NHS
Bridgewater Community Healthcare
NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS

2024 - 2025

Communities Matter

Creating stronger, healthier, happier communities.

Bridgewater Community Healthcare NHS Foundation Trust

Annual Report and Accounts 2024-25

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

Contents

1. Statement from Chair and Chief Executive

As Chair and Chief Executive of Bridgewater Community Healthcare NHS FT, it is a great pleasure and privilege to present our Annual Report & Accounts for 2024-25.

This has been a year of significant change within Bridgewater, yet the constant remains to ensure our patients, their families and carers continue to receive the very best care within the communities we serve.

Investment in community services is vital if we are to continue to grow and develop the network of care and support our patients need.

We have long recognised and openly discussed the need to better integrate our services with those provided by our hospital colleagues. At the start of the financial year, we entered formal discussions with our colleagues at Warrington & Halton Hospitals NHS FT, to better understand how integration of community and acute services might look and feel for our patients. This process of integration is being replicated across the Cheshire & Merseyside area and is being overseen by our colleagues in the Integrated Care Board. Such a process is complex and challenging but is the right thing to do.

In September 2024, long-standing Chief Executive Colin Scales left the organisation to pursue his NHS career in the Greater Manchester region. We wish to place on record our thanks for his years of dedicated service to the NHS and Bridgewater in particular.

In October 2024, the Boards of Bridgewater & Warrington & Halton Hospitals announced the appointment of Mr Nikhil Khashu as Joint Chief Executive. This appointment has supported a focused approach to the two organisations working better together for the benefits of the communities they serve.

The shared ambitions as set out in *Better Care Together: A Case for Change* articulates these intentions and explains the benefits of integration to our patients, partners and commissioners. We are both convinced we can achieve great things by pooling the knowledge, skills and resources within the two organisations.

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.

We have made a very clear commitment to engage, involve and communicate. We are making very real and steady progress in achieving our ambitions and have set an extremely challenging deadline of delivering a truly, integrated model of care by April 2027. Running alongside this is the challenge posed nationally to deliver neighbourhood health services models to prevent long and costly hospital admissions and we are extremely proud of the progress we are making in this area.

Our family hubs in Halton provide families with a wide range of health and social care services from one, single building, our frailty wards in Halton & Warrington are providing patients with

the targeted, multi-agency care and support patients receive on these wards support their safe discharge into community settings – be that their own homes or residential care facilities.

Strong leadership is key to delivering on the challenges we face. In February 2025, the Bridgewater Council of Governors approved the appointment of Non-Executive Director Martyn Taylor as Interim Chair of the organisation. Martyn will take up the position of Chair on April 1, 2025. This followed my own announcement as Chair to step down from the role on March 31, 2025. It is a role that I feel enormously proud and privileged to have held and I wish all my colleagues in Bridgewater and Warrington & Halton Hospitals every success in the future.

These are extremely difficult times for the NHS – we are both profoundly aware of the many challenges we face in continuing to meet ever increasing demand with limited resources at our disposal.

Throughout the year we have focused on how we might better deliver the care our patients needs in more imaginative and innovative ways. We cannot and shall not shy away from the difficult decisions, but we shall be open, honest and transparent in all our decision making.

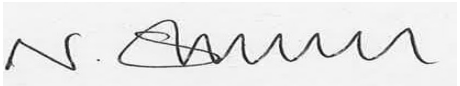
In all our discussions with colleagues, partners and stakeholders we are articulating the challenges we face and how we might better address them by working better together. There are many people within our communities who are living with complex health and social care needs.

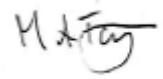
Our staff are our greatest asset and are ambassadors for the organisation. Our ambitions are vested in their knowledge, skills, and experience. The continued pressures within the health and social care systems locally, regionally, and nationally and the impact on our own workforce should not be underestimated.

We are committed to deliver a health care system that provides our patients and their families with seamless packages of care, that means they need only tell their story once and ensures they are receiving the care they need in the most appropriate setting.

Breaking down the barriers that has stalled integration in the past will require a shared sense of purpose and commitment, but we believe we have laid the foundations to build a health care system that better needs patient needs whilst ensuring the services within our communities and hospitals remain of the very highest quality.

Our annual report provides us with a unique opportunity to showcase some of the remarkable work that goes on within the Trust every day and we remain indebted to our staff for their continued commitment to their patients and families.





Nikhil Khashu

CHIEF EXECUTIVE OFFICER

Martyn Taylor

CHAIR (appointed 1 April 2025)

The statement from the Chair and Chief Executive includes contributions from Karen Bliss, who held the position of Chair during the reporting year.

2. Performance Report

2.1 Overview of Performance

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

Chief Executive's statement

Since my appointment as joint Chief Executive of Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals, I have been privileged to witness the dedication, skill, and compassion of colleagues across our services. From homes to hospitals, from clinics to community hubs, our teams work tirelessly to ensure patients receive the highest quality care, often in the most challenging circumstances.

I would like to extend my sincere gratitude to my predecessor Mr Colin Scales, who left Bridgewater in September 2024, and to Mrs Karen Bliss, who stepped down as Chair at the end of March 2025. Their leadership and commitment to community services have laid the groundwork for the next phase of our journey - one that embraces integration, innovation, and collaboration.

Our 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.

At the heart of our success is our people. I have been particularly inspired by our apprenticeship programme, which is nurturing the next generation of healthcare professionals - many of whom live in the very communities they now serve. Investing in our workforce, fostering talent, and supporting professional development is not only the right thing to do but essential for the sustainability of our services.

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 I look forward to sharing more successes in the future.

Every day, I am humbled by the stories of patients, families, and carers who share their experiences with us. Their feedback reminds us why we do what we do and reinforces our commitment to continuous improvement. Community services are a cornerstone of our healthcare system, and we must continue to strengthen them - through investment in facilities, digital transformation, and innovative models of care.

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 I am confident that, together, we can build a stronger, more integrated health and care system - one that truly meets the needs of those we serve.

To my colleagues across both Trusts: thank you. Your passion, expertise, and unwavering commitment inspires me every day, and I am proud to be on this journey with you.

Profile of the Trust

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

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

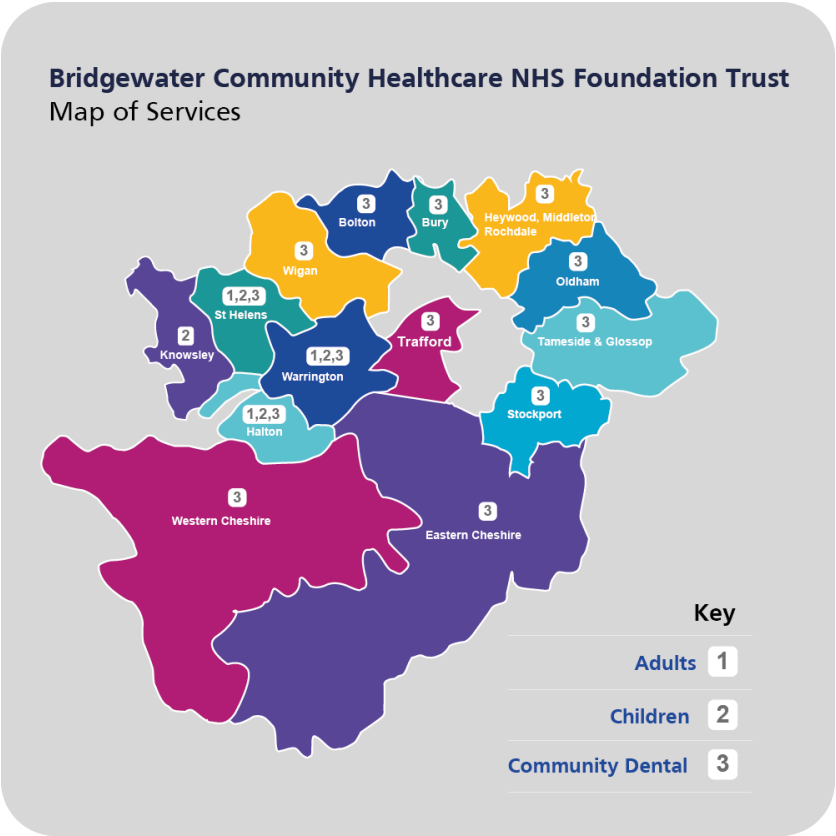
The Trust is part of the Cheshire & Merseyside Integrated Care System (ICS), place-based partnerships and Provider Collaboratives which deliver joined up approaches to improve health and care outcomes.

During 2024-25 Bridgewater provided community adult and children's nursing and therapy services in Halton, Warrington and St Helens.

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

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

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



In 2024, the Trust embarked upon an ambitious programme of integration with colleagues at Warrington & Halton Hospitals NHS FT.

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

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

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

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

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

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

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

In January 2025, the two Trusts launched an engagement exercise involving its members, governors, patients and stakeholders to seek their views about a name for the new organisation.

Warrington Adults

Our Warrington Adults' Services has a large team of community nurses supported by specialised nurses and matrons. The services provided include:

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

Halton and St Helens Adults

Our Halton Adults' Services comprise of a large team of community nurses supported by specialist nurses , therapists and community matrons. We work with system partners across Halton and Warrington to provide an urgent community response service within the borough and have recently launched our frailty virtual ward. We deliver a multi-disciplinary neuro rehabilitation service, stroke and heart failure services within Halton supporting our local community to promote self-care and the prevention of ill health and support the reduction of unavoidable admissions to our acute partners.

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

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

Children's Services

We provide services for children and young people from birth to 19 years old, and up to 25 years old for those with special educational needs in Warrington and Halton. Our specialised children's services include audiology, occupational therapy, physiotherapy, and speech and language therapy. Additionally, we offer community paediatric services and manage the neurodevelopment pathway in both Warrington and Halton.

Specialised Dental Services

The Bridgewater Dental Network currently provides services to a combined population of over two million people, who live across Cheshire, Merseyside and Greater Manchester. We provide specialised dental care on referral to people of all ages, with disabilities and special needs which make it impossible for them to access treatment from an NHS family dentist (General Dental Practice). We also are commissioned to provide a specialist oral surgery service and intravenous service for anxious adults in Cheshire and Merseyside.

