduced call transfer of 999 calls suitable for the Urgent Crisis Response service by enablement of electronic messaging between the ambulance system and the Trust's clinical systems.
- Commenced digital communications of national child measurement programme results and health promotion support.
- Started the structured introduction of artificial intelligence software and technology to support clinical and non-clinical requirements.
- Procured and deployed digital dictation and speech recognition software with ambient voice technology capabilities.
- Enabled system functionality to improve referral and waiting list management to track the status of children on neurodevelopmental pathways.
- We procured and deployed 300 new or replacement laptop and desktop devices and ancillary equipment as part of continued lifecycle technology management.
- Completed the trust wide migration of laptops and desktops to Windows 11; upgrading 100% of devices within required timeframe ensuring continuity of support.
- Deployed biometric authentication capability to all Windows 11 Laptops strengthening security. This also improved user experience, reduced account-lockout incidents, and lowered demand on IT support services.
- All digital disciplines now utilise our online service desk request/reporting portal improving responsiveness and management for Trust staff. 70% of support activity now comes via the portal and projects are tracked using the tool.
- Continued working with regional teams on 24x7x365 security operations centre and joint cyber security initiatives further improving our cyber posture.
- National annual Data Security Protection Toolkit (DSPT) for 2024-25 submission with 'approaching standards' and completed a number of internal / external audit digital reviews for assurance.
- Maintained 100% level Password using Multi Factor Authentication (MFA) across our NHS Mail service users, all internet facing applications hosted by Bridgewater now using the same MFA function, improving our cyber protection.
- All Trust systems and applications use fully supported operating systems and software for security, compliance and risk mitigation, with further progress on following cloud / internet first strategic programmes of work.
- Completed the migration of Bridgewater users' data from local home file areas to cloud, improving data security, resilience, and information governance. This enabled better collaboration, remote access, and full alignment with NHS best-practice standards.
- Refreshed Integrated Quality Performance Report (IQPR) indicators and reporting

format.

- Migrated to a new improved data warehouse feed from a key EPR supplier improving speed and timeliness of information.
- Implemented successful updates to national submissions to reflect latest version standards and Faster Data Flows requirement.
- Continued with data quality and improvement sessions across all services with the monthly data quality steering group (DQSG) effectively addressing data quality issues.
- Maintained and further developed self-serve Qlik Sense reports to enhance performance data, further utilising write-back functionality to facilitate two-way interaction with the data providing actionable insights.

Estates and Infrastructure

The Trust provides clinical and administrative services from 54 locations and for each location maintains an overall accountability in respect of the building and environment infrastructure The locations are classed as follows: 5 freehold, 13 leased from NHS Property Services, 13 leased from Community Health Partnerships, 3 leased from GP landlords, 6 leased from private landlords, 7 NHS hospital sites and 5 local authority sites.

In 2025-26, activity included:

- Capital refurbishment and adaptation of new leased premises for the North West Drive Ability Service, purchase of additional car parking land and backlog maintenance schemes including, roof/skylight improvements at Europa Point, car park re-surfacing, boiler replacement and refurbishment of several freehold health centres.
- Implementation of new waste processes including re-useable plastic sharps containers and enhanced domestic waste recycling processes.
- Participation in the 2025-26 NHSE PLACE programme in respect of Widnes Urgent Treatment Centre.
- Facilitation and co-ordination of a number of internal team re-locations.
- New contracts procured in respect of renewable energy, clinical waste collection services, confidential waste services and mail collection services.
- Reviewed and improved internal processes utilising, where appropriate, digital solutions in respect of postage (hybrid mail), flexible working practices within the organisation, minor works job allocation template and data portals in respect of utilities and waste management data.
- Continued management and operational responsibility across the wider agendas, in respect of health and safety, waste management, electrical and mechanical maintenance, cleaning, emergency planning arrangements, infection control framework compliance, landlord / tenant relationship management and resource management.
- Enhanced working with Warrington and Halton Hospitals NHSFT in respect of internal transport arrangements, grounds and gardens provision and medical engineering.
- Extension of Community Health Partnership property leases.

Emergency Preparedness, Resilience and Response

As defined in the Civil Contingencies Act 2004 (CCA 2004), Bridgewater Community Healthcare Services NHSFT has a responsibility to plan for, respond to, manage, and recover from any emergency that occurs within its own operational bounds, or the wider geographical

footprint in which it operates. CCA 2004 requires NHS organisations, and providers of NHS-funded care, to demonstrate that they can deal with such incidents, while maintaining normal services. Within Bridgewater, Emergency Preparedness, Resilience and Response (EPRR), encompassing emergency planning, business continuity and on call arrangements is managed, on behalf of the Board, by the Chief Operating Officer who is also the Accountable Emergency Officer.

The Trust is committed to working as part of a broader system of mutual aid and support and recognises that EPRR requires collaboration with resilience partners from other NHS organisations including the Local Health Resilience Partnership (LHRP), and non-NHS organisations such as the Local Resilience Forum (LRF) including the sharing of skills, experience, knowledge, data and resources.

During 2025-26, all trusts self-assessed themselves against the national EPRR framework, which consists of 58 core standards split into the functional domains of governance, duty to assess risk, duty to maintain plans, command and control, training and exercising, response, warning and informing, co-operation, business continuity and Hazmat / Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE).

Following assessment by Cheshire and Merseyside ICB, the Trust reported a compliance score of 83% against the standards therefore recording a partial assurance rating across the overall EPRR framework. The Trust has been undertaking a review of all the required information and meeting internally, with PLACE colleagues, provider collaborative community colleagues and at a system level, to address the identified areas of partial assurance rated standards and to support the development of policies and procedures and to source training as required.

Patient Feedback Received April 2025 – March 2026

Below are some of the comments received by Bridgewater about the services we provide and the healthcare professionals who deliver those services.

Names have been removed to comply with data protection requirements.

Halton

Catheter Care Service, Halton. I've been helped by the team since March 25 and every occasion the staff have gone out of their way to help, advice and reassure me, including follow up phone calls.

Start for Life, Wellbeing, Halton. I've loved the team. They've helped me no end. I didn't realise that there was this much help for parents in my area.

Adult Bladder and Bowel Service, Halton. Very helpful and explained everything well and made feel very comfortable in talking about a very personal problem.

Paediatric Occupational Therapy/Physiotherapy, Halton. Amazing appointment today. The reception lady was lovely, Occupational Therapists (OT) were wonderful with my daughter, made sure she was checked properly and very helpful with me too, thank you.

Newborn Hearing Screening, Halton. Friendly Patient and knowledgeable, gave clear explanations as to what was happening and the next steps.

Virtual Ward, Halton. Everyone who called on where courteous and explained in plain lang what treatment I was to be given.

Heart Failure Service, Halton. She was so helpful so easy to talk to and she listened and is resolving my problem with medication and very kind and extremely supportive.

Podiatry Service, Halton. Brilliant team of ladies all are kind and put you at ease and are very

professional... we are lucky to have them here in Halton.

District Nursing, Halton. The nursing staff are always pleasant, my husband has dementia and they always make him feel at ease.

Health Visiting, Halton. Jodie is very supportive and friendly. She guided us to many strategies to help us with our son's development and issues.

School Nursing, Halton. Nurse was fantastic. She was calm, not overwhelming, didn't lose her patience or get harsh. Because of her nature my daughter managed to get all three injections! My daughter is massively needle phobic. I can't thank her enough. My daughter is now vaccinated against some horrible diseases this is a huge relief!

Urgent Treatment Centre, Halton. Referred by 111, you were fully booked and short-staffed, but I was told to turn up anyway. My condition was time critical, but I expected to wait. Instead, I was seen to immediately and walked out twenty minutes after arrival with the treatment, I'd been unable to secure over the previous fortnight. Outstanding, thank you.

Warrington

Catheter Care, Warrington. To the amazing team, you are all brilliant, from hugs to tissues, which there have been many. The way you listen and explain everything in the smallest detail. You have contacted other teams when I felt standard, thank you from the bottom of my heart

Palliative Care, Warrington. I want to thank you so very much for all you did for [name & name] over the last week Without you I would have been lost, thank you for acting so quickly and put everything in place to help [name] keeping him pain free. Thank you for being there at the end of the phone and coming to my rescue at short notice. You are all amazing, kind people

Podiatry Service, Warrington. Podiatrist she was fantastic, quickly identified, then corrected, the problem with my toe. More importantly, her bedside manner helped me enormously. I ended up talking about my mental health problems, which only intersect with my diabetes insofar as it sometimes gets me down a bit, but she didn't shut me down and was able to do what she needed without the appointment overrunning.

Padgate House, Warrington. Thank you to everyone who cared for mum during her stay, she is now up and enjoying her weekly trips to M & S, thank you.

Treatment rooms, Warrington. I have received excellent treatment and advice and would like to thank you all wonderful people.

Community Matron, Warrington. My sincere gratitude for the wonderful care and support that [name] has provided to my late mum and to me as her career. From the very beginning, [name] has been compassionate, approachable, and incredibly professional. Her visits have not only ensured that Mum's medical needs were met, but she also offered emotional support and reassurance during what has been a very difficult and emotional time for us. Her kindness and understanding made such a difference — she treated Mum with dignity and respect, and she always took the time to listen, explain things clearly, and make sure we felt supported. I truly feel she went above and beyond.

Health Visiting, Warrington. HV has been our health visitor for 3 years - she first came out to our middle child who had development delays and suspected autism. HV made the relevant referrals for, as a result she ended up with a very rare place (1 in 10) at Sandy Lane Specialist Nursery this wouldn't have been possible without our HV she went above and beyond for her. Since then, I've had my third child 2 weeks ago, same HV has been out to me and my newborn son, and she has been amazing as always.

Paediatric Speech and Language Therapy Service, Warrington. We are amazed with the amount of progress Frankie has made since having therapy. I can't thank you enough. You are amazing with him. We are glad he will see you again in the future as he loves coming to his sessions with you.

Infant Feeding, Warrington. Entire staff starting from receptionist to the 3 amazing ladies, me and my wife met upstairs were nice, excellent in their duties. They are knowledgeable in their field of expertise, talking to them opened our eyes to so many things we never knew about breastfeeding, we left feeling hopeful and better.

Falls and Rehab, Warrington. To all the team thank you, you will never express our appreciation for all the support and quality of care we have received.

Specialised Dental Services

Dental, Bury. Staff are fantastic and very autism friendly'. Mum explained that her son was experiencing some pain in his mouth and was seen very quickly by a dentist. [Name] came away from his appointment a totally different person'.

Dental, Bury. Amazing staff, very caring and listened to and respected our son's needs.

Dental, Oldham. I just wanted to personally thank you for the incredible support, dedication, and compassion you've shown in helping my son, secure a General Anaesthetic appointment for his much-needed dental treatment. Your kindness and persistence mean the world to us. You listened carefully, took ownership of the concerns I raised, and followed through exactly as you promised. Thanks to your efforts, we now have an appointment scheduled for our son.

Dental, Bolton. I just wanted to thank you and the whole team involved in the care of [Name] yesterday. Your understanding, patients, care and compassion was very much appreciated and ensured the whole experience ran smoothly, enabled [Name] to receive the treatment he needed. Your person-centred approach is outstanding from the time taken with me to plan every last detail to making [Name] calm and comfortable

Dental, Trafford. The surgery and recovery went very well; [name] is doing great! I put the success down to thorough planning on your part, from his appointment to his best interest meeting to arriving on the day of surgery. We, as a team, have felt listened to and that you understood the difficulties he faces with medical professionals. The consideration and reassurance his allocated nurse [name] showed to him on the day was exceptional care. Please pass on our appreciation to the team that was involved.

Dental, West Cheshire. We have never experienced our daughter to be sedated for treatment. From the moment she arrived she was welcomed and explained all the treatment carefully. The doctor and the nurse were amazing; they used instrumental music and soft words to treat her. The dentist hides the needle and counts numbers while making treatment. Overall, this procedure was fantastic, and all children should be treated like this when they go to the dentist.

Dental, Halton. Thank you for the care and patience you have shown me along my journey, I think you're all amazing.

Dental, Leigh. We want to thank you all. Everyone was amazing and you'd have thought [name] was the queen. That was and is the best hospital visit [name] has ever had. Thank You for letting [name] have her treatment at here. All the staff was amazing.

Dental, Chester. I have been attending for several years and have always had wonderful treatment, professional, friendly, caring and thorough. If you leave a message they always call back punctually and usually have a solution ready. I was seen quickly and the team did everything possible to make sure I got the best and most appropriate treatment. They always

make sure they fully understand the problem, discuss the options available to me and treat me with great care and respect. I needed a series of appointments, and this was arranged very efficiently and quickly to reduce my pain. I suffer from Huntington's Disease which makes dental work problematic, but the team always put me at ease, treat me with great sensitivity and do everything possible to make it a good experience. I can't speak highly enough about the Chester team and wanted to record my gratitude

2.2 Performance Analysis

Performance Analysis

Bridgewater Community Healthcare NHS Foundation Trust aims to continually enhance service quality and performance. The Board requires assurance that its performance management approach is rigorous, allowing for the identification and escalation of performance concerns, as outlined in the Trust's Performance Framework.

The Performance Framework sets out guidance to ensure that there is an integrated approach to managing performance with clear visibility and lines of accountability from the Board to service level. The framework defines the governance and responsibilities for performance throughout the organisation. Effective performance management supports our ability to embed a continuous improvement cycle linked to the Trust's Boosting Efficiency Programme.

In 2025-26, the Trust continued to enhance performance data with automated self-serve reports via Qlik Sense. The monthly data quality steering group (DQSG) effectively addressed data quality issues. Scrutiny of activity and key performance indicators continued using Statistical Process Control (SPC) style reporting, in alignment with NHS England's 'making data count' guidance, which provides greater insight into performance at both service and directorate levels.

The Trust's Integrated Quality and Performance Report (IQPR) details metrics across performance, quality, people and financial indicators that are scrutinised on a monthly basis at Performance Council, Quality Council and Strategic People Committee in Common. Several adjustments have been made to the IQPR throughout the year to ensure continued alignment of the indicators with local and national guidance.

Integrated Quality and Performance Report (IQPR)

The Trust's IQPR is the primary document used to monitor and report the Trust's performance against Key Performance Indicators (KPIs). The IQPR comprises:

- 49 performance indicators
- 34 quality indicators
- 4 people indicators
- Summary of financial performance

Indicators are reported via Statistical Process Control (SPC) charts to specify performance control limits and identify trends and exceptions. Performance exceptions are individually reported within the IQPR, including both analytical and operational narrative.

The IQPR is reported at Performance Council, Quality Council, Quality and Safety Committee which was succeeded by the Quality and Assurance Committee in Common (quality indicators), Strategic People Committee in Common (people indicators), and the Finance and Performance Committee, which was succeeded by the Finance, Sustainability and Performance Committee in Common (all indicators), and a summary is reported to Board via the Finance and Performance / Finance, Sustainability and Performance Committee in Common Committee Chair's report.

Information is triangulated using the Risk Register, Performance Framework and IQPR along with the Board Assurance Framework. Detailed information on how risk is managed can be found in the table below and the Annual Governance Statement on page 104. The Quality and Safety Committee, succeeded by the Quality and Assurance Committee in Common, routinely requests reports on risks scored over 15 and monitor action plans and outcomes.

Performance Reporting and Escalation

Information Type	KPI sources	Data source	Data Quality	Data Snapshot dates	Analytical Source	Narrative Source	Reports included in	Exceptions presented at
Activity	Nationally Mandated Data sets / Targets; Information Schedule	Clinical systems data auto feeds into data warehouse daily.	Reports sent to operational leads prior to data snapshot. Post snapshot SPCs are used to facilitate data quality.	2nd working day of each month	Business Intelligence Team; Statistical Process Charts	Operational Managers; Associate Directors	Commissioner reports; Qlik Sense; IQPR	Directorate Leadership Team meetings; Performance Council; Finance & Performance Committee / Finance Sustainability & Performance Committee in Common, F&P/FSPCiC Chair's report to Board
Quality Indicators	National & Local	Ulysses data extract provided to Information team on a monthly basis.	Ongoing checks, raised before snapshot when identified. Raised through PSIRF governance structures after snapshot.	Ulysses - 3rd day each month Up to 10th working day	Business Intelligence Team; Statistical Process Charts	Head of Risk Management; Operational Managers; SMEs; Director of Quality Governance	Qlik Sense; IQPR; Quality and Safety Committee; Board; Patient Safety Incident Response Framework and Learning Panel (PSIRFaLP)	Quality and Safety Committee/ Quality & Assurance Committee in Common; Quality Council Q&S / QACiC Chair's report to Board
Finance	National Guidance, such as planning guidance & Local ICB requirements	SBS oracle ledger updated daily.	Reviewed on day 5 by finance team. Senior finance team review both key data and full return prior to submission. Submission has built in validation criteria. ICB review key data.	7th working day key data submission	Finance Team	Senior Finance Team	IQPR Board Finance & Performance Committee / Finance Sustainability & Performance Committee in Common, EMT Team brief	IQPR Board Finance & Performance Committee / Finance Sustainability & Performance Committee in Common EMT F&P/ FSPCiC Chair's report to Board
Workforce	National Benchmarks; Local - match WHH KPIs	Access to electronic data from ESR and E Roster.	HR team run regular DQ reports - national codes for op and job roles	Between 7th - 10th Working Day each month, when ESR and E-roster are integrated	Business Intelligence Team; Statistical Process Charts	Head of Workforce; Deputy Director of People & Organisational Development	Qlik Sense; IQPR; IPR (WHH); Board; National Workforce Return	Strategic People Committee in Common Directorate Leadership Team meetings; Performance Council; Finance & Performance Committee / Finance Sustainability & Performance Committee in Common, F&P/FSPCiC and SPCiC Chair's reports to Board

Quality Outcomes

It is a requirement of NHS England that trusts establish and effectively implement systems and processes to ensure that they can meet national standards for access to health care services. In 2025-26, a number of performance standards were measured in their assessment of the overall governance. These are summarised in the table below and demonstrates achievement against the threshold / target during each month of the year.

KPI Name	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96%	100% (▲)	56.25% (▼)	89.47% (▲)	95.45% (▲)	86.67% (▼)	33.33% (▼)	25% (▼)	40% (▲)	71.43% (▲)	62.5% (▼)	100% (▲)	90.91% (▼)
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%	91.18% (▼)	90.48% (▼)	94.74% (▲)	66.67% (▼)	86.36% (▲)	79.17% (▼)	71.43% (▼)	53.85% (▼)	72.5% (▲)	70.83% (▼)	89.29% (▲)	88.89% (▼)
28 day Faster Diagnosis Standard	75%	89.53% (▲)	85.94% (▼)	83.19% (▼)	79.88% (▼)	75.6% (▼)	65.14% (▼)	49.34% (▼)	66.87% (▲)	65.19% (▼)	67.16% (▲)	89.25% (▲)	92.11% (▲)
A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%	94.49% (▼)	98.5% (▲)	98.97% (▲)	98.08% (▼)	98.62% (▲)	98.2% (▼)	98.36% (▲)	96.01% (▼)	95.95% (▼)	99.12% (▲)	98.56% (▼)	98.18% (▼)
Audiology - Number of 6 weeks diagnostic breaches	0	57 (▼)	63 (▼)	98 (▼)	93 (▲)	71 (▲)	50 (▲)	16 (▲)	41 (▼)	50 (▼)	2 (▲)	5 (▼)	17 (▼)

Cancer Service

The Trust delivers dermatology community-based cancer services to patients living in the Warrington area which is commissioned by Warrington Place on behalf of the Cheshire & Merseyside Integrated Commissioning Board (ICB).

The Trust remains committed to achievement of all three core cancer performance standards

- The 28-day Faster Diagnosis Standard (75%)
- 62-day referral to treatment standard (85%)
- 31-day decision to treat to treatment standard (96%)

In November 2025, the 28 day Faster Diagnosis Standard compliance decreased to 66% as a result of an administrative error resulting in a number of patients not recorded within the appropriate system. An incident was duly reported, and actions were managed with input from relevant Trust teams. In addition, the Trust engaged with the Cancer Alliance who supported additional funding for two waiting list initiatives, which, along with a deep-dive undertaken by WHH's Cancer Manager, enabled the service to implement an appropriate action plan, resulting in an improved and above target position in February 2026.

Due to small numbers of patients progressing through to treatment for skin cancers, a single patient breaching the standard can have a significant impact upon the Trust's ability to achieve the 31-day wait from diagnosis to first treatment.

Audiology Diagnostics

The Trust delivers audiological assessment at all initial audiology contacts. The waiting time standard for all diagnostic testing is six weeks. The Trust have been working to reduce the numbers of patients breaching this standard and meet monthly with the Cheshire & Merseyside Diagnostic Programme team to track progress.

The service has maintained weekly performance meetings, with clear actions tracked and reviewed to ensure accountability and continuous improvement. In addition, the process for notifying parents and carers of their child or young person's appointment has been standardised, including clearer communication timelines, improved use of digital and written correspondence, and follow-up procedures to reduce missed appointments. Following this work, breaches have reduced month on month, which is evidenced in the table above, alongside improved compliance with waiting time standards and increased appointment utilisation.

Clinical Coding Error Rate Validity

Bridgewater Community Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2025-26 by NHS England.

Statement on Relevance of Data Quality and Actions to Improve Data Quality Validity

The Trust acknowledges the importance of basing all Trust and clinical decisions on reliable data and has implemented several controls to ensure high-quality data.

All Trust staff are required to maintain accurate records through:

- Legal obligations (Data Protection Act 2018)
- Contractual obligations (Contracts of employment)
- Ethical obligations (Professional codes of practice)
- Regulatory obligations (Care Quality Commission, IG Toolkit)

- The Trust has proactively worked to improve data quality by:
    - Ensuring national submissions are updated to reflect the latest version standards
    - Automating daily submissions into the NHS Demographics Batch Service for demographics data from main clinical systems, with ad hoc submissions for other specialised systems
    - Offering one-on-one data improvement sessions to all services
    - Maintaining and continuously developing Self-serve Qlik Sense data quality reports
    - Raising awareness of data quality issues at directorate leadership team meetings

NHS Number and General Medical Practice Code Validity

Bridgewater Community Healthcare NHS Foundation Trust submitted records during 2025-26 for inclusion in relevant national datasets.

The percentage of records in the latest published data (December 2025) which included the patient's valid NHS number was:

Data set	Bridgewater Compliance	National Average
Community Services Data Set	99.9%	87.8%
Emergency Care Data Set	99.8%	96.9%
Mental Health Services Data Set	100%	48.9%

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

Data set	Bridgewater Compliance	National Average
Community Services Data Set	100%	94.4%
Emergency Care Data Set	99.3%	97.4%
Mental Health Services Data Set	100.00%	69.6%

Financial Performance

The Trust's accounts have been prepared under a direction issued by NHS England under the National Health Service Act 2006.

For the financial reporting year ended 31st March 2026, Bridgewater Community Healthcare NHS Foundation Trust has reported a deficit of £6.019m (2024-25: £1.196m deficit) and this is the same figure as in the summarisation schedules that underpin the accounts. However, it should be noted that the deficit for 31 March 2025 includes technical adjustments for impairments to give an adjusted financial position of £4.428m deficit (2024-25: £1.1564m deficit).

Accounting Policies

The accounts have been prepared to comply with International Financial Reporting Standards (IFRS) as modified by the Foundation Trust Annual Reporting Manual, published by NHS England.

Budget Setting Principles

Budget setting principles are reviewed by the Finance and Performance Committee / Finance, Sustainability and Performance Committee in Common and the Trust Board every year. The process follows all published national and regional (ICB) guidance. Budgets are based on available resource from the Trust's agreed contracts and the service specifications contained within them and workforce planning with the appropriate managers.

Capital Expenditure

The Trust incurred capital expenditure in 2025-26 of £2.3m (2024-25: £2.2m), split between Estates schemes of £1.2m, clinical equipment replacement of £0.5m and IT investment of £0.5m.

Income

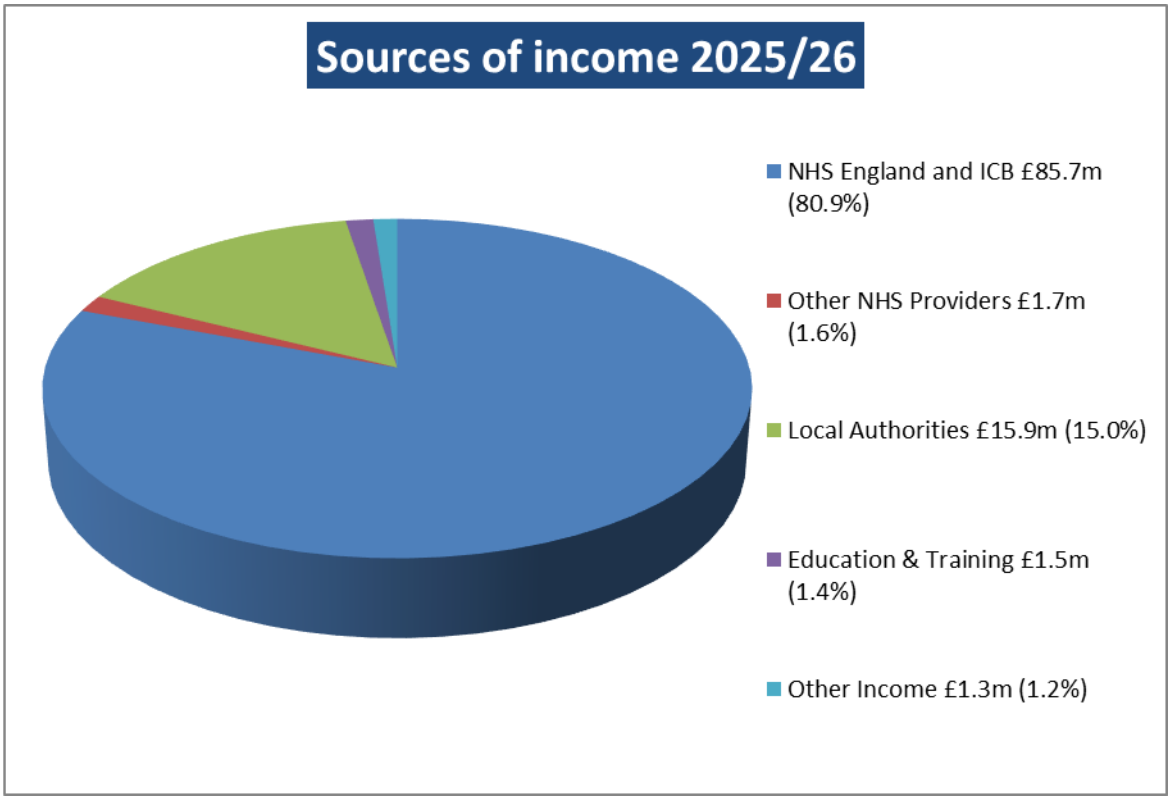
Our income for the year ended 31 March 2026 totalled £106.1m (2024-25: £107.6m) and included:

ICB and NHS England	£85.7m (2024-25 £84.8m)
Local authorities	£15.9m (2024-25 £16.4m)
Education and Training (including Health Education England)	£1.5m (2024-25 £1.9m)
Other NHS Providers	£1.7m (2024-25 £2.2m)
Other sources	£1.2m (2024-25 £2.2m)

The income for the provision of goods and services for the purposes of the health service in England is greater than our income for the provision of goods and services for any other purposes. (As per section 43(2a) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)).

