NHS

Warrington and Halton Teaching Hospitals

NHS Foundation Trust

Annual Report and Accounts

2025–26








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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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1. Overview of the Trust

1.1 Chair and Chief Executive's Introduction

This 2025-26 annual report, the last under the name of Warrington and Halton Teaching Hospitals (WHH), marks the end of one chapter and the start of a new one. It highlights the significant achievements we have continued to make amidst substantial pressures and against what can only be described as a challenging landscape right across the NHS.

As is the case every year, we must start by giving our sincere thanks to the staff and volunteers who make our organisation what it is. Their dedication, skill and compassion can be seen throughout our services, where we frequently hear examples of staff putting our Trust's five values (working together, excellence, inclusive, kind, and embracing change) into practice for the benefit of patients and our local communities. From homes to hospitals, clinics to community hubs, our teams work tirelessly to ensure patients receive the highest quality care, often in the most challenging circumstances.

This year in particular, staff have truly excelled as we have rapidly progressed plans for WHH to acquire Bridgewater Community Healthcare on 1 April 2026. With a joint executive team in place, we have successfully delivered what is arguably the fastest and most cost-effective transaction in NHS history. This has not been without challenge. It has required managing numerous competing demands, paving a way to safely bring together our services, and skilfully bringing colleagues and stakeholders along with us on the journey.

Our shared vision is to create a more seamless, patient-centred healthcare system. By breaking down barriers between hospital, community, local authority, and third-sector services, we can ensure that care is more coordinated, accessible and responsive to the needs of our population. We are proud to see the first steps of this becoming a reality, as our teams and services have worked increasingly closer together over this 12-month period. This will no doubt accelerate following our legal transaction to become North Cheshire and Mersey NHS Foundation Trust from 1 April 2026.

The work we are doing is fully aligned to the NHS 10-year plan, published in July 2025, focusing on greater community-based care, shifting to prevention and using effective digital approaches. This is an exciting time for healthcare as we seek to evolve to meet the needs of those we serve.

In the meantime, we would like to take this opportunity to celebrate some of our key achievements in 2025-26, as we have remained focused on our three strategic aims of quality, people, and sustainability.

Quality

We will always put our patients first, delivering safe and effective care and an excellent patient experience

In June 2025 we opened a multi-million-pound, purpose-built centre to help diagnose and treat a range of health conditions while improving waiting times for Warrington and Halton residents. Warrington and Halton Diagnostics Centre is located next to the existing Captain Sir Tom Moore Building at Halton Hospital, providing a modern space with state-of-the-art equipment to offer new MRI and CT services to more than 30,000 patients a year. The £11 million project was the final part of a three-phase £16 million Community Diagnostic Centre (CDC) programme, which has seen the refurbishment and modernisation of existing space in the Nightingale Building at Halton Hospital and a service at Halton Health Hub, based in Runcorn Shopping City.

Our collaboration with Bridgewater Community Healthcare saw the first patients attend Halton Health Hub in April 2025 to benefit from the latest AI technology to speed up the diagnosis of skin cancers. This partnership with artificial intelligence technology provider Skin Analytics uses cutting-edge, NICE-recommended AI by recognising cancerous, pre-cancerous and common harmless skin conditions through photographic images.

A new cone beam CT (CBCT) scanner was installed at Warrington Hospital's Radiology Department, helping to cut waiting times and speed up diagnosis for patients who need specialist dental scans. The new scanner delivers highly detailed 3D images of bone, teeth and soft tissue, providing information that cannot be seen by usual 2D X-rays. The advanced technology is used for diagnosis and treatment planning for a range of procedures including dental implants, root canals and oral surgery.

On the theme of dental, new state-of-the-art intraoral scanners were introduced at both Warrington and Halton hospital sites thanks to support from our WHH Charity and League of Friends. These scanners have significantly improved the experience of patients who now no longer need the use of unpleasant moulds to obtain dental impressions. The accurate digital impressions are quicker, more comfortable and have received overwhelmingly positive feedback from patients.

In September 2025, our Patient Experience and Inclusion Team were recognised for their efforts to improve healthcare accessibility for the d/Deaf community across Warrington and Halton. As finalists in the Communicating Effectively with Patients and

Families category at the Picker Experience Network (PEN) Awards 2025, they were recognised for their work with local advocacy groups and the d/Deaf community to transform how care is delivered to people who are deaf, deafened, hard of hearing or deafblind. Several initiatives have been developed to transform how care is delivered, including digital alerts to flag communication needs, deaf awareness training for staff, and guides on how to access interpretation and translation services to support patients.

We worked with Healthwatch Warrington to support the launch of a pioneering initiative designed to empower patients and improve communication with healthcare professionals. The 'About Me' card helps individuals disclose personal triggers and request reasonable adjustments in a simple, non-verbal format, enhancing patient experience and promoting person-centred care. The card has been developed by Healthwatch Warrington, in collaboration with the Patient Experience and Inclusion Team at Warrington and Halton Teaching Hospitals NHS Foundation Trust, and is currently recognised at Warrington Hospital.

We expanded our virtual ward programme and will continue to develop this significantly in the coming year, enabling more patients to receive high-quality clinical care safely in the comfort of their own homes. Using remote monitoring technology, patients are supported by clinical teams without the need for a hospital bed, ensuring they receive the right care in the right place. This approach helps to reduce unnecessary lengthy inpatient stays, freeing up capacity for those patients who need it most.

The innovative Living Well Warrington website, which is the latest development in the borough-wide Living Well programme, was shortlisted at the HSJ Digital Awards 2026. The website, which focuses on connecting residents with timely, relevant and inclusive support from across the NHS, local authority and voluntary sector, was shortlisted in the Reducing Health Inequalities through Digital category and the Driving Prevention and Early Intervention through Digital category. This follows national recognition, with the site having been named highly commended in the Health Service Journal Award's 'Integrated Care Initiative of the Year' category in November 2025.

People

We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future

Integration with Bridgewater Community Healthcare continued to progress at pace during 2025-26. Agreement was granted to bring the transaction date forward by one year to 1 April 2026. During the year, Ali Kennah became joint chief nurse for Bridgewater as well as WHH, and Lynne Carter became joint director of the delivery

unit, both providing further joint leadership to deliver our shared vision for future integration.

Andy Carter was appointed by WHH to be the chair of our integrated organisation from 1 April 2026. We were pleased that Andy joined WHH in January 2026 as chair designate and associate non-executive director.

In December, our HR Business Partnering Team at WHH were highly commended at the Healthcare People Management Awards (HPMA) 2025. The HPMA Excellence in People Awards recognise and reward outstanding work in healthcare human resource management. The team were recognised in the 'Health Education and Improvement Wales Award' category for their work to develop a structured career development pathway within the human resources department. The shortlisting recognises the team's commitment to advancing the HR profession and supporting people professionals to thrive.

The significant contribution made by long-serving staff was celebrated in December at a joint celebration with Bridgewater colleagues to mark 2,435 years of combined service. The awards recognise colleagues who have achieved 25, 40 and 50 years of continuous service with the NHS.

Our staff were also recognised through our annual Thank You Awards event, which is made possible thanks to sponsorship and income generated through advertising. Around 300 staff and sponsors joined us for a night of celebration in May 2025 at the Titanic Hotel, Liverpool, as we recognised the contribution of all our finalists and winners across 13 categories. Our 2025-26 annual Thank You Awards take place at the same venue on Friday 15 May 2026.

In January 2026 we took another step closer to integration with Bridgewater by bringing our staff inclusion activity together to launch six 'staff networks in common'. Joint meetings of these networks were scheduled for the final quarter of the year and will continue to thrive as we become one organisation.

Sustainability

We will work in partnership with others to achieve social and economic wellbeing in our communities

We made significant progress with what will be a key enabler of our sustainable future. Work on the acquisition of Bridgewater Community Healthcare by WHH continued at substantial pace throughout 2025-26, with a successful integration on 1 April 2026. This lays the foundations for more sustainable healthcare for the people of Warrington, Halton and beyond.

At the same time, we delivered numerous important estates developments, including the development of a new theatre at Halton Hospital's Nightingale Building. Opened in November 2025 and funded through the Targeted Investment Fund, the new theatre is providing additional capacity to help reduce waiting lists and improve our elective performance.

We were awarded £3.1 million in May 2025 from the Department of Health and Social Care's Estates Safety Fund. This is enabling us to improve and modernise building management systems, upgrade and replace lifts, carry out essential roof replacements, and upgrade ventilation systems in critical areas such as theatres. The funding will also support the installation of a new nurse call system to enhance patient safety and improve efficiency.

It was followed by a further £1 million as part of the national decarbonisation programme to support the delivery of clean energy. The funding will enable the installation of 996 solar panels at Warrington Hospital, generating almost 450,867 kWh of electricity each year. Halton Hospital will benefit from energy efficient LED lighting improvements. Both installations will help the organisation save almost £172,000 each year.

From a digital perspective, following the launch of our patient portal in 2024, we introduced a 'digital first' patient letters model which means we no longer send paper appointment letters to most patients who are registered with the NHS App or have a mobile phone number on file. Switching to digital-only letters for these patients is part of the Trust's ongoing commitment to improving communications with patients, reducing delays in receiving important healthcare information and supporting our efforts to become more environmentally friendly.

We commenced an artificial intelligence (AI) pilot to help scribe patient letters following a medical consultation, helping to increase the speed at which patients receive their outcome letters following an appointment and reduce administrative burden. The results have been successful, and we are rolling the technology out further.

In terms of finance, we implemented additional grip and control measures throughout the year, including via our Delivery Unit. We recorded an adjusted deficit of £40.7m for 2025-26 (the adjusted deficit is the value which NHS England monitors the Trust against). This was £12m away from our £28.7m deficit plan for the year, excluding deficit support funding.

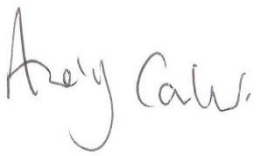
We continued to invest significantly in our annual capital programme, which started at £30.2m (including IFRS16 and donated assets). This was reduced to £20.9m, mainly due to rescheduled funding for a new electronic patient record, and the actual spend for the year was £20.8m. Further detail on our financial performance can be found in later sections of this report.

Looking ahead

2026-27 will certainly be another challenging year for the Trust as we continue our integration and transformation efforts post-transaction, focus on operational performance and work towards a three-year plan to become financially sustainable.

We will continue to invest significantly in infrastructure initiatives for the benefit of our staff and patients. This includes digital programmes, as we seek to replace our existing electronic patient record, as well as significant estates developments as we continue to work up the case for an Urgent Treatment Centre in Warrington.

Looking forward beyond 1 April 2026, as we become North Cheshire and Mersey NHS Foundation Trust, we are committed to our mission 'to be exceptional for our patients, our communities and each other'. We look forward to harnessing the benefits of integrating hospital and community services to deliver the best healthcare in the right place, at the right time for our patients across Halton, Warrington and our wider footprint.



Andy Carter
Chair
22 June 2026

Nikhil Khashu
Chief Executive
22 June 2026

1.2 About the Trust

The Trust comprises two acute care hospitals across two sites in the boroughs of Warrington and Halton and provides services across a number of community hubs. Services are delivered by our workforce of around 5,000 staff, many of whom live in the boroughs we serve.

The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England. The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes. The Trust may provide goods and services for any purposes related to:

1. the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness
2. the promotion and protection of public health

The Trust may also carry out activities other than those mentioned above for the purpose of making additional income available in order to fulfil its principal purpose.

The Trust and its place in the wider health economy

The Trust is part of the Cheshire and Merseyside Integrated Care System which is known as NHS Cheshire and Merseyside. This is one of 42 systems created nationwide on 1 July 2022 by the Health and Care Act 2022 to replace more than 100 Clinical Commissioning Groups.

Within this context, Warrington and Halton operate as place-based partnerships which aim to develop a plan to address the broader health, public health and social care needs of the local population and design the delivery of integrated services to address these. These partnerships are known as Warrington Together and One Halton, and involve the NHS, local authorities, community and voluntary organisations plus residents and people who use health and social care services.

Halton Hospital is located in Runcorn and is where the majority of elective and diagnostic care is delivered. The Runcorn Urgent Treatment Centre is also located here. Halton Hospital comprises two distinct buildings, the Captain Sir Tom Moore Building (formerly known as Cheshire and Merseyside Treatment Centre) and Nightingale Building (formerly known as Halton General). The site is also home to the Macmillan Delamere Support and Information Centre.

Although each site focuses on particular aspects of care, outpatient clinics for all specialties and diagnostic services are provided at both Warrington and Halton hospitals so patients can access their appointments closer to home wherever possible.

The two hospital sites are eight miles apart and are easily accessible, being very close to the north west motorway networks

Services provided at Warrington Hospital include:
Emergency Department (A&E), surgical services, general medicine, children's services (paediatrics), cardiac care and cardiac catheter lab, stroke care, cancer care, elderly care, maternity, gynaecology, neonatal, orthopaedic trauma, critical care and ophthalmology.

Support services include occupational therapy, pathology, physiotherapy, pharmacy, dietetics, outpatient services, diagnostic services, radiology and a range of specialist nursing services.

Services provided at Halton Hospital include:

Nightingale Building: General surgery, urology, endoscopy, step down care, cancer care, programmed investigations unit, renal dialysis, chemotherapy and cancer support, a full range of outpatient services.

Also located here:

- Halton Clinical Research Unit
- Warrington and Halton Diagnostics Centre (phase 1)
- Runcorn Urgent Treatment Centre which provides care and treatment for illness and injuries that are not life or limb-threatening but require urgent attention. Open 8am to 9pm, seven days a week

Captain Sir Tom Moore Building: Orthopaedic, urology, gynaecology, cancer and day case surgeries, and post-anaesthetic care unit.

Support services include breast care centre, occupational therapy, physiotherapy, dietetics, outpatient services, diagnostic services and a range of specialist nursing services.
Warrington and Halton Diagnostics Centre (phase 3) opened in June 2026.

The pre-treatment centre is located on the Halton site.

Services in the community

Through a network of community hubs, virtual service offers and mobile facilities we also provide a range of outpatient services in the community. This is a step towards ensuring services are delivered in the right place to improve access to quality care and address health inequalities.

Examples include:

- Bath Street Health and Wellbeing Centre, Warrington
- Halton Health Hub, Runcorn Shopping City
- Living Well Hub, Warrington

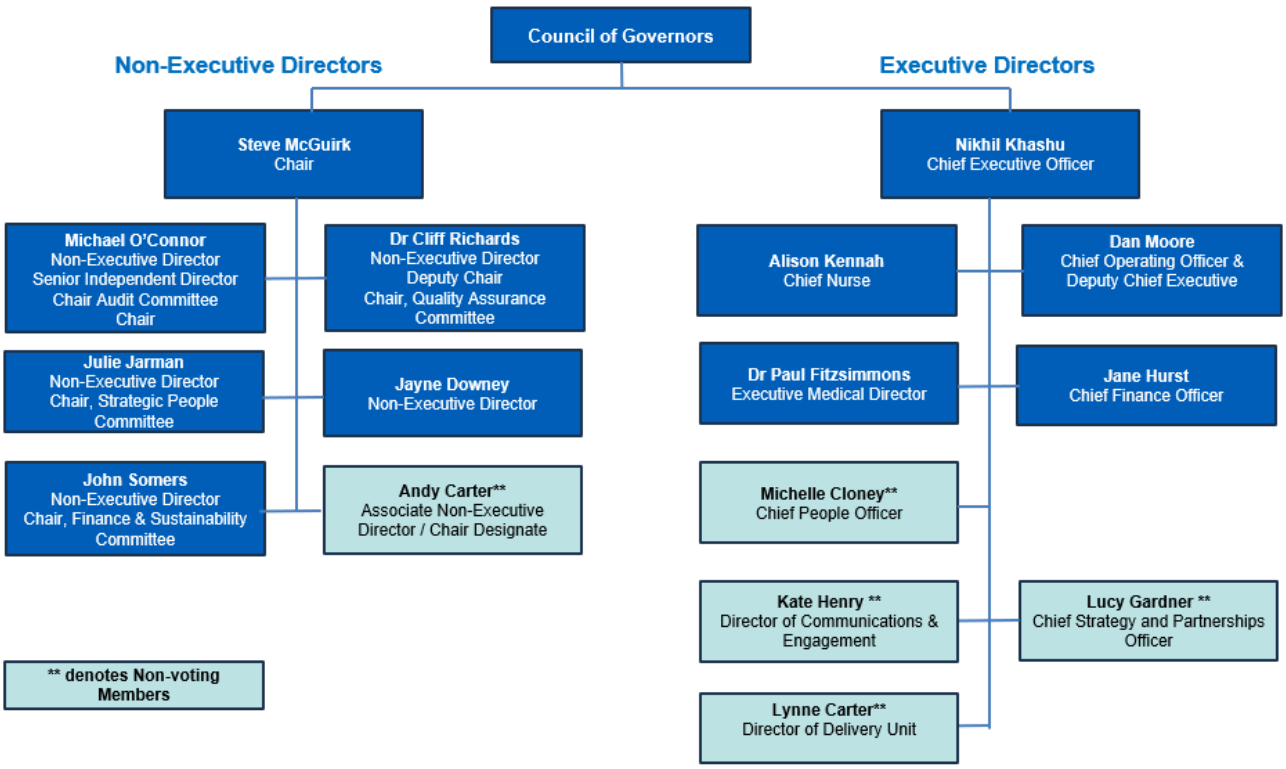
- Mobile breast screening services
- Virtual wards – using advances in technology and infrastructure to enable patients to receive the care they need at home rather than in hospital
- Virtual consultations – offering video outpatient appointments to enable flexible and responsive care

Trust key headlines in 2025-26

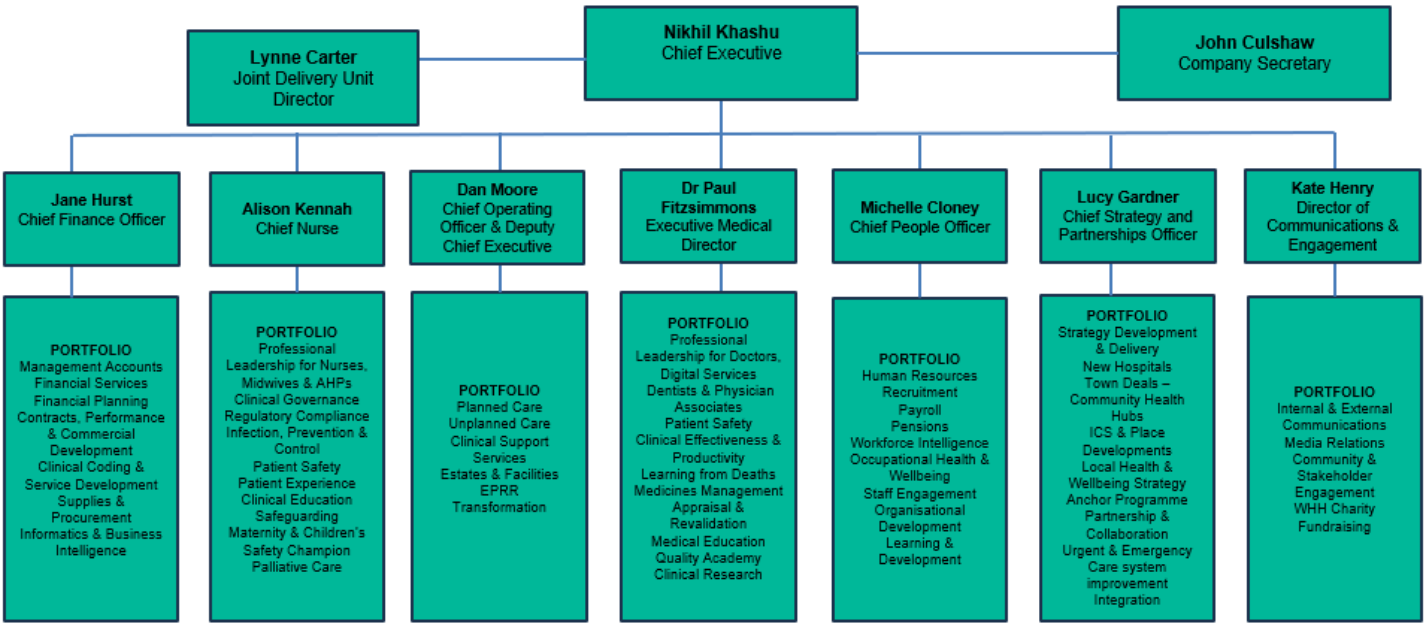
- **Served a population of approximately 347,000** across both Halton and Warrington boroughs
- Employed **around 5,000 staff** comprising 85 nationalities
- Delivered **2,300 babies** in hospital and in the community
- Delivered **57,701** hospital procedures and stays
- Delivered **111,676** individual new outpatient appointments (face to face and telephone)
- **Operated 701 assessment beds**
- **Provided 140,657 episodes of emergency care –** 82,270 episodes at the Emergency Department, 23,228 at the Warrington Same Day Emergency Care facility and 35,159 at Runcorn Urgent Treatment Centre

How the Trust is organised – 31 March 2026

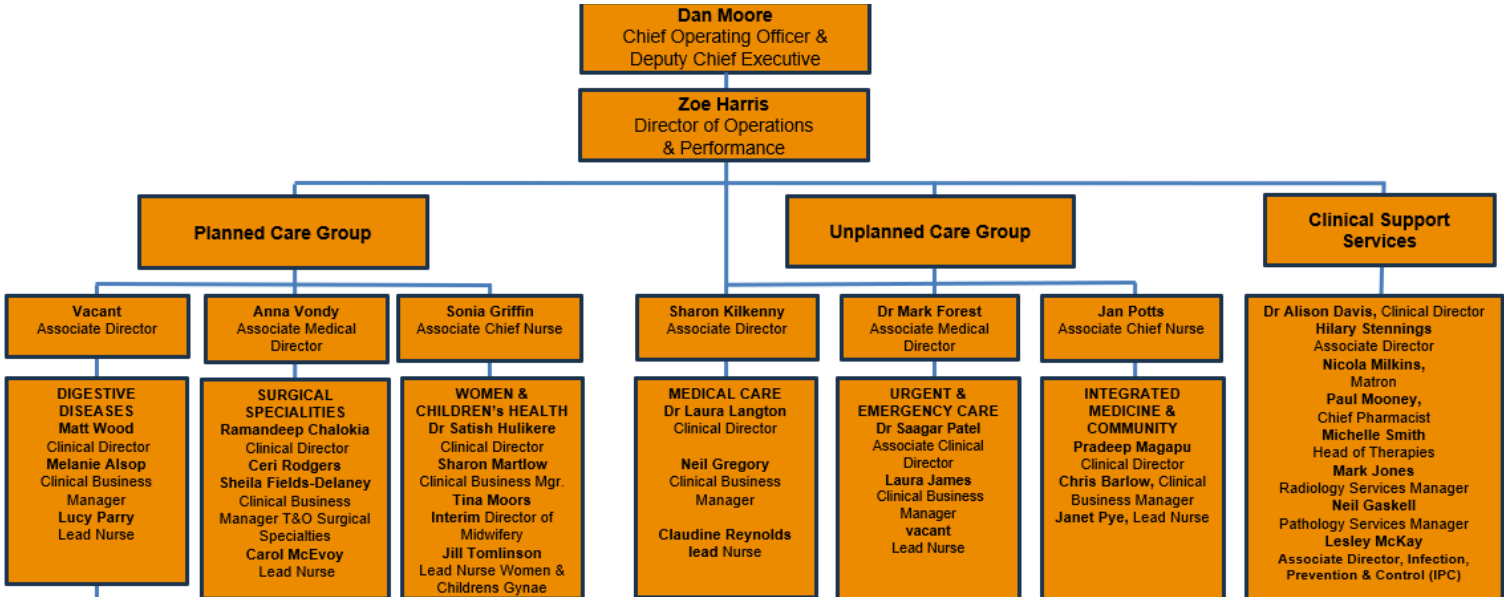
Trust Board



Executive Team



Care Groups and Clinical Business Units



Our Mission, Vision, Aims and Values

Our Mission

We will be outstanding for our patients, our communities and each other

Our Vision

We will be a great place to receive healthcare, work and learn

Our Aims

QUALITY

We will...
Always put our patients first delivering safe and effective care and an excellent patient experience.

PEOPLE

We will...
Be the best place to work with a diverse and engaged workforce that is fit for now and the future.

SUSTAINABILITY

We will...
Work in partnership with others to achieve social and economic wellbeing in our communities.

Our Values

Working Together

Excellence

Inclusive

Kind

Embracing Change

1.3 A brief history of the Trust and its statutory background

Warrington and Halton Hospitals NHS Foundation Trust (WHH) was created on 1 December 2008 from what was formerly known as North Cheshire Hospitals NHS Trust.

In 2008 we were awarded Foundation Trust status and currently have 3111 public members.

The Trust achieved Teaching Hospital status in November 2019 and was renamed Warrington and Halton Teaching Hospitals NHS Foundation Trust.

The Care Quality Commission rated the Trust 'Good' in 2019, with critical care achieving an 'Outstanding' rating for care. Maternity services retained their 'Good' rating following an inspection in September 2023.

A brief history of Warrington and Halton hospitals

1898: Warrington General Hospital is created from the workhouse building.

1929: Warrington General is renamed as Warrington Borough Hospital.

1973: Warrington District General Hospital is created by merging all hospitals with two other hospitals on site – Aikin Street (infectious diseases) and Whitecross Hospital (military). During the 1970s/80s the demolition of these buildings made way for Appleton Wing, then Burtonwood Wing, Croft Wing and Daresbury Wing.

1976: Halton General Hospital opens in Runcorn, part of the development of Runcorn New Town.

1993: Hospitals are handed over from Warrington Health Authority to the newly formed Warrington Hospital NHS Trust and from Halton Health Authority to the new Halton General Hospital NHS Trust.

2006: Warrington becomes the centre for acute medical and emergency care and planned surgical work moved to Halton. Halton retains Runcorn Urgent Treatment Centre.

2008: Warrington and Halton Hospitals NHS Trust achieves Foundation Trust status.

2012: The Trust takes ownership of Cheshire and Merseyside Treatment Centre at Halton from a private healthcare provider and services including orthopaedic surgery move in.

2019: The Trust achieves Teaching Hospital status.

2020: The Trust responds to the global COVID-19 pandemic and mobilises a vaccination service. Halton General Hospital is renamed Halton Hospital with buildings also renamed.

2021-22: A Clinical Research Unit, Breast Care Centre and Pre-Treatment Unit open at Halton. The Habab Education Centre and Same Day Emergency Care Centre open at Warrington.

2023-24: Facilities supporting people to access health services in convenient community locations open including Halton Health Hub at Runcorn Shopping City and the multi-million pound Living Well Hub in Warrington Town Centre, in which WHH is a lead partner.

2024: The Trust entered a formal partnership with Bridgewater Community Healthcare NHS Foundation Trust to begin integrating acute and community services.

2024-25: A dedicated Day Case Unit and theatre open at the Captain Sir Tom Moore Building and an Endoscopy Hub at the Nightingale Building, both on the Halton Hospital site.

2025-26: A new building for Warrington and Halton Diagnostics Centre opened at Halton Hospital and the Trust completed the final formal stages of the legal transaction to acquire Bridgewater Community Healthcare NHS Foundation Trust in readiness to become North Cheshire and Mersey NHS Foundation Trust on 1 April 2026.

1.4 The future of the Trust – our vision

Warrington and Halton Teaching Hospitals NHS Foundation Trust is committed to improving healthcare for our communities and since 2024 we have been working towards integration with Bridgewater Community Healthcare NHS Foundation Trust.

By working as one and becoming a single Trust from 1 April 2026 we will be able to integrate hospital and community services to deliver a healthcare system that is sustainable for the future and support local delivery of the three shifts outlined in the 10 Year Health Plan for England:

- hospital to community
- analogue to digital
- sickness to prevention

New operational models will provide care at home first, then in community settings when needed and only in hospital when necessary. Supported by digital capability that reduces the burden of administration and supports more personalised care, services will be designed in partnership with a wide range of partners and voices, including primary care, local authorities and people with lived experience of health services.

Our estates and facilities will be used more efficiently to support the delivery of more care at home or in at health centres, hubs and clinics in the community, enabling us to make the most of our Warrington Hospital site to care for patients with the most urgent and complex medical conditions. Halton Hospital will continue to support the delivery of effective diagnostics and as a centre for planned surgery and procedures.

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 innovation in how we deliver clinical pathways to improve patient care, address health inequalities and deliver a green and sustainable future.

Together with our colleagues from Bridgewater Community Healthcare NHS Foundation Trust we have developed a new vision for the future of our integrated organisation – North Cheshire and Mersey NHS Foundation Trust - which will support us in achieving our aims:

‘We will be a great organisation providing excellent healthcare and opportunities to work and learn’

1.5 Principal risks

The Trust's principal risks to achieving its strategic objectives are set out below

These risks are captured within the Board Assurance Framework (BAF), which serves as the Trust's key mechanism for monitoring exposure to strategic risk and the effectiveness of associated controls. Each risk is overseen by a designated Board Committee, with committees undertaking bi-monthly scrutiny of movements in risk ratings, the strength of assurance and the progress of mitigating actions. The full BAF is also received by the Trust Board and the Audit Committee to support robust, transparent governance.

The BAF is intentionally dynamic. Risks may be introduced, refined or de-escalated in response to operational pressures, emerging national requirements, and the delivery of improvement plans. As mitigations take effect and circumstances evolve, risk descriptions, associated risk appetites and scores are updated to reflect the Trust's current position. The risks presented here are validated as at **31 March 2026**.

The organisation has identified **11 strategic risks**, with those representing the highest levels of strategic exposure (scored 15 and above) highlighted in red. Further detail—including key controls, lines of defence assurances, and targeted mitigations—can be found in the Trust Board papers: Board Meetings and Papers : Warrington and Halton Hospitals NHS Trust (whh.nhs.uk)

Risk Appetite

The risk appetite is the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings. The Trust has defined the Risk Appetite Statement specifically for five types of risk: Quality, People, Finance and Sustainability, Regulation, and Reputation.

In light of integration plans and the work required to consolidate the WHH and Bridgewater Community Healthcare (BCH) Board Assurance Frameworks, the existing Risk Appetite Statement was extended to cover the full 2025/26 financial year. This updated position was reviewed and approved by the Trust Board in February 2025 and has guided decision-making throughout the year.

A revised Risk Appetite Statement for the enlarged organisation is now being developed. This version will reflect the broader service footprint, the emerging priorities of the enlarged organisation, and the enhanced governance arrangements

aligned to North Cheshire and Mersey NHS Foundation Trust. It will be presented for approval at the inaugural meeting of the enlarged Trust Board in April 2026.

Warrington and Halton Teaching Hospitals NHS FT – Risk Appetite Statement

WHH is an ambitious organisation – ambitious for its patients, its workforce and for the communities it serves.

Our goal is to provide high quality care that puts patients first, is both safe and effective, and delivers an excellent patient experience. Alongside this we aim to be the best place to work, with a diverse and engaged workforce, fit for now and the future. Together with our partners in the health and social care system, we will design our services to be fit for purpose and more integrated to achieve social and economic wellbeing in our communities.

The NHS unquestionably faces unprecedented economic and operational challenges, but these challenges are magnified at a local level by additional demographic factors, as well as specific WHH issues. The latter includes, for example, an aging estate on both our hospital sites. Achieving our goals, whilst meeting these challenges, will require significant change as well as extensive collaboration with partners across the NHS family and across the wider, public and third sectors. This degree of change brings significant opportunity but, correspondingly, it requires us to take more risk. Thus, we must endeavour to strike the best balance between the two.

Accordingly, we will continue to be guided by our risk management policy in order to understand and control risk. We will continue to develop our corporate risk register to monitor significant operational risks. We will also continue to apply our Board Assurance Framework to monitor strategic risks and ensure that the risks we take are consistent with the risk appetite set by the Board.

Our risk appetite, therefore, represents a collective agreement, understanding and decision by the Board about the level of risk that we are prepared to accept, after balancing the potential opportunities and threats any given situation presents.

To ensure clarity, we have broken down our approach to expressing our risk appetite into the five main types of risk facing the majority of NHS provider organisations within our own context and terminology – namely quality, financial and operational sustainability, regulation, people, and reputation.

Quality

Providing the best care and treatment we can is our purpose. We will actively avoid risks to the quality of clinical services and will take a cautious and balanced

approach. Where innovation may improve quality of care, we will however be more open to risk.

When making significant decisions about our services, we will assess and record any risks affecting safety, patient experience and clinical effectiveness, and apply the necessary control measures. The impact of changes on quality will be monitored continuously and reported using both quantitative data and qualitative intelligence.

People

We aim to provide a supportive and inclusive culture and working environment, in which both individuals and teams can thrive. We recruit, develop and train current as well as future staff. To achieve our goals in respect of quality services and financial sustainability we will need to take significant decisions about services that will affect our people and may impact their working arrangements. We are therefore open to risk where we can demonstrate longer-term benefits to patients from our decisions. In arriving at those decisions, we will engage with our staff to shape our proposals, to maximise the positive impact on patient care and mitigate any potential adverse impact on staff.

Financial and operational sustainability

We aim to be a highly productive organisation that consistently delivers on all our constitutional performance standards whilst demonstrating public value for money with integrity and probity. We aim to continuously improve and innovate in the best interests of our patients, staff and communities.

We are therefore open to seek out risk through innovative approaches, subject to appropriate procedures and controls.

Regulation

Our first aim is to provide safe and effective patient care, alongside an efficient use of resources. We use our regulated status to provide assurance of the quality of the services that we provide, the environment that we operate within and our efficiency. Our regulatory environment assists us in promoting outstanding patient care, working in collaboration with health and social care partners. We are therefore open to this risk.

Reputation

We are an outward-looking organisation and are determined to contribute fully to partnership working within our system and beyond, for example with other health and social care organisations, local authorities, education partners, and the voluntary, community and faith sectors. Involvement of patients and the public is important to us, and we proactively include them and their representatives as part of our decision-

making processes. We are open to reputational risk in that we may take decisions which may attract challenge when we can clearly demonstrate that they will achieve at least the same, if not better, outcomes for our patients, workforce and the communities we serve.

Risk ID	Executive lead**	Risk description	Strategic objective at risk	Current rating	Target rating	Risk appetite
224	COO	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	1	20 (L5xC4)	8 (L2xC4)	Open
1215	COO	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	1	20 (L4xC5)	6 (L3xC2)	Open
134	CFO	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington &	3	20 (L5xC4)	12 (L4xC3)	Open

		Halton				
2001	EMD	If services remain fragile or the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	1	20 (L5xC4)	6 (L2 xC3)	Minimal
1114	EMD	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (L4xC4)	5 (1x5)	Minimal
1372	EMD	If the Trust is unable to procure a new Electronic Patient Record, then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	3	16 (L4xC4)	8 (L2xC4)	Cautious
2273	CSPO	If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it	3	16 (L4xC4)	9 (L3 xC3)	Seek

		may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances				
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	16 (L6xC4)	8 (L2xC4)	Minimal
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	12 (L3xC4)	8 (L2xC4)	Open
1757	EMD	If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.	1	12 (L4xC3)	8 (L4 xC2)	Cautious
2253	CSPO	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder	1,2,3	6 (L2xC3)	2 (1LxC2)	Open

		the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management. In addition, following the completion of due diligence work, there is an increased risk that previously unidentified financial, operational, or regulatory issues may remain unaddressed, then it could compromise the enlarged organisation's ability to deliver safe, effective, and sustainable services if integration does not proceed				

Strategic Objective 1: We will…always put our patients first delivering safe and effective care and an excellent patient experience.
Strategic Objective 2: We will…be the best place to work with a diverse and engaged workforce that is fit for now and the future.
Strategic Objective 3: We will...work in partnership with others to achieve social and economic wellbeing in our communities.

***Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Finance Officer (CFO), Chief People Officer (CPO), Executive Medical Director (EMD), Chief Nurse (CN), Chief Strategy and Partnerships Officer (CSPO)*

1.6 Going concern disclosure

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.

2. Performance Analysis

2.1 Performance measures, KPIs, links to risk and uncertainties

The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed and refreshed at least annually.

The PAF sets out the approach the Trust undertakes to ensure there are effective systems in place to monitor, manage and improve performance. Prompt reviews will be undertaken where performance is deteriorating, and appropriate actions will be implemented to bring performance back to an acceptable level.

The PAF:

1. sets out clear lines of accountability and responsibility for delivery of performance from ward to Board
2. ensures performance objectives are agreed and transparent measurements are set to monitor performance against these standards, targets and plans
3. ensures performance delivery is focused and is seen as a continual process which is embedded in all aspects of organisational activity
4. provides assurance to the Board, governors, stakeholders and the public that the organisation has strong systems in place to deliver the highest standards of patient care
5. supports the achievement of the Trust's objectives
6. supports the delivery of the requirements of the Trust Foundation Licence, NHS Improvement Oversight Framework and the NHS Standard Contract
7. provides focus on and assurance of best value for money, ensuring that services meet the needs of the local population and local health economy
8. supports the delivery of an engaged and motivated workforce with the right skills and capacity to provide consistent, good quality care
9. recognises good performance and improvement, and shares good practice
10. sets out the process for managing performance risks/issues with a balance between challenge and support

The Trust Board meets bi-monthly and receives the Integrated Performance Report (IPR) which is presented with explanation from the executive directors. The Trust Board may request one or more performance improvement actions where there is a concern with any area of performance.

The IPR Dashboard contains the following elements which are designed to provide the Trust Board with assurance around the performance of the Trust against the KPIs and to highlight areas of improvement and good practice:

1. Exception Report – the front section of the document is an exception report which summarises all KPIs by both Assurance and Variation Category. This is followed by a report of KPIs consistently failing to meet set targets, and KPIs indicating special cause variation of

a concerning nature. This section also contains additional information around the Trust's financial performance including the capital programme.

2. Assurance and Variation Movements – this section details areas of special cause variation across all KPIs using Statistical Process Control (SPC) Assurance and Variation Icons (supported by NHS England as part of the "Making Data Count" initiative). Also detailed is whether KPIs are achieving their set targets.