The majority of our services are delivered in patients' homes or at locations close to where they live. This varies from clinics and health centres to GP practices and schools. As a provider of mainstream and specialist care, our role is to focus on providing cost effective NHS care.

We do this by keeping people out of hospital and supporting vulnerable people throughout their lives. As a dedicated provider of community services our strategy is to bring more care closer to home.

This means providing a wider range of services in community settings and to keep people healthier for longer by developing more specialist services to support people to live independently at home.

Staff headcount and Operating Income

On 31 March 2025, the headcount of our staff was 1655, and the whole time equivalent (WTE) was 1399.30. All staff are Staff Members of our Foundation Trust unless they opt out.

Operating Income

Our income for the year ended 31 March 2025 totalled £107.6m (2023-24: £101.9m) and included:

ICB and NHS England	£80.1m (2023-24 £77.0m)
Local authorities	£16.4m (2023-24 £16.2m)

Health Education England	£1.4m (2023-24 £1.5m)
Other NHS Providers	£2.4m (2023-24 £2.4m)

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

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

Our Mission and Strategy

Where people live matters. Communities matter.

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

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

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

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

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

Our mission statement is:

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

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

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

Our six Strategic Objectives are:

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

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

We are working to improve healthcare for our communities and have embarked on a process of integration with Warrington and Halton Hospitals NHS Foundation Trust. Since 2024, we have been moving towards working as one to ensure our healthcare system is sustainable for

the future. This includes establishing a formal partnership to deliver greater integration of community and hospital services with shared leadership and governance arrangements. These changes will help us develop new models of care with more care delivered at home and in the community and designed in partnership with a wide range of partners and voices, including primary care, local authorities and people with lived experience of health services.

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

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

Communities matter.

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

Influences and risks

The Trust will be exposed to many external influences and risks which will change and drive the way services are delivered in years to come.

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

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

Political	• The Integrated Care System (ICS) and place-based infrastructure and commissioning arrangements • Increased financial challenges for the entire system • Potential lack of coordination across the system when setting commissioning strategies • Patient choice and NHS Constitution • Impact of integration with, and across, local partners and Provider Collaboratives
Economic	• The current cost of living crisis, for the people we serve and our staff • Risk to sustained transformation programmes within current resources • Continued impact of reduced funding and ambitious Cost Improvement Programme (CIP) • Increasing demands e.g. increased acuity of patients' conditions, ageing population and long-term conditions

	• Reduction in services from system partners due to budgetary pressure and challenges • Current industrial action being witnessed across many UK sectors
Sociological	• Demographic changes and impact i.e. ageing population and health inequalities across local communities • Global pandemic which highlighted health disparities and complex access issues across different ethnic communities • People with increasing dependency on services for their long-term health and social care needs • Varied levels of deprivation across all boroughs and local neighbourhoods • Increased emphasis on community based preventative healthcare / self-management and health creation • Increased choice for where care is received e.g. in community, at home etc. • Growing culture of assertive consumerism with increasing expectation
Technological	• New IT solutions: People powered technology e.g. telehealth / telemedicine • New and innovative technologies to drive and transform how care and services are accessed and / or delivered • Alignment and sharing of data and information across IT platforms, and between partners • Greater access to the internet, apps and remote assessment • Potential for a widening of the digital inclusion / exclusion divide • Availability of new drugs to support conditions and disease • Diagnostic / service capability i.e. opening up opportunities for delivery of more services / diagnostics outside the acute hospital sector • Innovation to support care delivery and staff mobilisation e.g. Electronic Patient Records (EPR), Virtual Wards and agile working • A hybrid approach to home / office working, security and reliability • Maintenance and replacement of hardware / communications network / software
Legal	• Future organisational legal status i.e. ICSs • Changes due to reversion to UK law • Regulatory environment i.e. regulatory checks, changing CQC approach, NICE guidelines, governance etc. • Potential future changes to staff terms and conditions • On-going changes to drug and equipment licencing between EU and UK
Environmental	• Estates, i.e. available estate to meet expectations and requirements • Green Plan and Carbon Reduction targets • Investment in smart buildings control systems

	• Corporate responsibility to environmental factors e.g. carbon footprint, recycling etc. • Focus on NHS Prevention Pledge and Anchor Institution status • Provision of sustainable care • Increasing estate and utility costs

Going Concern

These accounts have been prepared on a going concern basis.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. The Trust is also required to disclose material uncertainties in respect of events or conditions that may cast significant doubt upon the going concern ability of the Trust and the Trust does not consider that there are any such events or conditions requiring disclosure. However, details have been provided below in respect of future potential core activity changes.

The Trust reported a deficit of £1.196m in 2024-25. However, this includes adjusting items such as the net impact of Department of Health and Social Care (DHSC) procured inventories. Excluding these items, the Trust's adjusted financial position for 2024-25 is a deficit of £1.156m.

The Trust has submitted a 2025/26 plan to both NHS Cheshire and Merseyside ICB and NHS England (NHSE) showing a deficit of £1.53m. The Board has approved the plan.

The Trust continues to actively seek new business opportunities with Commissioners either through tendering opportunities being advertised or collaborative working.

The Trust will potentially be acquired by Warrington and Halton Hospitals NHS Foundation Trust from 1 April 2027. Due to the continuity of services provision principle, this has no impact on the continued application of the Going Concern Principle.

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

Service Improvement and Transformation - Key Achievements in 2024-25

Halton Adult Services

Widnes Urgent Treatment Centre

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

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

The outcome of our most recent assessment, undertaken in October 2024, reported that patient assessors were happy with the environment of Widnes Urgent Treatment Centre (UTC) and were very confident that a good level of patient care and experience is being delivered . Comments were received that the building was generally nice, bright and welcoming, and that staff were friendly and helpful in their manner. They made some recommendations for how the environment could be further improved; these recommendations have been developed into an action plan for the service to implement. Assessors who returned in 2024 were pleased with the improvements made following the previous year's assessment.

Halton Urgent Community Response

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

The service continues to work in close partnership with the Mental Health, Learning Disabilities, and community collaborative Urgent Community Response Project Group. This group has focused on key Cheshire and Merseyside workstreams including development of the clinical navigator role supporting the pro-active deflection of activity from the 999 emergency calls directly to the two-hour response time offered by Urgent Community Response services supporting the call before conveyance workstreams.

Community Nursing Teams

Work has continued in 2024-25 to develop a new delivery model of community nursing which continues to deliver a high-quality service for patients whilst ensuring sustainability and resilience in the workforce.

Recruitment and retention of the nursing workforce have been key objectives of this piece of work and our senior community nursing role continues to be embedded within the services. In 2025-26 work will continues to develop the community nursing model focusing on seamless pathways of care.

Drive Ability North West

The Drive Ability North West service continues to grow and develop having increased the number and partnerships of our outreach services. The service is now working collaboratively with all local police forces, including Lancashire Police force to widen the avoidance of police prosecution schemes. 2025-26 will see the service move to their new operational delivery base.

Heart Failure

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

This workstream looks to improve access and health outcomes for those with heart failure. Work is currently focusing on development of a multi-disciplinary integrated hub for patients, reducing the structural challenges and inequalities across the healthcare system related to this condition.

The project has recently been nominated and shortlisted for a Health Service Journal award for their innovative integrated approach to patient care.

Halton Palliative Care Team

In the last 12 months, Halton Palliative Care Team has supported 156 patients to die in their preferred place of death.

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

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

The team have re-established education sessions for District Nurses(DNs) and provided education for the Out of Hours District Nursing (OOH DN) service. The team have also delivered face to face and virtual sessions for all community nurses to prepare for the launch of new prescribing guidance.

Podiatry

Halton Podiatry waiting list has been significantly high for several years and steadily increasing over the last couple of years. This year, the team have worked extremely hard to try to reduce it. In the last 12 months, they have reduced the waiting list by 40% which is no mean feat considering the volume of referrals received by the service every month.

A high level of knowledge, skill and expertise is required to deliver high quality safe and effective podiatry interventions to patients, especially those at high risk. Specialist podiatry intervention can prevent the need for amputation and hospital admissions. The team are keen to promote professional development and have supported one member of staff to undertake the Advanced Clinical Practice qualification and a third member of staff to complete the V300 Non-Medical Prescribers qualification.

Halton Podiatry is undergoing a transformation to ensure that the resources which are available are delivered in the most efficient and effective way and directed at those with the

highest clinical need. The team have developed a new needs-based eligibility criteria that is supported by evidence based best practice. The project has been ongoing throughout the year but is now at a point where the service is ready to share the changes and engage and communicate with the public and all stakeholders across Halton.

Wellbeing

The new Team Lead has been working closely with the Data Improvement Team to ensure accurate recording of performance figures in line with NHS England (NHSE) requirements. According to the quarterly data recorded by the Integrated Care Board (ICB), the team have been constantly underperforming and not meeting their targets; yet local Egton Medical Information System (EMIS) data contradicted this and showed that the team were meeting their targets. The lack of correlation between the ICB and EMIS data was explored by the Team Lead and Data Improvement Team. There were several potential issues around coding and the way that the information was recorded that could explain the anomalies. These issues have been addressed, and we are awaiting the latest quarterly data to assess the outcome of this work.

Following a Quality Review Visit last year, the team have implemented most of the recommended changes and / or improvements to their service. The team were enthused by the visit and have implemented many more changes and improvements including a significant office clear out which has resulted in a pleasanter working environment and a more efficient and effective service.

Wheelchairs

The team hold a current caseload of 4444 clients across Halton and St Helens. Although there is a waiting list, children and palliative care patients do not have to wait and there is no one waiting over 18 weeks.

Halton and St Helens Wheelchair services have implemented several service improvements in the last 12 months including a new system for scheduling appointments which has resulted in the waiting list times being dramatically reduced. This is a successful outcome for the team and for patients who can access the service in a timely manner.

The team have participated in the newly implemented Trust rotational post initiative meaning that they have supported the first band 5 occupational therapist rotation within their service. The initiative has been a resounding success with positive outcomes for the team and the individual. The team are looking forward to welcoming their next ‘rotational’ therapist in July 2025.