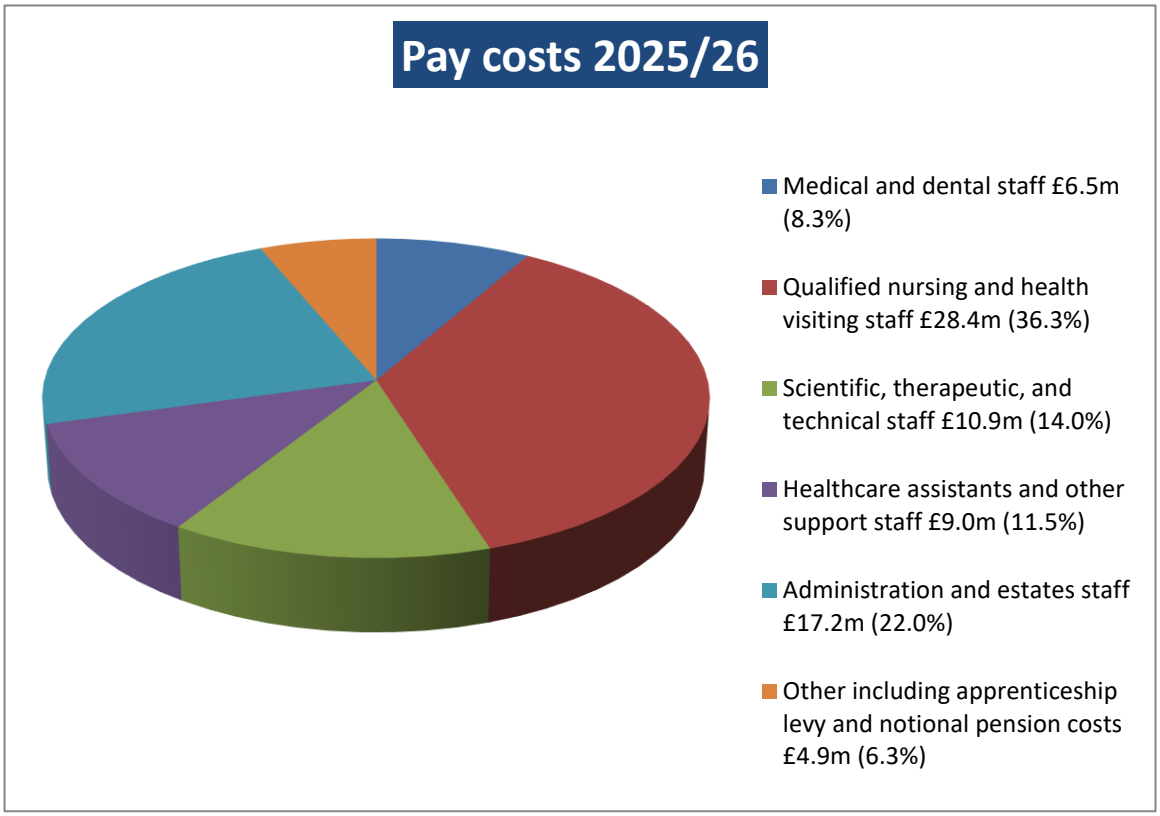
The Trust has utilised operating income received to fund the cost of services provided along with essential investments to support key service developments. (As per section 43 (3a) of the NHS Act 2006 (as amended by the Health and Social Care Act 2021))

The Trust's income was generated as shown in the chart below, which highlights the categorisation of all the Trust's income taken from the accounts.

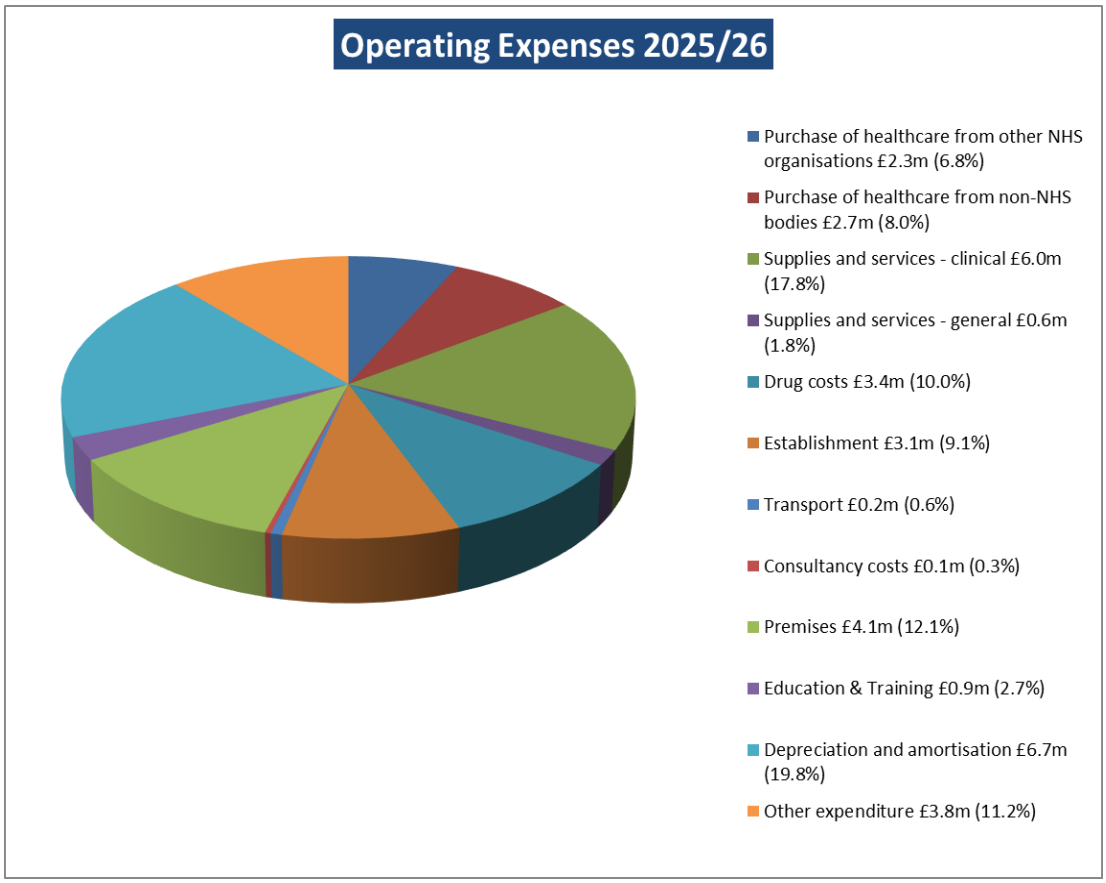


Expenditure

The Trust's main source of expenditure is Employee Costs (staff) totalling £77.7m representing 69.7% of total expenditure. The chart below highlights the breakdown of these costs.



Expenditure on Operating Expenses, excluding employee costs, amount to £33.9m. The chart below provides an analysis of this expenditure by category.



Events after the Reporting Period

On the 1st April 2026, all the assets/liabilities from Bridgewater Community Healthcare NHS Foundation Trust transferred to North Cheshire and Mersey NHS Foundation Trust.

Future Financial Performance

On the 1st April 2026, all the assets/liabilities from Bridgewater Community Healthcare NHS Foundation Trust transferred to North Cheshire and Mersey NHS Foundation Trust.

The major challenge the new organisation faces over the next few years, is to ensure expenditure levels are controlled in line with agreed system income envelopes.

For 2026-27 the Trust has planned for a Cost Improvement Programme (CIP) target of 6% of operating expenditure, which includes an element of non-recurrent CIP from previous financial years. The target is challenging and will require the Trust to continue to review all services to ensure that each service is performing efficiently whilst ensuring that the quality of service is not affected.

Collaboration with the relevant plans of the Cheshire & Merseyside Integrated Care Board (ICB)

The Trust has exercised its functions in collaboration with the relevant plans of the Cheshire & Merseyside Integrated Care Board (ICB) for which it is a partner trust.

These relate to relevant forward plans of the ICB, and any joint capital resource plans agreed between the ICB, the trust and the other partner trusts of the ICB.

Through its collaborative approach in local place-based partnerships with Warrington Together and One Halton, the Trust contributed to the development of the respective Health & Wellbeing

Strategies, and the priorities and key areas of focus identified within these plans fed into the overarching Cheshire & Merseyside Joint Forward Plan (C&M JFP).

This approach supports clear alignment between the Trust's Communities Matter Strategy (2023-26) and Strategic Objectives, the place-based objectives, and the four core strategic objectives of the C&M JFP, namely:

- Tackling health inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.
- Enhancing productivity and value for money.
- Helping to support broader social and economic development.

Partnerships and collaboration are one of our Strategic Objectives, where "We will work in close collaboration with partners and their staff, in place and across the system, to deliver the best possible care and positive impact in local communities."

This objective is underpinned and driven by five deliverables:

- We will continue to work in close partnership with local General Practice, the Primary Care Networks and GP Federations to further enhance the quality and provision of services across our local communities.
- We will work closely with all our partners and their staff to drive forward continuous quality improvements in the services we collectively provide.
- We will work across our organisational boundaries with partners and their staff in place as we create future integrated care and service models.
- We will work with partners to improve equity in health outcomes.
- We will work with our system partners to collaborate at scale to enable better care at place

Throughout our Strategy, we have described our ambition to deliver high quality, person-focused care and we believe that a partnership approach will best help us to collectively achieve this. The partnership between Community Healthcare, Primary Care, Local Government, the voluntary sector and wider partners is absolutely pivotal.

The benefits of developing and delivering services in collaboration are well documented and include:

- Improved outcomes.
- Improved equity in health outcomes.
- Improved experience (for patients, local people and staff).
- Faster access to the right intervention, first time.
- Reduced inefficiencies.
- Improved staff morale and job satisfaction

Anti-Fraud, Bribery and Corruption Measures 2025-26

Each year, the NHS is vulnerable to an estimated £1.346 billion in fraud; money which could otherwise be used to improve patient care, invest in medical staff and enhance services. Fraud has a significant impact on the NHS and is not a victimless crime.

Bridgewater Community Healthcare NHS Foundation Trust is fully committed to

promoting a robust anti-fraud, bribery and corruption agenda and takes a zero-tolerance approach towards such activity.

The Trust contracts Mersey Internal Audit Agency (MIAA) to deliver anti-fraud, bribery and corruption services on its behalf. A nominated Local Counter Fraud Specialist (LCFS) delivers a programme of work in collaboration with key stakeholders to raise staff knowledge and awareness of fraud, bribery and corruption, support prevention and detection efforts and maintain strong governance arrangements.

The Executive Director of Finance is the Senior Responsible Officer for fraud, bribery and corruption at the Trust and, together with the Audit Committee, is responsible for approving and monitoring the programme of work undertaken. The Deputy Director of Finance is the nominated Counter Fraud Champion and provides support to the LCFS. All anti-fraud, bribery and corruption work undertaken at the Trust is completed in accordance with the Government Functional Standard 013 for Counter Fraud.

On 1 September 2025, a new corporate offence of 'failure to prevent fraud' came into force. This introduced potential criminal liability for organisations where an 'associated person' commits fraud for the organisation's benefit, unless reasonable fraud prevention measures in place. MIAA has supported the Trust in ensuring it has reasonable fraud prevention measures are embedded including the circulation of staff briefings and delivered three webinars from September to November 2025 to 17 senior staff, including the Chair of the Audit Committee Chair and the Joint Chair of the Finance, Sustainability and Performance Committee in Common. In addition the Anti-Fraud, Bribery and Corruption Policy was updated to reflect the new offence and was approved by the Audit Committee on 22 January 2026, following the Trust's internal governance process.

During 2025-26, the LCFS undertook a range of activities to raise awareness including the circulation of fraud newsflashes, fraud prevention notices, a learning report, articles and newsletters, as well as promoting International Fraud Awareness Week. All new starters are required to complete a corporate induction which includes information on fraud, bribery and corruption. In addition, all staff (new and existing) are required to complete mandatory fraud, bribery and corruption e-learning every three years, with compliance consistently maintained between 95% and 99%.

A number of prevention and detection activities were also undertaken during the year including the review of Trust policies and procedures to ensure appropriate anti-fraud, bribery and corruption measures are in place, the conduct of a local proactive exercise to assist in identifying fraud and mitigating risk, and the circulation of local and national alerts in relation to specific identified fraud threats.

All allegations of fraud, bribery and corruption received by the Trust are referred to and considered by the MIAA Investigation Team, which was established on the 1 April 2025 and are investigated in line with the Trust's Anti-Fraud, Bribery and Corruption Policy. All staff are actively encouraged to report any concerns or suspicions to the LCFS or via the National Fraud and Corruption Reporting Line.

Task force on climate related financial disclosures (TCFD)

Note for 2025-26 report:

2025/26 is the final year of the three year implementation of TCFD.

From 2025/26 entities should disclose how the organisation's operations, strategy and financial planning are affected by actual and potential climate-related risks and opportunities.

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, stemming 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 terms of TCFD disclosure, the organisation's internal governance structure provides the framework for identification, assessment and management of climate related matters. The Trust Board is served by the following committees; Finance and Performance, succeeded in year by the Finance, Sustainability & Performance Committee in Common with WHH and Quality and Safety, succeeded in year by the Quality and Assurance Committee in Common with WHH, who are themselves served by the following operational councils of capital, risk, health and safety, people and organisational development, quality and performance.

These various forums enable strategical, tactical and operational objectives/work plans to be cognisant of climate related matters, over various timelines and in consideration of the wider NHS landscape.

These work-stream outputs, where appropriate, are also consolidated by various central bodies, to provide data set portals to allow for further review against the sustainability objectives referenced against the national net zero targets. These include the NHS Greener dashboard, Net Zero Travel and Transport and the Estate Reporting Information Collection. Data trends and associated datasets provide supporting information for project support and pipeline work-streams. These datasets include metrics relating to travel miles, fuel consumption, energy usage, waste stream processes and medical gas usage.

Further detail as to the Trust's deliverables and planning objectives are contained within the Environmental Management and Sustainability report.

Environmental Management and Sustainability

During 2025-26, the Trust has maintained its pathway to action, within the referenced timelines and the Trust Sustainability Objectives identified within the Board approved Green Action Plan.

Cheshire and Merseyside Integrated Care Board (ICB) have established a Sustainability Board of which Bridgewater is a member. This Board takes an overall strategic overview and provides oversight into the work programmes described in Bridgewater's Green Action Plan 2022-25 as well as providing a strategic facilitation, co-ordination and accountability framework for its members.

The Bridgewater Board receives quarterly updates, via the Finance and Performance Committee / Finance, Sustainability and Performance Committee in Common and separate updates are provided at the Trust's senior leadership team meeting on a quarterly basis.

The organisation's internal governance structure, below Board, is made up of several committees, who in turn are supported by a council structure namely, risk management, quality and safety, capital, people and organisational development, digital and performance. These councils are further supported by several internal groups. Across these committees, council and groups, climate related issues are included within their agendas / work-stream.

The Trust, through its Emergency Preparedness Resilience and Response (EPRR), arrangements, receives regular climate monitoring in respect of seasonal weather forecasts, flood forecasts and other supporting data. This enables cascade of information to support service planning. Any service, climate related incidents, are reviewed monthly and collated

within the annual Estate Returns Information Collection.

With reference to Local Resilience Forum and the Government published National Risk Register, the potential impact of climatic change is recorded on the Trust's risk register. Updates and are provided to Risk Management Council on a quarterly basis.

With reference to the Trusts internal governance structure and the strategic objectives outlined in the Trust's Green Plan, councils/groups with specific climate related workstreams include medical gases group (nitrous oxide), procurement group (utilities, social value procurement) digit (sustainable technology, models of care, AI), HR council (hybrid working, flexible working, lease cars), estates (decarbonisation, waste management processes, utility control), health and safety (waste management, medical gases), Infection Control (waste management) and capital council (bid approval).

These work-stream outputs, where appropriate, are consolidated by various central bodies, to provide data set portals to allow for further review against the sustainability objectives referenced against the national net zero targets. These include the NHS Greener dashboard, Net Zero Travel and Transport and the Estate Reporting Information Collection. Data trends and associated datasets provide supporting information for project support and pipeline work-streams. These datasets include metrics relating to travel miles, fuel consumption, energy usage, waste stream processes and medical gas usage.

Specific deliverables against Green Plan objectives include:

- The Trust has utilised the baseline carbon dashboard support tool and is looking to use this data baseline to trajectory forecast across its freehold and tenancy estate.
- Maintained and encouraged flexible working practices across its workforce thereby maintaining the significant green benefits accrued from reduced commuter and business mileage, reduced utility consumption and allowed the Trust to reduce its estate footprint.
- The Trust has attended climate adaption training and has reviewed the National Flood Risk Assessment data published by the Environment Agency against its property portfolio, to assess any potential risk. The Trust also subscribes to the Met Office weather alerting system and the Environment Agency's flood forecasting system to ensure up to date information relating to climatic risk can be cascaded into the organisation.
- The potential impact of Climatic Change is recorded on the Trust's risk register and is reviewed at Risk Management Council, as per the Trust's Risk Management Framework.
- The Trust continues to progress on its overall decarbonisation strategy with the fitting of heating, ventilation and air conditioning (HVAC) systems to improve environmental working conditions as well as phasing out reliance on fossil fuel systems.
- The Trust occupies 60 locations and 35 of these are leased from other NHS organisations i.e. NHS Property Services and Community Health Partnerships. The Trust continues to benefit from and work with these organisations to reduce building footprints and schemes this year include waste management / recycling schemes, light emitting diode (LED) lighting replacement, energy contract renewal and green space developments.
- Clinical models across services have been reviewed and the Trust is looking to reduce face to face visits, where appropriate, by utilising digital technology and the latest service to adopt this is the Trust's dermatology service.

- Processes continue to be reviewed to reduce resource consumption, and the Trust continues to roll out across services functionality such as hybrid mail, digital and text messaging, agile working practices and paper-light solutions in the context of digital technology.
- Electrical infrastructure has been upgraded at several sites to accommodate electric vehicle (EV) chargers.
- Promotion, through various payroll arrangements, of electric / low emission vehicles for Trust staff.
- Working with the Trust's dental network to review clinical delivery models alongside a targeted review of nitrous oxide infrastructure, usage, dispersal methods and sustainability.
- All A4 size paper continues to be purchased from recycled sources.
- Exit of several leased buildings thereby reducing the organisations carbon footprint.
- Switched its electricity contracts, as part of the national negotiated arrangements, to a renewable source across all freehold sites.
- Continued submission of the NHS Green Plan dataset.
- Working with our clinical waste provider, the Trust continues to meet the NHS Clinical Waste strategy objective in terms of waste disposal types, this has included the procurement of reuseable plastic waste containers and the roll out of Tiger Waste bags, to reduce reliance on high temperature incineration waste processes. The Trust has met the NHSE ratio proportion objective of waste categorisation across the various waste classifications.

Social, community and human rights issues

The Trust is committed to delivering equitable, inclusive and high-quality services for all the communities it serves, in line with its Communities Matter Strategy, legal duties, and values-based approach to population health and wellbeing. Equality and health inequality analysis of service delivery is embedded across service design, and transformation activity, ensuring that differences in access, experience and outcomes are identified and addressed.

The Trust demonstrates due regard to the three aims of the Public Sector Equality Duty by systematically considering the impact of policies, strategies, service redesign and transformation programmes on people who share protected characteristics and those affected by health inequalities. Updated equality and health inequalities assessment templates introduced in 2024–25 explicitly incorporate consideration of human rights, socio-economic deprivation, digital exclusion, low literacy, the armed forces community and other inclusion groups, ensuring that potential adverse impacts on employment or service access and experience are identified and mitigated at an early stage. Central to this analysis is meaningful consultation with those potentially affected.

Using available data, the Trust monitors experience and satisfaction to identify variation in access, experience and outcomes for different population groups, and uses this insight to co-design actions for improvement. This includes data from the NHS Staff Survey and Staff Inclusion Networks, mandated workforce reporting including the Workforce Race and Disability Equality Standards, Gender Pay Gap, and Equality Delivery System reports. The latter also includes detailed analysis of patient experience within four outcomes focused on patient access, meeting individual needs, safety, and experience. These reports, alongside strategy updates, equality and health inequalities assessments, patient safety incident learning, and other data and activity are embedded in the Trust's quality, safety and performance

frameworks, with relevant equality and health inequalities considerations reported through governance structures to Board.

During 2025-26 the Trust has undertaken a range of activities to promote equality of service delivery. This has included improvements in ethnicity data recording in patient record systems; development of new patient record templates, policies and processes to support consistent recording and sharing of disabled patient's reasonable adjustments needs, which once completed will contribute significantly to improved access, experience and outcome; joint work with colleagues at Warrington and Halton Teaching Hospitals NHS Foundation Trust on accessible information provision, and learning disabilities benchmarking; and work on community engagement on integration of services in partnership with Warrington and Halton.

Progress in this area is further supported in our employment offer through external frameworks and accreditations, including the Trust's successful submission to the bronze level of the NHS North West Anti-Racist Framework, alongside existing commitments to inclusion as a Disability Confident Leader, Navajo LGBT+ Charter Mark holder, Veteran Aware Trust, and silver level Defence Employer ensuring a consistent, Trust-wide approach to equality of service delivery.

Tackling health inequalities

Bridgewater Community Healthcare NHS Foundation Trust provides community and specialist services across a wide geographical footprint, including Halton, Warrington, Oldham, St Helens, Wigan, and specialist community dental services across Cheshire, Merseyside, Greater Manchester and parts of the North West. Across all these communities, we are committed to reducing health inequalities and improving outcomes for the people we serve.

This commitment is embedded in our Trust strategy Communities Matter, our role as an accredited Anchor Institution, and our adoption of the Cheshire & Merseyside NHS Prevention Pledge. We recognise that high-quality care is only truly high quality when it reaches everyone who needs it and delivers good outcomes for all, particularly those who face the greatest barriers to health.

Our Strategic Approach

Population health and health equity are central to our definition of quality. Our strategic commitments align with the NHS Long Term Plan, the Cheshire & Merseyside Population Health Framework, and the national Healthcare Inequalities Improvement Programme. These frameworks guide our action on the wider determinants of health, ensure we meet our statutory duties, and help us address disparities in access, experience and outcomes.

Guided by Marmot principles, we work with partners in the areas where we deliver integrated community services, particularly in Halton and Warrington, to address the structural factors that shape health. Across our wider footprint, including our specialist dental services, we apply the same principles of prevention, inclusive service design and targeted action for groups at greatest risk of poor outcomes, including those identified through the Core20PLUS5 framework.

Progress During 2025-26

1. Strengthening Leadership, Governance and Accountability

- The Health Equity Group (HEG) provides Trust-wide governance and oversees delivery of our Health Inequalities Action Plan.
- The Medical Director is the Executive Lead for health inequalities, supported by the Principal Lead for Public Health and operational leads across services as well as the Director of Population Health and Inequalities from Warrington and Halton NHS Foundation Trust.

- Health inequalities are now embedded in Board reporting, with biannual updates and strengthened links to the Board Assurance Framework.
- Prevention, equity and inclusion are reflected in our Communities Matter strategy and in directorate improvement plans.

2. Prevention and the NHS Prevention Pledge

We continue to deliver against all 14 commitments of the Cheshire & Merseyside NHS Prevention Pledge. Key achievements include:

- Strengthening secondary and tertiary prevention through cardiac and stroke rehabilitation pathways, virtual wards, and lifestyle support such as a family weight management programme.
- Delivering Making Every Contact Count (MECC) training and preparing to expand in-house training capacity.
- Supporting staff wellbeing through a comprehensive health and wellbeing programme, physical activity initiatives, and Just Culture training.
- Progressing our Green Plan and social value commitments as part of our Anchor Institution role.

3. Using Data to Understand and Reduce Inequalities

Bridgewater's activity and waiting list data is reviewed regularly through a health inequalities lens. This highlighted:

- variation in Urgent Care Referral rates between Halton and Warrington
- high levels of digital exclusion among older adults
- higher prevalence of depression, hypertension and smoking in our most deprived communities
- significant gaps in ethnicity recording, particularly in children's waiting lists

These insights are now informing targeted action, including improvements to data completeness and prevention pathways.

4. Improving Access, Experience and Communication

- We have strengthened compliance with the Accessible Information Standard through a draft Accessible Information and Health & Digital Literacy Policy.
- Digital exclusion remains a key focus, particularly for older adults and those in our most deprived communities. We continue to work with partners to improve access to digital tools and provide alternatives for those who need them.

5. Delivering Core20PLUS5 Priorities

Across adults and children, we have progressed work on the Core20PLUS5 priorities relevant to a community provider:

- **Smoking and Tobacco Dependency**

Smokefree policies have been refreshed, and new signage will be installed across sites.

- **Chronic Respiratory Disease**

We support children's respiratory health through targeted initiatives such as the Warrington Borough Council's Indoor Air Quality project

- **Hypertension and Cardiovascular Prevention**

Virtual wards support early intervention and monitoring.

- **Severe Mental Illness**

We work with system partners to support people with severe mental illness by providing prevention-focused interventions, including MECC brief advice and accessible communication.

- **Children's Priorities**

Oral health promotion in schools and care homes, including targeted packs for underserved communities.

6. Workforce, Culture and Anchor Responsibilities

- We continue to support staff wellbeing through a wide range of programmes, including physical activity initiatives, mental wellbeing support, and pastoral care.
- We have strengthened our role as an accredited Anchor Institution, contributing to local employment, sustainability, and social value.

Looking Ahead: 2026-27 Priorities

Our Shadow Joint Health Inequalities Action Plan sets out the next phase of our work. Key BCH-specific priorities include:

- Strengthening leadership and capability across the Trust.
- Embedding Core20PLUS5 into service redesign and quality improvement.
- Improving data completeness, particularly ethnicity and deprivation coding.
- Expanding MECC training.
- Tackling digital exclusion and improving accessible communication.
- Strengthening community voice and co-production.
- Ensuring equity is reflected in workforce policies and staff experience.

By April 2027, delivery of the plan will provide a strong foundation for a longer-term health inequalities strategy and measurable improvements in access, experience and outcomes for our communities.

Conclusion

Tackling health inequalities remains a core part of our mission and our statutory duty. Through prevention, partnership, data-driven action and a focus on inclusion, we are working to ensure that the populations we serve can access high-quality, person-centred care and live healthier, longer lives. Our progress this year demonstrates strong foundations, and our continued focus on prevention and equity will help us narrow the gaps that matter most.

Overseas Operations

There are no overseas operations to declare.

The Performance Report for Bridgewater Community Healthcare NHS Foundation Trust was approved by the Audit Committee on behalf of the Board on 22 June 2026.