3. Dashboard – The dashboard details current and historic levels of performance, reasons for underperformance and/or performance deterioration, and details of actions and investigations underway in order to improve performance against KPIs. Wherever possible KPIs are presented as Statistical Process Control charts which look at data over time to determine if a process is within control or not, or whether there is special cause variation which requires action.

There is an annual rolling programme of auditing of KPIs to ensure there is assurance around the quality of the data and reporting processes which are facilitated by the Trust's internal auditors MIAA.

Trust Strategic Objectives

The Performance Assurance Framework tracks the key performance indicators required to achieve the Trust's 12 Strategic Objectives for 2025/26:

Key Performance Indicators

OPERATIONS – ACCESS AND PERFORMANCE	FINANCE
1. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC) 2. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC) 3. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge 4. Average time in department ED 5. Ambulance Handovers within 15 minutes 6. Ambulance Handovers within 30 minutes 7. Ambulance Handovers within 45 minutes 8. Type 5 attendances 9. Patients seen in the Fracture Clinic within 72 hours 10. Diagnostic Waiting Times 6 Weeks 11. Referral to treatment Open Pathways 12. Referral to treatment - Number of patients waiting 52+ weeks 13. 28 Day Faster Cancer Diagnosis Standard 14. Cancer 31 Day Wait 15. Cancer 62 Day Wait 16. Reduction in Outpatient Follow Ups compared to 19/20 activity 17. Elective Recovery Activity (Grouped SPCs) 18. Elective Recovery Diagnostic Activity (Grouped SPCs) 19. Elective Outpatient Activity 20. Super Stranded Patients 21. COVID-19 Recovery Cancer First Treatment 22. Patient Initiated Follow Up (PIFU) Activity Levels 23. No Criteria to Reside (NCTR) 24. % Patients discharged to their usual place of residence 25. Cancelled Operations on the day for a non-clinical reason 26. Cancelled Operations on the day for a non-clinical reason 27. Capped Theatre Utilisation	1. Trust Financial Position 2. Cash Balance 3. Capital Programme 4. Better Payment Practice Code 5. Cost Improvement Programme – In year 6. Cost Improvement Programme recurrent – In year 7. Agency Reduction 8. Bank Reduction

WORKFORCE	QUALITY
1. Supporting Attendance 2. Turnover 3. Core/Mandatory Training 4. PDR compliance	1. Number of incidents open over 40 days 2. Total Incidents recorded in month 3. Total PSIIs recorded in month 4. Number of never events reported in month 5. Methicillin-resistant Staphylococcus aureus (MRSA) 6. MSSA 7. Clostridium difficile 8. Escherichia coli (E-Coli) bacteraemia 9. Klebsiella 10. Pseudomonas aeruginosa 11. Venous thromboembolism (VTE) month, however this indicator is reported quarterly. 12. Total number of inpatient falls which have occurred in month. 13. Total number of falls which have occurred in month 14. Moderate and above inpatient and ED falls 15. Inpatient Falls per 1000 bed days in month 16. Total Pressure Ulcers (Categories 2 and above) 17. Total Pressure Ulcers (Category 2) 18. Total Pressure Ulcers (Category 3) 19. Total Pressure Ulcers (Category 4) 20. Community Acquired Pressure Ulcers 21. % Medication reconciliation within 24 hours 22. % Medication reconciliation throughout the inpatient stay. 23. number of medication incidents WHH 24. number of medication incidents BW 25. % Medication reconciliation within 24 hours - Community 26. Staffing - Average Fill Rate - Day nurses/midwives 27. Staffing - Average Fill Rate - Day care staff 28. Staffing - Average Fill Rate - Night nurses/midwives 29. Staffing - Average Fill Rate - Night care staff 30. HSMR 31. SHMI 32. Total number of cases over 6 months old in month. 33. Complaints - Dissatisfies opened in month 34. Complaints - New Complaints 35. Number of PALS complaints received and closed in month

	36. Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service? 37. Percentage of AED (Accident and Emergency Department) patients responding as “Very Good” or “Good” Patients are asked - Overall, how was your experience of our service? 38. Number of MSA breaches in month (ITU). 39. Sepsis Emergency Patient Screening 40. Sepsis Emergency Patient Screen Blood cultures within 1 hour 41. Sepsis Emergency Patient Screen Lactate within 1 hour 42. Sepsis Inpatient Screening 43. Sepsis Inpatient Patient Screen Blood cultures within 1 hour 44. Sepsis Inpatient Patient Screen Lactate within 1 hour 45. Sepsis Emergency Patient Antibiotics (within 1hr) 46. Sepsis Emergency Patient Antibiotics (within 6hrs) 47. Sepsis Inpatient Screening (within 1hr) 48. Sepsis Inpatient Screening (within 6hrs) 49. Number of hospital acquired Acute Kidney Injuries (AKI) in month 50. Number of community acquired Acute Kidney Injuries (AKI) in month 51. Average Length of Stay (LoS) of patients within a AKI. 52. To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Regional Dashboard 53. The % of patients treated in line with Best Practice Tariff (BPT) 54. % of patients receiving surgery within 36hrs of admission 55. MUST Nutrition assessment completion

2.2 Detailed analysis and explanation of the financial and operational performance

Performance against equality of service delivery

The Trust continues to strengthen its performance against equality of service from an experience and inclusion perspective. Information relating to ethnicity, deprivation and other protected characteristics is accessible as part of the Key Performance Indicator dashboards.

Summary activity

Activity	2025/26	2024/25	% Change from 2024/25
Elective Inpatient Discharges	3391	3511	-3.42%
Elective Day Case Discharges	30383	29473	3.09%
Non-Elective Discharges	26530	26497	0.12%
New Outpatient Attendances (including virtual)	117509	110408	6.43%
A&E Attendances^	146995	144950	1.41%

^Includes A&E, UTC & SDEC

Delivering the four-hour standard

4-Hour Performance Type 1 & Type 3 Excluding Widnes UTC Activity 2025/26														
	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
% Departed <= 4 Hours	76% by March 2026	64.75%	64.61%	64.78%	62.30%	62.87%	64.83%	62.95%	64.91%	62.62%	63.26%	62.64%	65.96%	**63.89%**
Number of Attendances		10547	10861	10327	10945	9867	10080	10668	10236	10106	9757	8796	10384	**122574**
Number of Breaches		3718	3844	3637	4126	3664	3545	3952	3592	3778	3585	3286	3535	**44262**

4-Hour Performance Type 1 & Type 3 Including Widnes UTC Activity 2025/26*														
	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
% Departed <= 4 Hours	76% by March 2026	68.66%	68.94%	69.18%	66.96%	67.42%	69.05%	67.46%	68.94%	67.26%	68.35%	67.88%	70.58%	**68.40%**
Number of Attendances		12153	12459	11866	12584	11309	11543	12229	11763	11742	11381	10293	12128	**141450**
Number of Breaches		3809	3870	3657	4158	3685	3572	3979	3653	3844	3602	3306	3568	**44703**

The delivery of the four-hour urgent care standard has continued to be challenging with Warrington consistently ranked in the lower quartile of the national league tables.

A series of improvement initiatives have been rolled out in year to support streaming away from the Emergency Department and increased use of SDEC and other assessment areas. Despite these initiatives a growth in A&E attendances of 1.75% has still been seen.

Performance has continued to be impacted by a high number of patients with ‘no clinical right to reside’, with circa 24% of the available acute general adult beds being occupied by a patient with no clinical right to reside. The Trust continues to work closely with

community and local authority partners to overcome these challenges, as well as increasing bed capacity to meet the increased demand for services.

Diagnostics waiting times

The diagnostic performance has delivered against the target of <5% of patients waiting more than six weeks for a diagnostic test and has consistently been in the top quartile across the country for performance.

Diagnostics 6+ Week Waiters 2025/26													
	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% of Patients Waiting 6+ Weeks	5%	3.87%	3.76%	3.81%	3.95%	4.06%	3.80%	3.64%	3.12%	3.45%	3.05%	1.62%	2.85%
Number of Patients Waiting		6900	7269	6870	6252	5763	5657	5766	5674	5598	5675	7220	7618
Number of Patients Waiting 6+ Weeks		267	273	262	247	234	215	210	177	193	173	117	217

Referral to Treatment (RTT) waiting times

Submitted RTT 18 Weeks Performance 2025/26													
	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Incomplete Pathways % <18 Weeks	92%	56.55%	56.48%	56.78%	57.15%	57.00%	59.39%	60.08%	60.54%	61.10%	61.48%	63.02%	65.27%
Number of Incomplete Pathways		34476	33115	32561	33334	32519	32482	32754	32613	33189	33269	33711	33132
Number of Patients Waiting 18+ Weeks		14981	14413	14074	14282	13982	13191	13076	12868	12912	12814	12468	11506
Number of Patients Waiting 52+ Weeks		1528	1537	1635	1619	1497	1294	1279	1089	929	859	564	244
Number of Patients Waiting 65+ Weeks		124	135	130	56	33	31	17	11	1	0	1	4
Number of Patients Waiting 78+ Weeks		8	6	8	8	6	1	1	0	0	0	0	0

The Trust did not achieve the 18-week referral to treatment standard in 2025-26. The focus has remained on recovery for clinical priority patients and long-waiting patients. This has seen a reduction in the number of patients waiting more than 52 weeks for treatment to under 1% of the total waiting list. The Trust has delivered an RTT performance of 65.27% year end position.

Throughout the year the Trust has complied with all national elective restoration and recovery guidance. The Trust continues to undertake a recovery elective programme with:

1. urgent cancer and elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of vulnerable patients

2. prioritisation of P2, 52- and 65-week breaches for scheduling into capacity

3. 2026-27 planning submission in line with current national and local guidance for reduction of waiting lists has been completed

4. harm assurance on all long-waiting patients which continues to be undertaken. Patients are prioritised through using a clinical urgency score which identifies the most at-risk patients

5. funding that was approved for 2025-26 to use insourcing to support the reduction in the waiting list. This has been used to support reducing the number of patients waiting more than 52 weeks. Insourcing will continue in 2026-27.

National discharge policy – no criteria to reside

In March 2020 the national policy Hospital Discharge and Community Support: Policy and Operating Model was published and provided discharge-to-assess funding via the NHS to help cover the cost of rehabilitation and reablement care following discharge from hospital. There is a continued policy requirement that health and social care systems will build upon this work referenced in the revised guidance Hospital Discharge and Community Support Guidance published on 31 March 2022.

Whilst funding arrangements have changed, the essence of the policy requires trusts to adopt the discharge-to-assess principles where full assessment of need, especially long term, takes place in a more appropriate setting outside the hospital delivering:

1. a reduction in the length of stay for people in acute care

2. improvements in people's outcomes following a period of rehabilitation and recovery

3. a minimised need for long-term care at the end of a person's rehabilitation

Central to the approach is the stratification of patients' needs firstly into their right to reside and then onto simplified pathways (pathway 1 for home, pathway 2 for rehabilitation and pathway 3 for care homes) and the establishment of a transfer hub to oversee the initial assessment of need and co-ordination of discharge.

Achieving the ambitions for people, ensuring system flow, and supporting our system vision to support people to live well and independently at home requires investment in the hospital discharge team function and additional community service capacity so people can be discharged to the right destination.

The Warrington and Halton system strategy of developing integrated care aims to help support people to:

1. receive the right care in the right location at the right time

2. have a 'home first' focus wherever possible

3. ensure that stays in acute settings are for the right length of time, and that people move from an acute setting, to continue their recuperation most appropriate to their needs

4. ensure system capacity is optimised for those who need the care most

The vital role that the Hospital Transfer of Care Hub (formerly Discharge Team), reablement at home and domiciliary care plays is largely acknowledged, however there

are significant challenges with the current staffing model within the team. Investment proposals have been progressed to build on current good practice and deliver:

1. a change to the discharge model to a ‘pull’ model – the team actively seeks out patients with no criteria to reside and plans their transfer

2. a diversification of the skill mix within the team, creating case manager roles as single points of contact for wards and families for discharge planning and co-ordination

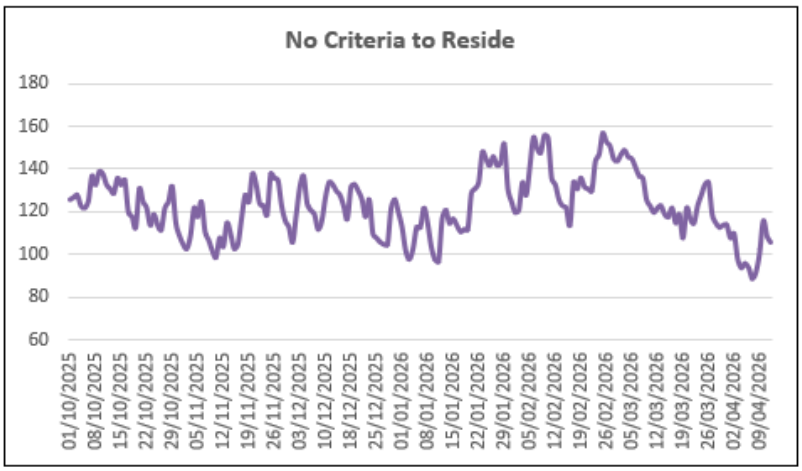
3. building on the transfer hub established to optimise resources towards ensuring the right amount of care is provided in the right place, and enhancing from a five to a seven-day service

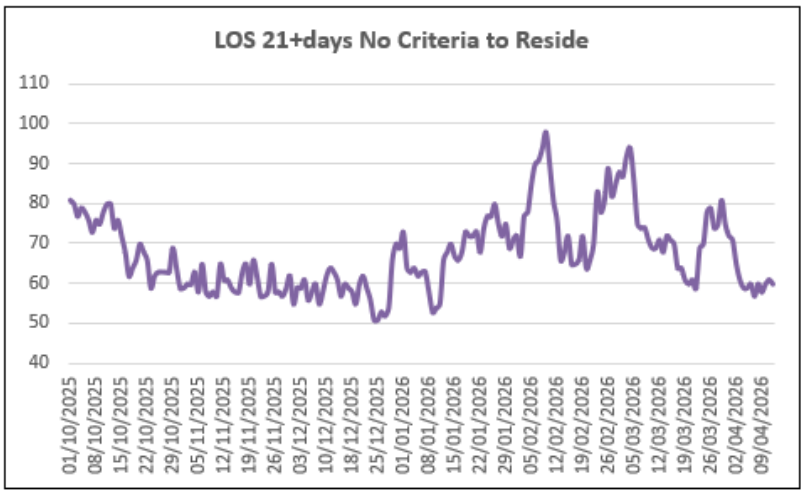
4. an enhancement of the staffing establishment in ICAHT and domiciliary care to promote independence and optimise flow, achieving a next day discharge for 80% of patients

The number of patients with a ‘clinical no right to reside’ has remained higher than the national average. In-year extensive partnership working across the health and social care economy ensured that patients were supported to return home or on to more appropriate care settings once their acute care was complete, thus ensuring that beds remained available for incoming patients.

The successful discharge of frail, older patients following emergency admission to hospital relies on effective joint working between NHS, social care partners and the independent sector. Early assessment and review using the most appropriate multidisciplinary team at the point of entry to urgent and acute services is essential for frail older patients to ensure a timely and appropriate diagnosis is made, and then a plan for discharge can be implemented.

The charts below show the number of patients who have no criteria to reside and the number who are over 21 days and classified as super stranded.





Cancer waiting times and regulatory requirements

Performance against the three key headline standards has been challenging throughout 2025-26 but this is in line with the regional and national picture:

The 28-day faster diagnosis standard (28 days FDS) which requires patients referred from GPs as urgent suspected cancer or a national screening programme to have cancer diagnosed or excluded within 28 days has been the most difficult of the three across the year. There have been a number of challenged priority pathways which have been subject to a programme of improvement during the year. This has included the implementation of an FDS nursing team for lower GI which has streamlined the front end of the pathway, the introduction of a Community Diagnostic Centre for gynae suspected cancer patients, and funding to support MRI scanning for suspected prostate cancer patients which has allowed for better capacity planning in the pathway for subsequent investigations. This has led to a sustained improvement in performance month on month with March 2026 performance on track to meet the 80% requirement. This has been a true collaborative approach to improvement between Cclinical teams, CBU Management and the Cancer Team with support from Cheshire and Merseyside Cancer Alliance.

The operational standard for 2026-27 will remain at 80% and will be calculated as an aggregate performance across the year.

The 62-day referral to treatment standard includes referrals from GPs, the national screening programme and consultant upgrade patients. The Trust has streamlined and updated the consultant upgrade process which has ensured that more patients are consistently upgraded, ensuring a safer process for patients who are not referred via their GP or a screening programme. Performance has been maintained above trajectory and the 75% commitment for the whole year which has seen the organisation ranked in the top 10 for this standard on a number of occasions.

The requirement for 2026-27 is that the 62-day standard achieves 80%.

The 31-day standard combines the 31 days from decision to treat to first treatment, and 31 days to subsequent treatment from the earliest clinically appropriate date (ECAD). The operational standard of 94% has been consistently met during 2025-26.

The operational standard remains unchanged for 2026-27.

Cancer waiting times and regulatory requirements

Cancer Waiting Times 2025/26													
	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
All Cancers 31-Day Wait from Diagnosis to First Treatment	96%	97.2%	98.4%	98.0%	99.0%	97.2%	98.9%	97.4%	96.9%	98.2%	99.3%	98.6%	100.0%
All Cancers 62-Day Wait for First Treatment - From Urgent GP Referral	85%	78.7%	80.8%	78.4%	77.9%	79.1%	77.3%	85.6%	84.0%	80.4%	84.2%	79.7%	81.6%
28-Day Faster Diagnosis	75%	73.7%	72.0%	74.0%	74.1%	72.0%	74.3%	75.5%	76.7%	77.6%	77.7%	78.6%	80.6%

2.3 Financial performance

The Trust's resources are managed within a financial governance framework that incorporates systems of financial control, budgetary control and the financial responsibilities for individuals outlined within the Trust's corporate governance policies and procedures. Financial and quality governance arrangements incorporate benchmarking activities and an internal audit function to ensure the economic, efficient and effective use of resources, including value for money.

Financial performance is reported into the non-executive led Finance, Sustainability and Performance Committee in Common, which meets monthly. Standing items on the agenda include the monthly financial position, CIP position, cash support requirements, capital schemes and cost pressure analysis to ensure regular review of any financial challenges and implementation of recovery measures.

The Trust has a policy and governance framework in place to guide staff on the appropriate use of resources through its Standing Orders, Standing Financial Instructions and Scheme of Delegation. In addition, there is a robust system for developing and routinely reviewing policies and procedures, and staff are appropriately updated and guided or trained on their application.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by counter fraud. Reports are presented to the Audit Committee in each meeting. In addition, further assurance on the use of resources is obtained from external agencies, including the external auditors and the regulators.

The Trust recorded an adjusted deficit of £40.7m which is £12.0m away from the £28.7m deficit plan (excluding deficit support funding). This adjusted deficit is the value which NHSE monitors the Trust against.

The annual capital programme started at £30.2m (including IFRS16 and donated assets), was reduced to £20.9m and the actual spend for the year was £20.8m.

The cash balance at the end of the year was £24.9m. The cash balance will be utilised to pay both capital (£11.7m) and revenue creditors.

(*For a detailed report please see the accounts section*)

2.4 Health Inequalities

Warrington and Halton Hospitals NHS Foundation Trust

1. Introduction

This chapter fulfils NHS England's requirement to publish information on healthcare inequalities in line with the 2025 Statement on Information on Health Inequalities. It demonstrates how the Trust has exercised its functions consistently with NHS England's views by collecting, analysing and publishing inequalities data throughout the year, and by embedding this insight into planning, commissioning, service redesign and governance.

To ensure full alignment with national expectations, the chapter is structured around the five Key Lines of Enquiry (KLOEs) and the three domains of the Measurement Framework. These frameworks shape how NHS bodies must understand population needs, improve data quality, analyse access and outcomes, act on inequalities, and publish information transparently.

The tables below summarise how this chapter aligns to these national requirements and provide a roadmap for the sections that follow.

How this chapter aligns with NHS England's KLOEs

This chapter is organised to mirror the five KLOEs, ensuring a clear line of sight between national expectations and local delivery.

Table 1. Alignment to the five KLOEs

KLOE	What NHS England expects	Where evidenced
1. Understanding population needs	Use JSNAs, CIPHA, Core20PLUS5, PLUS groups, qualitative insight	Section 2
2. Improving data quality	Improve ethnicity, disability, SOGI recording; triangulate datasets	Section 3
3. Understanding access, experience and outcomes	Disaggregate data; analyse drivers of variation	Section 4 and 5
4. Using information to act	Show how data informed decisions and redesign	Section 5
5. Publishing information	Embed inequalities in governance and reporting	Section 6

How this chapter aligns with the NHS England measurement framework

The Measurement Framework requires NHS bodies to report on three domains: Operational Priorities, Core20PLUS5, and Data Quality. The chapter uses these domains to organise the analysis of access, experience and outcomes.

Table 2. Alignment to the NHS England measurement framework

Domain	Required Areas	Where Reported
Operational Priorities	Elective care; Urgent & Emergency Care	Section 4.1 & 4.2
Core20PLUS5 – Adults	Maternity, Respiratory, Smoking, CVD, Cancer, LD&A	Section 4.4
Core20PLUS5 – CYP	Asthma, Diabetes, SEND/LD&A, Oral Health, Mental Health	Section 4.4
Data Quality	Ethnicity completeness; SOGI; disability	Section 3

2. Understanding population health needs (KLOE 1)

Our understanding of local health needs is based on the latest Joint Strategic Needs Assessments (JSNAs) for Warrington and Halton, which provide a comprehensive picture of demographics, deprivation, health outcomes and service use across both Places. These insights help us identify where need is greatest and where inequalities are most pronounced.

2.1 Population overview

Table 3. Summary of Trust catchment population characteristics

Indicator	Warrington	Halton
Population size	~210,000	~132,000
Ethnic diversity	11.9% minority ethnic groups	3.5% minority ethnic groups
Deprivation	Mixed profile; pockets of high deprivation	16th most deprived Local Authority area in England
Life expectancy	M: 78.7 yrs / F: 82.2 yrs	M: 77.1 yrs / F: 80.5 yrs
Healthy life expectancy	M: 63.4 yrs / F: 64.3 yrs	M: 56.6 yrs / F: 56.8 yrs

Warrington and Halton Hospitals NHS Foundation Trust (WHH) serves two communities with some of the most entrenched health inequalities in England. Over 40% of Halton residents and 20% of Warrington residents live in the most deprived quintile nationally. Life expectancy varies by more than ten years between neighbourhoods, and many residents spend their final 15 years in poor health.

2.2 Deprivation and service use

Deprivation has a major influence on how people use health services and the types of conditions they present with. The table below summarises two key indicators that help us understand how avoidable hospital admissions and inequality differ between Warrington and Halton.

Table 4. Inequality indicators

Indicator	Warrington	Halton
ACSC rate (per 100,000)	1,921	3,236
AGI (inequality gradient)	1,309 (moderate)	4,389 (very high)

ACSC stands for *Ambulatory Care Sensitive Conditions*. These are health problems — such as asthma, diabetes or heart failure — where people often do not need to be admitted to hospital if they receive timely support in the community. Halton's ACSC rate is much higher, meaning more people are being admitted for conditions that could often be managed earlier or outside hospital.

AGI stands for *Absolute Gradient of Inequality*. It shows how big the gap is between the most and least deprived areas when it comes to these avoidable hospital admissions.

- A higher AGI means a larger gap between communities.
- Halton's AGI is very high, which means avoidable admissions are heavily concentrated in the most deprived neighbourhoods.
- Warrington's AGI is moderate, meaning the difference between areas is smaller.

Put simply, Halton has more avoidable hospital admissions overall, and these admissions are far more common in its most deprived communities, showing a much steeper inequality gap than in Warrington.

2.3 Core20 and PLUS groups

Alongside the most deprived 20% of the population (the "Core20"), local insights highlight several groups who face additional barriers to accessing care. These "PLUS" groups include people from minority ethnic backgrounds, Gypsy, Roma and Traveller communities, LGBTQ+ residents, people with learning disabilities or autism, refugees and asylum seekers, veterans, and those experiencing digital exclusion or multiple long-term conditions.

These groups often experience poorer access, later presentation, and worse outcomes, and therefore require tailored approaches to engagement and service design.

2.4 Children and young people

The JSNAs highlight several challenges affecting children and young people across both Places. Halton experiences higher levels of child poverty, which is linked to poorer educational outcomes, increased safeguarding concerns and higher rates of asthma and dental decay. Warrington's growing diversity is reflected in rising demand for culturally responsive services, particularly in urban wards. Across both Places, mental health needs among children and young people continue to rise, and neurodevelopmental pathways face significant pressure.

2.5 Women, men, ethnic minorities, LGBTQ+ communities and veterans

The JSNAs also highlight important differences in health outcomes and access across population groups:

- **Men** in Halton have lower life expectancy and higher rates of premature mortality.
- **Women** in both Places live longer but spend more years in poor health, particularly in later life.
- **Ethnic minority communities** face barriers linked to language, trust, and digital exclusion, contributing to later presentation and lower screening uptake.
- **LGBTQ+ residents** experience higher rates of mental health need, but limited sexual orientation and gender identity (SOGI) data makes it difficult to fully understand outcomes.
- **Veterans** are more likely to experience PTSD, chronic pain and fragmented pathways between military and civilian services.

These insights help shape our approach to targeted prevention, personalised care and inclusive service design.

3. Improving data quality, collection and analysis (KLOE 2)

High-quality data is essential for understanding who uses our services, where inequalities exist, and how we can target improvement. During 2025/26 we strengthened our approach to data quality and insight across the Trust.

3.1 Progress in 2025/26

- Strengthened recording of disability, language and communication needs
- Introduced a Health Equity Dashboard using CIPHA
- Linked datasets across emergency, elective and maternity pathways
- Expanded the use of qualitative insight (Living Well, PREMs, FFT, Experts by Experience)

Although improving ethnicity completeness remains a priority, progress this year was limited while we prepared for the procurement of a new electronic patient record system, which will support more accurate and consistent data capture at source.

3.2 Remaining challenges

- Inconsistent SOGI (sexual orientation and gender identity) recording
- Incomplete ethnicity data in some services
- Variation in coding quality between acute and community settings

These gaps affect our ability to fully understand inequalities and remain a key focus for improvement.

3.3 Opportunities

A significant development this year has been the creation of the Trust Health Inequalities Dashboard on the CIPHA Cheshire and Merseyside portal. WHH provided leadership for this work, which was delivered in partnership with Mersey and West Lancashire NHS Foundation Trust (MWL), the Integrated Care Board and other Trusts. The dashboard draws ethnicity information directly from GP records, giving us a more complete and reliable view of our population than Trust-recorded data alone.

This access to GP-sourced ethnicity data is already supporting more informed planning and helping us understand variation across communities. As the new electronic patient record system comes into force, we expect to see improvements in Trust-level ethnicity recording, which will complement the intelligence available through CIPHA.

Population-rate metrics (per 100,000) will be embedded into core reporting, and further integration of datasets will support more proactive population health management and real-time monitoring of inequalities.

4. Understanding healthcare access, experience and outcomes (KLOE 3)

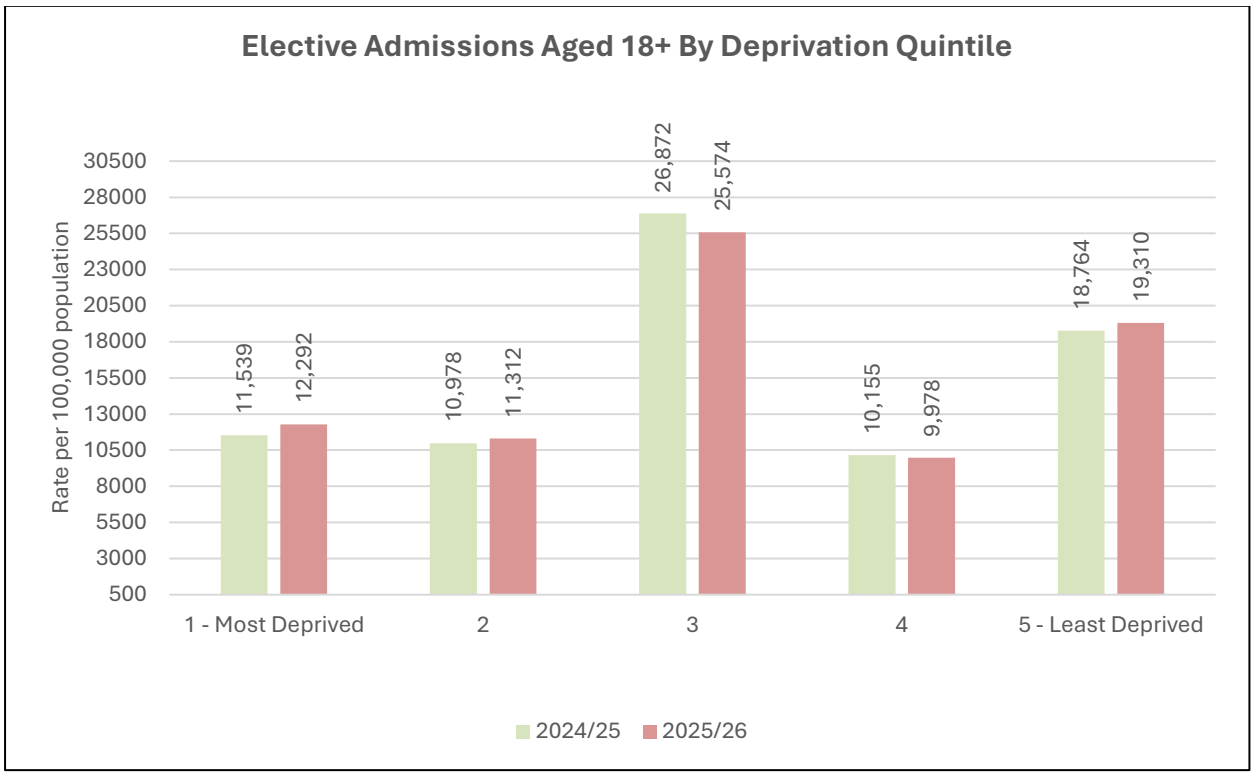
4.1 Operational priority: Elective Care

Elective admissions per 100,000 population increased slightly overall between 2024/25 and 2025/26, indicating stable access despite operational pressures.

4.1.1 Deprivation

Elective admission rates increased across all deprivation groups, with the largest improvement seen in Quintile 1 (most deprived). Rates rose more slowly in the least deprived areas, resulting in a narrowing of the inequality gap.

Figure 1: Elective admissions by deprivation Quintile (adults)

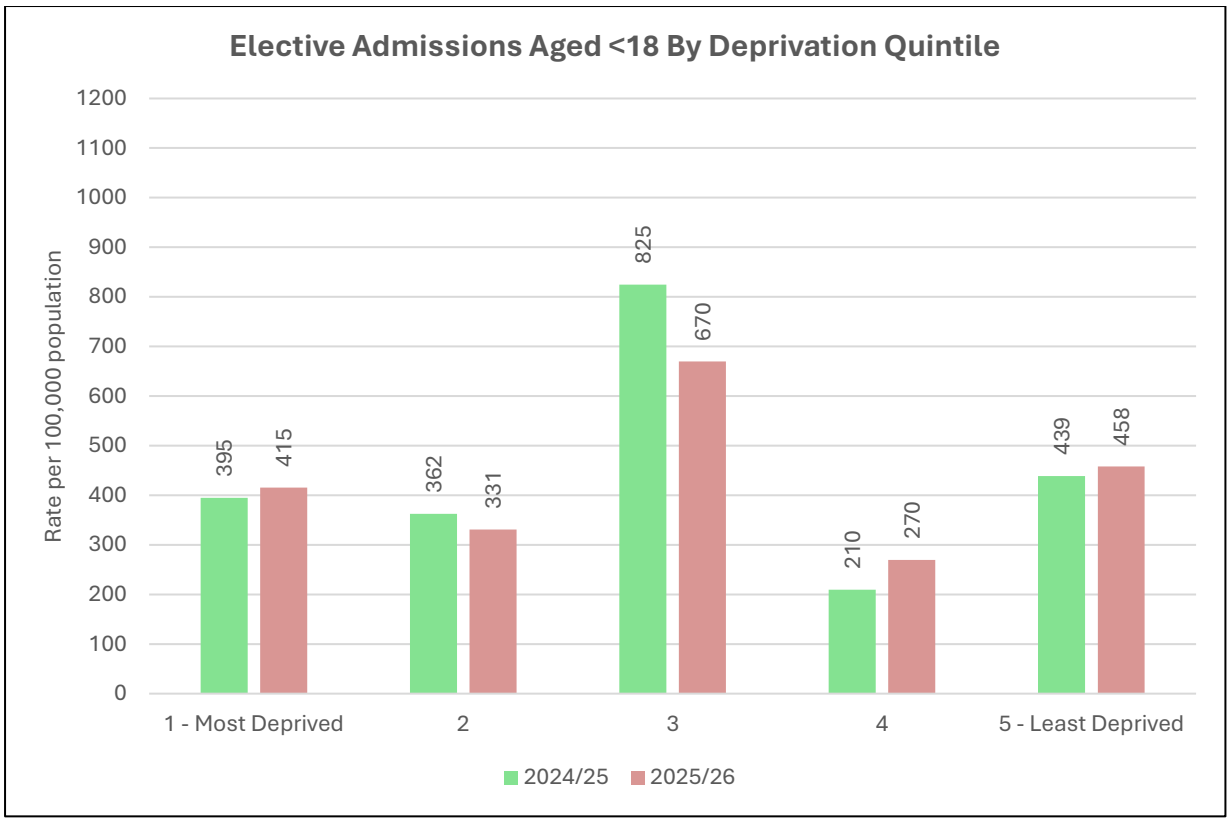


4.1.2 Children (<18)

Elective access for children remained broadly equitable.

- Rates increased slightly in Quintile 1 and Quintile 5
- Rates fell modestly in Quintiles 2 and 3
- No widening of deprivation gaps was observed

Figure 2: Elective activity for under 18s by deprivation quintile



4.1.3 Ethnicity – improved access for minority groups

When adjusted for population size:

- Black (Black British or Black African or Black Caribbean) children and adults saw the largest proportional increase in elective admissions per 1,000 population.
- Asian (Asian British or other Asian) and mixed heritage groups also saw increases.
- White (White British) residents saw only a marginal rise.

4.1.4 Age

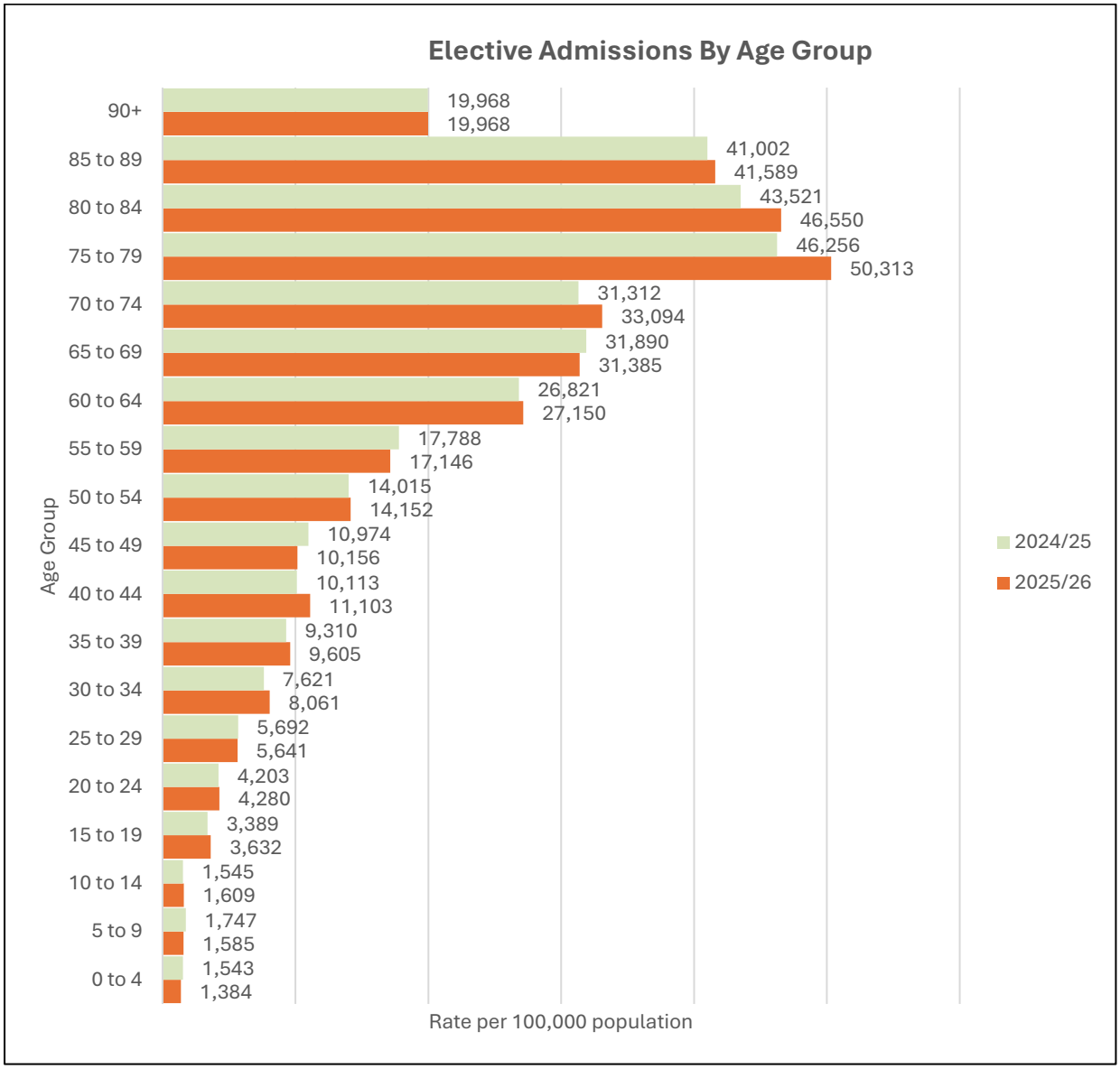
Elective admission rates rise sharply with age, with the steepest increases seen in adults aged 70 and over. This reflects both demographic pressures and higher levels of multimorbidity:

- **75–79:** 46,256 → 50,313 per 100,000
- **80–84:** 43,521 → 46,550 per 100,000

- **70–74:** 31,312 → 33,094 per 100,000

Rates for younger adults (20-49) remained stable, and rates for children and young people remained low.