Amongst other service improvements, the team have implemented a new multi-disciplinary team (MDT) Panel pathway for children who do not meet the service criteria because they have no mobility impairment but who may require a wheelchair for safety reasons. This has led to a reduction in the number of wheelchairs supplied to children inappropriately but also provided assurance that children with neurodivergent needs are still considered for the provision of a wheelchair based on a robust risk assessment.

Parkinson's Disease Nurse

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

Occupational Therapist for Assistive Technology

The Occupational Therapist (OT) for Assistive Technology continues to provide expert support and advice for all healthcare practitioners within Bridgewater and for other local healthcare providers. They are currently working in collaboration with social care and Warrington & Halton Hospital (WHH) colleagues to review and update the Halton Equipment Guidance – the unequivocal equipment resource for health and social care staff across Halton.

Warrington Adult Services

Palliative Care Team Warrington – Ethics Group

A new Palliative Care Ethics Group has been developed and is led by the Clinical Director for Community Palliative Care in Warrington and Halton. The group is an advisory forum supporting clinicians with complex ethical decision making in the context of end of life and palliative care. The group helps and supports clinicians, patients and families to navigate complex and sensitive situations. The group meets on alternate months, and more frequently if required, to discuss both current and retrospective ethical issues. The group has attracted a diverse membership, and clinical discussions are found to be very productive. Anyone making a referral into the group is expected to attend and will receive a written recommendation.

Warrington Neurosciences Team – Splinting and FES Projects

Last year the Neuro Rehabilitation service secured Catalyst funding to develop specialist orthotics and bespoke thermoplastic splinting for upper and lower limb dysfunction and Functional Electrical Stimulation (FES), their great work continued across 2024-25.

Splinting

The team are now successfully able to provide splints to house-bound patients, addressing inequality and ensuring that the necessary equipment is issued in a timely manner. This has helped to prevent complications, improve the patients' outcomes, ensure the patient receives a high-quality service, all resulting in an improved patient experience.

Functional Electrical Stimulation (FES) Project - joint project in partnership with Warrington and Halton Hospitals NHS Foundation Trust (WHH)

The Neuro Rehabilitation team implemented the use of FES. Electrical stimulation is recommended in the Royal College of Physicians (RCP) guidelines for the upper and lower limb (RCP, 2018). There was only one outpatient clinician in Warrington trained in the use of this modality and as a result there were long waiting lists to access this treatment.

This project sought to increase the availability of FES to patients across Warrington and Halton by upskilling the workforce in the use of FES in the rehabilitation of the upper and lower limb post-stroke, and to be able to offer FES equitably across the Warrington and Halton boroughs for patients in the community setting, as well as those attending outpatients.

The project has been successfully completed, and the team are now able to utilise FES as an adject to their rehabilitation. House-bound patients also have access to this treatment modality, thus improving patient experience and patient outcomes.

Wheelchair Service – Warrington

Warrington Wheelchair Service has been collaborating with the Tissue Viability Service over the past 12 months to deliver pressure ulcer management training sessions to Bridgewater nursing and allied health professional staff.

The Tissue Viability Service recognised the important role that the Wheelchair Service plays in contributing to pressure ulcer prevention and management for wheelchair users in Warrington, and invited the Wheelchair Service team lead to take an active role in delivering an hour-long training session at the Trust's mandatory pressure ulcer management training sessions.

The aim of the training is to develop an awareness of what the Wheelchair Service does, and to convey the positive effects that good sitting posture and pressure care management can have on pressure ulcer prevention.

The team leader created a presentation covering the following topics:

- Anatomy of the Pelvis
- The Relationship Between Posture and Pressure
- What Does Good Sitting Posture Look Like?
- The Benefits of Pressure Mapping
- The Benefits of Tilt-in-Space Wheelchairs

The training has been well received by staff who have attended the session, with some very positive feedback being returned. Following the training, several nursing staff have liaised with the wheelchair service about specific patients and have sought advice regarding specific patients on their caseloads.

There are plans to continue delivering the training for the foreseeable future, as it has benefitted both staff and patients alike, improving patient outcomes and pressure ulcer prevention.

Phlebotomy Service – Warrington

Following an extensive piece of work over several years, we are pleased to announce that our Phlebotomy Service has now transferred over to a new and exciting system called WASP (Waiting Area, Assessment, Sampling and Phlebotomy).

The complete phlebotomy procedure has moved to an online platform which includes GP ordering of bloods, patient engagement, appointment scheduling and booking, clinic administration and sample collection. The WASP system model allows the phlebotomy service to be more streamlined, delivering patient-centred care, optimising clinical safety, improving efficiencies and enhancing patient experience. This transition offers reduced waiting times, a patient management system and improved patient flow. The WASP software implements crucial cutting-edge technologies that revolutionises the services we provide to our patients. The software includes an online electronic patient booking system which enables patients to book their own phlebotomy appointments at a time and location that is appropriate for

them. These appointments are offered at Orford Jubilee Park, Bath Street Clinic and Warrington Hospital.

Urgent Care Response (UCR)

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

The Clinical & Operational UCR model has been revised and improved. The model is an evidence-based delivery model which is aligned with National, Cheshire & Mersey and local models, to reduce hospital admissions in the over 65 years target cohort in Warrington. Moving into 2025-26 the model will be implemented with a phased approach, whilst continuing to focus on caring for patients in the community.

The UCR team have been working in partnership with North West Ambulance Service (NWAS) on a pilot to prevent unnecessary hospital admissions and attendance in patients over 65 years. The ‘call before conveyance’ pilot has been in operation since early February 2025. NWAS will contact UCR prior to conveyance of patients identified as category 3 and 4, to establish if the patient is suitable to be onboarded to UCR and be cared for in their own home.

Dermatology

The skin cancer pathway team have consistently achieved the 28-day faster diagnosis standards throughout the year, ensuring patients are seen within a timely manner to improve cancer outcomes. The objective of the Faster Diagnosis Standards is to ensure that patients are informed if they have a cancer diagnosis or not within the 28-day timeframe.

Frailty Virtual Ward

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

Moving into 2025-26 a step-up pathway will be developed and implemented to onboard patients from their own homes into the virtual ward.

The Warrington Virtual Ward is currently open to a maximum of 14 beds. All beds have remained consistently occupied

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

MADE (Multi-Agency Discharge Event)

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

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

Several teams from the Warrington Directorate - Community Matron, Community Equipment Stores, Intravenous Team, Catheter Team, Urgent Care Response service, Intermediate Care, Enhanced Care Home Support Service and District Nursing all play a fundamental part within the MADE events that are carried out throughout the year.

Community Dental Service

In 2024-25, Dentally, a new patient administration system, replaced two separate systems, ensuring greater consistency in records and reporting.

Significant capital investment was secured in 2024-25 to replace dental chairs, inhalation sedation, x-ray, and decontamination equipment.

Following successful CQC registration during the year, we will move into our new Dental Hub in Altrincham on May 6, 2025.

In Cheshire and Merseyside, we have been recommissioned to provide paediatric exodontia and special care services. These contracts are potentially for the next 10 years.

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

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

We conducted the 2024-25 epidemiology survey across Cheshire and Merseyside and in eight boroughs of Greater Manchester (GM), focusing on the dental health of care home residents.

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

Following a hiatus, our in-house inhalation and intravenous sedation courses were reaccredited by the Royal College of Surgeons, and we have resumed delivering these courses. We have also successfully delivered clinical holding and safety intervention training to all of our staff.

In collaboration with Bangor University, we are contributing to the Senior Trial Research programme, which examines the use of dental therapists in care homes. We also completed

the Paediatric Pathways (PANDA) trial, which assessed the outcomes of patients attending child-friendly dental practices during the Covid pandemic.

We completed a project reviewing our acceptance and discharge criteria and introduced new triage systems across the network, reducing inappropriate referrals into our service. Clinical harm reviews are ongoing to assess the impact on patients waiting for treatment. We are working with our commissioners in Greater Manchester as they develop General Anaesthetic Hubs across Greater Manchester.

Children's Services

Halton 0-19 Service

Achievements

Halton 0-19 team are working in partnership with the Family Hubs creating an emotional wellbeing team that supports parents with mild to moderate mental health, this team have created Mindful Me parenting groups and Time for Me, a group where parents carers can come and do a therapeutic craft while their child is in the creche. The feedback for the groups is very positive. The team are delivering parenting programmes (Lighthouse Parenting and Circle of Security) to support parents mentalising their children and bond and attachment. The team are also offering 1-1 interventions such as newborn behavioural observations, baby massage, emotional wellbeing visits and video interactive guidance. The team also provide psychology consultation and Health Visitor (HV) consultation for staff and can complete joint visits; this supports practitioners in their practice when assessing/referring/supporting families with emotional wellbeing.

Halton 0-19 have been successful in securing Ready to Relate training for Halton and Warrington HV teams. This is a pilot scheme that includes an e-learning package on parent infant relationships for staff, an online platform to share with families and a pack of cards to facilitate discussions on attachment with parents.

Emotional wellbeing team have focused on early intervention by universally contacting expecting parents to invite to the baby shower information events and introducing the local offer in Halton. Targeted families are supported in accessing relevant services by the Emotional Wellbeing Team. The baby showers are now held at the same time as the HV weigh clinic and Antenatal clinic which is increasing attendance numbers.

Emotional wellbeing team have created our 'Perinatal Infant Mental Health (PIMH) Village' and strengthened our links between services that provide mental health support for Halton. We have produced a strategy to support the multidisciplinary approach to supporting parental mental health for our families.

Emotional wellbeing team have just completed their first emotional wellbeing storytelling workshop which has been invaluable to the attendees and staff are being trained to deliver them in house in the future.

Halton 0-19 team now have support for fathers to refer to; Parents in Mind (Dads) and Dad's Matter.

Halton 0-19 team have updated our Systm One (S1) template (maternal mood assessment tab) to reflect the 'think family' approach. The adult template now reflects the practice of opening a S1 record for a father/partner/carer of a child if needs are identified.

Halton 0-19 have developed a pathway for PIMH, a neonatal pathway and birth trauma pathway together a decision matrix for practitioners.

We have provided training on PIMH, birth trauma, mental health first aid and trauma informed practice for our staff.