Accounting Officer, Nikhil Khashu (Chief Executive) 22 June 2026

3. Accountability Report

3.1 Directors' Report

Directors' statement

As directors, we take responsibility for the preparation of the annual report and accounts. We consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

The Board of Directors

Bridgewater Community Healthcare NHS Foundation Trust was authorised and awarded its Foundation Trust Licence by the independent regulator Monitor on 1 November 2014.

The Trust Board has overall responsibility for leading and setting the strategic direction for the organisation. It also takes a lead in holding the Trust to account for the delivery of its strategy through monitoring performance and seeking assurance that systems of control are robust and reliable. This includes ensuring the delivery of effective financial control, high standards of clinical and corporate governance and promoting partnership working in the communities we serve. The Board is also responsible for shaping the culture of the organisation.

The Board consists of both Executive and Non-Executive Directors, and we consider each Non-Executive Director to be independent. The length of each Non-Executive Director's appointment is detailed in the biographies below.

The directors of the Bridgewater Community Healthcare NHS Foundation Trust for the period 1 April 2025 to 31 March 2026 were as follows:

CHAIR	
Martyn Taylor **Chair** 	Martyn joined the Trust as a Non-Executive Director in February 2022, appointed for a three year tenure. His appointment was renewed for a further three year tenure in February 2025. Prior to joining Bridgewater Martyn was a NED, Deputy Chair and Senior Independent Director at Tameside and Glossop Integrated Care NHS FT, where he was also the Chair Quality and Governance Committee and a member of the Audit Committee. He was also the Lead NED for Freedom to Speak Up Guardian and also the Chair of the Organ Donation Committee. Before his retirement from a career in banking he led a risk management team across the North of England, supporting businesses facing financial challenges. Prior to that he headed a UK national team of specialist relationship managers, who supported customers with mergers, acquisition, buy-outs etc. He graduated from senior management development programmes at Harvard Business School and the Wharton University of Pennsylvania, focusing on Strategy and Risk Management. Martyn was appointed as Chair from 1 April 2025.
EXECUTIVE TEAM	
Nikhil Khashu **Chief Executive Officer** 	Nik started as joint Chief Executive of Warrington and Halton Teaching Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust in November 2024. This followed his previous role at NHS England's North West regional team, where he served as Director of Finance from April 2022 and, more recently, as NHS England's national Deputy Chief Finance Officer. Nik joined the NHS in 1997, having started his career as a financial management graduate trainee. Throughout his career he has held senior leadership roles in prominent North West provider organisations, including Salford Royal, Alder Hey Children's Hospital, and St Helens and Knowsley Teaching Hospitals. He lived in Warrington for 20 years, with his twins born at WHH in 2010. Nik is deeply committed to driving positive change in equality, diversity, and inclusion, while actively working to reduce health inequalities across the communities he serves. He is dedicated to leading Warrington and Halton Hospitals and Bridgewater through a successful integration, to ensure the highest quality healthcare is delivered for the people of Warrington, Halton, and surrounding areas.

Lynne Carter **Director of Delivery Unit / Deputy Chief Executive Officer** 	Lynne has been Chief Nurse in acute, community and integrated providers and has also been Head of Governance and Chief Operating Officer. She has extensive experience in developing new roles in order to meet the changing needs of healthcare including Advanced Clinical Practitioners, Nursing Associates, Consultant Nurse and Therapists. As an interim Lynne has delivered financial turnaround, safeguarding systems and new clinical pathways and is confident in all areas of leadership and management. Lynne remains a committed clinician with a strong professional perspective and belief in supporting healthcare services which meet the needs of local populations. Lynne joined the Trust on 23 March 2018 as an Interim Chief Nurse and was appointed in her substantive role from 1 May 2018. She was also appointed to the role of Chief Operating Officer from 13 July 2019 which she carried out until July 2020 when she assumed the role of Deputy Chief Executive Officer alongside of her role of Chief Nurse. In June 2025, Lynne was appointed Director of the Delivery Unit, leading a dedicated team to ensure financial grip, operational efficiency, and sustainable service delivery. She oversees finance, performance, workforce, and quality standards for the Trust and for Warrington & Halton Hospitals NHS FT <u>Qualifications</u> Post Graduate Diploma Medical Law Post Graduate Diploma Professional Studies in Management BSc (Hons) Nursing Studies Registered Nurse - Learning Disabilities Registered Nurse – Adult
Dr Paul Fitzsimmons **Medical Director** 	Paul joined Warrington and Halton Teaching Hospitals NHS Foundation Trust in December 2021 from Liverpool University Hospitals Foundation Trust where he was the Deputy Executive Medical Director for five years. He was appointed as joint Medical Director for Bridgewater Community Healthcare NHS Foundation Trust in November 2024. A consultant geriatrician and stroke physician by background, he studied medicine at Manchester University before undertaking postgraduate training in the north west. Paul is also the Caldicott Guardian and Executive Lead for Digital for both Trusts. Prior to joining Warrington and Halton Teaching Hospitals NHS Foundation Trust, Paul was a Healthcare Leadership Fellow at the Health Foundation and Ashridge University. He has extensive experience of delivering quality improvement, patient safety initiatives, digital clinical programmes and hospital service reconfigurations

Ali Kennah **Chief Nurse** **from July 2025** 	Ali was appointed Chief Nurse and Director of Infection Prevention and Control (DIPC) at Warrington and Halton Hospitals NHS Foundation Trust in April 2024, having joined the Trust in 2017 as Deputy Chief Nurse before taking on the role of Associate Chief Nurse. In July 2025, Ali was appointed as joint Chief Nurse for Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare. Ali has over 28 years' NHS experience, qualifying in 1995 and working her way through the ranks from nurse to matron. Prior to starting at WHH she was Head of Quality at Mersey and West Lancashire Teaching Hospitals NHS Trust (previously St Helens and Knowsley Teaching Hospitals NHS Trust). Ali is passionate about patient safety and delivering the best possible care for our patients. Her role is also to support the Trust Board to understand how strategic decisions affect the quality and safety of patient care and the wider patient experience.
Daniel Moore **Chief Operating Officer** 	Dan was appointed Chief Operating Officer of Warrington and Halton Teaching Hospitals NHS Foundation Trust in January 2021, having previously joined in 2018 as its Director of Operations and Performance. He is also Deputy Chief Executive. Dan was appointed as joint Chief Operating Officer for Bridgewater Community Healthcare NHS Foundation Trust in December 2024. As Chief Operating Officer his role is to oversee operational delivery and performance achievement across both Trusts. Prior to his current role, Dan held a number of senior operational positions within the NHS. During that time he worked in operations management across acute hospital trusts in Greater Manchester and Cheshire. <u>Qualifications</u> Masters in Business Administration (MBA) from Manchester Business School BSc in Operational Management from Lancaster University Management School.
Nick Gallagher **Director of Finance** 	Nick is a member of the Chartered Institute of Management Accountants and started his career in the private sector in 1988. He has extensive NHS experience having worked in the NHS for over 30 years in numerous organisations including Primary Care Trusts, community providers and shared services. He was Interim Deputy Director of Finance for two years at Bridgewater before being appointed as Executive Director of Finance in January 2019. Married with three daughters, Nick has lived for over 43 years in the local borough of Warrington. <u>Qualifications</u> Chartered Institute of Management Accountants

Paula Woods **Director of People and Organisational Development** 	Paula has worked in the NHS since 2004. Prior to this, she worked for many years as an Assistant Director of Human Resources within the Housing Association sector in Merseyside. Paula was a Deputy Director of Workforce for many years within the NHS which included 'acting up' to the role of Director of Workforce, before securing the role of Director of People & Organisational Development at Bridgewater in June 2020. During her career, Paula has been involved in developing a range of 'people' services which improve work life balance, whilst ensuring quality and safe working practices for staff, patients and service users. She has project managed a range of national and regional 'people' initiatives and programmes of work, requiring extensive experience in leadership and people management. <u>Qualifications</u> Fellow of the Chartered Institute of Personnel & Development (FCIPD)
NON-EXECUTIVE TEAM	
Gail Briers **Non-Executive Director & Senior Independent Director** 	Gail joined the Trust as a Non-Executive Director in September 2020. Her appointment was renewed for a further three year tenure in August 2023. She is a registered mental health nurse with over 40 years' experience working within the NHS in a variety of clinical and leadership roles. Prior to taking up the NED role for Bridgewater, her most recent post was as Chief Nurse and Deputy Chief Executive within a neighbouring mental health and community trust. She has also worked as a NED within the quality improvement organisation Advancing Quality Alliance (AQuA). Gail was the Trust's Quality and Safety Committee Chair from 2021 to 2024.

Bob Chadwick **Non-Executive Director** 	Bob joined the Trust as a Non-Executive Director in February 2024, appointed for a three year tenure. His experience includes roles as an Executive Director of Finance in the NHS for over 20 years, holding many portfolios including finance, performance, information / IMT, procurement, estates and facilities. He has significant experience as an NHS leader in some of the most complex health economies in the UK with the delivery of key targets / objectives and strategies: • Pennine Acute Hospitals NHS Trust • Mid-Yorkshire Hospitals NHS Trust • Cardiff and Vale University Health Board Bob was born in Warrington and remained there for over 50 years before relocating to Wakefield / Leeds and then to Cardiff, returning on retirement to East Cheshire. <u>Qualifications</u> The Chartered Institute of Public Finance and Accountancy – CIPFA Bob became the Trust's Audit Committee Chair in 2024.
Imam Abdul Hafeez Siddique **Non-Executive Director** 	Abdul joined the Trust as a Non-Executive Director in September 2020. His appointment was renewed for a further three year tenure in August 2023. He is a Muslim chaplain currently working at Category C prison in Lancashire. He possesses an MA in social work and MPhil in community cohesion as well as being a graduate of ILM leadership programme and Common Purpose streetwise MBA. Abdul has 15 years of engagement, advocacy experience with communities experiencing racial inequalities (CERI). He is the founder and CEO of Flowhesion that delivers wide-ranging commissioned research, training, consultancy and projects, programmes across the North of England with CERI communities. Abdul became the Trust's People Committee Chair in 2021.

Dame Elaine Inglesby **Non-Executive Director** 	Dame Elaine Inglesby joined the Trust as a Non-Executive Director in March 2023, appointed for a three year tenure and was re-appointed in February 2026. Born in Orford, Elaine trained at Warrington General from 1977 to 1980 and qualified as a Registered Nurse. Elaine worked at Warrington for 14 years before taking up various posts across Merseyside, including Director of Nursing at the Walton Centre in Liverpool. Elaine was Director of Nursing and Midwifery at Stockport NHS Foundation Trust before taking up post at Salford Royal as Executive Nurse Director in 2004 and later held the positions of Executive Nurse Director and Deputy Chief Executive. She became Chief Nursing Officer for the Northern Care Alliance in 2016, an integrated hospital and community organisation which incorporated Salford Royal Foundation Trust and Pennine Acute NHS Trust. Elaine was a member of the Prime Minister's Nursing and Care Quality Forum and also the Berwick National Advisory Group on the Safety of Patients in England, following the Mid Staffordshire Report. In 2016, she became a Non-Executive Director of the National Institute of Care and Excellence. Elaine has been a strong advocate for both Safer Nurse Staffing and the quality and safety of patient care nationally. In 2015, Elaine was appointed a Commander of the Order of the British Empire for services to nursing. In 2019, Elaine became the first national recipient of NHS England's Chief Nursing Officers Gold Award for excellence in nursing. In October 2020, she was promoted to a Dame Commander of the Order of the British Empire in the 2020 Queen's Birthday Honours. She is also a Deputy Lieutenant for Merseyside. Elaine retired from full time roles in August 2022 following a period as interim Chief Nurse at Liverpool University Hospitals Trust. Elaine became the Trust's Quality and Safety Committee Chair in 2024.
Tina Wilkins **Non-Executive Director** 	Tina joined the Trust as a Non-Executive Director in September 2020. Her appointment was renewed for a further three year tenure in August 2023. Tina chairs the Finance and Performance Committee and sits on the Audit Committee, the People Committee and the Nominations and Remuneration Committee. During her career Tina worked in Local Government, and the NHS within the fields of health, education and social care, in both operational and strategic roles. Tina holds a degree in Cultural Studies, a Masters in Education Policy Studies and a Post Graduate Diploma in Strategic Management.

All Non-Executive Directors are considered to be independent as they do not hold any conflicts of interests.

Board Responsibilities

Additional governance roles are undertaken by members of the Executive Team as outlined in the table below:

Post	Governance or Champion roles	Responsible for
Chief Executive Officer	Accountable Officer	Responsible as parliamentary accountable officer for ensuring that the organisation works effectively in accordance with national policy and public service values, and maintains proper financial stewardship
Chief Nurse	Director of Infection Prevention & Control (DIPC)	Infection Prevention & Control Service and related policies. Publishing an annual IPC report.
	Safeguarding Lead Officer	Ensuring best practice principles are followed, appropriate recruitment processes followed, and job-specific training provided. Attends partnership boards. Publishing an annual safeguarding report
	Executive Nurse	Helps the board make strategic decisions in view of their effect on the quality and safety of patient care
	Nominated Individual (CQC)	Overseeing compliance with the CQC regulatory framework
	Freedom To Speak Up Champion	Ensuring that colleagues can speak up about anything that might affect the quality of staff experience or patient care
	Caldicott Guardian	Protecting the confidentiality of service-user information, enabling and applying the highest standards for appropriate information sharing.
Medical Director	Accountable Officer for Controlled Drugs	Ensures all incidents involving controlled drugs are reported correctly, communication with Local Intelligence Network.
	Responsible Officer (RO) for Medical Registrations & Revalidation	Provides local leadership in developing systems of appraisal

		and clinical governance; lead for End of Life Care
Director of Finance	Security Management Director	Overseeing and providing strategic management and support for all security management work within the organisation
	Anti-Fraud Champion	Providing a senior strategic voice within the organisation to champion the counter fraud agenda and to enable and support the counter fraud programme of work
	Senior Information Risk Owner (SIRO)	Managing information risks to the organisation; oversight of information security incident reporting and response
Chief Operating Officer	Accountable Emergency Officer (AEO)	Ensuring that the NHS England core standards for Emergency Planning Resilience and Response are met
Director of People and Organisational Development	none	

Additional roles undertaken by members of the Non-Executive Team as outlined in the table below:

Non-Executive Director (Gail Briers)	Freedom To Speak Up Guardian	Ensuring that all colleagues are supported to speak up; that any barriers to doing so are addressed; that the Trust encourages a positive culture of speaking up and that matters raised are used as opportunities for learning and improvement.

Balance, Completeness and Appropriateness of Board Membership

Our Board is satisfied that it has the appropriate balance of knowledge, skills and experience to enable it to carry out its duties effectively. This is supported by the Council of Governors which takes into consideration the collective performance of the Board via the Nominations and Remuneration Committee.

Performance Evaluation of the Board

The Trust has used a combination of internal subject matter experts and external development support as part of its wider journey of continuous improvement of the performance of the Board. All Board members had an appraisal with the Chair or Chief Executive in year. The Council of Governors oversee the performance review of the Chair and the Non-Executive Directors of the Trust to help inform their decisions on the re-appointment or termination of Non-Executive Directors, as necessary. The Nominations & Remuneration Committee reviews the output from the appraisals of the Executive Directors including the Chief Executive Officer.

The Board meets on a bi-monthly basis, allowing the intervening month to be spent on a day of development as a team. During 2025-26 the Board continued to spend some of these sessions ensuring the 'Better Care Together' programme which focused on the proposed integration with Warrington and Halton Hospitals NHS Foundation Trust (WHH).

Non-Executive Directors' appointments may be terminated on performance grounds or for contravention of the qualification criteria set out in the Constitution with the approval of three quarters of the Council of Governors or by mutual consent for other reasons. There is no provision for compensation for early termination or liability on the Trust's part in the event of termination.

Throughout 2025-26, the Terms of Reference and Business Cycles for all Board Committees were reviewed. At the conclusion of each Board or Committee meeting, a review is conducted, and feedback is provided to enhance performance in the upcoming months. During the year Committees In Common were established with WHH for Finance, People and Quality. Each Committee submits an annual report on its effectiveness. This process is further supported by meetings to set the agenda and optimise meeting functionality. Additionally, a formal evaluation is conducted annually through an assessment questionnaire distributed to all members, attendees and observers.

Register of Interests

The Foundation Trust has published an up-to-date register of interests on its website throughout the year. The current declarations can be found on the North Cheshire and Mersey NHS FT website at Declarations including gifts and hospitality to 31 March 2026. To request a copy of registers for previous years, please email bchft.global@nhs.net.

This applies to all decision-making staff which includes staff employed as Band 7 with budgetary responsibility and staff employed as Band 8A and above. This also includes all other members of staff with an interest to declare over within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance. For these purposes we have interpreted 'decision making staff' as:

- Executive and non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Band 7 staff with budget responsibility and all Band 8a and over
- All registered doctors and dentists
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or

equipment, and formulary decisions

- Governors of the Trust.

Board Committees

A schedule of director attendance for all committees can be found at Appendix 1.

Audit Committee

The aim of the Audit Committee is to provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non- clinical) both generally and in support of the Annual Governance Statement.

In addition, the Audit Committee:

- Provides assurance of independence for external and internal audit.
- Ensures that appropriate standards are set and compliance with them is monitored, in non- financial and non-clinical areas that fall within the remit of the Audit Committee.
- Monitors corporate governance, e.g., compliance with codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests.
- Ensures the provision of an effective system of internal control and risk management including the Trust's financial controls.
- Provides oversight of the pending integration of the Trust by Warrington and Halton Teaching Hospitals NHS FT

The Trust has a Finance and Performance Committee, succeeded by the Finance, Sustainability and Performance Committee in Common with Warrington and Halton Teaching Hospitals NHS FT in July 2025 which reviews the challenges and issues associated with financial planning and forecasting, and the Audit Committee seeks assurances in respect of the processes and work undertaken.

All Non-Executive Directors, except for the Trust Chair, are members of the Audit Committee. There were six Committee meetings during the year. The Committee was quorate at all meetings and no meetings were cancelled. Internal and external audit and anti-fraud colleagues regularly attended the meeting.

A schedule of attendance at the meetings is provided in Appendix 1 which demonstrates the compliance with the quoracy requirements and regular attendance by those invited by the Committee.

The Trust maintains a Board Assurance Framework (BAF) which seeks to provide the Trust Board with a tool for the effective and focussed management of the risks which threaten the delivery of the strategic objectives. The Audit Committee supports the Trust Board regarding the management of the BAF by seeking assurance on the processes used to manage the risks on the BAF and Corporate Risk Register at each meeting. The Committee has consistently received the BAF throughout 2025-26 and provided direction where further information should be provided to the Trust Board.

The Trust's internal audit and anti-fraud functions are carried out through Mersey Internal Audit Agency (MIAA). The Trust's external auditors are KPMG.

Self-Assessment

During the financial reporting period for 2025-26, the Committee has complied with 'good

practice' recommended through:

- Agreement of Internal and External Audit and Anti-Fraud plans.
- Regular review of progress and outcomes, including risks identified, and internal audit action plans agreed.
- Private meetings with External, Internal Audit and Counter Fraud.
- Regular review of the Audit Committee Business Cycle.
- Review of the Committee's Terms of Reference.

Anti-Fraud

During the year, the Committee has reviewed the progress of the local Anti-Fraud Specialist's programme of work. The Anti-Fraud Plan has been delivered in accordance with the schedule of days agreed with the Committee at the start of the financial year.

Internal Audit

Throughout the year the Committee has worked effectively with the internal auditors to strengthen the Trust's internal control processes. The Internal Audit Plan has been delivered in accordance with the schedule of days agreed with the Committee at the start of the financial year.

The detail of these audits is provided within the Annual Governance statement.

The Committee has ensured that, where gaps in assurance are identified, appropriate action plans are agreed with management, and progress against these plans is regularly reviewed by management, internal audit and the Committee.

During the course of the year, the Trust has taken steps to address and strengthen its systems of internal control across a range of areas, including further development of the Board Assurance Framework arrangements and enhancing the follow up process to improve monitoring and timely implementation of actions

For 2025-26, MIAA completed 10 internal audit reviews covering both clinical and non-clinical systems and processes and formed a view on the level of assurance as follows:

	Review	Assurance Opinion	Recommendations Raised					Issue Category	
			Critical	High	Medium	Low	Total	Control Design	Operating Effectiveness
1	Assurance Framework	-	-	-	-	-	-	-	-
2	Conflicts of Interest	High	-	-	-	-	-	-	-
3	Fit & Proper Person Test	High	-	-	-	1	1	-	1
4	Risk Management Core Controls	High	-	-	-	1	1	1	-
5	Key Financial Systems Controls	High	-	-	-	-	-	-	-
6	PSIRF	Substantial	-	-	1	4	5	3	2
7	IM&T: Ivanti Neurons	Substantial	-	-	3	-	3	3	
8	Devolved Autonomy	Moderate	-	-	5	-	5	1	4
9	Quality Spot Checks	Moderate	-	1	5	-	6	5	1
10	DSPT	High Risk / High Confidence	-	2	-	-	2	2	-
	TOTAL		-	3	14	6	23	15	8

These audits were all presented to the Audit Committee for oversight and to provide assurance. Individual committees take responsibility for tracking progress against recommendations and action plans. The Quality and Safety Committee, succeeded by the Quality and Assurance Committee in Common was also in receipt of the progress of Clinical Audit programmes across the Trust.

External Audit

The Audit Committee has separate internal and external audit plans. The Committee meets on a quarterly basis with representation from both internal and external audit functions. An annual work plan is produced. The Audit Committee's primary role is to conclude upon the adequacy and effective operation of the organisation's overall internal control system.

The Trust's external auditors for 2025-26 were KPMG, this is the seventh year using these auditors, following appointment in 2019-20. The scope of work for external auditors is set out in guidance issued by the National Audit Office.

Disclosure to Auditors

So far as the directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditors are unaware.

The directors have taken all steps that they ought to have taken as directors to make themselves aware of any relevant audit information. Furthermore, the Trust has made all relevant audit information available to the external auditor, KPMG LLP, and the cost of work, exclusive of VAT, performed by them in the accounting period is as follows:

Category	2025-26 (£000)	2024-25 (£000)
Audit services	**189**	**186**
Further assurance services	**-**	**-**
Other services	**-**	**-**
Total	**189**	**186**

KPMG LLP does not provide any non-audit services.

Systems of Internal Control

As outlined in the previous section, the Board and its committees are responsible for monitoring the Trust's governance structure and systems of internal control to ensure that risk is managed to a reasonable level and that governance arrangements exist to enable the Trust to adhere to its policies and achieve its objectives.

Ongoing assurance that the Board is sighted on its key strategic risks is provided in the Board Assurance Framework (BAF) which was regularly reviewed by Committees and the Board in 2025-26. The quality of the content demonstrates clear connectivity with the Board agenda, the Trust's strategy and the external environment.

More detail is contained in the Annual Governance Statement.

In line with the requirements of the Financial Reporting Manual (FReM) paragraph 5.3.9, the Directors make the following statements on behalf of the Trust:

- Bridgewater has complied with the cost allocation and charging guidance issued by HM Treasury.
- It has not made any political donations.

Better Payment Practice Code (BPPC)

The Better Payment Practice Code gives NHS organisations a target of paying 95% of invoices within agreed payment terms or in 30 days where there are no terms agreed.

	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	10,537	24,831	11,082	26,884
Total Non-NHS Trade Invoices Paid Within Target	10,455	24,461	10,910	26,464
Percentage of Non-NHS Trade Invoices Paid Within Target	99.2%	98.5%	98.5%	98.4%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,169	13,127	835	11,075

Total NHS Trade Invoices Paid Within Target	1,154	13,044	813	10,890
Percentage of NHS Trade Invoices Paid Within Target	98.7%	99.4%	97.4%	98.3%

Liabilities

The Trust maintained compliance with the BPPC target throughout 2025-26; no liability for late payment interest has been recognised.

Late Payment of Commercial Debts (Interest) Act 1998

The Late Payment of Commercial Debts (Interest) Act 1998 allows entities to claim interest on the late payment of debts by contracting partners.

The Trust paid a total of £8,500 as a final settlement figure in 2025-26. As such, there is no split available between interest and compensation.

Other Financial Commitments

The Trust has no non-cancellable contracts and therefore no financial commitments as a result.

Finance and Performance Committee, succeeded in July 2025 by the Finance, Sustainability and Performance Committees in Common

The committee was established to enable collaboration, strategic alignment, and efficient decision-making for BCH and this continues with the Committees in Common with WHH.

It oversees financial and operational planning, operational performance, strategic and business development, estates and digital matters, and sustainability across both Trusts, ensuring compliance with NHS regulations and local priorities.

The Committees in Common provides assurance to both Trust Boards that financial strategies align with quality aims as the Trusts progress toward integration by April 2026

Nominations and Remuneration Committee of the Board

The primary role of the Nominations and Remuneration Committee is to identify and appoint candidates for all Executive Director positions on the Board, as well as to determine their remuneration and other conditions of service. Further details on the Committee's work can be found in the Remuneration report. at Section 3.2.

Quality and Safety Committee, succeeded in February 2026 by the Quality and Assurance Committee in Common

The committee was established to ensure the BCH Board receives assurance that the Trust provides high standards of care and this continues with the Committees in Common with WHH.

Its objectives are to:

- Advocate an active role in maintaining the safety of the Trust's services.
- Seek assurance on safe and effective clinical governance within the Trust.
- Ensure the Trust complies with relevant national standards and statutory legislation.
- Promote continuous quality improvement in patient safety, clinical effectiveness, and patient experience, including the wellbeing and safety of Trust employees.
- Identify risks and concerns to be escalated to the Board of Directors according to the agreed assurance and escalation procedure outlined in the Accountability and

Performance Frameworks.

The Committee in Common provides assurance to both Trust Boards that quality strategies align with financial aims as the Trusts progress toward integration by April 2026.

Strategic People Committee in Common

The Committee was established to provide strategic oversight of the Trust's human resources, organisational development, and staff engagement arrangements for BCH and WHH.

Its objectives are to:

- Ensure these arrangements are designed to provide a positive working environment for all colleagues.
- Ensure the Trust has effective people systems and processes in place at all levels to deliver safe, high-quality care from a patient and service user perspective. to enable safe, high-quality care.

The Committee in Common provides assurance to both Trust Boards as the organisations progressed toward integration by April 2026.

CQC Well Led Framework

The Trust was last inspected during 2018, during which it received a 'Requires Improvement' rating for Well Led. A re-inspection had not taken place due to the pandemic and the change in CQC inspections, so in 2020 the Trust commissioned and undertook an external independent well-led review by Facere Melius with a follow up review in January 2023. The report noted significant improvement across the Trust, with the recommendations being reduced to nine. The report was presented at the public meeting of the Board of Directors in June 2023. The report of the review is publicly available on the Trust's website.

The recommendations were centred around building upon the work done so far, engagement plans to deliver the refreshed Trust Strategy, continuation of focus on improving mandatory training compliance and maintaining the high governance standards. All recommendations were fully implemented and signed off by Board in 2024-25.

Further information on how the Trust discharges its well led obligations can be found in the Annual Governance Statement which describes how performance is monitored, internal control and the Board Assurance Framework.