Figure 3: Elective care by age group



These patterns reflect the growing ageing population across Warrington and Halton. As more people live longer with multiple long-term conditions, elective demand is increasingly driven by older adults rather than system-wide growth across all age groups.

This shift is associated with higher acuity, more complex presentations, and higher conversion rates when older adults attend hospital. *Conversion rate* refers to the proportion of people who come to hospital and then need to be admitted because their condition is serious or complex enough that they cannot be safely treated and

discharged home. Rising conversion rates indicate that a greater proportion of patients are arriving with higher levels of need.

As a result, our hospital is seeing more people who require admission, specialist input and coordinated discharge planning.

Following the formal integration of WHH and Bridgewater Community Healthcare on 1 April 2026, the enlarged organisation will take a more coordinated neighbourhood-based approach to supporting older adults and people with complex needs, through services such as virtual wards and the Urgent Community Response (UCR). Integration strengthens the links between acute, community, and neighbourhood teams, enabling earlier intervention, smoother transitions of care, and more consistent support for people to remain well at home.

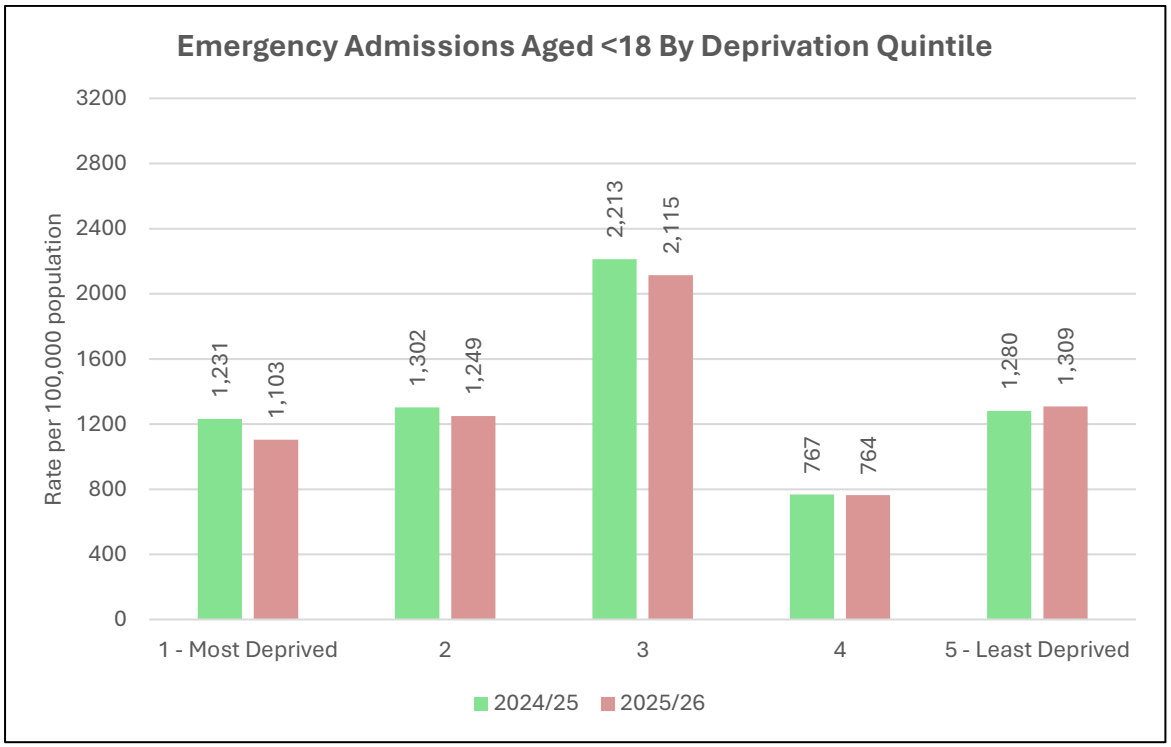
This joined-up approach will be increasingly important as our ageing population continues to drive higher acuity and rising conversion rates.

4.2 Operational priority: Urgent and Emergency Care

4.2.1 Children (<18)

Emergency admissions per 100,000 children fell overall, with the largest reductions in the most deprived areas.

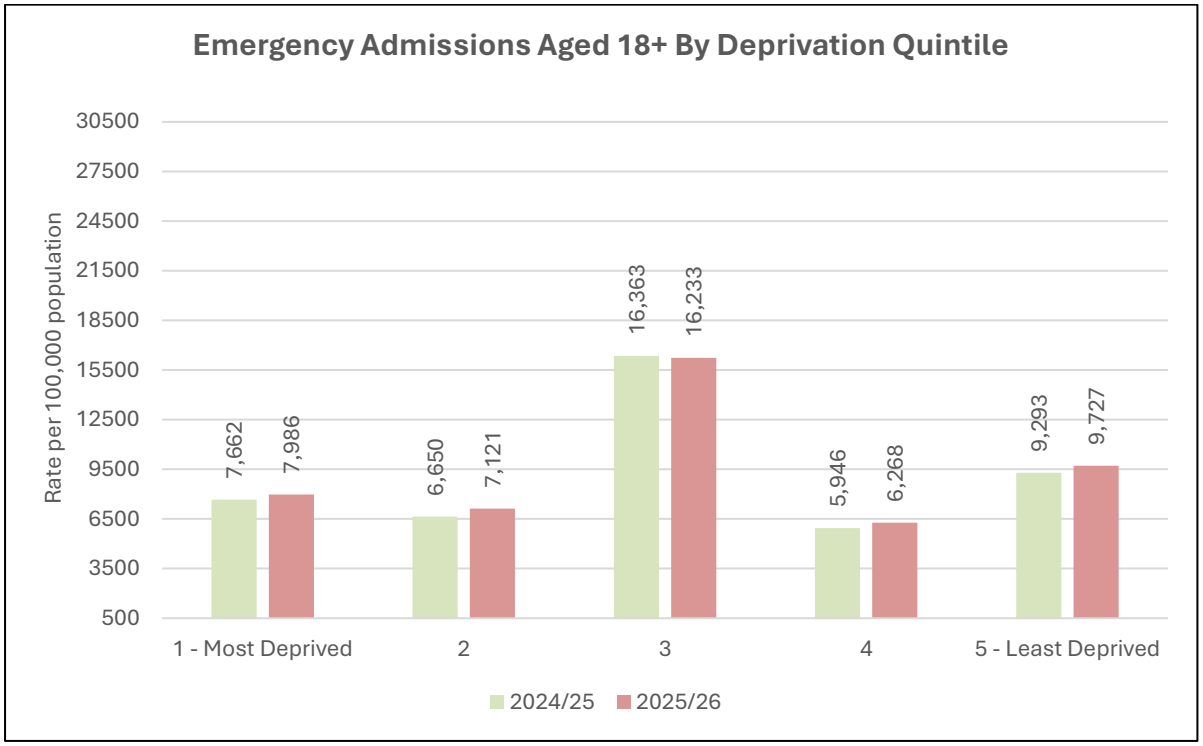
Figure 4: Emergency admissions for under 18s by deprivation quintile



4.2.2 Adults (18+)

Emergency admissions increased across all deprivation groups, with the highest increase of rates across Quintiles 1 and 2.

Figure 5: Emergency admissions for adults by deprivation quintile



4.2.3 Ethnicity

Ethnic minority groups experienced the largest proportional increases.

4.2.4 Age

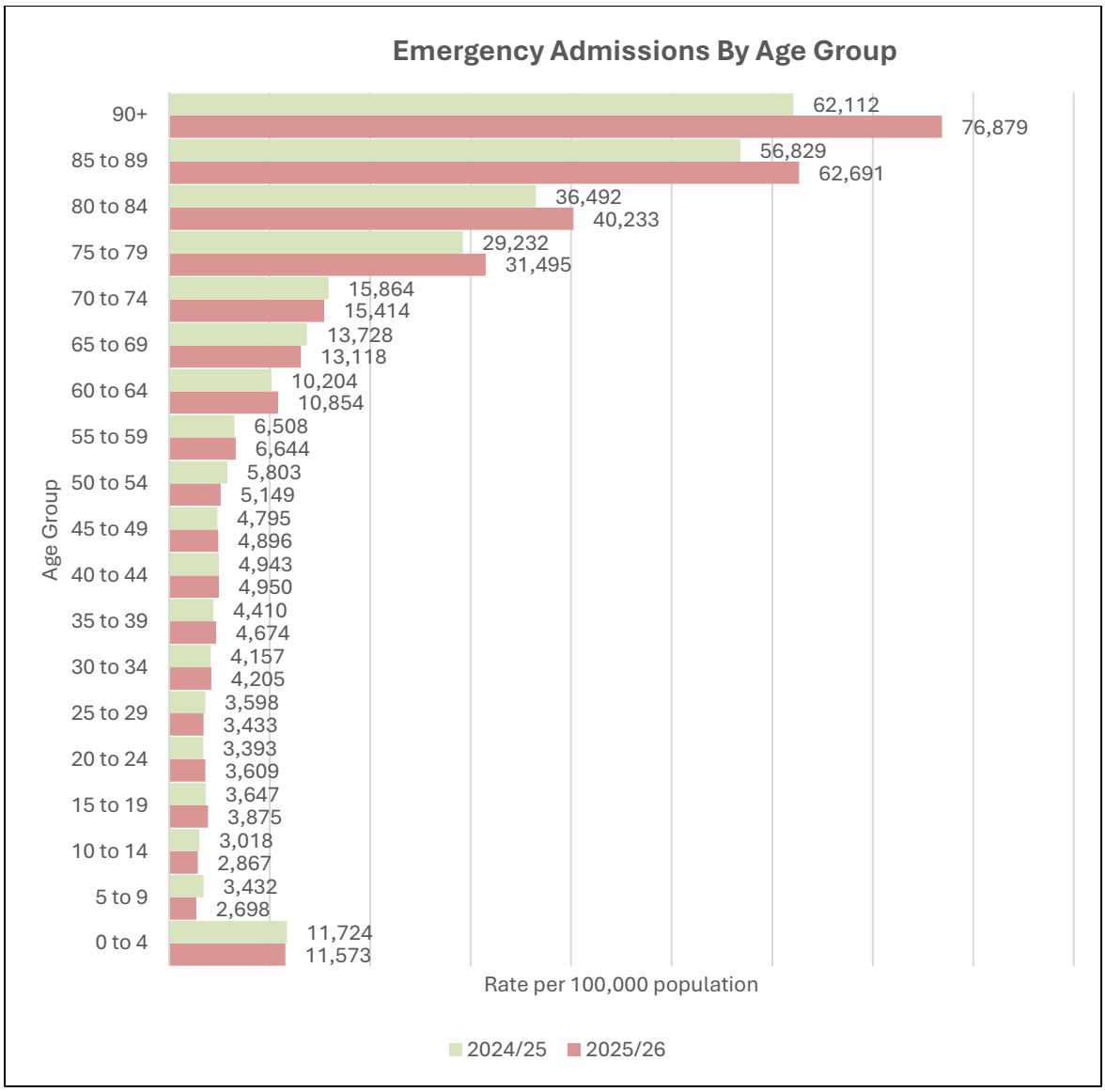
Population-adjusted emergency admission rates show a strong age gradient, with rates rising sharply as age increases. The highest rates are seen in people aged 85 and over, and these groups also experienced the largest year-on-year increases.

Between 2024/25 and 2025/26:

- 90+: increased from 62,112 → 76,879 per 100,000, the steepest rise of any age group
- 85-89: increased from 56,829 → 62,691 per 100,000
- 80-84: increased from 36,492 → 40,233 per 100,000
- 75-79: increased from 29,232 → 31,495 per 100,000

Younger adults (20–49) saw only marginal changes, and rates for children and young people remained broadly stable, with small reductions in some age bands.

Figure 6: Emergency admissions by age group



4.3 Patient experience

4.3.1 Friends and Family Test (FFT)

FFT data shows:

- Inpatient and day-case experience remains consistently high (96-98%).
- Emergency Department experience remains below target but improved in several months compared to the Cheshire and Merseyside average.
- Protected characteristic data is increasingly used to identify themes and target improvements.

4.3.2 Interpretation and translation

Demand for interpretation increased by 32%, reflecting improved identification of need and population change.

- Cantonese, Arabic, Polish, Sorani and Romanian were the most requested languages.
- 147 British Sign Language bookings were delivered, ensuring equitable access for d/Deaf patients.
- Staff now have access to a comprehensive intranet hub for interpretation, translation and accessible information.

4.3.3 Accessible Information and Health Literacy

The Trust strengthened compliance with the Accessible Information Standard through:

- A new Accessible Information and Health & Digital Literacy Policy
- Updated branding and communication style guide
- Patient information being rewritten to a reading age of 9-11 years
- Health literacy champions and training being embedded across services

These changes support equitable access for people with disabilities, low literacy or communication needs.

4.4 Patient outcomes

See section 5 below.

5. Using information to act on inequalities (KLOE 4)

5.1 Elective care and smoking cessation

Insight from population health data highlighted higher smoking prevalence and poorer elective outcomes in the most deprived communities. In response:

- Supported quit attempts increased across all deprivation groups in the latter part of the year.
- Smoking in pregnancy reduced in the most deprived areas, supported by the incentive scheme and tobacco dependency pathway.

- Targeted prehabilitation was delivered in Core20 communities to improve readiness for surgery and reduce avoidable complications.
- Health literacy approaches were embedded to support informed decision-making and self-management.

5.2 Emergency care and frailty

Emergency care data showed rising acuity and higher conversion rates among older adults. This informed:

- Expansion of services in the Living Well Hub to support earlier intervention and reduce avoidable attendances.
- Strengthening of frailty pathways, including rapid assessment, same-day support and improved discharge coordination.
- Integration with Bridgewater from 1 April 2026, enabling neighbourhood-based urgent community response and virtual ward support for people with complex needs.

5.3 Maternity

Maternity insight identified inequalities in smoking, access and outcomes. Actions included:

- Early signs of improvement in smoking at booking and non-smoker status at 36 weeks.
- Targeted tobacco dependency treatment for families in the most deprived quintile.
- Trauma-informed, culturally sensitive parent education.
- Enhanced non-clinical maternity support workers supporting families with nutrition, finances and infant feeding.

5.4 Respiratory disease

Population health data and CIPHA intelligence highlighted higher COPD prevalence and poorer outcomes in deprived areas. In response:

- COPD case-finding was strengthened using CIPHA data.
- Health literacy was embedded into respiratory pathways, improving inhaler technique and self-management.
- The Trust contributed to Warrington Borough Council’s Indoor Air Quality project for children aged 2-11

Case Study: Improving Health Literacy in Respiratory Care

Many adults in Warrington and Halton have low health literacy, which can make it harder to understand appointment letters, inhaler instructions and digital information. To explore the impact on respiratory care, the Trust worked with patients, an Expert by Experience and clinicians to review letters, consultations and digital content.

As part of this work, a short film was produced with one Expert by Experience, who is also a COPD patient. The film captured a real respiratory consultation and demonstrated how clearer explanations and teach-back can support understanding. This helped highlight the practical barriers people face and the value of simple communication changes.

The wider review identified opportunities to make information clearer. In response, respiratory letters and digital materials were reviewed, teach-back was promoted in training, and patient-facing resources were co-designed to support inhaler technique and self-management.

The learning is now informing prevention, digital and neighbourhood-based work, and health literacy is being positioned as a strategic enabler across Cheshire and Merseyside.

5.5 Digital Access

Digital exclusion remains a barrier for many residents, particularly those in the most deprived communities. Through the Living Well Hub and our digital inclusion volunteers, we have strengthened support for people who face challenges accessing online health services.

- Residents received practical support to use the NHS App, book appointments and access their health records.
- The Trust promoted the National Databank and local digital skills support, helping people without data or devices to stay connected.

This work is improving access, confidence and digital capability, ensuring that more residents can benefit from online health tools and the Patient Portal.

Case Study: Living Well Warrington – Improving Access and Reducing Inequalities

Living Well Warrington brings together digital access, community outreach and a physical hub to make it easier for residents to find support early. Since opening in 2024, the Living Well Hub recorded **over 50,000 attendances**, with **88%** of visitors coming from the most deprived areas and **9%** saying they would not have accessed any support otherwise. More than **900 Talking Points visits** took place across ten neighbourhoods, helping residents with issues such as benefits, food support, family wellbeing and mental health.

The Living Well digital platform has provided a single, trusted gateway to local services, with **93,000 views in six months** and over **700 services** now visible and searchable. Digital inclusion volunteers have supported residents to use the NHS App and access online information, helping reduce barriers linked to low confidence or limited data access.

This combined model has strengthened early intervention, improved navigation of local support, and generated over **£1.3 million in social value**, demonstrating how a co-produced, community-led approach can reduce inequalities and connect people to the right support at the right time.

5.6 Gypsy, Roma and Traveller (GRT) Outreach

Insight from JSNAs and local engagement highlighted significant inequalities for GRT communities.

Case study: Outreach with Gypsy, Roma and Traveller (GRT) communities

In 2025/26, WHH carried out targeted outreach to Gypsy, Roma and Traveller communities to better understand their experiences of accessing healthcare. This work focused on listening to residents, building trust, and gathering insight into the barriers they face when engaging with services. Activities included:

- spending time on site with GRT families
- discussing experiences of maternity, urgent care and primary care
- working through trusted community intermediaries to ensure conversations were culturally appropriate and safe

The insights gathered are now informing how we design services, improve communication, and strengthen relationships with communities who are often under-represented in mainstream engagement. This work responds directly to inequalities identified in the JSNAs and aligns with the Core20PLUS5 framework.

5.7 Making Every Contact Count (MECC)

MECC is being strengthened across the Trust as a core approach to reducing inequalities. Insight from population health data and frontline staff highlighted the need for more personalised, accessible conversations about health and wellbeing. In response:

- In-house MECC trainers were developed to build capacity across teams.
- Digital MECC prompts were piloted in the Living Well Hub to support consistent, health-literacy-informed conversations.
- MECC principles were aligned with the Health Literacy Programme, including Teach Back and Chunk and Check.

This ensures that every interaction — whether in hospital, community or neighbourhood settings — supports prevention, confidence and self-management.

5.8 Workforce inequalities

Workforce data and staff feedback informed targeted action to improve equity and inclusion:

- Trauma-informed care training to support staff working with vulnerable groups.
- Inclusive recruitment practices to widen access and representation.
- Implementation of the Reasonable Adjustments Passport to support staff with disabilities.

5.9 Leadership, governance and accountability

Strong governance has underpinned the Trust's approach to tackling inequalities. The Joint Health Equity Group strengthened oversight through the development of the Health Inequalities Action Plan, introduction of a Health Inequalities Dashboard, and starting to embed inequalities into CBU planning and quality governance. The Group also supported targeted QI projects, including improving the experiences of International Medical Graduates. From 2026/27, it will evolve into a North Cheshire and Mersey Health Equity Group, providing system-wide oversight.

Executive leadership has reinforced this focus, with health inequalities objectives embedded into Executive Performance Development Reviews and the Equalities and Health Inequalities Impact Assessments (EHIA) implemented across service change and business cases.

6. Publishing information on health inequalities (KLOE 5)

WHH:

- Reported quarterly to the Health Equity Group
- Published inequalities data in Board papers
- Developed a Trust Health Inequalities Dashboard
- Used Equalities and Health Inequalities Impact Assessments (EHIAs) across service change and business cases

From 2026/27, the new North Cheshire and Mersey Health Equity Group will oversee system-wide inequalities work.

7. Priorities for 2026/27

As we become North Cheshire and Mersey NHS Trust, our priorities are:

- Scaling prevention and early intervention
- Deepening neighbourhood working
- Strengthening Core20PLUS5 delivery
- Embedding health literacy and MECC across all pathways
- Reducing long waits for the most disadvantaged
- Improving data completeness and real-time analytics
- Enhancing digital inclusion and accessible communication

8. Conclusion

In 2025/26, WHH made significant progress in identifying, understanding and addressing health inequalities. As we transition into the new North Cheshire and Mersey NHS Trust, we are building on these foundations to deliver a more integrated, preventative and equitable health system.

Our commitment is clear: to ensure that every resident – regardless of background, circumstance or identity – can access high-quality care, experience equitable treatment and achieve the best possible health outcomes across our wider footprint.

2.5 Customer satisfaction scores

The NHS Adult Inpatient Survey has been conducted annually as part of the NHS Patient Survey Programme since its introduction in 2002. The Care Quality Commission (CQC) uses the results to inform regulatory activities and to support NHS Trusts in evaluating care standards, improving services and monitoring performance. Each year, over 130 eligible NHS Trusts across England participate in the survey.

The survey captures the experiences of patients aged 16 years and over who stayed at least one night as an inpatient during November 2024 at Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH). The survey was administered by IQVIA on behalf of the Trust, with support from the Trust Data Team, in accordance with national sampling guidance.

Between January and April 2025, questionnaires were distributed to a sample of 1,250 eligible patients, with a Trust response rate of 41%: consistent with the average response rate across all trusts. This response rate was in line with the national average and represented a 4% increase compared with the previous year. To promote participation, the survey was supported through onsite promotional posters, social media campaigns and translation of materials into the Trust's five most commonly spoken languages.

The survey is split into a total of 12 sections as follows:

- Section 1. Admission to hospital
- Section 2. The hospital and ward
- Section 3. Basic needs*
- Section 4. Doctors
- Section 5. Nurses
- Section 6. Your care and treatment
- Section 7. Individual needs*
- Section 8. Virtual wards
- Section 9. Leaving hospital
- Section 10. Kindness and compassion
- Section 11. Respect and dignity
- Section 12. Overall experience

*sections introduced since the 2023 survey.

Table 1 below shows a comparison of the 2024 survey results (published in 2025) to the 2023 survey results. This comparison highlights areas of improvement following the previous year's action plans and identifies areas requiring continued focus.

Table 1. National Adult Inpatient Survey Results 2025 compared to 2024.

Section	2024 score	2023 score
Section 1. Admission to hospital	6.0	6.5
Section 2. The hospital and ward	7.5	7.4
Section 3. Basic needs*	8.0	Not included
Section 4. Doctors	8.7	8.6
Section 5. Nurses	8.6	8.3
Section 6. Your care and treatment	8.4	8.1
Section 7. Individual needs*	8.8	Not included
Section 8. Virtual wards	7.6	7.4

Section 9. Leaving hospital	7.0	6.8
Section 10. Kindness and compassion	9.1	9.0
Section 11. Respect and dignity	9.2	9.0
Section 12. Overall experience	7.9	7.9

Performance overview

Analysis of the 2024 survey results compared with national benchmarks indicates:

- 1 question performed better than expected
- 44 questions performed in line with expectations
- 1 question performed worse than expected
- 0 questions were rated much better than expected, somewhat better, somewhat worse or much worse than expected

When results are compared to the previous year results:

- 3 questions showed significant improvement
- 35 questions showed no statistically significant change
- 0 questions showed significantly worse performance

The question that showed a decline in performance compared with the national average related to:

Section 1. Admission to hospital - question 7: How long did you have to wait before you were admitted to a ward?

Improved performance compared with the national average was identified in:

Section 2. The hospital and ward – question 8.6: Were you prevented from sleeping at night by the room temperature?

Areas of Strong Patient Experience

The five areas where the Trust performed most positively compared with the national average were:

- Staff taking account of patients' **religious needs**
- Staff taking account of patients' **cultural needs**
- Staff taking account of patients' **language needs**
- Patients receiving information about the **risks and benefits of continuing treatment on virtual wards**
- Staff taking account of patients' **accessibility needs**

Areas for Improvement

The five areas where results were lowest compared with the national average were:

- Length of time waiting **in another location before admission to a ward**
- Length of time **on the waiting list before hospital admission**
- Patients being told **who to contact if concerned about their condition or treatment after discharge**

- **Waiting time for a bed** on a ward after arrival at hospital
- Patients receiving **information about medicines to take at home**

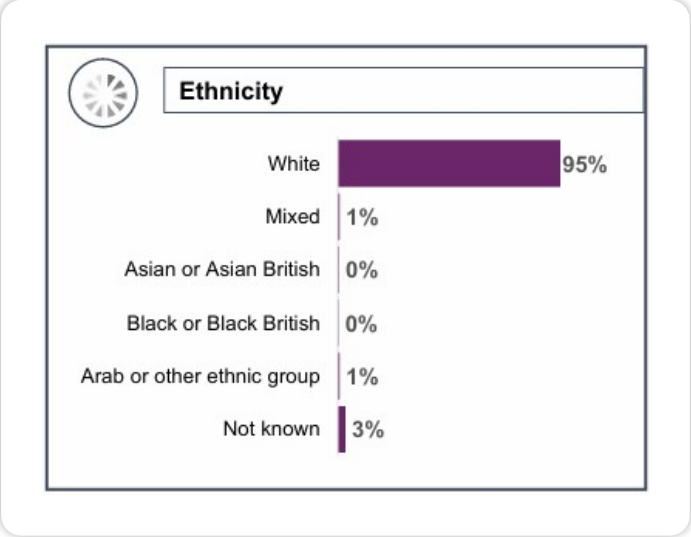
Respondent Demographics

The survey sample included patients across a range of demographic characteristics, including:

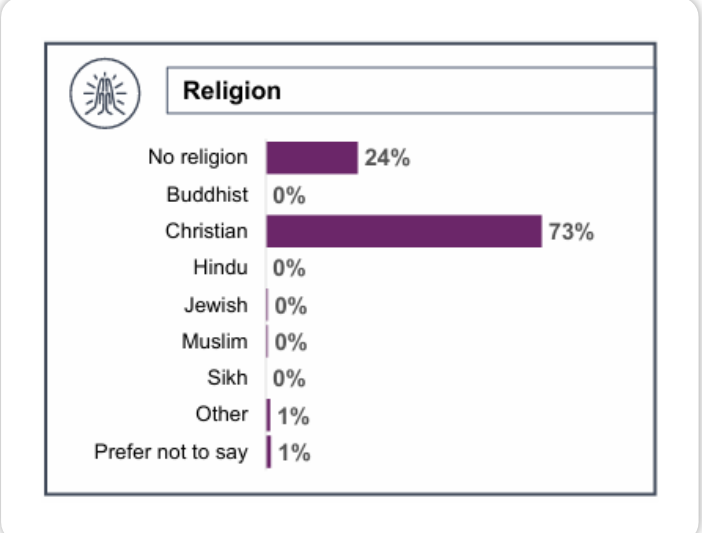
- Ethnicity
- Religion
- Long-term conditions
- Sex at birth
- Age

The population of patients who took part in the survey is broken down as shown below:

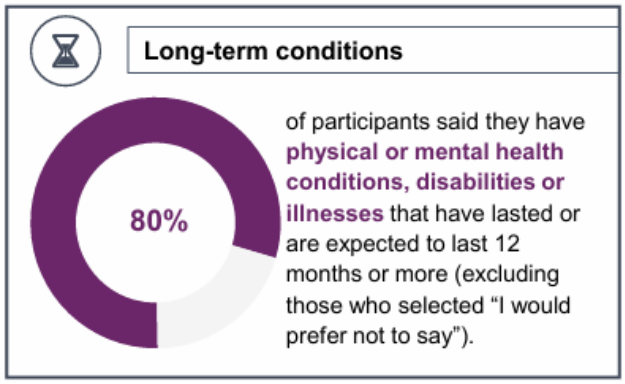
Ethnicity



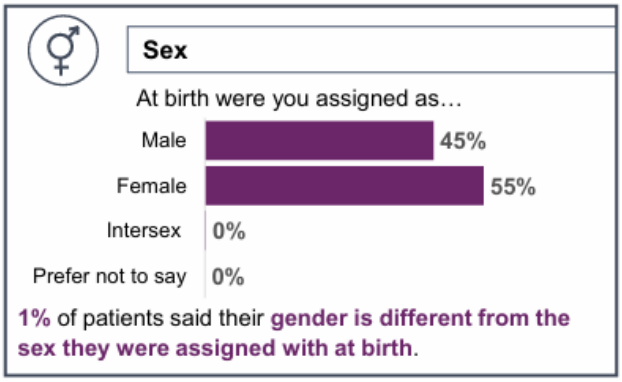
Religion



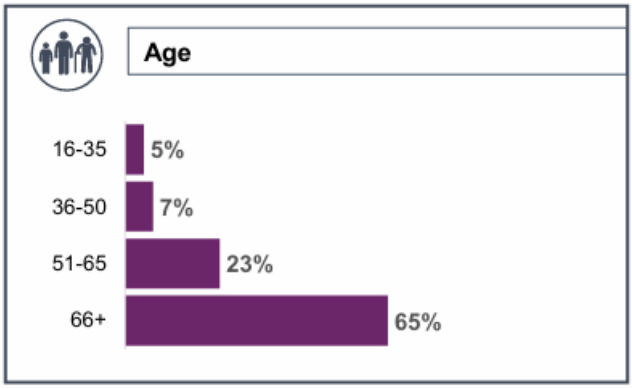
Long-term conditions



Sex at birth



Age



Accessibility

To ensure inclusivity and maximise participation, the survey was available in a range of accessible formats, including:

- Easy Read
- Braille

- Large print
- Translation into 23 languages

All national surveys, including the Adult Inpatient Survey, are routinely reviewed, with action plans developed and monitored through the Trust's monthly Patient Experience and Inclusion Sub-Committee to drive continuous improvement.

2.6 Risk profile

As part of the Board Assurance Framework, key strategic risks are identified and linked to the Trust's three core strategic objectives:

1. **Quality:** We will always put our patients first delivering safe and effective care and an excellent patient experience
2. **People:** We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future
3. **Sustainability**: We will work in partnership with others to achieve social and economic wellbeing in our communities

The Trust opened the year with 10 strategic risks it felt could affect the achieving of its objectives. Of these risks, four were rated 20, three rated 16, two rated 12 and one rated nine, using the 5x5 risk rating matrix widely adopted across NHS organisations.

The Trust closed the financial year with 11 strategic risks it felt could affect the Trust in achieving its objectives, although not all of the risks were the same when the year opened. Four of these risks were rated as 20, four rated 16, two rated 12 and one rated six.

During Q1, the Board approved the merger of risks 1898, 145 and 125 to form a single new strategic risk 2273, around the risk to delivering new hospital facilities and strategic vision, which with monitoring by the Finance and Sustainability Committee (FSC). Given this, risks 1898 and 145 were closed and risk 125 de-escalated to the Corporate Risk Register (CRR).

During Q2, the Board approved the re-escalation of risk 1757 (relating to industrial action) from the CRR to the Strategic Risk Register. The Board also approved an updated risk description and an increased risk rating, reflecting the potential for significant workforce gaps across critical services during periods of industrial action. These gaps had the potential to disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.

During Q3 the Trust Board approved the updated description of Risk 2001 (fragile services) to clarify the scope of the fragile services risk. The revised description acknowledged that the risk remains present both where services continue to be fragile and where the Trust is unable to mitigate the associated challenges.

During Q4, the Board approved the updated description of Risk 2253 (integration with BCH) to reflect additional insights gained from the completion of due diligence work. While the original description focused on the strategic and governance implications of not proceeding with integration, the revised wording incorporates the heightened risk that previously unidentified financial, operational, or regulatory issues may remain unresolved.

Furthermore, during Q4 the Trust Board approved revised risk ratings for two of the Trust's strategic risks. These were:

- **Risk 2253** (integration with BCH)**:** Likelihood reduced **3** → **2**, lowering overall score **9** → **6.** This reflected that the integration programme was now well established, with predominantly shared executive leadership in place and fully functioning joint governance structures.
- **Risk 115** (staffing levels in clinical areas): Likelihood increased **3** → **4**, raising overall score **12** → **16.** This reflected ongoing operational pressures, including higher levels of sickness absence across several clinical areas, a modest rise in vacancy levels, and increased reliance on agency staffing.

During Q4 2025/26, work was undertaken to develop a consolidated Board Assurance Framework (BAF) in preparation for the acquisition of Bridgewater Community Healthcare NHS FT (BCH) by Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH), forming North Cheshire and Mersey (NCM) NHS Foundation Trust from 1 April 2026. This consolidation aimed to create a modernised, strategic, and coherent approach to assurance across the enlarged organisation, eliminating duplication, ensuring consistency in scoring and escalation, and strengthening alignment with NHSE's *Fit for the Future: 10-Year Health Plan for England*, the Well-Led Framework, and Integrated Care System (ICS) requirements and updated NCM strategic objectives.

Draft versions of the consolidated BAF were presented during Q4 at the Board Development Day and at committee meetings to secure support and input from Board members. The consolidated BAF has been designed to elevate true strategic risks for Board-level oversight, while ensuring operational risks continue to be managed appropriately through established operational processes.

The final consolidated BAF for 2026/27 is scheduled for presentation and approval at the inaugural meeting of the Trust Board of the enlarged organisation during April 2026.

The Board will also be asked to discuss and approve the unified 2026/27 Risk Appetite Statement for the enlarged organisation, drafts of which were shared with and supported by both committees and the Trust Board during Q4 meetings.

Given this consolidation work, the current risks set out in the Annual Governance Statement have been mapped across to the new framework and will continue to be recognised as the principal risks to the enlarged Trust. This ensures continuity and clarity during the transition period, with further risks expected to emerge as North Cheshire and Mersey NHS FT establishes its new operating model in the year ahead.

2.7 Environment

To support the Trust's goal of achieving net zero carbon by 2040 works have been progressed to decarbonise the trust estate. The Estates Teams have worked with external partners to secure funding to reduce the Trust's impact on the environment.

Sections of the Trust's lighting systems have been upgraded to LED to reduce energy consumption and reduce carbon emissions. The project was funded by the Department for Energy Security and Net Zero and Great British Energy, with support from NHS England.

Funding has also been obtained from Great British Energy for the installation of 996 solar panels at Warrington and Halton hospitals to reduce the amount of electricity imported from the grid by 450,867kWh.

We have made building improvements to improve energy efficiency and reduce carbon emissions such as window replacements in the maternity wing, building management system upgrades, boiler burner replacements and chiller replacements.

The Trust has decommissioned the piped nitrous oxide system at Halton Hospital to reduce environmental impact due to nitrous oxide being a super pollutant which contributes to global warming. Plans to decommission the Warrington Hospital site nitrous oxide system are being developed at the Trust Medical Gas Committee.

Task force on climate-related disclosures (TFCD)

NHS England's NHS foundation trust annual reporting manual adopted a phased approach to incorporate the TFCD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TFCD aligned disclosure guidance for public sector annual reports. TFCD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TFCD requirements as these are computed nationally by NHSE.

These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

Governance

Delivery of environmental ambitions is included within the Trust Strategy 2023-25, extended by approval from the Trust Board to March 2027 in line with the organisation's Better Care Together Integration programme, under objectives 10.2 and 10.4. Key performance indicators have been agreed, and progress is reported to the Trust board twice annually. This includes an update on relevant climate-related issues as identified through the plan. Ad-hoc updates are brought to the Trust Board

for assurance as and when there are significant impacts on trust programmes of work as relating to climate issues.

Strategy

The green plan is supported by an action plan to support delivery of the goals for each area of focus. Owners are assigned to all actions, along with timescales for delivery. This includes both clinical and non-clinical members of staff as it relates to individual portfolios across the Trust's areas of operation. Elements of this plan undertaken and completed in 2025-26 are provided above.

The Trust currently does not have a dedicated post for management and delivery of the green plan and associated actions, and as such this role is undertaken jointly by the Estates and Facilities Directorate, and the Strategy and Partnerships Directorate. Oversight is undertaken by the Director of Strategy and Partnerships, who is also the executive lead for the green plan, with monitoring of risks related to climate impacts managed through the Trust's usual risk management of escalation and assurance governed through the Executive Team to Trust Board where appropriate. A refreshed Trust green plan is expected to be published in 2026-27, in line with the Trust's Better Care Together integration programme.

Risk Management

Complementary to the strategic approach, the Trust also has a Heatwave Plan, Cold Weather Plan, Excess Death Management Plan, Rapid Relocation Plan and Flood Management Plan to appropriately manage identified risks related to climate change. These are operationalised as required, and ownership is governed via the Trust's Emergency Preparedness, Resilience and Response (EPRR) team.

The Trust's approach to risk management and risk appetite is described elsewhere in this report. No climate-related risks are currently reported to the Board as part of the Board Assurance Framework. Climate-related risks are currently identified and monitored at service level, with mitigations appropriate to likeliness and impact ratings, as detailed in accompanying action plans. These are monitored as per the organisation's usual risk management processes.

Metrics and targets

Descriptions of the metrics and targets are detailed within the Trust's green strategy, which will be reported on and updated across 2026/27, aligned to our integration programme. Current metrics include

- Fossil fuels, including gas and oil
- Anaesthetic Gases
- NHS Fleet & Leased Vehicles
- Electricity

- Waste
- Water
- Metered Dose Inhalers

2.8 Information about social, community, anti-bribery and human rights issues

The Modern Slavery Bill was introduced into Parliament on 10 June 2014 and passed into UK law on 26 March 2015. The Modern Slavery Act is an act to make provision about slavery, servitude and forced or compulsory labour and about human trafficking, including the provision for the protection of victims.

A person commits an offence if:

- the person holds another person in slavery or servitude, and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude
- the person requires another person to perform forced or compulsory labour, and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, has a strict set of ethical values that we use as guidance regarding our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

The Trust has a non-pay budget of £115.2m (inclusive of drugs at £23.1m) of which more than £58m per annum is spent on goods and services.

It is important to ensure that suppliers to the Trust have in place robust systems to ensure that their own staff, and organisations within their own supply chain, are fully compliant with the requirements of the Modern Slavery Act 2015.

In compliance with the consolidation of offences relating to trafficking and slavery within the Modern Slavery Act 2015, the Trust has an ongoing process of reviewing its supply chains with a view to confirming that such behaviour is not taking place.