The 0-19 team and emotional wellbeing team lead with Monthly baby showers and were finalist in The National Children & Young People Awards in October 2024.

Halton breastfeeding rates are the highest in over a decade! 37% of infants are receiving breastmilk at 6-8 weeks which is an unprecedented 12% increase in two years. When comparing our initiation rates alongside continuation rates we can see that 72.5% of mothers who had chosen to breastfeed were able to continue to breastfeed beyond 6-8 weeks. We believe this is due to the collaboration between services and partners and innovative ways of working, upskilling of the workforce and improved access to skilled support at the times it is needed.

The Halton infant feeding team have reached out to The Holding Time Project that started in the Liverpool City Region to bring this wonderful work to Halton. Beautiful artwork of mothers from Cheshire and Merseyside breastfeeding their infants were displayed at Norton Priory in the walled gardens last summer with the aim to help our borough overcome the cultural barriers to breastfeeding. By normalising breastfeeding and encouraging women to acknowledge and talk about the emotional aspect and trauma associated with breastfeeding. We have more images within our family hub buildings and the outdoor trail has been relocated to Victoria Park in Widnes for the spring / summer.

Halton's infant feeding lead has made connections with Halton's GP's providing training around medications in breastmilk at practice learning time sessions alongside a specialist pharmacist. This led to further connections with medicines management at Halton place who have requested our collaboration in creating and supporting a new cow's milk protein pathway as they recognise the skills that we can bring to this area of infant feeding as a 0-19 service. Connections have been made with paediatric dietetics to support this pathway and to help reduce the overdiagnosis of cow's milk protein allergy and the overprescribing of specialist infant milks. We recently discovered through these connections that Halton is the 5th borough in the UK on spend for these milks and we are working together to tackle this issue through providing specialist training for GPs and 0-19 service and through the expansion of the infant feeding team.

Halton 0-19 Service has successfully been awarded the 25/30 Healthy Child programme through a direct award from Halton Borough council.

The 0-19 Service has achieved 1,000 followers on their social media platform and this number continues to increase.

Transformation

Halton 0-19 service are leading on Start for Life, infant feeding and parent infant mental health with family hubs.

They have been involved with developing father- inclusive practice strategy as part of the family hub model.

Key partner in the Family Hub celebration two-day event.

The service has raised the 0-19 years profile by creating quarterly newsletter of our service to our partners.

School Nurses are offering confidential drop in's sessions in specialist provision schools / college.

A digital reception health questionnaire process has been developed by the School Nursing Team, so that communication with families of children that are starting school is efficient and responsive.

A digital process has been developed to engage parents/carers of school-aged children and young people who move into Halton to enable health needs to be identified promptly.

The School Nursing Team are currently developing a digital national child measurement programme process to enable parents / carers to receive their child's results electronically and to receive positive public health messages.

Our Widnes School Nurses are currently supporting a successful Young Women's group during the evening along with members of the Early Help Team.

Health Visitors and School Nurses have supported multi-agency plans in a Lead role and full access to Eclipse is being facilitated for them.

Halton Children Specialist Services

Achievements

Neurodevelopment development pathway (NDP) drop-in sessions re-established and will take place in the family hubs with plans to extend to partnership involvement from the company ADDvanced Solutions.

On 4th Feb 2025, the Newborn Hearing screening service was audited as part of the wider Midwifery Service quality assurance inspection and received a positive outcome.

SMS text messages fully established within community paediatric service and have supported families to understand when their prescriptions have been processed and sent to the pharmacy for collection.

Following the Special Education Needs and Disability (SEND) inspection in November 2023, the service has liaised with local authority to improve seating arrangements for children with SEND. Children are now able to access education as suitable seating is purchased for them allowing children to thrive.

Halton Childrens Specialist Services (CSS) are key attendees at the Halton SEND parent / carer co-production meetings together with other health providers in the borough. The meeting is key for building good working relationships and support contributions to the Halton SEND forum newsletter about service updates.

Transformation

NDP undergoing a full transformation to better improve the journey children and young people take when being assessed for autism, attention deficit hyperactivity disorder (ADHD) and / or

neurodisability conditions which will support and contribute to the sustainability of the future pathway.

Co-production commenced with the Halton and Warrington SEND parent / carer forum members as part of the NDP transformation work as we work together to pinpoint and improve communication between the service, families and professionals.

The Halton CSS are fully engaged and committed to the Family Hub steering group to make positive changes for children and families across the borough.

The Halton CSS is engaged and working with new colleagues of Warrington and Halton Hospitals Foundation Trust (WHH) as we plan for the opening of the brand-new Halton Health and Education Hub in Runcorn with a planned opening of January 2026.

Warrington 0-19 Service

Achievements

Success of the living well hub for children, families and partners coming together provide a hub of excellence for Warrington families. Warrington 0-19 are an anchor service at the hub offering a wide range of services including an evening offer for families which has been well received.

Warrington 0-19 Service consistently achieve a high level of compliance against their mandated offer.

Local midwifery and Warrington Health Visiting information sharing pathway has been shared with Northwest Office for Health Improvement and Disparities (OHID), Department of Health and Social Care and presented at a recent network workshop as an example of excellent practice.

Exemplary feedback for high quality learning environment which is provided to a range of students placed within the Warrington 0-19 service. Feedback scores and comments are consistently high and this has been recognised as excellent practice.

Successful implementation of the Warrington Enhanced Health Visiting Service for the most vulnerable mothers and families to ensure that these families receive enhanced continuity of care from pregnancy until the child starts Primary school from the named family Health Visitor. The new enhanced pathway with midwifery and the new offer has launched and a link Health Visitor has been assigned to Team River.

Specific pathways now in place between Bridgewater 0-19 & WHH Warrington Infant Feeding Team and WHH maternity service.

Healthy Start Initiative launched across Warrington 0-19 to provide and distribute local families with easy access to the vitamins.

Over 12,000 dental packs have been distributed by the Oral Health Promotion Team to vulnerable families via education settings, children’s centres and food banks.

Implementation and roll out of the new 3 year development review to support the school readiness agenda.

Transformation

Colleagues from Bridgewater, WHH and Warrington Borough Council are exploring whether a Joint or Independent Controller Agreement will achieve the ambition of ensuring a consistent and quality flow of information from antenatal (Maternity Services) into Health Visiting and Family Hubs.

Warrington 0-19 work closely with local agencies as part of Best Start for Life project.

Work underway to achieve stage 3 UNICEF Baby Friendly reaccreditation alongside our children's centres and Family Hub partners.

Warrington Oral Health Promotion Team have been recognised regionally by the 'Beyond All together Smiling Programme' as providing exemplary high levels or care with our 'supervised tooth brushing scheme' in early years settings. The Warrington team were asked to support the development of the service in neighbouring areas and trusts to support their design of their services. For Warrington Children additional investment in the program has been secured for 2025-26 to increase the support for the town's most vulnerable and disadvantaged children in our 20% most deprived areas of the borough.

The co-design of the Healthy Weight Declaration Strategy and Active Warrington with the design of healthy weight pathways.

The establishment of the Specialist Perinatal Mental Health, Health Visitor. Which has improved the service offering and training in this important area of the Health Visiting Service.

Warrington Children Specialist Services

Specialist Nursing Team

Achievements

At the Warrington Parent and Carers (WARRPAC) Forum conference, two members of the team received a SEND superstars award.

Direct feedback from carers / parents has included:

- "I can email, and they will triage and either suggest an appointment or help by return. Nice to know they are there to support."
- "The ADHD nurses are great at answering questions and offering advice on request and I can usually get an appointment when needed too".

Transformation

Phone reviews have been set up so parent / carers and children / young people do not need to take time off school / work to attend in person.

People and Organisation Development

- The Trust continues to focus on the work within its People Operational Delivery (POD) infrastructure, through POD Council. The POD Council was established in August 2023

to replace the previous four POD Groups, to support with the delivery of the NHS People Plan 2020-21 and the NHS 'Our People Promise' of which there are seven elements. The POD Council focusses on key aspects of staff experience in line with the NHS People Promises as follows:

1. We are compassionate and inclusive
2. We are recognised and rewarded
3. We each have a voice that counts
4. We are safe and healthy
5. We are always learning
6. We work flexibly
7. We are a team

- The Trust utilises NHS England frameworks to support the delivery of people agendas, such as the Nursing and Midwifery Retention Self-Assessment Toolkit, Civility and Respect, Health and Wellbeing and Retention Frameworks, all of which are considered alongside what our People tell us using our Trust People data such as turnover, sickness rates and staff survey results.
- Supported by our Workforce and Performance Team, we have developed a new People dashboard which has been in development for some time. It allows better oversight and triangulation of the Trust's People data and can be broken down by service/directorate. We are continuing to develop the dashboard and intend to include Equality, Diversity & Inclusion (EDI), Organisational Development (OD) and Staff Survey data in the near future.
- Our turnover rate has reported green consistently for the last year, which is a fundamental indicator in relation to how people feel about working at Bridgewater. Equally, our Performance and Personal Development Review (PPDR) and Induction attendance has reported green consistently.
- We launched our 'Choose Kindness' campaign which has had external recognition from NHS England (NHSE). All of our Civility and Respect initiatives now sit under the umbrella of 'Choose Kindness' and our OD Team have developed a 'Choose Kindness' training package which has received positive feedback from those who have engaged so far.
- We have launched a Behavioural Framework aligned to the NHS People Promise, Our Leadership Way and the Trust's People Values.
- Following extensive preparation, we submitted our Bronze application for the North West Anti-Racist Framework.
- The Trust continued its Just Culture journey by way of supporting the embedding of the learning principles into Trust processes. Staff communication and engagement has continued to be a focus for us, by way of supporting culture change. Referral to formal procedures such as suspension from duty and disciplinary action is a last resort, where feasible, resulting in a reduction in the number of disciplinaries and grievances as we continue to strive to look at incidents via a learning lens.
- The Trust has Staff Networks to support the voices of staff from ethnically diverse backgrounds; staff with disabilities, long term conditions, and neurodivergence; and staff who identify with diverse gender and sexual identities. In addition, we also have staff networks for carers support, and menopause support.