There are no material inconsistencies between:

- the annual governance statement,
- the corporate governance statement and annual report, and
- reports arising from response reviews of the Trust and consequent action plans developed.

Council of Governors and Membership

The Bridgewater Council of Governors plays an integral and important role in the work of the Trust. Our public governors are drawn from the communities we serve. Each of our governors bring with them knowledge, skills and experience of working in the public and private sector and play a key role in ensuring the organisation meets the needs of the community and patients.

Governors are responsible for:

- Appointing Non-Executive Directors to the Trust's board.

- Holding the Board to account and ensuring that it delivers its strategic aims.
- Participating in discussions on the Trust's strategy and future direction.
- Being involved in decisions related to major capital investments.
- Providing feedback from the public and members

Further information is found in the Constitution, the Council of Governors and Council of Governors Nominations Committee Terms of Reference on the Membership and Governors area of the Bridgewater website. To request a copy of these items, please email bchft.global@nhs.net.

As an NHS Foundation Trust, Bridgewater has a membership base consisting of patients, staff, and the public. Members are encouraged to participate in the governance process and stay informed about the Trust's activities. Our members can vote in the governor elections, stand for election as governors and are invited to give their views about the services we provide within the communities we serve.

Many of our public members are patients and / or carers of service users. Our key means of communication is via our quarterly newsletter which is sent out electronically. We also post the newsletter, and our Governor Focus newsletters were found on the Membership and Governors area of the Bridgewater website. To request a copy of these items, please email bchft.global@nhs.net.

As a Foundation Trust we have a duty and responsibility to hold an Annual Members Meeting. In September 2025, this was held via Microsoft Teams and invitations were issued electronically. We also utilised social media to advertise the event and again posted details via the Membership and Governor area of the website. The Deputy Lead Governor gave an overview of the work that had taken place within the Council during the previous year.

During the year, our governors undertook a series of visits to staff to better understand the work of the organisation and understand some of the challenges they face. The visits also provide an opportunity to speak with patients / their families to hear about their views and experiences of using our services.

Our internal, local governor meetings allow our public governors to share their experiences with their Non-Executive Director colleagues, as do the formal meetings of the Council.

Governors are also actively encouraged to observe the Board and its Committee meetings and during the year they have made a significant contribution to the work of the Trust in better engaging with its patients.

Building on the publication of the Trust's three-year strategy 'Communities Matter' in 2023, both Governors and the Trust have continued to engage in meaningful ways with members and the public. The Trust's Public and Community Engagement Group (PACE), chaired by the Chief Executive and reported to the Council of Governors, which is chaired by the Chair of the Trust is primarily comprised of public governors and the Trust Lead Governor also sits on the Bridgewater Engagement Group.

Crucially, Governors have been actively involved in the proposals for the potential acquisition of the Trust by Warrington and Halton Hospitals NHS Foundation Trust from 1 April 2026 and have ensured that the voice of those the Trust serves is at the heart of this. As Bridgewater works more collaboratively with Warrington and Halton Hospitals, Governors will continue to be included in considering forward plans, including the strategy, priorities and objectives. The Governors have been active with Warrington and Halton NHS Foundation Trust Governors in drafting a new constitution for the enlarged organisation.

Governors' Views, Meetings and Observation of Committees

During 2025-26, the Council of Governors considered the views of Governors with Non-Executive Directors routinely in attendance. The Council is constituted to require Executive Directors to attend to discuss specific items.

Governors also serve as observers of the Committees and Committees-in-Common with WHH and their views on the Chair's performance in holding the Executive Directors to account are publicly shared. Each of our main committees, including those committees-in-common is chaired by a Non-Executive Director and one of the key responsibilities of a governor is to hold the Non-Executive Directors to account.

The Council continued to address key areas of its own development, focusing on key areas of the Trust's business including finance and budgeting; audit, including the internal audit process, NHS Counter Fraud, and the Board Assurance Framework.

Named Non-Executive Directors attended local Governor meetings and issues or areas of concern from these were raised at the Public Board. Responses were considered and discussed at the Council of Governor meetings.

Governor views were captured at meetings including the Council of Governors and local governor meetings and minutes of the Council of Governors are available on request. In 2025-26, all minutes of the Council of Governors continued to be made available to staff and the public with the process led by the Lead Governor and the Trust Chair.

In the event of any conflict or disagreement between the Council of Governors and the Board, this would be addressed by the process laid out in the Trust's Constitution and in compliance with the NHS Act 2006, Schedule 7, paragraph 10C. There had been no dispute during 2025-26 which required this process to be enacted.

Our commitment to open and honest dialogue continued, as did our involvement and engagement with our Council of Governors, particularly during the proposed integration with Warrington and Halton Hospitals NHS FT so they in turn could communicate key areas of the Trust's business during their conversations and discussions with members.

Executive Directors regularly attend the Council providing, operational, strategic and financial updates. There has been a focus in the year on the engagement and integration agenda. The Trust's Lead Governor and several governor colleagues are represented on key committees including the Bridgewater Engagement Group and the Public and Community Engagement Group (PACE).

The Trust's 'Time to Shine' sessions continued to be a source of great interest and provide a useful insight into the diverse range of services provided by the Trust and hear about the everyday experiences of staff who deliver services and the views of patients / service. These sessions are delivered online via MS Teams.

Constituencies, Membership Numbers and Governors' Responsibilities

Our public governors represent people living within the geographic boundary of the areas they serve. We are now served by three main constituencies: Warrington, Halton and the Rest of England. The Rest of England constituency comprises members in St Helens, Community Dental and areas of the North West where the Trust provides community dental services.

The Trust has a total public membership of 3222 which includes staff membership totalling 1531 as of 31 March 2026.

In May 2025, the Trust undertook elections to the Council and in July 2025, seven Governors were elected and two were re-elected.

We also had three appointed partner governors. Two represented the voluntary / third sector in Warrington and Halton until the retirement of one in January 2026, and one was appointed in June 2025 representing the further / higher education sector.

The 2025-26 Council of Governors' membership is shown below:

Constituency	Governor	Dates of election/ departure
Public: Halton (1)	Peter Hollett	Elected 29/07/2019 Departed 28/07/2025
Public: Halton (2)	Vacancy	
Public: Halton (3)	Vacancy	
Public: Halton (4)	Vacancy	
Public: Warrington (5)	Matt Machin	Elected 30/07/2019
Public: Warrington (6)	Vacancy	
Public: Warrington (7)	Audrey Fitzpatrick	Elected 29/07/2025
Public: Warrington (7)	Kevin Goucher	Elected 15/09/2023
Public: Warrington (8)	36Norman Holding	Elected 29/07/2025

Constituency	Governor	Date of appointment / leaving
Public: Rest of England (9)	Christine Stankus – **Lead Governor** (elected Sept 2022)	Elected 29/07/2019
Public: Rest of England (10)	Vacancy	
Public: Rest of England (11)	Jonathan Berry	Elected 29/07/2025
Public: Rest of England (12)	Rita Chapman	Elected 15/09/2023
Public: Rest of England (13)	Arshad Ashraf	Elected 15/09/2023
Public: Rest of England (14)	Vacancy	
Staff Registered Nurses and Midwives (15)	Nicola Wilson	Elected 29/02/2022 Departed 28/07/2025
Staff: Registered Nurses and Midwives (16)	Sue Mackie	Elected 29/02/2022 Departed 28/07/2025
Staff Registered Nurses and Midwives (15)	Katie Brown	Elected 29/07/2025
Staff: Registered Nurses and Midwives (16)	Phillip Lynch	Elected 29/07/2025
Staff: Allied health professionals/other registered healthcare professionals (17)	Jillian Wallis	Elected 29/02/2022 Departed 28/07/2025
Staff: Clinical Support Staff including Assistant Practitioners/ Healthcare assistants and trainee clinical staff (18)	Vacancy	
Staff: Registered Medical Practitioners or community dental staff (19)	Claire Barton	Elected 15/09/2023
Staff: Non-clinical support staff including managerial and administrative staff (20)	Sarah Power	Elected 28/07/2025
Staff: Non-clinical support staff including managerial and administrative staff (20)	Dave Smith	Elected 29/07/2025
Constituency	**Governor**	**Date of appointment**
Partner: Higher Education (21)	Katie Jones Priestley College, Warrington	Appointed 22/06/2025
Partner: Statutory Borough based organisation (22)	Dave Wilson Healthwatch, Halton *	Appointed 19/04/2023
Partner: Borough based organisation (23)	Janet Hennessy Signing Solutions, Warrington	Appointed 01/06/2023

* retired from office January 2026

Directors' statement

As directors, we take responsibility for the preparation of the Annual Report and Accounts. We consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Signed

Nikhil Khashu

Chief Executive **Date: 22 June 2026**

3.2 Remuneration Report

The remuneration report includes:

- Annual Statement on Remuneration
- Nominations and Remuneration Committee
- Nominations Committee – Council of Governors
- Senior Managers Remuneration Policy
- Non-Executive Director Remuneration
- Governor and Director Expenses
- Salaries and Allowances
- Fair Pay Multiple
- Exit Packages
- Service Contracts
- Pension Benefits
- Cash Equivalent Transfer Values (CETV)
- Real Increase in CETV

Annual Statement on Remuneration

Nominations and Remuneration Committee

The Nominations and Remuneration Committee met on four occasions between 1 April 2025 and 31 March 2026. During this period, the committee approved the ongoing secondments and salaries of joint Executive Director posts with WHH, the appointment and secondment of a joint Chief Nurse with WHH, the appointment of the Director of the Delivery Unit, the annual pay increase recommendations for Very Senior Managers (VSMs) of 3.25% for BCH Executive Directors and the running of a Mutually Agreed Resignation Scheme (MARS) for BCH.

The Nominations and Remuneration Committee is attended by all Non-Executive Directors and chaired by the Chair of the Trust, as outlined in the Committee's Terms of Reference. During the year, the Chief Executive attended the Committee twice to present information. The Committee sets pay levels for Executive Directors and senior managers not covered by Agenda for Change pay arrangements. It also approves the proposed appointments of Executive Directors including joint posts with WHH. Contracts for Executive Directors are substantive unless the individual resigns or is removed from the role. The Trust continues to follow national guidance on this matter.

Nominations Committee – Council of Governors

The Council of Governors appoints Non-Executive Directors, for three year tenures which can be renewed on expiry for a single further period of three years. Notice periods are generally one month. There are no contractual provisions for the early termination of Non-Executive Directors. Furthermore, the Committee operates an Annual Performance

Development Review process to agree the objectives for the following year and performance against these is then jointly assessed after the twelfth month elapses. The cycle is then repeated on an ongoing annual basis.

The Nominations Committee reappointed an extension to the term of a Non-Executive Director during this period.

Senior Managers Remuneration Policy

With the exception of Executive Directors and the CEO, all senior managers within the Trust are employed on Agenda for Change terms and conditions and associated salary scales. Bridgewater Community Healthcare NHS Foundation Trust has adopted the NHS very senior managers (VSM) pay framework as the salary scale for all Executive Directors. This provides a spot salary for each post, based on a percentage of the CEO salary. The Trust continues to follow national guidance on this matter.

As outlined above, salary levels of the Executive Directors have been reviewed in year. The Trust is required to explain the steps taken to ensure remuneration is reasonable where one or more senior managers are paid more than £150,000.

The following Executive Directors were paid more than £150,000 during 2025-26, which was not pro-rated:

- Nikhil Khashu – Chief Executive Officer
- Lynne Carter – Chief Nurse / Director of Delivery Unit / Deputy Chief Executive (BCH)
- Dan Moore – Joint Chief Operating Officer / Deputy Chief Executive (WHH)
- Paul Fitzsimmons – Joint Executive Medical Director (WHH)
- Ali Kennah – Joint Chief Nurse from July 2025 (WHH)

The Nominations and Remuneration Committee considered the market rates using NHS Providers Annual Remuneration survey to provide benchmarking information, prompted by the need to recruit new Executive Directors, but extended to ensure parity between those already in post and newly appointed staff.

The Trust is required to report what constitutes the senior manager's remuneration policy in tabular format set out below:

Components of Remuneration Package of Executive and Non-Executive Directors	Basic pay in accordance with their contract of employment (Executive) and letters of appointment (Non-Executive)
Components of Remuneration Report that is relevant to the short and long-term Strategic Objectives of the Trust	The Executive Directors do not receive any remuneration tailored towards the achievement of Strategic Objectives

Explanations of how the components of remuneration operate	With the exception of Executive Directors and the CEO, all senior managers within the Trust are employed on Agenda for Change terms and conditions and associated salary scales. Bridgewater Community Healthcare NHS Foundation Trust has adopted the NHS VSM pay framework as the salary scale for all Executive Directors. This provides a spot salary for each post, based on a % of the CEO salary.
Maximum amount that could be paid in respect of the component	Maximum payable is the Executive Director's annual salaries as determined by the NHS VSM pay framework.
Explanations of any provisions for recovery	If an individual is overpaid in error, there is a contracted right to recover the overpayment.

There was no facility for performance related pay within the Trust's pay structure.

As a Community Trust, with the requirement to travel across a wide geographical footprint, all Executive Directors are entitled to receive a lease car or take a car allowance equivalent to £5,700 pa.

All Directors are set annual objectives, in line with the organisational strategy and objectives and are assessed against these on an annual basis. There is input into the assessment from the Chair and CEO (for Executive Directors). Should any Executive Director performance be determined to be at an unacceptable level, the Trust would use its agreed performance management policies and procedures. The assessment period runs from 1 April to 31 March each year.

All Executive Directors have been issued with NHS contracts of employment, with notice periods not exceeding six months. There is no provision for any additional payments to be made to Executive Directors over and above their agreed salary level and car allowance. There is no payment for loss of office, other than those terms contained in section 16 of the Agenda for Change terms and conditions relating to redundancy situations.

All Executive Directors have been issued with NHS contracts of employment, with notice periods not exceeding six months. There is no provision for any additional payments to be made to Executive Directors over and above their agreed salary level and car allowance. There is no payment for loss of office, other than those terms contained in section 16 of the Agenda for Change terms and conditions relating to redundancy situations.

Non-Executive Director Remuneration

The remuneration levels for the Chair and Non-Executive Directors are as follows:

- Chair: £45,100 per annum (p.a.)
- Non-Executive Directors: £13,650 p.a.

There are no additional payments that are considered to be remuneration in nature.

The above remuneration levels were considered and agreed by the Council of Governors in line with NHS England guidance.

The tables shown on the following pages provide information on the remuneration and pension benefits for Senior Managers for the period 1 April 2025 to 31 March 2026.

Governor and Director Expenses

During the reporting period, one Governor (out of 20 Governors) claimed a total of £149 in expenses.

A total of two Directors (out of 13 directors Executive and Non-Executive) claimed a total of £630 in expenses.

	2025-26	2024-25
DIRECTORS (EXECUTIVE AND NON-EXECUTIVE)		
Total number of Directors in the year	**13**	**20**
Number of Directors who claimed in the year	**2**	**6**
Total number of expenses claimed by Directors in the year	**£630**	**£2,095**
GOVERNORS		
Total number of Governors in the year	**20**	**15**
Number of Governors who claimed in the year	**1**	**0**
Total number of expenses claimed by Governors in the year	**£149**	**£nil**

Salaries and Allowances

Salaries and Allowances 2025-26

Period from 1 April 2025 to 31 March 2026.

Directors **Name and title**	**Salary at 31.3.2026 (note)** **Bands of £5,000 £'000s**	**Taxable benefits at 31.3.2026** **Total to nearest £100**	**Performance pay and bonuses at 31.3.2026** **Bands of £5,000 £'000s**	**Long term performance pay and bonuses at 31.3.2026** **Bands of £5,000 £'000s**	**All pension-related benefits at 31.3.2026 (1)** **Bands of £2,500 £'000s**	**TOTAL at 31.3.2026** **Bands of £5,000 £'000s**
Martyn Taylor Chair / Non-Executive Director In post to 31/3/26	45-50	-	-	-	-	45-50
Nikhil Khashu* Chief Executive	90-95	-	-	-	380-382.5	470-475
Lynne Carter Chief Nurse In post to 30/6/25 Delivery Unit Director and Deputy Chief Executive In post from 01/07/25	60-65	6	-	-	-	65-70
Ali Kennah Chief Nurse In post from 01/07/25	40-45	-	-	-	70-72.5	145-50
Paul Fitzsimmons* Medical Director	40-45	-	-	-	115-117.5	155-60

Nick Gallagher Executive Director of Finance	145-150	6	-	-	-	140-155
Dan Moore* Chief Operating Officer	70-75	-	-	-	47.5-50	120-125
Paula Woods Director of People and Organisational Development	145-150	8	-	-	47.5-50	205-210
Tina Wilkins Non-Executive Director	10-15	-	-	-	-	10-15
Abdul Siddique Non-Executive Director	10-15	-	-	-	-	10-15
Gail Briers Non-Executive Director	10-15	-	-	-	-	10-15
Elaine Inglesby Non-Executive Director	10-15	-	-	-	-	10-15
Robert Chadwick Non-Executive Director	10-15	-	-	-	-	10-15

All of the above Directors were in post for the year ended 31 March 2026 except where indicated.

(1) Calculated in line with the prescribed guidance in Chapter 7 of the NHS Annual Reporting Manual for Foundation Trusts

* - These posts are shared with Warrington & Halton Hospitals NHS FT and the salary costs reflect the portion that is attributable to Bridgewater Community Healthcare NHS FT. However, the salary ranges in full are as follows:

Nikhil Khashu: 230-235

Paul Fitzsimmons: 190-195

Dan Moore: 180-185

Lynne Carter: 155-160

Ali Kennah: 150 -160

- Lynne Carter chose not to be covered by the pension arrangements during the reporting year.

Salaries and Allowances 2024-25

Period from 1 April 2024 to 31 March 2025.
(The following table has been subject to audit)

Directors	**Salary at 31.3.2025**	**Taxable benefits at 31.3.2025**	**Performance pay and bonuses at 31.3.2025**	**Long term performance pay and bonuses at 31.3.2025**	**All pension-related benefits at 31.3.2025 (1)**	**TOTAL at 31.3.2025**
Name and title	**Bands of £5,000 £'000s**	**Total to nearest £100**	**Bands of £5,000 £'000s**	**Bands of £5,000 £'000s**	**Bands of £2,500 £'000s**	**Bands of £5,000 £'000s**
Karen Bliss Chair In post to 31/03/25	45-50	-	-	-	-	45-50

Colin Scales Chief Executive In post to 17/09/24	85-90	-	-	-	5-7.5	90-95
Nikhil Khashu* Chief Executive In post from 01/11/24	35-40	-	-	-	32.5-35	70-75
Lynne Carter Chief Nurse and Deputy Chief Executive Acting Chief Executive 18/09/24 to 31/10/24	155-160	-	-	-	-	155-160
Ted Adams Medical Director In post to 21/11/24	65-70	600	-	-	-	70-75
Paul Fitzsimmons* Medical Director In post from 22/11/24	5-10	-	-	-	25-27.5	30-35
Nick Gallagher Executive Director of Finance	145-150	-	-	-	22.5-25	170-175
Sarah Brennan Chief Operating Officer In post to 08/09/24	60-65	-	-	-	5-7.5	65-70
Dan Moore* Chief Operating Officer In post from 09/12/24	20-25	-	-	-	45-47.5	65-70
Paula Woods Director of People and Organisational Development	140-145	8000	-	-	22.5-25	175-180
Robert Foster Programme Director - Collaboration & Integration In post to 30/06/24	20-25	-	-	-	-	20-25
Mark Charman Acting Chief Operating Officer In post from 09/09/24 to 08/12/24	20-25	-	-	-	32.5-35	50-55
Jeanette Hogan Acting Chief Nurse	10-15	-	-	-	137.5-140	150-155

In post from 18/09/24 to 31/10/24						
Linda Chivers Non-Executive Director In post to 24/05/24	0-5	-	-	-	-	0-5
Tina Wilkins Non-Executive Director	10-15	-	-	-	-	10-15
Abdul Siddique Non-Executive Director	10-15	-	-	-	-	10-15
Gail Briers Non-Executive Director	10-15	-	-	-	-	10-15
Martyn Taylor Non-Executive Director	10-15	-	-	-	-	10-15
Elaine Inglesby Non-Executive Director	10-15	-	-	-	-	10-15
Robert Chadwick Non-Executive Director	10-15	200	-	-	-	10-15

All of the above Directors were in post for the year ended 31 March 2025 except where indicated.

(1) Calculated in line with the prescribed guidance in Chapter 7 of the NHS Annual Reporting Manual for Foundation Trusts

Fair Pay Multiple

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

The mid-point of the banded remuneration of the highest paid director in Bridgewater Community Healthcare NHS Foundation Trust in the year ended 31 March 2026 was £232,500 which is a 6.89% increase from the previous year (2024-25: £217,500 – 22.5%). The increase is due to the appointment of a new Chief Executive, a post which is shared between Bridgewater and Warrington & Halton Hospitals NHS FT and as such attracts a higher salary.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind, but not severance payments. It does not include employer's 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 £237 to £232,500*, (2024-25, £1,825 to £194,955). 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 was 5.7% (2024-25: -2.5%). No employees received remuneration in excess of the highest paid director in 2025-26.

* - Reflects annualised basic salaries.

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 pay	£29,584	£38,694	£50,114
Total pay and benefits (excluding pension benefits)	£29,699	£39,005	£50,273
Pay and benefits excluding pension: pay ratio for highest paid director	7.83:1	5.96:1	4.64:1

2024-25	25th percentile	Median	75th percentile
Salary component of pay	£27,039	£36,728	£46,636
Total pay and benefits (excluding pension benefits)	£27,257	£36,901	£47,060
Pay and benefits excluding pension: pay ratio for highest paid director	7.98:1	5.89:1	4.62:1

The median pay ratio is consistent with the Trust's policies on pay, progression and reward as they are embedded within the Trust's payroll system to ensure proper application.

The movement is due to the impact of pay awards for both Agenda for Change and non-agenda for change staff and increased highest paid director salary.

In the previous year, Non-Executive Directors were included in the fair pay disclosure: current year guidance has placed them outside scope for 2025-26.

Exit Packages

There were 12 packages paid during 2025-26 (2024-25: none).

Service Contracts

Name and Job Title	Date appointed	Tenure	Notice Period	Left the Trust
Lynne Carter: Chief Nurse / Deputy Chief Executive to July 2025. From July 2025: Director of Delivery Unit / Deputy Chief Executive	23/03/2018 as Interim Chief Nurse and appointed in substantive role from 01/05/2018	Permanent	6 months	31/03/2026

Nick Gallagher: Director of Finance	07/01/2019	Permanent	6 months	N/A
Paula Woods: Director of People & Organisational Development	01/07/2020	Permanent	6 months	N/A

Pension Benefits

Period from 1 April 2025 to 31 March 2026

Executive Directors

Name	Real increase in pension at pensionable age	Real increase in pension lump sum at pensionable age	Total accrued pension at pensionable age at 31 March 2026	Lump sum at pensionable age related to accrued pension at 31 March 2026	Cash Equivalent Transfer Value at 1 April 2025	Cash Equivalent Transfer Value at 31 March 2026	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	Bands of £2,500	**Bands of £2,500**	**Bands of £5,000**	**Bands of £5,000**				
	£'000s	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Nikhil Khashu* Chief Executive	17.5-20	40-42.5	80-85	200-205	1,334	1,764	380	-
Nick Gallagher Director of Finance	0-2.5	0-2.5	40-45	95-100	985	1025	5	-
Lynne Carter* Chief Nurse/Delivery Unit Director and Deputy Chief Executive	-	-	-	-	-	-	-	1
Dan Moore* Chief Operating Officer	2.5-5	0-2.5	40-45	90-95	712	779	36	-
Paula Woods Director of People and Organisational Development	2.5-5	0-2.5	40-45	95-100	891	977	52	-
Paul Fitzsimmons* Medical Director	5-7.5	7.5-10	50-55	115-120	852	987	99	-

Ali Kennah* Chief Nurse (from 01/07/25)	2.5-5	5-7.5	55-60	140-145	1203	1361	85	-

There are no entries in respect of pensions for Non-Executive Directors as they do not receive pensionable remuneration.

* - These posts are shared with Warrington & Halton Hospitals NHS FT and disclose the full value of pensions as notified by NHS Business Services Authority, rather than the proportion applicable to Bridgewater Community Healthcare NHS FT.

Negative values are not disclosed in this table but are substituted with a zero.

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.

Should a senior manager retire early then there are no additional benefits that would be payable under the terms of the NHS Pension Scheme.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Cash Equivalent Transfer Values (CETV)

Cash Equivalent Transfer Values (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates.

The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Signed

Nikhil Khashu

Chief Executive **Date: 22 June 2026**

3.3 Staff Report

Staff Analysis

As of 31 March 2026, Bridgewater employed staff 1530 (1274.72 WTE), the majority of whom are clinically trained, including district nurses, health visitors, specialist nurses, occupational therapists, speech and language therapists, physiotherapists and clinical administrators.

The breakdown of male and female employees is as follows:

	Male		Female	
	Headcount	**WTE**	**Headcount**	**WTE**
Directors	3	3	7	6.8
Other Senior Managers	11	10.90	21	20.08
Employees	146	133.05	1342	1098.89
Total	160	148.95	1370	1125.77

Staff sickness

The sickness absence rate for the Trust for the period 1st January to 31st December 2025 was 7.47%. This equates to a Long Term Sickness Absence rate of 5.49% and Short Term Sickness Absence rate of 1.98%.

The top three reasons for sickness absence were:

Anxiety/stress/depression/other psychiatric illnesses	42.1%
Gastro	7.4%
Musculoskeletal	7.2%

Turnover

The Trust's turnover rate for the period 1st April 2025 to 31st March 2026 was 14.57% and includes all reasons for leaving.

The top three reasons for leaving were:

Voluntary Resignation / Not Specified Reason	18.83%
Retirement age	17.48%
Employee Transfer TUPE Out	11.68%

Audited staff cost

Staff costs

	Permanent	Other	2025-26 Total	2024-25 Total
	£000	£000	£000	£000
Salaries and wages	55,208	1,124	**56,332**	56,606
Social security costs	6,596	133	**6,729**	5,269
Apprenticeship levy	262	4	**266**	267
Employer's contributions to NHS pensions	12,206	242	**12,448**	12,433
Pension cost – other	18	-	**18**	23
Termination benefits	771	-	**771**	-
Temporary staff	-	1,567	**1,567**	3,010
Total gross staff costs	**75,061**	**3,070**	**78,131**	**77,608**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**75,061**	**3,070**	**78,131**	**77,608**
Of which				
Costs capitalised as part of assets	-	-	**-**	24

Average number of employees (WTE basis)

	Permanent	Other	2025-26 Total	2024-25 Total
	Number	Number	Number	Number
Medical and dental	54	1	**55**	56
Administration and estates	324	14	**338**	361
Healthcare assistants and other support staff	187	8	**195**	220
Nursing, midwifery and health visiting staff	466	28	**494**	521
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	261	4	**265**	278
Other	-	-	-	-
Total average numbers	**1,292**	**56**	**1,347**	**1,436**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	**-**	1

Reporting of compensation schemes - exit packages 2025-26

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number

Exit package cost band (including any special payment element)

<£10,000	-	-	**-**
£10,000 - £25,000	-	2	**2**
£25,001 - £50,000	-	2	**2**
£50,001 - £100,000	-	7	**8**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**11**	**12**
Total cost (£000)	£60,000	£572,000	**£632,000**

Reporting of compensation schemes - exit packages 2024-25

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	**Number**	**Number**
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	-
Total number of exit packages by type	**-**	**-**	**-**
Total cost (£)	-	-	**-**

Payment for Loss of Office - Nick Gallagher

The total amount payable to the individual (£199,050) is as follows:

- Redundancy: £60,066 – this based on 9 years of continuous NHS service, in accordance with Section 16 of the Agenda for Change NHS Terms and Conditions of Service Handbook.
- Capitalised pension costs: £138,984 - this is in line with NHSBSA guidance and is the excess cost over and above the redundancy payment.