The standard NHS Terms and Conditions of Contract which form the basis of all orders and contracts with suppliers have a specific clause contained within them relating to modern slavery that determine that suppliers (and their sub-contractors) will:

- comply with the Modern Slavery Act 2015
- implement due diligence polices for its sub-contractors
- respond promptly to all slavery and trafficking due diligence questionnaires
- at the request of the Trust, prepare and deliver an annual slavery and trafficking report setting out steps to ensure slavery and trafficking is not taking place within its supply chain
- implement a system for all employees to ensure compliance with the slavery act

As part of the Trust's commitment to ensuring that we do not trade with organisations which do not meet the requirements of the act, suppliers will be required to provide a

copy of their annual Modern Slavery Act statutory statement detailing actions undertaken to ensure they meet and enforce the requirements of the act.

This will only apply to a supplier defined as a 'commercial organisation' in accordance with the act if it:

- supplies goods and services
- has a turnover of not less than £36m

The Trust's Procurement Team is committed to raising awareness with all suppliers by ensuring that all suppliers the Trust trades with are aware of our commitment to ensure compliance with the act.

As part of the Trust's ongoing procurement processes, when trading with new suppliers, and prior to establishing the supplier on Trust systems, the supplier will be requested to confirm in writing that they are compliant with the act.

The act is referred to in all tendering activity undertaken by the Procurement Team. All tendering for goods and services is managed centrally by the Procurement Team. A copy of the act is sent to all organisations involved in the tendering process, along with a short statement from the Trust reminding bidders of their obligations under the act. All suppliers will be requested to issue a statement as part of their tender response regarding their compliance with the act.

The Trust employs around 5,000 staff comprising 85 nationalities. Most of these staff are employed and paid as per national terms and conditions which are Agenda for Change or Medical and Dental terms and conditions. A small number of staff, which comprises the Trust Board are employed under local terms and conditions of service and remunerated as per the national Very Senior Manager Pay Framework. and renumerated as per the national Very Senior Manager Pay Framework.

All staff are appointed subject to meeting the NHS Standards on Employment Checks which includes references, health checks, DBS checks, immigration checks and identity checks. In addition, the Trust has developed several values and behaviours which are fully embedded into the organisation. The Trust expects its existing staff to comply with these standards, and all future appointments will be expected to demonstrate these attributes as part of the appointment process. This ensures that the Trust can be confident, before staff commence employment, that we know some background about our staff and that they have a legal right to work for the Trust.

By adopting the national pay, terms and conditions of service, the Trust has the assurance that all staff will be treated fairly and will comply with the various legislation. This includes the assurance that staff receive at least the National Living Wage.

The Trust has various employment policies and procedures in place designed to provide guidance and advice to staff and managers but to also comply with employment legislation. Every policy is impact assessed from an equality and diversity perspective.

The Trust does have specific policies in place to deal with the safeguarding of children and vulnerable adults but does not have a specific policy on the Modern Slavery Act and does not feel the need to develop one. However, should the Trust become aware of any issue covered under the Modern Slavery Act, it would immediately report the matter to the police.

The Trust has an extensive training and development programme which is based on a minimum requirement to complete all statutory and mandatory training and other ad-hoc training which staff are required to undertake for their various roles. Training needs are identified through individual performance development reviews (PDRs) and a personal development plan produced.

The Trust employs a Head of Strategic Workforce Development and Culture, and an Associate Chief Nurse of Safeguarding and Complex Care, who take the lead on the Modern Slavery Act. Where possible, the Trust also supports awareness raising events both locally and nationally to support disability, the lesbian, gay, bisexual, trans community (LGBT+), honour crime and forced marriages amongst others.

In relation to fraud risks to the organisation, the Trust agrees an annual counter fraud plan using a nominated and nationally Accredited Local Counter Fraud Specialist (LCFS) via its internal audit provider Mersey Internal Audit Agency (MIAA). The MIAA counter fraud specialist provided services in line with the agreed work plan which is approved at the Audit Committee.

Regular monitoring of counter fraud activity is undertaken by the Trust's Audit Committee via progress reports and an annual report of counter fraud activity. This monitoring process includes the identification of any fraudulent activity against the Trust. During 2024-25 MIAA received 16 potential fraud referrals, and from these four have been converted into investigations, 11 referrals closed, and 1 referral remains open and will be carried forward into 2025-26. There was one investigation brought forward from 2023-24, which has now been closed. 24, which has now been closed.

2.9 Any important events since year end

There were no events after the reporting period that require disclosure.

Nikhil Khashu
Chief Executive
22 June 2026

3. Accountability Report

3.1 Directors' report

Board of Directors

Between 1 April 2025 and 31 March 2026, there were six ordinary and four extraordinary meetings of the Board of Directors.

In compliance with the requirements of the Health and Social Care Act 2012, the Board holds part of its meetings in public, followed by a private business section. Meetings are held bi-monthly, with a private Board development session held on the months in between formal meetings.

Board meetings are facilitated as hybrid meetings, whereby members and guests have the opportunity to attend in person or via video-conferencing utilising Microsoft Teams software. Typically board members attend meetings in person.

The Board has overall responsibility for the strategic direction of the Trust, taking into account the views of the governors. Executive and non-executive directors have an open invitation to attend meetings of the Council of Governors. The Board is responsible for ensuring that the day-to-day operation of the Trust is as effective, economical and efficient as possible and that all areas of identified risk are managed appropriately.

A detailed Schedule of Reservation and Delegation of Powers is in place, and it sets out explicitly those decisions which are reserved for the Board, those that may be determined by standing committees, and those that are delegated to managers.

The Trust has an established governance structure with the following committees, each chaired by a non-executive director, with the exception of the Nominations and Remuneration Committee and the Charitable Funds Committee which are chaired by the Trust Chair.

The following committees were established to provide assurance to the Board of Directors:

- Nominations and Remuneration Committee
- Audit Committee
- Finance, Sustainability and Performance Committee in Common
- Strategic People Committee in Common
- Quality, Safety and Assurance Committee in Common
- Charitable Funds Committee

Throughout the year, Committees in Common were established with Bridgewater Community Healthcare NHS Foundation Trust (BCH) to strengthen joint governance as both organisations progressed toward integration. This arrangement enabled aligned committees to meet jointly while each Trust retained full sovereign authority. The Committees in Common provided assurance to both Boards that high-quality, safe and effective care was being delivered, that financial strategies remained aligned with quality aims during the integration period, and that people and organisational

development strategies continued to support improved patient care, operational efficiency and effective use of resources in line with NHS regulations and local priorities.

The balance, completeness and appropriateness of the members of the Board is reviewed periodically and when vacancies arise among executive or non-executive directors.

Chair and CEO

Steve McGuirk CBE, QFSM, DL – Chair

Steve joined the Trust as Chair in April 2015. He has been reappointed for further terms of office until March 2026.

He previously served as Chief Fire Officer and Chief Executive of Cheshire and then Greater Manchester Fire and Rescue Services, and was president of the Chief Fire Officers Association. He was Deputy Lieutenant for Greater Manchester and has extensive experience in governance of public authorities.

At WHH Steve is Chair of the:

- Trust Board of Directors
- Council of Governors
- Board Nominations and Remuneration Committee
- Governor Nominations and Remuneration Committee
- Charitable Funds Committee

Steve, who lives in Warrington, is a trustee of the Fire Research and Training Trust and an assessor for the Queen's Award for Voluntary Service. He is also a Strategic Advisory Board member for the National Leadership Centre.

He was awarded the Long Service and Good Conduct Medal in 1996, the Queen's Fire Service Medal in 2002, and the CBE in 2005.

Steve will conclude his final term with the Trust on 31 March 2026, marking the end of more than a decade of distinguished service since joining as Chair in April 2015. Throughout his tenure, he has provided strong, values-driven leadership and steadfast support to the organisation during periods of significant challenge and transformation.
The Trust extends its sincere thanks to Steve for his outstanding commitment, leadership and support.

Nikhil Khashu, Chief Executive

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 NHSE'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.

Directors of the Trust: The non-executive directors

Steve McGuirk CBE, QFSM, DL (see above)

Andy Carter, Associate Non-Executive Director / Chair Designate

Andy joined Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) as Associate Non-Executive Director / Chair Designate in January 2026.

He will lead the Trust's Board of Directors as chair from 1 April 2026.

Andy previously served as a member of parliament from 2019 to 2024, representing the Warrington South constituency. He also served as parliamentary private secretary in the Department of Work and Pensions and in the Department for Transport, as well as being a member of the Standards and Privileges Select Committee and Justice Select Committee.

During his time in parliament Andy chaired the All Party Parliamentary Media Group, helping to shape UK legislation including the Media Act 2024, Digital Markets and Competition Act 2024 and Online Safety Act 2023.

Prior to becoming an MP Andy had a successful career in commercial broadcast media management, followed by a consultancy role working with major high street brands.

In addition to his role at WHH he is also a non-executive director of WJEC / CBAC, the UK's third-largest examination board at GCSE and A-level.

Dr Cliff Richards, MBE – Deputy Chair

Cliff joined the Trust as a non-executive director having previously been Chair of Halton CCG from 2012 until retirement in 2017. He was appointed as Deputy Chair of the Trust in November 2022. He was also previously the inaugural Chair of Merseyside CCG Network, and Chair of Cheshire and Merseyside Urgent and Emergency Network.

He undertook GP training before joining Brookvale Practice in Runcorn as a partner in 1983, which he led until 2014. He has been a trainer and appraiser, and a member of several regional forums including Cheshire and Merseyside Cancer Network. Cliff has a strong patient focus through his GP career and other leadership and commissioning roles.

He was awarded an MBE in recognition of his contribution to services to health in Cheshire and Merseyside.

Michael O'Connor – Senior Independent Director

Mike is a partner with an international law firm and joined the Trust's board in November 2021. He has practiced as a commercial lawyer for more than 30 years and has a wide range of experience and knowledge representing commercial business and public sector bodies. Mike is the Trust's Senior Independent Director, as appointed by the Trust Board in consolidation with the Council of Governors in November 2022.

Mike led his firm's infrastructure projects group for 15 years and was head of its Manchester office for three years. Mike, who lives in Warrington, was a non-executive at North West Ambulance Services NHS Trust for seven years.

He has chaired the Bridgewater Hall board of trustees for six years and is also chair of a medical charity providing services to music and contemporary arts festivals.

Julie Jarman

Julie joined the Board of Warrington and Halton Hospitals NHS Foundation Trust as a non-executive director in January 2022.

She has a background in community development and has spent most of her career in the voluntary sector, working on anti-poverty projects both in the UK and in international development. For many years Julie was the England Country Director for Oxfam's UK Poverty Programme. More recently, she was responsible for strategy at the Equalities and Human Rights Commission.

Julie previously worked for Stockport Borough Council as Head of Fair and Inclusive Stockport. Prior to joining Warrington and Halton Teaching Hospitals she was a non-executive director of Greater Manchester Mental Health Foundation Trust for seven years.

Julie has a strong interest in mental health, equalities and population health, and sits on the Board of Trustees for three charities including Mind in Salford.

Jayne Downey

Jayne started as an associate non-executive director of the Trust in November 2021 and was appointed as a non-executive director of the Board in May 2022. Jayne has almost 40 years' nursing experience and has worked across a number of nursing specialities including orthopaedics, general surgery and A&E.

She previously worked at Warrington and Halton Hospitals between 2004 and 2007 as Head of Governance and Risk Management. Prior to that she held director of nursing positions in both specialist and commissioning NHS organisations, having moved into nurse management at a specialist orthopaedic hospital in 1998.

Originally from Widnes, Jayne has a passion for nursing, governance and quality. She qualified as an enrolled nurse in 1985 and subsequently as a registered nurse in 1989.
Jayne has worked across public and private health care sectors supporting organisations with risk management and CQC compliance, including responsibility for supporting organisations to achieve and maintain CQC 'outstanding' ratings.

John Somers

John joined the Board as a non-executive director in October 2022. He is an experienced leader who has more than 22 years' board level experience in public and private sector organisations.

For the past 14 years he has worked in senior NHS roles across commissioning, community services and acute hospital care. His most recent position until retirement was as Chief Executive Officer of Sheffield Children's NHS Foundation Trust, which he joined in 2014.

John held a regional leadership role in an Integrated Care System and a local leadership role in a Place-based Accountable Care Partnership with a track record of successfully delivering transformational change by partnership working. He also worked as an executive reviewer for the CQC. John, who trained as a chartered accountant, has a passion for the NHS and is keen to utilise his experience to improve services for the residents of Warrington and Halton.

Jan O'Driscoll – partner non-executive director (Chester University) – until 30 April 2025

Jan is the Dean of Lifelong Learning at the University of Chester and heads up the Centre for Foundation Studies, which delivers the University's foundation years.

In her dean role, Jan champions students returning to learning, particularly mature students seeking to enter academia at a later stage of life. Jan has an academic background in the sociology of health and politics and taught in universities and colleges prior to moving into management roles.

She developed a growing interest in local people having access to their local university, particularly for communities that may not always be represented within a university population.

Jan started her own degree journey on a foundation year aged 28 after previously working as a florist and children's nanny. She began at the University of Chester in 2015 to start up a new department offering foundation years of study.

Jan joined the board of Warrington and Halton Teaching Hospitals in 2023 and is also a trustee for Chester Cathedral Education Trust.

Directors of the Trust: The executive directors

Nikhil Khashu, Chief Executive (see above)

Daniel Moore – Chief Operating Officer and Deputy Chief Executive

Dan was appointed Chief Operating Officer in January 2021, having previously joined Warrington and Halton Teaching Hospitals NHS Foundation Trust in 2018 as its Director of Operations and Performance. He is also Deputy Chief Executive.

In December 2024, Dan was appointed as joint Chief Operating Officer for Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare.

As chief operating officer his role is to oversee operational delivery and performance achievement across the Trust.

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.

Throughout his career, Dan has maintained a keen interest in furthering his academic knowledge; he holds a Masters in Business Administration (MBA) from Manchester Business School, and a BSc in Operational Management from Lancaster University Management School.

Jane Hurst – Chief Finance Officer

Jane was appointed Chief Finance Officer in September 2023, having joined the Trust in September 2016 as Deputy Director of Finance (Strategy) prior to becoming Deputy Chief Finance Officer in October 2019. In May 2017 she took on additional responsibility as the Trust's Freedom to Speak up Guardian, supporting staff to cultivate a speak up culture.

A qualified accountant with 26 years' NHS experience, Jane is committed to supporting and developing individuals and teams to be the best they can be. She led her current team to achieve HfMA National Team of the Year in 2020, Level 3 FFF Accreditation in 2022 and several other national and regional awards. Jane is passionate about ensuring the Finance Directorate is trained to provide professional advice and guidance to the Trust and wider health and social care system, supporting the delivery of high-quality patient care.

Michelle Cloney – Chief People Officer

Michelle was appointed Director of Human Resources and Organisational Development in November 2017, having undertaken the role in an interim position in March 2017.

Prior to joining the Trust she was Associate Director of Workforce at Pennine Lancashire Transformation Programme and Senior Responsible Officer for Workforce, Organisational Development and Leadership, working across organisational boundaries within East Lancashire and Blackburn with Darwen.

Michelle started her NHS career in nursing in 1984 and developed a passion for working with teams to deliver excellent care to patients and service users. Moving into HR and OD in 1997, she gained extensive knowledge and experience including the management of HR services, employee engagement, staff health and wellbeing, equality, diversity and inclusion.

Michelle is committed to supporting staff to put patients at the heart of all we do and to enable them to recognise the Trust as a great place to work and receive care.

Michelle will be leaving the Trust to retire on 31 March 2026. Throughout her tenure she has provided dedicated service and steady support across her areas of responsibility, making a valued contribution to the organisation. The Trust extends its appreciation for her commitment and wishes her every happiness in her retirement.

Dr Paul Fitzsimmons – Executive Medical Director

Paul joined the Trust in December 2021 from Liverpool University Hospitals Foundation Trust where he was the Deputy Executive Medical Director for five years.

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 Trust's Caldicott Guardian and Executive Lead for Digital.

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

Ali was appointed Chief Nurse in April 2024, having joined the Trust in 2017 as Deputy Chief Nurse before taking on the role of Associate Chief Nurse.

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.

Lucy Gardner – Chief Strategy and Partnerships Officer

Lucy joined the Trust in February 2016 from her role as a director at Ernst & Young's healthcare advisory practice. She has held a number of operational management positions within the NHS and subsequently, in her role at Earnest & Young, led largescale change programmes to deliver significant financial, quality and performance benefits within healthcare.

Since joining WHH, Lucy has led the development and delivery of the Trust's strategy, as well as key strategic programmes including our new hospitals bid and securing funding to deliver the Living Well Hub in Warrington town centre.

Lucy started her career as an NHS general management trainee, gaining a master's degree in health and social care leadership and management. She is committed to developing others and working in partnership with other organisations and individuals to not only deliver outstanding healthcare, but also to enable wider regeneration.

Kate Henry – Director of Communications and Engagement

Kate joined the Trust in October 2022 and brought with her a wealth of experience in internal and external communication, engagement and consultation, crisis and reputation management, and marketing and branding.

She has led award-winning teams nationally and locally in the NHS over the past 17 years, including in roles focused on communicating and

engaging about organisational and service change, quality improvement, and research and innovation. Kate's most recent NHS role was as director of communications at a mental health and community services provider, after which she worked as a consultant advising private and third sector organisations on strategic communications.

Kate has an MSc in corporate communications and reputation management from Manchester Business School and a CMI Level 7 diploma in strategic management and leadership. She is passionate about effective internal communication and engagement, and the impact that this has on patient care. Kate is also executive lead for the Trust's charity.

Lynne Carter - Director of the Delivery Unit

Lynne, Deputy Chief Executive at Bridgewater Community Healthcare (BCH), was appointed joint Director of the Delivery Unit for Warrington and Halton Teaching Hospitals and BCH on 1 July 2025. The unit was created to support the delivery of both Trusts' operational plans for the current financial year.

A registered general nurse and learning disability nurse, Lynne has enjoyed an extensive career in the NHS, working in acute, community and mental health organisations at an executive level and also as an independent consultant. Her most recent role has been as BCH's Chief Nurse.

Lynne's primary focus is on putting patients first, delivering high standards of care, and supporting people to thrive in their own communities.

Significant interests of directors or governors

Register of Interests

A register of significant interests of directors and governors which may conflict with their responsibilities is available on the Trust's website here: Statutory information :: Warrington and Halton Hospitals NHS Trust (whh.nhs.uk)

Board member terms of appointment

Board member	Term of appointment
Steve McGuirk (Chair)	01.04.2015 to 31.03.2018 Second term 01.04.2018 to 31.03.2021 Third term 01.04.2021 to 31.03.2023 (appointed for a further term in November 2022 effective 01.04.2023 to 31.03.2026)
Nikhil Khashu	from 01.11.2024
Cliff Richards	10.06.2019 to 09.06.2022 Second term 10.06.2022 to 09.06.2025 (with extension to 31.03.2026),
Michael O'Connor	First term 01.11.2021 – 31.10.2024 Second term from 01.11.2024
Julie Jarman	First term 01.01.2022 – 31.12.2024 Second term from 01.01.2025
Jayne Downey	From 01.11.2021, voting from 01.05.2022 – 30.04.2025 Second term from 01.05.2025
John Somers	First term 08.10.2022 – 31.07.2025 Second term 01.08.2025
Jan O'Driscoll	From 01.07.2023 – 30.04.25
Jane Hurst	From 01.10.2023
Ali Kennah	From 01.04.2024
Daniel Moore	20.01.2021, Deputy Chief Executive from 01.04.2024
Paul Fitzsimmons	From 01.12.2021
Non-voting members	**Term of appointment**
Lucy Gardner	From 01.02.2016
Kate Henry	From 01.10.2022
Michelle Cloney	From 01.11.2017, voting from 01.11.2021 – 30.04.2025 and nonvoting thereafter
Lynne Carter	From 01.07.2025
Andy Carter	Associate NED and Chair Designate from 01/01/2026

1 April 2025 to 31 March 2026

Board member	Trust Board 6 meetings and 9 extraordinary meetings	Audit Committee 5 meetings	Quality and Safety Committee and Quality and Safety Assurance Committee in Common from Feb 2026 12 meetings 1 extraordinary	Finance and Sustainability Committee and Finance, Sustainability and Productivity Committee in Common from July 2025 12 meetings	Strategic People Committee in Common – from April 2025 12 meetings
Attendance (actual/max)					
Steve McGuirk (Chair)	15/15	n/a	n/a	n/a	n/a
Andy Carter,	4/4	n/a	n/a	n/a	n/a
Cliff Richards	14/15	2/5	11/13	n/a	n/a
Michael O'Connor	15/15	5/5	n/a	n/a	11/12
Julie Jarman	14/15	5/5	n/a	12/12	12/12
Jayne Downey	14/15	5/5	12/13	n/a	n/a
John Somers	13/15	3/5	n/a	11/12	n/a
Jan O'Driscoll	0/1	n/a	n/a	n/a	n/a
Nikhil Khashu	14/15	n/a	n/a	n/a	n/a
Daniel Moore	14/15	n/a	9/13	11/12	11/12
Michelle Cloney	14/15	n/a	8/13	11/12	10/12
Paul Fitzsimmons	15/15	n/a	9/13	11/12	7/12
Jane Hurst	15/15	5/5	10/13	11/12	10/12
Ali Kennah	12/15	n/a	12/13	9/12	11/12
Lucy Gardner	15/15	n/a	6/13	11/12	2/12
Kate Henry	15/15	n/a	n/a	10/12	10/12
Lynne Carter	6/11	n/a	2/2	6/9	9/12

The Director of Midwifery attends all ordinary Trust Board meetings and extraordinary meetings where maternity papers are being presented, along with all Quality Assurance Committee meetings.

Attendance in year is provided below:

Director of Midwifery	Trust Board 6 meetings	Audit Committee 5 meetings	Quality Assurance Committee 12 meetings	Finance and Sustainability Committee 12 meetings	Strategic People Committee 12 meetings
Attendance (actual/max)					
Ailsa Gaskill-Jones	3/3	n/a	6/7	n/a	n/a
Tina Moors (acting)	5/6	n/a	n/a	n/a	n/a

The Work of the Audit Committee

The Audit Committee is required to report annually to the Board and to the Council of Governors outlining the work it has undertaken during the year and where necessary, highlighting any areas of concern. The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The committee's activities cover the whole of the Trust's governance agenda, not only the finances, and are in support of the achievement of the Trust's objectives.

During the reporting period, the committee has been composed of at least three non-executive directors with a quorum of two. During the year the committee met five times. Michael O'Connor holds the position of Chair of the Audit Committee. The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by members of the committee. The Chair of the Trust is not a member of the Audit Committee in line with best practice.

Regular attendees at the Committee Meetings were the Trust's external auditors Grant Thornton (External Auditors from January 2017), Mersey Internal Audit Agency (MIAA - Internal Audit and Counter-Fraud Services), the Chief Finance Officer and the Company Secretary.

In year the significant issues that the committee considered in relation to financial statements, operations and compliance were as detailed below. They were addressed through inclusion in the Internal Audit work plan and assurance sought for each element:

- **High assurance** was provided in the following: Risk Management Core Controls, General Ledger, Accounts Payable, Accounts Receivable, Budgetary Control
- **Substantial assurance** was provided in the following: Conflicts of Interest, Patient Activity Data Capture, Learning From Deaths, PSIRF, Recruitment, Safe Staffing Governance
- **Limited assurance** was provided for IT Third Party Providers

There were no areas reported as providing moderate or no assurance.

Governance and risk management

During the year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks, considered the Trust's Risk Appetite Statement ahead of the integration with Bridgewater Community Healthcare NHS Foundation Trust and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and at committee meetings each month in year. Each strategic risk is allocated to a committee for focused oversight and scrutiny.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management

and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a substantial assurance rating from the Head of Internal Audit (HOIA).

System of internal control

The Trust's governance structure aligns the Trust's various governance groups to the Trust Board committees. The Board Assurance Framework provides an overview of the internal control environment and evidence of the effectiveness of the controls that manage the risks to the Trust in achieving its strategic objectives as identified in the annual plan. The Audit Committee is charged by the Board in reviewing and evaluating the system of internal control through the delivery of the internal audit plan. The Chair of the Audit Committee provides an annual report of the work of the Committee to the Board as well as periodic escalation reports following each meeting.

Internal audit activities

MIAA acted as internal auditors for the Trust during the year. Internal audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is discussed with the Executive Team and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the committee uses a three-cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency. Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented regularly to the committee by internal audit throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

External audit

Grant Thornton LLP commenced its initial three-year term as auditors to the Trust in January 2017. The company then commenced a two-year term in October 2020, following a competitive procurement exercise and recommendation by the Council of Governors. The contract contained the option to extend for additional years and following support from the Audit Committee and approval by the Council of Governors, an extension up to 30 September 2024 was agreed. In September 2024 a new three-year contract, with the option of one 12-month extension, for the provision of an external audit service by Grant Thornton LLP was approved.

During the year the auditors reported on the 2025-26 financial statements. Information relating to material or significant issues to be added following completion of audit technical support has been provided on an ongoing basis to the Trust and representatives of Grant Thornton have attended each Audit Committee meeting.

Grant Thornton has since audited these 2025-26 financial statements, and their report and opinion is enclosed herein.

Anti-fraud activity

The committee and the Trust are supported in carrying out anti-fraud activity by MIAA's Anti-Fraud Service (AFS) working to a programme agreed with the Audit Committee. The role of AFS is to assist in creating an anti-fraud culture within the Trust; deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

Various fraud awareness material was developed, and activities conducted during the year to raise fraud awareness and underpin an anti-fraud culture at the Trust. The AFS engaged with the Communications and Engagement Team and other key stakeholders to promote the antifraud, bribery and corruption agenda by arranging the circulation of Fraud Newsflashes, MIAA's 'Talking Fraud' newsletters, fraud 'recent cases' articles, Fraud Information Alerts and a suite of materials during International Fraud Awareness Week that were shared Trust-wide via the intranet and the weekly newsletter.

Fraud awareness activity at the Trust has included a fraud presentation to HR staff. As a guest speaker, the AFS delivered a fraud presentation to attendees at a Finance Directorate team brief focussing on the types of referrals which MIAA investigate and discussed 'real life' cases along with outcomes and the impact against the subject as well as the Trust.

The Trust received 16 referrals in this reporting year which is the same number of referrals received in 2024/25 and was an increase from 7 received in 2023/24. The referrals covered a varied range of fraud types including working whilst sick, timesheet fraud, working elsewhere in NHS time, recruitment fraud, mandate fraud, credit card fraud and false documentation. Of the 16 referrals, 6 were converted to formal investigations and recorded onto CLUE. 1 investigation was carried forward from the previous reporting year.

The 2025-26 self-assessment against the Government Functional Standard 013 for Counter Fraud resulted in the Trust achieving an overall 'green' rating.

The Foundation Trust governors and membership following elections in November 2025

The Council of Governors is made up of the following representative constituencies:

- 17 public governors – elected by the Trust's public membership who represent the local community
- 5 staff governors – elected by the Trust's staff members, whom they represent
- 5 partner governors – nominated by partner organisations who work closely with the Trust

Governor elections

Public and staff governor elections were held between September and November 2025 to appoint or renew governor terms of five public governors and two staff governors. Details of the current composition of the Council of Governors as of 31 March 2026 is detailed below.

Governors are appointed for a term of three years and are eligible for re-election or re-appointment at the end of their initial term, for two further terms (nine years in total).

Understanding the views of the governors, members and the public

The Board recognises the value and importance of engaging with governors in order that the governors may properly fulfil their role as a conduit between the Board and the Trust's members, the public and stakeholders.

The Board and Council of Governors meet regularly and enjoy a strong and working relationship. Each is kept advised of the other's progress through the chair and includes standing items at both the Board meeting and Council of Governors meeting for the chair to share any views or issues raised by directors, governors and members.

Any disputes or disagreements between the Board and the Council of Governors are set out in the Trust's Constitution, Section 9: Resolution of Disputes with Board of Directors.

Members of the Board are invited to attend all Council of Governors meetings (four per year) and some governor committees to provide input and support. Each committee of the council is supported by relevant executive directors and senior managers from the Trust who report openly and collaboratively on the activities and performance of the Trust.

The Governors Nominations and Remuneration Committee (GNARC) met on five occasions 2025-26 to:

1. **17 April 2025 -** review and support the extension of the terms of office of two non-executive directors; both extensions were supported for a second term.
2. **8 May 2025** – review and support the extension of the terms of office of non-executive director/deputy chair for a third term to 31 March 2026
3. **29 August 2025** - approve the process and terms of appointment for the Chair of the Trust.
4. **28 October 2025** – review the interview process and outcomes and agree to recommend the preferred candidate for appointment as Chair of the Trust to the Council of Governors.
5. **3 February 2026** - review and support the extension of the terms of office of non-executive director/deputy chair to 31 March 2027

The role of this committee is outlined in more detail in the Remuneration Report.

The Council of Governors receives copies of all Board meeting agendas and minutes in accordance with the requirements of the Health and Social Care Act 2012 and the Trust's Constitution. All governors (and members of the public) are able to observe

the meeting of the Board held in public in order to understand the issues raised at the Trust Board. Governors are encouraged to attend the Board meetings to observe the non-executive directors' performance at the meetings in challenging and scrutinising reports presented by the executive directors.

Governors attend Board committees as observers which supports the governors in discharging their duty of holding the non-executive directors, individually and collectively, to account for the performance of the Board. They provide a formal written report to the Council of Governors with their views about the manner in which the respective non-executive director chaired the meeting. Furthermore, the lead governor attends the private Board meeting as an observer.

The chair provides informal briefings to governors through monthly informal question and answer sessions, enabling governors to raise matters outside of formal council meetings. Non-executive directors are also invited to participate in the meetings and typically do so on a rotational basis.

At governors' meetings there is a standing item for governors to ask questions of board members. Questions may be in relation to issues raised by constituency members or members of the public, or queries following governor observational visits. Questions are submitted in writing following governor only meetings where the Council of Governors meeting agendas are reviewed and approved.

Responses to questions are provided by executive or non-executive directors in meeting papers and discussed in detail at meetings. During the year, a new method was adopted to support governors in fulfilling their statutory duty of holding non-executive directors to account for the performance of the Trust.

Non-executive director chairs of committees present a highlight slide, providing governors with detail on committee discussion and assurance received against key performance indicators as per the integrated performance report.

The council has the following statutory powers and responsibilities:

- Hold the non-executive directors to account individually and collectively for the performance of the Board
- The appointment and, if appropriate, removal of the chair
- The appointment and, if appropriate, removal of the other non-executive directors
- Approve the remuneration and allowances, and other terms and conditions of office, of the chair and other non-executive directors
- Approve the appointment of the chief executive on recommendation from the Board Nominations and Remuneration Committee
- Appoint, re-appoint and, if appropriate, remove the auditor
- Receive the annual report and accounts and any report on these provided by the auditor
- Approve any 'significant transactions' as defined within the Trust's constitution
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution

- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions
- Approve amendments to the Trust's constitution

In addition to the statutory responsibilities, the CoG focuses on the following activities:

- Contribute to the business planning process and the development of forward plans for the Trust in co-operation with the Board of Directors
- Represent the interests of the communities served by the Trust and ensure they are appropriately represented
- Consult with members and reflects the view of the membership
- Develop and maintain the Trust's membership and engagement strategy
- Consider whether the interests of the public at large have been factored into decision-making and seek assurance on the Board's performance in the context of the whole system and as part of the wider provision of health and social care
- Consider how the Board's decision making complies with the triple aim – duty of better health and wellbeing for everyone; better quality of health services for all; sustainable use of NHS resources; as well as the role the Trust is playing in reducing health inequalities.

All committees are attended by non-executive, executive directors and senior management who provide advice and support in order for the committee to carry out its functions in the provision assurance to the Council of Governors.

Other meetings and involvement

Alongside the formal meetings and committees, a number of briefing sessions and workshops have taken place to both inform the governors of Trust initiatives and work programmes and gain their views and support.

In line with the requirements of the Provider Licence all governors have made 'fit and proper person test' declarations.

Composition of the Council of Governors – 31 March 2026

Constituency	Governor	Term (of 3)	Term Ends
Warrington and Halton	Sue Fitzpatrick	2	30/11/2026
	Diane Nield	1	30/11/2025
	Catherine Ardern	1	30/11/2027
	Margaret Bamforth	1	30/11/2027
	Helen Bennett	1	30/11/2028

	Alan Davies	1	30/11/2027
	Colin Jenkins	3	30/11/2026
	Paula Jones	1	30/11/2027
	Carol Ann Kelly	1	30/11/2026
	Matt Machin	1	30/11/2028
	Linda Mills	3	30/11/2027
	Nigel Richardson	2	30/11/2027
	Jack Roper	1	30/11/2027
	Stephen Walton	1	30/11/2028
	VACANT		
Rest of England – 2 seats	Dorkas Akeju	1	30/11/2028
	Kevin Keith	2	30/11/2026
STAFF (5)		**Term (of 3)**	**Term ends**
Medical and dental	**VACANT**		
Nursing and midwifery	Michelle Kho	1	30/11/2028
Staff – support	Erwin Tuballes	1	30/11/2027
Clinical scientist or Allied Health Professionals	**VACANT**		
Estates, administration, managerial	Suresh K Arni Sukumaran	1	30/11/2028
Constituency (partners APPOINTED BY TRUST – 6)		**DATE**	**N/A**
Halton Borough Council	Cllr. Colin Hughes.	09/2025	
Warrington Borough Council	Cllr Maureen McLaughlin	06/2024	
Warrington Sikh Gurdwara	Mansimran Singh	08/2024	

Warrington and Vale Royal College	Nichola Newton	06/2019	-
Voluntary and Community Services	**VACANT**		

The Council of Governors

Attendance of the Council of Governors and sub-committees
1 April 2025 to 31 March 2026

Name	Position	Council of Governor	GNARC
Steve McGuirk	Chair	5/7	3/3
Nikhil Khashu	Chief Executive	5/7	
Public governors			
Sue Fitzpatrick	Warrington and Halton	6/7	4/4
Diane Nield	Warrington and Halton	5/7	3/3
Catherine Ardern	Warrington and Halton	7/7	1/1
Margaret Bamforth	Warrington and Halton	6/7	
Helen Bennett (from 01.12.25)	Warrington and Halton	2/2	
Keith Bland (to 30.11.25)	Warrington and Halton	0/5	
Alan Davies	Warrington and Halton	6/7	
Colin Jenkins	Warrington and Halton	5/7	3/3
Paula Jones	Warrington and Halton	6/7	
Carol Ann Kelly	Warrington and Halton	2/7	
Matt Machin (from 01.12.25)	Warrington and Halton	1/2	
Colin McKenzie (to 30.11.25)	Warrington and Halton	0/5	
Linda Mills	Warrington and Halton	5/7	
Edward Rawlinson	Warrington and Halton	0/2	
Anne Robinson (to 30.11.25)	Warrington and Halton	3/5	1/1
Jack Roper	Warrington and Halton	6/7	
Nigel Richardson	Warrington and Halton	7/7	
Stephen Walton (from 01.12.25)	Warrington and Halton	2/2	
Rest of England			
Dorcas Akeju (from 01.12.25)	Rest of England	2/2	
Kevin Keith	Rest of England	4 /7	
Staff governors			
Akash Ganguly	Medical and dental	0/2	
Jonathan Cliffe	Nursing and midwifery	2/5	1/1
Michelle Kho	Nursing and midwifery	2/2	
Erwin Tuballes	Staff – support	3/7	

Gemma Leach	Estates, administration, managerial	4/5	1/1
Suresh K Arni Sukumaran	Estates, administration, managerial	1/2	1/1
Rachel Bold	Clinical sciences and AHPs	0/5	0/1
Partner governors			
Nichola Newton	Warrington and Vale Royal College	3/7	
Cllr Colin Hughes	Halton Borough Council	3/5	
Cllr Maureen McLaughlin	Warrington Borough Council	5/7	2/2
Mansimran Singh	Warrington Sikh Gurdwara	6/7	2/2
NEDs			
Cliff Richards	Non-Executive Director	4/7	2/2
Mike O'Connor	Non-Executive Director	4/7	
Jayne Downey	Non-Executive Director	4/7	
Julie Jarman	Non-Executive Director	4/7	
Jan O'Driscoll	Partner Non-Executive Director	0/0	
John Somers	Non-Executive Director	5/7	
Andy Carter	Associate Non-Executive Director / Chair Designate	1/2	

Changes to the Foundation Trust Constitution in Year

As per Article 45 'Amendment to the Constitution' the Trust may make amendments to its constitution if more than half of the members of the Board of Directors of the Trust voting approve the request. In year, there were three amendments to the constitution supported by governors and the Trust Board, these were:

1 **21. Board of Directors – composition** - the removal of **Condition 21.6**, the requirement for a specific Non-Executive Director from the University of Chester, in order to broaden the pool of candidates for future board appointments.
2 **ANNEX 3 – COMPOSITION OF THE COUNCIL OF** GOVERNORS - Approval of the appointment of a partner Governor from 'Walking Mums Cheshire. To provide a valuable and further diverse perspective to the existing Partnership Governors, to support the Trust to access it's the group's membership for such things as surveys and support for important ad hoc campaigns and communications.
3 **ANNEX 3 – COMPOSITION OF THE COUNCIL OF GOVERNORS** – Reallocation of the Partnership Governor position currently held by Walking Mums Cheshire to a Voluntary and Community Services Representative. This update aligned the membership of the WHH Council of Governors with that of Bridgewater Community Healthcare NHS Foundation Trust (BCH).

Furthermore, at its meeting 12 March 2026, the Council of Governors approved the new Constitution of the enlarged organisation (North Cheshire and Mersey NHS FT), which was a required component of the application. It was noted that the Constitution would take effect automatically following approval of the acquisition of BCH by WHH by NHS England, in line with the NHS Transactions Guidance.