- The Trust is committed to improving equity and inclusion for all staff and is working to embed a culture of inclusion in employment and service delivery. This includes action plans and monitoring on the Gender Pay Gap, Equality Delivery System and Workforce Force Disability Equality Standard, supported by the commitments as a Disability Equality Leader, and the Workforce Race Equality Standard, and disparity ratio, supported by work to implement our commitment to the North West Black, Asian, and Minority Ethnic Assembly Anti-Racist Framework and the recently released NHS EDI Improvement Plan.
- The Trust is externally validated as a Disability Confident Leader, and in 2022 was honoured to be re-accredited with the Navajo LGBT+ (Lesbian, Gay, Bisexual, Transgender, and people with gender and/or sexual expressions and identities outside the binary norm) Charter Mark. We also have Veteran Aware accreditation and were awarded silver level in the Defence Employer Recognition Scheme.
- We have recently introduced a 'My Kinder People' recognition initiative in line with our 'Choose Kindness' campaign. This recognition scheme is nominated by staff who feel they have been treated with kindness by colleagues and those nominated feature in our 'Feel Good Friday' monthly bulletin.
- We held our best ever Staff Awards ceremony at Haydock Park.
- We have developed a new approach to staff survey action plans, which are driven by direct feedback from staff on the ground.
- We have revamped the role of the Trust's Staff Engagement Champions to People Promise Champions and have developed a comprehensive training package, so they understand their role and contribution to this agenda.
- We continue with the Time to Talk sessions, whereby members of the Board and Executive Team meet with services to understand how well we are meeting the NHS People Promises, acting on feedback directly.
- Our Health and Wellbeing offer continues to grow with programmes running throughout the year which are adapted based on our absence and wellbeing data.
- We have developed a Health and Wellbeing Prospectus with all our offers in one place for ease of access and signposting.
- We held a Health and Wellbeing fortnight in November which involved two weeks of various sessions offered to staff in relation to mental and physical health including nutrition and tai chi sessions. The evaluation was reported to the People Committee.
- We were 1 of 4 early adopters of the Northwest Wellbeing Policy which we launched in May 2024; the principles of which are a person-centred approach to wellbeing for all staff, not just those who are absent from work and a move away from absence triggers. This has been a significant culture change programme - communication and training commenced in April 2024 and continues to ensure that the policy is embedded across the Trust.
- Our Health and Wellbeing lead has been working in a targeted way in teams with high absence rates, signposting, delivering training and utilising Rugby League Cares when appropriate.
- We launched our new 'Sexual Misconduct Policy' which supports the delivery of the NHSE Sexual Safety Charter, of which we are a signatory. The 'We say no to sexual misconduct' campaign, launched in September 2024.
- We have developed a Health and Wellbeing Leaders Programme, recognising the contribution managers play in looking after their own and their staff's wellbeing.

- Following the ratification of our Multi-Professional Preceptorship Policy in 2023, our Preceptorship offer continues to grow and newly qualified turnover has reduced.
- We have grown our Apprenticeship offer for current staff which enhances their study experience with the additional support an apprenticeship has to offer. Our Apprenticeship Levy has been fully utilised, with no expiry of funds for the last year.
- We have progressed well with a project to have standardised job descriptions and competency frameworks for staff. A suite of District Nursing job descriptions has been developed and will be tested at an Agenda for Change panel once the new anticipated national profiles have been released and cross referenced with the new job descriptions. The standardised approach allows all staff to clearly see the role and competency requirements consistently and understand the career paths available and how they can progress through them.
- Our Education Team have worked with our Performance Team to create a Training Needs Analysis and Study Support Application process via Qlik, an online management and reporting system. This allows better oversight of training needs to support forward planning as well as fairness and equity via an approval process.
- Our Leadership and Management offer continues to grow, supported by our Leadership and Management Prospectus and Passport which has been aligned with the NHSE Framework for line Managers which focusses heavily on the fundamental role that line managers play in staff satisfaction rates. The programme covers areas such as Recruitment, EDI, workplace culture and staff development.
- We launched our flexible working campaign 'Making Flexible Work' in April 2024 which focussed on the Trust's commitment to flexible working and encouraging staff to come forward should they feel it will help, in addition to encouraging managers to be more open to considering requests to work flexibly.
- We have seen circa 400 applications since the launch and feedback from our Staff Survey in relation to 'We work flexibly' is positive for 2024.
- We launched our new Recruitment Pack which enhances our attraction and branding for new potential candidates focusing on how we deliver the NHS People Promises to our staff.

Communication and Engagement

There have once again been great and notable achievements made by the Trust's Communication and Engagement Team. A brief snapshot is below:

- Perhaps the biggest achievement this past year is how the team has adapted and embraced the changing landscape of the partnership integration. This is a hugely important piece of internal and external work and is being fully adopted by the communication and engagement teams of both trusts.
- The annual NHS Staff Survey continues to be a major piece of engagement each year. The work undertaken by the team resulted in an equal best-ever response rate of 62% in 2024. Comprehensive Staff Survey Action Plans and a 'You said… We did… We are doing' document were compiled and embedded throughout the organisation.
- Perhaps one of the most successful campaigns this year has been around flexible working. 'Making Flexible Work' was launched in April and has been well received throughout the organisation.

- A bespoke recruitment pack was finalised and is now attached to all adverts on the NHS Jobs website. This pack further promotes the benefits of joining the organisation to prospective applicants.
- Engagement wise, a Communities Matter – Start of the Year event was held for all senior leaders to discuss the 2024-25 priorities.
- In July, a Leader in Me event took place around the NHS People Promise of 'We are compassionate and inclusive'. Guest speakers provided a masterclass about being kind and respectful.
- 2024 also saw a hugely successful Bridgewater 'Thank You' Awards held in September. This was a perfect way to further reward and recognise colleagues for their hard work and dedication.
- As part of the wider work around civility and respect, a 'Choose Kindness' campaign continues to embed internally and externally. With a simple call to action around the promotion of kindness, the campaign has received regional NHS endorsement.
- The way the Trust communicates with its workforce is important. The weekly MyBridgewater staff bulletin is emailed to all colleagues at 12-noon each Monday. This regular communication will often have a 70% plus open rate – making it a must-read for staff.
- Newly introduced in 2024, Trust screensavers have proved an additional way to push key Trust campaigns and messaging, via colleague laptops and desktop devices. After much testing, the rollout of the screensaver messaging continues have a dramatic visual impact.
- The Bridgewater public facing website continues to go from strength to strength. This important shop window has moved from nineteenth place (out of 252 NHS websites for accessibility), to ninth place.
- The ingenuity of two community nurses traveling by raft to a patients home due to flood waters resulted in some of the biggest ever exposure on social media for the Trust. This item was not only picked up by the media as it was also included on all NHS England social platforms. A video on the Bridgewater TikTok page went viral and was viewed over 118,000 times.

Digital Services

- The Trust continued its planned digital enabling and infrastructure developments in line with its Digital Strategy during 2024-25.
- Completed the migration of our second legacy dental Electronic Patient Record (EPR) system to our new cloud based dental EPR. All our dental locations now use one common specialist system with comprehensive service reports provided by the Trusts data warehouse and analytics systems.
- Commenced the enablement of the option of patient facing digital services for dental services including self-check in, electronic correspondence and questionnaires.
- Reviewed and optimised clinical records templates with various clinical services.
- Provided access to the Cheshire and Merseyside Connecting Care Record services.
- Completed the rollout of e-Prescribing to community pharmacies from Bridgewater services.
- Introduced 2-way appointment booking between GP's and our Widnes Urgent Treatment Centre along with a range of wider electronic referrals initiatives.

- We procured and deployed 250 new or replacement laptop and desktop devices and ancillary equipment as part of continued lifecycle technology management.
- Completed external legacy telephony replacement in readiness for the revised Public Switched Telephone Network (PSTN) switch off.
- All digital disciplines utilise our online service desk request/reporting portal improving responsiveness and management for Trust staff. 65% of support activity now comes via the portal.
- The Digital Services Team achieved Level 1 accreditation to the Digital Skills Development Network 'Towards Excellence in Digital Standards' award.
- Continued working with regional teams on 24x7x365 security operations centre and joint cyber security initiatives further improving our cyber posture.
- National annual Data Security Protection Toolkit (DSPT) for 2023-34 submission with 'standards met' and completed a number internal / external audit digital reviews for assurance.
- Maintained 100% level Password using Multi Factor Authentication (MFA) across our NHS Mail service users, all internet facing applications hosted by Bridgewater now using the same MFA function, improving our cyber protection.
- All Trust systems and applications use fully supported operating systems and software for security, compliance and risk mitigation, with further progress on following cloud / internet first strategic programmes of work.
- Commenced a trial of a range of Microsoft Artificial Intelligence tools as part of a national evaluation programme.
- Refreshed Integrated Quality Performance Report (IQPR) indicators and reporting format.
- Migrated to a new improved data warehouse feed from a key EPR supplier improving speed and timeliness of information.
- Implemented successful updates to national submissions to reflect latest version standards and Faster Data Flows requirement.
- Continued with data quality and improvement sessions across all services with the monthly data quality steering group (DQSG) effectively addressing data quality issues.
- Maintained and further developed self-serve Qlik Sense reports to enhance performance data, with write back functionality to facilitate two-way interaction with the data providing actionable insights.
- Provided a range of dashboard and monitoring capabilities which are updateable in real time by our users to drive a data driven / digital first culture.

Estates and Infrastructure

The Trust provides clinical and administrative services from 56 locations and for each location maintains an overall accountability in respect of the building and environment infrastructure The locations are classed as follows: 5 freehold, 14 leased from NHS Property Services, 16 leased from Community Health Partnerships, 3 leased from GP landlords, 6 leased from private landlords, 7 NHS hospital sites and 5 local authority sites.

In 2024-25, activity included:

- Capital and backlog maintenance schemes completed include new clinic heating systems, upgraded fire security, refurbishment of several freehold health centres.

