



**Warrington and Halton  
Teaching Hospitals**  
NHS Foundation Trust

# Annual Report and Accounts 2024–25







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# Overview of the Trust



# 1. Overview of the Trust

## 1.1 Chair and Chief Executive's Introduction

**This 2024-25 annual report highlights the significant achievements we have continued to make at Warrington and Halton Teaching Hospitals (WHH), against what can only be described as a challenging landscape right across the NHS.**

We must start by giving heartfelt thanks to our circa 5,000-strong workforce and volunteers. The dedication, skill and compassion of colleagues can be seen throughout our services, where we 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.

We must also extend our gratitude to former chief executive Simon Constable, who left WHH in August 2024. Simon's leadership and commitment has laid the groundwork for the next phase of our journey – one that embraces integration, innovation and collaboration. This paved the way for the creation of a joint chief executive role across WHH and Bridgewater Community Healthcare NHS Foundation Trust, as we work to bring our two organisations together as one.

Our shared vision, as outlined in *Better Care Together: A Case for Change*, 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. Over the coming years we will continue engaging with our patients, service users and partners to shape and refine this approach, always striving for better outcomes and experiences.

We are already seeing the impact of integration in areas such as dermatology, where collaboration has led to a more efficient and patient-friendly service at the Halton Health Hub, located in Runcorn Shopping City. This is just one example of how we can work differently to improve care, and we look forward to sharing more successes in the future.

As we anticipate the publication of the NHS 10-year plan, we welcome the long-overdue shift towards greater community-based care. This is an exciting and necessary evolution, and we are confident that, together, we can build a stronger, more integrated health and care system – one that truly meets the needs of those we serve.

In the meantime, we would like to take this opportunity to celebrate some of our key achievements in 2024-25, 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*

May 2024 saw the official opening of a new theatre and day case unit in the Captain Sir Tom Moore Building at Halton Hospital. The work is the first phase of a £9.2 million project to re-configure theatres, create additional capacity for the treatment of elective patients and help to reduce waiting lists for surgery. The unit has been designed to provide 10 new day case pods, a state-of-the-art laminar flow theatre and a new treatment room for low complexity surgery, supporting new ways of working and innovative methods of delivering care to provide an excellent experience for elective patients.

This was swiftly followed in September 2024 by the opening of a new £5 million Endoscopy Hub in Halton Hospital's Nightingale Building. The hub, which is part of a wider endoscopy transformation programme, provides a modern space for diagnostics, surveillance and bowel cancer screening for patients across Cheshire and Merseyside. The space has four new endoscopy rooms, each equipped with state-of-the-art technology and equipment, along with a new recovery area to provide five additional beds.

At our Warrington Hospital site, we were pleased that our maternity services were named in the top 10 Trusts nationally in the Care Quality Commission's 2024 Maternity Survey. The report findings, published in November 2024, captured what women who gave birth in February 2024 felt about the care they received while pregnant, in hospital during and after labour, and once at home in the weeks following the arrival of their baby. WHH was revealed to be one of eight Trusts across the country (and one of only two in the North West) whose results were rated as 'better than expected' overall – meaning families' experiences of using maternity services were substantially better than the national average.

We were also proud during 2024-25 to see the impact of our Gynaecology Super Clinics, set up in May 2024 to ensure no patient waits more than 52 weeks to receive the care they need. The super clinic service, held every Saturday, delivers four simultaneous clinics to offer consultation, diagnostic scans and perform minor gynaecology procedures for women who present with symptoms of pelvic pain or irregular bleeding. This has reduced the need for multiple face-to-face appointments and expanded capacity without compromising patient safety or quality of care. In less than a year, the super clinics have seen more than 1,500 patients, with 80 per cent starting or completing their treatment plan at the clinic.

Our dedicated Dementia Team received a national award at the annual Dementia Care Awards. The team, who deliver care on Warrington Hospital's Forget Me Not Unit, were presented with the 'Outstanding Dementia Care Team' award, recognising the commitment of the multidisciplinary team to deliver high quality person-centred care in an environment that promotes wellbeing and positive outcomes for patients.

There have been many other success stories of improved quality and experience of care over the past year. We're now pleased, for example, to offer free hot meals for parents who are staying in hospital with their sick child on the Children's Ward, thanks to funding from Sophie's Legacy and WHH Charity.

## **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 has been a key theme throughout 2024-25, with the year seeing several notable joint appointments and teams starting to explore ways of working closer together. November 2024 saw Nikhil Khashu start in post as joint chief executive, with WHH's medical director and chief operating officer both appointed to joint roles shortly thereafter. Joint internal communication channels have helped to provide clarity around our shared vision and direction of travel.

In 2024 the Trust was recognised by NHS England for the high-quality support provided to internationally recruited nurses and midwives. The NHS Pastoral Care Quality Award is presented to organisations that have met a set of standards for pastoral and professional support throughout the recruitment process, on joining the organisation and beyond.

Kate Brintworth, Chief Midwifery Officer for England, visited Warrington Hospital in November 2024 and presented our Maternity Support Worker, Rachel Wood, with a coveted Chief Midwifery Officer Award. Rachel received the national accolade for her hard work and dedication to maternity practice, having been nominated by colleagues for her kindness, compassion and professional excellence.

The significant contribution made by long-serving WHH staff was celebrated at the Trust's Long Service Awards in December 2024. The awards recognise colleagues who have achieved 25, 40 and 50 years of continuous service with the NHS. This year's award recipients, who had amassed an impressive 1,735 years' combined service, were invited to attend a celebration event with a guest of their choice.

Our staff are also recognised through our annual Thank You Awards event, which is made possible thanks to the support of our partners and local businesses. The 2023-24 awards ceremony was held in May 2024 at the Concorde Conference Centre, Manchester Airport. Our 2024-25 annual Thank You Awards take place on Friday 16 May 2025 at the Titanic Hotel, Liverpool.

The past year also marked some significant milestones for volunteers at WHH. We were pleased to celebrate Keith Inman, who has dedicated 50 years of volunteer service to Warrington Hospital's Radio General after starting in January 1974. Meanwhile, hospital volunteer James (Alan) Petley marked more than 1,500 hours' service since 2019, going above and beyond to support staff and patients. All our volunteers contribute significantly and provide a vital service supporting our services throughout the year.

From a governor perspective, we held elections in September 2024 and appointed new staff and public governors. We continue to support the fundamental role that governors play across the organisation and the invaluable insight they bring.

Our five staff networks continue to meaningfully influence our organisation. We were pleased to receive the North West Anti-Racist Framework Bronze status in 2024, and to retain our Navajo Merseyside and Cheshire LGBT Charter Mark.

## **Sustainability**

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

Discussions with Bridgewater Community Healthcare to integrate our two organisations recommenced in April 2024. Our subsequent Better Care Together programme aims to bring about transformational change – improving services and pathways for the benefit of our patients and communities. In February 2025, the two organisations' Boards considered a detailed options appraisal and approved plans for the acquisition of Bridgewater by WHH. Bringing our two organisations together as one will be an important milestone in helping us collectively become sustainable for the future.

Building on our commitment to work collaboratively and provide services in the heart of our communities, the Living Well Hub in Warrington town centre celebrated its first anniversary since opening in March 2024. Hundreds of people are now benefiting from its health and wellbeing services each week, with more than 15,000 visitors to the hub in its first year. Around 70 different services, ranging from dementia support and domestic abuse advice to baby weighing clinics and weight management assistance, are offered at the hub, with 25 organisations providing a wide range of NHS and non-clinical services under one roof.

March 2025 also saw the launch of a new community website, Living Well Warrington, created to be the 'go to' place for residents to get information about local services, groups and activities. It contains information about what's available in neighbourhoods across Warrington, with a particular emphasis on supporting people's overall health and wellbeing. It's a one-stop shop signposting to a huge number of services and activities.

In terms of finance, we recorded a deficit of £16.8m for 2024-25, which was £5.5m away from our £11.3m deficit plan for the year. We continued to invest significantly in our annual capital programme, with £21.7m planned spend and £21.9m actual spend for the year.

Finally, we continued to invest significantly in our digital infrastructure to stand us in good stead for the future. This includes the launch of our patient portal in summer 2024, meaning patients can now manage their hospital appointments easily online via the NHS App, and the implementation of the NHS Federated Data Platform inpatient solution in March 2025.

## **Looking ahead**

2025-26 will be another challenging year financially for the Trust, with current plans showing a deficit in the region of £9.1m. This is dependent upon multiple factors, including a 4% reduction in workforce and delivery of performance targets.

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.

Work continues on the third phase of Warrington and Halton Diagnostics Centre, to provide additional checks and scans that can help diagnose and treat a range of health conditions. Construction is under way on the new £8m centre, adjacent to the existing Captain Sir Tom Moore Building at Halton Hospital, set to open in 2025. And construction of a new theatre in the Nightingale Building will also provide much-needed capacity later this year.

Looking forward, we will continue to deliver to the best of our ability for the people of Warrington and Halton, and commit to playing the fullest of parts, both within local place partnerships and within the Cheshire and Merseyside Integrated Care System. We will continue our work to integrate with Bridgewater Community Healthcare NHS Foundation Trust, seeking to become one organisation by April 2027.



**Steve McGuirk**  
**Chair**  
**23 June 2025**



**Nikhil Khashu**  
**Chief Executive**  
**23 June 2025**

## 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 surgery, urology and gynaecology surgeries, cancer surgeries, day case surgery 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.

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:

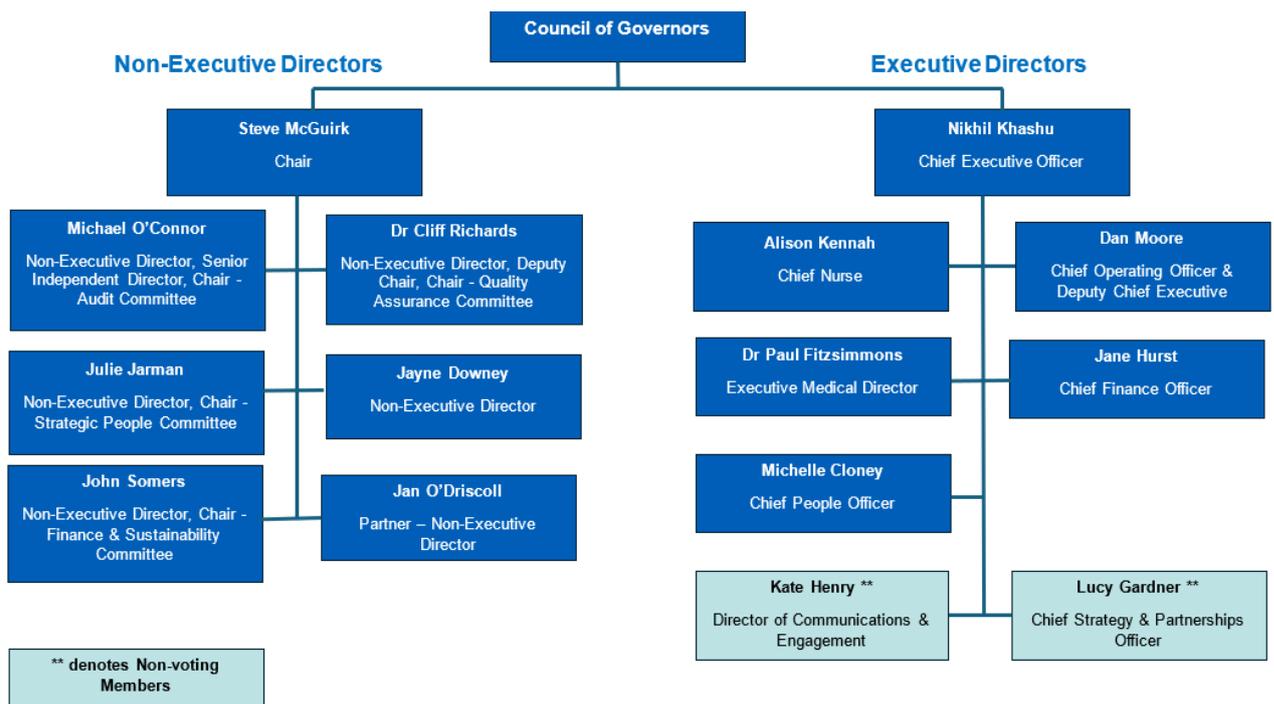
- Bath Street Health and Wellbeing Centre, Warrington
- Halton Health Hub, Runcorn Shopping City
- Living Well Hub, Warrington
- Mobile breast screening services
- Virtual wards – using advances in technology and infrastructure to enable patients to receive the care they need at home rather than in hospital
- Virtual consultations – offering video outpatient appointments to enable flexible and responsive care

## Trust key headlines in 2024-25

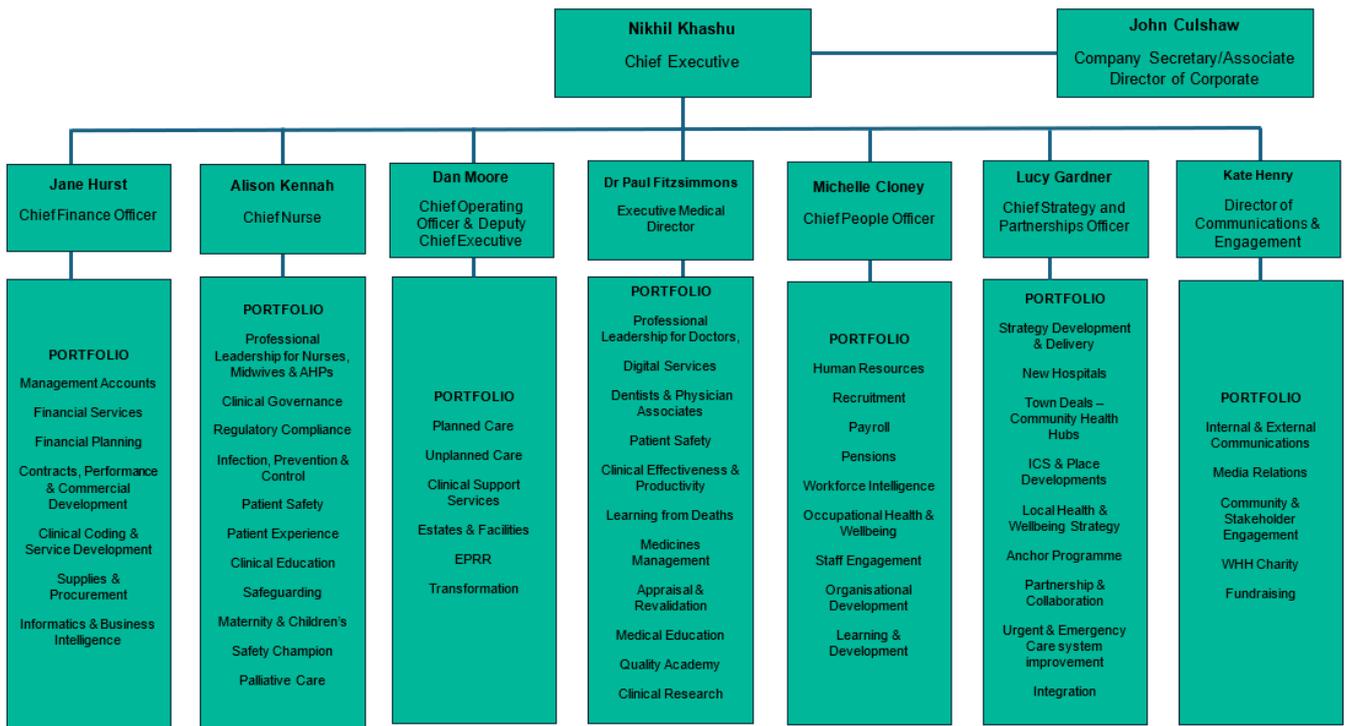
- Served a population of approximately **342,000** across both Halton and Warrington boroughs
- Employed **around 5,000 staff** comprising 79 nationalities
- Delivered **2,473 babies** in hospital and in the community
- Delivered **59,474** procedures and stays
- Delivered **109,928** individual new outpatients appointments each year (face to face and telephone)
- **Operated 744 beds** – assessment beds and trolleys – across both sites
- **Provided 144,951 episodes of emergency care** – 84,816 episodes at the Emergency Department, 22,842 at Warrington Same Day Emergency Care facility and 37,293 at the Runcorn Urgent Treatment Centre

## How the Trust is organised

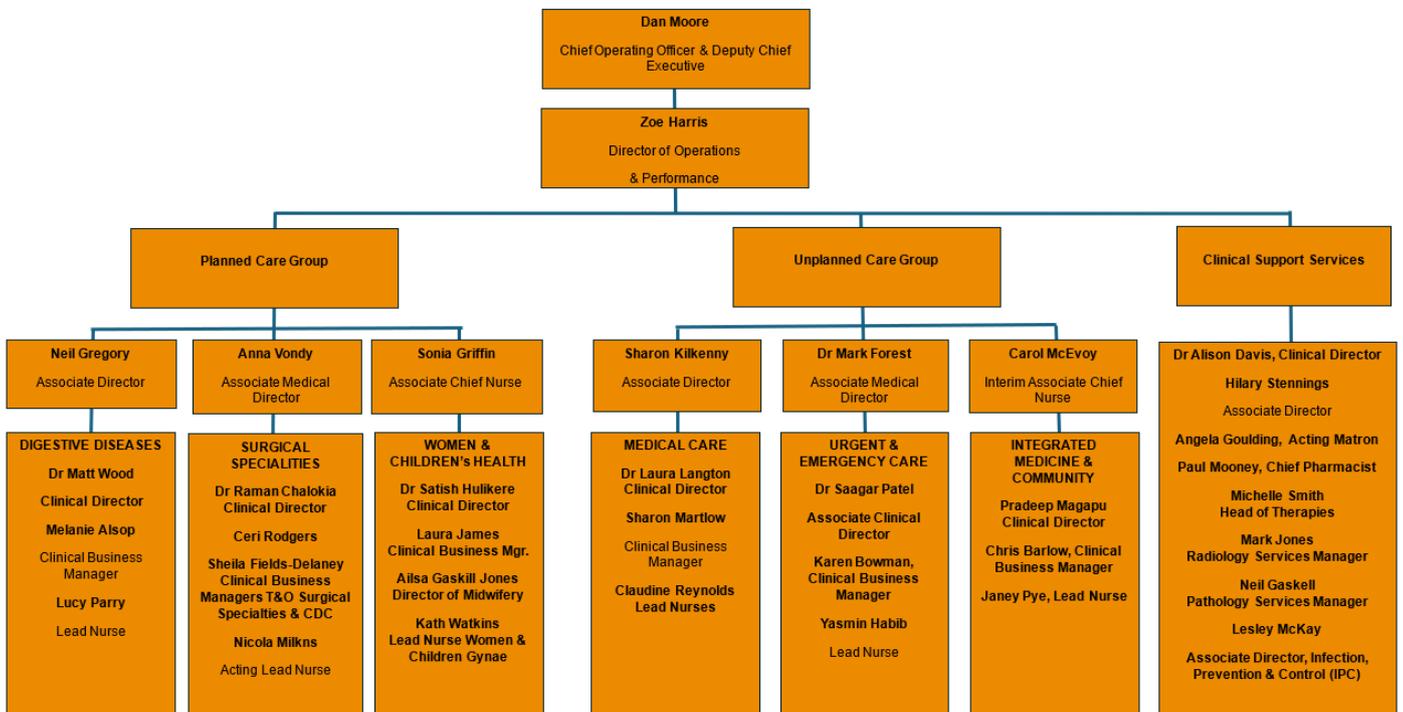
### Trust Board



## Executive Team



## Care Groups and Clinical Business Units



## 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

|  |   |   |
|--|---|---|
|   |                                        |                                |
| <b>QUALITY</b>   | <b>PEOPLE</b>   | <b>SUSTAINABILITY</b>   |
| We will...<br><b>Always put our patients first</b> delivering safe and effective care and an excellent patient experience. | We will...<br><b>Be the best place to work</b> with a diverse and engaged workforce that is fit for now and the future. | We will...<br><b>Work in partnership</b> with others to achieve social and economic wellbeing in our communities. |

## Our Values

|   |   |   |  |   |
|---|---|---|--|---|
|  |  |  |  |  |
| <b>Working Together</b>   | <b>Excellence</b>   | <b>Inclusive</b>  | <b>Kind</b>  | <b>Embracing Change</b>   |

### **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 just under 3096 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 created from the workhouse building.

1929: Warrington General renamed as Warrington Borough Hospital.

1973: Warrington District General Hospital created by merging all hospitals with two other hospitals on site - Aikin Street (infectious diseases) and Whitecross Hospital (military). During the 1970s/1980s the demolition of these buildings made way for Appleton Wing, then Burtonwood Wing, Croft Wing and Daresbury Wing.

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

1993: Hospitals 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 became the centre for acute medical and emergency care and planned surgical work is 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 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 enters 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 opened at the Captain Sir Tom Moore Building and an Endoscopy Hub at the Nightingale Building, both on the Halton Hospital site.

## 1.4 The future of the Trust – our vision

**Our vision for the future of Warrington and Halton Teaching Hospitals NHS Foundation Trust is to be a great place to receive healthcare, work and learn. We are committed to providing high quality, safe, and sustainable services, delivered by staff who are trained and supported to deliver their best work and we will work with our partners, across all levels of health and social care, the voluntary sector and the independent sector, to achieve this and meet the needs of our local population. We have three strategic aims framed around Quality, People and Sustainability, which underpin our vision.**

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

To do this we need to use our estates and facilities differently and our Estate Strategy sets out our ambition to make the most of our Warrington Hospital site so that space is protected for the care of patients with the most urgent and complex medical conditions. Space at Halton Hospital will be used to support the delivery of effective diagnostics and as a centre for planned surgery and procedures.

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

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

## 1.5 Principal Risks

The key issues and risks that could affect the Trust in delivering its objectives are as below.

These risks are recorded on the Board Assurance Framework (BAF) and are scrutinised either monthly or bi-monthly by the Board Committees who each have allocated risks, the Trust Board and Audit Committee receives the BAF in full. The BAF is fluid and risks are added or de-escalated as required. Furthermore, risk ratings, descriptions and risk appetites will vary on an ongoing basis as a result of changing circumstances and the implementation of mitigations. These risks are valid on 31 March 2025.

The organisation has identified the following strategic risks (red risks rated at 15 and above) and details of the full Board Assurance Framework including mitigations can be found in the Trust Board papers here: [Board Meetings and Papers : Warrington and Halton Hospitals NHS Trust \(whh.nhs.uk\)](https://www.whh.nhs.uk/Board-Meetings-and-Papers-Warrington-and-Halton-Hospitals-NHS-Trust)

### **In February 2025, the Board reviewed and approved the Trust's Risk Appetite Statement:**

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.

### **Warrington & 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 in order 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 pro-actively 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<br>(L5xC4)  | 8<br>(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<br>(L4xC5)  | 6<br>(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<br>(L5xC4)  | 12<br>(L4xC3) | Open          |

|          |      |   |   |               |                  |          |
|----------|------|---|---|---------------|------------------|----------|
|          |      | Halton  |   |               |                  |          |
| 200<br>1 | EMD  | If 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<br>(L5xC4) | 6 (L2<br>xC3)    | Minimal  |
| 111<br>4 | 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<br>(L4xC4) | 5 (1x5)          | Minimal  |
| 137<br>2 | 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<br>(L4xC4) | 8<br>(L2xC4)     | Cautious |
| 227<br>3 | CSPO | If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the support and resource required from the Cheshire & 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 | 3 | 16<br>(L4xC4) | 9<br>(L3<br>xC3) | Seek     |
| 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 | 12<br>(L3xC4) | 8<br>(L2xC4)     | Minimal  |
| 113<br>4 | CPO  | If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of  | 2 | 12<br>(L3xC4) | 8<br>(L2xC4)     | Open     |

|          |      |   |       |              |              |      |
|----------|------|---|-------|--------------|--------------|------|
|          |      | 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  |       |              |              |      |
| 225<br>3 | CSPO | If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder 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, potentially impacting both Trusts' decision-making and service management. | 1,2,3 | 9<br>(L3xC3) | 2<br>(1LxC2) | Open |

**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.



# 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 in ensuring 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 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 action 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 highlights KPIs both consistently failing to meet set targets and with special cause variation of a concerning variation. This is followed by a report detailing all KPIs with their 'Making Data Count' variation and assurance category. This section also details assurance and variation movements from the previous IPR.
2. High level summary – the IPR is split into four key areas: Quality, Access and Performance, Workforce and Finance. A high-level summary is provided for each of these areas.

3. Dashboard – The dashboard details current and historic levels of performance, reasons for under performance and/or performance deterioration and detail of actions and investigations underway to improve performance against the KPI. The dashboard contains statistical process control charts which look at data over 12+ months 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 is 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:



## Key Performance Indicators

| OPERATIONS - ACCESS AND PERFORMANCE  | FINANCE  |
|--|--|
| <ol style="list-style-type: none"> <li>1. Diagnostic waiting times – six weeks</li> <li>2. RTT – open pathways</li> <li>3. RTT – number of patients waiting 52+ weeks</li> <li>4. ED waiting times without WUTC</li> <li>5. ED waiting times - with WUTC</li> <li>6. ED waiting times – more than 12 hours</li> <li>7. Average time in ED</li> <li>8. Cancer 28-day faster diagnostic</li> <li>9. Cancer 31 day wait</li> <li>10. Cancer 62 day wait</li> <li>11. Ambulance handovers within 15 minutes</li> <li>12. Ambulance handovers 30 to &lt;60 minutes</li> <li>13. Ambulance handovers at 60 minutes or more</li> <li>14. Discharge summaries – % sent within 24hrs</li> <li>15. Discharge summaries – number not sent within seven days</li> <li>16. Cancelled operations on the day for a non-clinical reason</li> <li>17. Cancelled operations – not offered a date for readmission within 28 days</li> <li>18. Urgent operations – cancelled for a 2nd time</li> <li>19. Super stranded patients</li> <li>20. No criteria to reside</li> <li>21. Elective Recovery Activity</li> <li>22. Elective Recovery Diagnostic Activity</li> <li>23. Elective Outpatient Activity</li> <li>24. Percentage of patients seen in the fracture clinic within 72 hours</li> <li>25. Percentage of patients referred to Long COVID service not assessed within 15wks</li> <li>26. Type 5 attendance</li> <li>27. Reduction in outpatient follow ups</li> <li>28. Percentage of patients discharged to their usual place of residence</li> <li>29. Uncapped theatre utilisation</li> <li>30. Capped theatre</li> <li>31. Virtual appointments</li> </ol> | <ol style="list-style-type: none"> <li>1. Trust financial position</li> <li>2. Cash balance</li> <li>3. Capital programme</li> <li>4. Better payment practice code</li> <li>5. 'Agency ceiling' – agency spending (monthly)</li> <li>6. Cost Improvement Programme – plans in progress (recurrent and non-recurrent)</li> <li>7. Cost Improvement Programme – plans in progress (recurrent)</li> </ol> |

| WORKFORCE   | QUALITY   |
|---|---|
| <ol style="list-style-type: none"> <li>1. Supporting attendance</li> <li>2. Retention</li> <li>3. Turnover</li> <li>4. Bank and agency reliance</li> <li>5. Core/mandatory training</li> <li>6. Performance and development review (PDR) – compliance rate</li> </ol> | <ol style="list-style-type: none"> <li>1. Incidents</li> <li>2. Duty of Candour</li> <li>3. HCAI (MSSA)</li> <li>4. HCAI (MRSA)</li> <li>5. HCAI (Ecoli)</li> <li>6. HCAI (Klebsiella)</li> <li>7. HCAI (CDI)</li> <li>8. HCAI (PA Gram Negative)</li> <li>9. Healthcare Acquired Infections COVID-19 hospital onset and outbreaks</li> <li>10. VTE assessment</li> <li>11. Inpatient falls and harm levels</li> <li>12. Pressure ulcers</li> <li>13. Medication safety</li> <li>14. Staffing average fill levels</li> <li>15. Care hours per patient day (CHPPD)</li> <li>16. HSMR mortality ratio</li> <li>17. SHMI mortality ratio</li> <li>18. NICE compliance</li> <li>19. Complaints</li> <li>20. Friends and family test (inpatient and day cases)</li> <li>21. Friends and family (ED and UCC)</li> <li>22. Mixed sex accommodation breaches (ITU)</li> <li>26. Sepsis</li> <li>27. Ward moves between 10pm and 6am</li> <li>28. Acute kidney injury</li> <li>29. Postpartum haemorrhage &gt;1500ml</li> <li>30. Fractured neck of femur</li> <li>31. MUST nutritional assessment completion</li> </ol> |

## 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. Further developments are planned with the aim of being able to review and monitor disparities in waiting lists/times/DNAs between different patient groups.