Governors' Register of Interests

A register of interests for the Council of Governors is available publicly to view via the Trust website:

https://whhft.mydeclarations.co.uk/declarations

Governors may be contacted at:

Warrington and Halton Teaching Hospitals NHS Foundation Trust
Foundation Trust Office
Ground Floor, Kendrick Wing
Warrington Hospital
Lovely Lane
Warrington WA5 1QG
Telephone: 01925 662139
E-mail: whh.foundation@nhs.net

The Foundation Trust Membership

As an NHS Foundation Trust, Warrington and Halton Teaching Hospitals has a membership scheme that means members of the public aged 12 and over (anyone aged between 12 and 16 must have parental consent to become a member) can become members of the Trust. Staff automatically become members on appointment, with the opportunity to opt out should they wish.

Members play a key role in the hospitals, providing input into what services they want their hospitals to provide. They do this by electing public and staff governors who represent the membership's views and views of the local community.

There are two constituencies of membership of the Foundation Trust, those are public and staff. The public constituency comprises of those members that live in one of the public constituencies:

- Warrington and Halton
- Rest of England

The staff constituency is divided into five classes. Staff automatically become staff members unless they choose to opt-out of the membership:

- Medical and dental
- Nursing and midwifery
- Support

- Clinical scientist or Allied Health Professional
- Estates, administration and managerial

The figures for membership constituencies as of 31 March 2026, are detailed below:

Constituency Membership	31 March 2026
Warrington and Halton	2122
Rest of England	953
Total public	**3111**
Staff	4736
Total membership	**7847**

Membership Strategy 2023-26

Our membership strategy builds on the success of the Trust's Working with People and Communities Strategy 2022-2025 and seeks to help the organisation progress as a Foundation Trust that better supports its members and actively recruits new members. The aim of the strategy is to improve membership recruitment and engagement and enable the Council of Governors to set implementation plans to successfully deliver the objectives set out within the strategy.

In Quarter 3 the Council of Governors approved the extension of the Trust's Membership Strategy through to 2026, following a recommendation from the Governor Engagement Group. The extension provides continuity and stability in member engagement arrangements during the period of organisational integration with BCH, while maintaining progress against the existing strategic objectives and enabling preparation for a refreshed strategy for the future enlarged Trust.

The objectives of the strategy are detailed below:

Objective 1: **High quality information**
Provision of high-**quality** information to WHH members to provide them with the knowledge they need to understand the offer of membership at WHH and to be ambassadors for the Trust.

Objective 2: Inclusivity
Ensure our membership is reflective of the different **people** and communities we serve, with a focus on attracting younger members and those from groups that are currently underrepresented.

Objective 3: Sustainability
Taking meaningful steps so we can make sure that we are promoting **sustainability** in all membership communications and activities.

The Council of Governors receives quarterly reports on progress against the objectives set out in the Membership Strategy, at Governor Engagement Group

meetings chaired by the deputy lead governor and at quarterly Council of Governors meetings.

Engaging with our members

The Governors Engagement Group meets quarterly in advance of the Council of Governors meetings. The group considers matters relating to Foundation Trust membership, communications, engagement and involvement, ensuring that the interests of public and staff members, patients and wider stakeholders are represented on behalf of the Council of Governors.

During Quarter 3, the Governors of Warrington and Halton Teaching Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust reviewed and agreed revised Terms of Reference to establish a **Governor Engagement Group in Common (GEGiC)**. The GEGiC provided a shared forum for Governors from both Trusts to consider matters relating to foundation trust membership and the Trusts' approach to communication, engagement and involvement, taking account of the interests of public and staff members, patients and wider stakeholders. The establishment of the GEGiC supported closer collaborative working during the integration period by enabling consistent oversight, shared learning and a more coordinated approach to governor-led engagement on behalf of the respective Councils of Governors.

During 2025–26, governors hosted several engagement stands across Trust sites to connect with staff members, patient members and the wider public. For the first time, an engagement stand was also held at Birchwood Shopping Centre, providing an additional opportunity to promote the Trust and encourage the recruitment of new members.

Governors also participated in several Trust-wide and community engagement events and activities. These included International Clinical Trials Day, Armed Forces Day, Warrington Pride, Disability Awareness Day and Warrington Mela, helping to strengthen connections with the local community.

The Council of Governors continued to share information and updates about the Trust through the quarterly Members' Newsletter. The newsletter is circulated to all members for whom the Trust holds a valid email address. It continues to be well received, with engagement monitored through open and click-through rates reported in quarterly membership strategy updates.

Emails promoting Trust membership were also circulated to volunteers and to colleagues at Bridgewater Community Healthcare NHS Foundation Trust ahead of the planned acquisition on 1 April 2026, offering them the opportunity to become members of the Trust.

Engaging with governor colleagues within the Cheshire and Merseyside ICS and nationally

The lead governor actively participates in national and local governor forums and events. Several governors attended the inaugural Cheshire and Merseyside Governors' Symposium, which brought together governors from across the region to

share updates on governance arrangements and developments within the NHS. The symposium also provides an opportunity for governors to enhance their knowledge, exchange best practices, and network with colleagues across the Integrated Care System (ICS).

The lead governor provides a quarterly report to the Council of Governors, summarising national and local developments and detailing the events and activities attended during the quarter.

3.2 NHS England Well-Led Framework

The CQC carried out a well-led assessment between 30 April and 2 May 2019. It rated the Trust 'Good' for well-led because:

1. leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the services for patients and staff
2. the Trust had a well embedded vision and values which were well understood by staff. It had refreshed its strategy which was focused on sustainability of services and aligned to local plans within the wider health economy
3. staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear
4. leaders operated effective governance processes throughout the service and with partner organisations
5. leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. The Trust had made improvements to its risk management since the last inspection
6. the Trust collected reliable data and analysed it. It had a good range of reports and dashboards for staff to understand performance, make decisions and improvements
7. leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients
8. the Trust was committed to continually learning and improving services. Staff received training in quality improvement methodology and were encouraged to share learning

In 2022-23 the Trust undertook an externally facilitated developmental well-led governance review using the NHS England well-led framework, taking into account expected changes in the CQC's regulatory approach, and with a focus on working as part of an integrated care system.

In September 2023 an inspection of the Trust's Maternity Services took place, resulting in the service retaining its good rating.

The Annual Governance Statement within this report outlines the review of leadership and governance in line with NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance, internal control and Board assurance. Work on self and external assessment continues and these assurances can be found in the Annual Governance Statement.

The Trust can confirm that there are no material inconsistencies between the:

- Annual Governance Statement
- Corporate Governance Statement
- annual report; and
- reports from the CQC planned and responsive reviews of the Trust and any consequent action plans developed by the Trust

3.3 Statement of cost allocation HM Treasury

We have complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

3.4 Political donations

There were no donations of a political nature in the period.

3.5 Better payment Practice Code

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. Performance for the financial year is contained in the table below:

	2025-26	2025-26
	Number	£000
Non-NHS trade invoices paid in the period	45,692	110,958
Non-NHS trade invoices paid within target	26,410	65,580
Percentage of non-NHS trade invoices paid within agreed payment terms or in 30 days	**58%**	**59%**
NHS trade invoices paid in the period	2,275	25,086
NHS trade invoices paid within target	857	12,806
Percentage of NHS trade invoices paid within agreed payment terms or in 30 days	**38%**	**51%**

The total paid within 2025-26 for late payment of commercial debt was £12k (£25k in 2024-25).

3.6 Interest payments

In year, the Trust made payments totalling £11,845.51 for the late payment of invoices. There are no accrued charges as at 31 March 2026.

3.7 Stakeholder relations

Development of services involving local services/agencies and local initiatives

As an anchor organisation across the boroughs of Halton and Warrington, the Trust is committed to enhancing social value, reducing its carbon footprint and addressing health inequalities. This strategic intent is realised through leading and delivering key projects that foster collaboration with local services and agencies.

WELL Runcorn Hub

Delivered in collaboration with partners, the WELL Runcorn Hub will deliver services aimed at families, young people and people living with long-term conditions with a focus on prevention and supporting people to live healthier, happier lives, and providing education opportunities to residents. Core partners are Warrington and Halton Hospitals, Bridgewater Community Trust (integrating to become North Cheshire and Mersey Foundation Trust from 1 April 2026), Riverside College, Halton Borough Council and Mersey Care.

The core timetable will be enhanced with services provided by local voluntary, community, faith and social enterprise organisations to create a hub where working in partnership provides a community asset, and where people can have multiple needs met to help them live better for longer. Services are expected to commence in June 2026.

Living Well Warrington

The Trust is a core partner in the delivery of the Living Well Warrington programme, developing and delivering new and innovative approaches to delivering health and care services in the community as a way to prevent ill health, tackle health inequalities and meet the needs of the population in different ways.

The Living Well Hub is a pioneering multi-agency wellbeing hub, unique for its extensive partnership model involving more than 20 organisations from physical and mental health, local authority, and voluntary sectors. It focuses on early intervention, ill-health prevention, and self-care, targeting key population cohorts such as children and families, older people, and care leavers/children in care. The hub’s timetable, developed collaboratively, ensures integrated service delivery. More than 50,000 people have visited the town centre Living Well Hub, which offers dedicated support from around 70 different services, ranging from dementia support and domestic abuse advice to baby weighing clinics and weight management assistance. The hub

is included as a case study by the National Neighbourhood Health Implementation Programme.

The Living Well Warrington online platform, launched in March 2025, co-developed with statutory and voluntary sector partners to promote services and support wellbeing. It has received more than 100,000 views to December 2025, and the supportive network of Talking Points across Warrington have collectively helped over 900 people with advice and support over the past 12 months.

Halton Health Hub

Opened in November 2022 within Shopping City, Runcorn, Halton Health Hub is a standalone outpatient unit offering Trust services such as optometry, orthoptics, audiology, and dietetics for adults and children. It provides space for partners to deliver preventative and early intervention services, including:

- an out-of-hours GP service by the local GP Federation
- Halton Borough Council's Health Improvement Team delivering smoking cessation and tier three weight management services
- 'Travel Well' link workers from Halton Travel Well, a service by Wellbeing Enterprises in partnership with Liverpool City Region Combined Authority and the Trust, promoting active travel to improve health and wellbeing

Wider determinants of health

The Trust's Director of Strategy and Partnerships co-chairs the Wider Determinants of Health workstream within the One Halton place-based partnership. This workstream addresses economic regeneration, crime reduction, education, workforce, living conditions, and adopts a Marmot approach, with workplans integrated into One Halton's 2024-25 strategy.

Consultation with large groups and organisations

The Trust adheres to legal duties for public involvement (NHS statutory guidance, Patient and Public Involvement Strategy 2021-26, and National Healthcare Inequalities Improvement Programme), applying best practice to engagement. No service changes required public consultation during this period, but engagement continued through:

- **Experts by Experience (EbyE) Programme**: Volunteers with lived experience provide insights into service access. In 2025-26, 36 new participants joined our EbE Programme, increasing the total to 221. EbyEs supported projects including map improvements at Warrington Hospital, hospital associated deconditioning experience feedback, Ward A8

redevelopment at Warrington Hospital, development of a patient forum for those affected by chronic respiratory conditions, estates development within outpatient services and a patient communications skills workshop to support MSc Pre-registration Physiotherapy students.

- **Community engagement**: This year we hosted 18 stands at community events across both Warrington and Halton, including Chinese Lunar New Year, International Clinical Trials Day, Disability Awareness Day, Warrington Armed Forces Day, Warrington Pride, Warrington Mela and more.
- **Digital projects:** Public engagement was supported this year through EbyE development and user testing of the refreshed WHH Charity website and awareness sessions about the use of Ambient Voice Technology within the Trust.
- **Third-sector engagement**: We attend multiple voluntary sector networks, including the Trans Advocacy and Protection Network (Cheshire), Halton Voluntary, Community, Faith and Social Enterprise Network, Warrington Disability Partnership's Staying Connected Forum and Warrington and Halton Maternity and Neonatal Voices Partnership meetings.
- **Better Care Together engagement:** Throughout engagement events this year, we asked the public to share their thoughts on the coming together of the Trust and Bridgewater Community Healthcare. Although there were some concerns about implementation, particularly around staffing and service capacity, responses from both staff and the public were overwhelmingly positive overall. Feedback suggested the public understood potential benefits but also wanted assurance that the integration programme would be properly resourced and managed.

Significant partnerships and alliances

The Trust has forged robust partnerships at national, regional (Cheshire and Merseyside), and local (Halton and Warrington) levels to enhance healthcare delivery and address health inequalities.

Regional partnerships

- **Cheshire and Merseyside Acute and Specialist Trusts provider collaborative (CMAST)**: The Trust is a core member, collaborating on pathology services, paediatric surgery, and sustainable regional services (e.g. ENT).
- **Pathology collaboration**: A regional Laboratory Information Management System (LIMS) will standardise pathology result management. The Trust

partners with Mersey and West Lancashire Teaching Hospitals NHS Trust to develop an East Pathology Hub.

- **Clinical Research**: Partnerships with the NHS University Hospitals of Liverpool Group and Clinical Research Network Northwest Coast enhance research participation.

Local partnerships

- **Place-based partnerships**: Active engagement in Warrington and Halton's place-based partnership boards, chairing the Warrington Place Estates Group and co-leading the One Halton Wider Determinants of Health workstream. The Trust is also a member of a Halton Borough Council-led strategic board leading development of Widnes Town Centre
- **Integration with Bridgewater Community Healthcare NHS Foundation Trust**: Work has begun to integrate both Trusts by April 2026, subject to approvals, to deliver care closer to home, enhance population health, and reduce inequalities through shared leadership and technology.
- **Educational partnerships**: A supported internship scheme with Warrington and Vale Royal College aids students with special educational needs and disabilities (SEND) to gain employment skills. Riverside College is a core partner in the delivery of the Well Runcorn Hub project, due to open in June 2026.
- **Commercial partnerships**: Collaboration with Halton Borough Council and Runcorn Shopping City supports regeneration in deprived areas.

Funding and innovation

The Trust has secured non-traditional funding through partnerships with One Public Estate, Liverpool City Region, local councils and housing associations. The Living Well Warrington platform and Runcorn Health and Education Hub exemplify innovative funding models, leveraging Towns Fund and Shared Prosperity Fund contributions.

Conclusion

Through strategic partnerships, community engagement and innovative service delivery, the Trust is transforming healthcare in Halton and Warrington. By addressing health inequalities, enhancing diagnostic capacity and fostering collaborative models like the Living Well Hub and CDC, the Trust is delivering on its

commitment to improve health outcomes and support resilient, integrated local services.

Nikhil Khashu

Chief Executive

22 June 2026

4. Remuneration Report

4.1 Annual statement on remuneration

Statement from the Chair of the Nominations and Remuneration Committee:

The Board of Directors delegates the responsibility to a Board Nominations and Remuneration Committee (NARC) to make decisions regarding the nomination, appointment, remuneration and conditions of service for executive directors including the chief executive. This committee also has general oversight of the Trust's pay policies but only determines the reward package for directors and staff not covered by Agenda for Change. The vast majority of staff remuneration, including the first layer of management below Board level, is covered by the NHS Agenda for Change pay structure.

The membership of the committee consists of the Trust chair and all non-executive directors. The chief executive, company secretary and chief people officer also attend as appropriate.

Between 1 April 2025 and 31 March 2025, the committee held four meetings and considered one proposal which was approved virtually via email.

Committee members' attendance at meetings is given in the table below.

Member	**Attendance (Actual v Max)**
Steve McGuirk, Chair	4/4
Cliff Richards, Non-Executive Director and Deputy Chair	2/4
Mike O'Connor, Non-Executive Director and Senior Independent Director	3/4
Jayne Downey, Non-Executive Director	1/4
John Somers, Non-Executive Director	2/4
Julie Jarman, Non-Executive Director	4/4

Nominations

In year, the committee considered and approved matters relating to appointments, role design and executive arrangements, including:

- recruitment of the Chief Nurse

- approval of secondment arrangements associated with joint executive roles, with Bridgewater Community Healthcare NHS Foundation Trust (BCHT), including the Chief Nurse and Director of the Delivery Unit
- consideration of governance and board role arrangements following the acquisition of BCHT
- recognition of joint working arrangements where roles were not formally established as joint executive posts

Remuneration

In year, the committee considered and approved matters relating to executive pay, remuneration frameworks and severance arrangements, including:

- Application of the National Very Senior Managers (VSM) Pay Framework
- Remuneration of the Chief Nurse, Executive Medical Director and Chief Operating Officer, including salary arrangements and associated addenda to secondment agreements where applicable
- Remuneration of the Executive Team post transaction
- Consideration of VSM pay in the context of the NHS National Oversight Framework and National Performance and Assessment Framework segmentation
- Approval of arrangements under the Mutually Agreed Resignation Scheme (MARS)
- Approval of the Mutually Agreed Resignation Scheme for 2026-27

4.2 Senior Manager Remuneration Policy

The definition of ‘senior managers’ for the purpose of the following disclosures is those staff with ‘authority or responsibility for directing or controlling major activities within the group body. This means those who influence the decisions of the entity as a whole, rather than the decisions of individual directorates or departments. The Chief Executive has confirmed that, in this context, the Trust’s Executive Directors, together with the Chair and Non-Executive Directors, are its ‘senior managers’.

On 15 May 2025, the Minister of State for Health published the ‘Very Senior Managers Pay Framework’, designed to support the NHS in securing the best senior leaders, with the right skills and experience, to deliver exceptional care and services for patients and their local communities. The framework took effect from 1 April 2025.

The framework applies to all Integrated Care Boards (ICBs) and NHS Provider Trusts and seeks to strengthen the link between reward and performance outcomes, increase transparency, and offer flexibility to attract talented candidates to the most challenging roles.

The VSM pay framework has been jointly produced by NHS England and the Department of Health and Social Care (DHSC), with the policy owned by DHSC as instructed by the Secretary of State for Health and Social Care.

The Trust’s Executive Medical Director is renumerated as per the NHS Consultant Contract.

Compliance with the Very Senior Managers Framework

The Trust has complied with the requirements of the VSM Pay Framework for 2025-26 and applied the 3.25% uplift recommended for VSMs in 2025/26. In 2025-26, there were no salary proposals above the operational maximum or £170,000 requiring NHS England approval.

Explanation of how the components of remuneration operate

CEO and Executive Directors

Basic pay of the CEO and Executive Directors is determined by the Board Nominations and Remuneration Committee, taking into account past performance, future objectives, market conditions, other NHS renumeration terms i.e. Agenda for Change, and comparable remuneration information from trusts within the region.

The CEO and Executive Directors are employed on substantive contracts of employment (contracts of service).

The Trust is required to report the components of the senior managers remuneration policy in tabular format as set out below:

Components of Remuneration Package of Executive Directors and CEO	The Trust's Executive Pay policy only allows for basic pay; there is no performance related pay within the Trust's pay structure for VSMs. There is an additional responsibility payment for the Executive Director undertaking the role of Deputy Chief 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	The Executive Directors and the CEO are paid as per the VSM Pay Framework. The Trust's Executive Medical Director is renumerated as per the NHS Consultant Contract.
Maximum amount that could be paid in respect of the component	Determined by the NHS VSM Pay Framework or the NHS Consultant Contract.
Explanations of any provisions for recovery	If an individual is overpaid in error, there is a contractual requirement to recover the overpayment as per the Trust's Overpayment and Underpayment Policy.

New components of Renumeration Package in 2025/26

Following the secondment of Executive Director roles from Warrington and Halton NHS FT to also include Bridgewater Community NHS FT, as per the VSM Pay Framework, additional non-pensionable and non-consolidated payments were approved for the joint roles of Chief Nurse and Chief Operations Officer.

Difference between Trust Policy on VSM Renumeration and General Policy on Employee's Renumeration

The Trust complies with the renumeration schemes operated by the NHS which include the VSM Pay Framework, Agenda for Change and Medical and Dental Terms and Conditions.

Non-Executive Directors

Basic pay of the Non-Executive Directors is determined by the Governor Nominations and Remuneration Committee.

The Trust is required to report the components of the Non-Executive Directors remuneration policy in tabular format as set out below:

Fee payable to Non-Executive Directors	Non-executive director fees are determined in line with national guidance and approved by the Council of Governors.
Any additional fees payable for any other duties to the Trust	None
Any other items considered as renumeration in nature	No

Policy on payment for loss of office

Notice periods are included in the CEO and Executive Directors' employment contracts and are currently set at six months. Payments in lieu of notice are contained within the contract of employment and are subject to tax and national insurance deductions. Payments made other than through notice periods are set out in the Organisational Change Policy i.e. through redundancy/mutually agreed severance schemes. Payments to any staff member outside contractual terms are scrutinised by the Board's Nominations and Remuneration Committee.

There are no special contractual compensation provisions for early termination of the CEO or Executive Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the Agenda for Change (AfC): NHS Terms and Conditions of Service Handbook (section 16).

Diversity and inclusion

The Trust has a Workforce Equality, Diversity and Inclusion (EDI) Strategy 2022-25 and an Equality and Diversity Policy in place which is used as a reference point for equality and diversity. Both governance documents highlight the importance of equality impact analysis in the form of an Equality Impact Assessment being completed for all policies and procedures. This is therefore relevant to all policies pertaining to remuneration, for example, the Trust Organisational Change Policy.

In addition, the Trust's Workforce EDI Strategy includes objectives focused on improving and reviewing the Trust's approach to attraction, recruitment and retention, ensuring processes are fair, equitable and continue to promote diversity. This is and will continue to be a consideration for the Nominations and Remuneration Committee in its decision making.

The Trust completes its gender pay gap reporting on an annual basis, which is reviewed at the Workforce EDI Sub-Committee and ratified at the Strategic People Committee on behalf of the Trust Board. This is reported annually on the Trust

website and can be found here: https://whh.nhs.uk/about-us/corporate-publications-and-statutory-information/equality-diversity-and-human-rights

All progress relating to the objectives of the Workforce EDI Strategy 2022-2025 are monitored and reported to the Workforce Equality, Diversity and Inclusion Sub-Committee and Strategic People Committee for assurance. A copy of the Workforce EDI Strategy is available via our external website.

4.3 Annual report on remuneration

Annual report on directors' remuneration – year ended 31 March 2026 (and comparison year ended 31 March 2025) (subject to Audit)

The following table includes salary, benefits-in-kind and all pension related benefits received (whether in cash or otherwise) by each director during the year under review. Pension related benefits included here are the annual increase (expressed in £2,500 bands) in pension entitlement less any contributions paid by employees.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

SENIOR MANAGERS REMUNERATION 2025-26 (and comparison 2024-25 audited)

INCLUDES SALARY SACRIFICE

	2025-26						2024-25					
	Directors ' salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual performance -related bonuses (in bands of £5,000)	Long-term performance -related bonuses (in bands of £5,000)	All pension-related benefits (bands of £2500)	**Total (bands of £5,000)**	Directors ' salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual performance -related bonuses (in bands of £5,000)	Long-term performance -related bonuses (in bands of £5,000)	All pension-related benefits (bands of £2500)	**Total (bands of £5,000)**
	£000's	£	£000's	£000's	£000's	**£000's**	£000's	£	£000's	£000's	£000's	**£000's**
Executive directors												
Nikhil Khashu Chief Executive From 1st November 2024 **Note 1**	140-145	0	0	0	380-382.5	**520-525**	55-60	0	0	0	45.47.5	**105-110**

Prof Simon Constable Chief Executive **Left August 2024**	0	0	0	0	0	0	95-100	0	0	0	22.5-25	120-125
Alison Kennah Chief Nurse From 1st April 2024 **Note 4**	100-105	0	0	0	100-102.5	**200-205**	130-135	0	0	0	205-207.5	335-340
Dan Moore Chief Operating Officer **Note 2**	105-110	0	0	0	47.5-50	155-160	145-150	0	0	0	150-152.5	295-300
Zoe Harris Acting Chief Operating Officer From September 24 to October 24	0	0	0	0	0	**0**	20-25	0	0	0	10-12.5	30-35
Michelle Cloney Chief People Officer **Left March 2026**	150-155	0	0	0	0	150-155	145-150	0	0	0	70-72.5	215-220
Dr Paul Fitzsimmons Medical Director **Note 3**	175-180	0	0	0	115-117.5	290-295	185-190	0	0	0	70-72.5	255-260
Lucy Gardner Director of Strategy & Partnership	145-150	0	0	0	40-42.5	185-190	140-145	0	0	0	40-42.5	180-185
Kate Henry												

Director of Communications & Engagement	125-130	0	0	0	37.5-40	**165-170**	120-125	0	0	0	22.5-25	145-150
Jane Hurst Chief Finance Officer from 1 October 2023	155-160				110-112.5	**265-270**	140-145	0	0	0	**115-117.5**	255-260
Chairman and non-executive Directors												
Steve McGuirk Chairman	45.-50	0	0	0	0	45-50	45-50	0	0	0	0	45-50
Clifford Richards Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Michael O'Connor Non-Executive Director from November 2021	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Julie Jarman Non-Executive Director from January 2022	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Jayne Downey Non-Executive Director from April 2022	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
John Somers Non-Executive Director from August 2022	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
	0-5					**0-5**	0	0	0	0	0	**0**

Andrew Carter Non-Executive Director from January 2026												

Notes:

Note 1

N Khashu is 2 days Temporary Chief Executive for Bridgewater NHS Trust wef 1st November 2024. For Financial Year 2025-26 the banding for the Chief Executive of total salary and pension related was 610-615

Note 2

D Moore is 2 days Temporary Chief Operating Officer for Bridgewater NHS Trust wef 9th December 2024. For Financial Year 2025-26 the banding for the Chief Operating Officer of total salary and pension related was 230-235

Note 3

P Fitzsimmons is 1 day Temporary Medical Director for Bridgewater NHS Trust wef 18th November 2024. For Financial Year 2025-26 the banding for the Chief Medical Officer of total salary and pension related was 330-335

Note 4

A Kennah is 2 days Temporary Chief Nurse for Bridgewater NHS Trust wef July 2025. For Financial Year 2025-26 the banding for the Chief Nurse of total salary and pension related was 245-250

Pension entitlements year ended 31 March 2026 (subject to Audit)

Name and title	Real increase in pension at age 60 (bands of £2,500)*	Real increase in pension lump sum at age 60 (bands of £2,500)*	Total accrued pension at age 60 at 31 March 2026 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real increase in Cash Equivalent Transfer Value*	Cash Equivalent Transfer Value at 31 March 2026	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Nikhil Khashu Chief Executive From 1st November 2024	17.5-20	40-42.5	80-85	200-205	550	**1,177**	1,764	0

Jane Hurst Chief Finance Officer	5-7.5	7.5-10	55-60	135-140	1,059	109	1,206	0
Alison Kennah Chief Nurse From 1st April 2024	5-7.5	7.5-10	55-60	140-145	1,203	120	1,361	0
Dan Moore Chief Operating Officer	2.5-5	0-2.5	40-45	90-95	712	36	779	0
Dr. Paul Fitzsimmons Medical Director	5-7.5	7.5-10	50-55	115-120	852	99	987	0
Michelle Cloney Chief People Officer	0	0	65-70	170-175	1,773	0	188	0
Lucy Gardner Director of Strategy and Partnerships	2.5-5	0	25-30	5-10	341	24	388	0
Kate Henry Director of Communication and Engagement	2.5-5	0	25-30	0	338	22	380	0

Notes:

As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive directors. The benefits and related CETVs do not allow for potential future adjustment for some eligible employees arising from the McCloud judgement.

As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive directors. The benefits and related CETVs do not allow for potential future adjustment for some eligible employees arising from the McCloud judgement.

Total remuneration

During the year the following payments were made by the Trust to the executive and non-executive directors.

	2025-26 £000	2024-25 £000
Remuneration including employers' national insurance contribution for executive and non-executive directors	1,408	1,475
Employers' contribution to pension in relation to executive directors	158	155

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

4.4 Remuneration report

Expenses paid to directors and governors (unaudited)

Expenses paid to directors of the Trust include all business expenses arising from the normal course of business and are paid in accordance with the Trust's policy. Non-executive directors are also reimbursed reasonable expenses relating to their work as directors of the Trust.

Expenses paid to governors are made in accordance with the Trust's constitution and related to the work as governors of the Trust. Governors do not receive any other payments from the Trust. All governors have a responsibility to ensure that they incur only reasonable expenses, which includes travel costs for attendance at, for example, Council of Governors and committee meetings held at the Trust or for attendance at training courses and conferences and that the cost to the Trust is kept as low as possible. The table below states the total amount of expenses reimbursed to directors and governors for 2025-26 and comparative figures for 2024-25.

	Number in office	Number claiming expenses during the year	**Total expenses claimed**	Number in office	Number claiming expenses during the year	**Total expenses Claimed**
	2025-26 Number	2025-26 Number	**2025-26 £**	2024-25 Number	2024-25 Number	**2024-25 £**
Directors	15	4	**2,733**	15	6	3,016
Governors	31	1	81	28	0	0
Total 2025-26:						

Fair pay multiple (subject to Audit)

2025-26	**25th percentile**	**Median**	**75th percentile**
Salary component of pay	£26,998	£37,796	£46,580
Total pay and benefits excluding pension benefits	£29,691	£37,796	£52,507
Pay and benefits excluding pension: pay ratio for highest paid director	6.06 :1	4.76:1	3.42 :1

2024/25	25th percentile	Median	75th percentile
Salary component of pay	£29,101	£34,653	£44,836
Total pay and benefits excluding pension benefits	£29,101	£37,100	£51,869
Pay and benefits excluding pension: pay ratio for highest paid director	6.96 :1	5.46 :1	3.90 :1

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 banded remuneration of the highest paid director in the organisation in the financial year 2025-26 was £180,000 (2024-25 £202,500). This is a change between years of -11.1%. This is mainly due to secondment arrangement with Bridgewater Community Healthcare NHS Foundation Trust for 12 months in 2025/26.

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

For employees of the Trust as a whole, the range of remuneration in 2025-26 was £17,560 to £419,664 (2024-25 £13,000 to £430,922). The percentage change in the average employee remuneration between years is 1.49%. 91 employees received remuneration in excess of the highest-paid director in 2025-26 (2024-25: 57 employees).

Expenditure on consultancy

The Trust has incurred the following expenditure on consultancy services:

	2025-26	2024-25
Total expenditure (£000's)	**0**	270

There was zero expenditure on consultancy services in 2025-26

Nikhil Khashu
Chief Executive
22 June 2026

4.5 Reporting high paid off-payroll arrangements

For all off-payroll engagements as of 31 March 2026 for more than £245 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2024	0
of which...	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2025 and 31 March 2026, for more than £245 per day and that last for longer than six months:	
Number of new engagements, or those that reached six months in duration between 1 April 2024 and 31 March 2025	0
of which...	
Number assessed as within the scope of IR35	0
Number assessed as NOT within the scope of IR35	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026	
Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year	37*

**All directors (including non-executive directors) and bands 8d and 9 (all on payroll) employed within 2025-26*

5. Staff Report

5. Staff Report Introduction

The Trust employs around 5,000 staff comprising 85 nationalities. Most of these staff are employed and paid as per national terms and conditions which are Agenda for Change or Medical and Dental terms and conditions. A small number of staff, which comprises the Trust Board, are employed under local terms and conditions of service and remunerated as per the national Very Senior Manager Pay Framework.

All staff are appointed subject to meeting the NHS Standards on Employment Checks which includes workplace references, health checks, DBS checks, immigration checks and identity checks. This ensures that the Trust can be confident, before staff commence employment, that we know some background about our staff and that they have a legal right to work for the Trust. In addition, the Trust has developed a number of values and behaviours which are fully embedded into the organisation. It expects its staff to demonstrate these values and behaviours in their day-to-day work, and all future appointments are required to demonstrate these values and behaviours as part of the selection process.

By adopting the national pay and terms and conditions of service, the Trust has the assurance that all staff will be treated fairly and will comply with various legislation. This includes the assurance that staff receive at least the National Living Wage, and that equal pay considerations are met.

The Trust has various employment policies and procedures in place designed to provide guidance and advice to staff and managers, and to also comply with employment legislation. Every policy is impact assessed from an equality, diversity and inclusion perspective, ensuring that equality of opportunity is considered as well as ensuring no staff experience discrimination, harassment or victimisation.

The Trust has specific policies in place to deal with the safeguarding of children and adults at risk, with our approach to the Modern Slavery Act embedded into current safeguarding policies. The Trust employs an Associate Chief People Officer of Strategic Workforce Development and Culture and an Associate Chief Nurse of Safeguarding, who take the lead on the Modern Slavery Act. The Trust supports awareness raising events both locally and nationally on such matters, including events focused on hate crime, disability, LGBTQIA+, race, honour crime and forced marriages.

The Trust has an extensive training and development programme which is based on a minimum requirement to complete all statutory and mandatory training and other role specific training which staff are required to undertake for their various roles. Training needs are identified through individual appraisals, and a specific personal development plan is produced.

The Trust recognises that its workforce is central to achieving its mission of ‘being outstanding for our patients, communities and each other’. By harnessing the talents of the workforce and creating the conditions for staff to provide excellent care, the Trust believes it will be recognised as ‘outstanding’ – somewhere where people want to be cared for, and somewhere where people want to work.

People Strategy

The Trust's People Strategy 2022-25 has been of prime focus since launching in 2022. The strategy is aligned to the NHS People Plan, NHS People Promise and the NHS Future of HR and OD report, creating an overarching strategic people delivery plan for 2022-25.

Our strategic objective for our workforce is to 'be the best place to work, with a diverse and engaged workforce that is fit for now and the future'. We will achieve this strategic objective through the four People Pillars set out in the People Strategy:

- **Looking after WHH people** – We will prioritise the safety, health and wellbeing of our people to ensure work has a positive impact through the recognition and appreciation of our people, and by providing the best patient and staff experience.
- **Innovating the way we work** – We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for patients.
- **Growing our WHH workforce for the future** – We will support personal and professional development ensuring equal access to opportunities, and will nurture, grow and develop diverse teams with a shared purpose to care for our patients.
- **Belonging in WHH** – We will enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

The Trust has continued to deliver against its people objectives, recognising their importance in supporting the workforce. Successes to date include:

- the development of WHH leaders to support staff health and wellbeing
- refreshed appraisal and health and wellbeing conversations
- maintaining SEQOSH accreditation
- development of a formalised OH support mechanism with a focus on service delivery
- implementation of new electronic recruitment system
- implementation of new electronic occupational health system
- enhanced use of apprenticeships
- enhanced digital capability
- widening participation in development programmes including 'supported internship' programme for adults with learning disabilities
- staff voice leading improvement
- equality related objectives for all staff dedicated within the Workforce Equality, Diversity and Inclusion Strategy 2022-25 (see section 5.5)
- enriched core training and development offer

We continue to strive to be the best place to work with a diverse and engaged workforce that is fit for now and for the future.

5.1 Analysis of staff costs

	2025/26	2024/25
	£'000s	£'000s
Salaries and wages	212,970	200,345
Social security costs	26,446	20,485
Apprenticeship levy	1,028	987
Pension costs (employer contributions to NHS Pensions)	24,381	23,203
Pension costs (employer contributions paid by NHSE on Provider's behalf (6.3%))	15,936	15,216
Pension costs (other)	52	70
Termination benefits	661	77
Temporary staff - external bank (note 1)	31,148	31,841
Temporary staff - agency/contract staff (note1)	2,975	3,732
Total employee benefit expenses	**315,597**	**295,956**
Less costs capitalised as part of assets	(1,752)	(1,583)
Total per employee expenses in Note 4.1	**313,845**	**294,373**

5.2 Analysis of average staff numbers

The average number of employees is calculated as the whole-time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.

	2025-26		2024-25		2023-24	
Staff category	**Permanently employed**	**Other**	**Permanently employed**	**Other**	**Permanently employed**	**Other**
Medical and dental	243	123	230	109	214	121
Administration and estates	1162	13	1179	24	1224	26
Healthcare assistants and other support	685	11	696	17	719	18
Nursing, midwifery and health visiting	1163	6	1149	4	1144	9
Scientific, therapeutic and technical	592	5	560	5	550	6
Total	**3844**	**158**	**3814**	**159**	**3851**	**180**

5.3 Breakdown each year end of each gender by directors, other senior managers and employees

Below is a breakdown of the number of male and female directors and senior managers, calculated by using the average headcount for each month in the financial year.

	2025-2026		2024-2025		2023-2024		2022-2023		2021-2022		2020-2021		2019-2020	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Directors (executive, non-executive and associate non-executive director)	7	8	5	7	7	9	9	7	8	8	8	8	8	8
Senior managers (band 8a and above)	61	264	53	231	60	243	58	230	57	210	57	191	54	168
Other employees	948	3791	854	3,486	893	3,709	808	3,414	964	3,673	913	3,568	843	3,459

5.3.1 Gender pay gap

The Trust is committed to furthering equality, diversity and human rights and reducing inequalities in the workplace. Warrington and Halton Teaching Hospitals NHS Foundation Trust addresses equality and fair access to career pathways and progression in our Workforce Equality, Diversity and Inclusion Strategy 2022-25.

Under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and with reference to the Cabinet Office website (https://gender-pay-gap.service.gov.uk/), WHH is required to report annually by 30 March on its gender pay gap.

A full report, including the analysis of the data, can be found here: https://northcheshireandmersey.nhs.uk/about-us/statutory-information/equality-diversity-and-inclusion/

5.4 Sickness absence data

Supporting attendance
The Trust has a clear and robust framework within which managers are able to address the issues of attendance and sickness absence with a consistent, supportive and fair approach through the Supporting Attendance Policy. There is a strong focus on workforce health and wellbeing across the organisation, as set out within our People Strategy.

The Trust has initiatives to support health and wellbeing, which include targeting areas with higher sickness absence rates and offering education, support and signposting to health and wellbeing services. The Trust has introduced health and wellbeing appraisals, and bespoke training for managers around the importance of health and wellbeing. These preventative measures support the workforce to remain healthy in the workplace.