- Capital programme, working with NHS Property Services, to fit out new community dental facilities at Altrincham Well Being Hub.
- Capital programme to replace ageing dental gas manifolds.
- Major refurbishment at the Warrington Wolves Clinics, including replacement automatic doors, painting and decoration, replacement fire security system and new domestic cleaning facilities.
- The Estates Team has maintained stock management systems and ordered and delivered Personal Protective Equipment (PPE) to clinical and admin teams within the Trust.
- Implementation of new clinical waste processes including re-useable plastic sharps containers and roll out of revised waste collection processes to all sites.
- Participation in the 2024 - 2025 NHSE PLACE programme in respect of Widnes Urgent Treatment Centre.
- Facilitation and co-ordination of a number of internal team re-locations.
- New contracts procured in respect of renewable energy, clinical waste collection services, confidential waste services and mail collection services.
- Reviewed and improved internal processes utilising, where appropriate, digital solutions in respect of postage (hybrid mail), flexible working practices within the organisation, minor works job allocation template and data portals in respect of utilities and waste management data.
- Continued management and operational responsibility across the wider agendas, in respect of health and safety, waste management, electrical and mechanical maintenance, cleaning, emergency planning arrangements, infection control framework compliance, landlord / tenant relationship management and resource management

Emergency Preparedness, Resilience and Response

As defined in the Civil Contingencies Act 2004 (CCA 2004), Bridgewater Community Healthcare Services NHSFT has a responsibility to plan for, respond to, manage, and recover from any emergency that occurs within its own operational bounds, or the wider geographical footprint in which it operates. CCA 2004 requires NHS organisations, and providers of NHS-funded care, to demonstrate that they can deal with such incidents, while maintaining normal services. Within Bridgewater, Emergency Preparedness, Resilience and Response (EPRR), encompassing emergency planning, business continuity and on call arrangements is managed, on behalf of the Board, by the Chief Operating Officer who is also the Accountable Emergency Officer.

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

During 2024-25, all Trusts self-assessed themselves against the national EPRR framework, which consists of 58 core standards split into the functional domains of governance, duty to assess risk, duty to maintain plans, command and control, training and exercising, response, warning and informing, co-operation, business continuity and Hazmat / Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE).

The Trust reported a fully compliant score of 77% against the standards therefore recording a partial assurance rating across the overall EPRR framework. The Trust has been undertaking a review of all the required information and meeting internally, with PLACE colleagues, provider collaborative community colleagues and at a system level, to address the identified areas of partial/non-compliance and to support the development of policies and procedures and to source training as required.

Patient Feedback Received April 2024 – March 2025

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

Names have been removed to comply with data protection requirements.

Halton Borough

Urgent Treatment Centre, Halton All staff were very professional and caring, from receptionist, triage nurse and then nurse [Name] who reviewed him. Thank you for great care.

School Aged Immunisations, Halton They gave me all the information that I needed about the vaccines and the effects it may have on me after the jab.

Paediatric Community Medical Service, Halton [Name] was really good with my little girl and explained everything to myself. He listened and answered all questions I had.

Paediatric Occupational Therapy/Physiotherapy, Halton Everything explained well and in depth, very friendly. [Name] was at ease throughout. Thank you.

Community Neuro Service, Halton [Name] is amicable, knowledgeable and a caring person. I couldn't be in better hands.

School Nursing, Halton Let me open up about my feeling and gave me advice on how to stop it in the future.

Start for Life Wellbeing Team, Halton The staff are amazing and always make you feel relaxed and are there with listening ear. It's great to meet other mums and give baby a chance to play.

Treatment Room Service, Halton Nurse was very helpful and explained what was going to happen and then explained the results.

District Nursing, Halton The nurses that have tended to my Dad have been amazing, so caring & professional, and they are always smiling, listen to concerns & give good advice 10/10. Thank you.

Health Visiting, Halton I was made to feel comfortable and not judged at all. Helped me with some sleeping tips (it actually worked last night with white noise) and she was a lovely health visitor and understood everyone's different circumstances.

Warrington Borough

Phlebotomy Service, Warrington Very pleasant nurse took my blood. This is the second time I have had this lovely, pleasant nurse.

District Nursing, Warrington The staff were so helpful and pleasant. No wait at all for my father's appointment and they went out of the way to help him with accessibility issues. He's 88 and a little unsteady.

Podiatry Service, Warrington I was impressed with the overall service. It was prompt, professional, friendly and punctual.

Wheelchair Service, Warrington Very informative, prompt, lovely and very understanding. They are so approachable.

OCATS, Warrington [Name] was amazing, calmed nan down, had her laughing throughout, told lots of information, very nice, thanks.

Dermatology Service, Warrington Appointment was exactly on time. Polite and friendly staff, and doctor explained everything and very professional. This was the fifth time I have been seen here and every time has been the best experience thank you.

Health Visiting, Warrington [Name] was super lovely with ourselves and [Name]. Offered lots of information and advice, perfect for the job. Thank you.

Paediatric Speech and Language Therapy Service, Warrington We've been seen without waiting time and was made to feel very comfortable. [Name] was incredibly helpful, reassuring and professional all the while being friendly with my little one.

Paediatric Bladder & Bowel Service, Warrington An excellent service offering great advice, the team are not in any rush to discharge my daughter and want to make sure everything is on track with a gradual reduction in prescribed medication.

IV Therapy Service, Warrington I have regular appointments with the IV team and [Name & Name] are always friendly, professional and funny. I have been using the service for over 3 years and have always had a great service.

Dental

Dental, Bury Lovely reception and dentist giving full explanation of treatment needed. Will be back for further treatment and was relaxed visit, no rush and promptly seen.

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

Dental, Oldham I have received close support with my child's dental problems and treatment. Plans that helped take knowledgeable decisions in regards to his treatment options. Staff are empathetic and amazing with children.

Dental, Bolton All staff friendly, kept up to date with everything. Made us feel safe and happy, at ease. Very child friendly.

Dental, Ashton The staff were outstanding in the care they provided. Exceptional service. Many thanks.

Dental, West Cheshire Staff communicated what was going to happen and why. Was kept updated all through procedure. [Name & name] were both professional and friendly which put me at ease.

Dental, Halton I was treated with courtesy throughout and my treatment plan was explained clearly.

Dental, Bolton Staff were very polite and made sure we were taken care of. Answered all our questions and made sure we were aware of every step of the process.

Dental, Stockport They were kind and understanding and helped me stay calm. Amazing experience.

Dental, Chester The care for my very nervous daughter was exceptional. They involved her in every step and were so caring. I am so grateful.

2.2 Performance Analysis

Performance Analysis

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

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

In 2024-25, the Trust continued to enhance performance data with automated self-serve reports via Qlik Sense. The monthly data quality steering group (DQSG) effectively addressed data quality issues. New Statistical Process Control (SPC) style reporting was introduced, in alignment with NHS England's 'making data count' guidance, which provided greater insight into performance at both service and directorate levels.

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

Integrated Quality and Performance Report (IQPR)

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

- 47 performance indicators
- 32 quality indicators
- 7 people indicators
- Summary of financial performance

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

The IQPR is reported at Performance Council, Quality Council (quality indicators), People Committee (people indicators), and Finance and Performance Committee (all indicators), and a summary is reported to Board via the F&P Committee Chair's report.

Information is triangulated using the Risk Register, Performance Framework and IQPR along with the Board Assurance Framework. Detailed information on how risk is managed can be found in the table below and the Annual Governance Statement on page 115. Quality and Safety Committee routinely requests reports on risks scored over 15 and monitor action plans and outcomes.

Performance Reporting and Escalation Cycle

Information Type	KPI sources	Data source	Data Quality	Data Snapshot dates	Analytical Source	Narrative Source	Reports included in	Exceptions presented at
Activity	Nationally Mandated Data sets / Targets; Information Schedule	Clinical systems data auto feeds into data warehouse daily.	Reports sent to operational leads prior to data snapshot. Post snapshot SPCs are used to facilitate data quality.	4th working day of each month	Business Intelligence Team; Statistical Process Charts	Operational Managers; Associate Directors	Commissioner reports; Qlik Sense; IQPR	Directorate Leadership Team meetings; Performance Council; Finance & Performance Committee F&P Chair's report to Board
Quality Indicators	National & Local	Ulyssess data extract provided to Information team on a monthly basis.	Ongoing checks, raised before snapshot when identified. Raised through PSIRF governance structures after snapshot.	Ulysses - 3rd day each month Up to 10th working day	Business Intelligence Team; Statistical Process Charts	Head of Risk Management; Operational Managers; SMEs; Director of Quality Governance	Qlik Sense; IQPR; Quality and Safety Committee; Board; Patient Safety Incident Response Framework and Learning Panel (PSIRFALP)	Quality and Safety Committee; Quality Council Q&S Chair's report to Board
Finance	National Guidance, such as planning guidance & Local ICB requirements	SBS oracle ledger updated daily.	Reviewed on day 5 by finance team. Senior finance team review both key data and full return prior to submission. Submission has built in validation criteria. ICB review key data.	7th working day key data submission	Finance Team	Senior Finance Team	IQPR Board Finance and performance committee EMT Team brief	IQPR Board Finance and Performance Committee EMT F&P Chair's report to Board
Workforce	National Benchmarks; Local - match WHH KPIs	Access to electronic data from ESR and E Roster.	HR team run regular DQ reports - national codes for op and job roles	Between 7th - 10th Working Day each month, when ESR and E-roster are integrated	Business Intelligence Team; Statistical Process Charts	Head of Workforce; Deputy Director of People & Organisational Development	Qlik Sense; IQPR; IPR (WHH); Board; National Workforce Return	People Committee Directorate Leadership Team meetings; Performance Council; Finance & Performance Committee F&P Chair's report to Board

Quality Outcomes

It is a requirement of NHS England that trusts establish and effectively implement systems and processes to ensure that they can meet national standards for access to health care services. In 2024-25, a number of performance standards were measured in their assessment of the overall governance. These are summarised in the table below and demonstrates achievement against the threshold / target during each month of the year.