### Summary activity (2024-25 vs 2023-24)

| Activity                                       | 2024/25 | 2023/24 | % Change 2024/25 vs 2023/24 |
|--|---------|---------|-----------------------------|
| Elective Inpatient Discharges                  | 3513    | 3005    | 16.91%                      |
| Elective Day Case Discharges                   | 29473   | 25783   | 14.31%                      |
| Non-Elective Discharges                        | 26490   | 30788   | -13.96%                     |
| New Outpatient Attendances (including virtual) | 110076  | 101790  | 8.14%                       |
| A&E Attendances <sup>A</sup>                   | 144951  | 134033  | 8.15%                       |

<sup>A</sup>Includes A&E, Runcom UTC & SDEC

### Delivering the four-hour standard

| 4-Hour Performance Type 1 & Type 3 Excluding Widnes UTC Activity 2024/25 |                   |        |        |        |        |        |        |        |        |        |        |        |        |        |
|--|-------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|  | Target            | Apr    | May    | Jun    | Jul    | Aug    | Sep    | Oct    | Nov    | Dec    | Jan    | Feb    | Mar    | YTD    |
| % Departed <= 4 Hours  | 78% by March 2025 | 66.56% | 65.45% | 66.36% | 65.85% | 64.83% | 64.37% | 63.27% | 63.02% | 63.21% | 62.09% | 62.42% | 64.09% | 64.33% |
| Number of Attendances  |                   | 10319  | 11292  | 10108  | 10311  | 9625   | 10005  | 10649  | 10189  | 10278  | 9561   | 9119   | 10623  | 122079 |
| Number of Breaches   |                   | 3451   | 3901   | 3400   | 3521   | 3385   | 3565   | 3911   | 3768   | 3781   | 3625   | 3427   | 3815   | 43550  |

| 4-Hour Performance Type 1 & Type 3 Including Widnes UTC Activity 2024/25 |                   |        |        |        |        |        |        |        |        |        |        |        |        |        |
|--|-------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|  | Target            | Apr    | May    | Jun    | Jul    | Aug    | Sep    | Oct    | Nov    | Dec    | Jan    | Feb    | Mar    | YTD    |
| % Departed <= 4 Hours  | 78% by March 2025 | 71.30% | 70.31% | 71.04% | 70.47% | 69.43% | 68.79% | 68.07% | 67.67% | 67.56% | 67.18% | 66.74% | 68.44% | 68.96% |
| Number of Attendances  |                   | 12127  | 13303  | 11775  | 12003  | 11133  | 11463  | 12323  | 11771  | 11907  | 11110  | 10548  | 12308  | 141771 |
| Number of Breaches   |                   | 3480   | 3949   | 3410   | 3545   | 3403   | 3578   | 3935   | 3806   | 3863   | 3646   | 3508   | 3884   | 44007  |

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

An external system-wide diagnostic and operational programme to improve urgent and emergency care effectiveness and efficiency has been rolled out, which has led a drop in 4% attendances to the Emergency Department, with an increase seen in type 5 areas such as SDEC and frailty assessment units.

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 against the target of less than 5% of patients waiting more than six weeks for a diagnostic test has been achieved at an aggregate level in February 2025 which is a month ahead of trajectory. It has however not been achieved across all individual modalities. Challenges remain for cystoscopy, echo and sleep studies, with recovery plans in place.

| Diagnostics 6+ Week Waiters 2024/25 |        |        |        |        |        |        |        |        |        |        |        |       |       |
|-------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------|-------|
|                                     | Target | Apr    | May    | Jun    | Jul    | Aug    | Sep    | Oct    | Nov    | Dec    | Jan    | Feb   | Mar   |
| % of Patients Waiting 6+ Weeks      | 5%     | 10.83% | 11.12% | 14.06% | 18.35% | 19.66% | 17.28% | 13.79% | 11.90% | 11.07% | 13.20% | 4.95% | 3.35% |
| Number of Patients Waiting          |        | 8012   | 8723   | 8858   | 8972   | 8552   | 8778   | 8761   | 8751   | 8697   | 7726   | 7918  | 7337  |
| Number of Patients Waiting 6+ Weeks |        | 868    | 970    | 1245   | 1646   | 1681   | 1517   | 1208   | 1041   | 963    | 1020   | 392   | 246   |

## Referral to Treatment (RTT) waiting times

| Submitted RTT 18 Weeks Performance 2024/25 |        |        |        |        |        |        |        |        |        |        |        |        |        |
|--|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|  | Target | Apr    | May    | Jun    | Jul    | Aug    | Sep    | Oct    | Nov    | Dec    | Jan    | Feb    | Mar    |
| Incomplete Pathways % <18 Weeks            | 92%    | 57.60% | 59.48% | 59.91% | 59.28% | 57.84% | 58.61% | 58.76% | 59.54% | 59.47% | 58.60% | 57.86% | 58.41% |
| Number of Incomplete Pathways              |        | 36248  | 36475  | 36141  | 36396  | 35373  | 35065  | 34674  | 34137  | 33606  | 33777  | 34446  | 34748  |
| Number of Patients Waiting 18+ Weeks       |        | 15369  | 14780  | 14488  | 14821  | 14912  | 14512  | 14301  | 13812  | 13620  | 13983  | 14516  | 14453  |
| Number of Patients Waiting 52+ Weeks       |        | 2287   | 2123   | 1930   | 1847   | 1728   | 1549   | 1329   | 1135   | 1163   | 1293   | 1455   | 1387   |
| Number of Patients Waiting 65+ Weeks       |        | 531    | 521    | 484    | 397    | 292    | 93     | 90     | 100    | 110    | 129    | 126    | 128    |
| Number of Patients Waiting 78+ Weeks       |        | 41     | 37     | 23     | 27     | 30     | 14     | 12     | 10     | 8      | 9      | 12     | 11     |

The Trust did not achieve the 18-week referral to treatment standard in 2024-25. The focus has remained on recovery for clinical priority patients and long waiting patients.

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, 65- and 78-week breaches for scheduling into capacity
3. 2025-26 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 2024-25 to use insourcing to support the reduction in the waiting list. This has been used to treat circa 2,800 patients and can be seen in the reduction of 64 weeks and over 52-waits. Insourcing will continue in 2025-26

## **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 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.

The policy and new operating model sets an ambition that people with no criteria to reside are discharged within two hours of being determined not to have a criterion to reside.

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:

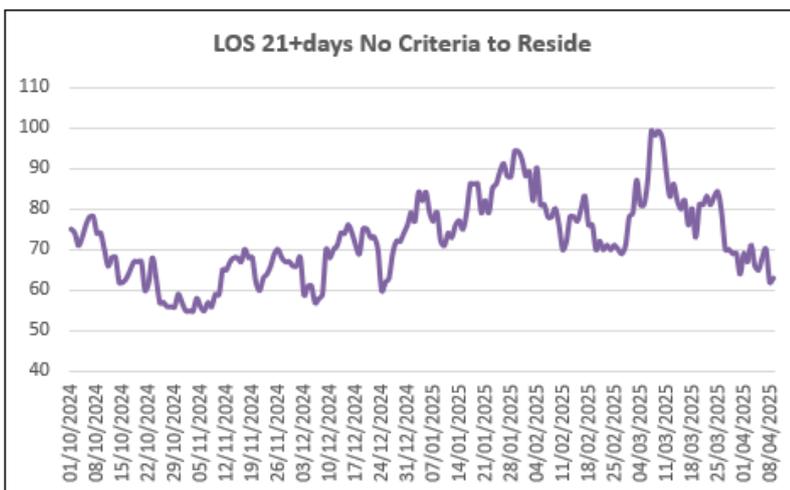
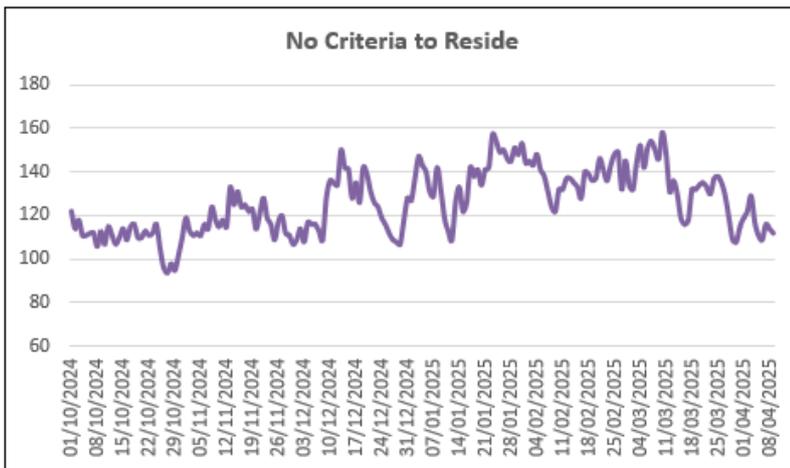
1. a change to the discharge model to a 'pull' model – the team actively seeks out patients with no criteria to reside and plans their transfer

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 a no criteria to reside and the number who are over 21 days and classified as super stranded.



## Cancer waiting times and regulatory requirements

The Trust has seen a challenging year with regards to cancer performance, but this remains in line with the regional and national picture.

From 1 October 2023, after a clinical review of the national cancer waiting times standards, they have been rationalised into three key headline standards which are:

**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. This standard has been challenging to achieve in 2024-25 as a result of pressures within specific pathways namely breast, lower GI, gynae and prostate. Breast performance has recovered and there are long term plans in place for significant improvement work in the other pathways which will improve performance during 2025/26. This work includes the implementation of an FDS nursing team for lower GI which will streamline the front end of the pathway and is a proven concept in other organisations, the introduction of a Community Diagnostic Centre for gynae suspected cancer patients, and the introduction of nurse-led transperineally biopsy for prostate patients.

The operational standard will be 75%, moving to 80% by March 2026.

**The 62-day referral to treatment standard** includes referrals from GPs, the national screening programme and consultant upgrade patients. There is recognition nationally that there is variation in practice in relation to consultant upgrades and therefore there will be a requirement that all patients not already on a 62-day pathway will be upgraded at the point of referral to a cancer MDT. The 62-day standard has seen an improvement with the combined standards in place and the interim commitment of 70% has been achieved. There is an expectation that organisations will achieve 75% by March 26.

**The 31-day standard** combines the existing 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 has been consistently met during 2024-25.

### Cancer Waiting Times and Regulatory Requirements

| Cancer Waiting Times 2024/25*   |        |       |       |       |       |        |       |       |       |       |       |        |       |
|---|--------|-------|-------|-------|-------|--------|-------|-------|-------|-------|-------|--------|-------|
|   | Target | Apr   | May   | Jun   | Jul   | Aug    | Sep   | Oct   | Nov   | Dec   | Jan   | Feb    | Mar   |
| All Cancers 31-Day Wait from Diagnosis to First Treatment             | 96%    | 96.7% | 97.9% | 98.5% | 96.9% | 100.0% | 98.6% | 98.6% | 98.6% | 97.3% | 98.7% | 100.0% | 98.8% |
| All Cancers 62-Day Wait for First Treatment - From Urgent GP Referral | 85%    | 83.0% | 80.3% | 79.3% | 77.7% | 75.1%  | 73.1% | 76.7% | 72.1% | 79.0% | 73.7% | 77.7%  | 73.4% |
| 28-Day Faster Diagnosis   | 75%    | 75.1% | 61.2% | 58.5% | 61.9% | 68.0%  | 70.3% | 71.6% | 74.5% | 73.8% | 70.3% | 72.2%  | 74.2% |

## 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 and Sustainability Committee, which meets monthly. Standing items on the agenda include the monthly financial position, CIP position, 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 £16.8m which is £5.5m away from the £11.3m deficit plan (adjusted from £27.8m following receipt of £16.5m deficit support funding). This adjusted deficit is the value which NHSE monitors the Trust against and the movement from plan was approved by the ICS.

The annual capital programme was £21.7m (including IFRS16 and donated assets) and the actual spend for the year was £21.9m.

The cash balance at the end of the year was £16.3m. The cash balance will be utilised to pay both capital (£8.4m) and revenue creditors.

(For detailed report please see the accounts section)

## 2.4 How equality of service delivery to different groups has been promoted through the organisation

**As a public sector organisation, all NHS Trusts are required to demonstrate how they meet the Public Sector Equality Duty as outlined in section 149 of the Equality Act 2010.**

The Trust ensures it provides equality of access to its patients, workforce and members of the public. It is committed to furthering equality, diversity, inclusion and human rights, and works in partnership with a variety of external partners and advocacy groups. This allows for a greater understanding of the local population, their health needs and any barriers to accessing health care, which enable the Trust to better address potential health inequalities across the boroughs that we serve. At Warrington and Halton Teaching Hospitals (WHH), adherence to the Public Sector Specific Equality Duties are demonstrated through the production of the Equality, Diversity and Inclusion Annual Report which is published on the Trust website, available [here](#).

In addition to the Equality Act 2010 and Human Rights Act 1998, the Armed Forces Act 2021 further enshrines the Armed Forces Covenant into law to help prevent service personnel and veterans being disadvantaged when accessing public services.

The act introduces a duty to have 'due regard' to the principles of the Armed Forces Covenant, as follows:

- The unique obligations of, and sacrifices made by, the armed forces
- The principle that it is desirable to remove disadvantages arising for service people from membership, or former membership, of the armed forces
- The principle that special provision for service people may be justified by the effects on such people of membership, or former membership, of the armed forces

WHH considers the element of 'due regard' associated with the Armed Forces Act 2021 in its equality analysis and considerations process. Progress and achievements against the Armed Forces Act 2021 are reported through the Equality, Diversity and Inclusion Annual Report to demonstrate progress against the Act and its duties.

In April 2022 the Trust, in line with the specific duties of the Public Sector Equality Duty, reviewed and refreshed its equality objectives. Part of this review included the formation of two new strategies:

- Workforce Equality, Diversity and Inclusion Strategy 2022-2025
- Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy 2022-2025

The two strategies provide an approach to delivering on the expectations of the Public Sector Equality Duty and Armed Forces Act 2021 whilst supporting the delivery of the Trust's commitment to being an inclusive employer and outstanding place to receive healthcare. The contents of the strategies were informed by national reports, regulated reporting such as the Workforce Equality Standards, and known health inequality data to ensure they delivered meaningful impact.

The Workforce Equality, Diversity and Inclusion Strategy 2022-2025 sets out the Trust's commitment to be the best place to work, creating a culture of belonging for all. The Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy 2022-2025 was designed with our patients and communities at its centre, acknowledging the role WHH plays in ensuring our hospitals are accessible and that our services address health inequalities in our community.

The Workforce Inclusion and Culture Sub-Committee and the Patient Experience and Inclusion Sub-Committee are chaired by the Chief People Officer and Deputy Chief Nurse, respectively. Both committees in turn ensure oversight of the equality, diversity and inclusion agenda via respective Board committees, with escalations reported to the Board of Directors as required. The sub-committees have internal and external stakeholder membership, with active involvement from patient representatives, staff networks and members of third sector bodies.

The Trust complies with the Equality Delivery System (EDS) reporting, which is in place for both patients and service users and workforce. EDS grading is completed on an annual basis is graded in collaboration with community partners, key stakeholders and the wider public. This is published annually and is available on the Trust website.

A commitment to undertaking equality analysis ensures that our policies, strategies, functions and any services we deliver endeavour not to lead to an unfavourable effect on different people. Equality analysis also helps to identify any positive action we can take to promote equality of opportunity and access for our patients, workforce and communities. Equality and Health Inequalities Impact Assessments (EHIA) are used as a tool for Warrington and Halton Teaching Hospitals (WHH) to evidence that it is paying 'due regard' to the general aims of the Public Sector Equality Duty, Armed Forces Act 2021 and Human Rights Act 1998. This includes ensuring that actions are taken to systematically identify and assess the impact of proposals on groups who face health inequalities.

The Trust is confident in securing the views of its patients, their families and our workforce and this is evidenced by:

- Friends and Family Test scores – inpatients, Emergency Department, maternity and outpatients
- national Patient Survey results
- patient feedback reported through the Patient Experience and Inclusion Team, local community partners and Healthwatch
- national NHS Staff Survey – completed on an annual basis
- national People Pulse Surveys – completed on a quarterly basis

Scores and data collated from the Friends and Family Test, survey results and subsequent action plans and key themes identified through engagement with the public and community partners are reported monthly to the Patient Experience and Inclusion Sub-Committee. The Trust assesses feedback from the Friends and Family Test and national by protected characteristic to review if there are any disproportionate impact on patients' experience.

Learnings from patient feedback and results are presented to the Patient Experience and Inclusion Sub-Committee and are used in patient stories, enabling continued learning across the Trust.

Data and qualitative information collated from the National NHS Staff Survey and People Pulse Surveys are reported to the Operational People Committee and Workforce Equality, Diversity and Inclusion Sub-Committee to monitor findings and subsequent action plan progress. This includes breaking down the results by protected characteristic to identify any disproportionate impacts – this is supported by the Trust's five Staff Networks:

1. Multi-Ethnic Staff Network
2. Progress Staff Network – supporting the LGBTQIA+ community
3. Disability Awareness Network
4. Armed Forces and Military Veterans Community Staff Network
5. Women's Staff Network

## Performance report: Health inequalities

An equality, diversity and inclusion annual report has been published for the period April 2024 to March 2025.

The report is a crucial tool in assessing and analysing the Trust’s commitment to fairness, equity and inclusivity. The report provides an overview of the Trust’s progress in promoting inclusive practices for its patients, service users, community and workforce.

In addition, it looks at the personal demographics of individuals currently working at the Trust and those entering or leaving the workforce. This includes:

1. understanding what the diversity of the Trust’s workforce looks like at a snapshot in time
2. monitoring the effectiveness of our enabling equality, diversity and inclusion related strategies, policies and processes
3. making improvements in our employment policies and practices to ensure all staff have equal opportunities to employment, development and a good employment experience

The full report is available on the Trust’s public webpage, within the statutory information section.

In November 2023 NHS England published a statement setting out the monitoring and reporting responsibilities of NHS bodies (ICBs, trusts and foundation trusts) to identify and act on health inequalities. The three aims of the statement are:

- understanding healthcare needs
- understanding health access, experience and outcomes
- publishing information on health inequalities

Indicators and associated data sources are specified with the statement and are aligned to the five healthcare inequalities priorities and the Core20PLUS5 approach. Analysis of the data for each indicator the Trust is required to report on is detailed below.

Context – Trust catchment population Census 2021 data – key statistics:

| <b>Halton</b>  | <b>Warrington</b>  |
|--|--|
| <ul style="list-style-type: none"> <li>• Population of 128,478</li> <li>• White is the stated ethnicity for 96.5% of the population</li> <li>• Ranked 31st most income-deprived of all 316 local authorities in England</li> <li>• 35/79 neighbourhoods among the 20% most income-deprived in England; 12 were in the 20% least income-deprived neighbourhoods</li> <li>• Ranked in the bottom 20% of local authorities in England for health in 2021</li> <li>• Female healthy life expectancy is 58, male healthy life expectancy is 61.4</li> </ul> | <ul style="list-style-type: none"> <li>• Population of 210,974</li> <li>• White is the stated ethnicity for 93.5% of the population</li> <li>• Ranked 153rd most income-deprived of all 316 local authorities in England</li> <li>• 22/127 neighbourhoods among the 20% most income-deprived in England; 40 were in the 20% least income-deprived neighbourhoods</li> <li>• Ranked around average among local authority areas in England for health in 2021</li> <li>• Female healthy life expectancy is 64.8, male healthy life expectancy is 64.6</li> </ul> |

The above is a snapshot of available statistics but shows that the Trust catchment is one of two halves. The Halton population is considerably more deprived and healthy life expectancy

is worse than that of Warrington residents by 6.8 years for females and 3.2 years for males. There is some variability of outcomes at ward level across both boroughs.

### **Summary analysis of required indicators set out in the statement**

Data for the Trust covers the period April 2024 to March 2025 inclusively. Data for the pre-pandemic period has been provided for April 2018 to March 2019. Below is a summary of the analysis for each indicator, work being undertaken to address health inequalities and a gap analysis.

The statement sets out that the data for each indicator should be analysed by deprivation, age, sex and ethnicity.

### **Elective recovery**

*Indicator: Elective activity vs pre-pandemic levels for under 18s and over 18s (by ethnicity and deprivation)*

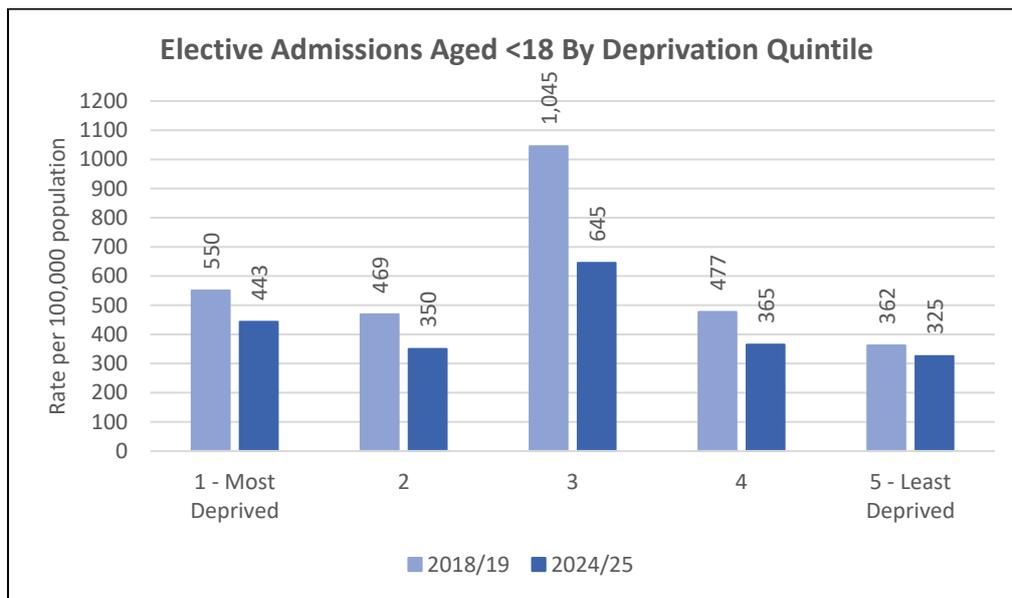
Overall, elective activity pre and post pandemic has increased in adults (over 18s) from 30,783 to 32,104. In contrast it has decreased in under 18s from 1,155 to 896. Many specialisms for over 18s, including gastroenterology, rheumatology, geriatric medicine and respiratory, have seen an increase in activity with only a few with lower activity such as cardiology and gynaecology.

When we look at total numbers of elective admissions in all age groups by deprivation we have more from the most deprived 20% of our population and the next largest proportion is from our least deprived population.

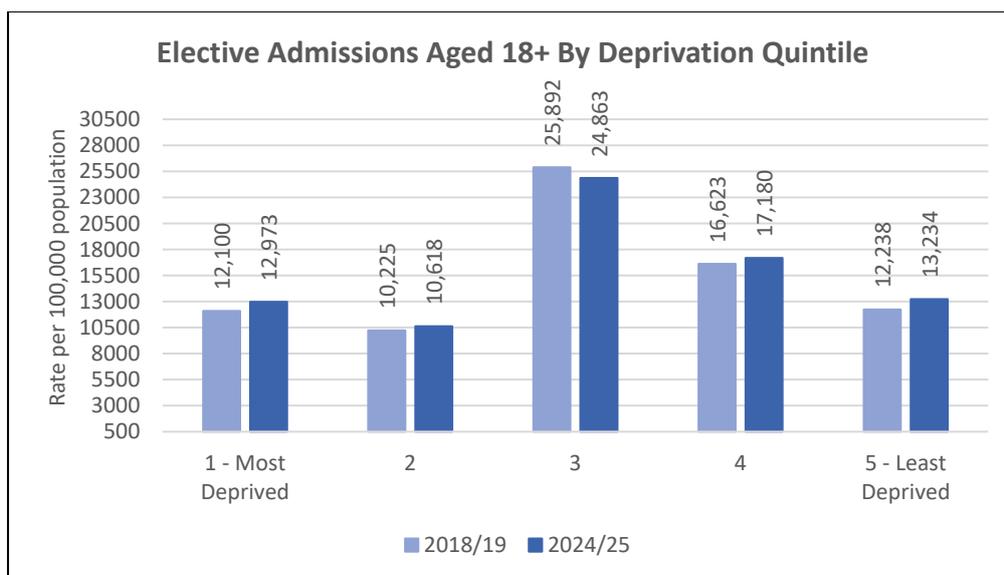
If we look at the same data by population rate, we see that despite the lower proportion of our trust catchment coming from deprivation quintile 3 (i.e. not the most or least deprived) their admission rates are much higher at 645 per 100,000 population compared to 443 from the most deprived and 325 from the least deprived.

The population rate data is calculated using the Office for Health Improvement and Disparities baselines for this Trust. Deprivation quintiles are a way of grouping areas into five groups (like neighbourhoods) based on how deprived they are, with quintile 1 being the most deprived and quintile 5 the least.

### Elective activity for under 18s by deprivation quintile



### Elective activity for over 18s by deprivation quintile



The proportions of admissions for under and over 18s by gender (male and female patients) remain broadly similar pre and post pandemic.

Admissions in under and over 18s by ethnicity are in line with the ethnicities in our population with most admissions amongst White British with the next highest being from 'Other', which includes a range of ethnicities including Eastern European communities. Because of the relatively smaller numbers of Asian, Black and Mixed ethnicities very little difference can be noted pre and post pandemic. Although, in under 18s there is almost a 10% reduction in elective admissions amongst White British and almost a 10% increase in 'Other' ethnicities when we compare pre and post pandemic activity.

When we look at admissions more closely by age group, activity levels post pandemic are slightly lower than pre-pandemic in the 0 to 14 age groups, 20 to 34 age groups, 45 to 59

age groups and 70 to 74 age groups. Activity levels are higher post pandemic in all other age groups, which means that activity levels in 2024-25 are higher in 75s and over.

The highest proportion of total admissions (around 12% of all admissions) pre-pandemic was amongst the 70 to 74 age group whereas in 2024-25 the highest proportion is in the 75 to 79 age group.

Delving further, there has been an 18% reduction in admissions pre and post pandemic in 55 to 59-year-olds and a 17% increase amongst 60 to 64-year-olds, a 10% increase in 70 to 74-year-olds and more than a 30% increase in 85 to 89-year-olds.

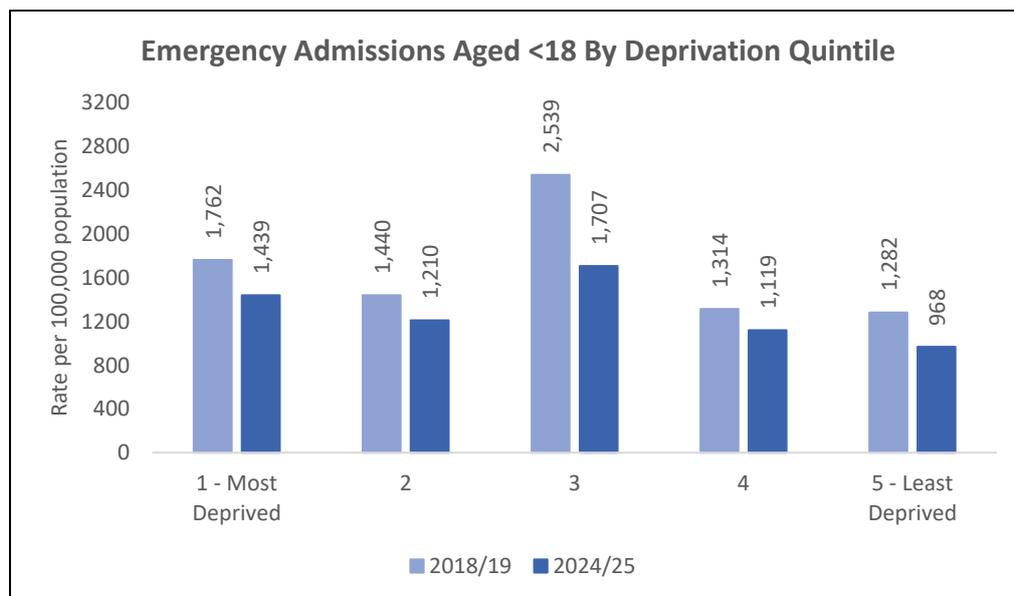
### Urgent and emergency care

*Indicator: Emergency admissions for under 18s (by ethnicity and deprivation)*

Overall emergency admissions, pre and post pandemic, have decreased from 3,549 to 2,811, although many specialisms for under 18s, including general surgery, urology (diseases of the kidney and bladder), ENT (ear, nose and throat), and ophthalmology have seen increased admissions.

When we look at total numbers of emergency admissions in under 18s by deprivation, there are more from the most deprived 20% of our population and the next largest proportion is from our least deprived population. If we look at the same data by population rate, we see that despite the lower proportion of our trust catchment coming from deprivation quintile 3 (i.e. not the most or least deprived) their admission rates are much higher at 1,707 per 100,000 population compared to 1,439 per 100,000 population from the most deprived 20% of our population.