Exit packages: other (non-compulsory) departure payments

	2025-26		2024-25	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	**£000**	**Number**	**£000**
Mutually agreed resignations (MARS) contractual costs	11	572	-	-

Contractual payments in lieu of notice	-	-	-	-
Total	**11**	**572**	-	-
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Gender Pay Gap

To comply with the requirements of the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 we analyse and publish details of our gender pay gap results annually before 30 March 2026.

While we have seen continued improvements in results since the first publication in 2017, the Trust continues to work to eliminate the gender pay gap, including using data from sources such as the NHS Staff Survey and from the Trust's Women's Staff Network.

Our actions look to understand and address the structural factors that may impact on gender pay, and to embed proactive and supportive workplace practices that recognise the diversity of personal experiences that contribute to gender pay gaps.

Our Gender Pay Gap reports can be requested by emailing bchft.global@nhs.net or by viewing the Gender Pay Gap Service website at Search and compare gender pay gap data - Gender pay gap service - GOV.UK

Modern Slavery Act

We are committed to improving our practices to combat slavery and human trafficking. We recognise the responsibilities we hold towards our patients, service users, employees and the local community. Our commercial activities are guided by a strong set of ethical values, and we expect all suppliers to the Trust to uphold the same ethical principles.

Our policies on slavery and human trafficking

We are committed to ensuring that modern slavery and human trafficking have no place in our business. We strive to ensure our suppliers share this commitment. Our Trust Safeguarding and Vulnerable Adults policies incorporate guidance on human trafficking and modern slavery. We adhere to strict employment checks and standards, including verifying the right to work and obtaining suitable references

We are also committed to social and environmental responsibility, maintaining a zero-tolerance policy towards modern slavery and human trafficking. Any concerns identified in this area are escalated through our organisational safeguarding processes, in collaboration with partner agencies such as Local Authorities and the Police, where appropriate.

Our guidance on Modern Slavery includes:

- Compliance with all relevant legislation and regulatory requirements.
- Informing suppliers and service providers that we uphold the principles of the legislation.
- Taking modern slavery factors into account when making procurement decisions.
- Raising awareness of modern slavery issues.

We will:

- Strive to incorporate modern slavery conditions or criteria in specification and tender

documents whenever possible.

- Assess specifications and tenders, giving appropriate weight to modern slavery considerations.
- Encourage suppliers and contractors to take proactive measures and understand their obligations under the new requirements.
- Expect supply chain and framework providers to demonstrate compliance with their obligations in their processes

Trust staff must:

- Contact and work with the Procurement Team when seeking to work with new suppliers so appropriate checks can be undertaken

Procurement staff will:

- Undertake awareness training where possible.
- Aim to check and draft specifications to include a commitment from suppliers to support the requirements of the Act.
- Will not award contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2026.

Equality, Diversity and Inclusion

As a public sector organisation, the Trust is required to demonstrate how it meets the Public Sector Equality Duty under section 149 of the Equality Act 2010. This includes having due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations in both employment and service delivery. Evidence of compliance is provided through the Trust's annual Public Sector Equality Duty reports and is supported by further mandated reporting for Gender Pay Gap, Workforce Race and Disability Equality Standards, which include ethnicity and disability pay gap reporting, and the annual NHS Equality Delivery System reports.

The Trust serves and employs a diverse population, including people from protected characteristic groups and wider health inclusion groups such as carers, and communities experiencing socioeconomic disadvantage. Equity and inclusion are embedded as a core principle of the Trust's Communities Matter Strategy 2023–2026, ensuring that equality considerations are integral to strategic decision-making and service delivery.

Since 2023 the Trust's strategic equality objective has been 'to ensure that equality, diversity and inclusion are at the heart of what we do, creating compassionate and inclusive conditions for both staff and patients. Delivery of the strategic equality objective, along with those for staff and for health inequalities have been guided by the Trust's People Strategy, and the Equality, Diversity and Inclusion Strategy, both of which have been informed by national workforce requirements, Trust data and staff survey insights. Executive Directors hold equality objectives aligned to this ambition.

To embed due regard to equality in decision making, the Trust requires equality and health inequalities assessments for policies, strategies, service changes and transformation programmes. In 2024, in partnership with colleagues at Warrington and Halton Teaching Hospitals NHS Foundation Trust, the Trust implemented refreshed assessment templates to

strengthen the focus on protected characteristic groups, wider inclusion groups, and health inequalities, and to deepen the focus on effective consultation with potentially affected groups. The assessment process aligns with the Equality Act 2010, the Human Rights Act 1998 and the Trust's anti-racism commitments.

The templates also incorporate the duty of due regard introduced by the Armed Forces Act 2021, reflecting the Trust's responsibilities to service personnel, veterans and reservists as set out in the signing of the Armed Forces Covenant in 2022, and within Trust policy for reservists, adult cadet force volunteers, service leavers and veterans, and the wider armed forces community.

Equality governance, including that for the equality and health inequalities assessments, is embedded through the quality and people governance structures up to Board. In addition, as part of integration work with Warrington and Halton Teaching Hospitals, our Board and Committee papers have been updated to further strengthen the equality narrative provided to decision makers, ensuring due regard is embedded throughout reporting governance.

The Trust is committed to being an actively anti-racist organisation and to improving race equality for staff and communities and was honoured to be awarded bronze level in the NHS North West Anti-Racist Framework in May 2025. This commitment is set out in the Trust's Anti-Racism Statement and zero tolerance approach to discrimination and abuse. In this work we have been supported and guided by the members of the Trust's Race Inclusion Network.

Staff networks are recognised as critical friends and partners in shaping policy, culture and improvement activity. Five staff networks support inclusion, peer support and organisational learning: the Carers Support Network, Enabled Network, LGBTQIA+ Staff Network, Women's Staff Network, and Race Inclusion Network. Work to strengthen collaboration and shared learning across networks, including partnership with staff networks in Warrington and Halton Teaching Hospitals, continued during 2025 with establishment of networks in common with refreshed terms of reference, executive sponsorship, and network governance, including protected time for those in network chair roles. Next steps will focus on maturity of the staff inclusion networks, ensuring their voice is maintained while enabling the networks to meet the needs of the groups affected, a particular example is further development and evolution of the armed forces and veterans' network.

Through the staff network, critical friend and partnership approach the Trust is honoured to hold the following equality accreditations, and during 2026-27 equality work will focus on next steps for all of these important areas of inclusion:

- Disability Confident Leader
- Navajo Charter Mark for LGBT+ inclusion in Cheshire and Merseyside and Greater Manchester
- Defence Employer Recognition - Silver
- Veteran Aware
- NHS North West Anti-Racist Framework

Equality Reporting

The Trust recognises its legal duties under the General Equality Duty of the Equality Act 2010 (Part 149: Public Sector Equality Duty).

All legally required and mandated Trust reports can be requested by emailing bchft.global@nhs.net, the full list is as follows:

- **Public Sector Equality Duty** (from 2012)
- **Gender Pay Gap** (from 2017)
- **NHS Workforce Race Equality Standard, including ethnicity pay gap** (from 2015)
- **NHS Workforce Disability Equality Standard, including disability pay gap** (from 2019)
- **Equality Delivery System** (from 2015)

Internal Communications

Throughout 2025-26, internal communications played a pivotal role in supporting colleagues through an intense year of organisational change, most notably the integration between Bridgewater Community Healthcare (BCH) and Warrington and Halton Teaching Hospitals (WHH). Our focus remained firmly on ensuring colleagues felt informed, supported and connected, while continuing to deliver engaging campaigns that strengthened our culture and celebrated our people.

Strengthening communication foundations during major change

The 'MyBridgewater' bulletin remained the Trust's primary internal communication channel and the most consistently accessed source of updates for colleagues. Sent every Monday at midday, it continued to act as a 'one-stop shop' for essential information, training opportunities, operational messaging, and updates on the integration programme.

Alongside the bulletin, global emails were reserved for urgent and time-sensitive messages. Their intentionally limited use preserved their impact, with several reaching record-high opening rates.

Supporting people through the integration journey

Integration with WHH continued to be the single largest area of communications activity throughout the year. A dedicated Communications and Engagement Workstream met monthly, and the team supported a wide range of actions to ensure colleagues had the information needed at each stage.

Campaigns that shaped culture and experience

A defining feature of the year was the delivery of high-impact, values-driven campaigns positioned around staff wellbeing, belonging, safety and flexibility.

- **Making Flexible Work** – showcased nationally at the NHS Employers conference.
- **Choose Kindness** – strengthened through the 'My Kinder People' initiative.

Other key internal campaigns included **Sexual Safety, Cutting Our Costs Together, NHS Staff Survey, Winter Vaccinations and Spotlight on Services**.

Recognising and celebrating our people

'Feel Good Friday' continued to be one of the most valued recognition tools in the organisation, offering a positive, low-cost way to celebrate colleague achievements.

Digital channels supporting a mobile workforce

The MyBridgewater Extranet and Staff App were heavily used throughout the year, supporting colleagues working across a wide geography with quick access to essential resources.

Staff Engagement

NHS Staff Survey

The NHS Staff Survey is a key listening tool. Following the 2025 survey results, the Staff Engagement Team met regularly with relevant colleagues to address areas of concern. The Staff Engagement Team created key headline documents for each directorate, giving in-depth detail around areas of improvement and areas for further development to support Directorates with action planning.

2025 NHS Staff Survey Results

In 2025, BCHFT closed the NHS Staff Survey with a final response rate of 52.5% equalling 821 responses from a sample size of 1,564. For comparison the overall response rate for Community Trusts contracted by IQVIA was 61.49% meaning BCHFT's final response rate was 8.99% lower than the Community Trust average.

National Quarterly Pulse Survey (NQPS)

The NQPS is a regular temperature check on staff engagement. Although response rates are lower than the NHS Staff Survey, it provides valuable quantitative and qualitative indicators. The Staff Engagement team uses this data to inform Trust-wide initiatives and programmes.

Integration Programme Engagement

Positive colleague engagement is vital as Bridgewater integrates with WHH. The Staff Engagement teams are working together to implement engagement activities as part of the Better Care Together programme. Regular Staff Engagement sessions allow colleagues to ask questions and stay informed about the integration.

Reward and Recognition

In 2025, BCHFT completed a full review of its Reward and Recognition offer whilst also allowing colleagues to comment on what they want from a reward and recognition offer. This information has been shared with WHH to create a joint reward and recognition offer once integrated.

Adapting to Change

From a communications and staff engagement perspective, the Trust will continue to work closely with colleagues to adapt its methods to meet their needs, especially during the integration programme in the months ahead.

Health and Safety Performance and Occupational Health

Health, Safety, Fire and LSMS Performance - work undertaken during period April 2025 – March 2026

This includes:

- Review and updated Policies and guidance:
    - Security Policy

    - Slips, Trips, Falls (including Falls form Height) Policy
    - Stress Policy
    - Lockdown Policy
    - Bomb Threat Policy
- Undertake and monitoring of Fire Drills in freehold sites and specific leasehold sites and gathering of Fire Drill/Evacuation Reporting form
- Attendance at Fire Drills at Community Health Partnerships (CHP) sites and National Health and Performance Safety (NHSPS) sites
- Provide comment, recommendations on various Safe Operating Procedures (SOP) and policies for services
- Advice and support on completing Risk Assessments – example for lone working, violence and aggression
- Provide advice, support in review of Ulysses Incident Reporting system, regarding application of 'Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) as per Health and Social Care guidance
- A range of communications has been produced via the internal bulletin and Team Brief, plus the following were provided directly to freehold premises, specific leasehold managers, and sites:
    - Policy
    - Fire safety
    - Legionella – water safety – flushing infrequently used outlets
    - Personal Emergency Evacuation Plans (PEEP's)
- Update Trust regarding Counter Terrorism (CT) and actions required and national initiatives. Promotion of 'Action Counters Terrorism' (ACT) training. Meetings with Education and Professional Development (EPD) and Safeguarding. Proposal to EMT for implementation and Education Governance – rollout across the Trust
- Interpretation and application of new Building Safety Act, Martyn's Law, and Fire Regulations and updated Health Technical Memoranda documents
- Production of contract reports twice yearly
- Advice, support, and promotion of first aid provision. Level of training required to suit needs of the Trust
- Advice, support, and promotion of evac-chair/ski-pad training
- Advice and support in development of Personal Emergency Evacuation Plans (PEEPS) – for patients and staff
- Advice regarding asbestos removal and staff/patient safety
- Review of the Violence & Aggression Prevention and Reduction Standards detailing the Trust's responsibilities to manage violence and aggression. This is supported by the 'Sexual safety in healthcare – organisation charter'
- Support and advice to Warehouse manager, and monitoring of warehouse action plan
- Attendance at NHSE – Northern Safety and Learning Network
- Attendance seminars NHSE VPR Standards, support and guidance documents

- Assisted with investigations of accidents, incidents, thefts, and security and generation of reports detailing recommendations
- Liaison and meetings with local with Police Officers (LPCSO)
- Reports for, and attendance at Quality Council
- Monitor and review Lone Working Contract and attendance at meetings.
- Communication of weekly lone working reports to senior management for action
- CES Improvement Plan Group: review of risk assessments
- Advice and assistance to managers regarding RIDDOR reporting to the Health and Safety Executive (HSE) for both staff incidents and patients/members of public incidents/accidents
- Dissemination and communication of 'external warning notices' regarding violent patients
- Lone Working Devices - Contract meetings with provider, RELIANCE for lone worker devices. Monitor staff usage of equipment and training accessed and completed. Highlighting areas of weakness and recommendations. Weekly reports generated and provided to senior managers for actioning

Risk assessments with reports and action plans produced:

  - 22 Fire Risk Assessments (freehold and leasehold sites)
  - 22 Building Health and Safety Risk Assessments (freehold and leasehold sites)
  - Additional 16 Fire risk assessments (leasehold sites)
- 9 fire warden training sessions - delivered face-to-face
- Development of stress risk assessment sessions and delivery of approximately 8 sessions to managers and staff

Accident/incident investigations: Where appropriate liaise with landlords i.e. CHP, NHSPS, GP and private landlords.

- Advice and assistance with, slips, trips and falls – staff and patients
- Manual handling – staff
- Violence and aggression – staff and patients
- Unauthorised access to premises

Attendance at:

- Attendance at Contract meetings four times year
- Health, Safety, Fire and Security Committee meetings, three per year and production of minutes
- Estates meetings – weekly
- Stress Working Group meetings – stress risk assessments and compliance issues
- Community Health Partnerships (CHP) Building User Group meetings
- Community Health Partnerships (CHP) Water Safety Groups
- Dental health and safety meetings
- HR Project Operational Development (POD) meetings

- Quality Council, including providing reports for discussion and highlighting areas for improvement and areas of strength
- Multi-Disciplinary Team meetings in relation to specific incidents of violence and aggression
- Medical Gasses Group meetings and actions required as per ALERT issued
- CCPG Policy meetings

Support, advice, and assistance:

Has been provided to managers and staff, including liaison with Trade Union Representatives where appropriate for:

- Risk assessments for policies and procedures including Safe Operating Procedures
- Lockdown Policy and Procedures including development of local procedures
- Stress risk assessments
- Display Screen Equipment risk assessments
- Planning and design of office and desk layout
- Heating
- Update and communications regarding Counter Terrorism and actions required and national initiatives
- Personal Emergency Evacuation Plans (PEEP's) – for patients and staff
- Violence and aggression risk assessments
- Assistance with investigations of incidents e.g. violence and aggression towards staff, security, and theft
- Lone working management and risk assessments

Seminars:

- Violence Prevention and Reduction Standards
- Stress Management
- Martyn's Law – PROTECT UK

Occupational Health

The Trust's Occupational Health Services are provided externally by People Asset Management (PAM).

PAM offer a fully consolidated Occupational Health Service including:

- Occupational health appointments via management referral
- Support and advice for musculoskeletal issues
- Physiotherapy, both management referral and employee led via the Physiotherapy Information Line (PhIL)
- Pre-employment screening
- Vaccinations and health surveillance for staff
- Needlestick injury support
- Stress management support

- Ergonomics advice
- PAM Assist (Employee Assistance Programme) – a 24-hour / 7 days per week confidential helpline providing advice and support on a range of issues including bereavement, divorce, addiction and stress
- Ill health retirement application assessments
- Counselling and cognitive behavioural therapy
- Trauma support

In addition to our Occupational Health offer, as part of the Trust's People Strategy pledge of '*creating and sustaining a progressive person-centred health and wellbeing* offer' some of our achievements have included**:**

- Holding a Health and Wellbeing fortnight in November which involved two weeks of various sessions offered to staff in relation to mental and physical health including nutrition and tai chi sessions, with evaluation informing input for future events.
- Introduction of a virtual learning workshop offer featuring the "Looking After You and Your Colleagues" informing a broader rollout of wellbeing workshops enabling staff to access self-directed learning and support at their convenience.
- Continuation of the Rugby League Cares (RLC) programme providing a chance for staff to 'offload' and talk about any issues troubling them and learn the tools and techniques professional athletes use to enjoy good mental fitness and build resilience.

NHS Staff Survey 2025

The NHS has a number of key important listening channels to hear and respond to employee voice. One such channel is the annual NHS Staff Survey. This gives us a great opportunity to hear what matters to our NHS people and make positive steps to improving our experience of work.

Locally, Bridgewater also uses many approaches to staff engagement and a wealth of interactive communication channels to gain colleague feedback. We take the employee voice seriously and will always encourage feedback through the many mechanisms we have. The NHS Staff Survey is however the best annual tool in gaining important colleague information to help shape improvements to the organisation.

In 2021, the questions of the survey were aligned with the NHS People Promise to track progress against its ambition to make the NHS the workplace we all want it to be. These replaced the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The fieldwork for the 2025 NHS Staff Survey was carried out between September and November 2025 and results were published in March 2026. 52.5% of Bridgewater staff completed the survey.

The 2025 NHS Staff Survey benchmark report showcases a challenging year for the organisation. When considering another challenging and turbulent year ahead for the NHS, it is important that we continue to listen to and look after our staff and do all we can to maintain focus on delivery of the NHS People Promises.

Staff experience and engagement

The Trust is committed to creating a positive, inclusive and supportive working environment where colleagues feel valued, heard and able to contribute to service improvement. Our

approach to staff engagement is underpinned by the NHS People Promise, ensuring that staff experience is consistently measured, understood and improved across all services.

As Bridgewater has now integrated with Warrington and Halton Teaching Hospital Foundation Trust to form North Cheshire and Mersey NHS Foundation Trust, staff engagement will continue to evolve to support the development of a single, shared culture. Future engagement arrangements and priorities will be aligned across the new organisation, with a strengthened focus on consistent employee voice, joint engagement approaches, and the co-production of workforce initiatives. This will ensure that all colleagues are supported through organisational change and that feedback continues to shape the development of the new Trust.

Overall Trust Responses – 2025-26, 2024-25 and 2023-24

The table below illustrates the Trust's results, compared to the national average of NHS Community Trusts (of which there are 14 in this benchmarking category).

	2025-26		2024-25		2023-24	
	Trust score	**Community Trust benchmarking score**	**Trust score**	**Community Trust benchmarking score**	**Trust score**	**Community Trust benchmarking score**
We are compassionate and inclusive	7.41	7.70	7.87	7.76	7.8	7.8
We are recognised and rewarded	5.82	6.36	6.41	6.42	6.4	6.5
We each have a voice that counts	6.56	6.98	7.17	7.11	7.2	7.2
We are safe and healthy	6.00	6.41	6.55	6.49	6.5	6.4
We are always learning	5.14	5.92	5.80	5.97	5.9	6.0
We work flexibly	6.30	6.89	6.95	6.91	6.8	6.9
We are a team	6.81	7.12	7.28	7.2	7.2	7.2
Staff engagement	6.56	7.09	7.21	7.23	7.3	7.3
Morale	5.44	6.09	6.24	6.26	6.3	6.2

In 2025, all nine elements/themes show a score lower than the community average. This is a contrast with 2024, where there were three themes which scored below the community average.

Comparison compared to Community Trust Average:

We are compassionate and inclusive (-0.29)
We are recognised and rewarded (-0.54)
We each have a voice that counts (-0.42)

We are safe and healthy (-0.41)
We are always learning (-0.78)
We work flexibly (-0.59)
We are a team (-0.31)
Staff Engagement (-0.53)
Morale (-0.65)

The following table highlights the journey of the Trust between the 2024 results and the 2025 results.

In 2025, all nine elements/themes show a score lower than the Trust's 2024 survey results.

People Promise Element / Theme	2025 score	2024 score	Trust scores – 2025 vs 2024 Green - improvement Red - Deterioration
We are compassionate and inclusive	**7.41**	**7.87**	**-0.46**
We are recognised and rewarded	**5.82**	**6.41**	**-0.59**
We each have a voice that counts	**6.56**	**7.17**	**-0.61**
We are safe and healthy	**6.00**	**6.55**	**-0.55**
We are always learning	**5.14**	**5.80**	**-0.66**
We work flexibly	**6.30**	**6.95**	**-0.65**
We are a team	**6.81**	**7.28**	**-0.47**
Staff engagement	**6.56**	**7.21**	**-0.65**
Morale	**5.44**	**6.24**	**-0.80**

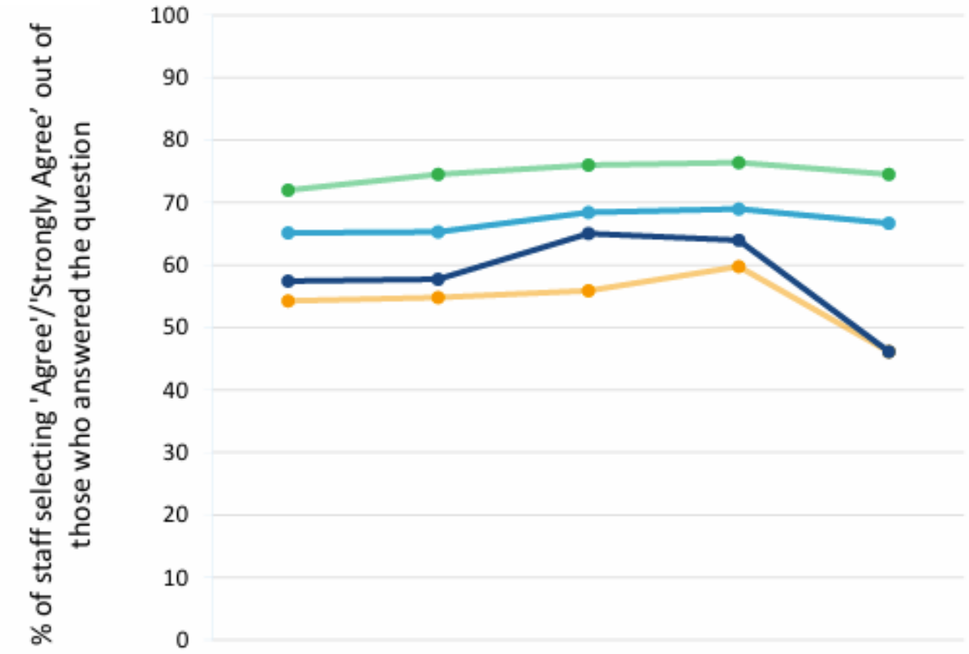
The following image outlines the encouraging improvement being made on two key NHS Staff Survey questions. These are:

a. Q25c: I would recommend my organisation as a place to work

b. Q25d: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

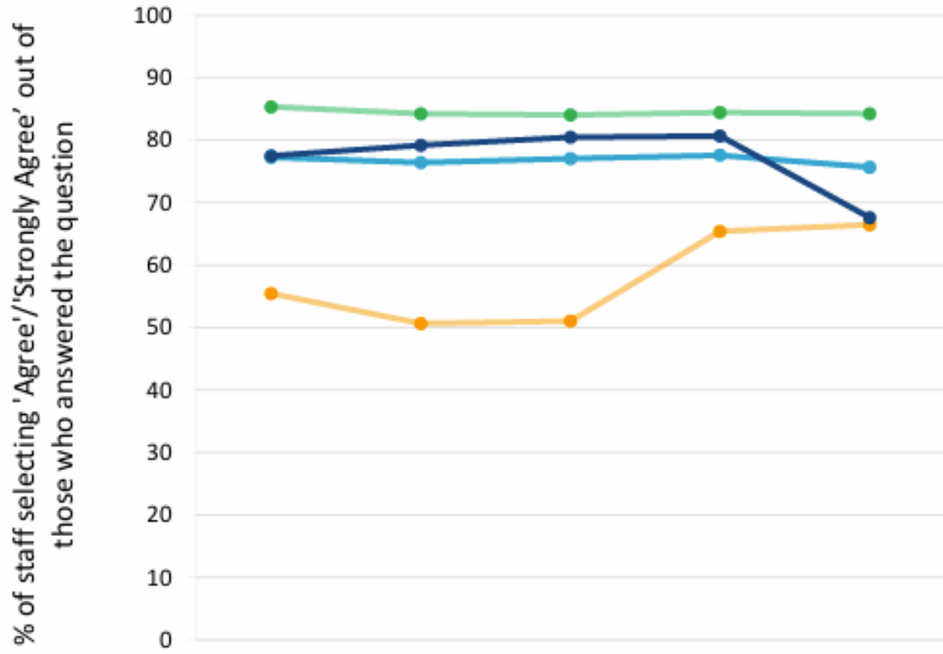
The five-year trajectory shown in this image has shown a steady score between 2022 – 2024. However, in 2025 both questions have seen a significant decline. Q25c has seen a -17.83% decline and Q25d has seen a -13.09% decline.

Q25c I would recommend my organisation as a place to work.



	2021	2022	2023	2024	2025
Your org	57.43%	57.72%	65.04%	63.97%	46.14%
Best result	71.99%	74.51%	76.01%	76.41%	74.52%
Average result	65.14%	65.33%	68.41%	68.98%	66.68%
Worst result	54.25%	54.83%	55.90%	59.76%	46.14%
Responses	852	827	961	1007	818

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2021	2022	2023	2024	2025
Your org	77.48%	79.16%	80.44%	80.68%	67.59%
Best result	85.33%	84.21%	84.02%	84.44%	84.24%
Average result	77.25%	76.42%	77.04%	77.57%	75.67%
Worst result	55.44%	50.63%	51.06%	65.41%	66.46%
Responses	850	824	961	1004	818

The full breakdown of the NHS Staff Survey benchmark results can be found on the dedicated NHS Staff Survey website at www.nhsstaffsurveys.com.