KPI Name	Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96%	100% (►)	100% (►)	92.31% (▼)	92.86% (▲)	100% (▲)	100% (►)	90.91% (▼)	61.54% (▼)	100% (▲)	94.12% (▼)	83.33% (▼)	100% (▲)
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%	97.22% (▲)	100% (▲)	100% (►)	93.75% (▼)	93.48% (▼)	93.33% (▼)	100% (▲)	82.35% (▼)	92.31% (▲)	88.1% (▼)	89.47% (▲)	90.91% (▲)
28 day faster diagnosis	75%	92.56% (▼)	90.57% (▼)	87.31% (▼)	87.5% (▲)	81.27% (▼)	91.69% (▲)	89.33% (▼)	88.82% (▼)	82.01% (▼)	83.53% (▲)	82.69% (▼)	91.89% (▲)
A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%	98.64% (▼)	97.81% (▼)	99.49% (▲)	98.67% (▼)	98.84% (▲)	99.14% (▲)	98.92% (▼)	97.72% (▼)	95.06% (▼)	98.68% (▲)	94.5% (▼)	96.88% (▲)
Audiology - Number of 6 weeks diagnostic breaches	0	154 (▼)	194 (▼)	217 (▼)	192 (▲)	149 (▲)	100 (▲)	88 (▲)	71 (▲)	76 (▼)	53 (▲)	43 (▲)	32 (▲)

Cancer Service

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

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

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

We are in a good position to embrace the 5% increase to the 28-day faster diagnosis next year, having consistently achieved above 80% compliance throughout 2024-25.

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

Audiology Diagnostics

The Trust delivers audiological assessment at all initial Audiology contacts. The waiting time standard for all diagnostic testing is 6 weeks. The Trust have been working to reduce the numbers of patients breaching this standard and meet monthly with the Cheshire & Merseyside Diagnostic Programme to track progress.

Clinical Coding Error Rate Validity

Bridgewater Community Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2024-25 by NHS England.

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

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

All Trust staff are required to maintain accurate records through:

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

The Trust has proactively worked to improve data quality by:

- Ensuring national submissions are updated to reflect the latest version standards
- Automating daily submissions into the NHS Demographics Batch Service for demographics data from main clinical systems, with ad hoc submissions for other specialised systems
- Offering bi-annual one-on-one Data Improvement sessions to all services
- Maintaining and continuously developing Self-serve Qlik Sense data quality reports
- Holding monthly Data Quality Steering Group meetings with attendance from operational leads and corporate support services, which feed into the Trust's Digital and Performance Councils

NHS Number and General Medical Practice Code Validity

Bridgewater Community Healthcare NHS Foundation Trust submitted records during 2024-25 for inclusion in relevant national datasets.

The percentage of records in the latest published data (December 2024) which included the patient's valid NHS number was:

Data set	Bridgewater Compliance	National Average
Community Services Data Set	99.9%	89.7%
Emergency Care Data Set	99.5%	97.9%
Mental Health Services Data Set	100%	50.1%

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

Data set	Bridgewater Compliance	National Average
Community Services Data Set	100%	96.9%
Emergency Care Data Set	99.2%	98.1%
Mental Health Services Data Set	100.00%	70.3%

Financial Performance

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

For the financial reporting year ended 31st March 2025, Bridgewater Community Healthcare NHS Foundation Trust has reported a deficit of £1.196m (2023-24: £0.82m deficit) and this is the same figure as in the summarisation schedules that underpin the accounts. However, it should be noted that the deficit for 31 March 2025 includes technical adjustments for DHSC procured inventories to give an adjusted financial position of £1.156m deficit (2023-24: £0.004m surplus).

Accounting Policies

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

Budget Setting Principles

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

Capital Expenditure

The Trust incurred capital expenditure in 2024-25 of £2.21m (2023-24: £2.42m), split between IT investment of £1.10m and other schemes, including clinical equipment replacement, of £0.51m and Estates schemes of £0.60m.

Income

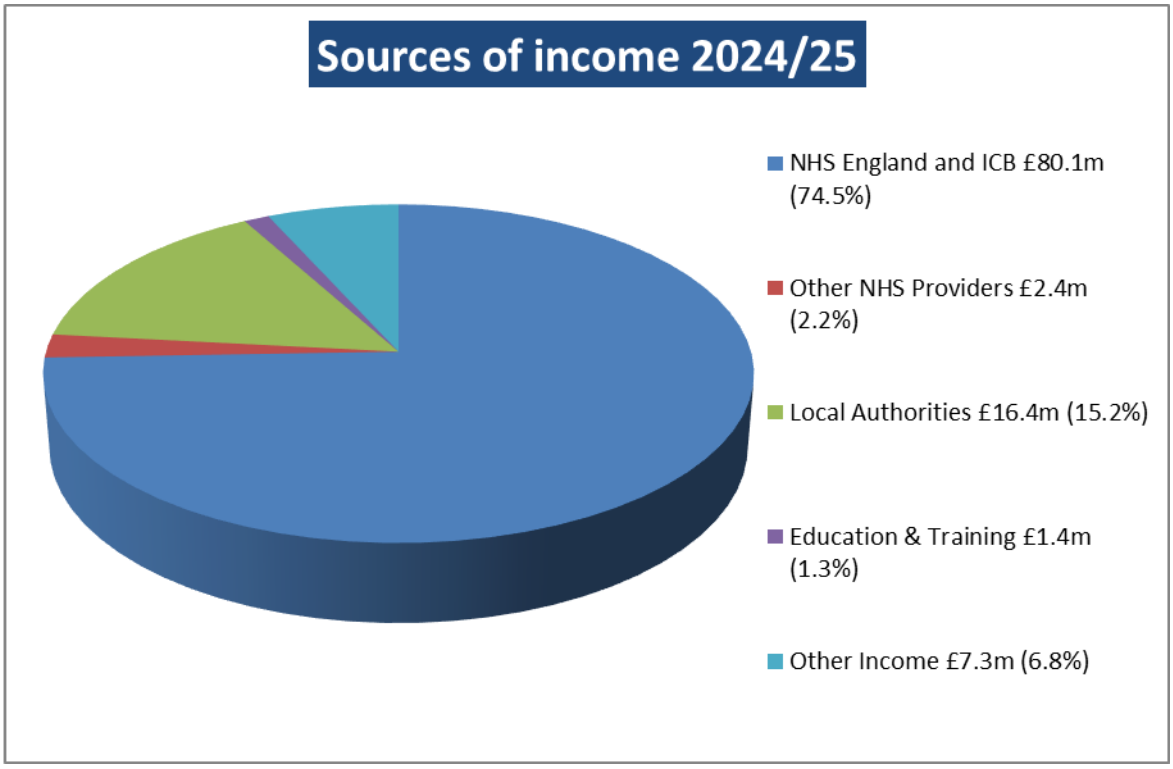
Our income for the year ended 31 March 2025 totalled £107.6m (2023-24: £101.9m) and included:

ICB and NHS England	£80.1m (2023-24 £77.0m)
Local authorities	£16.4m (2023-24 £16.2m)
Health Education England	£1.4m (2023-24 £1.5m)
Other NHS Providers	£2.4m (2023-24 £2.4m)

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

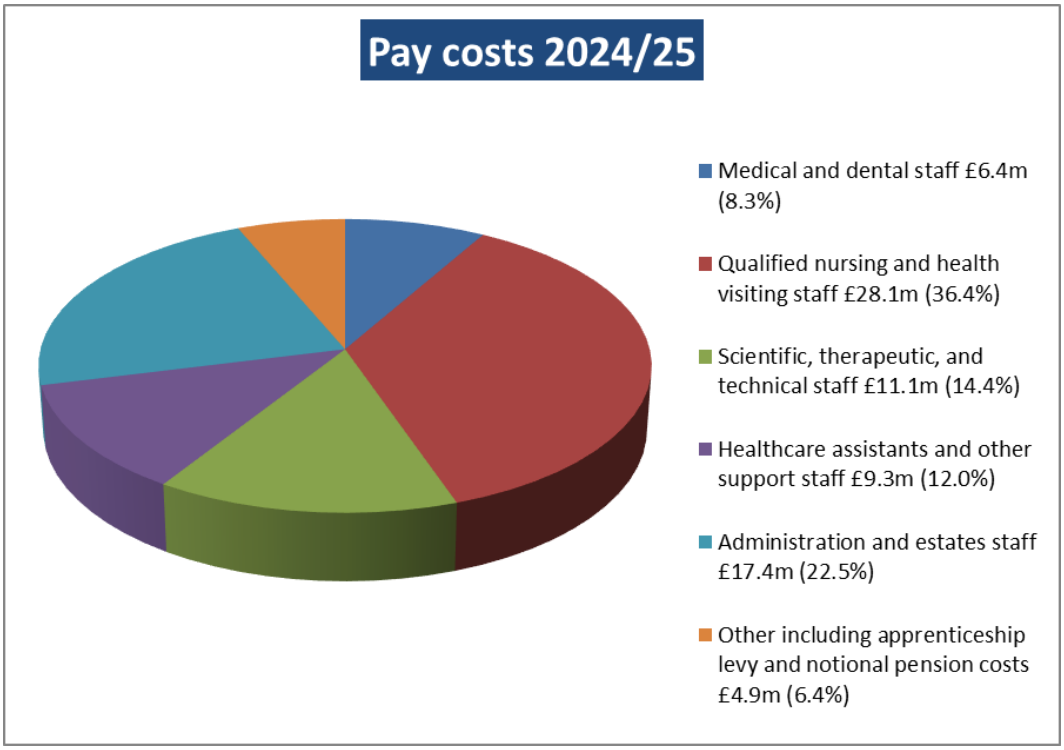
The Trust has utilised operating income received to fund the cost of services provided along with essential investments to support key service developments. (As per section 43 (3a) of the NHS Act 2006 (as amended by the Health and Social Care Act 2021))

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



Expenditure

The Trust's main source of expenditure is Employee Costs (staff) totalling £77.2m representing 70.9% of total expenditure. The chart below highlights the breakdown of these costs.



Expenditure on Operating Expenses, excluding employee costs, amounted to £31.6m. The chart below provides an analysis of this expenditure by category.