### Emergency admissions for under 18s by deprivation quintile



Proportions of admissions for under 18s by gender (male and female patients) are broadly similar.

As with elective admissions, our emergency admissions by ethnicity are in line with the ethnicities in our population with most admissions amongst White British both pre and post pandemic with the next highest being from 'Other', which includes a range of ethnicities including Eastern European communities. Because of the relatively smaller numbers of Asian, Black and Mixed ethnicities very little difference can be noted pre and post pandemic. Although in under 18s there is almost a 10% reduction in elective admissions amongst White British and almost a 10% increase in 'Other' ethnicities when we compare pre and post pandemic activity.

### **Oral health**

*Indicator: Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions, not number of teeth extracted)*

Due to the very low numbers within the data for this indicator, they have not been included to protect individual confidentiality.

### **Smoking cessation**

*Indicators: Proportion of adult acute inpatient settings offering smoking cessation services; Proportion of maternity inpatient settings offering smoking cessation services*

The Trust established a new tackling tobacco dependency service in July 2023. It is operating across our acute inpatient settings. The service includes behavioural advice and provision of smoking cessation aids, including nicotine replacement therapy (NRT). There have been staff capacity issues, however it is hoped these will be resolved soon.

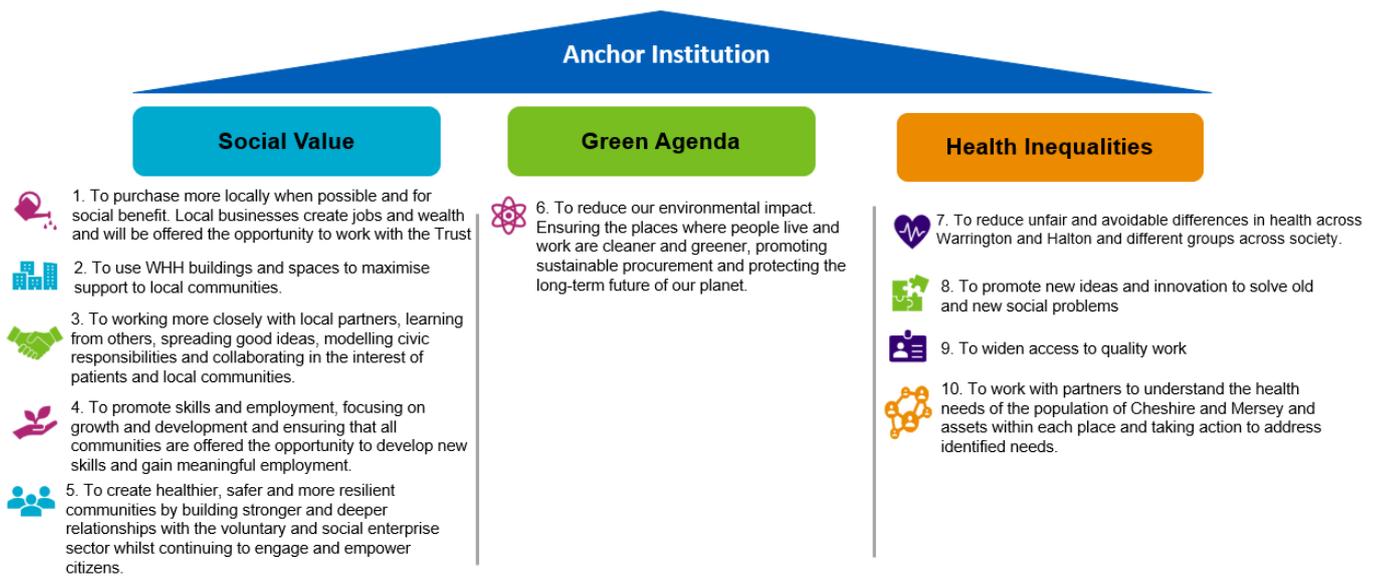
The maternity service also provides in-house smoking cessation support and has introduced the national incentive scheme within the service.

The majority of our patients who smoke live in the most deprived areas of our Trust catchment population and we work closely with our community smoking cessation services to target support within the hospital and in the community. The in-house service makes onward referrals to local authority smoking cessation services where appropriate.

### **Work to address health inequalities**

The Trust has been actively working to address health inequalities across our populations since 2021. The Trust has formalised its approach to improving health inequalities as part of its focus as an anchor institution, and has an agreed set of principles in place.

**Figure 1. Anchor Institution principles**



### **Warrington Living Well Hub**

Opened in March 2024, the Living Well hub is designed to target and address health inequalities in Warrington by providing a range of services focused on prevention and early intervention in a town centre location, with proximity to the areas of the town with the highest levels of deprivation.

Since opening, the Hub has seen more than 15,000 visitors; 88% of these visitors are from areas of Warrington experiencing the highest levels of deprivation. The hub is accessible from all areas of Warrington by taking only one bus to the Warrington Bus Interchange, where the hub is then less than five minutes away on foot, reducing travel time and costs for attendance. 15% of all visitors also use more than one service at time of visiting the hub, and a further 5% are signposted to other services after coming in to make use of one service.

### **Joint Health Equity Group**

To support the integration of the Trust and Bridgewater Community Healthcare Trust, a joint health equity group has been established to bring together the health inequalities work of both organisations.

A workshop took place in January 2025 to agree the priorities of the group through 2025 and 2026, and the following areas were identified:

- Carrying out a gap analysis against the five strategic priorities (tackling digital exclusion etc) plus tackling workforce inequalities.
- Carrying out a health needs assessment with our workforce (this would be undertaken by one of our public health teams).
- Using population health approaches to service improvement and to drive our approach to tackling health inequalities starting with the respiratory pathways.

## Embedding addressing health inequalities across the Trust

### Appraisal objectives

Starting in 2024 a requirement was included in annual appraisals to pick an objective linked to equality, diversity and inclusion. Five objectives were included in total, with one being specifically regarding addressing health inequalities:

|                     |   |  |
|---------------------|---|--|
| Health inequalities | I will identify opportunities to address health inequalities in my speciality/service which impact on my patients, workforce and/or the local community, through clinical practice, engagement and/or process change over the next 12 months. | <ul style="list-style-type: none"><li>• Review information which is relevant to our local communities and identify opportunities to reduce/remove health inequalities.</li><li>• Work with local community groups to identify any areas of inequality and work towards putting steps in place process change over the next 12 months.</li><li>• Work as a team to identify small steps to make sure a service is as inclusive as it can be.</li><li>• Work as part of a collaborative (internal and external) to improve inclusivity in the workplace.</li></ul> |
|---------------------|---|--|

### Equality and Health Inequalities Assessment

The equality impact assessment documentation has also been reviewed to include consideration of addressing health inequalities when changing or implementing a service or scheme. The new equality and health inequalities impact assessment (EHIA) analyses the proposal/project/plan or policy against the protected characteristics, general aims of the Equality Act 2010, Armed Forces Act 2021 and considers the impact against groups which face health inequalities.

This ensures alignment with existing Trust processes, embedding health inequalities as part of business-as-usual activity.

### Trust Strategic Objectives Review

The Trust Strategy runs from 2023 to 2025 and was due to be reviewed and a new strategy launched in May 2025. As the Trust is undertaking a programme of integration with Bridgewater Community Healthcare NHS Foundation Trust, this full refresh of the strategy will take place as part of the integration programme, with a joint interim strategy launching in 2026.

To ensure that the strategy remains valid, relevant and supports the Trust to achieve its three strategic aims, a review of the strategic objectives, priorities, measures of success and the strategic content of the 2023 to 2025 document has been carried out.

The strategic objective focusing on health inequalities remains unchanged, keeping it as a core aim of the Trust's way of working.

*10.1 We will work in coordination with our system and place partners to prioritise the five strategic priorities for tackling health inequalities and improving population health, as outlined in the Core20PLUS5 approach.*

## 2.5 Customer satisfaction scores

The National Adult Inpatient Survey has been an annual requirement since 2002 by the Care Quality Commission (CQC) which looks at the experiences of adults that have been an inpatient at Warrington and Halton Teaching Hospitals (WHH) during November 2022. The aim is to obtain detailed patient feedback on the standards of service and care – this can then be used to help set priorities for delivering a better service for patients and the public. The results are also used by the CQC to measure and monitor performance at both regional and national levels, and as intelligence to monitor, influence and add weight at inspection planning stages to identify possible areas or fields to look at on inspection.

At WHH the survey is undertaken by IQVIA on behalf of the Trust, with sampling completed by the WHH Data Warehouse Team. They follow the national guidance issued on the NHS Patient Survey Programme by the CQC on behalf of NHS England and the Department of Health and Social Care.

The Trust response rate for 2023 was 37%. Following promotion of the survey through poster and social media campaigns, there was a 26% increase in response rate from the 2022 survey. The national average response rate for this survey was 42%; this is made up of a mix of specialist, acute and community trusts.

The survey is made up of 11 sections, which are:

1. Admission to hospital
2. The hospital and ward
3. Doctors
4. Nurses
5. Your care and treatment
6. Virtual wards\*
7. Leaving hospital
8. Feedback on the quality of your care
9. Kindness and compassion
10. Respect and dignity
11. Overall experience

\*This section has changed from the 2022 survey, previously Operations and Procedures

The results of the National Inpatient Survey 2023 have been analysed in direct comparison to the results of the same survey undertaken in 2022 to ascertain where improvements have been made and to highlight areas of improvement. Results have been broken down into sections and rag rated according to performance.

**Table 1 – National Inpatient Survey Results 2024 compared to 2023**

| <b>Section</b>                         | <b>WHH 2024 response</b> | <b>WHH 2023 response</b> |
|--|--------------------------|--------------------------|
| Section 1. Admission to hospital       | 6.5                      | 6.6                      |
| Section 2. The hospital and ward       | 7.4                      | 7.7                      |
| Section 3. Doctors                     | 8.6                      | 8.8                      |
| Section 4. Nurses                      | 8.3                      | 8.4                      |
| Section 5. Your care and treatment     | 8.1                      | 8.2                      |
| Section 6. Virtual wards*              | 7.4                      | Not included             |
| Section 7. Leaving hospital            | 6.8                      | 7.2                      |
| Section 8. Feedback on quality of care | 4.0                      | 1.9                      |
| Section 9. Kindness and compassion     | 9.0                      | Not included             |
| Section 10. Respect and dignity        | 9.0                      | 8.8                      |
| Section 11. Overall experience         | 7.9                      | 8.0                      |

Overall results demonstrate a secure picture:

- 1 question demonstrated a decline in performance
- 37 questions demonstrated a static performance
- 7 questions were new or changed therefore no comparison data is available

Analysis of the survey results in 2023 have demonstrated a decline in performance in relation to 1 question as detailed below:

- Q35: To what extent did staff involve you in decisions about you leaving hospital?
- The survey results for 2023 indicate a reduction in performance from a score of 7.1 to 6.5 – a reduction of 0.6.

The results below detail where WHH perform higher compared to the national average:

- **Provide views on care:** Patients being given the opportunity to give views on the quality of their care while at hospital.
- **Help from staff to wash:** Help from staff to wash or keep patients clean.
- **Information while on virtual ward:** Patient feeling they were given enough information about care and treatment on virtual ward.
- **Leaving hospital:** Staff discussing with patient whether they would need any additional equipment in their home after leaving.
- **Sleeping:** Patient being prevented from sleeping at night due to hospital lighting.

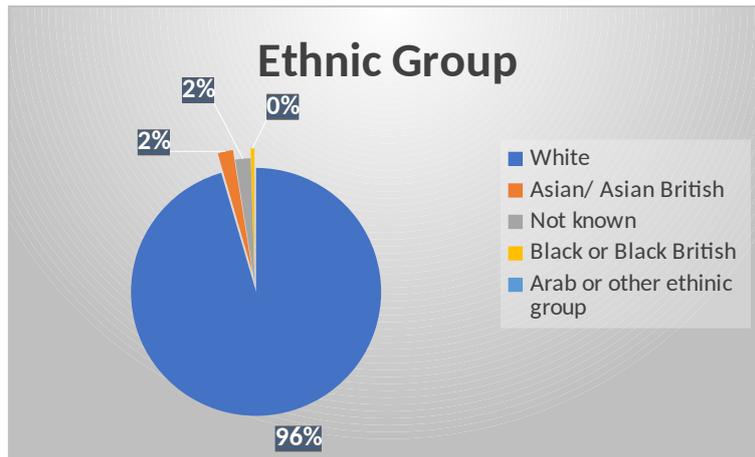
The respondent demographic characteristics recorded for the National Adult Inpatient Survey 2023 are:

- **Ethnicity**
- **Religion**

- **Long term conditions** – physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more
- **Sex** (at birth you were registered as...)
- **Age**

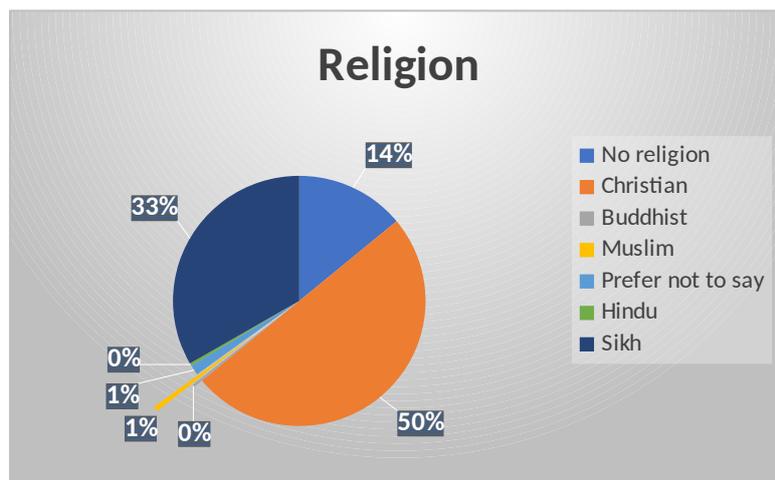
### Ethnicity

Of those surveyed 98% stated their ethnicity was 'white'. This is made up of English/Welsh/Scottish/Northern Irish/British/Irish and any other white background.



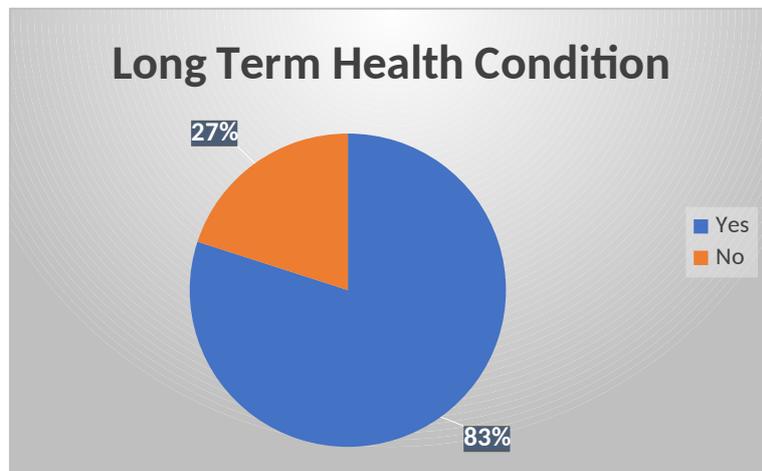
### Religion

Of those surveyed 78% stated their religion as 'Christian' followed by 16% stating they did not identify with any religion.



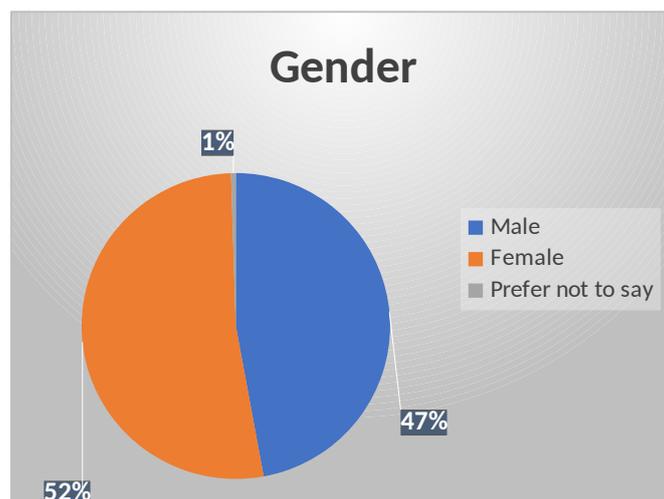
### Long term conditions

Of those surveyed 80% of respondents said they have physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more.



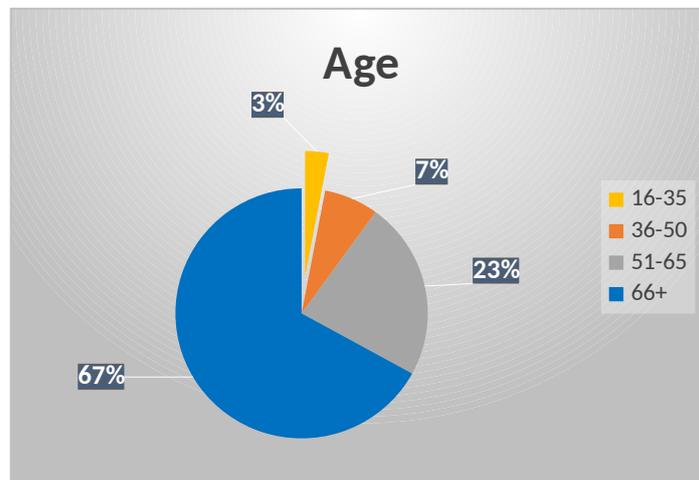
### Sex and gender

Of those surveyed 52% of participants identified as female, with 47% identifying as male. There was one participant who stated their gender is different from the sex they were registered with at birth.



## Age

Of those surveyed 65% stated they were over 66 years of age followed by 22% stating they were aged between 51 and 65.



### Accessibility formats:

The 2023 online survey included the following accessible formats:

- change font size
- change background colour
- screen-reader compatible
- other language options
- British Sign Language (BSL)

By request, contractors were also able to supply:

- a helpline – utilising Language Line Solutions® for interpretation
- large-print questionnaires
- easy read format
- Braille

Dissent posters were also displayed in common languages across the Trust.

## 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 other to achieve social and economic wellbeing in our communities

The Trust opened the year with 12 strategic risks it felt could affect the achieving of its objectives. Of these risks, seven were rated 20, three rated at 16, one rated 15 and one rated 12, using the 5x5 risk rating matrix widely adopted across NHS organisations.

The Trust closed the financial year with 10 strategic risks it felt could affect the Trust in achieving its objectives, although not all of the risks were the same and when the year closed. Four of these risks were rated as 20, three rated 16, two rated 12 and one rated nine.

During quarter 3, the Board approved the de-escalation of risk 1757, given that the remaining risk related to the operational impact of the GP collective action, the only remaining assurance gap. The risk is now monitored through the Corporate Risk Register.

In quarter 4, two new strategic risks were introduced following committee and Board approval Risk 2253 associated with integration, and risk 2273 around the Trust delivering its strategic vision and securing funding for new hospital facilities. Risk 2273 was introduced following the closure of risks 1898 and 145, and the de-escalation of risk 125.

During quarter 2 2025/26 of the monitoring committees undertook a deep dive of their assigned strategic risks. The aim of this was to review the risk details including agreeing individual risk appetites for each of the Trusts strategic risks and to align target risk ratings to the agreed risk appetites.

The current risks described in the Annual Governance Statement continue to be acknowledged as the principal risks to the Trust with likely new risks emerging in the new year.

The Trust Board reviewed and approved the Trust's Risk Appetite Statement at its meeting on 5 February 2025. Full details can be found within the Annual Governance Statement.

## 2.7 Environment

Progress has been made in several areas of the Trust's green plan. Schemes of work are being identified and led by staff, reflecting the engagement of staff with sustainability issues.

From the 1st April 2024 until 31st March 2025, the Trust has installed 1,900 new Smartsan LED light fittings, following successful bids for National Energy Efficiency Funding (NEEF) through NHS England. The new fittings will help to reduce energy consumption across sites by 1,056,785 kWh and reduce carbon emissions by 218,860 kg CO<sub>2</sub> e.

The Energy Performance Contract has performed well in year 9 of 15 and has reduced energy consumption by 17,250,354 kWh and carbon emissions by 3,354,000 kg CO<sub>2</sub> e between 1st April 2024 – 31st March 2025.

Works have completed on the catering refurbishment at Warrington site which has seen a change over from gas cooking appliances over to electric appliances. This shift is a move to greener clean electric energy from natural gas from fossil fuels.

The estates team have developed feasibility studies to install solar panels on the Warrington Hospital site and an expression of interest for funding was made to NHS England.

The trust has developed plans to decommission nitrous oxide systems through the medical gas safety group has received funding from NHS England to decommission its nitrous oxide plant and equipment to reduce the trusts impact on the environment.

Works completed under Targeted investment Fund (TIF) in collaboration with the Cheshire and Merseyside Endoscopy Network to increase capacity for treatment from across Cheshire and Merseyside areas by providing a central hub for Endoscopy services. The hub demonstrates our commitment to working as one system that delivers Endoscopy services without borders to reduce inequalities of access to services and make the best use of our resources, not only as a Trust but as a region.

The medical engineering team has strategically planned the procurement of a new anaesthetic equipment, eliminating the reliance on piped nitrous gas at the Halton site. Medical Engineering collaborates with a range of companies to resell medical devices that are no longer needed, reducing WEEE waste and landfills.

### **Task force on climate-related disclosures**

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

The phased approach incorporates the disclosure requirements of the governance pillar for 2023/24. These disclosures are provided below with appropriate cross referencing to

relevant information elsewhere in the annual report and accounts and in other external publications.

Delivery of environmental ambitions is included within the Trust Strategy 2023-2025, 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 Board for assurance as and when there are significant impacts on Trust programmes of work as relating to climate issues.

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 relates to individual portfolios across the Trust's areas of operation. Elements of this plan undertaken and completed in 2024/25 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 2025/26, in line with NHS England deadlines.

## 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 £85m (inclusive of drugs at £18m) of which more than £60m 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 supplier 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 policies 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 who do not meet the requirements of the act, suppliers will be required to provide a copy of their annual Modern Slavery Action 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 Trust's Procurement Team. All tendering for goods and services is managed centrally by the procurement team. A copy of the act will be 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 more than 4,750 staff comprising 79 nationalities. Most of these staff are employed and paid under national pay arrangements established under Agenda for Change or medical and dental provisions. A small number of staff, which comprises the Trust Board and very senior managers, are employed under local pay and terms and conditions of service which are established by the Remuneration Committee of the Board.

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 & 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 via 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 24/25 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 on investigation brought forward from 2023/24, 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**  
**23 June 2025**



# Accountability Report



## 3. Accountability report

### 3.1 Directors' report

#### Board of Directors

Between 1 April 2024 and 31 March 2025, 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 and Sustainability Committee
- Strategic People Committee
- Quality Assurance Committee
- Charitable Funds Committee

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.

### 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)**

**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)**



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**

**Professor Simon Constable – Chief Executive (until 30 September 2024)**

**Nikhil Khashu – Chief Executive (from 1 December 2024)**

See profile above

**Daniel Moore – Chief Operating Officer and Deputy Chief Executive, Interim Chief Executive 1 October to 30 November 2024**



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

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 has 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 master’s degree in business administration (MBA) from Manchester Business School, and a BSc in operational management from Lancaster University Management School.

In March 2024 Dan was successfully appointed as Deputy Chief Executive, and started in this role on 1 April 2024.

### **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.

### **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.

## 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 \(whh.nhs.uk\)](http://www.warringtonandhaltonhospitals.nhs.uk/statutory-information)

## Board member terms of appointment

| Board member          | Term of appointment  |
|-----------------------|--|
| Steve McGuirk (Chair) | 01.04.2015 to 31.03.2018<br>Second term 01.04.2018 to 31.03.2021<br>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 01.12.2024  |
| Prof Simon Constable  | from 14.11.2019 to 31.08.24  |
| Cliff Richards        | 10.06.2019 to 09.06.2022<br>Second term 10.06.2022 to 09.06.2025   |
| Michael O'Connor      | First term 01.11.2021 – 31.10.2024<br>Second term 01.11.2024   |
| Julie Jarman          | First term 01.01.2022 – 31.12.2024<br>Second term 01.01.2025   |
| Jayne Downey          | From 01.11.2021, voting from 01.05.2022  |
| John Somers           | From 01.10.2022  |
| Jan O'Driscoll        | From 01.07.2023  |
| Jane Hurst            | From 01.10.2023  |
| Ali Kennah            | From 01.04.2024  |
| Daniel Moore          | 20.01.2021<br>Deputy Chief Executive from 01.04.2024<br>Acting Chief Executive from 01.10.2024 – 30.11.2024  |
| Michelle Cloney       | From 01.11.2017, voting from 01.11.2021  |
| Paul Fitzsimmons      | From 01.12.2021  |
| Non-voting members    | Term of appointment  |
| Lucy Gardner          | From 01.02.2016  |
| Kate Henry            | From 01.10.2022  |

**April 2024 to 31 March 2025**

| Board member                   | Trust Board<br>6 meetings and<br>4 extraordinary<br>meetings | Audit<br>Committee<br><br>5 meetings | Quality<br>Assurance<br>Committee<br><br>12 meetings<br>1<br>extraordinary | Finance and<br>Sustainability<br>Committee<br><br>12 meetings<br>1 extraordinary | Strategic<br>People<br>Committee<br><br>12 meetings |
|--------------------------------|--|--------------------------------------|--|--|---|
| <b>Attendance (actual/max)</b> |  |                                      |  |  |   |
| Steve McGuirk<br>(Chair)       | 10/10  | n/a                                  | n/a  | n/a  | n/a   |
| Cliff Richards                 | 8/10   | 4/5                                  | 11/13  | n/a  | n/a   |
| Michael O'Connor               | 9/10   | 5/5                                  | n/a  | n/a  | 11/12   |
| Julie Jarman                   | 10/10  | 5/5                                  | n/a  | 13/13  | 12/12   |
| Jayne Downey                   | 9/10   | 5/5                                  | 12/13  | n/a  | n/a   |
| John Somers                    | 8/10   | 5/5                                  | n/a  | 13/13  | n/a   |
| Jan O'Driscoll                 | 1/10   | 0/3                                  | n/a  | n/a  | n/a   |
| Prof Simon<br>Constable        | 3/4  | n/a                                  | n/a  | n/a  | n/a   |
| Nikhil Khashu                  | 4/4  | n/a                                  | n/a  | n/a  | n/a   |
| Daniel Moore                   | 10/10  | n/a                                  | 9/13   | 10/13  | 10/12   |
| Michelle Cloney                | 9/10   | n/a                                  | 8/13   | 11/13  | 10/12   |
| Paul Fitzsimmons               | 10/10  | n/a                                  | 9/13   | 10/13  | 9/12  |
| Jane Hurst                     | 10/10  | 5/5                                  | 10/13  | 11/13  | 9/12  |
| Ali Kennah                     | 10/10  | n/a                                  | 12/13  | 10/13  | 12/12   |
| Lucy Gardner                   | 9/10   | n/a                                  | 6/13   | 11/13  | 6/12  |
| Kate Henry                     | 10/10  | n/a                                  | n/a  | 4/5  | 10/12   |

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<br>6 meetings and<br>4 extraordinary<br>meetings | Audit<br>Committee<br><br>5 meetings | Quality<br>Assurance<br>Committee<br><br>12 meetings | Finance and<br>Sustainability<br>Committee<br><br>12 meetings | Strategic<br>People<br>Committee<br><br>12 meetings |
|--------------------------------|--|--------------------------------------|--|---|---|
| <b>Attendance (actual/max)</b> |  |                                      |  |   |   |
| Ailsa Gaskill-Jones            | 6/7  | n/a                                  | 12/13  | 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 below. They were addressed through inclusion in the Internal Audit work plan and assurance sought for each element:

1. High assurance was provided in the following: EPRR, risk management core controls, general ledger, accounts payable, accounts receivable, treasury management.
2. Substantial assurance was provided in the following: Fit and proper persons, fractured neck of femur, patient activity data capture (six-week diagnostics) and IT service continuity.
3. Moderate assurance was provided in the following: Consultant job planning.
4. Limited was provided for the following: Medical devices and WHO checklist/ NatSSIPs 2

There were no areas reported as providing 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, approved the Trust's Risk Appetite Statement 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 2024-25 financial statements. No material or significant issues were raised in respect of these statements and accounts. 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 2024-25 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 attended in-person events on separate days at Warrington and Halton Hospitals, as part of International Fraud Awareness Week (IFAW) during November 2024, where they spoke with staff, patients and members of the public offering fraud prevention advice and introducing themselves as the Trusts AFS.

There was a series of four payslip messages circulated to all staff, two recent fraud case articles, two Talking Fraud newsletters, one spotlight article on specific fraud risk area, six fraud newsflashes and a conflicts of interest awareness animated video.

The AFS has attended HR's weekly 'Team Hot Topics' meeting via Teams and provided training to staff (BP and admin) on mandate fraud and fraud trends.