Future priorities and targets

As previously mentioned, Bridgewater has now integrated with Warrington and Halton Teaching Hospital Foundation Trust to form North Cheshire and Mersey NHS Foundation Trust, meaning a collective approach to address the combined Staff Survey results is underway.

- As an example, some of our emerging priorities include:
- Enhancing senior leadership visibility and strengthening our 'you said, we did' approach
- Strengthening psychological safety and speaking up
- Addressing violence, bullying and unacceptable behaviours
- Embedding everyday recognition and refreshing formal recognition schemes
- Providing clearer information about career pathways, meaningful appraisals and better access to training
- Identifying and scaling great practice across the organisation

After listening to feedback, we will create a simple approach that allows teams to focus on the issues that matter most to them, act on feedback in real time, and sustain improvements over the long term.

Expenditure on consultancy

The Trust spent £0.11m in 2025-26 (2024-25: £0.33m) on consultancy. Of this, £0.06m was spent on consultancy to support the development and implementation of Business Intelligence and Information Technology solutions. There was a further £0.03m spent on consultancy in respect of specialist VAT advice and £0.01m for the medical lead for the virtual ward programme.

Off-payroll engagements

The Trust had the following highly paid off-payroll engagements as at 31 March 2026, earning £245 per day or greater:

No. of existing engagements as of 31 March 2026	3
Of which:	
No. that have existed for less than one year at time of reporting	2
No. that have existed between one & two years at time of reporting	0
No. that have existed between two & three years at time of reporting	0
No. that have existed between three & four years at time of reporting	0

No. that have existed for four or more years at time of reporting	1

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

Number of off-payroll workers engaged during the year ended 31 March 2026	5
Of which:	
Not subject to off-payroll legislation*	5
Subject to off-payroll legislation and determined as in scope of IR35*	0
Subject to off-payroll legislation and determined as out of scope of IR35*	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which:	
Number of engagements that saw a change to IR35 status following review	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Any requests for off-payroll engagement would be subject to the same robust controls that are in place for any variable staff costs including agency, bank and overtime. These requests would need to be approved by a local vacancy control panel, an executive control panel and then a final review by the full Executive Management Team (EMT).

Liabilities

The Trust incurred no off-payroll worker tax liabilities and/or HMRC penalties.

Off-payroll engagements of board members, and / or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

No. of off-payroll engagements of board members, and / or senior officials with significant financial responsibility, during the financial year.	0
No. 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.	13

3.4 The disclosures set out in the Code of Governance for NHS provider trusts

The Code of Governance for NHS Provider Trusts was published in October 2022 and has been applicable since 1 April 2023. It replaces the previous NHS foundation trust code of governance issued by Monitor.

Bridgewater Community Healthcare NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis.

The Trust Board and Council of Governors are committed to the principles of best practice and good corporate governance as detailed in the Code of Governance. The Audit Committee and Trust Board regularly review metrics in relation to regulatory obligations, contractual obligations and additional internal performance targets/standards of the Trust. To review the performance and effectiveness of the Trust, a number of arrangements are in place including governance structures, policies and processes to ensure compliance with the code. These arrangements are set out in documents that include:

- The constitution of the Trust
- Standing orders
- Standing financial instructions
- Schemes of delegation and decisions reserved to the Board
- Accountability framework
- Terms of reference for the Board of Directors, Council of Governors and Committees of the Board
- Role descriptions
- Annual declarations of interest

In accordance with the code, all directors and non-directors of the Trust Board scrutinise and constructively challenge the performance of the Trust to drive improvement and achieve high quality safe care. The Non-executive Directors of the board are held to account by the Council of Governors who are responsible for ensuring that Non-executive Directors (individually and collectively) are exercising their duty in constructively challenging Executive Directors, developing strategic objectives, and ensuring the on-going effectiveness and performance of the Trust Board. The Chair of the Trust ensures that the Council of Governors meet on a regular basis and are fully consulted on areas of potential development or change in a timely manner thus supporting the Governors to fulfil their role and discharge their duties of representing the interests of members within their constituencies to whom they are accountable. NHS foundation trusts are required to provide (within their annual report) a specific set of disclosures in relation to the provisions within schedule A of the code of governance.

Where applicable, the Trust complies with all provisions of The Code of Governance for NHS Provider Trusts published in October 2022.

3.5 Regulatory Ratings

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

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

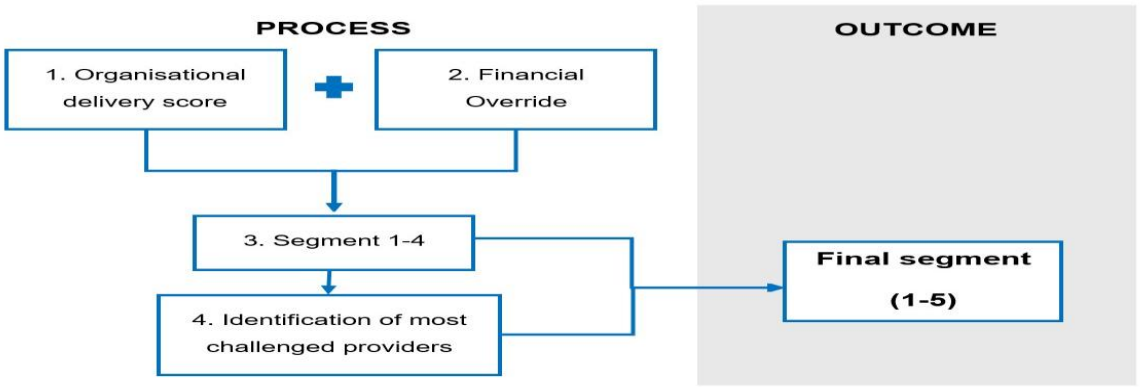
a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) Additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

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

Segment	Description
1	The organisation is consistently high-performing across all domains, delivering against plans.
2	The organisation has good performance across most domains. Specific issues exist.
3	The organisation and/or wider system are off-track in a range of domains or are in financial deficit.
4	The organisation is significantly off-track in a range of domains.
5	The organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve. or The organisation is a challenged provider where NHS England has identified significant concerns.

Segmentation approach



Segment support

Segment	How NHS England supports	How NHS England drives improvement	How NHS England intervenes
1	No specific support or intervention needs are identified. All organisations will have access to NHS IMPACT, the universal NHS improvement approach.	The organisation is expected to take a leadership role in developing and sharing best practice and improvement initiatives in areas that it excels in.	NHS England's use of its enforcement powers is not expected for organisations in this segment as they do not have intervention or support needs, but, if necessary, we will take enforcement action.
2	The organisation can diagnose and clearly explain its support needs, which are predominantly met locally. Our support on specific issues is provided where appropriate.	The organisation works with us to support the development of best practice in areas it shows high performance in and is expected to lead on its own improvement. Minimal, targeted support is aimed at improving specific areas where issues have been identified.	Due to the relatively high-performing nature of the organisation and its level of maturity, NHS England's use of its enforcement powers will be uncommon, but we may use these where specific issues call for this approach.
3	NHS England agrees the support needs of the organisation involving the provider's relevant ICB in the decision. To do this we take account of segmentation and capability. Support is delivered through local support offers, defined national support programmes and bespoke regional interventions.	The organisation receives increased scrutiny targeted at delivering improvement in challenged performance areas.	NHS England may apply interventions and/or require the organisation to take action in specific areas of low performance. This may involve use of our enforcement powers, particularly where performance concerns persist.
4	NHS England will consider the organisation's challenges and support needs, taking account of segmentation and capability to inform the appropriate support or intervention. As with segment 3, support needs are prioritised through local support offers, defined national support programmes and bespoke regional interventions.	The organisation receives intense scrutiny targeted at delivering improvement in the most challenged performance areas. Recovery KPIs and trajectories are agreed and proactively monitored.	NHS England may apply interventions and/or require the organisation to take broad actions or address specific concerns related to known issues. This may involve use of our enforcement action, particularly to secure improvement or where improvement is insufficient.
5	The organisation will be subject to NHS England's most intensive support – the Provider Improvement Programme (PIP) – to ensure it meets improvement goals.	The organisation is subject to the highest level of NHS England scrutiny and performance management to meet agreed transition criteria to leave the PIP or meet its agreed improvement plan. These demonstrate it can sustain levels of improvement.	Alongside support for the most challenged organisations, it is likely that enforcement action will be agreed through the relevant executive governance group if deemed necessary. Transition out of segment 5 requires the transition criteria to be met.

Segmentation

The Trust is currently placed in segment ‘3’ which represents a need for closer monitoring and structured support to improve. The Trust is offered additional support by NHSE to address the challenges, which may include financial sustainability and operational improvements. Any Trust in deficit can be no higher than segment 3.

This segmentation information is the Trust’s position as of Quarter 3 2025-26 (published 1 April 2026). Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: NHS England » NHS oversight framework – NHS trust performance league tables process and results

Finance and use of resources

Reporting against use of resources continues to be suspended in 2025-26.

3.6 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 NHS foundation 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 NHS foundation 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 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 Bridgewater Community Healthcare 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 Bridgewater Community Healthcare NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Directors oversaw all aspects of organisational performance and foreseeable risk during the year, including challenges in meeting financial duties, ongoing financial sustainability, operational service pressures, and the maintenance of effective relationships across the local health economy and with commissioners. This included engagement with integrated commissioning arrangements and system partnership plans. Executive Directors' performance appraisals were undertaken by the Chief Executive, with objectives set annually. The Nominations and Remuneration Committee oversaw the outcomes of these appraisals.

The Chief Nurse / Deputy Chief Executive held delegated authority for the Risk Management Framework and acted as Executive Lead for maintaining the Board Assurance Framework and its supporting processes. The postholder also held executive responsibility for clinical governance, clinical risk, patient safety and patient experience, with joint responsibility with the Medical Director for the quality of services.

The Head of Risk Management and Patient Safety was responsible for ensuring that the Trust maintained suitable and sufficient systems and processes for the effective management of risk across the organisation.

The Medical Director provided leadership as the Responsible Officer and, together with the Chief Nurse, was responsible for monitoring and improving clinical service delivery, safety and quality. This included responsibility for medical revalidation. The Chief Nurse was responsible for nursing revalidation and acted as Executive Lead for Safeguarding and the Trust's Caldicott Guardian. The Medical Director also held the role of Controlled Drugs Accountable Officer and Executive Lead for medical equipment, in accordance with Trust policies.

Directors and managers were supported by the Head of Risk Management and Patient Safety, who provided specialist advice and leadership on risk registers, incident reporting systems, and risk management processes, and facilitated training for managers and staff with risk management responsibilities.

The Risk Management Framework and Incident Reporting Policy set out the mechanisms by which staff identified, assessed and managed risks. The Trust's web-based Ulysses 'Safeguard' system supported the management of the risk register, incident reporting, medical equipment, central alerts, safeguarding, complaints and Freedom of Information processes.

Lessons learned were identified through the Patient Serious Incident Review Framework and Learning Panel (PSIRFaLP) and were disseminated across the Trust using established communication mechanisms, including executive briefings, electronic bulletins, the intranet and Team Brief. Recommendations arising from serious incident investigations were fed back directly to services and teams to support service improvement.

The risk and control framework

The Risk Management Policy (the Risk Management Framework) clearly differentiates between strategic risks, which may affect delivery of the Trust's strategic objectives, and operational risks, which relate to the safe and effective delivery of services. The framework defines risk identification sources, responsibilities, escalation routes and a consistent methodology for assessment and review using the NHS standard 5 x 5 risk scoring matrix.

Risk assessments require clear identification of hazards, potential impact, existing controls, sources of assurance, control or assurance gaps, and actions to address those gaps. This ensures a consistent and proportionate approach to risk management across the organisation. Policies, procedures, clinical guidelines and associated training form the principal controls for both strategic and operational risks and are subject to formal review and approval through the Clinical and Corporate Policy Group. All policies require the completion of an Equality Impact Assessment prior to approval.

The Board's appetite for risk is defined within the Risk Management Framework and applies to both strategic and operational risks. Risks with an overall score of 12 or above, or those retaining a potential severity score of 4 (Major), are treated as high risk. Strategic risk appetite is documented and monitored through the Board Assurance Framework. All risks meeting the high-risk threshold are managed through the Corporate Risk Register and escalated to the Risk Management Council for scrutiny and challenge.

Operational risks are monitored monthly through Directorate arrangements and the Risk Management Council, with all risks scoring 12 or above escalated to the relevant Board Committee. Board Committees (or Committees in Common), provided assurance on risks within their remits, while the Audit Committee retained oversight of the overall effectiveness of the Trust's risk management framework and processes.

During the year, the Trust continued to embed the Patient Safety Incident Response Framework and Learning Panel, supported by Directorate-level incident review and learning arrangements, providing assurance that patient safety incidents were subject to appropriate scrutiny and learning.

Specialist expertise in areas including health and safety, medicines management, information governance, security and equality and diversity supported compliance with regulatory requirements and strengthened risk mitigation and assurance arrangements.

Information and digital risks were overseen through the Digital Information Governance and Information Technology Group, which reported to the Finance and Performance Committee. The group provided assurance on delivery of the Digital Strategy and compliance with information governance requirements, including the Data Security and Protection Toolkit.

All managers remained accountable for managing risks within their areas of responsibility. Risks, incidents and complaints were recorded via the Ulysses 'Safeguard' system and were

monitored and triangulated through established governance arrangements. The Board received regular assurance through the Integrated Quality Performance Report, supported by defined validation, review and escalation processes.

The Board of Directors retained accountability for regulatory compliance and delivery of services in accordance with the Provider Licence. The Quality and Safety Committee and the Finance and Performance Committee provided routine assurance on quality, safety and financial controls respectively. In support of organisational integration with Warrington and Halton NHS Foundation Trust, these Committees, together with the People Committee, operated as Committees-in-Common to enable consistent oversight during transition.

Operational risks are those that may foreseeably impede the safe delivery of high-quality services on a day-to-day basis and, if not effectively managed, could adversely affect the achievement of organisational objectives.

Operational risks are identified, assessed and recorded at service level and are subject to routine review through Directorate Leadership Teams. Significant risks are escalated through established performance and risk governance arrangements, including the Risk Management Council, with all risks scoring 12 or above escalated to the relevant Board Committee (or Committee-in-Common) or the Board as a standing agenda item. Board Committees review the Corporate Risk Register and Integrated Quality Performance Report to identify areas of concern and seek additional assurance where required.

The Risk Management Council met monthly throughout 2025–26 and provided assurance that operational risks were being consistently identified, monitored and managed. The Council reviewed the Corporate Risk Register and received regular reports from Directorates and services on risks within their portfolios.

During the year, the Trust identified a number of recurring operational risks requiring continued management into 2026–27. These related primarily to demand and capacity pressures, performance against waiting time standards, delivery of key performance indicators, and information technology resilience. These risks were subject to ongoing monitoring and mitigation through established governance arrangements. Oversight of information and digital risks was strengthened through consolidated information governance and digital governance structures.

Potential breaches of waiting times were reported and reviewed in line with Trust policy, with clinical harm reviews undertaken where appropriate. No significant patient harm was identified through this process.

Collectively, these arrangements provide assurance that operational risks were appropriately escalated, scrutinised and managed, and that the Board retained effective oversight of risks affecting the delivery of safe and effective services.

Operational finance risks. These were acknowledged and reported to the Finance & Performance Committee / Finance, Sustainability and Performance Committee in Common during 2025-26. There were no Finance risks with a risk score of 12 or above.

Strategic risks are the principal risks recorded on the Board Assurance Framework (BAF) that may foreseeably impede delivery of the Trust’s strategic objectives. Each strategic risk is assigned to a named executive lead director and overseen by a designated Board Committee, with clearly defined controls, sources of assurance and identified gaps.

The Board receives regular assurance on strategic risks through reports aligned to the BAF, enabling it to monitor the effectiveness of controls, scrutinise assurance, and oversee the delivery of actions to address any gaps. These arrangements ensure that strategic risks are

actively managed and that the Board retains effective oversight of the Trust's ability to deliver its objectives.

Governance. Failure to implement and maintain sound systems of Corporate systems of Corporate Governance and failure to deliver on the Trust's Strategy.

If the Trust is unable to put in place and maintain effective corporate governance structures and implement and maintain sound systems of Corporate Governance, then there may be poor oversight of Board level risks and challenges, resulting in failure to deliver the strategy.

Quality. Failure to deliver quality services and continually improve.

If we fail to deliver safe and effective services, then there may be potential harm to patients and their outcomes.

Health Equity. Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients. If we fail to understand health inequity with our communities, we may fail to deliver services equitably, which could contribute to health inequity and our patients' abilities to improve their health.

Staff. Failure to sustain an environment for staff to develop, grow and thrive. If we fail to maintain a safe and inclusive environment where staff can develop, grow, and thrive, it may lead to low staff morale, less effective teamwork, reduced compliance with policies and standards, high levels of staff absence, and high staff turnover rates. National regional and system finance and workforce targets to reduce headcount, agency, overtime and sickness.

Resources. Failure to use our resources in a sustainable and effective way. Failure use our resources in a manner to deliver our operational plan. Failure to achieve the CIP target and the additional system savings required. Resources include workforce, finance, estates and digital.

Equality, Diversity & Inclusion. Failure to build a culture that champions ED&I for staff.

If we fail to continue to build a culture that champions EDI for staff, (the baseline) then:

- We will not meet the diverse needs of our workforce, which will adversely impact the provision of compassionate care to our diverse population, representative of the communities we serve.
- staff with protected characteristics may have a poor experience.

Partnerships. Failure to work in close collaboration with partners and staff in place and across the system. If we fail to work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities, then:

- we will fail to work with partners to champion patient care, resulting in failure to optimise outcomes and failure to effectively use resources
- we will fail to deliver on our Strategic Objectives and the Strategic Objectives of the Integrated Care Board

The Board met on a bi-monthly basis and delegated to the Committees of the Board. The Trust Chair was responsible for the leadership of the Board and ensured that members of the Board had access to relevant information to assist them in the delivery of their duties. Records of Board attendance are reported in the Annual Report, and these confirm that their attendance ensured that all the meetings of the Board and Committees of the Board were quorate. The Non-Executive Directors actively provided scrutiny and contributed challenge at Board and Board Committee level. The Board and its Committees comprised membership and

representation from appropriate staff and Non-Executive Directors with sufficient experience and knowledge to support the Committees in discharging their duties. The Board was well attended by all Executives and Non-Executives throughout the year, ensuring that the Board was able to make fully informed decisions to support and deliver the strategic objectives.

Governors were invited and attended Board and Committee meetings as observers and were therefore, party to the presentation of information and assurance that related to Trust risks and incidents. Routine quality meetings, and performance meetings, were held with each of the Trust's commissioners (commissioners, local authorities or NHS England depending on the service) in order that they received assurance on service quality, risks, and were challenged on any exceptions are being addressed.

In 2025-26 the Trust completed a Corporate Governance Statement (required under NHS foundation trust condition 4(8) (b)). The Board was satisfied that systems and standards of corporate governance are sound. The Director of Corporate Governance engaged with the NHS Providers Company Secretaries Network and routinely checked the NHS England website and publications to ensure the Trust remained compliant and responsive to any new information or requirements. Terms of Reference of all the Board Committees were reviewed during 2025-26. External audit reports supported the annual financial accounts. The Finance and Performance Committee, as a Committee of the Board, routinely scrutinised the Trust's financial decision-making, management, and control. There continues to be an Integrated

Quality Performance Report (IQPR), Accountability Framework and Performance Framework in place to ensure the Board is sighted on significant issues and risks in an appropriate manner. The Trust undertook a range of engagement with its stakeholders, through Governors and Patient Partners via Healthwatch. A Trust-wide staff engagement programme was in place, and directors regularly undertook drop-ins to team meetings, both virtual and face-to-face.

Policies, procedures, and clinical guidelines and associated staff training / implementation are the most common form of control for most of both strategic and operational risks. The Clinical and Corporate Policy Approval Group has delegated responsibility for establishing policy development guidelines, reviewing, and recommending ratification of the policies. Built into the process for policy development, each document was only be approved once evidence of an equality impact assessment had been completed.

The IQPR and quality dashboard continued to be reviewed regularly by Board and the Executive Management Team. Each responsible director reviews their component contribution, and these were triangulated to provide a rounded picture of risks, outcomes, and impact on service safety and delivery, and the strategic objectives of the organisation. This process was overseen by the Performance Council.

All services were encouraged to report incidents and team leaders and managers had access to training with the Head of Risk Management and Patient Safety to cascade and engender a culture of incident reporting, including drafting trigger lists for staff to adhere to. Ulysses reporting maintained a record of apologies or acknowledgement to patients or relatives in accordance with the Being Open Policy and as part of the Trust's Duty of Candour requirements.

There was an escalation framework that ensured Board members were briefed on any significant events or risks between Board meetings. When this happened, Board members received an email from the Director of Corporate Governance, with detail including the nature of the issue, immediate remedial action, any likely media interest, long-term action, and to which Board or committee meeting a formal report on the issue would be presented. For serious incidents, the Head of Risk and Patient Safety completed a Directors' notification for the Board.

The Audit Committee oversaw a programme of counter fraud arrangements, including the contract with Mersey Internal Audit Agency (MIAA) for an Anti-Fraud Specialist. An MIAA Internal Audit Plan was developed and produced to address and ensure coverage of key risk areas of the Trust, with reference to strategic risks identified within the BAF, management requests into areas of potential gaps and weaknesses etc. along with mandated reviews.

The overall opinion from MIAA, internal auditors, for the period 1st April 2025 to 31st March 2026 provides Substantial Assurance that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust continues to strive to deliver high quality services and has arrangements in place to monitor ongoing compliance with the Care Quality Commission's single assessment framework.

The Trust was last inspected during 2018, during which it received a 'Requires Improvement' rating for Well Led. A re-inspection had not taken place due to the pandemic and the change in CQC inspections, so in 2020 the Trust commissioned and undertook an external independent well-led review by Facere Melius with a follow up review in January 2023. The report noted significant improvement across the Trust, with the recommendations being reduced to nine. The report was presented at the public meeting of the Board of Directors in June 2023. The report of the review is publicly available on the Trust's website.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality for decision-making staff (as defined by the trust within reference to the guidance), within the past twelve months as required by the *'Managing Conflicts of Interest in the NHS'* guidance.

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.

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

As a result of the changes to the NHS Finance regime reporting against the Single Oversight Framework for use of resources was suspended.

NHS organisations were required to deliver efficiencies during 2025-26.

The Trust's Finance & Performance Committee / Finance, Sustainability and Performance Committee in Common (FSPCiC) oversaw delivery of the Trust's efficiency programmes and provided appropriate assurance directly to the Board.

Cost savings requirements were identified in the planning guidance and were followed up with an additional stretch target identified by the ICS of £2.9m for system stretch savings.

This results in total savings of £8.38m (Trust plan of £5.48m 5% plus the stretch target of £2.9m) in line with ICB instruction.

The Trust plan to month twelve is £8.38m, against which achievement of £5.74m is reported. Of this achievement, £0.376m has been achieved non recurrently. The ICB recognised towards the end of the financial year that the additional stretch savings of £2.9m would not be achieved.

The FSPCiC received regular reports on the use of agency staff throughout the year, including updates on the agency workplan to reduce agency usage including the elimination of high cost off framework agency and increasing the number of staff registered and available on the Trust bank.

Information Governance

Information Governance provides the framework through which the Trust ensures lawful, secure and appropriate handling of personal and corporate information. Responsibilities for information governance are embedded across the organisation, supported by defined roles including information asset ownership, service and departmental management, and specialist support functions.

Information governance arrangements cover all information processed by the Trust, including patient, staff and corporate information. The Trust maintains up-to-date Privacy Notices for patients, staff and service users, including a bespoke notice for children and young people, and ensures that information is accessible in appropriate formats.

Oversight of digital and information risks is provided through the Digital Information Governance and Information Technology (DIGIT) Group, which reports to the Finance and Performance Committee. The Group provides assurance on delivery of the Trust's Digital Strategy and the operation of the information governance framework.

The Trust complies with the Data Security and Protection Toolkit (DSPT) requirements and has consistently achieved a "standards met" rating since 2022. Compliance with the DSPT provides assurance against the National Data Guardian's data security standards and includes oversight of third-party suppliers where personal data is processed.

Arrangements are in place to identify, manage and report serious data security incidents in line with Department of Health and Social Care requirements. No serious data security incidents were reported during 2025–26.

These arrangements provide assurance that information governance risks are effectively managed and that the Trust maintains high standards of data security and confidentiality.

Data quality and governance

The Trust recognises the necessity of making Trust and clinical decisions based on sound data and has implemented several controls to support the assurance of high-quality data.

We employ a variety of data quality methods to ensure robustness in our data. The Trust engages MIAA as independent auditors to audit performance and performance management processes.

The Trust has established a data quality policy to complement its data quality strategy, and a data consistency programme aimed at ensuring a uniform Place-Based approach to recording data and performance management across all its Boroughs. The multidisciplinary Data Quality Steering Group oversees the implementation of the data quality strategy and ensures that data consistency is maintained on an ongoing basis.

The Trust remains proactive in improving data quality by providing:

- Accessible dashboards to monitor any outliers for further investigation.
- System training (with refresher training available on request) and drop-in sessions for assistance with data recording system use.
- Guidance and frequently asked questions (available on the Trust intranet).
- Inclusion of activity and data quality as standing items on clinical team meeting agendas.

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 foundation 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, the o audit committee, and the Quality and Safety Committee. Where areas for improvement have been identified, appropriate action plans are in place to address weaknesses and support continuous improvement of the system of internal control.

During the year, the Audit Committee undertook a formal review of its effectiveness, reporting an overall satisfaction score of 4.77 out of 5, representing an improvement on the previous year. In support of ongoing Board development, the Trust has utilised a combination of internal subject-matter expertise and external development support. All Board members participate in an annual appraisal conducted by the Chair or Chief Executive, with outcomes reported to the Remuneration Committee or the Governors' Nominations Committee as appropriate. The Council of Governors oversees the performance appraisal of the Chair and Non-Executive Directors to inform decisions on re-appointment or, where necessary, termination.

The Audit Committee oversees the delivery and outcomes of the internal and external audit programmes. The Committee meets quarterly and includes representation from both internal and external audit. An annual work plan is maintained, and the Committee's primary role is to provide assurance to the Board on the adequacy and effectiveness of the Trust's overall system of internal control.

The Committee's work primarily focuses on internal financial controls, the maintenance of proper accounting records, and the reliability of financial reporting, alongside a wider oversight role in relation to the safety and quality of patient care.

During the 2025-26 financial year, the Audit Committee complied with recognised good practice through:

- agreement of the Internal Audit, External Audit and Counter Fraud plans;
- regular review of progress and outcomes arising from audit and counter fraud activity;
- holding private meetings with Internal Audit, External Audit and Counter Fraud;
- routine review of the Audit Committee work plan; and
- review of the Committee's Terms of Reference.