Sickness Absence Data:
Sickness absence data Sickness absence data for NHS organisations is published online by NHS Digital. The table below shows the figures for January to December 2025 which is required to be disclosed in an organisation's annual report:

Figures Converted by DH to Best Estimates of Required Data Items				**Statistics Published by NHS Digital from ESR Data Warehouse**	
Months	Average FTE for 2025	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
12	4,158	57,829	13.9	1,517,501	93,811

For more information in respect of sickness absence, please use the following link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff turnover

Improving staff turnover and retention is a fundamental part of the People Strategy and NHS People Plan. The Trust's focus on staff wellbeing and personal development supports a sustained reduction in turnover. In addition, the Trust continues to support individuals to return to the workplace following retirement,

recognising their invaluable skills and experience. Fifty per cent of individuals who retire return to the Trust in some capacity.

The Trust supports staff to achieve a work/life balance by offering flexible and agile working arrangements, and this year has trialled preference rostering, a process by which individuals select their preferred shifts. Individuals and line managers are encouraged to reflect upon the flexibility of roles and are supported to do so through dedicated policies and toolkits.

The Trust measures both overall turnover and retention of permanent staff only. For information in respect of staff turnover, please use the following link:
NHS workforce statistics - NHS England Digital

5.5 Staff policies and actions applied during the financial year

All workforce policies are subject to consultation through the Policies and Procedures meeting which both staff side and management attend. Agreed workforce policies are ratified by the Trust's Operational People Committee. An Equality and Health Inequalities Impact Assessment (EHIA) must be completed for all workforce policies.

Employment and Support for Disabled People

During the financial year, the Trust continued to apply robust equality and recruitment policies to ensure that disabled applicants receive full and fair consideration for employment. Recruitment processes are designed to focus on an individual's skills, experience and competencies, with reasonable adjustments offered throughout the recruitment process where required. All recruiting managers are supported to apply the Equality Act 2010, and the Trust maintains its commitment to inclusive recruitment practices that value difference and promote equality of opportunity.

The Trust has clear policies in place to support employees who become disabled during their employment. These include access to occupational health services, workplace assessments, flexible working arrangements and reasonable workplace adjustments. The Trust aims to retain the skills and experience of staff wherever possible and works proactively with individuals and managers to facilitate continued employment in a supportive and safe environment.

Disabled employees have equal access to learning, development and promotion opportunities. The Trust's learning and development framework supports personalised development plans, reasonable adjustments for training, and flexible approaches to progression. Policies and practices are reviewed to ensure that disabled staff are not disadvantaged in accessing development or advancement opportunities.

Employee Information, Consultation and Engagement

The Trust has a range of formal and informal communication mechanisms to ensure employees are kept informed about matters affecting them. These include staff briefings, intranet updates, regular trust-wide communications, team meetings and engagement events. These channels are used systematically to communicate organisational priorities, performance updates, and significant changes.

Team Brief continues to be an open invitation to all staff within the organisation, presented by the Chief Executive in a virtual format. The content focuses on strategic updates including national and regional developments and trust priorities, while also ensuring that there is an opportunity for any questions to be asked. During

2025-26 this has been supplemented by regular joint staff engagement sessions focused on our integration with Bridgewater Community Healthcare.
Safety Brief provides an update on key patient safety matters each day Monday to Friday.

In addition, the Culture, Engagement and Inclusion Team visit clinical and non-clinical areas across the organisation to deliver any key messages or information on campaigns that will be of interest to the workforce. The organisation has also implemented culture champions made up of representatives from all staff groups across the organisation to support the delivery of the organisation's culture, and to keep department areas updated with initiatives that affect the workforce.

The Trust has a strong culture of partnership working with staff side colleagues and continues with the ongoing Joint Negotiating and Consultative Committee (JNCC) meetings, providing a forum for communication and collaborative working. The groups meet every two months as a forum for consultation and negotiation on a range of issues that are of common interest to the workforce. Staff side colleagues work in partnership with the People Directorate on a range of engagement initiatives such as enhancing staff facilities, WHH staff lottery and the You Made a Difference monthly recognition panels. There is also a bi-monthly Joint Local Negotiating Committee (JLNC) which feeds into JNCC, relating to medical staff. In addition to the formal partnership working structures, there are a range of informal 'touch points' each month between the People Directorate and staff side colleagues.

During the year, the Trust consulted regularly with employees and their representatives, including recognised trade unions and staff side. Consultation arrangements ensure that staff views are considered in decisions likely to affect their interests, particularly in relation to organisational change, workforce policies and service transformation. Formal consultation forums and engagement sessions are supplemented by local mechanisms to support meaningful dialogue.

The Trust encourages the involvement of employees in improving organisational performance through staff engagement activity, improvement initiatives and feedback mechanisms. Staff are supported to contribute ideas for service improvement, quality and safety, and efficiency through local improvement work, engagement events and leadership programmes. This approach supports a culture of continuous improvement and shared ownership of performance.

In addition to internal mechanisms, employee voice is also heard through the national annual staff survey and the Quarterly People Pulse survey, which provides consistent questions aligned to the NHS People Promise. Staff networks continue to be supported within the organisation, each with an executive sponsor who continues to ensure that employee voice is heard and acted upon. The chairs of each network meet regularly with the Chief Executive and Chief People Officer to escalate any issues or concerns, and to share best practice.

Our Culture and Engagement Team continue to seek engagement from all areas of our workforce through the delivery of Culture Corners, which has been cited as best practice by NHS England to bring ideas to life and to improve patient care and staff experience. To ensure that there is equality of opportunity and diversity of thought in

our decision-making, the team support improving diversity in any staff group feedback mechanisms to ensure representation from our workforce profile and local population census.

Health and Safety Performance

The Trust is committed to providing a safe and healthy working environment for all employees. Health and safety performance is monitored through formal governance arrangements, including reporting of incidents, risk assessments and compliance with statutory duties.

Occupational Health

Employees have access to occupational health services to support physical and mental wellbeing, sickness absence management and workplace adjustments. Health and safety training and wellbeing initiatives continue to support a preventative approach.

Our Occupational Health and Wellbeing Team deliver our in-house occupational health service and have responsibility for supporting staff health and wellbeing. The department is a Safe Effective Quality Occupational Health service (SEQOSH) accredited nurse-led unit. The team consists of specialist nurses, physiotherapists, administrators and an external occupational health doctor offering a robust occupational health and wellbeing service, supporting our People Strategy.

The department provides pre-employment health clearance, vaccinations, winter vaccination campaigns, wellbeing and health support, response to management referrals, support with ill health retirement, health surveillance, needlestick injuries, crisis support, case conferencing, targeted education sessions and physiotherapy. In 2025-26, the Occupational Health Team continued to provide proactive public health initiatives to support the health needs of the workforce.

The organisation also has an in-house Mental Wellbeing Hub providing a space where staff feel safe within a confidential environment to explore any difficulties they may be facing. The team has two counsellors who offer a range of therapeutic and self-care interventions. Treatments include cognitive behaviour therapy, hypnotherapy, counselling, EDMR (commonly used for post-traumatic stress), group therapy and mental health training for individuals and line managers.

Key highlights of the year include:

- Flu vaccination programme
    - The Trust supported the delivery of a flu vaccination programme.
    - 2,383 flu vaccinations were delivered.

- Partnership working
    - The Ruby League Cares partnership supports the delivery of ‘Offload’ sessions to teams, supporting their health and wellbeing.
    - Bespoke interventions and health promotion activity were delivered with local organisations such as Living Well, who delivered drop-in

sessions for Cervical and Bowel Cancer Screening and the Halton Health Improvement Team, who supported with further Mental Wellbeing sessions.

- Be Present, Be Here – Supporting Attendance and Wellbeing Programme
    - The Occupational Health and Wellbeing service are part of the Be Present, Be Here, Be WHH programme, which targeted support at leadership teams, developing their knowledge and equipping them with tools to enhance support for our employees.

- Bespoke interventions
    - Health and wellbeing day events for areas experiencing high levels of sickness have taken place.
    - There has also been proactive blood pressure monitoring in high-risk areas.

Counter Fraud and Corruption

The Trust has policies and procedures in place to prevent, detect and address fraud, bribery and corruption. These arrangements align with national NHS Counter Fraud Authority requirements and include awareness training, investigation arrangements and clear reporting mechanisms. Staff are expected to adhere to the highest standards of integrity and professionalism, and concerns can be raised confidentially through established reporting routes.

Diversity and Inclusion

The Trust is committed to equality, diversity and inclusion across our workforce. We aim to be a leading organisation which is recognised locally, regionally and nationally for promoting equality, diversity and inclusion.

As part of the specific duties outlined in the Public Sector Equality Duty, the Trust published the Workforce Equality, Diversity and Inclusion Strategy for 2022-25 in April 2022. This includes a review of the organisation's strategic objectives and aligns a separate strategy for patients, service users and staff. This strategy was extended in March 2025 to run until April 2026.

The strategy outlines the Trust's commitment to workforce equality, diversity and inclusion, ensuring WHH is the best place to work and details the steps we will take to be an inclusive employer creating a culture of belonging for all. The strategy is aligned to the NHS People Plan, and internal People Strategy 2022-25, outlining the ambition for our workforce strategy to support the delivery of the NHS Long Term Plan.

The integrated 'People Promises' within the Workforce Equality, Diversity and Inclusion Strategy 2022-25 are:

Looking after our WHH people:

1. We will address health inequalities at WHH

2. We attract and retain people at WHH creating a positive impact on our communities

Innovating the way we work:

3. Create an open, productive and learning environment that educates and addresses privilege and everyday bias
4. Reach into WHH communities, understanding and drawing from the communities it serves, acting as an 'anchor institution'

Growing our WHH workforce for the future:

5. Ensure that WHH talent management, recruitment and career pathways address under-representation and promote diversity
6. Champion policies and practices that achieve tangible, measurable improvements to workforce equality, diversity and inclusion

Belonging in WHH:

7. To understand, encourage and celebrate diversity, making WHH a place where we all feel we belong
8. Develop and embed a 'restorative just culture' across WHH that helps to eliminate cultures that bring blame or fear

The Trust continues to undertake a strategic review of equality, diversity and inclusion practice within the organisation which has resulted in a revised Equality and Health Inequalities Impact Assessment (EHIA) and 'due regard' toolkit. This has included the implementation of a bespoke equality analysis training, available to all staff within the organisation. This ensures the cascading of information through operational teams. The approach will enable the organisation to demonstrate the importance of thinking of equality, diversity and inclusion at the outset of any policy, programme, project and as part of the organisational change review process. In addition, this applies best practice from the Health Equity Assessment Tool (HEAT), allowing the organisation to systematically identify and assess the impact of proposals on groups who face health inequalities.

The development of opportunities to engage with our staff voice has continued with the investment in our staff networks. The organisation has five thriving staff networks, which in 2025/26 were connected with Bridgewater Community Healthcare NHS Foundation Trust to become networks 'in common' in the following areas:

- Disability Awareness Network (WHH) and Enabled Network (BCH)
- Progress LGBTQ+ Network (WHH) and LGBTQIA+ Staff Network (BCH)
- Multi-Ethnic Staff Network (WHH) and Race Inclusion Network (BCH)
- Women's Staff Network (both)
- Armed Forces and Veterans Community Network (both)
- Carers Support Network (both)

An annual review of network achievements and activity can be found in the Trust Equality, Diversity and Inclusion Annual Report 2025-26, accessible via the Trust website.

Staff network members have also had the opportunity to participate in a career development programme developed in partnership with Nursing and Organisational

Development and implemented as a result of the findings in the statutory Workforce Race Equality Standard (WRES). This has also led to the development of career progression and cultural competency training programmes, such as the Your Future Your Way leadership development programme.

As part of our organisation's commitment to being recognised as a Trust which promotes and celebrates diversity, WHH is actively seeking to act as a pioneer in the equality, diversity and inclusion agenda. The Trust is recognised for its work in this agenda by a series of charter marks and accreditations externally. They include:

- Disability Confident Leader – re-accredited in 2025/26, demonstrating our commitment to supporting people in work who have a disability
- In-Trust Merseyside and Cheshire Navajo Charter Mark – supporting the LGBTQIA+ community, both in healthcare and accessing work
- Veterans Covenant Healthcare Alliance (VCHA) – supporting our armed forces and military veterans' community in accessing healthcare and work
- Henpicked Menopause Friendly Organisation – achieved in February 2026 as part of our commitment to recognising the impact of menopause in the workplace
- Armed Forces Covenant: Employer Recognition Scheme – Silver Award – recognition for the work the Trust is doing to support our armed forces communities in accessing employment
- NHS Rainbow Badge Phase II (Bronze Award) – in recognition of the work being undertaken to improve the experience and access of our local LGBTQIA+ communities
- NHS North West Anti-Racist Organisation Framework Accreditation. The 'bronze' status has been achieved highlighting that WHH is an inclusive organisation with zero tolerance to any form of discrimination, harassment and victimisation. To support this the Trust has a zero-tolerance statement which was developed with staff networks, recognising the importance of co-designing this with our staff. A copy of this can be found here.

The Trust utilises the NHS Staff Survey annually to identify improvements in equality, diversity and inclusion. In 2025, actions were taken to engage with the workforce; this included working with staff networks and groups to listen, learn and make improvements. It also included disparities for age, race, disability and sexual orientation. Additionally, local departmental actions were monitored at People Committees on a bi-monthly basis for improvements in the workforce profile and experience.

To ensure a representation voice as part of the Equality Delivery System review process, the Trust has engaged with staff network members, union representatives, community partners and other internal stakeholders. This ensures that the views of a wide range of equality and diversity characteristics, and other socioeconomic factors, are considered as part of our equality reporting and sustainability processes.

As part of the Trust's Public Sector Equality Duty requirements the Trust has met all of its statutory reporting. All reports are published on the Trust website, available here.

The outputs of these publications continue to direct our engagement with our patients, our workforce and our communities, and have been an integral part of the Trust's operational and strategic equality, diversity and inclusion agenda.

5.6 NHS Staff Survey

Staff experience and engagement

The organisation has a dedicated culture and engagement function based within the People Directorate which is responsible for ensuring that all members of the workforce feel valued, included, supported and developed irrespective of staff group or protected characteristic.

The Culture and Engagement team are supported by subject matter experts in other areas, including occupational health and mental wellbeing, equality, diversity and inclusion, learning and development, apprenticeships and HR business partnering. There are formal and informal mechanisms in place to support and facilitate effective staff engagement across the whole organisation. Formal mechanisms include the Culture Champion Network, our trade unions and also staff networks such as the Multi-Ethnic Staff Network, Progress LGBTQ+ Network, Disability Awareness Network, Women's Network and Armed Forces and Veterans Community Staff Network.

Informal mechanisms include monthly visibility of the Culture and Engagement Team within clinical and non-clinical areas to disseminate information, share best practice and highlight opportunities for staff voices to be heard and to facilitate staff participation. This is referred to as Culture Corners, recognised nationally by NHS England and NHS Employers as best practice.

The culture and engagement function also leads on the annual National NHS Staff Survey and Quarterly People Pulse surveys. These mechanisms allow for our workforce to share their voice in a confidential space. The team then work with senior leaders and managers to develop robust action plans to address findings from surveys to improve the experience of all our workforce.

In addition, the Culture and Engagement Team support staff engagement through internal mechanisms such as the monthly You Made a Difference Award, which celebrates members of our workforce who have gone above and beyond in their work, making a difference to the lives of those around them. In November 2025 the Trust held long service celebrations, recognising our staff meeting milestones in their NHS career. In May 2025 the Trust also recognised the impact of all our workforce and held its annual Thank You Awards at the Titanic Hotel in Liverpool. This will be followed in May 2026 with a further annual celebration event.

NHS Staff Survey
The NHS Staff Survey is conducted annually. From 2021-22 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replaced the 10 indicator themes used in 2020-21 and earlier years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2025 survey among Trust staff was 39%. A total of 1,812 staff responded to the survey.

Scores for each indicator together with that of the survey benchmarking group (acute and acute and community trusts) are presented below.

Indicators ('People Promise' elements and themes)	**2025-26**		**2024-25**		**2023-24**	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:						
We are compassionate and inclusive	**7.31**	7.28	**7.42**	7.21	**7.48**	7.24
We are recognised and rewarded	**5.96**	5.87	**6.09**	5.92	**6.16**	5.94
We each have a voice that counts	**6.63**	6.60	**6.85**	6.67	**6.91**	6.70
We are safe and healthy	**6.11**	6.07	**6.32**	6.09	**6.37**	6.06
We are always learning	**5.62**	5.57	**5.83**	5.64	**5.77**	5.61
We work flexibly	**6.32**	6.22	**6.39**	6.24	**6.38**	6.20
We are a team	**6.85**	6.75	**6.94**	6.74	**6.97**	6.75
Staff engagement	**6.64**	6.74	**6.92**	6.84	**6.98**	6.91
Morale	**5.86**	5.84	**6.16**	5.93	**6.22**	5.91

The survey findings were analysed across the NHS People Promise themes, Engagement and Morale. Emerging themes are summarised below.

Cultural strengths – Compassion, inclusion and teamwork

WHH continues to perform above sector averages in:

- Compassionate leadership (+0.13)
- Inclusion (+0.11)
- Diversity and equality (+0.16)
- Team working (+0.09)
- Line management (+0.13)

These results show that WHH's interpersonal culture remains a significant asset. Staff continue to experience kindness, respect and cohesion within their teams.

Declining organisational climate – Voice, morale and advocacy

Despite strong team-level culture, the following areas show significant deterioration:

- Advocacy (-0.52)
- Morale (-0.30)
- Voice / Freedom to Speak Up (-0.30)

Staff feel supported by teams but express reduced trust in organisational decision-making and responsiveness. Fewer staff would recommend WHH as an employer or care provider.

Workload, pressure and resources

Staff report sustained operational pressures including:

- Insufficient staffing
- Increasing work demands
- Difficulty meeting job requirements
- Lower satisfaction with equipment and materials

These pressures significantly impact morale and link strongly to turnover intent.

Learning, development and recognition

Areas of decline include:

- Access to development (-0.26)
- Appraisal effectiveness (-0.16)
- Feeling valued (-0.13)
- Pay satisfaction (remains below sector)

Staff perceive insufficient organisational investment in their long-term growth.

Improvements – Burnout indicators and reporting culture

Despite wider pressures, WHH saw improvements in:

- Burnout and emotional exhaustion
- Energy for family/friends (+6.3% to +6.4%)
- Reporting of violence/harassment incidents

This suggests that while systems pressures remain, emotional resilience has improved slightly.

Benchmark Sector Comparison

Areas where WHH performs better than sector

- Compassionate culture
- Compassionate leadership
- Inclusion
- Diversity and equality
- Teamworking
- Line management
- Work–life balance support

These reflect WHH's strength in local leadership and interpersonal climate.

Areas where WHH performs worse than sector

- Advocacy
- Morale
- Work pressure and resourcing
- Patient experience related questions
- Organisational responsiveness

When benchmarked against other acute and acute and community trusts, WHH performed better than the average Trust for all elements of the 2025 NHS Staff Survey except for staff engagement.

The 2025 Staff Survey results provide the Trust with the opportunity to directly respond to staff feedback through robust assurance and priority setting, both at organisational and local departmental level. Following their release in March 2025, the results have been shared with the wider organisation in a variety of accessible methods that capture all staff by utilising existing engagement approaches and communication channels. This includes verbal, written text and infographics.

All care groups and corporate services received their results by People Promise theme. Further work to develop local action plans for improvement are currently under way led by the Culture, Engagement and Inclusion Team and HR Business Partners. The Staff Survey is the primary intelligence source to the We are WHH: Culture Plan. This provides the Trust with the opportunity to review services and departments by a consistent set of metrics at a single point in time. Updates on the delivery of the We are WHH: Culture Plan are reported through the Strategic People Committee bi-annually from 2025-26.

In addition to local priorities, the Culture, Engagement and Inclusion Team are collaborating with trade unions, staff networks, people champions and clinical leads to identify organisational priorities which demonstrate how the Trust is responding to feedback.

It is important that this is undertaken via a collaborative approach in order to secure buy-in, whilst also empowering individuals and ensuring that their contribution is valued by the organisation. This aims to have an impact on future staff engagement scores. This collaborative approach demonstrates that the organisation values the contribution and feedback that the workforce has made and enables the Culture, Engagement and Inclusion Team to facilitate collaborative interventions that directly resonate with and are owned by our workforce.

5.7 Staff exit packages (subject to Audit)

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change and the NHS Pension Scheme. Exit costs are accounted for in full in the year of departure. Where the organisation has agreed early retirements, the additional costs are met by Warrington and Halton Teaching Hospitals and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in the table.

The table below discloses the number and value of exit packages agreed in 2025-26.

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000	Number	£000	Number	£000	Number	£000
<£10,000	1	10	3	36	4	46		
£10,00 – £25,000			27	155	27	155		
£25,001 – £50,000			1	29	1	29		
£50,001 – £100,000			6	435	6	435		
£100,001 – £150,000								
£150,001 - £200,000								
>£200,000								
Total	**1**	**10**	**37**	**655**	**38**	**665**		

The number and value of exit packages agreed in 2024-25 are listed in the table below for comparison.

2024-25

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000	Number	£000	Number	£000	Number	£000
<£10,000			21	64			1	8
£10,00 – £25,000			1	13				
£25,001 – £50,000								
£50,001 – £100,000								
£100,001 – £150,000								
£150,001 - £200,000								
>£200,000								
Total			**22**	**77**			**1**	**8**

Exit packages: non-compulsory departure payments

	2025-26		2024-25	
	Agreements Number	Total value of agreements £000	agreements Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	12	530	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	25	125	22	77
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval *	0	0	1	8
Total	**37**	**655**	**23**	**85**
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

*Includes any non-contractual severance payment made following judicial mediation, and £0 relating to non-contractual payments in lieu of notice.

The Remuneration Report provides details of exit payments payable to individuals named in that report.

6. Statutory Information

6.1 Disclosures set out in the Code of Governance for NHS provider trusts

The Code of Governance for NHS provider trusts was most recently updated in April 2023 and sets out a common overarching framework for the corporate governance of trusts, reflecting developments in the UK corporate governance and the development of integrated care systems.

Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code.

The provisions of the code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of Condition FT4 of the NHS Provider Licence.

The Annual Reporting Manual requires the Board of Directors to have considered the Trust's compliance/non-compliance with the code and to include a statement to this effect in the Annual Report.

The Code of Governance for NHS Provider Trusts comprises the following sections:

Section A: Board leadership and purpose
Section B: Division of responsibilities
Section C: Composition, succession and evaluation
Section D: Audit, risk and internal control
Section E: Remuneration
Appendix: Council of Governors

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation. The purpose of the code is to assist foundation trust boards to ensure good governance and to improve their governance practices by bringing together the best practice of public and private sector corporate governance.

The code imposes some disclosure requirements on foundation trusts and boards are expected to observe the code or to explain where they do not comply. It includes a number of main and supporting principles and provisions, and foundation trusts are required to publish a statement in the Annual Report confirming how these have been applied.

Warrington and Halton Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The Code, which is based on the UK Corporate Governance Code issued in 2012, sets out the expected standards of governance for Foundation Trusts. The Trust has identified two areas of partial compliance; explanations for these are provided in the tables below.

The Trust is declaring compliance with all elements of the code except:

- C.4.3
- D.2.1

The table below provides an explanation where the Trust has departed from the code:

Ref	Code Provisions	Trust Position	Evidence
C.4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the Board of Directors and any decision to extend a term beyond six years should be subject to rigorous review.	**Explain**	The Chair remained in post beyond nine years following a rigorous review and with the agreement of the Council of Governors, in line with the Code of Governance. The decision to extend the Chair's tenure was taken to support continuity and stability at a time of significant organisational change, including the preparation for and delivery of the acquisition of Bridgewater Community Healthcare NHS Foundation Trust, alongside wider system pressures. During this period, succession planning remained a priority. A new Chair was appointed by the Council of Governors in November 2025, with the appointment taking effect from 1 April 2026. To ensure a smooth and effective transition, the incoming Chair was appointed as an Associate Non-Executive Director from 1 January 2026 to 31 March 2026, enabling appropriate handover and continuity of leadership. The extension of the outgoing Chair's tenure was time limited, reviewed regularly, and communicated to NHS England as part of routine governance engagement.
D.2.1	The chair of the Board of Directors should	**Explain**	The Audit Committee is chaired by the Senior Independent Director. This arrangement was agreed by the Board of

	not be a member and the vice chair or senior independent director should not chair the Audit Committee.		Directors following consideration of the skills, experience and within the Non-Executive Director cohort. At the time of appointment, the Committee and Board benefited from the individual's significant and recent audit and financial governance experience, and the need to maintain continuity and effective oversight during a period of Non-Executive Director turnover and organisational change. The Board remains satisfied that the effectiveness and independence of the Audit Committee are not compromised by this arrangement, which is kept under regular review. Succession planning arrangements are in place to ensure future alignment with the Code of Governance.

NHS foundation trusts are required to provide some disclosures in their annual report to meet the requirements of the code of governance. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication. These are replicated in a table below.

Required disclosures:

Code Section	Summary or requirement	Annual Report Section Reference
A 2.1	The Board of Directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The Board of Directors should ensure the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The Trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	**Section 1.2 , Section 3.7 Stakeholder Relations and Section 6.4**
A 2.3	The Board of Directors should assess and monitor culture. Where it is not satisfied that policy,	**Section 5 Staff report – see**

	practices or behaviour throughout the business are aligned with the Trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the Board's activities and any action taken, and the Trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	**5.5, 5.5.1, 5.5.2 and 5.6**
A. 2.8	The Board of Directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the Trust has entered. The Board of Directors should keep engagement mechanisms under review so that they remain effective. The Board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	**Section 3.7 Stakeholder relations**
B 2.6	The Board of Directors should identify in the Annual Report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the Trust within the past two years • has, or has had within the past two years, a material business relationship with the Trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the Trust • has received or receives remuneration from the Trust apart from a director's fee, participates in the Trust's performance-related pay scheme or is a member of the Trust's pension scheme • has close family ties with any of the Trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through	**Section 3.1 Directors' report**

	involvement in other companies or bodies • has served on the Trust Board for more than six years from the date of their first appointment • is an appointed representative of the Trust's university medical or dental school Where any of these or other relevant circumstances apply, and the Board of Directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	
B 2.13	The Annual Report should give the number of times the Board and committees met, and individual director attendance.	**Section 3.1 Directors' report**
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by the Board, the Council of Governors, board committees and the types of decisions which are delegated to the executive management of the Board of Directors.	**Section 3.1 Directors' report**
C 2.5	If an external consultancy is engaged, it should be identified in the Annual Report alongside a statement.	**Section 4.4 Remuneration report**
C 2.8	The Annual Report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	**Section 3.1 Directors' report**
C 4.2	The Board of Directors should include in the annual report a description of each director's skills, expertise and experience.	**Section 3.1 Directors' report**

C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the Annual Report and a statement made about any connection it has with the Trust or individual directors.	**n/a developmental review completed in 2022-23**
C.4.13	The Annual Report should describe the work of the Nominations Committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the Board has been evaluated, the nature and extent of an external evaluator's contact with the Board of Directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to the Trust's strategy, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the Board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the Board reflects the ethnic diversity of the Trust's workforce and communities served • the gender balance of senior management and their direct reports	**Section 4.1**
C 5.15	Foundation trust governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	**Section 3.1 Directors' report – Membership Strategy**
D 2.4	The Annual Report should include: • the significant issues relating to the financial statements that the Audit Committee	**Section 3.1 Directors' report – the**

	considered, and how these issues were addressed • an explanation of how the Audit Committee has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor, length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services	**work of the Audit Committee** **And section 6.4 Annual Governance Statement**
D 2.6	The directors should explain in the Annual Report their responsibility for preparing the Annual Report and Accounts, and state that they consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.	**Section 6.4 Annual Governance Statement**
D 2.7	The Board of Directors should carry out a robust assessment of the Trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the Annual Report.	**Section 2.1 and section 2.6 Risk profile**
D 2.8	The Board of Directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the Annual Report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The Board should report on internal control through the Annual Governance Statement in the Annual Report.	**Section 2.6 Risk profile and 6.4 Annual Governance Statement**
D.2.9	In the annual accounts, the Board of Directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC Group Accounting Manual and NHS Foundation Trust Annual	**Section 6.1 Going Concern Disclosure**

	Reporting Manual, which explain that this assessment should be based on whether a Trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	
E.2.3	Where a trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	N/A
Appendix B, para 2.3 (not in Schedule A)	The Annual Report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments.	**Section 3.1 Directors' report**
Appendix B, para 2.14 (not in Schedule A)	The Board of Directors should ensure the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the Annual Report.	**Section 3.1 Directors' report**
Appendix B, para 2.15 (not in Schedule A)	The Board of Directors should state in the Annual Report the steps it has taken to ensure that the members of the Board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g. through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	**Section 3.1 Directors' report**
Additional requirement of FT ARM resulting	If, during the financial year, the governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the Annual Report. This is required by paragraph 26(2) (aa) of schedule 7 to the NHS Act 2006, as amended by	**N/A**

from legislation	section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	

6.2 NHS England System Oversight Framework and Segmentation

The NHS Oversight Framework 2025/26 sets out the national arrangements for assessing NHS providers and determining the level of oversight and support required. The framework is based on a defined set of metrics aligned to national priorities, providing a headline assessment of operational performance, quality and financial sustainability.

Under the framework, providers are allocated to one of five segments. Segment 1 reflects strong performance with no specific support needs, while segment 5 identifies the most challenged organisations requiring intensive support through the Provider Improvement Programme. Segmentation informs the level of oversight and support but does not prescribe the specific interventions an organisation will receive.

Segmentation is determined through the following process:

- Each delivery metric is scored on a scale of 1 to 4, with 1 representing the strongest performance.
- All metric scores are consolidated and averaged to produce an overall score.
- Organisations are then placed into one of four initial segments based on their overall score.
- A financial safeguard ensures that organisations with an underlying deficit cannot be placed above segment 3.
- NHS England reviews organisational capability and context to identify the most challenged providers, who may be placed into segment 5.

Where a provider is unable to meet required standards of quality, performance or financial sustainability, NHS England may use its enforcement powers to secure improvement. These powers include issuing formal directions, requiring the development and delivery of improvement plans, commissioning independent reviews and placing conditions on a provider’s licence. In the most serious cases, statutory intervention powers may be used, such as directing how specific functions must be carried out or making changes to board leadership. Enforcement action is applied proportionately and only where enhanced oversight and support have not achieved the necessary progress.

NHS England has indicated that the Oversight Framework will be reviewed for 2026/27; however, at the time of publishing this Annual Report, the updated framework had not yet been released.

(iii) Segmentation

On 31 March 2026, the Trust is assigned to segment 4. Current segmentation of NHS trusts and foundation trusts is published on the NHS England website.

6.3 Statement of the chief executive's responsibilities as the accounting officer of Warrington and Halton Teaching Hospitals 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, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given accounts directions which require Warrington and Halton Teaching Hospitals 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 Warrington and Halton Teaching Hospitals 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. They are 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.

Nikhil Khashu
Chief Executive
22 June 2026

6.4 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 Warrington and Halton Teaching Hospitals 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 Warrington and Halton Teaching Hospitals 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 Warrington and Halton Teaching Hospitals 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

As accounting officer, supported by the Board members, I have responsibility for the overall direction of the risk management systems and processes within the Trust. I have delegated the executive lead for risk management to the chief nurse who in turn is supported by the director of clinical governance who manages the risk team.

The Quality Assurance Committee/ Quality and Safety Assurance Committee in Common oversees all aspects of risk relating to quality, including improvement, delivery, clinical risk management and governance, clinical audit and the regulatory standards relevant to quality and safety on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register.

The Finance and Sustainability Committee/Finance, Sustainability and Performance Committee in Common oversees financial and digital risks on behalf of the Trust and

reports on any additional risk/controls/assurances which are recorded on the appropriate risk register.

The Strategic People Committee in Common oversees workforce risk on behalf of the Trust and reports on any additional risk/controls/assurances which are recorded on the appropriate risk register.

The Risk Review Group oversees the Corporate Risk Register and CBU risk registers on a rolling programme making recommendations to the appropriate board committees regarding new strategic risks, review of existing strategic risks and assurance review of the Corporate Risk Register and CBU risk registers.

The Audit Committee oversees the entire risk management system. It commissions an annual audit of the board assurance framework and strategic risk register, as part of the internal audit plan, to satisfy itself that the system of internal control is effective. It examines the assurances on the effectiveness of controls for all strategic risks received from the Chairs of the committees, and from internal and external auditors.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a substantial rating from the Head of Internal Audit (HOIA).

Risk training

Staff are trained and equipped to manage risk in a way appropriate to their authority and duties. All new staff receive information as part of the local induction programme facilitated by line managers. Monthly risk assessment training is in place for all staff who are required to undertake risk assessments as part of their role.

All senior managers are required to complete risk management training.

Further education is provided with cyclical mandatory training undertaken by both clinical and non-clinical staff; the content for this programme is continually reviewed in light of any changes. There is a robust appraisal process which facilitates the identification of individual staff training needs. These are reviewed as part of the member of staff's annual performance and development appraisal. All relevant risk policies are available to staff via the Trust's SharePoint including:

- Risk Management Strategy
- Risk Management Policy
- Patient Safety and Incidents Response Framework (PSIRF) Policy
- Complaints and Concerns Policy

The Trust is committed to quality improvement and recognises the benefits gained from shared learning which helps to minimise future risk and to improve the care that the Trust provides. To achieve this, the Trust uses a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and the application of evidence-based practice. The revalidation process that a number of health professionals now undertake further supports learning and development.

Lessons learned and good practice are shared throughout the Trust, for example via the Trust-wide safety huddles, daily safety briefings, Quality Assurance Committee/ Quality and Safety Assurance Committee in Common, Patient Safety and Clinical Effectiveness Sub-committee, Safety Oversight Meeting, Quality Compliance Oversight Group, Patient Experience and Inclusion Sub-committee and the Clinical Claims Review Group. The Clinical Business Units (CBUs) also have a robust governance process for feedback.

The risk and control framework

During the year, the Trust continued to strengthen and enhance its governance and risk management systems and processes. The Board fully appraised its key strategic risks, considered the Trust's Risk Appetite Statement, and refreshed the Board Assurance Framework, which is reviewed by the Board at each of its meetings and through its committees. In preparation for the acquisition of Bridgewater Community Healthcare NHS Foundation Trust, focused work took place to align the legacy Board Assurance Frameworks of Warrington and Halton Teaching Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust into a single, consolidated framework. This ensured consistency in risk identification, scoring and assurance, and provided a coherent strategic view of risk across acute and community services. During the year there was further alignment of the Board Assurance Framework to the committees of the Board, with each strategic risk allocated to a designated committee for focused oversight and scrutiny.

The Risk Management Policy provides the framework for managing risk across the Trust and is aligned to the Risk Management Strategy, which sets out a clear, structured and systematic approach to the identification, assessment, escalation and assurance of risk. Together, these documents define the roles and responsibilities of the Board of Directors, its committees and all staff, and ensure that risk management is embedded within clinical, managerial and financial processes across the organisation.

During the year, the Trust strengthened its risk management arrangements through the review and refresh of the Risk Management Strategy and associated policies, enhanced oversight through the Risk Review Group, and improvements to the Datix risk management system, including clearer ownership, executive accountability for high risks and strengthened reporting. In preparation for the integration of community

services on 1 April 2026, risk management policies and procedures were harmonised and the Datix system was confirmed as operationally ready as the single integrated platform for incidents, risks, complaints, claims and inquests. This work supported consistent risk identification, scoring, escalation and assurance across the enlarged organisation and ensured that risk assessment remained an integral part of decision making and governance arrangements throughout 2025-26.

Local risk registers are monitored and maintained locally within the Clinical Business Units (CBU) which enables risk management decision-making to occur as near as practicable to the risk source. For those risks that cannot be managed locally these are escalated to the Corporate Risk Register and Strategic Risk Register where required.

Risks are scored by the competent person undertaking the risk assessment and validated by a manager according to the residual risk score:

1. **8 or below** (low and very low) are verified by the ward or department manager
2. **9-12** (moderate) are verified by CBU managers, corporate heads of service, lead nurse, matron
3. **≥15** (significant) are verified at executive level. They are reviewed at the Risk Review Group which is chaired by the chief nurse and attended by the deputy director governance, chief operating officer and deputy chief executive, medical director, company secretary and head of safety and risk. CBU managers, lead nurses and heads of service also attend on a rotational basis. This group will review the risk for inclusion onto the Board Assurance Framework. The recommendation will then be reviewed and ratified by the relevant committee or the Trust Board

The Trust employs a number of systems to ensure that risk management is embedded within the organisation including business planning, performance management frameworks and clinical information systems. Regular reports are also available to the various committees responsible for aspects of risk management.

There are corporate policies and procedures in place to support risk management, covering the management of incidents, risk assessment and consent and general risk management arrangements. Risk appetite levels will depend on circumstances; for example, the Trust will have a low tolerance to taking risks which may impact on patient or staff safety, but a greater appetite for opportunity risks such as major service developments which present significant challenges but will ultimately bring benefits to the organisation. Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board. Risk appetites are determined by the relevant assurance committees and the Trust Board.

The Trust encourages stakeholder and partner organisations' participation and has developed an active Patient Experience and Inclusion Sub-committee. Partners and governors are encouraged to raise issues, be involved in determining solutions and input to all aspects of risk management.

The Trust has a Board Assurance Framework in place which is reviewed by the Board of Directors and includes the identification of the key risks to the achievement of the Trust strategic objectives and the systems in place to manage/mitigate these risks; the control systems in place to manage the key risks; the identification of sources of internal and external assurances evidencing the management of risk; and evidence of compliance with equality, diversity and human rights legislation. The Board Assurance Framework is reviewed by the Board of Directors and the Audit Committee at each of their meetings, and monthly by the Board assurance committees, which provide additional challenge and scrutiny of the risks identified.

Incidents, complaints, claims, coroners' inquests and patient feedback are routinely analysed to identify lessons for learning and improve internal control. To enhance learning and improve governance, the Trust actively pursues external peer review of all serious incidents should this be necessary.

Learning and improvement from incidents, complaints and claims has continued to be a focus for the Trust to help to improve internal controls impacting patient experience and patient safety. Risk KPIs are reported through the Quality Assurance Committee/ Quality and Safety Assurance Committee in Common, its sub-committees and CBU-level reports, and shared with the lead commissioners as part of the Quality Contract. Lessons for learning are also disseminated to staff using a variety of methods including trust-wide Safety Huddle, which convenes on each weekday, the subsequent Safety Briefings and regular safety alerts.