During 2024-25 the AFS 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.

The 2024-25 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 2024**

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
- 6 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 2024 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 2025 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 twice in 2024-25 to review the extension of the Terms of Office of two non-executive directors; both extensions were supported for a second term. 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 2025

| Constituency  | Governor          | Term (of 3)        | Term Ends        |
|---|-------------------|--------------------|------------------|
| Warrington and Halton                                 | Sue Fitzpatrick   | 2                  | 30/11/2026       |
|   | Diane Nield       | 1                  | 30/11/2025       |
|   | Margaret Bamforth | 1                  | 30/11/2027       |
|   | Keith Bland       | 3                  | 30/11/2025       |
|   | Colin Jenkins     | 3                  | 30/11/2026       |
|   | Anne Robinson     | 3                  | 30/11/2025       |
|   | Catherine Ardern  | 1                  | 30/11/2027       |
|   | Carol Ann Kelly   | 1                  | 30/11/2026       |
|   | Jack Roper        | 1                  | 30/11/2027       |
|   | Nigel Richardson  | 2                  | 30/11/2027       |
|   | Linda Mills       | 3                  | 30/11/2027       |
|   | Edward Rawlinson  | 1                  | 30/11/2025       |
|   | Paula Jones       | 1                  | 30/11/2027       |
|   | Alan Davies       | 1                  | 30/11/2027       |
|   | Colin McKenzie    | 2                  | 30/11/2025       |
| Rest of England – 2 seats                             | Kevin Keith       | 2                  | 30/11/2026       |
|   | <b>VACANT</b>     |                    |                  |
| <b>STAFF (5)</b>                                      |                   | <b>Term (of 3)</b> | <b>Term ends</b> |
| Medical and dental                                    | Akash Ganguly     | 2                  | 30/11/2027       |
| Nursing and midwifery                                 | Jonathan Cliffe   | 1                  | 30/11/2025       |
| Staff – support                                       | Erwin Tuballes    | 1                  | 30/11/2027       |
| Clinical scientist or Allied Health Professionals     | Rachel Bold       | 1                  | 30/11/2026       |
| Estates, administration, managerial                   | Gemma Leach       | 1                  | 30/11/2025       |
| <b>Constituency (partners APPOINTED BY TRUST – 6)</b> |                   | <b>DATE</b>        | <b>N/A</b>       |

|                                   |                         |         |   |
|-----------------------------------|-------------------------|---------|---|
| Halton Borough Council            | <b>VACANT</b>           |         |   |
| Warrington Borough Council        | Cllr Maureen McLaughlin | 06/2024 |   |
| Warrington Sikh Gurdwara          | Mansimran Singh         | 08/2024 |   |
| Warrington and Vale Royal College | Nichola Newton          | 06/2019 | - |
| Education sector                  | <b>VACANT</b>           |         |   |
| Private sector                    | <b>VACANT</b>           |         |   |

### The Council of Governors

#### Attendance of the Council of Governors and sub-committees 1 April 2024 to 31 March 2025

| Name                              | Position               | Council of Governor | GNARC  |
|-----------------------------------|------------------------|---------------------|--------|
| Steve McGuirk                     | Chair                  | 4 of 5              | 2 of 2 |
| Simon Constable                   | Chief Executive        | 2 of 2              |        |
| Nikhil Khashu                     | Chief Executive        | 1 of 1              |        |
| Dan Moore                         | Acting Chief Executive | 1 of 1              |        |
| <b>Public governors</b>           |                        |                     |        |
| <b>Warrington North</b>           |                        |                     |        |
| Norman Holding (to 30.11.24)      | Warrington and Halton  | 4 of 6              | 1 of 1 |
| Keith Bland                       | Warrington and Halton  | 2 of 7              |        |
| Colin Jenkins                     | Warrington and Halton  | 7 of 7              |        |
| Anne Robinson                     | Warrington and Halton  | 7 of 7              |        |
| Diane Nield                       | Warrington and Halton  | 5 of 7              | 1 of 1 |
| Sue Fitzpatrick                   | Warrington and Halton  | 6 of 7              | 1 of 1 |
| Carol-Ann Kelly                   | Warrington and Halton  | 6 of 7              |        |
| Mark Britton (resigned June 2024) | Warrington and Halton  | 0 of 2              |        |
| Nigel Richardson                  | Warrington and Halton  | 4 of 7              |        |
| Linda Mills                       | Warrington and Halton  | 2 of 7              |        |
| Edward Rawlinson                  | Warrington and Halton  | 0 of 7              |        |
| John Fagen                        | Warrington and Halton  | 3 of 6              | 1 of 1 |
| Nathan Fitzpatrick (to 30.11.24)  | Warrington and Halton  | 2 of 7              |        |
| Colin McKenzie                    | Warrington and Halton  | 3 of 7              |        |
| Margaret Bamforth (from 01.12.24) | Warrington and Halton  | 1 of 1              |        |
| Catherine Arden (from 01.12.24)   | Warrington and Halton  | 1 of 1              |        |
| Jack Roper (from 01.12.24)        | Warrington and Halton  | 1 of 1              |        |
| Paula Jones (from 01.12.24)       | Warrington and Halton  | 1 of 1              |        |

|   |                                     |        |        |
|---|-------------------------------------|--------|--------|
| Alan Davies (from 01.12.24)                   | Warrington and Halton               | 0 of 1 |        |
| <b>Rest of England</b>                        |                                     |        |        |
| Kevin Keith                                   | Rest of England                     | 2 of 7 |        |
| VACANT  | Rest of England                     |        |        |
| <b>Staff governors</b>                        |                                     |        |        |
| Akash Ganguly                                 | Medical and dental                  | 3 of 7 |        |
| Jonathan Cliffe                               | Nursing and midwifery               | 4 of 7 |        |
| Erwin Tuballes (from 01.12.24)                | Staff – support                     | 0 of 1 |        |
| Gemma Leach                                   | Estates, administration, managerial | 5 of 7 |        |
| Rachel Bold                                   | Clinical sciences and AHPs          | 4 of 7 |        |
| <b>Partner governors</b>                      |                                     |        |        |
| Nichola Newton                                | Warrington and Vale Royal College   | 4 of 7 | 1 of 1 |
| Cllr Chris Loftus (until 31.05.24)            | Halton Borough Council              | 0 of 2 |        |
| Cllr Eddie Dourley (from 01.06.24 – 01.07.24) | Halton Borough Council              | 1 of 1 |        |
| Cllr Maureen McLaughlin                       | Warrington Borough Council          | 3 of 5 |        |
| Kuldeep Singh Dhillon                         | Warrington Sikh Gurdwara            | 0 of 3 |        |
| Mansimran Singh (from 01.08.24)               | Warrington Sikh Gurdwara            | 1 of 4 | 1 of 1 |
| Vacant  | Education Sector                    |        |        |
| Vacant  | Private Sector                      |        |        |
| <b>NEDs</b>                                   |                                     |        |        |
| Cliff Richards                                | Non-Executive Director              | 5 of 5 |        |
| Mike O'Connor                                 | Non-Executive Director              | 2 of 4 |        |
| Julie Jarman                                  | Non-Executive Director              | 3 of 4 |        |
| John Somers                                   | Non-Executive Director              | 3 of 4 |        |
| Jayne Downey                                  | Non-Executive Director              | 2 of 4 |        |
| Jan O'Driscoll                                | Non-Executive Director              | 0 of 4 |        |

## 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 four amendments to the constitution supported by governors and the Trust Board, these were:

1. Annex 1 – the Public Constituency – minimum number of members required, updated to 50 per constituency
2. Updates to align with the NHS Code of Governance, around:
  - a. non-NHS income
  - b. significant transactions
3. The merger of the public constituencies of Warrington North, Warrington South and Halton to form a Warrington and Halton combined constituency
4. Removal of point 2 of Annex 5 allowing governors to represent more than one Trust.

## 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](mailto: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 at 31 March 2025, are detailed below:

| <b>Constituency Membership</b> | <b>31 March 2025</b> |
|--------------------------------|----------------------|
| Warrington and Halton          | 2101                 |
| Rest of England                | 961                  |
| <b>Total public</b>            | <b>3062</b>          |
| Staff                          | 4790                 |
| <b>Total membership</b>        | <b>7852</b>          |

## Membership Strategy 2023-25

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. These are:

### **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 prior to Council of Governors meetings. The group considers all matters relating to Foundation Trust membership, communications, engagement and involvement, having regard to the interests of its public and staff members, its patients and stakeholders on behalf of the Council of Governors.

During 2024-25, governors hosted several engagement stands to engage with both staff and patient members and the public at large. The stands were held across Trust sites; recruitment of new members was also encouraged.

In addition, governors took part in a number of Trust-wide and community engagement events and activities. These included a Hong Kong nationals' information event, Living Well Hub launch, International Clinical Trials Day, Armed Forces Day, Warrington Pride, Disability Awareness Day and Warrington Mela.

The Council of Governors relayed information and news about the Trust through the quarterly Members Newsletter. The newsletter is circulated to all members for which the Trust has a valid email address. The newsletter continues to be well received by our members; assurance on this is provided through open and click through rates, reported through quarterly membership strategy updates.

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

The lead governor participates in national and local governor forums and events. In year the first Cheshire and Merseyside Governor's Symposium meeting took place, which brought together governors from Cheshire and Merseyside to inform and update on the latest governance arrangements and developments across the NHS. In addition, the symposium helps governors gain further knowledge and share learning whilst developing and networking with colleagues within the ICS.

Governors took part in the national governor focus conference facilitated by NHS Providers on 9 July 2024. The conference featured presentations from key influencers and decision makers in the healthcare sector and provided an opportunity to network with other NHS foundation trust governors from across the country.

The lead governor reports into the Council of Governors on a quarterly basis. The report covers national and local developments along with details of events and activities participated in 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. The trust 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. The Trust 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 Trust retaining the rating of 'Good'.

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
- the 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:

|  | 2024/25    | 2024/25    |
|--|------------|------------|
|  | Number     | £000       |
| Non NHS trade invoices paid in the period  | 46,380     | 126,170    |
| Non NHS trade invoices paid within target  | 40,715     | 117,305    |
| <b>Percentage of non-NHS trade invoices paid within agreed payment terms or in 30 days</b> | <b>88%</b> | <b>93%</b> |
| NHS trade invoices paid in the period  | 2,219      | 24,809     |
| NHS trade invoices paid within target  | 1,694      | 22,548     |
| <b>Percentage of NHS trade invoices paid within agreed payment terms or in 30 days</b>     | <b>76%</b> | <b>91%</b> |

The total paid within 2024/25 for late payment of commercial debt was £25k (£3k in 2023/24).

### **3.6 Interest payments**

In year, the Trust made payments totalling £24,635.63 for the late payment of invoices. There are no accrued charges as at 31 March 2025.

## 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.

#### 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

#### Living Well Hub

Launched on 11 March 2024 in Warrington town centre, 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. Key features include:

- More than 500 weekly visitors, with more than 14,500 total visitors by February 2025, 88% from central Warrington postcodes (WA1, WA2, WA4, WA5) with the poorest health outcomes
- 51% of visitors accessing drop-in services, demonstrating demand for accessible face-to-face support
- a Collaboration and Contribution Agreement among four core statutory partners (Warrington and Halton Teaching Hospitals NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Mersey Care NHS Foundation Trust, and Warrington Borough Council), ensuring shared financial responsibility and enabling smaller partners to contribute based on value rather than cost.
- funded initially by the national Towns Fund, with ongoing costs covered by core partners

- 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 received nearly 30,000 views in its first week and added more than 200 new activities, funded by Warrington Borough Council and the Central Government Shared Prosperity Fund

### **Runcorn Health and Education Hub**

Developed with Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Halton Borough Council, voluntary and third-sector partners, and Riverside College, this hub targets high-need populations, including young people, families, and those with long-term conditions from Runcorn Old Town. It will offer health, care and flexible education facilities to support workforce development. Construction began in April 2025, funded by £2.9m from the Reconnecting Runcorn Town Deal, with services expected to commence in early 2026. The building design was collaboratively developed to ensure functionality and flexibility

### **Community Diagnostic Centre (CDC)**

Funded by £16.9m from central government, the CDC at Halton enhances diagnostic capacity to address health inequalities in one of Cheshire and Merseyside's most deprived areas. The three-phase rollout includes:

- **Phase 1** (May 2023): Dedicated areas for phlebotomy, ultrasound and spirometry at Nightingale Hospital.
- **Phase 2** (December 2023): Expanded services at Halton Health Hub, including sleep studies, audiology and respiratory services, delivering an additional 89,000 tests since May 2023.
- **Phase 3** (June 2025): A state-of-the-art imaging facility with MRI and CT scanners. New services launched include a paediatric respiratory service (November 2024), Post Menopausal Bleeding, and Fibroscan services (May 2025), supporting early diagnosis and improved outcomes.

### **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 Programme:** Volunteers with lived experience provide insights into service access. In 2024-25, 68 new participants joined, increasing the total to 195 (noting a prior report of 129 after adding 61 in 2023-24, reflecting updated figures). They supported projects including the Patient Engagement Portal, Trust website redevelopment, breast screening services and capital projects (CDC, Living Well Hub, Halton Health and Education Hub, Endoscopy Hub).
- **Community engagement:** Participation in events such as Warrington Pride, Disability Awareness Day, Warrington Mela, and Armed Forces Day, supported by staff and public governors, to engage vulnerable communities.
- **Digital projects:** Public involvement in user testing for the Patient Engagement Portal, Trust website, breast screening website, and phlebotomy eBooking system.
- **Third-Sector engagement:** Regular attendance at Warrington Disability Partnership's Staying Connected Forum, Halton Voluntary, Community, Faith and Social Enterprise Network, Warrington Dementia Network, and Maternity and Neonatal Voices Partnership meetings.
- **Living Well Warrington website:** Shaped by public input through Experts by Experience, community workshops and a photo competition capturing residents' wellbeing stories.

### 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. The Halton Clinical Research Unit (HCRU) delivers trials, and a 2024 mobile research bus event with NIHR, ARC NWC, and others promoted research in underserved communities.

## Local partnerships

- **Place-based partnerships:** Active engagement in Warrington and Halton's place-based partnership boards, chairing the Warrington Together Estates Enabler Group and co-leading the One Halton Wider Determinants of Health workstream.
- **Integration with Bridgewater Community Healthcare NHS Foundation Trust:** Work has begun to integrate both Trusts by April 2027, 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.
- **Commercial partnerships:** Collaboration with Halton Borough Council and Runcorn Shopping City supports regeneration in deprived areas.
- **Living Well Hub:** The Collaboration and Contribution Agreement formalises partnerships with four statutory partners, enabling equitable service delivery.
- **Runcorn Health and Education Hub:** Multi-partner collaboration with health, education and voluntary sectors to serve high-need populations.

## 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**

**23 June 2025**



# Remuneration Report



## Section 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.

During the period 1 April 2024 and 31 March 2025, the committee met on six occasions.

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

| <b>Member</b>  | <b>Attendance<br/>(Actual v Max)</b> |
|--|--------------------------------------|
| Steve McGuirk, Chair   | 6/6                                  |
| Cliff Richards, Non-Executive Director and Deputy Chair              | 6/6                                  |
| Mike O'Connor Non-Executive Director and Senior Independent Director | 5/6                                  |
| Jayne Downey, Non-Executive Director                                 | 6/6                                  |
| John Somers, Non-Executive Director                                  | 3/6                                  |
| Julie Jarman, Non-Executive Director                                 | 5/6                                  |
| Jan O'Driscoll, Partner Non-Executive Director                       | 0/6                                  |

### Nominations

In year the committee considered and approved the following:

1. Interim Chief Executive recruitment process
2. Executive acting up arrangements
3. Update to the role title of the Director of Strategy & Partnerships to Chief Strategy and Partnerships Officer
4. Appointment of the Interim Chief Executive
5. Appointment of Joint Executive Medical Director
6. Appointment of Joint Chief Operating Officer
7. Appointment of the substantive Chief Executive

## **Remuneration**

In year the committee considered and approved the following:

1. Remuneration of the Interim and Substantive Chief Executive
2. Very Senior Managers Pay – following the statement published by the Secretary of State for Health and Social Care around the acceptance of the recommendations made by the Senior Salaries Review Body (SSRB)

## **4.2 Senior Manager Remuneration Policy**

On 2 June 2015, the Secretary of State for Health wrote formally to all chairs of all NHS Provider Trusts, NHS Foundation Trust and Clinical Commissioning Groups in relation to the pay for very senior managers (defined as chief executives and executives), and the need to ensure that executive pay remains proportionate and justifiable.

The Trust does not consult with employees when preparing the Senior Manager Remuneration Policy. However, the pay and conditions of all employees are taken into account when setting the remuneration policy for senior managers.

The Trust's executive pay structure is very simple and only includes basic pay and enhancements for the chief executive officer and deputy chief executive officer roles. All pay is taxed at source and there are no bonus payments. Salaries are benchmarked against the NHS Providers national report and similar trusts in the Cheshire and Merseyside and wider North West region. All new appointments are sourced at the benchmark level and adjustments are made only if the market rate or existing salary indicates this is necessary. Where salaries of very senior managers exceed £150,000 per annum, these have been reviewed and found to be appropriate with market rate, maintain relativities with other very senior manager posts, and to match pay in the jobs from which individuals were recruited.

### **Performance appraisal**

Performance of the executive directors is assessed and managed through regular appraisal against predetermined objectives along with one-to-one reviews with the chief executive. Similarly, the chair conducts both one-to-ones and a formal appraisal with the chief executive. Any deficit in performance is identified during these regular meetings. Serious performance issues are managed via our Supporting Performance Improvements policy. Performance of the non-executive directors is assessed and managed through regular appraisal by the chair against predetermined objectives, along with regular one-to-one reviews with each non-executive director.

### **Provisions for termination of contract**

There are no special contractual compensation provisions for early termination of 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). For those above the minimum retirement age, early termination by reason of redundancy is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme. The principles for determining how payments for loss of office will be approached, including: how each component will be calculated and whether, and if so how, the circumstances of the loss of office and the senior manager's performance are relevant to any exercise of discretion would all be considered on a case by case basis by the Nominations and Remuneration Committee and would be approved by NHS England in advance.

The Trust is required to report what constitutes the Senior Manager Remuneration Policy in tabular format set out on the next page. At the date of completion of this Annual Report, there have been no changes to this policy. The Trust is awaiting the issue of the national

very Senior Managers pay framework to understand any impact on the policy and any changes required.

### **Components of remuneration package of executive and non-executive directors**

Basic pay in accordance with their contract of employment (executive) and letters of appointment (non-executive).

### **Components of remuneration that is relevant to the short and long term strategic objectives of the Trust**

The directors do not receive any remuneration tailored towards the achievement of strategic objectives.

### **Explanation of how the components of remuneration operate**

Basic pay of the executive directors is determined by the Board Nominations and Remuneration Committee, taking into account past performance, future objectives, market conditions and comparable remuneration information from Trusts within the locality. Basic pay of the non-executive directors is determined by the Governor Nominations and Remuneration Committee.

### **Maximum amount that could be paid in respect of the component**

Maximum payable is the directors' annual salaries as determined by the relevant Nominations and Remuneration Committee.

### **Payment for loss of office**

Notice periods are included in all directors' 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. All payments to any staff member outside contractual terms are scrutinised by the Board's Nominations and Remuneration Committee.

### **Explanation of any provisions for recovery**

If an individual is overpaid in error, there is a contracted right to recover the overpayment.

### **Diversity and inclusion**

The Trust has a Workforce Equality, Diversity and Inclusion (EDI) Strategy 2022-2025 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 Organisation 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 by the Workforce EDI Team 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 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 2025 (and comparison year ended 31 March 2024) (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 2024-25 (and comparison 2023-24 audited)

INCLUDES  
SALARY  
SACRIFICE

|   | 2024-25                    |                       |                                    |                                       |                              | 2023-24                 |                            |                       |                                    |                                       |                              |                         |
|---|----------------------------|-----------------------|------------------------------------|---------------------------------------|------------------------------|-------------------------|----------------------------|-----------------------|------------------------------------|---------------------------------------|------------------------------|-------------------------|
|   | Directors' salary and fees | Taxable benefits      | Annual performance-related bonuses | Long-term performance-related bonuses | All pension-related benefits | Total (bands of £5,000) | Directors' salary and fees | Taxable benefits      | Annual performance-related bonuses | Long-term performance-related bonuses | All pension-related benefits | Total (bands of £5,000) |
|   | (bands of £5,000)          | (to the nearest £100) | (in bands of £5,000)               | (in bands of £5,000)                  | (bands of £2500)             |                         | (bands of £5,000)          | (to the nearest £100) | (in bands of £5,000)               | (in bands of £5,000)                  | (bands of £2500)             |                         |
| £000's  | £                          | £000's                | £000's                             | £000's                                | £000's                       | £000's                  | £                          | £000's                | £000's                             | £000's                                | £000's                       | £000's                  |
| <b>Executive directors</b>  |                            |                       |                                    |                                       |                              |                         |                            |                       |                                    |                                       |                              |                         |
| <b>Nikhil Khashu</b><br>Chief Executive<br>From 1 <sup>st</sup> November 2024<br>Note 5 | 55-60                      | 0                     | 0                                  | 0                                     | 45-47.5                      | 105-110                 | 0                          | 0                     | 0                                  | 0                                     | 0                            | 0                       |

|  |         |   |   |   |           |                |         |   |   |   |   |         |
|--|---------|---|---|---|-----------|----------------|---------|---|---|---|---|---------|
| <b>Prof Simon Constable</b><br>Chief Executive   | 95-100  | 0 | 0 | 0 | 22.5-25   | 120-125        | 200-205 | 0 | 0 | 0 | 0 | 200-205 |
| <b>Andrea McGee</b><br>Chief Finance Officer and<br>Deputy Chief Exec until 30<br>September 2023       | 0       | 0 | 0 | 0 | 0         | 0              | 80-85   | 0 | 0 | 0 | 0 | 80-85   |
| <b>Alison Kennah</b><br>Chief Nurse<br>From 1 <sup>st</sup> April 2024                                 | 130-135 | 0 | 0 | 0 | 205-207.5 | <b>335-340</b> | 0       | 0 | 0 | 0 | 0 | 0       |
| <b>Kimberley Salmon-Jamieson</b><br>Chief Nurse & Deputy<br>Chief Exec                                 | 0       | 0 | 0 | 0 | 0         | 0              | 160-165 | 0 | 0 | 0 | 0 | 160-165 |
| <b>Dan Moore</b><br>Chief Operating Officer<br>Note 1 & 2  | 145-150 | 0 | 0 | 0 | 150-152.5 | 295-300        | 135-140 | 0 | 0 | 0 | 0 | 135-140 |
| <b>Zoe Harris</b><br>Acting Chief Operating<br>Officer<br>From September 24 to<br>October 24<br>Note 3 | 20-25   |   |   |   | 10-12.5   | <b>30-35</b>   |         |   |   |   |   |         |
| <b>Michelle Cloney</b><br>Chief People Officer   | 145-150 | 0 | 0 | 0 | 70-72.5   | 215-220        | 135-140 | 0 | 0 | 0 | 0 | 135-140 |
| <b>Dr Paul Fitzsimmons</b><br>Medical Director<br><b>Note 4</b>  | 185-190 | 0 | 0 | 0 | 70-72.5   | 255-260        | 200-205 | 0 | 0 | 0 | 0 | 200-205 |

|   |         |   |   |   |           |         |         |   |   |   |         |         |
|---|---------|---|---|---|-----------|---------|---------|---|---|---|---------|---------|
| <b>Lucy Gardner</b><br>Director of Strategy & Partnership                         | 140-145 | 0 | 0 | 0 | 40-42.5   | 180-185 | 135-140 | 0 | 0 | 0 | 35-37.5 | 170-175 |
| <b>Kate Henry</b><br>Director of Communications & Engagement<br>from October 2022 | 120-125 | 0 | 0 | 0 | 22.5-25   | 145-150 | 115-120 | 0 | 0 | 0 | 0       | 115-120 |
| <b>Jane Hurst</b><br>Chief Finance Officer<br>from 1 October 2023                 | 140-145 | 0 | 0 | 0 | 115-117.5 | 255-260 | 65-70   | 0 | 0 | 0 | 0-2.5   | 90-95   |
| <b>Chairman and non-executive Directors</b>                                       |         |   |   |   |           |         |         |   |   |   |         |         |
| <b>Steve McGuirk</b><br>Chairman  | 45-50   | 0 | 0 | 0 | 0         | 45-50   | 45-50   | 0 | 0 | 0 | 0       | 45-50   |
| <b>Clifford Richards</b><br>Non-Executive Director                                | 10-15   | 0 | 0 | 0 | 0         | 10-15   | 10-15   | 0 | 0 | 0 | 0       | 10-15   |
| <b>Michael O'Connor</b><br>Non-Executive Director<br>from November 2021           | 10-15   | 0 | 0 | 0 | 0         | 10-15   | 10-15   | 0 | 0 | 0 | 0       | 10-15   |
| <b>Julie Jarman</b><br>Non-Executive Director<br>from January 2022                | 10-15   | 0 | 0 | 0 | 0         | 10-15   | 10-15   | 0 | 0 | 0 | 0       | 10-15   |
| <b>Jayne Downey</b><br>Non-Executive Director<br>from April 2022                  | 10-15   | 0 | 0 | 0 | 0         | 10-15   | 10-15   | 0 | 0 | 0 | 0       | 10-15   |

|   |       |   |   |   |   |       |       |   |   |   |   |       |
|---|-------|---|---|---|---|-------|-------|---|---|---|---|-------|
| <b>John Somers</b><br>Non-Executive Director<br>from August 2022                            | 10-15 | 0 | 0 | 0 | 0 | 10-15 | 10-15 | 0 | 0 | 0 | 0 | 10-15 |
| <b>Adrian Carridice-Davids</b><br>Associate Non-Executive<br>Director<br>from November 2021 | 0     | 0 | 0 | 0 | 0 | 0     | 5-10  | 0 | 0 | 0 | 0 | 5-10  |
| <b>David Thompson</b><br>Associate Non-Executive<br>Director<br>from November 2021          | 0     | 0 | 0 | 0 | 0 | 0     | 5-10  | 0 | 0 | 0 | 0 | 5-10  |

**Notes:**

Note 1

D Moore was Acting Chief Exec from 1st September 2024 to 31st October 2024

Note 2

D Moore is 2 days Temporary Chief Operating Officer for Bridgewater NHS Trust wef 9th December 2024. For Financial Year 2024-25 the banding for the Chief Operating Officer of total salary and pension related was 315-320

Note 3

Z Harris was Acting Chief Operating Officer from 1st September 2024 to 31st October 2024

Note 4

P Fitzsimmons is 1 day Temporary Medical Director for Bridgewater NHS Trust wef 18th November 2024. For Financial Year 2024-25 the banding for the Chief Medical Officer of total salary and pension related was 270-275

Note 5

N Khashu 2 day Temporary Chief Executive for Bridgewater NHS Trust wef 1st November 2024. For Financial Year 2024-25 the banding for the Chief Executive Officer of total salary and pension related was 140-145

**Pension entitlements year ended 31 March 2025 (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 2025 (bands of £5,000) | Lump sum at age 60 related to accrued pension at 31 March 2025 (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 2025 | Employer's contribution to stakeholder pension |
|--|---|--|--|--|--|--|---|--|
|  | £000  | £000   | £000   | £000   | £000   | £000   | £000  | £000   |
| Nikhil Khashu<br>Chief Executive<br>From 1 <sup>st</sup> November 2024   | 2.5-5   | 2.5-5  | 60-65  | 155-160  | 464  | 47   | 550   | 0  |
| Prof Simon Constable<br>Chief Executive<br>Until 31 <sup>st</sup> August 2024  | 0-2.5   | 0-2.5  | 35-40  | 90-95  | 736  | 35   | 824   | 0  |
| Jane Hurst<br>Chief Finance Officer  | 5-7.5   | 10-12.5  | 50-55  | 125-130  | 869  | 117  | 1059  | 0  |
| Alison Kennah<br>Chief Nurse<br>From 1 <sup>st</sup> April 2024  | 7.5-10  | 20-22.5  | 50-55  | 130-135  | 899  | 231  | 1203  | 0  |
| Dan Moore<br>Chief Operating Officer   | 7.5-10  | 12.5-15  | 35-40  | 90-95  | 535  | 124  | 712   | 0  |
| Zoe Harris<br>Acting Chief Operating Officer<br>From 1 <sup>st</sup> September 2024 to 31 <sup>st</sup> October 2024 | 0-2.5   | 0-2.5  | 35-40  | 95-100   | 108  | 11   | 129   | 0  |
| Dr. Paul Fitzsimmons<br>Medical Director   | 2.5-5   | 2.5-5  | 40-45  | 105-110  | 726  | 61   | 852   | 0  |
| Michelle Cloney<br>Chief People Officer  | 2.5-5   | 2.5-5  | 70-75  | 185-190  | 1559   | 97   | 1773  | 0  |
| Lucy Gardner<br>Director of Strategy and Partnerships  | 2.5-5   | 0  | 25-30  | 5-10   | 282  | 23   | 341   | 0  |

|   |       |   |       |   |     |    |     |   |
|---|-------|---|-------|---|-----|----|-----|---|
| Kate Henry<br>Director of Communication and<br>Engagement | 0-2.5 | 0 | 25-30 | 0 | 293 | 13 | 338 | 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.

|   | <b>2024-25</b> | <b>2023-24</b> |
|---|----------------|----------------|
|   | <b>£000</b>    | <b>£000</b>    |
| Remuneration including employers' national insurance contribution for executive and non-executive directors | 1,475          | 1,531          |
| Employers' contribution to pension in relation to executive directors                                       | 155            | 151            |

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 2024-25 and comparative figures for 2023-24.

|                                 | Number in office | Number claiming expenses during the year | Total expenses claimed | Number in office | Number claiming expenses during the year | Total expenses Claimed |
|---------------------------------|------------------|--|------------------------|------------------|--|------------------------|
|                                 | 2024-25 Number   | 2024-25 Number                           | 2024-25 £              | 2023-24 Number   | 2023-24 Number                           | 2023-24 £              |
| Directors                       | 15               | 6  | 3,015.79               | 17               | 8  | 1,453.51               |
| Governors                       | 28               | 0  | 0                      | 28               | 1  | 24                     |
| <b>Total 2024-25: £3,015.79</b> |                  |  |                        |                  |  |                        |

##### Fair pay multiple (subject to Audit)

| 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         |

| 2023/24   | 25th percentile | Median  | 75th percentile |
|---|-----------------|---------|-----------------|
| Salary component of pay                           | £21,878         | £36,586 | £42,591         |
| Total pay and benefits excluding pension benefits | £26,790         | £36,586 | £52,143         |
| Pay and benefits excluding pension:               | 7.30 :1         | 5.53 :1 | 3.88 :1         |

|                                     |  |  |  |
|-------------------------------------|--|--|--|
| pay ratio for highest paid director |  |  |  |
|-------------------------------------|--|--|--|

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 2024-25 was £202,500 (2023-24 £202,500). This is a change between years of 0%.