The overall opinion from the Director of Internal Audit for the period 1st April 2025 to 31st March 2026 provides Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied

consistently.

This opinion is provided in the context that the Trust like other organisations across the NHS is continuing to face a number of challenging issues and wider organisational factors particularly with regards to the changes to national and local bodies and the corresponding uncertainty this causes, ongoing elective recovery response, workforce challenges, financial challenges and increasing collaboration across organisations and systems.

Financially, at month 10 the Trust was expecting to report a deficit and deliver cost improvements that are in line with plan. The Trust is currently placed in segment three of the NHS Oversight Framework.

In year, the Trust and Warrington & Halton Teaching Hospitals NHS Foundation have been collaborating on increased integration (including the appointment of joint Executive posts). This integration has developed further, and the two trusts came together as one organisation on 1st April 2026, North Cheshire & Mersey NHS Foundation Trust.

During the year MIAA has completed 10 internal audit reviews, covering both clinical and nonclinical systems and processes and formed a view on the level of assurance as follows:

	Review	Assurance Opinion	Recommendations Raised					Issue Category	
			Critical	High	Medium	Low	Total	Control Design	Operating Effectiveness
1	Assurance Framework	-	-	-	-	-	-	-	-
2	Conflicts of Interest	High	-	-	-	-	-	-	-
3	Fit & Proper Person Test	High	-	-	-	1	1	-	1
4	Risk Management Core Controls	High	-	-	-	1	1	1	-
5	Key Financial Systems Controls	High	-	-	-	-	-	-	-
6	PSIRF	Substantial	-	-	1	4	5	3	2
7	IM&T: Ivanti Neurons	Substantial	-	-	3	-	3	3	
8	Devolved Autonomy	Moderate	-	-	5	-	5	1	4
9	Quality Spot Checks	Moderate	-	1	5	-	6	5	1
10	DSPT	High Risk / High Confidence	-	2	-	-	2	2	-
	TOTAL		-	3	14	6	23	15	8

These audits were presented to the Audit Committee for oversight and to provide assurance.

Individual Committees take responsibility for tracking progress against recommendations and action plans. The Quality and Safety Committee were also in receipt of the progress of Clinical Audit programmes across the Trust.

The Trust takes the view that Internal Audit is a key management tool for improvement and therefore consciously asks its auditors to review areas where it is aware it can benefit from advice or recommendations relating to good practice from elsewhere. All audits carry responses to any risks identified in internal audits.

Conclusion

In preparing this statement I have considered the corporate, quality and clinical governance infrastructure, functionality and effectiveness in place at the Trust. The Board of Directors remain committed to continuous improvements and enhancement of the systems of internal control. In line with the guidance on the definition of the significant control issues, I have no significant internal controls issues to declare within this year's statement. My review confirms that Bridgewater Community NHS Foundation Trust has a good system of governance and stewardship that supports the achievement of its policies, aims and objectives.

No significant internal control issues have been identified in the body of the AGS above.

Signed

Nikhil Khashu

Chief Executive **Date: 22 June 2026**

3.7 Statement of Accounting Officer's Responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Bridgewater Community Healthcare 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 Bridgwater Community Healthcare 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 Bridgewater Community Healthcare NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

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

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

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

Signed

Nikhil Khashu

Chief Executive **Date: 22 June 2026**

4. Annual Accounts for year ended 31 March 2026

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 March 2026

5. Independent auditors' report to the Council of Governors of Bridgewater Community Healthcare NHS Foundation Trust

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORTH CHESHIRE AND MERSEY NHS FOUNDATION TRUST IN RESPECT OF BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Bridgewater Community Healthcare NHS Foundation Trust ("the Trust") for the year ended 31 March 2026 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.2 to the financial statements which explains that on 1 April 2026, Bridgewater Community Healthcare NHS Foundation Trust integrated with Warrington and Halton Hospitals NHS Foundation Trust to form a newly statutory body. All the Trust's assets and liabilities, and their services transferred to North Cheshire and Mersey NHS Foundation Trust. Under the continuation of service principle, the financial statements of Bridgewater Community Healthcare NHS Foundation Trust have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of North Cheshire and Mersey NHS Foundation Trust ("the successor Trust") and the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer of the successor Trust has prepared the financial statements of Bridgewater Community Healthcare NHS Foundation Trust on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services within the successor Trust or dissolve the successor Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the successor Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and

- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the successor Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the successor Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to the high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. The Trust's various other income streams are largely high volume, low value transactions with simple recognition criteria. We therefore assessed that there was limited opportunity to manipulate the income that was reported.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual journal combinations surrounding revenue and cash journals.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, there are laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, there are many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery and employment law, recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer of the successor Trust is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 112, the Accounting Officer of the successor Trust is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the successor 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 either cease the Trust's services within the successor Trust or dissolve the successor Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 112, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of that Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the successor Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the successor Trust in respect of Bridgewater Community Healthcare NHS Foundation Trust, as a body, 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 Council

of Governors of the successor Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of Bridgewater Community Healthcare NHS Foundation Trust's accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Bridgewater Community Healthcare NHS Foundation Trust NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

James Boyle

for and on behalf of KPMG LLP

Chartered Accountants

One St. Peter's Square
Manchester
M2 3AE

24 June 2026

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 March 2026

FOREWORD TO THE ACCOUNTS

These accounts, for the period ended 31 March 2026, have been prepared by Bridgewater Community Healthcare NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed:

Name: Nikhil Khashu
Job title: Chief Executive
Date: 22 June 2026

7. Primary Financial Statements

Statement of Comprehensive Income for year ended 31 March 2026

	Note	**2025/26 £000**	2024/25 £000
Operating income from patient care activities	3	104,291	104,365
Other operating income	4	1,796	3,221
Operating expenses	6,8	(111,535)	(108,756)
Operating (deficit)/surplus from continuing operations		**(5,448)**	**(1,170)**
Finance income	10	383	729
Finance expenses	11	(423)	(369)
PDC dividends payable		(498)	(386)
Net finance (costs)/income		**(538)**	**(26)**
Other (losses)/gains	12	(33)	-
(Deficit)/surplus for the year from continuing operations		**(6,019)**	**(1,196)**
(Deficit)/surplus for the year		**(6,019)**	**(1,196)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	63	-
Revaluations	15	175	139
Other reserve movements		44	-
Total comprehensive (expense)/income for the year		**(5,737)**	**(1,057)**

Statement of Financial Position as at 31 March 2026

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets:			
Intangible assets	13	696	1,013
Property, plant and equipment	14	12,136	10,879
Right of use assets	16	34,444	36,524
Receivables	18	75	80
Total non-current assets		**47,351**	**48,496**
Current assets:			
Inventories	17	1,056	799
Receivables	18	11,059	14,254
Cash and cash equivalents	19	5,578	8,179
Total current assets		**17,693**	**23,232**
Current liabilities			
Trade and other payables	20	(8,097)	(9,194)
Borrowings	22	(4,881)	(4,484)
Provisions	23	(280)	(172)
Other liabilities	21	(160)	(61)
Total current liabilities		**(13,418)**	**(13,911)**
Total assets less current liabilities		**51,626**	**57,813**
Non-current liabilities:			
Borrowings	22	(32,282)	(32,944)
Total non-current liabilities		**(32,282)**	(32,944)
Total assets employed		**19,344**	**24,873**
Financed by:			
Public dividend capital		34,203	33,996
Revaluation reserve		2,886	2,659
Income and expenditure reserve		(17,746)	(11,782)
Total taxpayers' equity		**19,344**	**24,873**

The notes on pages 8 to 43 form part of this account

Chief Executive: N. Adams **Date: 22 June 2026**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	**33,996**	**2,659**	**(11,782)**	**24,873**
Surplus/(deficit) for the year	-	-	(6,019)	**(6,019)**
Other transfers between reserves	-	(57)	57	**-**
Impairments	-	63	-	**63**
Revaluations	-	175	-	**175**
Public dividend capital received	207	-	-	**207**
Other reserve movements	-	46	(2)	**44**
Taxpayers' equity at 31 March 2026	**34,203**	**2,886**	**(17,746)**	**19,344**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	**33,821**	**2,593**	**(10,659)**	**25,755**
Taxpayers' equity at 1 April 2024 - restated	**33,821**	**2,593**	**(10,659)**	**25,755**
Surplus/(deficit) for the year	-	-	(1,196)	**(1,196)**
Other transfers between reserves	-	(73)	73	**-**
Revaluations	-	139	-	**139**
Public dividend capital received	195	-	-	**195**
Public dividend capital repaid	(20)	-	-	**(20)**
Taxpayers' equity at 31 March 2025	**33,996**	**2,659**	**(11,782)**	**24,873**

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.

Statement of Cash Flows for the year ended 31 March 2026

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating (deficit)/surplus		(5,448)	(1,170)
Non-cash income and expense:			
Depreciation and amortisation	6	6,654	6,296
Net impairments	7	1,591	-
(Increase) in receivables and other assets		3,152	(4,528)
Decrease in inventories		(257)	(759)
(Decrease) in payables and other liabilities		(466)	(2,240)
(Decrease) in provisions		108	(43)
Other movements in operating cash flows		53	8
Net cash flows (used in)/from operating activities		**5,387**	**(2,436)**
Cash flows from investing activities			
Interest received		383	729
Purchase of intangible assets		(111)	(788)
Purchase of property, plant, equipment and investment property		(2,690)	(1,280)
Sales of property, plant, equipment and investment property		-	-
Initial direct costs or up front payments in respect of new right of use assets (lessee)		-	-
Net cash (used in) investing activities		**(2,418)**	**(1,339)**
Cash flows from financing activities			
Public dividend capital received		207	175
Capital element of finance lease rental payments		(4,897)	(4,730)
Interest paid on finance lease liabilities		(422)	(369)
PDC dividend (paid) / refunded		(458)	(456)
Net cash (used in) financing activities		**(5,570)**	**(5,380)**
(Decrease) in cash and cash equivalents		**(2,601)**	**(9,155)**
Cash and cash equivalents at 1 April – brought forward		**8,179**	17,334
Cash and cash equivalents at 31 March	19	**5,578**	**8,179**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

"These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity’s services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

The Trust is also required to disclose material uncertainties in respect of events or conditions that may cast significant doubt upon the going concern ability of the Trust and the Trust does not consider that there are any such events or conditions requiring disclosure. However, details have been provided below in respect of future potential core activity changes.

The Secretary of State for Health and Social Care approved a transaction business case in March 2026 which had the following impact. On 1st April 2026, Bridgewater Community Healthcare NHS Foundation Trust dissolved. All its assets and liabilities were acquired by Warrington and Halton Teaching Hospitals NHS Foundation Trust who subsequently renamed as North Cheshire and Mersey NHS Foundation Trust. Services at all trust sites continue but under the management of the new entity. This does not prevent the going concern basis for accounts being adopted and is not a material uncertainty over going concern.

Having considered the uncertainties in the Trust’s financial plans, the directors have determined that these are not material, and it remains appropriate to prepare these accounts on a going concern basis as per the statement below:

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

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4 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.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

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 employers, 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 and when 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.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes

• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust

• it is expected to be used for more than one financial year

• the cost of the item can be measured reliably

• the item has cost of at least £5,000, or

• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Subsequent expenditure

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

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (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 are determined as follows:

- Land and non-specialised buildings – market value for existing use

- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

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 lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’."

Impairments

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is

transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	5	99
Plant & machinery	3	24
Information technology	2	9
Furniture & fittings	10	20

Note 1.8 Intangible assets

Recognition

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

Internally generated intangible assets

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

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

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

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

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

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	2	8
Other (purchased)	4	5

Note 1.9 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.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities 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.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term."

"The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. 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.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

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

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 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.

Note 1.14 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.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax

The Trust has determined that it has no corporation tax liability as it does not operate any commercial activities that are not part of core health care delivery.

Note 1.18 Third party assets

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

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Early adoption of standards, amendments and interpretations

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

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

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

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

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £12.27m as at 31 March 2026.

Note 1.23 Critical judgements in applying accounting policies

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

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision only affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Non-consolidation of the Trust's element of the registered charity Mersey Care NHS Foundation Trust Charity (charity number 1191576). In making this judgement the Trust has made reference to the DHSC GAM 2025/26. The Trust's element of this fund is managed under a Service-level agreement with Mersey Care NHS Foundation Trust. Whilst the Trust is able to requisition expenditure from this fund within the constraints of the fund objective, corporate Trusteeship of the fund remains with Mersey Care NHS Foundation Trust. Where a body acts as a corporate Trustee, there is a presumption that the body possesses 'control' of the fund. Therefore, there is no need for the Trust to consolidate; and

Valuation of the Trust's land and buildings. In making this judgement the Trust has engaged with an independent RICS Registered Valuer, 'DVS - Property Services arm of the VOA' which performs a full revaluation of the Trust's land and buildings every 5 years. The Trust considers this to be of sufficient regularity to ensure that the carrying values of land and buildings are not materially misstated and further confirms this by (i) requesting the DVS to perform a desktop revaluation exercise in the intervening years; and (ii) performing an annual impairment review of the asset register (including land and buildings).

Note 1.24 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:

Accounting for Impairments

The Trust accounts for impairments using an adaptation of IFRS as per the FReM and Department of Health and Social Care Group Accounting Manual (GAM). Details of impairments are included in note 7.

Actuarial assumptions for costs relating to the NHS Pension Scheme

The Trust reports as operating expenditure employer contributions to staff pensions. These contributions are based on an annual actuarial estimate of the required contribution to meet the scheme's liabilities.

Accruals

Accruals are largely based on known commitments and are assessed accurately. Where estimates are made, they are based on historical records, precedence and officers' knowledge and experience. In all cases, the Trust adopts a prudent approach to avoid overstating its resources.

Asset valuations and lives

The value and remaining useful lives of land and building assets are estimated by DVS - Property Services arm of the VOA, who provide professional valuation services. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the DHSC and HM Treasury. Valuations are carried out primarily on the basis of Depreciated Replacement Cost based on the Modern Equivalent for specialised operational property (property rarely sold on the open market) and Current Value in Existing Use for non-specialised operational property.

Note 2 Operating Segments

The Trust operates in a single segment, the provision of community healthcare services.There are therefore no reportable segments.

Income from transactions with the following organisations is in excess of 10% of total income:

	2025/26	2024/25
	£000	£000
NHS England	5,070	5,966
Integrated Care Boards	80,667	78,887
Local Authorities	15,906	16,338
	101,643	101,191

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	**2025/26**	**2024/25**
	£000	**£000**
Community services		
Income from commissioners under API contracts*	80,805	79,933
Income from other sources (e.g. local authorities)	18,554	19,512
All services		
Additional pension contribution central funding**	4,932	4,920
Total income from activities	**104,291**	**104,365**

*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.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2025/26 £000	2024/25 £000
NHS England	5,070	5,966
Integrated care boards	80,667	78,887
Department of Health and Social Care	62	68
Other NHS providers	1,704	2,226
Local authorities	15,906	16,338
Injury cost recovery scheme	38	51
Non NHS: other	844	829
Total income from activities	**104,291**	**104,365**
Of which:		
Related to continuing operations	104,291	104,365
Related to discontinued operations	-	-

Note 4 Other operating income

	2025/26			2024/25		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	-	-	**-**	-	-	**-**
Education and training	1,176	336	**1,512**	1,368	555	**1,923**
Non-patient care services to other bodies	275		**275**	1,282		**1,282**
Other income	9	-	**9**	16	-	**16**
Total other operating income	**1,460**	**336**	**1,796**	**2,666**	**555**	**3,221**
Of which:						
Related to continuing operations			1,796			3,221
Related to discontinued operations			-			-

Note 5 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:

	2025/26 £000	2024/25 £000
Income from services not designated as commissioner requested services	**104,291**	104,365
Total	**104,291**	**104,365**

Note 6 Operating expenses

	2025/26 £000	2024/25 £000
Purchase of healthcare from NHS and DHSC bodies	2,271	2,522
Purchase of healthcare from non-NHS and non-DHSC bodies	2,733	2,444
Staff and executive directors costs *	77,669	77,156
Remuneration of non-executive directors	126	140
Supplies and services - clinical (excluding drugs costs)	5,977	5,240
Supplies and services - general	567	573
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,436	3,501
Consultancy costs	112	335
Establishment	3,072	3,329
Premises	4,104	4,208
Transport (including patient travel)	227	238
Depreciation on property, plant and equipment	6,239	5,794
Amortisation on intangible assets	415	502
Net impairments	1,591	-
Movement in credit loss allowance: contract receivables / contract assets	507	82
Movement in credit loss allowance: all other receivables and investments	4	3
Increase/(decrease) in other provisions	-	(3)
audit services- statutory audit **	246	209
Internal audit costs	113	108
Clinical negligence	1,001	870
Research and development	65	61
Education and training	943	1,421
Redundancy	60	-
Losses, ex gratia & special payments	13	1
Other	44	22
Total	**111,535**	**108,756**
Of which:		
Related to continuing operations	111,535	108,756
Related to discontinued operations	-	-

* Includes £0.771m of Mutually Agreeable Resignation Scheme (MARS) costs and other termination costs.

"** Fees payable to the external auditor of £246k include VAT relating to the statutory audit for the financial year ended 31 March 2026. The fee payable to the external auditor for the statutory audit for the financial year ended 31 March 2025 is £209k including VAT.

Note 6.1 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2025/26 or 2024/25.

Note 7 Impairment of assets

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	1,591	-
Total net impairments charged to operating surplus / deficit	**1,591**	**-**
Impairments charged to the revaluation reserve	(63)	-
Total net impairments	**1,528**	**-**

An impairment charge was recognised on a right of use (ROU) asset (Warrington Wolves) following a landlord initiated rent review during the year. Although the revised rental level was assessed as being consistent with current market rates, the carrying amount of the ROU asset had already been updated to reflect expected future economic benefits. As a result, the increase in lease payments reduced the recoverable amount of the asset, giving rise to an impairment in accordance with IAS 36.

Note 8 Employee benefits

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	56,332	56,606
Social security costs	6,729	5,269
Apprenticeship levy	266	267
Employer's contributions to NHS pensions	12,448	12,433
Pension cost - other	18	23
Termination benefits	771	-
Temporary staff (including agency)	1,567	3,010
Total gross staff costs	**78,131**	**77,608**
Recoveries in respect of seconded staff	-	-
Total staff costs	**78,131**	**77,608**
Of which		
Costs capitalised as part of assets	-	24

Includes £0.771m of Mutually Agreeable Resignation Scheme (MARS) costs and other termination costs.

Note 8.1 Retirements due to ill-health

During 2025/26 there was 1 early retirement from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £106k (£140k in 2024/25).

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

Note 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 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 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.

Note 13.1 Intangible assets - 2025/26

	Software licences	Other (purchased)	Total
	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**1,695**	**-**	**1,695**
Additions	85	26	**111**
Reclassifications	(23)	23	**-**
Disposals / derecognition	(29)	-	**(29)**
Cost at 31 March 2026	**1,728**	**49**	**1,777**
Amortisation at 1 April 2025 - brought forward	**682**	**-**	**682**
Provided during the year	410	5	**415**
Disposals / derecognition	(16)	-	**(16)**
Amortisation at 31 March 2026	**1,076**	**5**	**1,081**
Net book value at 31 March 2026	**652**	**44**	**696**
Net book value at 1 April 2025	**1,013**	**-**	**1,013**

Note 13.2 Intangible assets - 2024/25

	Software licences	Other (purchased)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**1,968**	**63**	**2,031**
Valuation / gross cost at 1 April 2024 - restated	**1,968**	**63**	**2,031**
Additions	426	-	**426**
Disposals / derecognition	(699)	(63)	**(762)**
Valuation / gross cost at 31 March 2025	**1,695**	**-**	**1,695**
Amortisation at 1 April 2024 - as previously stated	**879**	**62**	**941**
Amortisation at 1 April 2024 - restated	**879**	**62**	**941**
Provided during the year	502	-	**502**
Disposals / derecognition	(699)	(62)	**(761)**
Amortisation at 31 March 2025	**682**	**-**	**682**
Net book value at 31 March 2025	**1,013**	**-**	**1,013**
Net book value at 1 April 2024	**1,089**	**1**	**1,090**

Note 14.1 Property, plant and equipment - 2025/26

	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	**903**	**5,831**	**41**	**2,886**	**3,671**	**244**	**13,576**
Additions	400	849	-	522	380	7	**2,158**
Reversals of impairments	-	63	-	-	-	-	**63**
Revaluations	-	17	-	-	-	-	**17**
Reclassifications	-	41	(41)	-	-	-	**-**
Disposals / derecognition	-	-	-	(19)	(64)	-	**(83)**
Valuation/gross cost at 31 March 2026	**1,303**	**6,801**	**-**	**3,389**	**3,987**	**251**	**15,731**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**74**	**-**	**945**	**1,550**	**128**	**2,697**
Provided during the year	-	249	-	290	636	17	**1,192**
Reversals of impairments	-	(73)	-	-	-	-	**(73)**
Revaluations	-	(158)	-	-	-	-	**(158)**
Disposals / derecognition	-	-	-	(14)	(49)	-	**(63)**
Accumulated depreciation at 31 March 2026	**-**	**92**	**-**	**1,221**	**2,137**	**145**	**3,595**
Net book value at 31 March 2026	**1,303**	**6,709**	**-**	**2,168**	**1,850**	**106**	**12,136**
Net book value at 1 April 2025	**903**	**5,757**	**41**	**1,941**	**2,121**	**116**	**10,879**

Note 14.2 Property, plant and equipment - 2024/25

	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 2024 - as previously stated	**903**	**5,345**	**-**	**2,576**	**4,125**	**372**	**13,321**
Valuation / gross cost at 1 April 2024 - restated	**903**	**5,345**	**-**	**2,576**	**4,125**	**372**	**13,321**
Additions	-	537	41	522	690	-	**1,790**
Revaluations	-	(51)	-	-	-	-	**(51)**
Disposals / derecognition	-	-	-	(212)	(1,144)	(128)	**(1,484)**
Valuation/gross cost at 31 March 2025	**903**	**5,831**	**41**	**2,886**	**3,671**	**244**	**13,576**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**52**	**-**	**882**	**2,101**	**238**	**3,273**
Accumulated depreciation at 1 April 2024 - restated	**-**	**52**	**-**	**882**	**2,101**	**238**	**3,273**
Provided during the year	-	212	-	268	593	18	**1,091**
Revaluations	-	(190)	-	-	-	-	**(190)**
Disposals / derecognition	-	-	-	(205)	(1,144)	(128)	**(1,477)**
Accumulated depreciation at 31 March 2025	**-**	**74**	**-**	**945**	**1,550**	**128**	**2,697**
Net book value at 31 March 2025	**903**	**5,757**	**41**	**1,941**	**2,121**	**116**	**10,879**
Net book value at 1 April 2024	**903**	**5,293**	**-**	**1,694**	**2,024**	**134**	**10,048**

Note 14.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	1,303	6,709	-	2,168	1,850	106	**12,136**
Total net book value at 31 March 2026	**1,303**	**6,709**	**-**	**2,168**	**1,850**	**106**	**12,136**

Note 14.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	903	5,757	41	1,941	2,121	116	**10,879**
Total net book value at 31 March 2025	**903**	**5,757**	**41**	**1,941**	**2,121**	**116**	**10,879**

Note 10 Finance income

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	383	729
Total finance income	**383**	**729**

Note 11.1 Finance expenditure

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	423	369
Interest on late payment of commercial debt	-	-
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	-	-
Contingent finance costs	-	-
Remeasurement of the liability resulting from change in index or rate	-	-
Total interest expense	**423**	**369**
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	**423**	**369**

Note 12 Other gains / (losses)

	2025/26	2024/25
	£000	£000
Losses on disposal of assets	(33)	-
Total gains / (losses) on disposal of assets	**(33)**	**-**
Total other gains / (losses)	**(33)**	**-**

Note 15 Revaluations of property, plant and equipment

All of the Trust's owned land and buildings have been revalued at 31 March 2026 based on a desktop revaluation exercise. The revaluation was carried out independently by:

DVS - Property Specialists for the Public Sector
(DipSurv MRICS RICS Registered Valuer)
Valuation Office Agency (VOA)
Wycliffe House
Green Lane
Durham
DH1 3UW

The revaluation was undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the Annual Reporting Manual. The assumption has been made

that the properties valued will continue to be held for the foreseeable future having regard to the prospect and viability of the continuance of occupation. The basis of valuation is Current Value which has been interpreted as market value for existing use.

For those properties where there is market-based evidence to support the use of 'Existing Use Value' (EUV) to arrive at Current Value the comparative method of valuation has been adopted.

For those properties where there is no market based evidence to support the use of EUV to arrive at Current Value, the Depreciated Replacement Cost (DRC) approach has been used.

Note 16 Leases - Bridgewater Community Healthcare NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust leases properties from a wide range of landlords - whilst some landlords issue longer term leases, NHS Property Services and Community Health Partnerships, in particular, historically only issued short-term arrangements. For these properties, the Trust adopted a lease term, on transition to IFRS 16, of either:

• **10 years**, where the services delivered from these properties were 'core services' provided by the Trust and there was no intention to cease that provision nor vacate the property.

• **5 years**, where the services delivered from these properties were 'core services' provided by the Trust and there was no intention to cease that provision however the location of the service provision was being reconsidered as part of the Estates Strategy and was not known with certainty.

The Trust has confirmed with NHS Property Services and Community Health Partnerships that this assessment of lease term, where a signed lease is not in place, is appropriate.

The Trust also leases pool vehicles with contract terms of 3 to 5 years.

Information about leases for which the Trust is a lessee is presented below:

Note 16.1 Right of use assets - 2025/26

	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	**49,397**	**301**	**49,698**	**37,896**
Additions	265	22	**287**	-
Remeasurements of the lease liability	4,782	-	**4,782**	1,663
Revaluations	(1,786)	-	**(1,786)**	-
Disposals / derecognition	(712)	(61)	**(773)**	(712)
Valuation/gross cost at 31 March 2026	**51,946**	**262**	**52,208**	**38,847**
Accumulated depreciation at 1 April 2025 - brought forward	**13,014**	**160**	**13,174**	**10,946**

Provided during the year	4,966	81	**5,047**	3,972
Impairments	1,664	-	**1,664**	-
Revaluations	(1,786)	-	**(1,786)**	-
Disposals / derecognition	(274)	(61)	**(335)**	(274)
Accumulated depreciation at 31 March 2026	**17,584**	**180**	**17,764**	**14,644**
Net book value at 31 March 2026	**34,362**	**82**	**34,444**	**24,203**
Net book value at 1 April 2025	**36,383**	**141**	**36,524**	**26,950**

Net book value of right of use assets leased from other DHSC group bodies 24,203

Note 16.2 Right of use assets - 2024/25

	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	**47,654**	**301**	**47,955**	**36,153**
Valuation / gross cost at 1 April 2024 - restated	**47,654**	**301**	**47,955**	**36,153**
Additions	893	-	**893**	893
Remeasurements of the lease liability	850	-	**850**	850
Valuation/gross cost at 31 March 2025	**49,397**	**301**	**49,698**	**37,896**
Accumulated depreciation at 1 April 2024 - brought forward	8,406	65	**8,471**	7,132
Accumulated depreciation at 1 April 2024 - restated	**8,406**	**65**	**8,471**	**7,132**
Provided during the year	4,608	95	**4,703**	3,814
Accumulated depreciation at 31 March 2025	**13,014**	**160**	**13,174**	**10,946**
Net book value at 31 March 2025	**36,383**	**141**	**36,524**	**26,950**
Net book value at 1 April 2024	**39,248**	**236**	**39,484**	**29,021**

Net book value of right of use assets leased from other DHSC group bodies 26,950

Note 16.3 Revaluations of right of use assets

For the majority of right of use assets. the Trust has applied the 'IFRS 16 cost model' as an appropriate proxy for current value in existing use. The Trust has identified right of use assets where the rental paid on the properties was not indicative of market value and for those leases the revaluation model under IFRS 16 is required and has been supplied as at 31 March 2026 by DVS (Property Services arm of the VoA). Refer to Note 15 for further details regarding the valuer.