Learning is further supported by meetings that include the Clinical Claims Group, Policy Review Group and Mortality Review Group.

Furthermore, each quarter a Learning from Experience Report and a Learning from Deaths report is compiled and submitted to the Quality Assurance Committee/ Quality and Safety Assurance Committee in Common and the Trust Board. This includes aggregated analysis of incidents, complaints, claims, health and safety incidents and Inquests. The report contains trend data and through qualitative and quantitative data analysis, provides assurance of lessons learned from past harms together with the changes to clinical practice that have subsequently been put in place.

The NHS Digital Data Security and Protection Toolkit, an online tool that enables organisations to measure compliance against data security and information governance requirements, was introduced in June 2018.

The table below sets out the top eight risks identified at the end of 2025-26. As the organisation moves into 2026-27, and as part of the integration programme, the strategic risks of Warrington and Halton Teaching Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust are being consolidated into a revised Board Assurance Framework. This will comprise nine strategic risks for the enlarged organisation and will be in place from 1 April 2026. All risks will continue to be managed through established risk governance arrangements**.**

Risk description/key controls

Risk description	Key controls
224: If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	• Trust Wide Capacity meetings led by the Tactical Manager for the day four time a day, bed reports detailing site position, risks and actions circulated 6 times per day • Strategic, Tactical, Operational management structure in place with clear roles and responsibilities aligned to roles • Bi-annual training provided to Tactical managers provided by the EPRR Lead and Director of Operations and Performance • Daily C&M system calls with the system control centre to escalate any risks or any external delays • ED escalation processes/intentional rounding with ED consultant and nurse in charge • Private ambulance transport to complement patient providers in and out of hours • Frailty Assessment Unit FAU/operational 5 days per week • Gynae Assessment Unit (GAU) and Paediatric Assessment Unit (PAU) operational 7 days per week • Relaunch of the deflection policy for minor injury patients overnight, where appropriate • Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. • Co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Became operational April 24 • Additional bed capacity opened in response to surge in hospital • Integrated Discharge Team – daily huddle between hospital discharge team and the hospital social care team now in place • Same Day Emergency Care Centre (SDEC)

	completed July 2022. Open 24/7 • Co-located and upgraded Minor Injuries Unit • Meetings with senior leaders from the ICB and local authority to review and discharge taking place weekly • Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI meetings • Additional senior manager on-call support a weekends • Senior doctor at triage function • CT scanner co-located in the main body of the ED department in 2023 • Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients • Winter planning in place to identify additional community and Trust-based capacity to support expected activity levels for winter • Virtual frailty ward, live from 1 February 2023, in line with national planning, to help reduce admissions from care home to A&E • Additional nurse staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board • On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy • Progress chaser in ED to support flow and timely • Introduction of the new Manchester Triage Process from 14 April 2024 to support reduced overcrowding in ED and improve clinical quality and patient experience • Winter escalation capacity (ward A10 and bay of 6 on Ward B4) planned to be open in winter 2025-26 to support flow and urgent care • The Performance Improvement and Oversight Group has been established in place of the ED Improvement Group and is the oversight group for the performance of the Urgent and Emergency Care System Improvement Group • The Performance Improvement and Oversight Group reports to the Finance and Sustainability Committee • QI-led project completed to support improving Ambulance handover times • UEC improvement group established, supported by executives with a focus on sustained recovery

	• Workforce review completed to increase evening cover where demand is highest
1215: If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	• Inpatient capacity is reviewed with the patient flow and CBU teams daily through the bed meetings to ensure that there is adequate capacity for all patient groups to be admitted • Weekly review meetings with C&M diagnostics hub, mutual aid opportunities utilised across C&M to reduce delays • Recruitment and development of Transfer of Care Hub team is gaining maturity • Workforce is continually reviewed to ensure that all wards and teams are staffed safely • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery, via the Performance Review Group and weekly PTL meetings • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancellations as a result of urgent care pressures • Capacity identified and being utilised with appropriate independent sector providers and through mutual aid and surgical hubs • Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. This has given the Trust an additional endoscopy room and an additional theatre at Nightingale • Weekly theatre scheduling to ensure listing of patients in line with national guidance, with the support and guidance of Cheshire and Merseyside productive partners • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 65weeks • Continue to ensure urgent cancers are prioritised in line with national guidance • Continued use of insourcing and outsourcing providers (NHS approved contractors) in 2025-26 to support recovery will be reviewed to ensure value for money • Ongoing validation of the trust waiting lists to improve data quality • All performance activity monitored through weekly

	performance review group (PRG) • FOP platform launched to support effective theatre scheduling • Overnight capacity on Ward B4 at Halton planned to open October 25 will take pressure from the Warrington site and support elective recovery
134: If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington and Halton	• Core financial policies controls in place across the Trust • Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Planning Group (CPG) oversee financial planning • Procurement/tender waiver training in place • Latest guidance from MIAA Counter Fraud Team circulated • Counter Fraud campaign took place for national anti-fraud week 18 November 2025 • Revised approach to GIRFT/improvement/ CIP. Leadership from Executive Medical Director and joint reporting to FSC embedded • Appointed GIRFT Finance Lead Head of Improvement • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • High level 5-year plan presented to the Finance and Sustainability Committee in April 2024, high level 4-year plan shared with PWC, Chair and CEO. The 4-year plan was reviewed, and further developed at the Executive Away Day in September 2025 • Capital Plan for 2025-26 was approved at the 2 April 2025 Trust Board meeting • Operational Plan was approved by the Trust Board on 28 April 2025 • Introduced system of escalation where there are risks to CIP delivery • Process embedded that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient/staff safety and consideration whether CIP has been fully identified. • In addition, new revenue spends to support activity targets is approved by Executives/Trust Board only when the cost does not exceed tariff, all internal options have been considered (WLI, productivity) and no mutual aid is available • Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting

	to the Executive Team and the FSC with deep dive at FSC on highest cost • Tightening controls of non-pay expenditure with executive review of non-catalogue spend and implemented cease option to purchase some items • Cash support received for 2024-25 was £12.145m and £19.2m YTD 2025-26 • Enhanced ECF meetings in place with Chief Executive sign off, with ICS invited. Bridgewater Community Healthcare NHS FT in attendance • Urgent and Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 • Monthly review of non-recurrent CIP and move to recurrent if possible • Fortnightly executive-led meeting to monitor spend on WLI/Insourcing/LLP to support 65- and 52-week recovery • 2024-25 phase 2 PWC final report signed off, recommendations actioned and monitored each has an executive lead and PID • 2024-25 received high assurance for general ledger, accounts receivable, accounts payable, treasury management, with no recommendations to implement • Implemented reduction in bank rates 13 January 25, reducing exp circa £700k pm and to bottom of scale 1 May 2025 • Daily cash flow + 12-month forecast in place to manage cash • Delivery Unit Set Up – Delivery Unit Oversight Groups established, comprising the Delivery Unit Workforce (DUW), Delivery Unit Non-Pay (DUNP) and Delivery Unit Productivity (DUP), to provide robust oversight, challenge and accountability for key financial and operational workstreams, with focus on workforce pay, non-pay expenditure and productivity improvements.
2001: If services remain fragile or the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure	• Formal process in place for identification and designation of fragile services • Focused additional support to fragile services from senior medical, nursing and operational leadership teams • Appropriate prioritisation of fragile service revenue and capital requests

to achieve constitutional standards.	
1114: If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	• Digital Operations Governance including supplier management, product management, cyber management, Business Continuity and Disaster Recovery Governance and customer relationship management with CBUs (e.g. the Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard • Digital Change Management regime including the Digital Development Group, the WHH Change Advisory Group, The Digital Transformation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions • Trust Data Quality Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting EPR training regime for new starters including doctors' rotation and annual mandatory training • External NHS England approved cyber training for the Trust Board • The use of automatic patching software to roll-out security updates to devices • Existing external network traffic is monitored by NHS Digital for both HSCN and internet links • Secondary secure backup at Halton Data Centre • Remote devices no longer bypassing the web proxy • New phishing exercise by NHS England was arranged for 2024-25 • Local device (PC and laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched • MFA active on for NHSMail • MUSE migrated to new server • Unisoft Server upgraded to Windows 2019 • Comply with NHS England high cyber alerts • Version 7 of Clinisys Ice has been upgraded to version 7.1.9 which is cyber secure
1372: If the Trust is unable to procure a new Electronic Patient Record, then then the Trust may have to continue with its current	• Working with incumbent EPR vendor to extend contract for 2.5 years in support of time required to complete the procurement and deployment of a new EPR • Trust financial modelling includes 2.5-year extension Lorenzo costs • ICB executive leads and FD program supportive of

suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	single instance in partnership with Merseyside and West Lancs NHS Trust – with output-based specification (OBS) and pre procurement evaluation criteria complying with single instance guidance • Program director appointed • Financial modelling of realistic options to provide genuine 5, 10 and 15-year options to control whole life costs • Partnership procurement will lead to identification of further realistic cash releasing / cost reduction benefits • The collaboration agreement has been developed and endorsed by EMT and Board • Approach to standard clinical pathways and single instance architecture agreed with FD team
2273: If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the support and resource required from the Cheshire and Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances	• Annual capital funding is allocated for mandated and statutory estates projects • Estates Team manages Planned Maintenance (PPM) and reactive maintenance through CAFMS. • Six Facet survey annually assesses estate conditions, informing backlog maintenance priorities • The 10-year planned maintenance capital program is updated yearly based on the Six Facet survey and completed works • Effective clinical networking and partnerships are in place • Full delivery of the TIF (elective) programme due to complete in 2024-25, which includes £9m investment to provide 2 new operating theatres, an Endoscopy Room and elective ward capacity • Full Business Case (FBC) for Pathology Hub to be created with MWL, to be presented to the Trust Board in quarter 1 2025-26 • CSPO participates in Runcorn and Warrington Town Deal Boards, overseeing £50m in regeneration funds. • Living Well Hub funded via Warrington Town Deal fund and led by WHH, opened in March 2024 • Runcorn Health and Education Hub funded by the Runcorn Town Deal led by WHH, is due to open in quarter 1 2026-27. • Strategy refresh for 2026-27 approved by the Trust Board • WHH leads on addressing health inequalities and

	sustainability, with initial recognition in Cheshire and Merseyside • Consistent Trust representation in Cheshire and Merseyside ICS and Place-based boards • One Public Estate funding supports Halton redevelopment and Warrington public sector estate review • Partnerships with educational institutions have enable tailored education and research • CSPO co-led CMAST priorities for ICB 5-Year Joint Forward Plan • Trust estates priorities reflected in the ICB infrastructure plan • Agreement from the Boards of Warrington and Halton and Bridgewater to progress transaction to become a single organisation in 2027 • Joint Executive Team meetings with Bridgewater Community Healthcare NHS FT • Estates strategy for new hospital plans completed • External funding sought for estates developments supporting new hospitals • All partners support new hospitals plans, including MPs, Councils, Education Providers, Place Partners, and ICB • Financial and economic cases for new hospitals to be updated, with funding options explored • Capital Planning Group oversees capital funding allocation, prioritised schemes reported monthly • Health and Safety Sub-Committee escalates estates issues, managed through relevant safety groups • The Government's White Paper, Integration and Innovation: Working together to improve health and social care for all, was published in February 2021 and continues to inform and guide trust activities. • Bids recently submitted to UEC fund and CIR fund • Work on phased estates plan and clinical strategy commenced
115: If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity	• 6-weekly rostering, sign off by matrons, oversight by lead nurses and monitored through monthly Workforce Review Group (WRG) • Weekly ERostering KPI sign off meetings in place • NHSP Request Review/10% reduction review

and dependency then this may impact the delivery of basic patient care.	meetings chaired by Chief Nurse or Deputy Chief Nurse every week • Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity • Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas with movement off staff and consideration of skill mix to ensure safe staffing levels • Daily audit of gold command and safecare compliance to monitor completion of twice daily acuity scores and the adding of professional judgement, gaps highlighted weekly to the Senior Nursing Team • Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency with authorisation only by Chief Nurse, Deputy Chief Nurse or Associate Chief Nurse for Corporate Nursing • Staff numbers and skill mix and professional judgement recorded daily on Gold Command report for transparency of clinical decision making • Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust • Agency reduction plan in place • Local workforce plans in place for Emergency Department and Maternity with additional support from Executive Team • Local recruitment in place targeting ED and the remaining areas with outstanding vacancy • Open advert for RN/HCSW recruitment • Sickness absence being managed in line with trust policy • Weekly review of bank use/staffing challenges by Chief Nurse/ Deputy Chief Nurse/Director of Governance • Gant chart mapping projections of maternity leave and supernumerary staff with the information taken from E Roster • Twice daily Acuity Recording on Safe Care

CQC registration and assessment

The Trust is required to register with the Care Quality Commission. The Trust is fully compliant with the registration requirements.

The CQC inspected Warrington and Halton Teaching Hospitals NHS Foundation Trust from 29 March to 2 May 2019 and the final report was received in July 2019. During the visit the CQC looked at the quality and safety of the care provided, based on whether the service is safe, effective, caring, responsive and well-led. Included within the remit of the inspection was the Well-Led Inspection and NHSI Use of Resources Review. The Trust was rated as 'Good' overall with an 'Outstanding' rating for caring in critical care. In September 2023 the CQC undertook an inspection of the Trust's Maternity Services resulting in the Trust retaining the rating of 'Good'. The Trust is currently enhancing the specific workstreams developed to drive improvement actions, whilst identifying training, development, infrastructure and capital investment needs.

The Foundation Trust Code of Governance

The Foundation Trust's governance structure ensures that the Board of Directors holds overall responsibility for the leadership and direction of the organisation, and for assuring itself that the Trust operates with openness, transparency and candour, particularly in its engagement with patients, the wider community and staff. The Board holds itself to account through effective scrutiny and engagement with a wide range of stakeholders.

The Council of Governors plays a key role in holding the Board, and in particular the non-executive directors, to account in a constructive and challenging manner within a unitary board model. A Governor is nominated to observe each Board committee and provide feedback to the Council of Governors. The Council meets quarterly, supported by a quarterly Governor Engagement Group and regular Governor Working Group meetings. The Board has fostered a culture of openness across the organisation, including opportunities for non-executive directors, executive directors and Governors to visit wards and departments and, where possible, listen directly to feedback from staff, patients, carers and relatives.

Throughout the year, the Board of Directors has reviewed the purpose, responsibilities and inter-relationships of its committees and sub-committees to ensure that delegation of authority remains appropriate, and that effective assurance and oversight are maintained on behalf of the Board. The Board is supported by its principal committees, comprising the Quality and Assurance Committee/ Quality and Safety Assurance Committee in Common, the Finance and Sustainability Committee/ Finance, Sustainability and Performance Committee in Common and the Strategic People Committee in Common, all of which are chaired by and include non-executive directors. The Audit Committee is a key statutory committee of the Board and is also chaired by a non-executive director.

The Board receives formal Chair's Committee Assurance Reports from each committee, providing timely and accurate information, including matters requiring escalation. This enables the Board to maintain oversight of key risks, controls and performance, and to gain assurance that governance arrangements are effective and that care remains patient centred. To support this, each committee receives regular updates and high-level briefings from executive-led operational groups. Committee members are able to scrutinise operational group outputs, question assumptions and request further detail where necessary

The Board and its committees demonstrate leadership and the rigour of oversight of the Trust's performance by having formulated an effective strategy for the organisation, ensuring accountability by robustly challenging the control systems in place and where appropriate seeking further intelligence on the current trend analysis with the Trust's performance indicators to further understand the wider community's health needs.

Workforce Strategy and Workforce Safeguards

The Trust's People Strategy has been mapped against the NHS People Plan, NHS People Promise and the Future of HR&OD NHS Report to produce a cohesive strategic workforce delivery plan. Operational delivery of the plan continues to be overseen by the Operational People Committee, chaired by the Chief People Officer. The Strategic People Committee in Common, which is a sub-committee of the Board chaired by a non-executive director, has strategic oversight of delivery of the strategy and provides assurance to Board.

To meet the '*Developing Workforce Safeguards'* recommendations, the Board approves the workforce plan each year as part of the annual operational planning cycle, which considers projected activity growth or workforce resource changes, and agreed service developments. The nursing and maternity safer staffing report are provided to the Quality Assurance Committee and Strategic People Committee, and presented bi-annually to the Trust Board. These reports identify areas of acuity, safe nursing staffing numbers and any incidents associated with staffing are brought to the attention of the Committee and the Board for assurance. To support nurse safer staffing, the Trust utilises a suite of scheduling systems to roster staff, plan activities and monitor staffing in line with patient acuity on a day-to-day basis. Nurse staffing establishments reviews are undertaken to ensure compliance with the developing workforce safeguards guidance. The Trust has a guardian of safe working who reports twice a year on the working hours and shift patterns of doctors in training.

In addition, formal audits are undertaken into staffing processes such as recruitment and payroll, which are reported to the Trust Audit Committee. Board oversight of staffing processes is also achieved via the workforce elements of the Integrated Performance Report, which include key operational indicators such as absence, turnover and training compliance.

Register of interests

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 with reference to the guidance) within the past 12 months as required by the Managing Conflicts of Interest in the NHS guidance.

NHS pension scheme

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.

Equality, diversity and human rights

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

Delivering a net zero health service

The 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

The Trust has performance management processes in place that review the economy, efficiency and effectiveness of the use of resources. The Chief Finance Officer chairs the monthly Finance Resource Group (FRG) which reviews financial performance of all CBUs and corporate areas and reports into the non-executive led Finance and Sustainability Committee/ Finance, Sustainability and Performance Committee in Common Part of the remit of the Committee, which meets monthly, is to support the Trust Board in gaining assurances on the economy, efficiency and effectiveness of the use of resources. Standing items on the agenda include the monthly financial position report, pay assurance report, cost improvement plans and productivity improvement.

The Executive Team reviews and monitors the operational performance of the Trust. The Quality Committee/ Quality and Safety Assurance Committee in Common receives reports on the Cost Improvement Plan (CIP) Quality Impact Assessments to provide assurance that CIPs have not had a detrimental impact to the quality of services.

The Trust has a policy and governance framework in place to guide staff on the appropriate use of resources through its standing orders, standing financial instructions and scheme of reservation and delegation. In addition, there is a robust system for developing and routinely reviewing policies and procedures and staff are appropriately updated and guided or trained on their application.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by counter fraud. Reports are presented to the Audit Committee in each meeting. In addition, further assurance on the use of resources is obtained from external agencies, including the external auditors and the regulators.

Financial governance

The Trust recorded an adjusted deficit of £40.7m which is £12.0m away from the £28.7m deficit plan (excluding deficit support funding). This adjusted deficit is the value which NHSE monitors the Trust against.

The annual capital programme started at £30.2m (including IFRS16 and donated assets), was reduced to £20.9m and the actual spend for the year was £20.8m. The cash balance at the end of the year was £24.9m.

The cash balance will be utilised to pay both capital (£8.7m) and revenue creditors..

There were no failures in financial governance during the year. The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the chair's exception report. Furthermore, the Board reviewed the position and challenged forecast outturns and mitigations on a regular basis.

Capital has been monitored through the year via the Capital Planning Group and Finance and Sustainability Committee/ Finance, Sustainability and Performance Committee in Common, with a particular focus on schemes over £0.5m.

Over the past 12 months the Trust has continued to have regular meetings with the ICS where the financial position, forecast and capital have been discussed, reviewed and challenged.

Information Governance

Organisations that have access to NHS patient information must provide assurances that best practice data security and protection mechanisms are in place. The trust is contractually obliged to undertake assessments against the NHS England Data Security and Protection Toolkit on an annual basis.

The trust's most recent Data Security and Protection Toolkit assessment was finalised by Mersey Internal Audit Agency (MIAA) in November 2025 as part of the

trust's annual audit programme. The trust was the subject of a two-part Data Security and Protection Toolkit review conducted by MIAA from February to July 2025.

Mersey Internal Audit Agency assessed 12 outcomes, and found that, for 9 outcomes, the organisation has met the minimum achievement level. However, MIAA also found that 3 outcomes were rated as not meeting minimum achievement levels. MIAA assessed the risk in these areas as high.

In assessing the proposed DSPT submission for 12 outcomes MIAA concluded that 9 of the trust's proposed submissions aligned with their assessment. For the remaining 3 outcomes MIAA's rating did not align with the rating proposed by the trust. This represents a medium level of deviation between trust's proposed DSPT submission and the assessment by MIAA. As a result, the MIAA confidence level in the veracity of the DSPT assessment made by the trust is medium confidence.

In the 2025-26 financial year the Trust reported 10 data loss incidents via the NHS England Data Security and Protection Toolkit reporting tool which were escalated to the Information Commissioner's Office (ICO). After investigating the circumstances surrounding 9 of the reported incidents the ICO ruled that further action against the Trust was not necessary. One incident remains outstanding.

NHS England reference	Date reported	Detail	Information Commissioner's Office decision
41816	01/04/2025	A letter was sent in error via email to the wrong consultant's secretary. The letter contained sensitive information relating to a staff member and was sent by the trust's Occupational Health team.	No further action taken
43127	06/07/2025	Child's discharge summary sent to the parents of another child.	No further action taken
43326	17/07/2025	Email with a an attached VFC assessment was sent to the incorrect patient.	No further action taken
43800	19/08/2025	Patient records shared with incorrect data subject via email.	No further action taken

44432	01/10/2025	Breast Screening booking team responded to a client's e-mail, copying and pasting incorrect information into the body of the e-mail reply.	No further action taken
44839	24/10/2025	Confidential NHS correspondence was issued to an incorrect address.	No further action taken
45379	26/11/2025	Letter for patient A was sent to patient B alongside a letter intended for patient B.	No further action taken
45853	30/12/2025	A letter generated in the paediatric team which contained details about a patient was sent to the wrong patient.	No further action taken
46179	21/01/2026	A spreadsheet was shared with 90 students and a number of universities containing information about student's work rotas. This contained information about personal adjustments and student identifiers.	No further action taken
46951	05/03/2026	Member of staff accessed clinical systems for non-business purposes.	Awaiting outcome

Under the Network and Information Systems (NIS) Regulations 2018 the Trust is required to have adequate data and cyber security measures in place to protect against the increasing cyber threat. As an operator of essential services, we are

required to report network and information systems incidents which have significantly affected the continuity of services. The trust has recorded no such incidents in the 2025-26 financial year.

As required by the Data Protection Act 2018 the trust conducts Data Protection Impact Assessments (DPIAs) on projects that involve new types of data processing. No high-risk data processing issues which would require escalation to the ICO were identified in the impact assessments completed during 2025-26 financial year. In addition to the requirement to perform DPIAs trusts must now complete a DTAC. The NHS Digital Technology Assessment Criteria (DTAC) is a national framework used to evaluate digital health tools for safety, data protection, technical security, interoperability, and usability. Introduced to streamline procurement, it ensures that new technologies meet minimum standards before being adopted by the NHS.

The trust uses the Data Security and Protection Toolkit in conjunction with the Datix Risk Management system to inform the work of its Information Governance and Records Sub-Committee. The Information Governance and Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the trust's Board.

The trust's Senior Information Risk Owner (SIRO) chairs the Information Governance and Records Sub-Committee which is also attended by the trust's Caldicott Guardian (Medical Director). The SIRO (Chief Information Officer) acts as the Board level lead for information risk within the trust. Any areas of weakness in relation to the management of information risk which are identified, or are highlighted by internal audit review, are targeted with action plans to ensure that we continue to strive to be information governance assured.

Data quality and governance

A Data Quality and Assurance Group is established as a sub-group of the Information Governance and Corporate Records Sub-Committee and is chaired by the Associate Director of Information. The membership of the group includes the following as core members: Information Governance; Digital Analytics; Workforce; Contracting and Performance; ePR; Clinical Coding; Finance; Clinical Audit; Referral to Treatment, with subject experts from operational teams co-opted as and when required.

The standard agenda includes the following items:

- SUS (Secondary User Service) Data Quality Report
- Systems Data Quality corrections
- NHS Digital Information Standards Notifications tracking
- Data Security and Protection Toolkit update
- documents for review/approval
- Data Quality Policy

- finance update including NHS England Compliance report for financial data quality
- coding update
- contracts/model hospital updates
- workforce update
- ePR/(PAS) Patient Administration System update
- RTT update

The Trust Data Quality policy is available via the Trust's SharePoint for ease of access.

All staff including clinicians and administrative staff who collect and record data, both manually and on the Trust clinical information systems, are responsible for ensuring adherence to the relevant data standards and for ensuring good data quality.

In order to achieve this, they must:

- ensure the timely, accurate and complete recording of data in the appropriate Trust information systems or record
- ensure they have the appropriate level of knowledge and skills for using the information systems required to do their role
- undertake regular validation checks of data collection and input to confirm that the patient demographic data and personally identifiable data for our patients is accurate and up to date
- update any inaccuracies and/or missing data in server user records
- address any data quality issues as soon as possible and escalate appropriately, reporting any concerns to the appropriate Information Asset Owner (IAO) or Information Asset Administrator (IAA)
- have an awareness of and comply with national legislation, trust level and local procedures
- ensure that they meet the Trust's data quality standards where agreed for their area
- monitor their own competencies and access training where necessary both for clinical information systems and record keeping/data quality
- ensure all data is processed in a secure and confidential way to comply with general data protection regulation standards

Ensuring that data is accurate, valid, reliable, timely, relevant and complete will help the Trust and its partners to assess the quality of our data and take action to address potential weaknesses.

Internal Trust-wide Standard Operating Procedures (SOPs) are created, reviewed and maintained to ensure the consistency with data collection and adherence to standards. SOPs are used by clinical and non-clinical teams and are also available on the Trust's policy HUB for ease of access.

A dedicated Referral to Treatment (RTT) Team supported by the operational teams validate all clinical specialties focusing on inpatients, outpatients, diagnostics and cancer as part of the RTT pathways with the latter two also validated by the relevant teams. The team also follow up on issues, e.g. tests not ordered or patients not added to waiting lists to ensure the patient pathway is progress in a timely manner and avoiding any further delays to treatment.

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 Audit Committee, the Quality Assurance Committee and the Risk Review Group; and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Board of Directors: The Board Assurance Framework provides an overview of the internal control environment and evidence of the effectiveness of the controls that manage the risks to the Trust in achieving its strategic objectives as identified in the annual plan.

Audit Committee: The Audit Committee reviews the effectiveness of internal control through the delivery of the internal audit plan.

Clinical Audit: Clinical Audit is an integral part of the Trust's internal control framework. An annual audit programme is developed involving all clinical business units. Audit priorities are aligned to the Trust's clinical risk profile, compliance requirements under the provisions of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and national clinical audit priorities or service reviews. The Trust has adopted the Health Research Authority (HRA) procedures which moved the emphasis towards acceptance of HRA assessment within the framework of research governance, strict legislation and recognised good clinical practice, and local assessment of capability and capacity to run a study.

Internal Audit: MIAA acted as internal auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive

responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is discussed with the Executive Team and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the committee uses a three-cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency. Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented regularly to the committee by Internal Audit throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

Head of Internal Audit issued an overall opinion for 2025-26 of substantial assurance noting that there is a good system of internal control designed to meet the organisation's objectives. The HOIA confirmed continued compliance with the definition of internal audit (as set out in the Trust's Internal Audit Charter), code of ethics and professional standards. The HOIA also confirmed organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

External Audit: External Audit provides independent assurance on the Accounts, Annual Report, Annual Governance Statement and on the Annual Quality Report. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of internal and external audit, the external review processes for the clinical negligence scheme for Trusts along with NHS Resolution and the Care Quality Commission.

The BAF itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The effectiveness of the system of internal control is maintained and reviewed by the Board of Directors via its committees and individual management responsibilities at director and senior manager level. Regular reports have been reviewed by the committees of the Board and individuals in relation to all key risks.

Clinical governance and processes to ensure quality of patient care were overseen by the Quality Committee under the leadership of the chief nurse. Assurance reports from this committee were received by the Board of Directors together with ad hoc reports, as required, and an annual report summarises the most significant issues in this area.

The Chief Nurse has delegated lead responsibility for risk management across the Trust. Individual directors and senior managers are empowered to review and manage risks within their own areas of responsibility, linking closely with wider trust processes. Significant support has been provided via training, advice and guidance documentation to enable senior staff to effectively fulfil their functions.

An analysis of controls and assurance in relation to key organisational risks has been undertaken via the assurance framework.

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 Warrington and Halton Teaching Hospitals NHS Foundation Trust has a good system of governance and stewardship that supports the achievement of its policies, aims and objectives.

Nikhil Khashu
Chief Executive
22 June 2026

7. Annual Accounts 2025-26

Independent auditor's report to the Council of Governors of Warrington And Halton Teaching Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Warrington And Halton Teaching Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2026, which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows and notes to the accounts, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

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 its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter

In forming our opinion on the financial statements, which is not modified, we draw attention to note 27 to the financial statements, which discloses that from the 1st April 2026 Warrington and Halton Teaching Hospitals NHS Foundation Trust acquired Bridgewater Community Healthcare Foundation Trust, and are changing their name from Warrington and Halton Teaching Hospital NHS Foundation Trust, to, North Cheshire and Mersey NHS Foundation Trust.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

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

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

Other information

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

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

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2025/26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2025/26, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting

unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance**,** but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, risk of fraud in revenue recognition and the risk of fraud in expenditure recognition. We determined that the principal risks were in relation to:
  - high risk or unusual journal entries as identified by our risk assessment
  - other operating income (excluding education and training income)
  - completeness of other operating expenditure
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on significant journals at the end of the financial year which had an impact on the Trust's financial performance,
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations and revenue accruals;
  - testing of income and receivables
  - cut off testing
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
- knowledge of the health sector and economy in which the Trust operates
- understanding of the legal and regulatory requirements specific to the Trust including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

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

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in respect of the above matter, except on 22 June 2026 we identified two significant weaknesses in:

- how the Trust plans and manages its resources to ensure it can continue to deliver its services, in relation to the Trusts arrangements for developing a NHS England-compliant medium-term financial plan, and developing and delivering recurrent savings schemes. We recommend the Trust strengthen its medium-term financial planning arrangements to achieve this.
- how the Trust uses information about its costs and performance to improve the way it manages and delivers its services, in relation to the Trusts arrangements to deliver sustained performance improvement against key performance metrics. Further to this, the Trust remains under Teir 1 NHS England oversight for urgent and emergence care. We recommend the Trust strengthen its improvement arrangements in order to address under-performance against key urgent and emergency care metrics. This must be supported by robust challenge and oversight from the Oversight Forum, Finance, Sustainability and Performance Committee (FSPC) and Quality, Safety and Assurance Committee (QSAC), with adequate assurance reporting on progress to Trust Board.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Warrington And Halton Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed the work necessary in relation to the Trust's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Georgia Jones

Georgia Jones, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Liverpool
24 June 2026

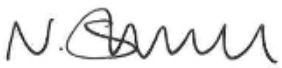
7.2 Forward to accounts

Trust name:	Warrington and Halton Teaching Hospitals NHS Foundation Trust
This year:	2025/26
This year ended:	31 March 2026
This year beginning:	1 April 2025

Foreword to the accounts for the year 1 April 2025 to 31 March 2026

Warrington and Halton Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Warrington & Halton Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of National Health Service Act 2006.



Nikhil Khashu
Chief Executive

22 June 2026

7.3 Primary Financial Statements

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2026

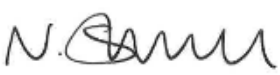
	NOTE	2025/26 £000	2024/25 £000
Income from activities	3	361,455	361,695
Other operating income	3	31,110	30,271
Operating income	3	**392,565**	**391,966**
Operating expenses	4	(427,528)	(411,466)
OPERATING (DEFICIT)		**(34,964)**	**(19,500)**
FINANCE INCOME / (EXPENSE)			
Finance income - interest receivable	7	1,314	1,444
Finance expense - interest payable	8	(124)	(144)
PDC dividends payable		(5,403)	(5,334)
NET FINANCE COSTS		**(4,213)**	**(4,034)**
Net gains on disposal of assets	9	43	12
DEFICIT FOR THE FINANCIAL YEAR		**(39,133)**	**(23,522)**
Other comprehensive income / (expense)			
Items that will not be reclassified to income and expenditure			
Net impairments on property, plant and equipment	10	641	(7,679)
Revaluation gains on property, plant and equipment		1,103	4,358
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**(37,389)**	**(26,843)**
Allocation of losses for the period			
(a) (Deficit) for the period attributable to:			
(ii) owners of the parent		(39,133)	(23,522)
TOTAL		**(39,133)**	**(23,522)**
(b) Total comprehensive income / (expense) for the period attributable to:			
(ii) owners of the parent		(37,389)	(26,843)
TOTAL		**(37,389)**	**(26,843)**

The notes on pages 5 to 37 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2026

	NOTE	31 March 2026 £000	31 March 2025 £000
NON-CURRENT ASSETS			
Intangible assets	11	1,290	1,483
Property, plant and equipment	12	201,002	196,277
Right of use assets	13	7,582	8,365
Trade and other receivables	15	916	757
Total non-current assets		**210,790**	**206,882**
CURRENT ASSETS			
Inventories	14	4,071	4,048
Trade and other receivables	15	11,312	9,564
Non-current assets held for sale and assets in disposal groups	16	132	132
Cash and cash equivalents	18	24,875	15,976
Total current assets		**40,390**	**29,720**
CURRENT LIABILITIES			
Trade and other payables	19	(49,743)	(39,991)
Borrowings	21	(1,999)	(1,976)
Provisions	22	(214)	(644)
Other liabilities	20	(13,836)	(5,466)
Total current liabilities		**(65,792)**	**(48,077)**
Total assets less current liabilities		**185,388**	**188,525**
NON-CURRENT LIABILITIES			
Borrowings	21	(5,632)	(6,469)
Provisions	22	(1,453)	(2,080)
Total non-current liabilities		**(7,085)**	**(8,549)**
TOTAL ASSETS EMPLOYED		**178,303**	**179,976**
TAXPAYERS' EQUITY			
Public dividend capital		299,594	263,878
Revaluation reserve		36,730	36,127
Income and expenditure reserve		(158,021)	(120,029)
TOTAL TAXPAYERS' EQUITY		**178,303**	**179,976**

The primary accounts on pages 1 to 4 and the notes on pages 5 to 37 were approved by the Audit Committee on 22 June 2026 on behalf of the Trust Board using the powers delegated to the Committee and signed on its behalf by Nikhil Khashu, Chief Executive.

Signed: .....  ..... Date: 22 June 2026

Nikhil Khashu
Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2026

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1 April 2025	179,976	263,878	36,127	(120,029)
Deficit for the year	(39,133)	0	0	(39,133)
Transfers between reserves	0	0	(1,141)	1,141
Net impairments on property, plant and equipment	641	0	641	0
Revaluation gains on property, plant and equipment	1,103	0	1,103	0
Public Dividend Capital received	35,911	35,911	0	0
Public Dividend Capital repaid	(195)	(195)	0	0
Taxpayers' equity as at 31 March 2026	**178,303**	**299,594**	**36,730**	**(158,021)**

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1 April 2024	182,464	239,523	40,689	(97,748)
Deficit for the year	(23,522)	0	0	(23,522)
Transfers between reserves	0	0	(1,241)	1,241
Net impairments on property, plant and equipment	(7,679)	0	(7,679)	0
Revaluation gains on property, plant and equipment	4,358	0	4,358	0
Public Dividend Capital received	24,355	24,355	0	0
Taxpayers' equity as at 31 March 2025	**179,976**	**263,878**	**36,127**	**(120,029)**

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) from continuing operations		**(34,964)**	**(19,500)**
Non-cash income and expense			
Depreciation and amortisation	4	16,434	16,019
Impairments and reversals	4	2,362	6,348
Income recognised in respect of capital donations	3	0	(51)
(Increase) / decrease in trade and other receivables		(1,309)	3,463
(Increase) / decrease in inventories	14	(23)	178
Increase / (decrease) in trade and other payables		6,552	(3,623)
Increase in other liabilities	20	8,370	879
Increase in provisions	22	(1,057)	(2,411)
Other movements in operating cash flows		0	(5)
Net cash used in operations		**(3,634)**	**1,297**
Cash flows from investing activities			
Interest received	7	1,314	1,444
Purchase of intangible assets		(471)	(444)
Purchase of property, plant and equipment		(15,292)	(21,074)
Sales of property, plant and equipment		43	38
Initial direct costs or up front payments in respect of new right of use assets (lessee)	13	0	(5)
Receipt of cash donations to purchase capital assets	3	0	51
Net cash used in investing activities		**(14,406)**	**(19,990)**
Cash flows from financing activities			
Public Dividend Capital received (note 1)		35,911	24,355
Public Dividend Capital repaid		(195)	0
Capital element of lease liability repayments	21.1	(2,152)	(2,640)
Other interest	8	(12)	(25)
Interest element of lease liability repayments	8	(112)	(120)
Public Dividend Capital paid		(6,501)	(4,535)
Net cash used in financing activities		**26,939**	**17,035**
Decrease in cash and cash equivalents	18	8,899	(1,658)
Cash and cash equivalents as at 1 April		15,976	17,634
Cash and cash equivalents as at 31 March	18	**24,875**	**15,976**

7.4 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 (DHSC) 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 DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) 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.

Note 1.1.1 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

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 Key sources of judgement and estimation uncertainty

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 affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.3.1 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations that management have made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Provisions
The Trust has the following categories of provisions:
- Pensions - relates to early retirement costs information is provided by NHS Business Service Authority.
- Legal - claims relates to third party legal claims advised by NHS Resolution.
- Other - employment tribunals.
- Clinical Pension - information is provided by NHSE.

The only category within provisions where the Trust applies a judgement and estimate is to the employment tribunal cases within other provisions. This is in respect of likelihood of outcome and any financial awards that may be made against the Trust.

Note 1.3.2 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:

Asset valuations and lives
The value and remaining useful lives of land and building assets are estimated by Cushman & Wakefield 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. A simple sensitivity analysis indicates that a 1% movement in these estimations would increase or decrease the valuation of assets by £1.5m. In comparison, a 10% movement in values is £15.4m.