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 2024-25 was £13,000 to £430,922 (2023-24 £6,000 to £406,634). The percentage change in the average employee remuneration between years is 3.09%. 57 employees received remuneration in excess of the highest-paid director in 2024-25 (2023-24: 52 employees).

### **Expenditure on consultancy**

The Trust has incurred the following expenditure on consultancy services:

|                            | 2024-25    | 2023-24    |
|----------------------------|------------|------------|
| Total expenditure (£000's) | <b>270</b> | <b>386</b> |



**Nikhil Khashu**

**Chief Executive**

**23 June 2025**

#### 4.5 Reporting high paid off-payroll arrangements

| <b>For all off-payroll engagements as of 31 March 2024 for more than £245 per day and that last for longer than six months</b> |   |
|--|---|
| 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.

| <b>For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2024 and 31 March 2025, for more than £245 per day and that last for longer than six months:</b> |   |
|--|---|
| 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 |

| <b>For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025</b> |     |
|---|-----|
| 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             | 34* |

\*All directors, and bands 8d and 9 (all on payroll) employed within 2024/25



# Staff Report



## Section 5: Staff report

### 5.0 Staff report introduction

The Trust employs more than 4,750 staff comprising of 79 nationalities. Most of these staff are employed and paid under national pay arrangements established under Agenda for Change or medical and dental provisions. A small number of staff, which comprises the Trust Board and very senior managers (VSM), are employed under local pay and terms and conditions of service which are established by the Remuneration Committee of the Board and adhere to national parameters for these roles.

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 with the Trust, 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. The Trust 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 a Head of Strategic Workforce Development & Culture, and an Associate Chief Nurse of Safeguarding and Complex Care, 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 2022-2025 has been of prime focus having been launched 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 2022-2025.

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 our 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 2022-2025 (see section 5.5.1)
- 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

|   | <b>2024/25</b> | <b>2023/24</b> |
|---|----------------|----------------|
|   | <b>£'000s</b>  | <b>£'000s</b>  |
| Salaries and wages  | 200,345        | 182,934        |
| Social security costs   | 20,485         | 19,494         |
| Apprenticeship levy   | 987            | 942            |
| Pension costs (employer contributions to NHS Pensions)                          | 23,203         | 20,835         |
| Pension costs (employer contributions paid by NHSE on Provider's behalf (6.3%)) | 15,216         | 101            |
| Pension costs (other)   | 70             | 9,142          |
| Termination benefits  | 77             | 65             |
| Temporary staff - external bank (note 1)  | 31,841         | 34,952         |
| Temporary staff - agency/contract staff (note1)                                 | 3,732          | 8,900          |
|   |                |                |
| <b>Total employee benefit expenses</b>  | <b>295,956</b> | <b>277,365</b> |
| Less costs capitalised as part of assets  | (1,583)        | (1,541)        |
| <b>Total per employee expenses in Note 4.1</b>                                  | <b>294,373</b> | <b>275,824</b> |

## 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.

| Staff category                          | 2024-25              |            | 2023-24              |            | 2022-23              |            |
|---|----------------------|------------|----------------------|------------|----------------------|------------|
|   | Permanently employed | Other      | Permanently employed | Other      | Permanently employed | Other      |
| Medical and dental                      | 230                  | 109        | 214                  | 121        | 201                  | 117        |
| Administration and estates              | 1179                 | 24         | 1224                 | 26         | 1166                 | 33         |
| Healthcare assistants and other support | 696                  | 17         | 719                  | 18         | 672                  | 14         |
| Nursing, midwifery and health visiting  | 1149                 | 4          | 1144                 | 9          | 1024                 | 18         |
| Scientific, therapeutic and technical   | 560                  | 5          | 550                  | 6          | 532                  | 10         |
| <b>Total</b>                            | <b>3814</b>          | <b>159</b> | <b>3851</b>          | <b>180</b> | <b>3595</b>          | <b>192</b> |

### 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.

|   | 2024-2025 |        | 2023-2024 |        | 2022-2023 |        | 2021-2022 |        | 2020-2021 |        | 2019-2020 |        | 2018-2019 |        |
|---|-----------|--------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|-----------|--------|
|   | Male      | Female |
| Directors (executive, non-executive and associate non-executive director) | 5         | 7      | 7         | 9      | 9         | 7      | 8         | 8      | 8         | 8      | 8         | 8      | 8         | 8      |
| Senior managers (band 8a and above)                                       | 53        | 231    | 60        | 243    | 58        | 230    | 57        | 210    | 57        | 191    | 54        | 168    | 53        | 160    |
| Other employees   | 854       | 3486   | 893       | 3,709  | 808       | 3,414  | 964       | 3,673  | 913       | 3,568  | 843       | 3,459  | 813       | 3,440  |

### 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 addresses equality and fair access to career pathways and progression in our Workforce Equality, Diversity and Inclusion Strategy 2022-2025.

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 summary of the data for 2024/25 can be found in the below table:

|                           | <b>Female</b> | <b>Male</b> | <b>Pay gap</b> |
|---------------------------|---------------|-------------|----------------|
| <b>Mean hourly rate</b>   | £20.29        | £25.85      | 21.52%         |
| <b>Median hourly rate</b> | £18.30        | £19.09      | 4.11%          |
| <b>Mean bonus pay</b>     | £13,559       | £8,099      | +67.42%        |
| <b>Median bonus pay</b>   | £9,048        | £6,032      | +50.00%        |

A full report, including the analysis of the data, can be found here: <https://whh.nhs.uk/about-us/corporate-publications-and-statutory-information/equality-diversity-and-human-rights>

## 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 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.

For 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 both flexible and agile working arrangements and this year have 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 and of the permanent staff only. The below table outlines the annual permanent turnover and retention percentages for 2024/2025. For all other information in respect of staff turnover, please use the following link:

[NHS workforce statistics published by NHS Digital](#)

|                           | 2024-25 | 2023-24 | 2022-2023 | 2021-2022 | 2020-2021 |
|---------------------------|---------|---------|-----------|-----------|-----------|
| Permanent staff Turnover  | 11.74%  | 11.34%  | 13.8%     | 14.6%     | 10.2%     |
| Permanent staff retention | 89.39%  | 89.89%  | 85.6%     | 87.5%     | 91.8%     |

## 5.5 Staff policies and actions applied during the financial year

|  |  |
|--|--|
| 1. Adoption Leave Policy   | 43. Payment of Travel and Expenses Policy  |
| 2. Agile Working Policy  | 44. Professional Clinical Registration Policy  |
| 3. Annual Leave Policy   | 45. Protection of Pay Policy   |
| 4. Annual Leave Policy for Consultant Medical and Dental Staff                                   | 46. Recruitment and Selection Policy   |
| 5. Annual Leave Policy for Specialty and Associate Specialist Medical and Dental Staff           | 47. Recovery of Employee Related Overpayments and Outstanding Debt Policy                            |
| 6. Appraisal Policy  | 48. Remediation Policy   |
| 7. Apprenticeship Policy   | 49. Removal Expenses Policy  |
| 8. Bank and Agency Staffing Policy   | 50. Registration Authority / Integrated Identity Management Policy (Smartcard and access management) |
| 9. Conflict of Interest Policy   | 51. Resolving Workplace Issues   |
| 10. Data Protection Policy   | 52. Resuscitation Policy   |
| 11. Disciplinary Policy  | 53. Reward and Recognition Policy  |
| 12. Employment Break Policy  | 54. Revalidation Policy  |
| 13. Employee Subject Access Request Policy   | 55. Secondment Policy  |
| 14. Equality Diversity and Inclusion Policy  | 56. Sexual Misconduct in the Workplace Policy  |
| 15. Equality Diversity, Inclusion and Human Rights Policy  | 57. Shared Parental Leave Policy   |
| 16. Fit and Proper Persons Policy  | 58. Special Leave Policy   |
| 17. Fire Safety Policy   | 59. Staff Car Park Policy  |
| 18. First Aid at Work Policy   | 60. Staff Mental Wellbeing, Stress and Emotional Resilience Policy                                   |
| 19. Flexible Working Policy  | 61. Staff Study Leave / Funding Policy (excluding medical workforce)                                 |
| 20. Freedom of Information Policy  | 62. Study and Professional Leave Policy for Non-Training Grade Medical Staff                         |
| 21. Freedom to Speak Up Policy   | 63. Supporting Attendance Policy   |
| 22. Health and Safety Policy   | 64. Supporting Performance Improvements Policy   |
| 23. Health Clearance Policy  | 65. Time off for TU Reps Policy  |
| 24. Induction Policy   | 66. Training and Development Policy  |
| 25. Internal Professional Standards Policy   | 67. Transitioning in the Workplace Procedure   |
| 26. Lone Worker Policy   | 68. Violence and Aggression Policy   |
| 27. Maintaining High Professional Standards (MHPS) Procedures of Medical and Dental Staff Policy | 69. Volunteers Policy  |
| 28. Management of Personal Relationships at Work Policy  | 70. WHH Uniform/Workwear Policy  |
| 29. Maternity Policy   | 71. Work Experience Policy   |
| 30. Manual Handling Policy   | 72. Workplace Transport Policy   |
| 31. Medical Appraisal Policy   | 73. Workplace Alcohol, Drug and Substance Misuse Policy  |
| 32. Medical Illustration Photography Policy  |  |
| 33. Medical Job Planning Policy  |  |
| 34. Multi-professional Clinical Supervision Policy   |  |
| 35. Multiprofessional Preceptorship Policy   |  |
| 36. Needlestick and Bodily Fluid Exposure Policy   |  |
| 37. Nursing and Midwifery Rostering Policy   |  |
| 38. On Call Policy   |  |
| 39. Organisational Change Policy   |  |
| 40. Overtime Policy  |  |
| 41. Paternity and Partner Leave Policy   |  |
| 42. Pay Progression Policy   |  |

## **5.5.1 Equality, 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 2022-2025 in April 2022. This includes a review of the organisations strategic objectives and aligns a separate strategy for patients, service users and staff.

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 2022-2025, 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 2022-2025 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. This 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 and 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 ensuring opportunities to engage with our staff voice has continued with the investment in our Staff Networks. The organisation has five thriving staff networks in the following areas:

1. Multi-Ethnic Staff Network
2. Progress LGBTQ+ Network
3. Disability Awareness Staff Network
4. Armed Forces and Veterans Community Staff Network
5. Women's Staff Network

An annual review of network achievements and activity can be found in the Trust [Equality, Diversity and Inclusion Annual Report 2024-2025](#), found on the Trust website.

Staff Network members have also had the opportunity to participate in a career development programme developed in partnership Nursing and Organisational Development and implemented as a result of the findings in both 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 commitment to being recognised as a Trust which promotes and celebrates diversity the Trust 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 – 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.
- Stonewall Diversity Champions – supporting the LGBTQIA+ workforce (up to October 2024).
- Henpicked Menopause Friendly Organisation – working towards being a menopause friendly Trust.
- 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.

In addition, the Trust made a commitment to strive to achieve the NHS North West Anti-Racist Organisation Framework Accreditation. The 'bronze' status was achieved in May 2024 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. Within 2024, actions were taken to engage with the workforce, this included holding listening events with protected characteristic groups to listen, learn and make improvements. This 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. Since the 2023 survey results, the Trust has performed significantly better than other acute Trusts for compassionate leadership, diversity and equality as well as inclusion.

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 throughout 2024/25. 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 has been an integral part of the Trust's operational and strategic equality, diversity and inclusion agenda.

## 5.5.2 Actions Taken in year - Health & Wellbeing Employees

### **Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees:**

We have continued to communicate with our workforce through a variety of different methods, both physically and digitally. We make use of a variety of platforms such as the monthly team brief, the emailed Weekly update and daily safety briefing arising from the daily safety huddle.

The safety huddle outcomes are used within clinical areas as part of the daily face-to-face huddle and handover. In addition, the Culture, Engagement and Inclusion team visit all 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 have also implemented Culture Champions made up of representatives from all Staff Groups across the organisation to support with the delivery of the organisation's culture and to keep department areas updated with initiatives that affect our workforce.

Team Brief continues to be an open invitation to all staff within the organisation, presented by our Chief Executive in a virtual format. The content focuses on our Quality, People and Sustainability (QPS) framework with subject matter experts providing information on upcoming changes to Trust services and offers whilst also ensuring that there is an opportunity for any questions to be asked.

Our social media profile continues to grow utilising this opportunity to communicate via X, Instagram and Facebook ensuring a wide reach for our communications. Our Executive Directors and Senior Leadership team continue to be a visible presence within the Trust engaging with staff through executive visits and seeking opinions, experience and feedback through Staff Forums and the Leadership Forum.

### **Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests:**

The Trust has a strong culture of partnership working with Staff Side Colleagues and the Trust continues with the ongoing Joint Negotiating and Consultative Committee (JNCC) meetings providing a forum for communication and collaborative working. The groups meets every two months as a forum for consultation and negotiation on 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 Negotiating Committee which feeds into JLNC, 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.

Staff side colleagues, members of the organisation's Staff Networks, Culture Champions and other staff voice groups are members of other committees where their experience can support and influence changes across the Trust. This includes the Workforce Inclusion and

Culture Sub-Committee and Strategic People Committee who include workforce stories and experience as part of a standard agenda item. The Workforce Inclusion and Culture Sub-Committee reports into Strategic People Committee which is chaired by a Non-Executive Director.

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 continued 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 culture and inclusion team support improving diversity in any staff group feedback mechanisms to ensure representation from our workforce profile and local population census.

#### **Information on health and safety performance and Occupational Health:**

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 with a team of fully qualified Occupational Health Nurses. The department provides pre-employment health clearance, vaccinations, winter vaccination campaigns, well-being 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.

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.

In 2024/25, Occupational Health continued to provide proactive public health initiatives to support the health needs of the workforce. 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.

Key highlights of the year include:

- **Winter vaccination programme**

- The Trust supported the delivery of an accelerated winter vaccination programme for flu and COVID-19
- 2,014 flu vaccinations were delivered
- 649 COVID-19 vaccinations were delivered
- **Award winning service**
  - The Occupational Health and Wellbeing service were highly commended in the inaugural NHS Health at Work Networks Network Recognition Awards under the category “growing the strategic identify of occupational health and wellbeing” for the team’s Senior Screening Nurse proactive approach to supporting the workforce.
- **Partnership working**
  - Extension of Ruby League Cares partnership to deliver Offload sessions to teams across the organisation to support health and wellbeing and a long-term sickness project to provide coaching for individuals to facilitate a quicker return to the workplace
  - Delivery of bespoke interventions and health promotion activity with local organisations such as LiveWire
- **Sleep Ambassador Programme**
  - Our organisation is the first NHS organisation to have a dedicated Sleep Ambassador
  - The Sleep Ambassador who is part of the clinical nursing team has undertaken an organisation -wide sleep audit and identified hotspot areas of poor sleep which may contribute to overall wellbeing
  - Group education sessions have been made available as well as 1:1 appointments to support individuals with onward referrals via Primary Care to Respiratory Consultants for sleep apnoea or sleep hygiene interventions
- **Bespoke interventions**
  - Health and wellbeing day events for areas experiencing high levels of sickness
  - Proactive blood pressure monitoring in high-risk areas

## 5.6 NHS Staff Survey

### Staff experience and engagement

The organisation has a dedicated staff 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. In 2024/25 the Trust re-established the team as a Culture and Engagement function, with the purpose of driving forward quality improvements which lead to improved organisational culture.

This team is 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 December 2024 the Trust held long service celebrations, recognising our staff meeting milestones in their NHS career. In May 2024 the Trust also recognised the impact of all our workforce and held its annual Thank You Awards at the Concorde Conference Centre in Manchester. This will be followed in May 2025 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 2024 survey among Trust staff was 52% a 7% improvement compared to 2023/24 at 45%. A total of 2,409 staff responded to the survey, highlighting the largest number of responses the Trust has ever achieved.

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

| Indicators<br>(‘People Promise’ elements and themes) | 2024/25     |                          | 2023/24     |                          | 2022/23     |                          |
|--|-------------|--------------------------|-------------|--------------------------|-------------|--------------------------|
|  | Trust score | Benchmarking group score | Trust score | Benchmarking group score | Trust score | Benchmarking group score |
| <b>People Promise:</b>                               |             |                          |             |                          |             |                          |
| <b>We are compassionate and inclusive</b>            | <b>7.42</b> | 7.21                     | <b>7.48</b> | 7.24                     | 7.3         | 7.2                      |
| <b>We are recognised and rewarded</b>                | <b>6.09</b> | 5.92                     | <b>6.16</b> | 5.94                     | 5.9         | 5.7                      |
| <b>We each have a voice that counts</b>              | <b>6.85</b> | 6.67                     | <b>6.91</b> | 6.70                     | 6.7         | 6.6                      |
| <b>We are safe and healthy</b>                       | <b>6.32</b> | 6.09                     | <b>6.37</b> | 6.06                     | 6.1         | 5.9                      |
| <b>We are always learning</b>                        | <b>5.83</b> | 5.64                     | <b>5.77</b> | 5.61                     | 5.2         | 5.4                      |
| <b>We work flexibly</b>                              | <b>6.39</b> | 6.24                     | <b>6.38</b> | 6.20                     | 6.0         | 6.0                      |
| <b>We are a team</b>                                 | <b>6.94</b> | 6.74                     | <b>6.97</b> | 6.75                     | 6.6         | 6.6                      |
| <b>Staff engagement</b>                              | <b>6.92</b> | 6.84                     | <b>6.98</b> | 6.91                     | 6.8         | 6.8                      |
| <b>Morale</b>  | <b>6.16</b> | 5.93                     | <b>6.22</b> | 5.91                     | 5.8         | 5.7                      |

The 2024 NHS Staff Survey results highlight that the Trust saw a positive improvement in two elements of the survey in comparison with 2023 results, specifically for:

- We are always learning
- We work flexibly

Although the Trust score deteriorated in seven elements, the highest difference was at 0.07%. When benchmarked against other Acute and Acute & Community Trusts, WHH performed better than the average Trust for all nine elements of the 2024 NHS Staff Survey for the second year running.

Significance testing highlights that staff report a slight decrease in satisfaction with the standard of care provided (-3.3% difference), while there is an increase in staff experiencing discrimination at work (+1.9%). Issues such as satisfaction for the recognition of good work (-3.0%) and a lack of adequate materials or supplies for tasks (-3.9%) are also noted,

alongside challenges related to burnout, with staff feeling worn out or lacking energy for personal time. With the survey being administered in a period of sustained operational and financial pressures for the organisation and wider NHS this is reflected in the national scores, all seeing a deterioration in the same themes.

Positively, appraisals performance has improved and are importantly perceived as helpful in improving job performance (+3.1%) and there is a slight increase in the reporting of incidents that could harm staff or patients. Overall, these insights provide a snapshot of employee satisfaction, challenges and areas needing attention within the Trust in 2025/26.

In addition, questions associated with the Patient Safety Incident Response Framework (PSIRF) will allow for further work to be developed in 2025/26 to improve incident reporting and embed a culture of learning. Results highlight that there are improvements required in how staff feel they will be treated should they report an incident and whether they will receive feedback on any lessons learned should they report.

The 2024 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 underway 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 in Common quarterly from 2025/26.

For the survey results and organisational priorities, actions will be presented and monitored through the People Directorate governance processes at the Workforce Inclusion and Culture Sub-Committee with reporting to the Strategic People Committee.

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 Trade union facility time

The Trust's statistics relating to our trade union (Facility Time Publication Requirements) Regulations Data 2023-24 for the period ending 31 March 2024 (published in July 2024) are as follows:

**Table 1 – Number of employees who were relevant union officials during the period 23-24**

| No. employees who were relevant union officials | Full time equivalent employee number |
|---|--------------------------------------|
| 23  | 13                                   |

**Table 2 – Percentage of time spent on facility time**

| Percentage | No. of individuals |
|------------|--------------------|
| 0%         | 12                 |
| 1 – 50%    | 11*                |
| 51 – 99 %  | 0                  |
| 100 %      | 2                  |

\*Excluding the chair and deputy chair, the 11 active representatives' capacity for trade union deployment in hours is estimated at 314 hours in total for the year.

**Table 3 – Total cost of facility time**

|   | £                   |
|---|---------------------|
| Total cost of facility time             | <b>£275,824,000</b> |
| Total pay bill (2019 – 20)              | <b>0.02%</b>        |
| % total pay bill spent on facility time | <b>£275,824,000</b> |

**Table 4 – Paid trade union activities**

|   | %            |
|---|--------------|
| Paid TU activity time as a percentage of paid facility time | <b>6.2 %</b> |

**Note: 2023/24 data not available until July; the Trust typically reports a year in arrears.**

## 5.8 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 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              |                                   |                                 |                                   |                                 |                               |                             |  |   |
| <b>Total</b>           |                                   |                                 | <b>22</b>                         | <b>77</b>                       |                               |                             | <b>1</b>   | <b>8</b>  |

The number and value of exit packages agreed in 2023-24 are listed in the table below for comparison.

**2023-24**

| 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               |                                   |                                 | 15                                | 50                              |                               |                             |  |   |
| £10,000 – £25,000      |                                   |                                 | 1                                 | 14                              |                               |                             |  |   |
| £25,001 – £50,000      | 1                                 | 27                              |                                   |                                 |                               |                             |  |   |
| £50,001 – £100,000     |                                   |                                 |                                   |                                 |                               |                             |  |   |
| £100,001 – £150,000    |                                   |                                 |                                   |                                 |                               |                             |  |   |
| £150,001 – £200,000    |                                   |                                 |                                   |                                 |                               |                             |  |   |
| >£200,000              |                                   |                                 |                                   |                                 |                               |                             |  |   |
| <b>Total</b>           | <b>1</b>                          | <b>27</b>                       | <b>16</b>                         | <b>64</b>                       |                               |                             |  |   |

**Exit packages: non-compulsory departure payments**

|  | 2024-25              |                                   | 2023-24              |                                   |
|--|----------------------|-----------------------------------|----------------------|-----------------------------------|
|  | Agreements<br>Number | Total value of agreements<br>£000 | agreements<br>Number | Total value of agreements<br>£000 |
| Voluntary redundancies including early retirement contractual costs  | 0                    | 0                                 | 0                    | 0                                 |
| Mutually agreed resignations (MARS) contractual costs                | 0                    | 0                                 | 0                    | 0                                 |
| Early retirements in the efficiency of the service contractual costs | 0                    | 0                                 | 0                    | 0                                 |

|   |           |           |           |           |
|---|-----------|-----------|-----------|-----------|
| Contractual payments in lieu of notice  | 22        | 77        | 16        | 64        |
| Exit payments following employment tribunals or court orders  | 0         | 0         | 0         | 0         |
| Non-contractual payments requiring HMT approval *   | 1         | 8         | 0         | 0         |
| <b>Total</b>  | <b>23</b> | <b>85</b> | <b>16</b> | <b>64</b> |
| Of which:<br>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.



# 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 of 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 NHS Foundation Trust Code of Governance, most recently revised in April 2023, is based on the principles of the UK Corporate Governance Code issued in 2012.

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        | <p>The Chair's term of office was renewed for a fourth term by the Council of Governors in October 2022.</p> <p>The rationale for the extension was:</p> <ol style="list-style-type: none"> <li>1. the number of changes amongst the non-executive directors in the preceding 12 months</li> <li>2. the NHS was/is faced with the most significant pressures in its history resulting from COVID-19. Consequently, it was/is felt the Trust would benefit from securing greater stability of leadership during this period</li> </ol> <p>The details of the extension have been shared with the North West Regional Director and Chair of the ICS</p> |
| D.2.1 | The Chair of the Board of Directors should not be a member and the Vice Chair or Senior Independent Director should not chair the Audit Committee.   | Explain        | <p>The Chair of the Audit Committee is the Senior Independent Director (SID).</p> <p>The Chair of the Audit Committee (who is an experienced Audit Committee Chair having held the role in a previous Trust) was appointed to the role prior to being appointed as the SID at a time when there had been several new NEDs/Associate NEDs joining the Trust.</p> <p>The member of the Audit Committee with relevant financial experience is the Chair of the Finance and Sustainability Committee so is not appropriate to chair the Audit Committee too.</p>  |

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.  | <b>Annual Governance Statement Section 6.4</b>                |
| A 2.3 | The Board of Directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the Board's activities and any action taken, and the Trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.   | <b>Section 5 Staff Report - see 5.5, 5.5.1, 5.5.2 and 5.6</b> |
| 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.  | <b>Section 3.7 Stakeholder Relations</b>                      |
| B.2.6 | <p>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:</p> <ul style="list-style-type: none"> <li>▪ has been an employee of the Trust within the last two years</li> <li>▪ 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</li> <li>▪ has received or receives remuneration from the Trust apart from a director's fee, participates in the</li> </ul> | <b>Section 3.1 Directors Report</b>                           |

|        |   |  |
|--------|---|--|
|        | <p>Trust's performance-related pay scheme or is a member of the Trust's pension scheme</p> <ul style="list-style-type: none"> <li>▪ has close family ties with any of the Trust's advisers, directors or senior employees</li> <li>▪ holds cross-directorships or has significant links with other directors through involvement in other companies or bodies</li> <li>▪ has served on the Trust Board for more than six years from the date of their first appointment</li> <li>▪ is an appointed representative of the Trust's university medical or dental school</li> </ul> <p>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.</p> |  |
| B.2.13 | The Annual Report should give the number of times the Board and committees met, and individual director attendance.   | <b>Section 3.1<br/>Directors<br/>Report</b>    |
| 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.   | <b>Section 3.1<br/>Directors<br/>Report</b>    |
| C 2.5  | If an external consultancy is engaged, it should be identified in the Annual Report alongside a statement.  | <b>Section 4.4<br/>Remuneration<br/>Report</b> |
| 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.  | <b>Section 3.1<br/>Directors<br/>Report</b>    |
| C 4.2  | The Board of Directors should include in the annual report a description of each director's skills, expertise and experience.   | <b>Section 3.1<br/>Directors<br/>Report</b>    |
| 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   | <b>n/a<br/>developmental<br/>review</b>        |

|        |   |   |
|--------|---|---|
|        | 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.  | <b>completed in 2022/23</b>   |
| C.4.13 | <p>The Annual Report should describe the work of the Nominations Committee(s), including:</p> <ul style="list-style-type: none"> <li>▪ the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline</li> <li>▪ 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</li> <li>▪ 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</li> <li>▪ 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</li> <li>▪ the gender balance of senior management and their direct reports</li> </ul> | <b>Section 4.1</b>  |
| 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.   | <b>Section 3.1 Directors Report - Membership Strategy</b>   |
| D.2.4  | <p>The Annual Report should include:</p> <ul style="list-style-type: none"> <li>▪ the significant issues relating to the financial statements that the Audit Committee considered, and how these issues were addressed</li> <li>▪ 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</li> <li>▪ an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services</li> </ul>   | <b>Section 3.1 Directors Report - The work of the Audit Committee</b><br><br><b>And Section 6.4 Annual Governance Statement</b> |
| D.2.6  | The directors should explain in the Annual Report their   | <b>Section 6.4</b>  |

|  |   |   |
|--|---|---|
|  | 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.   | <b>Annual Governance Statement</b>                                  |
| 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.  | <b>Section 2.1 and Section 2.6 Risk Profile</b>                     |
| 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.   | <b>Section 2.6 Risk Profile and 6.4 Annual Governance Statement</b> |
| D.2.9                                    | In the annual accounts, the Board of Directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC Group Accounting Manual and NHS Foundation Trust Annual Reporting Manual, which explain that this assessment should be based on whether a Trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare. | <b>Section 6.1 Going Concern Disclosure</b>                         |
| 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.   | <b>Section 3.1 Directors Report</b>                                 |
| Appendix B, para 2.14 (not in Schedule   | The Board of Directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who  | <b>Section 3.1 Directors Report</b>                                 |

|   |   |   |
|---|---|---|
| A)  | 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.   |   |
| 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.  | <b>Section 3.1<br/>Directors<br/>Report</b> |
| Additional requirement of FT ARM resulting from legislation | <p>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.</p> <p>This is required by paragraph 26(2) (aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012.</p> <p>* 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).</p> <p>** As inserted by section 151 (6) of the Health and Social Care Act 2012)</p> | <b>N/A</b>                                  |

## 6.2 NHS England System Oversight Framework & Segmentation

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

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

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

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

### (iii) Segmentation

On 31st March 2025, the Trust is assigned to segment 2. 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 Improvement.