Where the revaluation model under IFRS 16 has been adopted, the valuer has identified the current market rental value for existing use that could be achieved for the right-of-use asset as at the valuation date and used an appropriate yield as at the valuation date for the full remaining lease term (as defined in IFRS 16). For right-to-use specialised assets, the DRC method of valuation has been applied to arrive at the current value for existing use to the lessee.

Note 16.4 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 22.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**37,428**	**40,415**
Carrying value at 1 April - restated	**37,428**	**40,415**
Lease additions	287	893
Lease liability remeasurements	4,782	850
Interest charge arising in year	423	369
Early terminations	(438)	-
Lease payments (cash outflows)	(5,319)	(5,099)
Carrying value at 31 March	**37,163**	**37,428**

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. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.5 Maturity analysis of future lease payments

	Total 31 March 2026	Of which leased from DHSC group bodies: 31 March 2026	Total 31 March 2025	Of which leased from DHSC group bodies: 31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	5,260	4,163	4,847	4,001
- later than one year and not later than five years;	20,986	16,652	19,438	16,004
- later than five years.	13,231	5,284	15,192	8,664

Total gross future lease payments	**39,477**	**26,099**	**39,477**	**28,669**
Finance charges allocated to future periods	(2,314)	(1,231)	(2,049)	(1,370)
Net lease liabilities at 31 March 2026	**37,163**	**24,868**	**37,428**	**27,299**
Of which:				
Leased from other DHSC group bodies		24,868		27,299

Note 17 Inventories

	31 March 2026	31 March 2025
	£000	£000
Other	1,056	799
Total inventories	**1,056**	**799**

Note 18.1 Receivables

	31 March 2026	31 March 2025
	£000	£000
Current		
Contract receivables	10,588	13,442
Capital receivables	41	49
Allowance for impaired contract receivables / assets	(858)	(351)
Prepayments (non-PFI)	622	511
PDC dividend receivable	21	61
VAT receivable	383	304
Other receivables	262	238
Total current receivables	**11,059**	**14,254**
Non-current		
Allowance for other impaired receivables	(36)	(32)
Other receivables	111	112
Total non-current receivables	**75**	**80**
Of which receivable from NHS and DHSC group bodies:		
Current	5,662	4,977
Non-current	-	-

The majority of the Trust's revenue comes from contracts with other public sector bodies and therefore the Trust has low exposure to credit risk.

Note 18.2 Allowances for credit losses

	2025/26		2024/25	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**351**	**32**	**291**	**29**
Allowances as at 1 April - restated	**351**	**32**	**291**	**29**
New allowances arising	632	4	82	3
Reversals of allowances	(125)	-	-	-
Utilisation of allowances (write offs)	-	-	(22)	-
Allowances as at 31 Mar 2026	**858**	**36**	**351**	**32**

Note 18.3 Exposure to credit risk

The majority of the Trust's revenue comes from contracts with other public sector bodies and therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in the table above.

Note 19 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.

	2025/26	2024/25
	£000	£000
At 1 April	**8,179**	**17,334**
Net change in year	(2,601)	(9,155)
At 31 March	**5,578**	**8,179**
Broken down into:		
Cash at commercial banks and in hand	3	4
Cash with the Government Banking Service	5,575	8,175
Total cash and cash equivalents as in SoFP	**5,578**	**8,179**

Note 20 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	1,750	3,916
Capital payables	819	1,351
Accruals	3,088	1,630
Social security costs	1,409	1,253
Pension contributions payable	1,000	1,015
Other payables	31	29
Total current trade and other payables	**8,097**	**9,194**
Of which payables from NHS and DHSC group bodies:		
Current	1,051	2,480
Non-current	-	-

Note 21 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	160	61
Total other current liabilities	**160**	**61**

Note 22 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Lease liabilities	4,881	4,484
Total current borrowings	**4,881**	**4,484**
Non-current		
Lease liabilities	32,282	32,944
Total non-current borrowings	**32,282**	**32,944**

Note 22.1 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2025	**37,428**	**37,428**
Cash movements:		
Financing cash flows - payments and receipts of principal	(4,897)	**(4,897)**
Financing cash flows - payments of interest	(422)	**(422)**
Non-cash movements:		
Additions	287	**287**
Lease liability remeasurements	4,782	**4,782**
Application of effective interest rate	423	**423**
Early terminations	(438)	**(438)**
Carrying value at 31 March 2026	**37,163**	**37,163**

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2024	**40,415**	**40,415**
Carrying value at 1 April 2024 - restated	**40,415**	**40,415**
Cash movements:		
Financing cash flows - payments and receipts of principal	(4,730)	**(4,730)**
Financing cash flows - payments of interest	(369)	**(369)**
Non-cash movements:		
Additions	893	**893**
Lease liability remeasurements	850	**850**
Application of effective interest rate	369	**369**
Carrying value at 31 March 2025	**37,428**	**37,428**

Note 23.1 Provisions for liabilities and charges analysis

	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000
At 1 April 2025	**12**	**-**	**160**	**172**
Arising during the year	12	139	-	**151**
Utilised during the year	(3)	-	(40)	**(43)**
At 31 March 2026	**21**	**139**	**120**	**280**
Expected timing of cash flows:				
- not later than one year;	21	139	120	**280**
Total	**21**	**139**	**120**	**280**

The provision for legal claims as at 31 March 2026 relates to the Liabilities to Third Parties Scheme "LTPS" provision.

Other provisions include:

- Liability for VAT repayable of £120k to HMRC and employees relating to car leasing schemes following a VAT Tribunal case brought by Northumbria Healthcare NHS FT. The provision is calculated based on previous VAT returns and payroll information. Payment is expected to be made in the year ending 31 March 2026, but the amount and timing of payments is dependent on the Trust's success in contacting former employees; and

-Liability for pension capitalisation costs of £139K.

Note 23.2 Clinical negligence liabilities

At 31 March 2026, £3,206k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Bridgewater Community Healthcare NHS Foundation Trust (31 March 2025: £2,587k).

Note 24 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
Other	-	465
Gross value of contingent liabilities	**-**	**465**
Net value of contingent liabilities	**-**	**465**

Note 25 Financial instruments

Note 25.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS England, Integrated Care Boards and Local Authorities and the way NHS England, Integrated Care Boards and Local Authorities are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Department of Health and Social Care. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2026 are in receivables from customers, as disclosed in the Receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with other NHS bodies, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated resources. The Trust is not, therefore, exposed to significant liquidity risks.

Note 25.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	10,108	**10,108**
Cash and cash equivalents	5,578	**5,578**
Total at 31 March 2026	**15,686**	**15,686**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	13,378	**13,378**
Cash and cash equivalents	8,179	**8,179**
Total at 31 March 2025	**21,557**	**21,557**

Note 25.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	37,163	**37,163**
Trade and other payables excluding non financial liabilities	5,611	**5,611**
Total at 31 March 2026	**42,774**	**42,774**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	37,428	**37,428**
Trade and other payables excluding non financial liabilities	6,923	**6,923**
Total at 31 March 2025	**44,351**	**44,351**

Note 25.4 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.

	31 March 2026	31 March 2025
	£000	£000
In one year or less	10,871	11,770
In more than one year but not more than five years	20,986	19,438
In more than five years	13,231	15,192
Total	**45,088**	**46,400**

Note 26 Losses and special payments

	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	9	13	12	20
Total losses	**9**	**13**	**12**	**20**
Special payments				
Ex-gratia payments	-	-	3	12
Total special payments	**-**	**-**	**3**	**12**
Total losses and special payments	**9**	**13**	**15**	**32**

Note 27 Related parties

The Trust considers the Department of Health and Social Care as its parent department and the following provides a list of the main entities within the public sector with which the body has had dealings:

- Department of Health and Social Care ministers
- Board members of the trust
- The Department of Health and Social Care
- Other NHS providers
- ICBs and NHS England
- Other health bodies
- Other Government departments
- Local authorities
- NHS charitable funds (where not consolidated)

During the reporting period none of the Department of Health Ministers has undertaken any material transactions with Bridgewater Community Healthcare NHS Foundation Trust.

During the reporting period, the following Trust board members or members of the key management staff, or parties related to any of them, have undertaken material transactions with Bridgewater Community Healthcare NHS Foundation Trust:

In the reporting period, the Trust appointed 1 joint Executive Role split with Warrington and Halton Hospitals NHS Foundation Trust. This is part of the strategic collaboration and board approved acquisition of the Trust by Warrington and Halton Hospitals NHS Foundation Trust (WHH) by April 2026. The role appointed was Chief Nurse (Ali Kennah). Also, as part of the strategic collaboration 1 Bridgewater Executive took up a joint role with WHH. The role appointed was Delivery Unit Director (Lynne Carter). During 2025/26, the Trust has recognised Income of £850k and £1,166k Expenditure with the Hospital Trust. As at 31st March 2026, there was a receivable of £5k and a payable of £22k. These balances relate to recharge and contracts for healthcare services delivered throughout the reporting period. Balances are small as the two organisations cleared, where possible inter organisational balances as part of readiness for the acquisition.

One of the Trust's Non Executive Directors, Tina Wilkins, is an Associate Consultant at Mersey Internal Audit Agency ("MIAA"), the Trust's internal auditors. MIAA is hosted by Liverpool University Hospitals NHS Foundation Trust. During 2025/26, the Trust has recognised expenditure with Liverpool University Hospitals NHS Foundation Trust of £113k for internal audit and counter fraud services, together with a further £11.5k payable for penetration testing and as at 31 March 2026, the Trust recognises a contract payable of £28k.

Note 28 Events after the reporting date

On the 1st April 2026, all the assets/liabilities from Bridgewater Community Healthcare NHS Foundation Trust transferred to North Cheshire and Mersey NHS Foundation Trust.

Note 29 Final period of operation as a trust providing NHS healthcare

The Trust has prepared accounts for its final period of operation (up until 31st March 2026). These are prepared immediately before the outward transfers to North Cheshire and Mersey NHS Foundation Trust on 1st April 2026.Healthcare continues to be provided on all sites by the new organisation.

Note 30 Adjusted financial performance (control total basis)

The Trust's accounts have been prepared under a direction issued by NHS England under the National Health Service Act 2006.

For the financial reporting year ended 31st March 2026, Bridgewater Community Healthcare NHS Foundation Trust has reported a deficit of £4.4m (2024/25: £1.2m deficit) and this is the same figure as in the summarisation schedules that underpin the accounts.

	2025/26	2024/25
	£000	£000
(Deficit) / surplus for the period	**(6,019)**	(1,196)
Remove net impairments not scoring to the Departmental expenditure limit	**1,591**	-
Remove net impact of inventories received from DHSC group bodies for COVID response		40
Adjusted financial performance surplus	**(4,428)**	**(1,156)**

8. Appendices

Appendix 1a: Board and Committee Attendance Register – Bridgewater

Appendix 1b: Committees in Common Attendance Register – Bridgewater and WHH

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Appendix 1a

Board and Committee Attendance Register – April 2025 to March 2026

KEY: **AP** – apologies **A** – absent (no apologies) # extraordinary meeting		Apr	May	Jun	Jun #	Jul	Aug	Sep	Oct	Nov	Dec	Dec #	Jan #	Feb	Mar #	Total
Board of Directors 2025-26																
Nikhil Khashu	**Chief Executive**	✓		✓	✓		✓		✓		✓	✓	✓	✓	✓	**10/10**
Gail Briers	**Non-Executive Director**	✓		✓	✓		AP		✓		✓	✓	✓	AP	✓	**8/10**
Bob Chadwick	**Non-Executive Director**	✓		✓	✓		AP		✓		AP	✓	✓	✓	✓	**8/10**
Elaine Inglesby	**Non-Executive Director**	✓		✓	✓		✓		AP		✓	✓	✓	✓	✓	**9/10**
Abdul Siddique	**Non-Executive Director**	AP		✓	✓		AP		✓		AP	AP	✓	✓	✓	**6/10**
Martyn Taylor	**Trust Chair**	✓		✓	✓		✓		AP		✓	✓	✓	✓	✓	**9/10**
Tina Wilkins	**Non-Executive Director**	✓		✓	✓		✓		✓		✓	✓	✓	✓	✓	**10/10**
Ali Kennah	***Chief Nurse**						✓		✓		✓	✓	✓	✓	✓	**7/7**
Lynne Carter	***Chief Nurse / Dep Chief Exec Director of Delivery Unit**	✓		AP	✓		✓		✓		AP	AP	✓	✓	✓	**7/10**
Paul Fitzsimmons	**Medical Director**	✓		✓	✓		✓		✓		✓	AP	✓	✓	✓	**9/10**
Nick Gallagher	**Director of Finance**	✓		✓	✓		✓		✓		✓	✓	✓	✓	✓	**10/10**
Daniel Moore	**Chief Operating Officer**	✓		✓	✓		✓		✓		✓	AP	✓	✓	✓	**9/10**
Paula Woods	**Director of People and Organisational Development**	✓		✓	✓		✓		AP		✓	✓	✓	✓	✓	**9/10**

**Lynne Carter, Chief Nurse to July 2025 – then Director of Delivery Unit*
**Ali Kennah – Chief Nurse from July 2025*

KEY: **AP** – apologies **A** – absent (no apologies)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Nominations and Remuneration Committee 2025-26 (ad-hoc)														
Martyn Taylor	**Trust Chair**	✓	✓	✓			✓							**4/4**
Gail Briers	**Non-Executive Director / SID**	✓	✓	✓			✓							**4/4**
Bob Chadwick	**Non-Executive Director**	✓	✓	✓			✓							**4/4**
Elaine Inglesby	**Non-Executive Director**	✓	✓	✓			✓							**4/4**
Abdul Siddique	**Non-Executive Director**	AP	AP	✓			AP							**1/4**
Tina Wilkins	**Non-Executive Director**	✓	AP	✓			✓							**3/4**

KEY: **AP** – apologies **A** – absent (no apologies) # extraordinary meeting		Apr	May	Jun #	Jun #	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Audit Committee 2025-26															
Bob Chadwick	**Non-Executive Director**	✓		✓	✓	✓			✓			✓			**6/6**
Gail Briers	**Non-Executive Director / SID**	✓		✓	✓	AP			✓			✓			**5/6**
Elaine Inglesby	**Non-Executive Director**	✓		✓	✓	AP			AP			AP			**3/6**
Abdul Siddique	**Non-Executive Director**	✓		✓	✓	✓			AP			✓			**4/6**
Tina Wilkins	**Non-Executive Director**	✓		✓	✓	✓			✓			✓			**6/6**
Nick Gallagher	**Director of Finance**	✓		✓	✓	✓			✓			✓			**6/6**

KEY: **AP** – apologies **A** – absent (no apologies) # Extraordinary meeting		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar #	Total
Council of Governors 2025-26														
Martyn Taylor	**Chair**	✓		✓		✓		✓		✓		✓	✓	**7/7**
Gail Briers	**Non-Executive Director / SID**	✓		AP		✓		✓		✓		AP	✓	**5/7**
Bob Chadwick	**Non-Executive Director**	✓		✓		AP		✓		✓		AP	✓	**5/7**
Elaine Inglesby	**Non-Executive Director**	✓		✓		✓		✓		✓		✓	✓	**7/7**
Abdul Siddique	**Non-Executive Director**	✓		✓		✓		✓		AP		✓	AP	**5/7**
Tina Wilkins	**Non-Executive Director**	✓		AP		✓		✓		✓		✓	✓	**6/7**
Arshad Ashraf	**Public Governor – Rest of England (ROE)**	A		✓		A		✓		A		A	✓	**3/7**
Claire Barton	**Staff - Dental**	✓		AP		✓		AP		AP		AP	AP	**2/7**
Jonathan Berry	**Public Governor – ROE**					AP		✓		✓		✓	✓	**4/5**
Katie Brown	**Staff – Nursing**					✓		AP		AP		AP	✓	**2/5**
Rita Chapman	**Public Governor – ROE**	✓		✓		✓		✓		✓		✓	✓	**7/7**
Emma Crilly	**Staff – Clinical Support Staff**					AP		AP		AP		AP	✓	**1/5**
Audrey Fitzpatrick	**Public Governor – Warrington**					AP		AP		AP		AP	✓	**1/5**
Kevin Goucher	**Public Governor – Warrington**	✓		✓		AP		✓		AP		✓	AP	**4/7**
Janet Hennessy	**Partner Governor – Signing Solutions Warrington**	AP		AP		AP		✓		✓		AP	✓	**3/7**
Norman Holding	**Public Governor – Warrington**					✓		✓		✓		✓	✓	**5/5**
Peter Hollett	**Public Governor – Halton**	A		A										**0/2**
Katie Jones	**Partner Governor – Further/Higher Education**					✓		AP		AP		AP	✓	**2/5**
Phillip Lynch	**Staff – Nursing**					AP		AP		AP		AP	AP	**0/5**
Matt Machin	**Public Governor – Warrington**	✓		✓		AP		✓		✓		✓	✓	**6/7**
Sue Mackie	**Staff – Nursing**	A		A										**0/2**
Sarah Power	**Staff – Non-Clinical**	✓		✓										**2/2**
Dave Smith	**Staff – Non-Clinical**					AP		✓		AP		✓	✓	**3/5**
Christine Stankus	**Public Governor – ROE & Lead Governor**	✓		✓		✓		✓		✓		✓	✓	**7/7**

KEY: **AP** – apologies **A** – absent (no apologies) # Extraordinary meeting		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar** #	**Total**
Jilly Wallis	**Staff – Allied Health Professionals**	✓		✓										**2/2**
David Wilson	**Partner Governor - Healthwatch Halton**	AP		AP		AP		AP		AP				**0/5**
Nicola Wilson	**Staff – Nursing**	A		A										**0/2**

Finance, Sustainability and Performance Committee in Common (as from July 2025) Attendance Log 2025-26													
	2025										2026		
Name	Apr	May (2 June)	Jun	CIC commenced	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERSHIP													
John Somers, Chair - Non-Executive Director	✓	✓	✓	Committee in Common commenced	✓	A	✓	✓	✓	✓	✓	✓	✓
Julie Jarman, Non-Executive Director (Deputy Chair)	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Jane Hurst, Chief Finance Officer	✓	✓	✓		A/D	✓	✓	✓	✓	✓	✓	✓	✓
Jan Parker, Deputy Chief Finance Officer	✓	A	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Ali Kennah, Chief Nurse	A/D	✓	✓		✓	✓	A/D	✓	✓	✓	A	✓	✓
Michelle Cloney, Chief People Officer	✓	✓	A/D		✓	✓	✓	✓	✓	✓	✓	✓	✓
Dan Moore, Chief Operating Officer and Deputy CEO	✓	✓	✓		A/D	✓	✓	✓	✓	✓	✓	✓	✓
Paul Fitzsimmons, Executive Medical Director	✓	✓	✓		✓	A/D	✓	✓	✓	✓	✓	✓	✓
Lucy Gardner, Chief Strategy & Partnerships Officer	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	A/D	✓
Val Doyle, Interim Associate Director Estates	✓	✓	✓		A	✓	A	A	A	✓	✓	✓	✓
Kate Henry, Director of Communications & Engagement	✓	✓	✓		✓	✓	✓	✓	✓	A	✓	A	✓
Tom Poulter, CIO	✓	x	✓		A	A	A	A	✓	✓	A	A	A
John Culshaw, Company Secretary	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
CORE MEMBERS BCH													
	BCH F&P Committee												
Nick Gallager, Director of Finance	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Gail Briers, Non-Executive Director	✓	✓	✓										
Bob Chadwick, Non-Executive Director	✓	✓	A		✓	✓	✓	✓	A	A	✓	✓	A
Tina Wilkins, Non-Executive Director and BCH Committee Chair	✓	✓	✓		✓	✓	✓	A	✓	✓	✓	✓	✓
Dan Moore, Joint Chief Operating Officer and WHH Deputy CEO	A	A	✓										
Lynne Carter, *Chief Nurse/Director of Delivery Unit and Deputy CEO	✓	✓	✓		✓	✓	✓	✓	A	A	✓	✓	A

KEY:

A = Apologies

A/D = Apologies/Deputy in Attendance

R = Left Trust

QUALITY ASSURANCE COMMITTEE ATTENDANCE LOG - 2025-26															
	2025											2026			
NAME	Apr	May	Jun	Jul	Jul (extra mtg)	Aug	Sep	Oct	Nov	Dec		Jan	Quality, Safety and Assurance Committee in Common	Feb	Mar
WHH CORE MEMBERS AND ATTENDEES															
Cliff Richards, Non Executive Director - WHH Committee Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	A		A		✓	✓
Jayne Downey, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	A/D	✓	✓		✓		A	✓
Jane Hurst, Chief Finance Officer	✓	✓	✓	✓	A/D	✓	A/D	✓	✓	✓		✓		✓	✓
Michelle Cloney, Chief People Officer	✓	✓	A/D	A	✓	✓	✓	A/D	A/D	✓		A/D		✓	✓
Lucy Gardner, Chief Strategy & Partnerships Officer	✓	A/D	A/D	✓	A	✓	A	✓	✓	✓		✓		✓	✓
John Culshaw, Company Secretary	✓	✓	✓	A/D	✓	✓	✓	✓	✓	✓		✓		✓	✓
Tracy Fennell, Deputy Chief Nurse Patient Safety + Clinical Education	✓	✓	✓	A	✓	✓	✓	✓	✓	A		✓		✓	✓
Eshita Hasan, Deputy Medical Director	✓	✓	A	✓	✓	✓	✓	A/D	✓	✓		✓		A	✓
Paul Mooney, Chief Pharmacist	✓	✓	✓	✓	A	A	✓	✓	✓	✓		A		✓	✓
Ailsa Gaskill Jones, Director of Midwifery	✓	✓	A	✓	✓	✓	✓								
Tina Moors, Deputy Director of Midwifery								✓	✓	A		✓		✓	✓
Ernesto Quider, Associate Director of Quality	✓	✓	A	✓	✓	✓	A	✓	✓	A		✓		✓	✓
JOINT DIRECTORS															
Ali Kennah, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	A/D
Paul Fitzsimmons, Executive Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		A/D		✓	✓
Dan Moore, Chief Operating Officer	✓	✓	✓	A	A	✓	✓	✓	✓	A		✓		A/D	✓
BCH CORE MEMBERS AND ATTENDEES															
	BCH Quality and Safety Committee														
Elaine Inglesby, BCH Committee Chair and Non-Executive Director		✓	✓			✓		✓		✓				✓	✓
Gail Briers, Non-Executive Director		A	✓			✓		✓		✓				✓	✓
Abdul Siddique, Non-Executive Director		A	A			A		A		✓					
Lynne Carter, *Chief Nurse/Director of Delivery Unit and BCH Deputy CEO		✓	✓											A	✓
Nick Gallagher, Director of Finance														A	A
Paula Woods, Director of People and Organisational Development														A	✓
Ali Kennah, *Chief Nurse						✓		✓		✓				A	✓
Paul Fitzsimmons, Executive Medical Director		✓	✓			A/D		A/D		✓				✓	✓
Dan Moore, Chief Operating Officer		A/D	A/D			✓		✓		✓				A	A

*Ali Kennah - Joint WHH and BCH Chief Nurse from July 2025
*Lynne Carter - BCH Chief Nurse to July 2025 - then Director of Delivery Unit

KEY:
A = Apologies
R = Left Trust
A/D - Apologies - Deputy in attendance

STRATEGIC PEOPLE COMMITTEE IN COMMON
ATTENDANCE LOG 2025-26

	2025										2026		
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**		**Jan**	**Feb**	**Mar**
Julie Jarman - WHH Committee Chair, Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Abdul Siddique, BCH Committee Chair, Non-Executive Director	✓	✓	✓	✓	A	✓	✓	✓	✓		✓	✓	✓
Michael O'Connor, Non-Executive Director	✓	A	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Elaine Inglesby, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	A		A	✓	✓
Michelle Cloney, Chief People Officer	✓	✓	✓	✓	A/D	✓	✓	✓	✓		A/D	✓	✓
Paula Woods, Director of People and Organisational Development	✓	✓	✓	A/D	A/D	✓	✓	✓	✓		✓	✓	✓
Nick Gallagher, Director of Finance	✓	✓	✓	✓	A	✓	✓	✓	✓		A/D	✓	✓
Jane Hurst, Chief Finance Officer	✓	✓	✓	A	✓	A/D	✓	A	✓		✓	✓	✓
Lynne Carter, *Chief Nurse/Director of Delivery Unit and BCH Deputy CEO	A/D	✓	✓	✓	✓	✓	✓	✓	A		✓	✓	A/D
Ali Kennah, *Chief Nurse	✓	✓	✓	✓	✓	A/D	✓	✓	✓		✓	✓	✓
Dan Moore, Chief Operating Officer and WHH Deputy Chief Executive	✓	✓	✓	✓	✓	✓	✓	A	✓		✓	✓	✓
Paul Fitzsimmons, Executive Medical Director	✓	A/D	✓	A	✓	✓	✓	✓	A		✓	A/D	A/D
Lucy Gardner, Chief Strategy and Partnerships Officer	✓	A/D	A/D	A/D	A/D	✓	A	A	A		A/D	A/D	A/D
Kate Henry, Director of Comms and Engagement	A/D	A	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Jennie Dwerryhouse, Deputy Chief People Officer	✓	✓	✓	✓	✓	✓	✓	✓	A		✓	✓	✓
Jo Waldron, Deputy Director of People and Organisational Development (on secondment)	✓	✓	✓	✓	✓								
John Culshaw, Company Secretary	✓	A	✓	✓	A/D	✓	✓	✓	✓		✓	✓	✓
Jan McCartney, Director of Corporate Governance	✓	✓	A	A	✓	x	x	x	x		x	x	x

*Ali Kennah - Joint Chief Nurse WHH and BCH from July 2025
*Lynne Carter - BCH Chief Nurse to July 2025- then Director of Delivery Unit

KEY:
A = Apologies
A/D = Apologies/Deputy in Attendance
R = Left Trust

Get in touch

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