A full asset valuation is undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years.

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and / or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.

Note 1.4 Income

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 accounting policies for revenue recognition and the application of IFRS 15 are consistently applied.

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) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts (API) form the main payment mechanism under the NHSPS. In 2025/26 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.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for non-elective BPTs are included in the fixed element of API contracts with adjustments for actual achievement being made as part of planning for the following year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed. The CQUIN scheme was paused during 2025/26 which means that the Trust's income associated with CQUIN achievement is not at risk and is not required to be repaid if the CQUIN criteria is not fully achieved. CQUIN funding is included within tariff payments from commissioners.

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 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 1.4.1 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 consolidated 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 Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Income (continued)

Where income is received for a specific activity that is to be delivered in a future financial year that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

The main sources of other operating income are from the DHSC, Health Education England, NHS Trusts, NHS Foundation Trusts and Local Authorities.

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

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 1.6 Expenditure on 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 an intangible asset or an item of property, plant and equipment.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

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.

Note 1.7.2 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.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued 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.

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 is shown in the table below:

	Min life	Max life
	Years	Years
Intangible assets - purchased		
Software	2	15

Note 1.8 Property, plant and equipment

Note 1.8.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items which have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Note 1.8.1 Recognition (continued)

The whole of a site is designated as the property asset with the land, the separate buildings upon it and the external works being the main components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

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.

Note 1.8.2 Measurement

Valuation

All property, plant and equipment is initially measured at cost, representing the cost 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.

Land and buildings used for the Trust's services or for administrative purposes are stated in the SoFP at their revalued amounts, being the current value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and where it would meet the location requirements of the service being provided an alternative site valuation can be used. The Trust has used alternative site valuation from 2017/18 onwards. The Trust commissioned Cushman & Wakefield to undertake a "full" valuation as at 31 March 2025.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the SoFP date.

- Land and non specialised buildings - market value for existing use.
- Specialised buildings - depreciated replacement cost.
- Equipment - depreciated historical cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at current value. Assets are revalued and depreciation commences when they 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.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Note 1.8 Property, plant and equipment (continued)

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' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-SoFP 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 expenses.

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 SoCI as an item of 'other comprehensive income / expenses'.

Impairments

At the end of the financial year the Trust reviews whether there is any indication that any of its assets have suffered an impairment loss. If there is an indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

In accordance with the GAM, impairments that are due to a loss of economic benefits or 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 arising from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating 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, such as unforeseen obsolescence, are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains and classed as 'other operating income'.

Note 1.8 Property, plant and equipment (continued)

Note 1.8.3 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 life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.8.4 Donated, government grant and other grant funded assets

Donated, government grant and other grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited in full to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation / grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Min life	Max life
	Years	Years
Buildings, excluding dwellings	5	80
Dwellings	25	42
Plant & machinery	5	16
Transport equipment	7	10
Information technology	5	10
Furniture & fittings	5	15

Note 1.9 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.

Note 1.9.1 The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Note 1.9.2 The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula, which is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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.

Note 1.11 Cash and cash equivalents

Cash is defined as 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. Interest earned on bank accounts is recorded as interest receivable in the periods to which it relates. Balances exclude monies held in bank accounts belonging to patients (Note 18).

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.

The Trust is required to maintain a minimum cash balance of £2.080m to ensure that the Better Payment Practice code can be achieve to ensure prompt payment to suppliers. If the Trust falls below the minimum cash balance then PDC revenue support can be requested centrally from NHSE.

Note 1.12 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 SoFP is the best estimate of the expenditure 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. 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 22 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 the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of successful claims are charged to operating expenses as and when the liability arises.

Note 1.13 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 22, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Value added tax (VAT)

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 1.15 Corporation tax

Warrington and Halton Teaching Hospitals NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is temporarily exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA). Accordingly, the Trust will become within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare and where the profits exceed £50,000 per annum. However, there is no tax liability in respect of the current financial year (£nil in 2024/25).

Note 1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with requirements of HM Treasury's FReM (Note 18).

Note 1.17 Public Dividend Capital (PDC) and PDC dividend

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 Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at:-

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the unaudited version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.18 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 1.19 Consolidation

The Trust is the corporate Trustee to Warrington & Halton Teaching Hospitals NHS Foundation Trust Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to effect those returns and other benefits through its power over the fund.

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

The Trust has opted not to consolidate charitable funds with the main Trust Accounts in 2025/26 because they are immaterial. This will be reviewed each year for appropriateness.

Note 1.20 Financial assets and financial liabilities

Note 1.20.1 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, i.e. on receipt or delivery of the goods or services.

Note 1.20.2 Classification and measurement

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 in note 1.9.

Financial assets and liabilities are classified and 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 SoCI and a financing income or expense.

Note 1.20 Financial assets and financial liabilities (continued)

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

In determining the classification of financial assets the Trust has considered both the business model and associated cash flows for the collection of contractual income that are solely payments of principal and interest. Financial assets are measured at amortised cost. Contract receivables will initially be measured at their transaction price, as defined by IFRS 15 adjusted for any allowance for expected credit losses using a general approach.

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 SoCI and reduce the net carrying value of the financial asset in the SoFP.

Note 1.20.3 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expired.

Note 1.21.2 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 also recognised in operating expenses. 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.

Note 1.21.3 Income and expenditure reserve

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

Note 1.22 Early adoption of standards, amendments and interpretations

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

Note 1.23 Accounting standards and interpretations issued but not yet adopted

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.

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 £155m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £155m at 31 March 2026. The impact can't be currently quantified at this time.

Note 2. Operating segments

The Trust has considered segmental reporting, the Chief Executive and the Trust Board receive sufficient and appropriate high level information to enable the business to be managed effectively supporting the monitoring and management of the Trust's strategic aims. Sufficiently detailed information is used by middle and lower management to ensure effective management at an operational level. Neither of these are sufficiently discrete to profile operating segments, as defined by IFRS 8, that would enable a user of these financial statements to evaluate the nature and financial effects of the business activities that this Trust undertakes. Therefore, the Trust has decided that it has one operating segment for healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	**2025/26 £000**	**2024/25 £000**
Acute services		
Income from commissioners under API contracts - variable element (note 1)	82,922	76,513
Income from commissioners under API contracts - fixed element (note 1)	232,659	242,668
High cost drugs income from commissioners	17,041	17,076
Other NHS clinical income	11,667	8,511
All services		
Private patient income	7	9
Agenda for change pay award central funding (note 2)	0	656
Additional pension contribution central funding (note 3)	15,936	15,216
Other non-protected clinical income (note 4)	1,223	1,047
Total income from activities	**361,455**	**361,695**

note 1 - 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.

note 2 - Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

note 3 - Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2024/25: 23.7%) and related NHS England funding (9.4%, 2024/25: 9.4%) have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)	**2025/26 £000**	**2024/25 £000**
Income from patient care activities received from:		
NHS England	24,111	23,948
Integrated Care Boards	335,729	336,303
NHS Foundation Trusts	384	386
Department of Health and Social Care	8	10
Non NHS : private patients	7	9
Non NHS : overseas patients	170	60
Injury cost recovery scheme	914	888
Non NHS Other	133	92
Total income from activities	**361,455**	**361,695**

All income from activities relates, in its entirety, to continuing operations for 2025/26 and 2024/25.

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

	2025/26 £000	**2024/25 £000**
Income recognised this year	170	60
Cash payments received in-year	22	10
Amounts added to provision for impairment of receivables	179	64
Amounts written off in-year	52	14

Note 3. Operating income (continued)

Note 3.4 Other operating income	2025/26 £000	2024/25 £000
Research and development	1,059	945
Education and training	12,652	11,678
Non-patient care services to other bodies	1,135	1,375
Income in respect of staff costs where accounted on gross basis	1,103	1,288
Education and training - Notional income from apprenticeship fund	785	641
Cash donations / grants for the purchase of assets	0	51
Charitable and other contributions to expenditure - received from NHS charities	92	0
Rental revenue from operating leases	271	275
Other (note 1)	14,013	14,018
Total other operating income	**31,110**	**30,271**

note 1 - all other operating income relates in it's entirety to continuing operations for 2025/26 and 2024/25.

Analysis of other operating income 'other'	2025/26 £000	2024/25 £000
Car parking	2,111	1,729
Catering	289	401
Pharmacy sales	127	108
Staff accommodation rentals	0	7
Non-clinical services recharged to other bodies	885	803
Clinical tests	2,612	2,556
Other (note 2)	7,989	8,414
Total other operating income 'other'	**14,013**	**14,018**

note 2 - other income for 2025/26 contains £1,183k Intermediate Care Therapies, £500k MARS scheme, £460k Radiology Hub, £364k Pathology Funding, £278k Additional Roles Reimbursement Scheme (ARRS) Therapy Service, £230k Neurological Theatres and £192k Resusitation Training income.

Note 3.5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, 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 Trust failure. This information is provided in the table below.

	2025/26 £000	2024/25 £000
Income from services not designated as commissioner requested services	361,455	361,695
Total	**361,455**	**361,695**

Following a review of Note 3.5, the Trust has classified all income as ‘Income from services not designated as Commissioner Requested Services’ and has restated the 2024/25 accounts accordingly. This treatment has been confirmed by the ICB, which has confirmed that the Trust does not provide any Commissioner Requested Services due to the proximity of alternative providers who could deliver the activity in the event of Trust failure.

Note 3.6 Fees and charges

HM Treasury requires disclosure of fees and charges in respect of charges to service users where income from that service exceeds £1m and is presented as the aggregate of such income. There haven't been any costs exceeding £1m in either 2025/26 or 2024/25 in respect of fees and charges.

Note 3.7 Additional information on revenue from contracts with customers recognised in the period	2025/26 £000	2024/25 £000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	2,895	2,196

Note 4. Operating expenditure

Note 4.1 Operating expenses	NOTE	2025/26 £000	2024/25 £000
Purchase of healthcare from NHS and DHSC bodies		196	141
Purchase of healthcare from non-NHS and non-DHSC bodies		3,318	3,047
Purchase of social care		0	0
Staff and executive directors costs		309,273	289,599
Non-executive directors		127	120
Supplies and services (clinical; excluding drug costs)		28,880	28,617
Supplies and services (general)		3,745	4,624
Drug costs	14	21,309	22,901
Consultancy costs		0	270
Establishment		2,724	3,160
Premises (business rates)		1,542	1,537
Premises (other)		14,627	12,824
Transport (business travel only)		394	385
Transport (including patient travel)		1,248	1,180
Depreciation on property, plant and equipment and right of use assets	12 & 13	15,770	15,254
Amortisation on intangible assets	11	664	765
Net impairments	10	2,362	6,348
Movement in credit loss allowance: contract receivables/assets	17	183	187
Provisions arising / released in year		0	135
Change in provisions discount rate	22	(22)	3
Audit services (statutory audit) *		200	192
Internal audit costs		111	106
Clinical negligence, liability to third parties and property expenses scheme premiums		13,350	11,718
Legal fees		206	273
Insurance		299	266
Research and development - staff costs		1,004	1,124
Research and development - non-staff		122	0
Education and training - staff costs		3,033	3,117
Education and training - non-staff		986	1,894
Education and training - notional expenditure funded from apprenticeship fund		785	641
Lease expenditure		299	424
Redundancy		10	0
Car parking & security		0	0
Hospitality		0	0
Losses and special payments - staff costs		525	0
Losses and special payments (excl. debt write off) - non-staff costs		239	579
Other expenditure		19	35
Total operating expenses		**427,528**	**411,466**

All operating expenses relate, in their entirety, to continuing operations for 2025/26 and 2024/25.
* Audit service fees are inclusive of VAT

Note 4.2 Limitation on auditor's liability

The external auditors' liability is limited to £1m. The scope of work for the external auditors is to provide a statutory audit of annual accounts and report and provide opinion on them to the Trust and the Trust's Council of Governors. This will be conducted in accordance with schedule 10 of the National Health Service Act 2006 with due regard to the Comptroller and Auditor General's Code of Audit Practice (the Code) issued by the National Audit Office (NAO) in April 2015.

Note 5. Staff

Note 5.1 Employee expenses

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	212,970	200,345
Social security costs	26,446	20,485
Apprenticeship levy	1,028	987
Pension costs (employer contributions to NHS Pensions)	24,381	23,203
Pension costs (employer contributions paid by NHSE on Provider's behalf)	15,936	15,216
Pension costs (other)	52	70
Termination benefits (note 1)	661	77
Temporary staff - external bank (note 2)	31,148	31,841
Temporary staff - agency/contract staff (note 2)	2,975	3,732
Total employee benefit expenses	**315,597**	**295,956**
Less costs capitalised as part of assets	(1,752)	(1,583)
Total per employee expenses in Note 4.1	**313,845**	**294,373**

note 1 - includes £526k of Mutually Agreeable Resignation Scheme (MARS) costs.

note 2 - during 2025/26 the Trust has continued to work on reducing agency costs by using bank staff. Bank staff costs have also reduced due to rate reduction.

Employee costs include staff costs of £1,752k (£1,583k in 2024/25) which have been capitalised as part of the Trust's capital programme. These amounts are excluded from employee expenses (Note 5.1). The employee expenses table above is for executive directors, staff costs and redundancy payments only. It excludes non-executive directors.

An accrual in respect of the cost of annual leave entitlement carried forward at the SoFP date of £3,586k has been provided for within the accounts (£1,215k as at 31 March 2025).

Note 5.2 Early retirements due to ill-health

8 members of staff retired early on ill-health grounds during the year at an additional cost of £332k (3 members of staff costing £142k for the year ending 31 March 2025). The cost of ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

Note 6. Operating leases

This note discloses income generated in operating lease agreements where Warrington and Halton Teaching Hospitals NHS Foundation Trust is the lessor.

Note 6.1 Operating lease income	2025/26 £000	2024/25 £000
Lease receipts recognised as income in the year	271	275
Total	**271**	**275**

Future minimum lease receipts due:	2025/26 £000	2024/25 £000
Not later than one year	271	269
Later than one year and not later than five years	1,084	1,076
Later than five years	12,035	12,108
Total	**13,390**	**13,453**

Note 7. Finance revenue

	2025/26 £000	2024/25 £000
Interest on bank accounts	1,314	1,444
Total	**1,314**	**1,444**

Note 8. Finance expenditure

Note 8.1 Finance expenditure

	2025/26 £000	2024/25 £000
Interest on lease obligations	112	120
Interest on Late Payment of Debt	12	25
Unwinding of discount on provisions	(0)	(1)
Total interest expense	**124**	**144**

Note 8.2 The Late Payment of Commercial Debts (Interest) Act 1998

The total within 2025/26 for late payment of commercial debt was £12k (£25k in 2024/25).

Note 9. Other - Net Gains

	2025/26 £000	2024/25 £000
Gains on disposal of property, plant and equipment	43	37
Net Losses on disposal of property, plant and equipment	0	(25)
Total gains on disposal of assets	**43**	**12**

Note 10. Impairment of assets

	2025/26		
Impairments and (reversals) charged to operating surplus / (deficit):	**Net Impairments £000**	**Impairments £000**	**Reversal of Impairments £000**
Abandonment of assets in the course of construction	**0**	**0**	**0**
Total DEL	**0**	**0**	**0**
Change in market price	2,362	3,698	(1,336)
Total AME	**2,362**	**3,698**	**(1,336)**
Impairments charged to operating expenses	2,362	3,698	(1,336)
Impairments charged to the revaluation reserve	(641)	1,180	(1,821)
Total impairments due to change in market price	**1,721**	**4,878**	**(3,157)**

	2024/25		
Impairments and (reversals) charged to operating surplus / (deficit):	**Net Impairments £000**	**Impairments £000**	**Reversal of Impairments £000**
Abandonment of assets in the course of construction	262	262	0
Total DEL	**262**	**262**	**0**
Change in market price	6,086	6,465	(379)
Total AME	**6,086**	**6,465**	**(379)**
Impairments charged to operating expenses	6,348	6,727	(379)
Impairments charged to the revaluation reserve	7,679	7,679	0
Total impairments due to change in market price	**14,027**	**14,406**	**(379)**

A full asset valuation is undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years. Any increase in valuation which reverses a previous impairment has been credited to other operating income, to the extent of what has been charged there already relating to the asset. Any remaining balance has been credited to the revaluation reserve.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 (‘Red Book’), the valuer has declared that the valuation is not reported as being subject to ‘material valuation uncertainty’. This is due to property markets functioning again despite COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

Note 11. Intangible assets

	Total	Software licences	Intangible assets under construction
	£000	£000	£000
Cost as at 1 April 2025	**7,323**	**7,323**	**0**
Additions - purchased	471	273	198
Disposals	0	0	0
Cost as at 31 March 2026	**7,794**	**7,596**	**198**
Accumulated amortisation as at 1 April 2025	**5,840**	**5,840**	**0**
Provided during the year	664	664	0
Disposals	0	0	0
Accumulated amortisation as at 31 March 2026	**6,504**	**6,504**	**0**
Cost as at 1 April 2024	**6,945**	**6,945**	**0**
Additions - purchased	444	444	0
Disposals	(66)	(66)	0
Cost as at 31 March 2025	**7,323**	**7,323**	**0**
Accumulated amortisation as at 1 April 2024	**5,141**	**5,141**	**0**
Provided during the year	765	765	0
Disposals	(66)	(66)	0
Accumulated amortisation as at 31 March 2025	**5,840**	**5,840**	**0**
Net book value as at 31 March 2026	**1,290**	**1,092**	**198**
Net book value as at 31 March 2025	**1,483**	**1,483**	**0**

All intangible assets are owned assets.

Note 12. Property, plant and equipment

Note 12.1 Property, plant and equipment 2025/26	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1 April 2025	**224,713**	**17,500**	**125,814**	**722**	**15,326**	**41,159**	**184**	**17,369**	**6,639**
Additions - purchased	18,992	0	6,306	0	8,464	788	0	3,367	67
Additions - assets purchased from cash donations	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	(1,180)	0	(1,163)	(17)	0	0	0	0	0
Reversal of impairments credited to operating expenses	0	0	(1)	1	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	1,821	0	1,821	0	0	0	0	0	0
Revaluations	(7,480)	0	(7,427)	(53)	0	0	0	0	0
Reclassifications	0	0	11,190	0	(14,306)	3,102	0	14	0
Disposals	(1,505)	0	(1)	0	0	(299)	0	(1,205)	0
Cost or valuation as at 31 March 2026	**235,361**	**17,500**	**136,539**	**653**	**9,484**	**44,750**	**184**	**19,545**	**6,706**
Accumulated depreciation as at 1 April 2025	**28,436**	**0**	**0**	**0**	**0**	**18,666**	**114**	**8,087**	**1,569**
Provided during the year	13,649	0	6,165	57	0	4,457	13	2,347	610
Impairments charged to operating expenses	3,698	0	3,698	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	(1,336)	0	(1,332)	(4)	0	0	0	0	0
Revaluations	(8,583)	0	(8,530)	(53)	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Disposals	(1,505)	0	(1)	0	0	(299)	0	(1,205)	0
Accumulated depreciation as at 31 March 2026	**34,359**	**0**	**0**	**0**	**0**	**22,824**	**127**	**9,229**	**2,179**
Net book value as at 31 March 2026	**201,002**	**17,500**	**136,539**	**653**	**9,484**	**21,926**	**57**	**10,316**	**4,527**

Note 12. Property, plant and equipment

Note 12.1 Property, plant and equipment 2024/25	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1 April 2024	**222,698**	**17,500**	**122,208**	**665**	**22,692**	**38,676**	**173**	**14,035**	**6,749**
Additions - purchased	20,799	0	6,758	0	10,763	2,165	11	1,085	17
Additions - assets purchased from cash donations	51	0	0	0	0	23	0	0	28
Impairments charged to revaluation reserve	(7,679)	0	(7,679)	0	0	0	0	0	0
Revaluations	(7,713)	0	(7,507)	57	(263)	0	0	0	0
Reclassifications	0	0	12,034	0	(17,866)	1,795	0	4,037	0
Disposals	(3,443)	0	0	0	0	(1,500)	0	(1,788)	(155)
Cost or valuation as at 31 March 2025	**224,713**	**17,500**	**125,814**	**722**	**15,326**	**41,159**	**184**	**17,369**	**6,639**
Accumulated depreciation as at 1 April 2024	**25,036**	**0**	**0**	**0**	**0**	**16,228**	**102**	**7,588**	**1,118**
Provided during the year	12,545	0	5,673	49	0	4,259	12	1,946	606
Impairments charged to operating expenses	6,727	0	6,453	11	263	0	0	0	0
Reversal of impairments credited to operating expenses	(379)	0	(378)	(1)	0	0	0	0	0
Revaluations	(12,071)	0	(11,748)	(59)	(263)	0	0	(1)	0
Reclassifications	0	0	0	0	0	(342)	0	342	0
Disposals	(3,422)	0	0	0	0	(1,479)	0	(1,788)	(155)
Accumulated depreciation as at 31 March 2025	**28,436**	**0**	**0**	**0**	**0**	**18,666**	**114**	**8,087**	**1,569**
Net book value as at 31 March 2025	**196,277**	**17,500**	**125,814**	**722**	**15,326**	**22,493**	**70**	**9,282**	**5,070**

Note 12.3 Property, plant and equipment financing	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value as at 31 March 2026									
Owned	196,657	17,500	134,568	653	9,484	21,518	57	10,185	2,692
Donated / Granted	4,345	0	1,971	0	0	408	0	131	1,835
Total net book value as at 31 March 2026	**201,002**	**17,500**	**136,539**	**653**	**9,484**	**21,926**	**57**	**10,316**	**4,527**
Net book value as at 31 March 2025									
Owned	191,358	17,500	123,797	722	15,326	21,912	70	9,031	3,000
Donated / Granted	4,919	0	2,017	0	0	581	0	251	2,070
Total net book value as at 31 March 2025	**196,277**	**17,500**	**125,814**	**722**	**15,326**	**22,493**	**70**	**9,282**	**5,070**

Note 13 Leases

This note details information about leases for which the Trust is a lessee.

Note 13.1 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	**3,961**	**10,059**	**14,020**	**665**
Additions - lease liability	152	0	152	0
Additions - up front lease payments (before or on commencement)	0	0	0	0
Remeasurements of the lease liability	834	352	1,186	20
Disposals/derecognition - lease termination	(31)	0	(31)	0
Valuation/gross cost at 31 March 2026	**4,916**	**10,411**	**15,327**	**685**
Accumulated depreciation at 1 April 2025 - brought forward	**1,643**	**4,012**	**5,655**	**367**
Provided during the year	758	1,363	2,121	184
Disposals / derecognition	(31)	0	(31)	0
Accumulated depreciation at 31 March 2026	**2,370**	**5,375**	**7,745**	**551**
Net book value at 31 March 2026	**2,546**	**5,036**	**7,582**	**134**

Net book value of right of use assets leased from other NHS providers	7,448
Net book value of right of use assets leased from other DHSC group bodies	134
Net book value at 31 March 2026	**7,582**

Note 13.2 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	**5,416**	**10,080**	**15,496**	**644**
Additions - lease liability	28	36	64	0
Additions - up front lease payments (before or on commencement)	2	3	5	0
Remeasurements of the lease liability	395	169	564	21
Disposals/derecognition - lease termination	(1,880)	(229)	(2,109)	0
Valuation/gross cost at 31 March 2025	**3,961**	**10,059**	**14,020**	**665**
Accumulated depreciation at 1 April 2024 - brought forward	**2,270**	**2,785**	**5,055**	**198**
Provided during the year	1,253	1,456	2,709	169
Disposals / derecognition	(1,880)	(229)	(2,109)	0
Accumulated depreciation at 31 March 2025	**1,643**	**4,012**	**5,655**	**367**
Net book value at 31 March 2025	**2,318**	**6,047**	**8,365**	**298**

Net book value of right of use assets leased from other NHS providers	8,067
Net book value of right of use assets leased from other DHSC group bodies	298
Net book value at 31 March 2025	**8,365**

Note 13.3 Revaluations of right of use assets

The Trust measures right of use assets using the cost model. Therefore annual revaluations are not carried out.

Note 13.4 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 21.

	2025/26 £000	2024/25 £000
Carrying value at 31 March	8,445	10,457
Lease additions	152	64
Lease liability remeasurements	1,186	564
Interest charge arising in year	112	120
Lease payments (cash outflows)	(2,264)	(2,760)
Carrying value at 31 March	**7,631**	**8,445**

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 4.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above. The Trust does not sublease any of it's right of use assets.

Note 13.5 Maturity analysis of future lease payments

	Total 31 March 2026 £000	Of which leased from DHSC group bodies: 31 March 2026 £000
Undiscounted future lease payments payable in:		
- not later than one year;	2,104	88
- later than one year and not later than five years;	5,728	71
- later than five years.	47	0
Total gross future lease payments	**7,879**	**159**
Finance charges allocated to future periods	(248)	(5)
Net lease liabilities at 31 March 2026	**7,631**	**154**
Of which:		
- Current	1,999	84
- Non-Current	5,632	70

	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000
Undiscounted future lease payments payable in:		
- not later than one year;	2,069	188
- later than one year and not later than five years;	6,152	154
- later than five years.	471	0
Total gross future lease payments	**8,692**	**342**
Finance charges allocated to future periods	(247)	(12)
Net lease liabilities at 31 March 2025	**8,445**	**330**
Of which:		
- Current	1,976	180
- Non-Current	6,469	150

Note 14. Inventories

Note 14.1 Inventory movements 2025/26

	Total £000	Drugs £000	Consumables £000
Carrying value at 1 April 2025	4,048	1,803	2,245
Additions	40,998	21,295	19,703
Inventories consumed (recognised in expenses)	(40,975)	(21,309)	(19,666)
Total as at 31 March 2026	**4,071**	**1,789**	**2,282**

Note 14.1 Inventory movements 2024/25

	Total £000	Drugs £000	Consumables £000
Carrying value at 1 April 2024	4,226	1,864	2,362
Additions	49,111	22,840	26,271
Inventories consumed (recognised in expenses)	(49,289)	(22,901)	(26,388)
Total as at 31 March 2025	**4,048**	**1,803**	**2,245**

Note 15. Trade and other receivables

Current	2025/26 £000	2024/25 £000
Contract receivables (IFRS 15): invoiced	3,898	5,065
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	2,724	797
Allowance for impaired contract receivables / assets	(980)	(1,608)
Prepayments	2,217	2,316
PDC dividend receivable	598	0
VAT receivable	955	1,275
Clinical pension tax provision reimbursement funding from NHSE	26	41
Other receivables	1,874	1,678
Total current trade and other receivables	**11,312**	**9,564**
Non current		
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	884	869
Allowance for impaired contract receivables / assets	(368)	(532)
Clinician pension tax provision reimbursement funding from NHSE	400	420
Total non current trade and other receivables	**916**	**757**
Total trade and other receivables	**12,228**	**10,321**
Of which receivable from NHS and DHSC group bodies:		
Current	3,878	2,609
Non-current	400	420

Note 16. Non-current assets held for sale and assets in disposal groups

	2025/26 £000	2024/25 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**132**	**0**
Assets classified as available for sale in the year	0	132
NBV of non-current assets for sale and assets in disposal groups at 31 March	**132**	**132**

Note 17.1 Allowances for credit losses - 2025/26

	All receivables £000
Allowances as at 1 April 2025 - brought forward	2,140
New allowances arising	96
Changes in existing allowances	136
Reversals of allowances	(49)
Utilisation of allowances (write offs)	(975)
Allowances as at 31 March 2026	1,348

Note 17.2 Allowances for credit losses - 2024/25

	All receivables £000
Allowances as at 1 April 2024 - brought forward	1,988
New allowances arising	208
Reversals of allowances	(21)
Utilisation of allowances (write offs)	(35)
Allowances as at 31 March 2025	2,140

Note 18. Cash and cash equivalents

	2025/26 £000	2024/25 £000
As at 1 April	15,976	17,634
Net change in year	8,899	(1,658)
As at 31 March	**24,875**	**15,976**
Breakdown of cash and cash equivalents		
Cash at commercial banks and in hand	11	27
Cash with the Government Banking Service	24,864	15,949
Cash and cash equivalents as at 31 March	**24,875**	**15,976**
Third party assets held by the Trust	**25**	**22**

As at 31 March 2026 the Trust held £25k (£22k as at 31 March 2025) within the Trust bank accounts which related to monies held by the Trust on behalf of patients. These have been excluded from the cash at bank and in hand figure above.

Note 19. Trade and other payables

	2025/26 £000	2024/25 £000
Current		
Trade payables	15,426	10,805
Trade payables capital	10,789	7,089
Accruals	10,314	11,225
Annual leave accrual	3,586	1,215
Social security costs	2,897	2,413
Other taxes payable	2,962	2,841
PDC dividend payable	0	500
Pension contributions payable	3,396	3,191
Other payables	373	712
Total trade and other payables	**49,743**	**39,991**
Of which payables from NHS and DHSC group bodies:		
Current	4,392	4,200

Note 20. Other liabilities

	2025/26 £000	2024/25 £000
Current		
Deferred income	13,836	5,466
Total other liabilities	**13,836**	**5,466**

Note 21. Borrowings

	2025/26 £000	2024/25 £000
Current		
Lease liabilities	1,999	1,976
Total current borrowings	**1,999**	**1,976**
Non-current		
Lease liabilities	5,632	6,469
Total non-current borrowings	**5,632**	**6,469**
Total borrowings	**7,631**	**8,445**

Note 21.1 Reconciliation of lease liabilities arising from financing activities

	2025/26 £000	2024/25 £000
Carrying value at 1 April	8,445	10,457
Cash movements:		
Financing cash flows - payments and receipts of principal	(2,152)	(2,640)
Financing cash flows - payments of interest	(112)	(120)
Non-cash movements:		
Additions	152	64
Lease liability remeasurements	1,186	564
Interest charge arising in year (application of effective interest rate)	112	120
Carrying value at 31 March	**7,631**	**8,445**

Note 22. Provisions

Movements in provisions for liabilities and charges	Total £000	Legal £000	2025/26 Other £000	Clinical Pension Tax Reimbursement £000	Pensions £000
As at 1 April 2025	2,724	79	1,215	461	969
Change in the discount rate	(55)	0	0	(33)	(22)
Arising during the year	473	149	280	0	44
Utilised during the year	(660)	(130)	(406)	(26)	(98)
Reversed unused	(842)	(30)	(809)	(3)	0
Unwinding of discount	27	0	(0)	27	(0)
As at 31 March 2026	**1,667**	**68**	**280**	**426**	**893**
Expected timing of cash flows:					
Within one year	214	68	0	26	120
Between one and five years	768	0	280	66	422
After five years	685	0	0	334	351
Total	**1,667**	**68**	**280**	**426**	**893**

Movements in provisions for liabilities and charges	Total £000	Legal £000	2024/25 Other £000	Clinical Pension Tax Reimbursement £000	Pensions £000
As at 1 April 2024	5,136	135	3,510	466	1,025
Change in the discount rate	(1)	0	0	(4)	2
Arising during the year	620	220	230	0	170
Utilised during the year	(2,845)	(191)	(2,525)	(6)	(123)
Reversed unused	(207)	(85)	0	(17)	(105)
Unwinding of discount	21	0	(0)	22	(0)
As at 31 March 2025	**2,724**	**79**	**1,215**	**461**	**969**
Expected timing of cash flows:					
Within one year	644	79	403	41	121
Between one and five years	1,714	0	812	54	848
After five years	366	0	0	366	0
Total	**2,724**	**79**	**1,215**	**461**	**969**

The pensions provision relates to early retirement costs in line with the NHS Business Service Authority - Pensions Division. Legal claims relates to third party legal claims advised by NHS Resolution. These claims are generally expected to be settled within one year but may exceptionally take two years to settle.

Clinical negligence and employer liabilities

£185m is included in the provisions of NHS Resolution as at 31 March 2026 in respect of clinical negligence and employer liabilities of the Trust (£141m as at 31 March 2025).

Note 23. Contingent liabilities

Value of contingent liabilities	31 March 2026 £000	31 March 2025 £000
NHS Resolution legal claims	(19)	(12)
Gross value of contingent liabilities	**(19)**	**(12)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(19)**	**(12)**

Note 24. Financial instruments

Note 24.1 Financial risk management

Liquidity risk

The Trust's net operating costs are incurred under annual service level agreements / contracts with commissioners which are financed from resources voted annually by Parliament. The Trust receives such income for the activity delivered in that year in accordance with national and locally agreed tariffs. Monthly payments are received from Commissioners based on the annual contract values, this arrangement reduces liquidity risk.

The Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form.

Interest rate risk

All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest and the Trust is not therefore exposed to significant interest rate risk.

Credit risk

The main source of income for the Trust is from the Cheshire and Merseyside Integrated Care Board in respect of healthcare services provided under contract and Service Level Agreements. The credit risk associated with such customers is negligible.

The Trust has minimal exposure to credit risk as all cash balances are held within the Government Banking Services (GBS) account which generates additional cash through an applied interest rate. The Trust does not hold cash in any other investment institution on a short or long term basis.

Before entering into new contracts with non NHS customers, checks are made regarding creditworthiness. The Trust also regularly reviews debtor balances and has a comprehensive system in place for pursuing past due debt. Non NHS customers represent a small proportion of income and the Trust is not exposed to significant credit risk in this regard. There are no amounts held as collateral against these balances.

The movement in the allowances for credit losses for contract receivables / assets during the year is disclosed in Note 17. Of those assets which require an allowance for credit losses none are impaired financial assets (none in 2024/25).

There are no financial assets that would otherwise be past due date or impaired whose terms have been renegotiated (none in 2024/25).

Currency risk

The Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

All financial assets and liabilities are held in sterling and are shown at book value, which is not significantly different from fair value.

Note 24. Financial instruments (continued)

Note 24.2 Carrying values of financial assets

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2026				
Receivables (excluding non financial assets) - with DHSC group bodies	3,679	0	0	3,679
Receivables (excluding non financial assets) - with other bodies	4,779	0	0	4,779
Cash and cash equivalents at bank and in hand	24,875	0	0	24,875
Total as at 31 March 2026	**33,333**	**0**	**0**	**33,333**

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2025				
Receivables (excluding non financial assets) - with DHSC group bodies	3,029	0	0	3,029
Receivables (excluding non financial assets) - with other bodies	3,701	0	0	3,701
Cash and cash equivalents at bank and in hand	15,976	0	0	15,976
Total as at 31 March 2025	**22,706**	**0**	**0**	**22,706**

Note 24.3 Carrying value of financial liabilities

	Held at amortised cost	Held at fair value through the I&E	Total
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2026			
Obligations under leases	7,631	0	7,631
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	4,392	0	4,392
Trade and other payables (excluding non financial liabilities) - with other bodies	31,862	0	31,862
Total as at 31 March 2026	**43,885**	**0**	**43,885**

	Held at amortised cost	Held at fair value through the I&E	Total
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2025			
Obligations under finance leases	8,445	0	8,445
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	3,687	0	3,687
Trade and other payables (excluding non financial liabilities) - with other bodies	26,144	0	26,144
Total as at 31 March 2025	**38,276**	**0**	**38,276**

Note 24.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 24. Financial instruments (continued)

Note 24.5 Maturity of financial liabilities

	31 March 2026 £000	31 March 2025 £000
Financial liabilities fall due in:		
One year or less	39,589	31,900
More than one year but not more than five years	5,728	6,152
More than five years	47	471
Total	**45,364**	**38,523**

Note 25. Contractual Capital Commitments

The Trust has contractual capital commitments of £6,179k as at 31 March 2026 (£3,800k as at 31 March 2025). This includes: Ward Refurbishment £2,326k, ED Extension £2,210k, TIF Theatre Refurbishment £1,074k, Decarbonisation - Solar £327k and Xray room turnkey £242k.

Note 26. Related party disclosures

Note 26.1 Related party transactions

Value of transactions with other related parties in 2025/26	Revenue £000	Expenditure £000
Charitable funds (where not consolidated)	0	0
Total value of transactions with related parties in 2025/26	**0**	**0**

Value of transactions with other related parties in 2024/25	Revenue £000	Expenditure £000
Charitable funds (where not consolidated)	0	0
Total value of transactions with related parties in 2024/25	**0**	**0**

Note 26.2 Related party balances

Value of balances with other related parties as at 31 March 2026	Receivables £000	Payables £000
Charitable funds (where not consolidated)	240	0
Total value of balances with other related parties as at 31 March 2026	**240**	**0**

Value of balances with other related parties as at 31 March 2025	Receivables £000	Payables £000
Charitable funds (where not consolidated)	62	0
Total value of balances with other related parties as at 31 March 2025	**62**	**0**

Note 26.3 Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they are part of the DHSC group of bodies such that the DHSC is the parent department, and they fall under the common control of HM Government and Parliament. The GAM interprets IAS 24 (Related Party Disclosures) such that no information needs to be given about transactions relating to DHSC group bodies.

In line with this, these related parties notes only collect details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

Below is a list of the main entities within the public sector with which the Trust has had dealings with.

NHS England
Cheshire and Merseyside ICB
Greater Manchester ICB

Note 27. Events after the reporting period

On the 1st April 2026 Warrington and Halton Teaching Hospitals NHS Foundation Trust acquired Bridgewater Community Healthcare Foundation Trust with a change of name to North Cheshire and Mersey NHS Foundation Trust.

Note 28. Losses and special payments

	2025/26 Number	2025/26 £000
Losses		
Bad debts and claims abandoned	23	97
Stores losses and damage to property	24	158
Total losses	**47**	**255**
Special payments		
Ex-gratia payments	31	81
Special severance payments	0	0
Total special payments	**31**	**81**
Total losses and special payments	**78**	**336**
Value of compensation payments received		**52**

	2024/25 Number	2024/25 £000
Losses		
Bad debts and claims abandoned	39	31
Stores losses and damage to property	24	418
Total losses	**63**	**449**
Special payments		
Ex-gratia payments	33	122
Special severance payments	1	8
Total special payments	**34**	**130**
Total losses and special payments	**97**	**579**
Value of compensation payments received		**124**

There were no individual cases exceeding £0.3m in either 2025/26 or 2024/25.

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NHS Foundation Trust

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