NHS Improvement, 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 Improvement, 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.

A handwritten signature in black ink, appearing to read 'N. Khashu'.

**Nikhil Khashu**

**Chief Executive**

**23 June 2025**

## 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 2025 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 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 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 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 is shared throughout the Trust, for example via the Trust-wide safety huddles, daily safety briefings, Quality Assurance Committee, 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 develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks, reviewed and approved the Trust's Risk Appetite Statement, and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and at committee meetings. In year, there was further alignment of the relevant elements of the Board Assurance Framework to the committees of the board. Each strategic risk is allocated to a committee for focused oversight and scrutiny.

The Risk Management Policy provides a framework for managing risk across the Trust. The strategy describes the process for managing risks and the roles and responsibilities of the Board of Directors, its committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the Trust.

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, 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 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 details the top seven risks identified at the end of 2024-25 and these continue to be risks to the strategic objectives pertinent to 2024-5. All risks are effectively managed through the risk governance arrangements.

## Risk description/key controls

| Risk description   | Key controls   |
|--|--|
| <p><b>224</b> If there are capacity constraints in the Emergency Department (ED), 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 from time of arrival in ED, resulting in an overcrowded department.</p> | <ul style="list-style-type: none"> <li>• Trust-wide capacity meetings led by the tactical manager for the day four times a day, bed reports detailing site position, risks and actions circulated six times per day</li> <li>• Strategic, tactical, operational management structure in place with clear roles and responsibilities aligned to roles</li> <li>• Bi-annual training provided to tactical managers provided by the EPRR lead and director of operations and performance</li> <li>• Daily C&amp;M system calls with the system control centre to escalate any risks or any external delays</li> <li>• ED escalation processes/intentional rounding with ED consultant and nurse in charge</li> <li>• Private ambulance transport to complement patient providers in and out of hours</li> <li>• Frailty Assessment Unit FAU/ operational five days per week</li> <li>• Gynae Assessment Unit (GAU) and Paediatric Assessment Unit (PAU) operational seven days per week.</li> <li>• Relaunch of the deflection policy for minor injury patients overnight, where appropriate</li> <li>• Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint and more cubicle space. This supports compliance with RCEM guidance</li> <li>• 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 2024)</li> <li>• Additional bed capacity opened in response to surge in hospital</li> <li>• Integrated Discharge Team – daily huddle between hospital discharge team and the hospital social care team now in place</li> <li>• Same Day Emergency Care Centre (SDEC) completed July 2022</li> <li>• Co-located and upgraded Minor Injuries Unit</li> <li>• Meetings with senior leaders from the ICB and local authority to review and discharge taking place weekly</li> <li>• Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED &amp; KPI meetings</li> <li>• Additional senior manager on call support at weekends</li> <li>• Senior doctor at triage function</li> <li>• CT scanner co-located in the main body of ED in 2023</li> <li>• Phlebotomy business case approved to support earlier decision making and flow in AMU, to support flow out of ED for acute medical patients</li> <li>• Winter planning in place to identify additional community and Trust-based capacity to support expected activity levels for winter</li> </ul> |

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|  | <ul style="list-style-type: none"> <li>• Virtual frailty ward, live from 1 February 2023, in line with national planning, to help reduce admissions from care home to ED</li> <li>• Additional nurse staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board</li> <li>• 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</li> <li>• Introduction of the new Manchester Triage Process from 14 April 2024 to support reduced overcrowding in ED and improve clinical quality and patient experience</li> <li>• Winter escalation capacity (Ward A10 and bay of 6 on Ward B4) planned to be open winter 2024-25 to support flow and urgent care</li> <li>• 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</li> <li>• The Performance Improvement and Oversight Group reports to the Finance and Sustainability Committee</li> </ul>   |
| <p><b>1215</b> 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.</p> | <ul style="list-style-type: none"> <li>• 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</li> <li>• Weekly review meetings with C&amp;M diagnostics hub, mutual aid opportunities utilised across C&amp;M to reduce delays</li> <li>• Recruitment to Dom Care ICAHT and Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023-24</li> <li>• Workforce is continually reviewed to ensure that all wards and teams are staffed safely</li> <li>• 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</li> <li>• Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery</li> <li>• The Halton site developed as a cold elective site to protect it from cancellations as a result of urgent care pressures</li> <li>• Capacity identified and being utilised with appropriate independent sector providers and through mutual aid and surgical hubs</li> <li>• Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. The outcome of this project will increase diagnostic and elective capacity for the Trust in the form of an additional endoscopy room, a fifth theatre at CSTM, a day case unit and increased CT and MR capacity, due September 2025 (all phases to be complete)</li> </ul> |

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|   | <ul style="list-style-type: none"> <li>• Weekly theatre scheduling to ensure listing of patients in line with national guidance, with the support and guidance of Cheshire and Merseyside productive partners</li> <li>• 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</li> <li>• Continue to specifically focus on and monitor patients waiting greater than 52 weeks and 65 weeks</li> <li>• Continue to ensure urgent cancers are prioritised in line with national guidance</li> <li>• Continued use of insourcing and outsourcing providers (NHS approved contractors) in 2025-26 to support recovery will be reviewed to ensure value for money</li> <li>• Ongoing validation of waiting lists to improve data quality</li> </ul>  |
| <p><b>134</b> If the Trust's services are not financially sustainable then it is likely to restrict its ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington and Halton</p> | <ul style="list-style-type: none"> <li>• Core financial policies controls in place across the Trust</li> <li>• Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Planning Group (CPG) oversee financial planning</li> <li>• Deputy CEO-led improvement meeting (inc finance and improvement) now take place three times per month</li> <li>• Procurement/tender waiver training in place</li> <li>• TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over three years)</li> <li>• Latest guidance from MIAA Counter Fraud Team circulated</li> <li>• Counter fraud campaign took place for national anti-fraud week commencing 18 November 2024</li> <li>• Revised approach to GIRFT/ improvement/CIP. Leadership from executive medical director and joint reporting to FSC embedded</li> <li>• Appointed GIRFT finance lead and five PAs allocated, and head of improvement</li> <li>• Financial strategy developed to support improvement in financial sustainability. 2022-27 Financial Strategy approved by the Trust Board in May 2022</li> <li>• High level five-year plan presented to the Finance and Sustainability Committee in April 2024</li> <li>• CDC phases 1 and 2 complete. Phase 3 to be completed in spring 2025</li> <li>• Capital plans for 2024-25 approved by the Trust Board in March 2024. Draft Capital Plan for 2025-26 approved at November Trust Board meeting</li> <li>• Revenue plans 2024-25 approved by the Trust Board in June 2024, high level update on 2025-26 operational plan taken to Board January 2025, draft plan approved at Board 5 February 2025, with update received 5 March</li> <li>• Introduced system of escalation where there are risks to CIP delivery</li> <li>• 2023-24 position was in line with original plans and with the reported likely forecast throughout the year. The 2024-25</li> </ul> |

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|   | <p>month 11 position was in line with the forecast, for £7.8m off plan</p> <ul style="list-style-type: none"> <li>• New process introduced 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.</li> <li>• In addition, new revenue spend 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</li> <li>• 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</li> <li>• Tightening controls of non-pay expenditure with executive review of catalogue spend and implemented cease option to purchase some items</li> <li>• Cash support received for 2024/25 as of 31 December is £12.145m. The maximum expected amount of revenue cash support required for March 2025 is £5.166m.</li> <li>• Enhanced ECF meetings in place with chief executive sign off, with ICS invited. Bridgewater Community Healthcare NHS FT in attendance.</li> <li>• Urgent and Emergency Care System Improvement (UECSIP) lead with place support</li> <li>• Introduced system of escalation where capital paperwork has not been produced by Q1</li> <li>• Executive review of CIP gap and unfunded cost pressures</li> <li>• Review of non-recurrent CIP and move to recurrent if possible</li> <li>• Fortnightly executive-led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65 and 52-week recovery</li> <li>• Review of nurse variable pay – three times per week</li> <li>• Weekly review of medic variable pay</li> <li>• PWC final report signed off, recommendations being actioned and monitored – each has an executive lead and PID</li> <li>• 20245-25 received high assurance for gen ledger, accounts receivable, accounts payable, treasury management, with no recommendations to implement</li> <li>• Implemented reduction in bank rates 13 January 2025, reducing exp circa £700k pm</li> <li>• National cash team have indicated that they will not accept cash support application in April 2025 Q1, the suggested new process will be a meeting with provider DoF and NHSE deputy CFO. The Trust has provided the regional team with our Q1 cash requirements which they will collate and submit to the national team for an indication of potential cash requirements</li> </ul> |
| <p><b>2001</b> If the Trust is unable to mitigate for the challenges faced by its fragile services,</p> | <ul style="list-style-type: none"> <li>• Formal process in place for identification and designation of fragile services</li> </ul>   |

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| <p>then it 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</p>   | <ul style="list-style-type: none"> <li>• Focused additional support to fragile service from senior medical, nursing and operational leadership teams</li> <li>• Appropriate prioritisation of fragile service revenue and capital requests</li> </ul>   |
| <p><b>1114</b> 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.</p> | <ul style="list-style-type: none"> <li>• Digital operations governance including supplier management, product management, cyber management, business continuity and disaster recovery governance and customer relationship management with CBU's (e.g. Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard.</li> <li>• Digital change management regime including the Digital Development Group, WHH Change Advisory Group, Digital Transformation Group, Trust communication channels and structured capital planning submissions</li> <li>• 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</li> <li>• External NHS England approved cyber training for the Trust's Executive Board</li> <li>• The use of automatic patching software to roll-out security updates to devices</li> <li>• Existing external network traffic is monitored by NHS Digital for both HSCN and internet links</li> <li>• Secondary secure backup at Halton Data Centre</li> <li>• Remote devices no longer bypassing the web proxy</li> <li>• New phishing exercise by NHS England arranged for 2024-25</li> <li>• Local device (PC and laptop) based firewalls now enabled</li> <li>• Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched</li> <li>• MFA active on new starters for NHSMail</li> <li>• MUSE migrated to new server</li> </ul> |
| <p><b>1372</b> If the Trust is unable to procure a new Electronic Patient Record 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</p>  | <ul style="list-style-type: none"> <li>• Contract in place for a three (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment of a new EPR</li> <li>• Trust financial modelling includes five-year Lorenzo costs</li> <li>• ICB executive leads and FD program supportive of managed convergence relaunch in partnership with Merseyside and West Lancs NHS Trust – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance</li> <li>• Senior programme manager assigned, program director post to be advertised</li> <li>• Financial modelling of realistic options to provide genuine five, 10 and 15-year options to control whole life costs</li> <li>• Partnership procurement will lead to identification of further realistic cash releasing/cost reduction benefits</li> </ul>  |

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|  | <ul style="list-style-type: none"> <li>• The collaboration agreement has been developed and endorsed by the joint Procurement Delivery Group and EPCMS Project Group – March 2025</li> </ul>   |
| <p><b>2273</b> If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the support and resource required from 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</p> | <ul style="list-style-type: none"> <li>• Annual capital funding is allocated for mandated and statutory estates projects</li> <li>• Estates team manages planned maintenance (PPM) and reactive maintenance through CAFMS</li> <li>• Six Facet survey annually assesses estate conditions, informing backlog maintenance priorities</li> <li>• The 10-year planned maintenance capital program is updated yearly based on the Six Facet survey and completed works</li> <li>• Effective clinical networking and partnerships are in place</li> <li>• Full delivery of the TIF (elective) programme due to complete in 2024-25, which includes £9m investment to provide two new operating theatres, an endoscopy room and elective ward capacity</li> <li>• Full business case (FBC) for Pathology Hub to be created with MWL to be presented to the Board in Q1 2025-26</li> <li>• CSPO participates in Runcorn and Warrington Town Deal Boards, overseeing £50m in regeneration funds</li> <li>• Living Well Hub, funded via Warrington Town Deal, and led by WHH opened in March 2024</li> <li>• Runcorn Health and Education Hub funded by the Runcorn Town Deal led by WHH due to open in Q4 2025-26</li> <li>• Strategy refresh for 2025-26 approved by the Trust Board</li> <li>• WHH leads on addressing health inequalities and sustainability, with initial recognition in Cheshire and Merseyside</li> <li>• Consistent Trust representation in Cheshire and Merseyside ICS and place-based boards</li> <li>• One Public Estate funding supports Halton redevelopment and Warrington public sector estate review</li> <li>• Partnerships with educational institutions have enabled tailored education and research</li> <li>• CSPO co-led CMAST priorities for ICB 5-Year Joint Forward Plan.</li> <li>• Trust estates priorities reflected in the ICB infrastructure plan</li> <li>• Agreement from the Boards of Warrington and Halton and Bridgewater to progress transaction to become a single organisation in 2027</li> <li>• Joint Executive Team meetings with Bridgewater Community Healthcare NHS FT commence</li> <li>• Estates strategy for new hospital plans completed</li> <li>• External funding sought for estates developments supporting new hospitals</li> <li>• All partners support new hospitals plans, including MPs, Councils, Education Providers, Place Partners, and ICB</li> <li>• Financial and economic cases for new hospitals to be updated, with funding options explored</li> </ul> |

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|  | <ul style="list-style-type: none"><li>• Capital Planning Group oversees capital funding allocation, prioritised schemes reported monthly</li><li>• Health and Safety Sub-Committee escalates estates issues, managed through relevant safety groups</li><li>• The Government White Paper 'Integration and Innovation: working together to improve health and social care for all', published in February 2021, continues to inform and guide Trust activities</li></ul> |
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## **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 governance structure ensures that the Board has an overarching responsibility through its leadership and to ensure and be assured that the organisation operates with openness, transparency and candour, particularly in relation to its patients, the wider community and its staff. The Board holds itself to account including with a wide range of stakeholders.

The governors play a significant role in holding the Board, and particularly the non-executive directors, to account in a challenging but constructive way within a unitary board. A governor observes each Board committee and provides feedback to the Council of Governors. The Council of Governors meets quarterly as well as a quarterly Governor Engagement Group and regular Governor Working Party meetings. The Board has developed a culture across the organisation which supports open dialogue and includes non-executive directors, executive directors and governors visiting wards and departments to personally listen to feedback from staff, patients, their carers and relatives when possible.

The Board of Directors has throughout the year reviewed the relationship and responsibilities of the Board committees and sub-committees to ensure appropriate delegation of authority and that the appropriate assurance and oversight is maintained on behalf of the Trust Board. All the committees, which comprise the Quality Assurance Committee, Finance and Sustainability Committee and Strategic People Committee, have non-executive director (NED) membership and chairs. The Audit Committee is a significant statutory committee of the Board that is chaired by a non-executive director.

The Board receives the chair's Committee Assurance Reports from each of the committees which provide timely and accurate information and highlight areas of escalation. This facilitates an overarching and robust framework that allows the Board to make sense of the effective use of the information and data to gain further assurance of good practice in governance and provides confidence that the organisation provides patient centred care or provides alerts to where further investigation and monitoring may be required. To further support the Board, each of the committees receive regular updates and high level briefings from the operational groups which are chaired by the executive directors. There is an opportunity at each meeting

for the relevant operational group minutes to be questioned and where needed, further details requested and clarified.

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.

### **People and organisational development**

The Trust's People Strategy delivery plan 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. Strategic People Committee, which is a sub-committee of the Board, chaired by a non-executive director, has strategic oversight of the plan and provides assurance to Board.

Developing Workforce Safeguards support WHH to deliver high quality care through safe and efficient staffing. The National Quality Boards (NQBs) guidance in relation to safe staffing states that providers:

- must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- must use an approach that reflects current legislation and guidance where it is available

The development of the WHH Annual Workforce Plan, which contributes to the Cheshire and Merseyside overall Workforce Plan, enables the identification of skill gaps and supports a system-wide approach to addressing these gaps, enabling WHH to continue to deliver high quality care through safe and efficient staffing. Scrutiny and operational oversight on systems and processes to support safer staffing is provided from within the Trust's current governance structure. Strategic People Committee and Trust Board receive regular updates on safe staffing, staff development and key work developments such as the systematic approach to skill mixes or the introduction of new roles to support personal and professional development that will nurture, grow and develop sufficiently competent diverse teams with a shared purpose to care for patients.

In addition, formal audits are undertaken into staffing processes such as recruitment and payroll, which are reported to the Trust Audit Committee. 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 identifies 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.

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 (FSC). Part of the remit of the FSC, 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. In addition, the Productivity Improvement Oversight Group (PIOG), chaired by the Chief Operating Officer and Deputy Chief Executive, continues to meet once per month and the Financial Control Group meets twice per month.

The Executive Team reviews and monitors the operational performance of the Trust. The Chief Finance Officer reports to the Quality Committee 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 £16.8m which is £5.5m away from the £11.3m deficit plan (adjusted from £27.8m following receipt of £16.5m deficit support funding). This adjusted deficit is the value which NHSE monitors the Trust against and the movement from plan was approved by the ICS.

The annual capital programme was £21.7m (including IFRS16 and donated assets) and the actual spend for the year was £21.9m.

The cash balance at the end of the year was £16.3m. The cash balance will be utilised to pay both capital (£7.3m) 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, 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 July 2024 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 2024. Part one of the review concluded that the Trust's self-assessment deviated only minimally from the independent assessment. On that basis the assurance level awarded in relation to the veracity of the self-assessment was substantial assurance.

Part two of the review conducted by MIAA was comprised of an assessment against the National Data Guardian's 10 data security standards. The assurance level awarded across eight of the data security standards was substantial with two standards rated as moderate. Therefore, the overall assurance level across all 10 National Data Guardian standards was rated as moderate.

In the 2024-25 financial year the Trust reported 13 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 12 of the reported incidents the ICO ruled that further action against the Trust was not necessary. One incident remains outstanding.

| <b>NHS England reference</b> | <b>Date reported</b> | <b>Detail</b>  | <b>Information Commissioner's Office decision</b> |
|------------------------------|----------------------|--|---|
| 36671                        | 16/04/2024           | A patient attended the Emergency Department and on discharge his letter had been put onto the wrong patient's records  | No further action taken                           |
| 36708                        | 18/04/2024           | Misfile originating in Emergency Department resulted in release of information to wrong data subject via Medico-Legal team when responding to a subject access request   | No further action taken                           |
| 36771                        | 23/04/2024           | A patient's partner complained about a clinic letter from the Ophthalmology Dept that was sent but within the letter was also a clinic letter intended for another patient. This letter included the patient's details and treatment plans | No further action taken                           |
| 36772                        | 23/04/2024           | Patient received a letter relating to the wrong data subject   | No further action taken                           |
| 36802                        | 25/04/2024           | Patient's records accessed for non-business purposes   | No further action taken                           |
| 37191                        | 22/05/2024           | Patient given discharge note relating to another data subject.   | No further action taken                           |

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| 37828 | 03/07/2024 | Patient's records accessed for non-business purposes   | No further action taken |
| 38131 | 23/07/2024 | Paper records scanned to incorrect electronic record and subsequently released to the incorrect data subject | No further action taken |
| 38138 | 23/07/2024 | Records released as part of a subject access request sent to the incorrect data subject                      | No further action taken |
| 39091 | 10/09/2024 | Patient's records accessed for non-business purposes   | No further action taken |
| 39673 | 24/10/2024 | Employee information relating to one data subject lost in mail transit                                       | No further action taken |
| 39883 | 08/11/2024 | Maternity record released to incorrect data subject  | No further action taken |
| 40794 | 22/01/2025 | Annotated printouts from a clinical system lost  | Awaiting ICO decision   |

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 2024-25 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 2024-25 financial year.

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 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 2024-25 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**  
**23 June 2025**



# Annual Accounts 2024-25



# 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 2025, which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers equity, the statement of cashflows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 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 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

### Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the 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 2024-25 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 report and accounts, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in this regard.

### **Other information we are required to report on by exception under the Code of Audit Practice**

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

### **Opinion on other matters required by the Code of Audit Practice**

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2024/25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

### **Matters on which we are required to report by exception**

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

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

### **Responsibilities of the Accounting Officer**

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2024/25, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the 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 2024-25).
- 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. We determined that the principal risks were in relation to:
  - high risk or unusual journal entries as identified by our risk assessment.
- 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 capital additions and capital and revenue accruals;
  - 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](http://www.frc.org.uk/auditorsresponsibilities). This description forms part of our auditor’s report.

## Report on other legal and regulatory requirements – the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

### Matter on which we are required to report by exception – the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter except on 23 June 2025 we identified a significant weakness in how the Trust plans and manages its resources to ensure it can continue to deliver its services. This is in relation to:

- the trust did not have in place a medium term financial plan during 2024/25, and although the trust delivered 95% of its Cost Improvement Plan (CIP) these savings were not all recurrent and the trust faces an increased challenge to deliver CIP of £21.5m in 2025/26. This together with unidentified expenditure reductions indicates the trust is facing significant financial sustainability challenges.
  - We recommend the Trust develops a multi-year financial plan which delivers financial balance in the medium term and is based upon realistic assumptions that are supported by all partners. The Trust should also place a significant organisational focus on identifying, in collaboration with system partners, efficiencies which form part of the Trusts 2025/26 Plan. We also recommend the Trust Board closely monitors progress made by the Trust to identify such system efficiencies and considers the risk of non delivery on the viability of the 2025/26 Plan as part of the Board Assurance Framework.

### Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust’s resources.

### Auditor’s responsibilities for the review of the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of ‘proper arrangements’. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor’s Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

## Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Warrington And Halton Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until the National Audit Office has concluded their work in respect of WGA for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

### Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

*Georgia Jones*

Georgia Jones, Key Audit Partner  
for and on behalf of Grant Thornton UK LLP, Local Auditor

Liverpool  
24 June 2025

**Appendix 1. AAA Cloud Application Inputs**

| Creation date  | 10/06/2025 19:41:31   |
|--|---|
| Question   | Answer  |
| Action description   | audit report  |
| Is the entity one of these types of NHS organisation?                              | Foundation Trust  |
| How does the ICB refer to its governing body?                                      | N/A - entity is not an ICB                                    |
| Other 'How does the ICB refer to its governing body?'                              |   |
| Does the auditor's report contain an emphasis of matter?                           | No  |
| Does the auditor's report contain an other matter?                                 | No  |
| Does the auditor's report contain a material uncertainty related to going concern? | No  |
| Does the auditor's report contain a modification to the opinion?                   | No  |
| State the full name of the entity  | Warrington and Halton Teaching Hospitals NHS Foundation Trust |
| What is the year or period end date?   | 31 March 25   |
| Primary statement 1  | Statement of Comprehensive Income                             |
| Primary statement 2  | Statement of Financial Position                               |
| Primary statement 3  | Statement of Changes in Taxpayers Equity                      |
| Primary statement 4  | Statement of Cashflows  |
| Primary statement 5  |   |
| Primary statement 6  |   |
| Primary statement 7  |   |
| Primary statement 8  |   |
| Primary statement 9  |   |
| Primary statement 10   |   |
| Primary statement 11   |   |
| Primary statement 12   |   |
| Is the entity a group?   | No  |
| Does the group contain more than one subsidiary?                                   | N/A - entity is not a group                                   |
| How does management name the annual report?  | annual report and accounts                                    |
| Other 'How does management name the annual report?'                                |   |
| How does the entity refer to its governance statement?                             | annual governance statement                                   |
| Other 'How does the entity refer to its governance statement?'                     |   |

|  |   |
|--|---|
| How does the Foundation Trust refer to its accounting officer responsibilities statement?  | Statement of the Chief Executive's responsibilities as the accounting officer |
| Other 'How does the Foundation Trust refer to its accounting officer responsibilities statement?'  |   |
| How does the NHS Trust refer to its directors' responsibilities statement?   | N/A - entity is not an NHS Trust  |
| Other 'How does the NHS Trust refer to its directors' responsibilities statement?'   |   |
| How does the NHS Trust refer to its chief executive's responsibilities statement?  | N/A - entity is not an NHS Trust  |
| Other 'How does the NHS Trust refer to its chief executive's responsibilities statement?'  |   |
| In relation to procedures to detect irregularities, including fraud, what is the name of the committee with whom enquiries have been made?   | audit committee   |
| Other 'In relation to procedures to detect irregularities, including fraud, what is the name of the committee with whom enquiries have been made?'   |   |
| Has the engagement team enquired of internal audit as to 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? | Yes   |
| State the name of the engagement leader who will be signing the auditor's report   | Georgia Jones   |
| State the office location to be included in the signature section of the auditor's report  | Liverpool   |
| State the planned date the auditor's report will be signed   | 24 June 25  |

## 7.2 Forward to Accounts

**Trust name:** Warrington and Halton Teaching Hospitals NHS Foundation Trust  
**This year:** 2024/25  
**This year ended:** 31 March 2025  
**This year beginning:** 1 April 2024

Foreword to the accounts for the year 1 April 2024 to 31 March 2025

### **Warrington and Halton Teaching Hospitals NHS Foundation Trust**

These accounts, for the year ended 31 March 2025, 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  
23 June 2025

## 7.3 Primary Financial Statements

Warrington and Halton Teaching Hospitals NHS Foundation Trust - Annual Accounts 2024/25

### STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2025

|   | NOTE | 2024/25<br>£000  | 2023/24<br>£000  |
|---|------|------------------|------------------|
| Income from activities  | 3    | 361,695          | 316,660          |
| Other operating income  | 3    | 30,271           | 39,466           |
| <b>Operating income</b>   | 3    | <b>391,966</b>   | <b>356,126</b>   |
| <b>Operating expenses</b>   | 4    | <b>(411,466)</b> | <b>(379,645)</b> |
| <b>OPERATING SUPLUS / (DEFICIT)</b>   |      | <b>(19,500)</b>  | <b>(23,519)</b>  |
| <b>FINANCE INCOME / (EXPENSE)</b>   |      |                  |                  |
| Finance income - interest receivable  | 7    | 1,444            | 1,335            |
| Finance expense - interest payable  | 8    | (144)            | (135)            |
| PDC dividends payable   |      | (5,334)          | (5,380)          |
| <b>NET FINANCE COSTS</b>  |      | <b>(4,034)</b>   | <b>(4,180)</b>   |
| Net gains on disposal of assets   | 9    | 12               | 107              |
| <b>DEFICIT FOR THE FINANCIAL YEAR</b>   |      | <b>(23,522)</b>  | <b>(27,592)</b>  |
| <b>Other comprehensive income / (expense)</b>                                     |      |                  |                  |
| <b>Items that will not be reclassified to income and expenditure</b>              |      |                  |                  |
| Net impairments on property, plant and equipment                                  | 10   | (7,679)          | (1,565)          |
| Revaluation gains on property, plant and equipment                                |      | 4,358            | 2,650            |
| <b>TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR</b>                        |      | <b>(26,843)</b>  | <b>(26,507)</b>  |
| <b>Allocation of losses for the period</b>  |      |                  |                  |
| <b>(a) (Deficit) for the period attributable to:</b>                              |      |                  |                  |
| (ii) owners of the parent   |      | (23,522)         | (27,592)         |
| <b>TOTAL</b>  |      | <b>(23,522)</b>  | <b>(27,592)</b>  |
| <b>(b) Total comprehensive income / (expense) for the period attributable to:</b> |      |                  |                  |
| (ii) owners of the parent   |      | (26,843)         | (26,507)         |
| <b>TOTAL</b>  |      | <b>(26,843)</b>  | <b>(26,507)</b>  |

The notes on pages 5 to 37 form part of these accounts.

**STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2025**

|  | NOTE | 31 March<br>2025<br>£000 | 31 March<br>2024<br>£000 |
|--|------|--------------------------|--------------------------|
| <b>NON-CURRENT ASSETS</b>                                      |      |                          |                          |
| Intangible assets  | 11   | 1,483                    | 1,804                    |
| Property, plant and equipment                                  | 12   | 196,277                  | 197,662                  |
| Right of use assets  | 13   | 8,365                    | 10,441                   |
| Trade and other receivables                                    | 15   | 757                      | 852                      |
| <b>Total non-current assets</b>                                |      | <b>206,882</b>           | <b>210,759</b>           |
| <b>CURRENT ASSETS</b>  |      |                          |                          |
| Inventories  | 14   | 4,048                    | 4,226                    |
| Trade and other receivables                                    | 15   | 9,564                    | 13,231                   |
| Non-current assets held for sale and assets in disposal groups | 16   | 132                      | 132                      |
| Cash and cash equivalents                                      | 18   | 15,976                   | 17,634                   |
| <b>Total current assets</b>                                    |      | <b>29,720</b>            | <b>35,223</b>            |
| <b>CURRENT LIABILITIES</b>                                     |      |                          |                          |
| Trade and other payables                                       | 19   | (39,991)                 | (43,338)                 |
| Borrowings   | 21   | (1,976)                  | (2,530)                  |
| Provisions   | 22   | (644)                    | (2,849)                  |
| Other liabilities  | 20   | (5,466)                  | (4,587)                  |
| <b>Total current liabilities</b>                               |      | <b>(48,077)</b>          | <b>(53,304)</b>          |
| <b>Total assets less current liabilities</b>                   |      | <b>188,525</b>           | <b>192,678</b>           |
| <b>NON-CURRENT LIABILITIES</b>                                 |      |                          |                          |
| Borrowings   | 21   | (6,469)                  | (7,927)                  |
| Provisions   | 22   | (2,080)                  | (2,287)                  |
| <b>Total non-current liabilities</b>                           |      | <b>(8,549)</b>           | <b>(10,214)</b>          |
| <b>TOTAL ASSETS EMPLOYED</b>                                   |      | <b>179,976</b>           | <b>182,464</b>           |
| <b>TAXPAYERS' EQUITY</b>                                       |      |                          |                          |
| Public dividend capital  |      | 263,878                  | 239,523                  |
| Revaluation reserve  |      | 36,127                   | 40,689                   |
| Income and expenditure reserve                                 |      | (120,029)                | (97,748)                 |
| <b>TOTAL TAXPAYERS' EQUITY</b>                                 |      | <b>179,976</b>           | <b>182,464</b>           |

The primary accounts on pages 1 to 4 and the notes on pages 5 to 37 were approved by the Audit Committee on 23 June 2025 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: 23 June 2025

Nikhil Khashu  
Chief Executive

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2025**

|  | <b>Total<br/>Taxpayers'<br/>Equity<br/>£000</b> | <b>Public<br/>Dividend<br/>Capital<br/>£000</b> | <b>Revaluation<br/>Reserve<br/>£000</b> | <b>Income and<br/>Expenditure<br/>Reserve<br/>£000</b> |
|--|---|---|---|--|
| <b>Taxpayers' equity as at 1 April 2024</b>        | 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  |
| <b>Taxpayers' equity as at 31 March 2025</b>       | <b>179,976</b>                                  | <b>263,878</b>                                  | <b>36,127</b>                           | <b>(120,029)</b>                                       |

|  | <b>Total<br/>Taxpayers'<br/>Equity<br/>£000</b> | <b>Public<br/>Dividend<br/>Capital<br/>£000</b> | <b>Revaluation<br/>Reserve<br/>£000</b> | <b>Income and<br/>Expenditure<br/>Reserve<br/>£000</b> |
|--|---|---|---|--|
| <b>Taxpayers' equity as at 1 April 2023</b>        | 184,025   | 214,577   | 40,855                                  | (71,407)   |
| Deficit for the year                               | (27,592)  | 0   | 0                                       | (27,592)   |
| Transfers between reserves                         | 0   | 0   | (1,251)                                 | 1,251  |
| Net impairments on property, plant and equipment   | (1,565)   | 0   | (1,565)                                 | 0  |
| Revaluation gains on property, plant and equipment | 2,650   | 0   | 2,650                                   | 0  |
| Public Dividend Capital received                   | 24,946  | 24,946  | 0                                       | 0  |
| <b>Taxpayers' equity as at 31 March 2024</b>       | <b>182,464</b>                                  | <b>239,523</b>                                  | <b>40,689</b>                           | <b>(97,748)</b>  |

## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2025

|  | NOTE | 2024/25<br>£000 | 2023/24<br>£000 |
|--|------|-----------------|-----------------|
| <b>Cash flows from operating activities</b>  |      |                 |                 |
| Operating (deficit) from continuing operations   |      | <b>(19,500)</b> | <b>(23,519)</b> |
| <b>Non-cash income and expense</b>   |      |                 |                 |
| Depreciation and amortisation  | 4    | 16,019          | 14,349          |
| Impairments and reversals  | 4    | 6,348           | (656)           |
| Income recognised in respect of capital donations  | 3    | (51)            | (2,185)         |
| (Increase) / decrease in trade and other receivables                                     | 15   | 3,463           | 5,941           |
| (Increase) in inventories  | 14   | 178             | (81)            |
| Increase in trade and other payables   | 19   | (3,623)         | (3,493)         |
| Increase / (decrease) in other liabilities   | 20   | 879             | (526)           |
| Increase in provisions   | 22   | (2,411)         | 2,196           |
| Other movements in operating cash flows  |      | (5)             | 0               |
| <b>Net cash used in operations</b>   |      | <b>1,297</b>    | <b>(7,974)</b>  |
| <b>Cash flows from investing activities</b>  |      |                 |                 |
| Interest received  | 7    | 1,444           | 1,335           |
| Purchase of intangible assets  | 11   | (444)           | (254)           |
| Purchase of property, plant and equipment  | 12   | (21,074)        | (29,632)        |
| Sales of property, plant and equipment   |      | 38              | 223             |
| Initial direct costs or up front payments in respect of new right of use assets (lessee) | 13   | (5)             | (38)            |
| Receipt of cash donations to purchase capital assets                                     | 3    | 51              | 2,185           |
| <b>Net cash used in investing activities</b>   |      | <b>(19,990)</b> | <b>(26,181)</b> |
| <b>Cash flows from financing activities</b>  |      |                 |                 |
| Public Dividend Capital received (note 1)  |      | 24,355          | 24,946          |
| Capital element of lease liability repayments  | 21.1 | (2,640)         | (2,482)         |
| Other interest   | 8    | (25)            | (3)             |
| Interest element of lease liability repayments   | 8    | (120)           | (132)           |
| Public Dividend Capital paid   |      | (4,535)         | (5,466)         |
| <b>Net cash used in financing activities</b>   |      | <b>17,035</b>   | <b>16,863</b>   |
| Decrease in cash and cash equivalents  | 18   | (1,658)         | (17,292)        |
| Cash and cash equivalents as at 1 April  |      | 17,634          | 34,926          |
| <b>Cash and cash equivalents as at 31 March</b>  | 18   | <b>15,976</b>   | <b>17,634</b>   |

note 1 - The Trust received two types of PDC in 2024/25 £12.1m (2023/24, £7.2m) of revenue PDC cash support and £12.2m of capital PDC (2023/24 - £17.7m capital PDC).

## 7.3 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 2024/25 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 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 £1.4m. In comparison, a 10% movement in values is £14.0m.

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 2024/25 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 2024/25 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 continues to be included in fixed payments from commissioners.

Elective recovery funding provides additional funding to Integrated Care Boards to fund the commissioning of elective services within their systems. In 2024/25, Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners. In 2024/25 elective recovery funding for providers was separately identified within the API contracts.

### **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](http://www.nhsbsa.nhs.uk/pensions). Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

##### **a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

##### **b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

**Note 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:

|                                      | <b>Min life</b> | <b>Max life</b> |
|--------------------------------------|-----------------|-----------------|
|                                      | <b>Years</b>    | <b>Years</b>    |
| <b>Intangible assets - purchased</b> |                 |                 |
| Software                             | 2               | 10              |

**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:

|                                | <b>Min life</b> | <b>Max life</b> |
|--------------------------------|-----------------|-----------------|
|                                | <b>Years</b>    | <b>Years</b>    |
| Buildings, excluding dwellings | 5               | 80              |
| Dwellings                      | 19              | 42              |
| Plant & machinery              | 3               | 16              |
| Transport equipment            | 7               | 10              |
| Information technology         | 5               | 23              |
| 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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term. 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 £1.160m to ensure that the Better Payment Practice code can be achieved 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 2.40% in real terms (prior year: 2.45%).

#### ***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 21 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 2023/24).

### **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 2024/25 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 2024/25.

**Note 1.23 Accounting standards and interpretations issued but not yet adopted**

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM which is expected to be from the 1 April 2025. Early adoption is not permitted.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

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.

**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)**

|   | <b>2024/25</b>        | <b>2023/24</b>        |
|---|-----------------------|-----------------------|
|   | <b>£000</b>           | <b>£000</b>           |
| <b>Acute services</b>   |                       |                       |
| Income from commissioners under API contracts - variable element (note 1) | 76,513                | 69,805                |
| Income from commissioners under API contracts - fixed element (note 1)    | 242,668               | 216,851               |
| High cost drugs income from commissioners                                 | 17,076                | 13,980                |
| Other NHS clinical income   | 8,511                 | 5,967                 |
| <b>All services</b>   |                       |                       |
| Private patient income  | 9                     | 16                    |
| Agenda for change pay award central funding (note 2)                      | 656                   | 151                   |
| Additional pension contribution central funding (note 3)                  | 15,216                | 9,142                 |
| Other non-protected clinical income (note 4)                              | 1,047                 | 748                   |
| <b>Total income from activities</b>                                       | <b><u>361,695</u></b> | <b><u>316,660</u></b> |

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 2024/25 NHS Payment Scheme documentation.

note 2 - Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

note 3 - Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

note 4 - includes £16.458m deficit support funding from Cheshire and Merseyside ICB.

**Note 3.2 Income from patient care activities (by source)**

|   | <b>2024/25</b>        | <b>2023/24</b>        |
|---|-----------------------|-----------------------|
|   | <b>£000</b>           | <b>£000</b>           |
| <b>Income from patient care activities received from:</b> |                       |                       |
| NHS England   | 23,948                | 21,827                |
| Integrated Care Boards                                    | 336,303               | 293,517               |
| NHS Foundation Trusts                                     | 386                   | 445                   |
| Department of Health and Social Care                      | 10                    | 8                     |
| NHS Other   | 0                     | 106                   |
| Non NHS : private patients                                | 9                     | 16                    |
| Non NHS : overseas patients                               | 60                    | 75                    |
| Injury cost recovery scheme                               | 888                   | 602                   |
| Non NHS Other   | 92                    | 63                    |
| <b>Total income from activities</b>                       | <b><u>361,695</u></b> | <b><u>316,660</u></b> |

All income from activities relates, in its entirety, to continuing operations for 2024/25 and 2023/24.

**Note 3.3 Overseas visitors (relating to patients charged directly by the Trust)**

|  | <b>2024/25</b> | <b>2023/24</b> |
|--|----------------|----------------|
|  | <b>£000</b>    | <b>£000</b>    |
| Income recognised this year                              | 60             | 75             |
| Cash payments received in-year                           | 10             | 21             |
| Amounts added to provision for impairment of receivables | 64             | 68             |
| Amounts written off in-year                              | 14             | 0              |

**Note 3. Operating income (continued)**

| <b>Note 3.4 Other operating income</b>   | <b>2024/25</b> | <b>2023/24</b> |
|--|----------------|----------------|
|  | <b>£000</b>    | <b>£000</b>    |
| Research and development   | 945            | 1,057          |
| Education and training   | 11,678         | 11,428         |
| Non-patient care services to other bodies  | 1,375          | 3,883          |
| Income in respect of staff costs where accounted on gross basis  | 1,288          | 1,367          |
| Education and training - Notional income from apprenticeship fund  | 641            | 733            |
| Cash donations / grants for the purchase of assets   | 51             | 2,185          |
| Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response | 0              | 72             |
| Rental revenue from operating leases   | 275            | 267            |
| Other (note 1)   | 14,018         | 18,474         |
| <b>Total other operating income</b>  | <b>30,271</b>  | <b>39,466</b>  |

note 1 - all other operating income relates in it's entirety to continuing operations for 2024/25 and 2023/24.

| <b>Analysis of other operating income 'other'</b> | <b>2024/25</b> | <b>2023/24</b> |
|---|----------------|----------------|
|   | <b>£000</b>    | <b>£000</b>    |
| Car parking                                       | 1,729          | 1,833          |
| Catering  | 401            | 401            |
| Pharmacy sales                                    | 108            | 85             |
| Staff accommodation rentals                       | 7              | 85             |
| Non-clinical services recharged to other bodies   | 803            | 963            |
| Clinical tests                                    | 2,556          | 2,177          |
| Other (note 2)                                    | 8,414          | 12,930         |
| <b>Total other operating income 'other'</b>       | <b>14,018</b>  | <b>18,474</b>  |

note 2 - other income for 2024/25 contains £0.9m Intermediate Care Therapies, £0.4m Integrated Discharge Service, £0.4m Pathology Funding, £0.3m National Medical Examiners Funding, £0.3m Industrial Action Funding and £0.2m Midwifery Funding.

**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.

|  | <b>2024/25</b> | <b>2023/24</b> |
|--|----------------|----------------|
|  | <b>£000</b>    | <b>£000</b>    |
| Income from services designated as commissioner requested services     | 360,656        | 315,896        |
| Income from services not designated as commissioner requested services | 1,039          | 764            |
| <b>Total</b>   | <b>361,695</b> | <b>316,660</b> |

**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 2024/25 or 2023/24 in respect of fees and charges.

**Note 3.7 Additional information on revenue from contracts with customers recognised in the period**

|   | <b>2024/25</b> | <b>2023/24</b> |
|---|----------------|----------------|
|   | <b>£000</b>    | <b>£000</b>    |
| Revenue recognised in the reporting period that was included in contract liabilities at the previous period end | 2,196          | 2,452          |

**Note 4. Operating expenditure**

| <b>Note 4.1 Operating expenses</b>   | <b>NOTE</b> | <b>2024/25<br/>£000</b> | <b>2023/24<br/>£000</b> |
|--|-------------|-------------------------|-------------------------|
| Purchase of healthcare from NHS and DHSC bodies  |             | 141                     | 1,038                   |
| Purchase of healthcare from non-NHS and non-DHSC bodies  |             | 3,047                   | 1,320                   |
| Staff and executive directors costs  |             | 289,599                 | 271,781                 |
| Non-executive directors  |             | 120                     | 134                     |
| Supplies and services (clinical; excluding drug costs)   |             | 28,617                  | 25,014                  |
| Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response | 14          | 0                       | 72                      |
| Supplies and services (general)  |             | 4,624                   | 4,787                   |
| Drug costs   | 14          | 22,901                  | 21,238                  |
| Consultancy costs  |             | 270                     | 386                     |
| Establishment  |             | 3,160                   | 2,507                   |
| Premises (business rates)  |             | 1,537                   | 717                     |
| Premises (other)   |             | 12,824                  | 17,936                  |
| Transport (business travel only)   |             | 385                     | 466                     |
| Transport (including patient travel)   |             | 1,180                   | 1,086                   |
| Depreciation on property, plant and equipment and right of use assets  | 12 & 13     | 15,254                  | 13,429                  |
| Amortisation on intangible assets  | 11          | 765                     | 920                     |
| Net impairments  | 10          | 6,348                   | (656)                   |
| Movement in credit loss allowance: contract receivables/assets   | 17          | 187                     | 232                     |
| Provisions arising / released in year  |             | 135                     | 0                       |
| Change in provisions discount rate   | 22          | 3                       | 37                      |
| Audit services (statutory audit) (note 1)  |             | 192                     | 169                     |
| Internal audit costs   |             | 106                     | 122                     |
| Clinical negligence, liability to third parties and property expenses scheme premiums                          |             | 11,718                  | 9,110                   |
| Legal fees   |             | 273                     | 353                     |
| Insurance  |             | 266                     | 233                     |
| Research and development - staff costs   |             | 1,124                   | 1,125                   |
| Education and training - staff costs   |             | 3,117                   | 2,891                   |
| Education and training - non-staff   |             | 1,894                   | 2,019                   |
| Education and training - notional expenditure funded from apprenticeship fund                                  |             | 641                     | 733                     |
| Lease expenditure  |             | 424                     | 24                      |
| Redundancy   |             | 0                       | 27                      |
| Losses and special payments  | 28          | 579                     | 284                     |
| Other expenditure  |             | 35                      | 111                     |
| <b>Total operating expenses</b>  |             | <b>411,466</b>          | <b>379,645</b>          |

All operating expenses relate, in their entirety, to continuing operations for 2024/25 and 2023/24.

note 1 - 2023/24 includes £12k that relates to the 2022/23 audit.

**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**

|   | <b>2024/25</b> | <b>2023/24</b> |
|---|----------------|----------------|
|   | <b>Total</b>   | <b>Total</b>   |
|   | <b>£000</b>    | <b>£000</b>    |
| Salaries and wages  | 200,345        | 182,934        |
| Social security costs   | 20,485         | 19,494         |
| Apprenticeship levy   | 987            | 942            |
| Pension costs (employer contributions to NHS Pensions)                          | 23,203         | 20,835         |
| Pension costs (employer contributions paid by NHSE on Provider's behalf (6.3%)) | 15,216         | 9,142          |
| Pension costs (other)   | 70             | 101            |
| Termination benefits  | 77             | 65             |
| Temporary staff - external bank (note 1)  | 31,841         | 34,952         |
| Temporary staff - agency/contract staff (note1)                                 | 3,732          | 8,900          |
| <b>Total employee benefit expenses</b>  | <b>295,956</b> | <b>277,365</b> |
| Less costs capitalised as part of assets  | <b>(1,583)</b> | <b>(1,541)</b> |
| <b>Total per employee expenses in Note 4.1</b>                                  | <b>294,373</b> | <b>275,824</b> |

note 1 - during 2024/25 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 £1,583k (£1,541k in 2023/24) 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 £1,215k has been provided for within the accounts (£1,661k as at 31 March 2024).

**Note 5.2 Early retirements due to ill-health**

3 members of staff retired early on ill-health grounds during the year at an additional cost of £142k (no members of staff for the year ending 31 March 2024). 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.

| <b>Note 6.1 Operating lease income</b>          | <b>2024/25<br/>£000</b> | <b>2023/24<br/>£000</b> |
|---|-------------------------|-------------------------|
| Lease receipts recognised as income in the year | 275                     | 267                     |
| <b>Total</b>                                    | <b>275</b>              | <b>267</b>              |

| <b>Future minimum lease receipts due:</b>         | <b>2024/25<br/>£000</b> | <b>2023/24<br/>£000</b> |
|---|-------------------------|-------------------------|
| Not later than one year                           | 269                     | 267                     |
| Later than one year and not later than five years | 1,076                   | 1,068                   |
| Later than five years                             | 12,108                  | 10,521                  |
| <b>Total</b>                                      | <b>13,453</b>           | <b>11,856</b>           |

| <b>Note 7. Finance revenue</b> | <b>2024/25<br/>£000</b> | <b>2023/24<br/>£000</b> |
|--------------------------------|-------------------------|-------------------------|
| Interest on bank accounts      | 1,444                   | 1,335                   |
| <b>Total</b>                   | <b>1,444</b>            | <b>1,335</b>            |

**Note 8. Finance expenditure**

| <b>Note 8.1 Finance expenditure</b> | <b>2024/25<br/>£000</b> | <b>2023/24<br/>£000</b> |
|-------------------------------------|-------------------------|-------------------------|
| Interest on lease obligations       | 120                     | 132                     |
| Interest on Late Payment of Debt    | 25                      | 3                       |
| <b>Total interest expense</b>       | <b>145</b>              | <b>135</b>              |

**Note 8.2 The Late Payment of Commercial Debts (Interest) Act 1998**

The total within 2024/25 for late payment of commercial debt was £25k (£3k in 2023/24).

**Note 9. Other - Net Gains**

|   | <b>2024/25<br/>£000</b> | <b>2023/24<br/>£000</b> |
|---|-------------------------|-------------------------|
| Gains on disposal of property, plant and equipment      | 37                      | 107                     |
| Net Losses on disposal of property, plant and equipment | (25)                    | 0                       |
| <b>Total gains on disposal of assets</b>                | <b>12</b>               | <b>107</b>              |

**Note 10. Impairment of assets**

|  | 2024/25                    |                      |                                    |
|--|----------------------------|----------------------|------------------------------------|
|  | Net<br>Impairments<br>£000 | Impairments<br>£000  | Reversal of<br>Impairments<br>£000 |
| <b>Impairments and (reversals) charged to operating surplus / (deficit):</b> |                            |                      |                                    |
| Abandonment of assets in the course of construction                          | 262                        | 262                  | 0                                  |
| <b>Total DEL</b>   | <u>262</u>                 | <u>262</u>           | <u>0</u>                           |
| Change in market price   | 6,086                      | 6,465                | (379)                              |
| <b>Total AME</b>   | <u>6,086</u>               | <u>6,465</u>         | <u>(379)</u>                       |
| Impairments charged to operating expenses                                    | 6,348                      | 6,727                | (379)                              |
| Impairments charged to the revaluation reserve                               | 7,679                      | 7,679                | 0                                  |
| <b>Total impairments due to change in market price</b>                       | <u><u>14,027</u></u>       | <u><u>14,406</u></u> | <u><u>(379)</u></u>                |
|  |                            |                      |                                    |
|  | 2023/24                    |                      |                                    |
|  | Net<br>Impairments<br>£000 | Impairments<br>£000  | Reversal of<br>Impairments<br>£000 |
| <b>Impairments and (reversals) charged to operating surplus / (deficit):</b> |                            |                      |                                    |
| Abandonment of assets in the course of construction                          | 0                          | 0                    | 0                                  |
| <b>Total DEL</b>   | <u>0</u>                   | <u>0</u>             | <u>0</u>                           |
| Change in market price   | (656)                      | 332                  | (988)                              |
| <b>Total AME</b>   | <u>(656)</u>               | <u>332</u>           | <u>(988)</u>                       |
| Impairments charged to operating expenses                                    | (656)                      | 332                  | (988)                              |
| Impairments charged to the revaluation reserve                               | 1,565                      | 1,565                | 0                                  |
| <b>Total impairments due to change in market price</b>                       | <u><u>909</u></u>          | <u><u>1,897</u></u>  | <u><u>(988)</u></u>                |

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**

|   | <b>Software<br/>licences<br/>£000</b> |
|---|---------------------------------------|
| <b>Cost as at 1 April 2024</b>                      | <b>6,945</b>                          |
| Additions - purchased                               | 444                                   |
| Disposals   | (66)                                  |
| <b>Cost as at 31 March 2025</b>                     | <b><u>7,323</u></b>                   |
| <b>Accumulated amortisation as at 1 April 2024</b>  | <b>5,141</b>                          |
| Provided during the year                            | 765                                   |
| Disposals   | (66)                                  |
| <b>Accumulated amortisation as at 31 March 2025</b> | <b><u>5,840</u></b>                   |
| <b>Cost as at 1 April 2023</b>                      | <b>6,691</b>                          |
| Additions - purchased                               | 254                                   |
| Disposals   | 0                                     |
| <b>Cost as at 31 March 2024</b>                     | <b><u>6,945</u></b>                   |
| <b>Accumulated amortisation as at 1 April 2023</b>  | <b>4,221</b>                          |
| Provided during the year                            | 920                                   |
| Disposals   | 0                                     |
| <b>Accumulated amortisation as at 31 March 2024</b> | <b><u>5,141</u></b>                   |
| <b>Net book value as at 31 March 2025</b>           | <b>1,483</b>                          |
| <b>Net book value as at 31 March 2024</b>           | <b>1,804</b>                          |

All intangible assets are owned assets.

**Note 12. Property, plant and equipment**

|  | Total          | Land          | Buildings<br>excluding<br>Dwellings | Dwellings   | Assets Under<br>Construction | Plant &<br>Machinery | Transport &<br>Equipment | Information<br>Technology | Furniture &<br>Fittings |
|--|----------------|---------------|-------------------------------------|-------------|------------------------------|----------------------|--------------------------|---------------------------|-------------------------|
| <b>Note 12.1 Property, plant and equipment 2024/25</b> | <b>£000</b>    | <b>£000</b>   | <b>£000</b>                         | <b>£000</b> | <b>£000</b>                  | <b>£000</b>          | <b>£000</b>              | <b>£000</b>               | <b>£000</b>             |
| <b>Cost or valuation as at 1 April 2024</b>            | <b>222,698</b> | <b>17,500</b> | <b>122,208</b>                      | <b>665</b>  | <b>22,692</b>                | <b>38,676</b>        | <b>173</b>               | <b>14,035</b>             | <b>6,749</b>            |
| 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)                   |
| <b>Cost or valuation as at 31 March 2025</b>           | <b>224,713</b> | <b>17,500</b> | <b>125,814</b>                      | <b>722</b>  | <b>15,326</b>                | <b>41,159</b>        | <b>184</b>               | <b>17,369</b>             | <b>6,639</b>            |
| <b>Accumulated depreciation as at 1 April 2024</b>     | <b>25,036</b>  | <b>0</b>      | <b>0</b>                            | <b>0</b>    | <b>0</b>                     | <b>16,228</b>        | <b>102</b>               | <b>7,588</b>              | <b>1,118</b>            |
| 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)                   |
| <b>Accumulated depreciation as at 31 March 2025</b>    | <b>28,436</b>  | <b>0</b>      | <b>0</b>                            | <b>0</b>    | <b>0</b>                     | <b>18,666</b>        | <b>114</b>               | <b>8,087</b>              | <b>1,569</b>            |
| <b>Net book value as at 31 March 2025</b>              | <b>196,277</b> | <b>17,500</b> | <b>125,814</b>                      | <b>722</b>  | <b>15,326</b>                | <b>22,493</b>        | <b>70</b>                | <b>9,282</b>              | <b>5,070</b>            |

**Note 12. Property, plant and equipment**

|  | Total          | Land          | Buildings<br>excluding<br>Dwellings | Dwellings   | Assets Under<br>Construction | Plant &<br>Machinery | Transport &<br>Equipment | Information<br>Technology | Furniture &<br>Fittings |
|--|----------------|---------------|-------------------------------------|-------------|------------------------------|----------------------|--------------------------|---------------------------|-------------------------|
| <b>Note 12.1 Property, plant and equipment 2023/24</b>               | <b>£000</b>    | <b>£000</b>   | <b>£000</b>                         | <b>£000</b> | <b>£000</b>                  | <b>£000</b>          | <b>£000</b>              | <b>£000</b>               | <b>£000</b>             |
| <b>Cost or valuation as at 1 April 2023</b>                          | <b>199,487</b> | <b>17,500</b> | <b>121,074</b>                      | <b>991</b>  | <b>15,362</b>                | <b>31,177</b>        | <b>101</b>               | <b>11,208</b>             | <b>2,074</b>            |
| Additions - purchased  | 26,825         | 0             | 1,454                               | 0           | 19,880                       | 2,436                | 72                       | 2,034                     | 949                     |
| Additions - assets purchased from cash donations                     | 2,185          | 0             | 389                                 | 0           | 1,796                        | 0                    | 0                        | 0                         | 0                       |
| Impairments charged to revaluation reserve                           | (1,565)        | 0             | (1,336)                             | (229)       | 0                            | 0                    | 0                        | 0                         | 0                       |
| Revaluations   | (2,046)        | 0             | (1,949)                             | (97)        | 0                            | 0                    | 0                        | 0                         | 0                       |
| Reclassifications  | 0              | 0             | 2,576                               | 0           | (14,346)                     | 7,228                | 0                        | 793                       | 3,749                   |
| Transfers to/from assets held for sale and assets in disposal groups | (162)          | 0             | 0                                   | 0           | 0                            | (162)                | 0                        | 0                         | 0                       |
| Disposals  | (2,026)        | 0             | 0                                   | 0           | 0                            | (2,003)              | 0                        | 0                         | (23)                    |
| <b>Cost or valuation as at 31 March 2024</b>                         | <b>222,698</b> | <b>17,500</b> | <b>122,208</b>                      | <b>665</b>  | <b>22,692</b>                | <b>38,676</b>        | <b>173</b>               | <b>14,035</b>             | <b>6,749</b>            |
| <b>Accumulated depreciation as at 1 April 2023</b>                   | <b>21,538</b>  | <b>0</b>      | <b>0</b>                            | <b>0</b>    | <b>0</b>                     | <b>14,577</b>        | <b>96</b>                | <b>5,976</b>              | <b>889</b>              |
| Provided during the year   | 10,790         | 0             | 5,288                               | 64          | 0                            | 3,568                | 6                        | 1,612                     | 252                     |
| Impairments charged to operating expenses                            | 332            | 0             | 278                                 | 54          | 0                            | 0                    | 0                        | 0                         | 0                       |
| Reversal of impairments credited to operating expenses               | (988)          | 0             | (988)                               | 0           | 0                            | 0                    | 0                        | 0                         | 0                       |
| Revaluations   | (4,696)        | 0             | (4,578)                             | (118)       | 0                            | 0                    | 0                        | 0                         | 0                       |
| Transfers to/from assets held for sale and assets in disposal groups | (30)           | 0             | 0                                   | 0           | 0                            | (30)                 | 0                        | 0                         | 0                       |
| Disposals  | (1,910)        | 0             | 0                                   | 0           | 0                            | (1,887)              | 0                        | 0                         | (23)                    |
| <b>Accumulated depreciation as at 31 March 2024</b>                  | <b>25,036</b>  | <b>0</b>      | <b>0</b>                            | <b>0</b>    | <b>0</b>                     | <b>16,228</b>        | <b>102</b>               | <b>7,588</b>              | <b>1,118</b>            |
| <b>Net book value as at 31 March 2024</b>                            | <b>197,662</b> | <b>17,500</b> | <b>122,208</b>                      | <b>665</b>  | <b>22,692</b>                | <b>22,448</b>        | <b>71</b>                | <b>6,447</b>              | <b>5,631</b>            |

|  | Total          | Land          | Buildings<br>excluding<br>Dwellings | Dwellings   | Assets Under<br>Construction | Plant &<br>Machinery | Transport &<br>Equipment | Information<br>Technology | Furniture &<br>Fittings |
|--|----------------|---------------|-------------------------------------|-------------|------------------------------|----------------------|--------------------------|---------------------------|-------------------------|
| <b>Note 12.3 Property, plant and equipment<br/>financing</b> | <b>£000</b>    | <b>£000</b>   | <b>£000</b>                         | <b>£000</b> | <b>£000</b>                  | <b>£000</b>          | <b>£000</b>              | <b>£000</b>               | <b>£000</b>             |
| <b>Net book value as at 31 March 2025</b>                    |                |               |                                     |             |                              |                      |                          |                           |                         |
| 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                   |
| <b>Total net book value as at 31 March 2025</b>              | <b>196,277</b> | <b>17,500</b> | <b>125,814</b>                      | <b>722</b>  | <b>15,326</b>                | <b>22,493</b>        | <b>70</b>                | <b>9,282</b>              | <b>5,070</b>            |
| <b>Net book value as at 31 March 2024</b>                    |                |               |                                     |             |                              |                      |                          |                           |                         |
| Owned  | 192,101        | 17,500        | 120,199                             | 665         | 22,692                       | 21,336               | 71                       | 6,447                     | 3,191                   |
| Donated / Granted  | 5,561          | 0             | 2,009                               | 0           | 0                            | 1,112                | 0                        | 0                         | 2,440                   |
| <b>Total net book value as at 31 March 2024</b>              | <b>197,662</b> | <b>17,500</b> | <b>122,208</b>                      | <b>665</b>  | <b>22,692</b>                | <b>22,448</b>        | <b>71</b>                | <b>6,447</b>              | <b>5,631</b>            |

**Note 13 Leases**

This note details information about leases for which the Trust is a lessee.

**Note 13.1 Right of use assets - 2024/25**

|   | Property<br>(land and<br>buildings) | Plant &<br>machinery | Total         | Of which:<br>leased<br>from<br>DHSC<br>group<br>bodies<br>£000 |
|---|-------------------------------------|----------------------|---------------|--|
|   | £000                                | £000                 | £000          |  |
| <b>Valuation / gross cost at 1 April 2024 - brought forward</b>           | 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  |
| <b>Valuation/gross cost at 31 March 2025</b>                              | <b>3,961</b>                        | <b>10,059</b>        | <b>14,020</b> | <b>665</b>   |
| <b>Accumulated depreciation at 1 April 2024 - brought forward</b>         | 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  |
| <b>Accumulated depreciation at 31 March 2025</b>                          | <b>1,643</b>                        | <b>4,012</b>         | <b>5,655</b>  | <b>367</b>   |
| <b>Net book value at 31 March 2025</b>                                    | <b>2,318</b>                        | <b>6,047</b>         | <b>8,365</b>  | <b>298</b>   |
| 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  |
| <b>Net book value at 31 March 2025</b>                                    |                                     |                      |               | <b>8,365</b>   |

**Note 13.2 Right of use assets - 2023/24**

|   | Property<br>(land and<br>buildings) | Plant &<br>machinery | Total         | Of which:<br>leased<br>from<br>DHSC<br>group<br>bodies<br>£000 |
|---|-------------------------------------|----------------------|---------------|--|
|   | £000                                | £000                 | £000          |  |
| <b>Valuation / gross cost at 1 April 2023 - brought forward</b>           | 4,781                               | 8,569                | 13,350        | 289  |
| Additions - lease liability   | 389                                 | 611                  | 1,000         | 308  |
| Additions - up front lease payments (before or on commencement)           | 19                                  | 19                   | 38            | 9  |
| Remeasurements of the lease liability                                     | 227                                 | 1,102                | 1,329         | 38   |
| Disposals/derecognition - lease termination                               | 0                                   | (221)                | (221)         | 0  |
| <b>Valuation/gross cost at 31 March 2024</b>                              | <b>5,416</b>                        | <b>10,080</b>        | <b>15,496</b> | <b>644</b>   |
| <b>Accumulated depreciation at 1 April 2023 - brought forward</b>         | 1,098                               | 1,539                | 2,637         | 37   |
| Provided during the year  | 1,172                               | 1,467                | 2,639         | 161  |
| Disposals / derecognition   | 0                                   | (221)                | (221)         | 0  |
| <b>Accumulated depreciation at 31 March 2024</b>                          | <b>2,270</b>                        | <b>2,785</b>         | <b>5,055</b>  | <b>198</b>   |
| <b>Net book value at 31 March 2024</b>                                    | <b>3,146</b>                        | <b>7,295</b>         | <b>10,441</b> | <b>446</b>   |
| Net book value of right of use assets leased from other NHS providers     |                                     |                      |               | 9,995  |
| Net book value of right of use assets leased from other DHSC group bodies |                                     |                      |               | 446  |
| <b>Net book value at 31 March 2024</b>                                    |                                     |                      |               | <b>10,441</b>  |

**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.

|                                   | <b>2024/25</b>      | <b>2023/24</b>       |
|-----------------------------------|---------------------|----------------------|
|                                   | <b>£000</b>         | <b>£000</b>          |
| <b>Carrying value at 31 March</b> | 10,457              | 10,610               |
| Lease additions                   | 64                  | 1,000                |
| Lease liability remeasurements    | 564                 | 1,329                |
| Interest charge arising in year   | 120                 | 132                  |
| Lease payments (cash outflows)    | <u>(2,760)</u>      | <u>(2,614)</u>       |
| <b>Carrying value at 31 March</b> | <u><b>8,445</b></u> | <u><b>10,457</b></u> |

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 its right of use assets.

**Note 13.5 Maturity analysis of future lease payments**

|  | <b>Total</b>         | <b>Of which</b>      |
|--|----------------------|----------------------|
|  | <b>31 March 2025</b> | <b>leased from</b>   |
|  | <b>£000</b>          | <b>DHSC group</b>    |
|  |                      | <b>bodies:</b>       |
|  |                      | <b>31 March 2025</b> |
|  |                      | <b>£000</b>          |
| 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                    | <u><b>8,692</b></u>  | <u><b>342</b></u>    |
| Finance charges allocated to future periods          | <u><b>(247)</b></u>  | <u><b>(12)</b></u>   |
| <b>Net lease liabilities at 31 March 2025</b>        | <u><b>8,445</b></u>  | <u><b>330</b></u>    |
| Of which:  |                      |                      |
| - Current  | 1,976                | 180                  |
| - Non-Current  | 6,469                | 150                  |

|  | <b>Total</b>         | <b>Of which</b>      |
|--|----------------------|----------------------|
|  | <b>31 March 2024</b> | <b>leased from</b>   |
|  | <b>£000</b>          | <b>DHSC group</b>    |
|  |                      | <b>bodies:</b>       |
|  |                      | <b>31 March 2024</b> |
|  |                      | <b>£000</b>          |
| Undiscounted future lease payments payable in:       |                      |                      |
| - not later than one year;                           | 2,661                | 187                  |
| - later than one year and not later than five years; | 6,367                | 321                  |
| - later than five years.                             | 1,780                | 0                    |
| Total gross future lease payments                    | <u><b>10,808</b></u> | <u><b>508</b></u>    |
| Finance charges allocated to future periods          | <u><b>(351)</b></u>  | <u><b>(25)</b></u>   |
| <b>Net lease liabilities at 31 March 2024</b>        | <u><b>10,457</b></u> | <u><b>483</b></u>    |
| Of which:  |                      |                      |
| - Current  | 2,530                | 167                  |
| - Non-Current  | 7,927                | 316                  |

**Note 14. Inventories**
**Note 14.1 Inventory movements 2024/25**

|   | Total        | Drugs        | Consumables  | Consumables<br>donated from<br>DHSC group<br>bodies |
|---|--------------|--------------|--------------|---|
|   | £000         | £000         | £000         | £000  |
| Carrying value at 1 April 2024                | 4,226        | 1,864        | 2,362        | 0   |
| Additions                                     | 49,111       | 22,840       | 26,271       | 0   |
| Additions (donated) - from DHSC               | 0            | 0            | 0            | 0   |
| Inventories consumed (recognised in expenses) | (49,289)     | (22,901)     | (26,388)     | 0   |
| <b>Total as at 31 March 2025</b>              | <b>4,048</b> | <b>1,803</b> | <b>2,245</b> | <b>0</b>  |

**Note 14.1 Inventory movements 2023/24**

|   | Total        | Drugs        | Consumables  | Consumables<br>donated from<br>DHSC group<br>bodies |
|---|--------------|--------------|--------------|---|
|   | £000         | £000         | £000         | £000  |
| Carrying value at 1 April 2023                | 4,145        | 1,694        | 2,451        | 0   |
| Additions                                     | 45,764       | 21,408       | 24,356       | 0   |
| Additions (donated) - from DHSC               | 72           | 0            | 0            | 72  |
| Inventories consumed (recognised in expenses) | (45,755)     | (21,238)     | (24,445)     | (72)  |
| <b>Total as at 31 March 2024</b>              | <b>4,226</b> | <b>1,864</b> | <b>2,362</b> | <b>0</b>  |

**Note 15. Trade and other receivables**

|   | 2024/25<br>£000 | 2023/24<br>£000 |
|---|-----------------|-----------------|
| <b>Current</b>  |                 |                 |
| Contract receivables (IFRS 15): invoiced                        | 5,065           | 2,217           |
| Contract receivables (IFRS 15): not yet invoiced / non-invoiced | 797             | 5,547           |
| Allowance for impaired contract receivables / assets            | (1,608)         | (1,672)         |
| Prepayments   | 2,316           | 3,183           |
| PDC dividend receivable   | 0               | 299             |
| VAT receivable  | 1,275           | 1,865           |
| Clinical pension tax provision reimbursement funding from NHSE  | 41              | 18              |
| Other receivables   | 1,678           | 1,774           |
| <b>Total current trade and other receivables</b>                | <b>9,564</b>    | <b>13,231</b>   |
| <b>Non current</b>  |                 |                 |
| Contract receivables (IFRS 15): not yet invoiced / non-invoiced | 869             | 720             |
| Allowance for impaired contract receivables / assets            | (532)           | (316)           |
| Clinician pension tax provision reimbursement funding from NHSE | 420             | 448             |
| <b>Total non current trade and other receivables</b>            | <b>757</b>      | <b>852</b>      |
| <b>Total trade and other receivables</b>                        | <b>10,321</b>   | <b>14,083</b>   |
| <b>Of which receivable from NHS and DHSC group bodies:</b>      |                 |                 |
| Current   | 2,609           | 3,840           |
| Non-current   | 420             | 448             |

**Note 16. Non-current assets held for sale and assets in disposal groups**

|   | 2024/25<br>£000 | 2023/24<br>£000 |
|---|-----------------|-----------------|
| <b>NBV of non-current assets for sale and assets in disposal groups at 1 April</b>  | <b>0</b>        | <b>0</b>        |
| Assets classified as available for sale in the year                                 | 132             | 132             |
| <b>NBV of non-current assets for sale and assets in disposal groups at 31 March</b> | <b>132</b>      | <b>132</b>      |

**Note 17.1 Allowances for credit losses - 2024/25**

|  | All<br>receivables<br>£000 |
|--|----------------------------|
| <b>Allowances as at 1 April 2024 - brought forward</b> | 1,988                      |
| New allowances arising                                 | 208                        |
| Reversals of allowances                                | (21)                       |
| Utilisation of allowances (write offs)                 | (35)                       |
| <b>Allowances as at 31 March 2025</b>                  | <u><u>2,140</u></u>        |

**Note 17.2 Allowances for credit losses - 2023/24**

|  | All<br>receivables<br>£000 |
|--|----------------------------|
| <b>Allowances as at 1 April 2023 - brought forward</b> | 1,826                      |
| New allowances arising                                 | 232                        |
| Utilisation of allowances (write offs)                 | (70)                       |
| <b>Allowances as at 31 March 2024</b>                  | <u><u>1,988</u></u>        |

**Note 18. Cash and cash equivalents**

|                       | 2024/25<br>£000      | 2023/24<br>£000      |
|-----------------------|----------------------|----------------------|
| As at 1 April         | 17,634               | 34,926               |
| Net change in year    | (1,658)              | (17,292)             |
| <b>As at 31 March</b> | <u><u>15,976</u></u> | <u><u>17,634</u></u> |

**Breakdown of cash and cash equivalents**

|   | 2024/25<br>£000      | 2023/24<br>£000      |
|---|----------------------|----------------------|
| Cash at commercial banks and in hand            | 27                   | 5                    |
| Cash with the Government Banking Service        | 15,949               | 17,629               |
| <b>Cash and cash equivalents as at 31 March</b> | <u><u>15,976</u></u> | <u><u>17,634</u></u> |

**Third party assets held by the Trust**

|           |           |
|-----------|-----------|
| <b>22</b> | <b>21</b> |
|-----------|-----------|

As at 31 March 2025 the Trust held £22k (£21k as at 31 March 2024) 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**

|  | 2024/25<br>£000      | 2023/24<br>£000      |
|--|----------------------|----------------------|
| <b>Current</b>   |                      |                      |
| Trade payables   | 10,805               | 8,176                |
| Trade payables capital                                   | 7,089                | 7,313                |
| Accruals   | 11,225               | 17,006               |
| Annual leave accrual                                     | 1,215                | 1,661                |
| Social security costs                                    | 2,413                | 2,590                |
| Other taxes payable                                      | 2,841                | 3,169                |
| PDC dividend payable                                     | 500                  | 0                    |
| Pension contributions payable                            | 3,191                | 2,956                |
| Other payables   | 712                  | 467                  |
| <b>Total trade and other payables</b>                    | <u><u>39,991</u></u> | <u><u>43,338</u></u> |
| <b>Of which payables from NHS and DHSC group bodies:</b> |                      |                      |
| Current  | 4,200                | 6,097                |

**Note 20. Other liabilities**

|                                | 2024/25      | 2023/24      |
|--------------------------------|--------------|--------------|
|                                | £000         | £000         |
| Deferred income                | 5,466        | 4,587        |
| <b>Total other liabilities</b> | <b>5,466</b> | <b>4,587</b> |

**Note 21. Borrowings**

|                                     | 2024/25      | 2023/24       |
|-------------------------------------|--------------|---------------|
|                                     | £000         | £000          |
| <b>Current</b>                      |              |               |
| Lease liabilities                   | 1,976        | 2,530         |
| <b>Total current borrowings</b>     | <b>1,976</b> | <b>2,530</b>  |
| <b>Non-current</b>                  |              |               |
| Lease liabilities                   | 6,469        | 7,927         |
| <b>Total non-current borrowings</b> | <b>6,469</b> | <b>7,927</b>  |
| <b>Total borrowings</b>             | <b>8,445</b> | <b>10,457</b> |

**Note 21.1 Reconciliation of lease liabilities arising from financing activities**

|  | 2024/25      | 2023/24       |
|--|--------------|---------------|
|  | £000         | £000          |
| <b>Carrying value at 1 April</b>   | 10,457       | 10,610        |
| <b>Cash movements:</b>   |              |               |
| Financing cash flows - payments and receipts of principal                | (2,640)      | (2,482)       |
| Financing cash flows - payments of interest                              | (120)        | (132)         |
| <b>Non-cash movements:</b>   |              |               |
| Additions  | 64           | 1,000         |
| Lease liability remeasurements   | 564          | 1,329         |
| Interest charge arising in year (application of effective interest rate) | 120          | 132           |
| <b>Carrying value at 31 March</b>  | <b>8,445</b> | <b>10,457</b> |

**Note 22. Provisions**

|  | 2024/25      |             |              |  |              |
|--|--------------|-------------|--------------|--|--------------|
|  | Total        | Legal       | Other        | Clinical Pension<br>Tax<br>Reimbursement | Pensions     |
| <b>Movements in provisions for liabilities and charges</b> | <b>£000</b>  | <b>£000</b> | <b>£000</b>  | <b>£000</b>                              | <b>£000</b>  |
| 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)          |
| <b>As at 31 March 2025</b>                                 | <b>2,724</b> | <b>79</b>   | <b>1,215</b> | <b>461</b>                               | <b>969</b>   |
| <b>Expected timing of cash flows:</b>                      |              |             |              |  |              |
| 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            |
| <b>Total</b>   | <b>2,724</b> | <b>79</b>   | <b>1,215</b> | <b>461</b>                               | <b>969</b>   |
|  | 2023/24      |             |              |  |              |
|  | Total        | Legal       | Other        | Clinical Pension<br>Tax<br>Reimbursement | Pensions     |
| <b>Movements in provisions for liabilities and charges</b> | <b>£000</b>  | <b>£000</b> | <b>£000</b>  | <b>£000</b>                              | <b>£000</b>  |
| As at 1 April 2023   | 2,940        | 112         | 1,222        | 567                                      | 1,039        |
| Change in the discount rate                                | (64)         | 0           | 0            | (101)                                    | 37           |
| Arising during the year                                    | 2,763        | 124         | 2,571        | 0  | 68           |
| Utilised during the year                                   | (138)        | (14)        | 0            | (5)                                      | (119)        |
| Reversed unused  | (395)        | (87)        | (283)        | (25)                                     | 0            |
|  | 30           | 0           | 0            | 30                                       | 0            |
| <b>As at 31 March 2024</b>                                 | <b>5,136</b> | <b>135</b>  | <b>3,510</b> | <b>466</b>                               | <b>1,025</b> |
| <b>Expected timing of cash flows:</b>                      |              |             |              |  |              |
| Within one year  | 2,849        | 135         | 2,571        | 18                                       | 125          |
| Between one and five years                                 | 1,749        | 0           | 939          | 34                                       | 776          |
| After five years   | 538          | 0           | 0            | 414                                      | 124          |
| <b>Total</b>   | <b>5,136</b> | <b>135</b>  | <b>3,510</b> | <b>466</b>                               | <b>1,025</b> |

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**

£141m is included in the provisions of NHS Resolution as at 31 March 2025 in respect of clinical negligence and employer liabilities of the Trust (£138m as at 31 March 2024).

**Note 23. Contingent liabilities**

|  | 31 March    | 31 March    |
|--|-------------|-------------|
|  | 2025        | 2024        |
| <b>Value of contingent liabilities</b>       | <b>£000</b> | <b>£000</b> |
| NHS Resolution legal claims                  | (12)        | (44)        |
| <b>Gross value of contingent liabilities</b> | <b>(12)</b> | <b>(44)</b> |
| Amounts recoverable against liabilities      | 0           | 0           |
| <b>Net value of contingent liabilities</b>   | <b>(12)</b> | <b>(44)</b> |

## **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 (Clinical Commissioning Groups from April to June 2022). 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 16. Of those assets which require an allowance for credit losses none are impaired financial assets (none in 2023/24).

There are no financial assets that would otherwise be past due date or impaired whose terms have been renegotiated (none in 2023/24).

#### ***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<br>amortised<br>cost<br>£000 | Held at fair<br>value<br>through<br>I&E<br>£000 | Held at fair<br>value<br>through<br>OCI<br>£000 | Total<br>£000 |
|---|--------------------------------------|---|---|---------------|
| <b>Carrying values of financial assets as at 31 March 2025</b>        |                                      |   |   |               |
| 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        |
| <b>Total as at 31 March 2025</b>                                      | <b>22,706</b>                        | <b>0</b>  | <b>0</b>  | <b>22,706</b> |

|   | Held at<br>amortised<br>cost<br>£000 | Held at fair<br>value<br>through<br>I&E<br>£000 | Held at fair<br>value<br>through<br>OCI<br>£000 | Total<br>£000 |
|---|--------------------------------------|---|---|---------------|
| <b>Carrying values of financial assets as at 31 March 2024</b>        |                                      |   |   |               |
| Receivables (excluding non financial assets) - with DHSC group bodies | 3,989                                | 0   | 0   | 3,989         |
| Receivables (excluding non financial assets) - with other bodies      | 4,747                                | 0   | 0   | 4,747         |
| Cash and cash equivalents at bank and in hand                         | 17,634                               | 0   | 0   | 17,634        |
| <b>Total as at 31 March 2024</b>                                      | <b>26,370</b>                        | <b>0</b>  | <b>0</b>  | <b>26,370</b> |

**Note 24.3 Carrying value of financial liabilities**

|   | Held at<br>amortised<br>cost<br>£000 | Held at fair<br>value<br>through the<br>I&E<br>£000 | Total<br>£000 |
|---|--------------------------------------|---|---------------|
| <b>Carrying values of financial liabilities as at 31 March 2025</b>                     |                                      |   |               |
| Obligations under 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        |
| <b>Total as at 31 March 2025</b>  | <b>38,276</b>                        | <b>0</b>  | <b>38,276</b> |

|   | Held at<br>amortised<br>cost<br>£000 | Held at fair<br>value<br>through the<br>I&E<br>£000 | Total<br>£000 |
|---|--------------------------------------|---|---------------|
| <b>Carrying values of financial liabilities as at 31 March 2024</b>                     |                                      |   |               |
| Obligations under finance leases  | 10,457                               | 0   | 10,457        |
| Trade and other payables (excluding non financial liabilities) - with DHSC group bodies | 5,305                                | 0   | 5,305         |
| Trade and other payables (excluding non financial liabilities) - with other bodies      | 29,318                               | 0   | 29,318        |
| <b>Total as at 31 March 2024</b>  | <b>45,080</b>                        | <b>0</b>  | <b>45,080</b> |

**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**

|   | <b>31 March<br/>2025<br/>£000</b> | <b>31 March<br/>2024<br/>£000</b> |
|---|-----------------------------------|-----------------------------------|
| <b>Financial liabilities fall due in:</b>       |                                   |                                   |
| One year or less                                | 31,900                            | 37,284                            |
| More than one year but not more than five years | 6,152                             | 6,367                             |
| More than five years                            | 471                               | 1,780                             |
| <b>Total</b>                                    | <b><u>38,523</u></b>              | <b><u>45,431</u></b>              |

**Note 25. Contractual Capital Commitments**

The Trust has contractual capital commitments of £3.8m as at 31 March 2025 (£6.2m as at 31 March 2024). This includes: Ward Refurbishment £2.0m, TIF £0.5m, Appleton Ventilation £0.3m, Pharmacy Aseptic Unit £0.3m, Pneumatic Tube Transport System £0.2m, Doctors Mess £0.1m and other building works £0.4m.

**Note 26. Related party disclosures**

**Note 26.1 Related party transactions**

| <b>Value of transactions with other related parties in 2024/25</b> | <b>Revenue<br/>£000</b> | <b>Expenditure<br/>£000</b> |
|--|-------------------------|-----------------------------|
| Charitable funds (where not consolidated)                          | 0                       | 0                           |
| <b>Total value of transactions with related parties in 2024/25</b> | <b><u>0</u></b>         | <b><u>0</u></b>             |

| <b>Value of transactions with other related parties in 2023/24</b> | <b>Revenue<br/>£000</b> | <b>Expenditure<br/>£000</b> |
|--|-------------------------|-----------------------------|
| Charitable funds (where not consolidated)                          | 0                       | 0                           |
| <b>Total value of transactions with related parties in 2023/24</b> | <b><u>0</u></b>         | <b><u>0</u></b>             |

**Note 26.2 Related party balances**

| <b>Value of balances with other related parties as at 31 March 2025</b>       | <b>Receivables<br/>£000</b> | <b>Payables<br/>£000</b> |
|---|-----------------------------|--------------------------|
| Charitable funds (where not consolidated)                                     | 62                          | 0                        |
| <b>Total value of balances with other related parties as at 31 March 2025</b> | <b><u>62</u></b>            | <b><u>0</u></b>          |

| <b>Value of balances with other related parties as at 31 March 2024</b>       | <b>Receivables<br/>£000</b> | <b>Payables<br/>£000</b> |
|---|-----------------------------|--------------------------|
| Charitable funds (where not consolidated)                                     | 298                         | 0                        |
| <b>Total value of balances with other related parties as at 31 March 2024</b> | <b><u>298</u></b>           | <b><u>0</u></b>          |

**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**

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

**Note 28. Losses and special payments**

|  | <b>2024/25</b> |             |
|--|----------------|-------------|
|  | <b>Number</b>  | <b>£000</b> |
| <b>Losses</b>                                  |                |             |
| Bad debts and claims abandoned                 | 39             | 31          |
| Stores losses and damage to property           | 24             | 418         |
| <b>Total losses</b>                            | <b>63</b>      | <b>449</b>  |
| <b>Special payments</b>                        |                |             |
| Ex-gratia payments                             | 33             | 122         |
| Special severance payments                     | 1              | 8           |
| <b>Total special payments</b>                  | <b>34</b>      | <b>130</b>  |
| <b>Total losses and special payments</b>       | <b>97</b>      | <b>579</b>  |
| <b>Value of compensation payments received</b> |                | <b>124</b>  |
|  |                |             |
|  | <b>2023/24</b> |             |
|  | <b>Number</b>  | <b>£000</b> |
| <b>Losses</b>                                  |                |             |
| Bad debts and claims abandoned                 | 28             | 8           |
| Stores losses and damage to property           | 24             | 237         |
| <b>Total losses</b>                            | <b>52</b>      | <b>245</b>  |
| <b>Special payments</b>                        |                |             |
| Ex-gratia payments                             | 39             | 39          |
| <b>Total special payments</b>                  | <b>39</b>      | <b>39</b>   |
| <b>Total losses and special payments</b>       | <b>91</b>      | <b>284</b>  |
| <b>Value of compensation payments received</b> |                | <b>65</b>   |

There were no individual cases exceeding £0.3m in either 2024/25 or 2023/24.

## 7.5

### **Independent auditor's report to the members of the Council of Governors of Warrington and Halton Teaching Hospitals NHS FT**

#### **Audit completion**

In our auditor's report, issued on 24 June 2025, for Warrington and Halton Teaching Hospitals NHS FT (the 'Trust') for the year ended 31 March 2025, we reported an unqualified opinion on the Trust's financial statements.

We explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2025, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had received confirmation from the National Audit Office (NAO) that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. The NAO has confirmed the audit of the NHS group consolidation is complete for the year ended 31 March 2025.

We are therefore satisfied all audit work necessary has been completed.

#### **Report on other legal and regulatory requirements - the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources**

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

In our auditor's report for the year ended 31 March 2025 issued on 24 June 2025 we reported that: we have nothing to report in respect of whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025 except on 23 June 2025 we identified a significant weakness in how the Trust plans and manages its resources to ensure it can continue to deliver its services. This is in relation to:

- the trust did not have in place a medium term financial plan during 2024/25, and although the trust delivered 95% of its Cost Improvement Plan (CIP) these savings were not all recurrent and the trust faces an increased challenge to deliver CIP of £21.5m in 2025/26. This together with unidentified expenditure reductions indicates the trust is facing significant financial sustainability challenges.
  - We recommend the Trust develops a multi-year financial plan which delivers financial balance in the medium term and is based upon realistic assumptions that are supported by all partners. The Trust should also place a significant organisational focus on identifying, in collaboration with system partners, efficiencies which form part of the Trusts 2025/26 Plan. We also recommend the Trust Board closely monitors progress made by the Trust to identify such system efficiencies and considers the risk of non delivery on the viability of the 2025/26 Plan as part of the Board Assurance Framework.

No matters have come to our attention since that date that would have resulted in any additional exception reporting on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

## Report on other legal and regulatory requirements – audit certificate

We certify that we have completed the audit of Warrington and Halton Teaching Hospitals NHS FT for the year ended 31 March 2025 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

### 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

19 December 2025







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