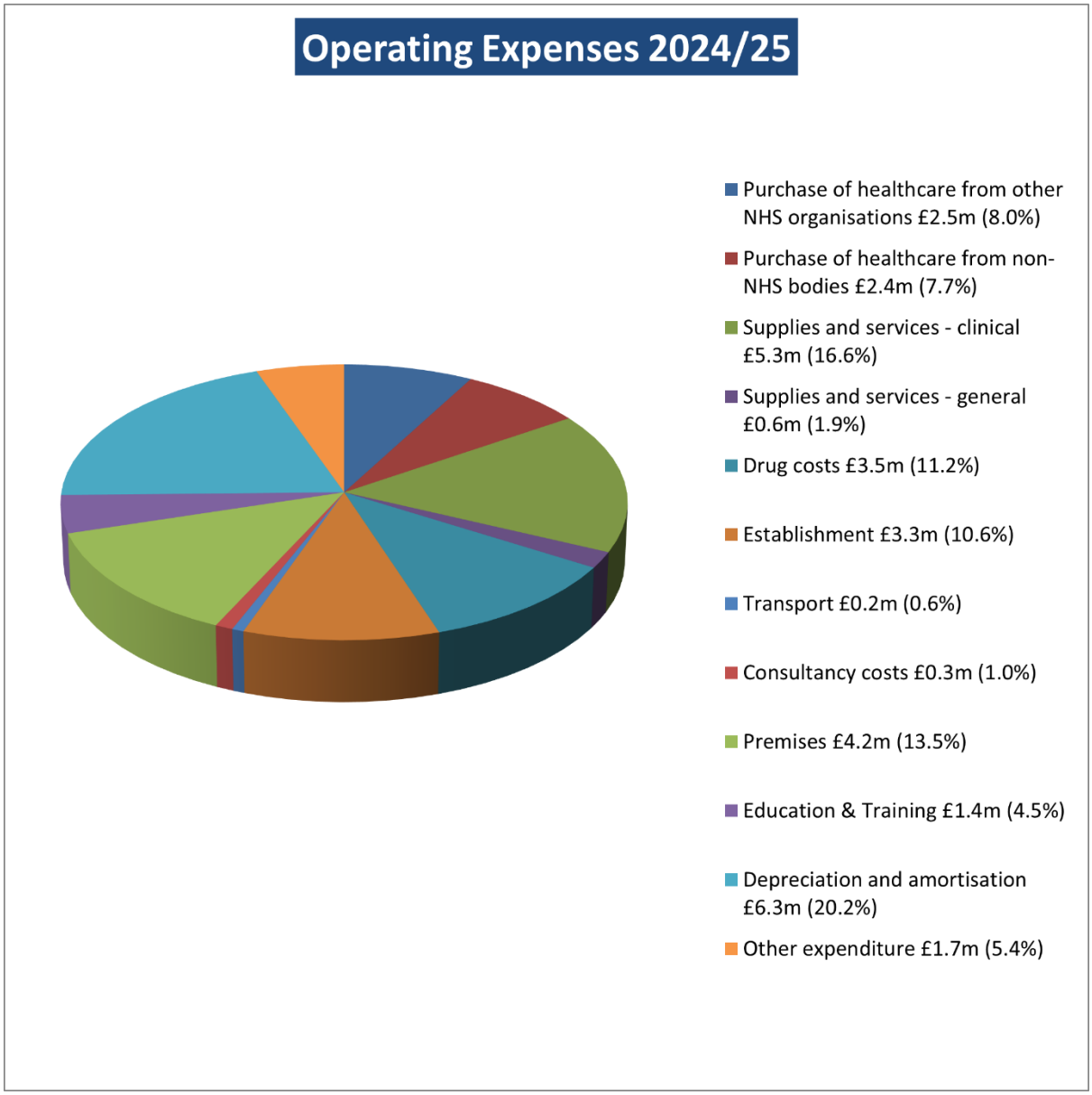
Events after the Reporting Period

There are no events after the reporting period requiring disclosure.

Future Financial Performance

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

For 2025-26 the Trust has planned for a Cost Improvement Programme (CIP) target of 5.2% of operating expenditure, which includes an element of non-recurrent CIP from previous financial years plus recovery of financial trajectories coming out of the pandemic. The target is challenging and will require the Trust to continue to review all services to ensure that each service is performing efficiently whilst ensuring that the quality of service is not affected.



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

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

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

Through its collaborative approach in local place-based partnerships with Warrington Together and One Halton, the Trust contributed to the development of the respective Health & Wellbeing Strategies, and the priorities and key areas of focus identified within these plans fed into the overarching Cheshire & Merseyside Joint Forward Plan (C&M JFP).

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

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

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

This objective is underpinned and driven by five deliverables:

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

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

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

- Improved outcomes.
- Improved equity in health outcomes.

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

The table below presents a summary of our Communities Matter objectives and deliverables, and shows clear alignment with the four core strategic objectives set out in the Cheshire & Merseyside Joint Forward Plan:

Strategy mapping and alignment

BW Objectives	Objective deliverables	C&M objectives			
		Tackling Health Inequalities in outcomes, experiences and access	Improve population health and healthcare	Enhancing productivity and value for money	Helping to support broader social and economic development
QUALITY	D1) We will apply a systematic approach to the measurement of safety, patient experience, continuous learning, leadership and governance, ensuring accountability for improvement in line with the CQC quality statements.	Y	Y		
	D2) We will use Our Building On Our Strengths Together (BOOST) methodology to drive forward continuous quality improvements in the services we provide, led by our staff. This will be supported by access to learning, mentoring and training to improve the care delivered.	Y	Y	Y	
	D3) We will ensure patients and their families, including children and young people, are more involved in shaping our services, and the voice of the child, and their feedback will shape service transformation plans, alongside the views, insight and experience of our staff.	Y	Y		
	D4) We will learn through an open approach when things go well and when things go wrong, and we will continually strive to improve the care we provide to patients. Implementing the new NHS Patient Safety Strategy including the Patient Safety Incident Response Framework and Patient Safety Partners.	Y	Y		
	D5) We will support staff and services to recover from the impact of the pandemic and ensure that patients receive care in a timely way.	Y	Y		
HEALTH EQUITY	D6) We will implement the evidence-based, priority areas of focus from the NHS Prevention Pledge	Y	Y	Y	Y
	D7) We will work with partners in place to change the way our services are designed and delivered to ensure more equitable access, which will support improved outcomes and experience.	Y	Y		
	D8) We will influence, shape and support the delivery of Health and Wellbeing strategies in the places that we work.	Y	Y	Y	Y
	D9) We will further develop working relationships with all our health and care partners to identify high intensity users of services and support these patients to access the right services at the right time.		Y		
	D10) We will enhance our relationships with the voluntary sector and we will work in partnership with them to support the needs of our most vulnerable and at risk patients.	Y	Y		Y
PEOPLE	D11) We will maximise our workforce intelligence to fully understand our workforce profile to inform workforce planning utilising Population Centric Workforce Planning approaches.		Y	Y	
	D13) We will promote 'Grow your Own' initiatives with the local community to understand the potential future workforce and create job pipelines with colleges, local businesses and our strategic partners within each borough.			Y	Y
	D14) We will maximise utilisation of the apprenticeship levy to support the development of our workforce.			Y	Y
	D15) We will realise the added value to our workforce of our volunteers, third sector organisations and the armed forces.			Y	Y
	D16) We will create opportunities for working together with our community and other health and social care providers.		Y	Y	Y
	D17) We will create a culture where we are supportive of innovative roles – new ideas and innovative ways of working, upskilling and transforming services.		Y		
RESOURCES	D18) We will work in collaboration with staff, partners and communities to transform the way we provide services to generate efficiencies, which can be reinvested to improve the quality of care and improve outcomes in health equity.	Y	Y	Y	
	D19) We will enable excellent digital and data services to drive and deliver efficiency and optimisation.		Y	Y	
	D20) We will look to reduce carbon emissions and deliver the Trusts Green Plan.		Y	Y	Y
	D21) We will embed Anchor principles and look to procure locally where we can.	Y	Y	Y	Y
	D22) We will work with partners to maximise and right size our estates.			Y	
	D23) We will work with partners to operate within our financial allocations and maintain financial balance.			Y	
EQUITY, DIVERSITY & INCLUSION	D24) We will build a culture that champions diversity, equity and inclusion. Supporting and developing our people to provide compassionate and culturally competent care to our patients and each other.	Y	Y		
	D25) We will be proactive in anticipating the diversity of our patient needs and will respond to them to ensure we achieve the best outcomes.	Y	Y		
	D26) We will become an Anchor Institute in the community: We will take our social and environmental responsibility seriously, addressing the socioeconomic determinants of health.	Y	Y	Y	Y
	D27) We will improve the reach of our organisation and grow our standing in the community through local partnerships.				Y
PARTNERSHIPS	D28) We will continue work in close partnership with local General Practice, the Primary Care Networks and GP Federations to further enhance the quality and provision of services across our local communities.	Y	Y	Y	Y
	D29) We will work closely with all our partners and their staff to drive forward continuous quality improvements in the services we collectively provide.	Y	Y	Y	
	D30) We will work across our organisational boundaries with partners and their staff in place as we create future integrated care and service models.	Y	Y	Y	
	D31) We will work with partners to improve equity in health outcomes.	Y	Y		
	D32) We will work with our system partners to collaborate at scale to enable better care at place.	Y	Y	Y	

The Trust is also a committed member of the Mental Health, Learning Disability and Community Provider Collaborative ('the Collaborative').

The Collaborative has identified six strategic objectives, all of which align to the objectives of our Communities Matter strategy, and feed into the C&M JFP. The objectives are:

- Tackle inequalities and deliver health equity.
- Level-up standards and outcomes.
- Secure investment in community-based services.
- Address financial challenges through efficiencies delivered at scale.
- Operate as a trusted and reliable partner.
- Transform our workforce to meet the future health and care challenges.

The Collaborative is shaping work programmes for the forthcoming year.

Anti-Fraud, Bribery and Corruption Measures

Each year, the NHS is vulnerable to an estimated £1.3 billion in fraud; money which could otherwise be used to improve patient care, invest in medical staff and enhance services. Fraud has a significant impact on the NHS and is not a victimless crime.

Bridgewater Community Healthcare NHS Foundation Trust is fully committed to promoting an anti-fraud, bribery and corruption agenda and takes a zero-tolerance approach towards it.

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

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

In 2024-25, the LCFS conducted a number of activities to raise awareness including a fraud presentation to the Council of Governors, circulating articles and newsletters and promoting International Fraud Awareness Week. New starter staff are required to complete a corporate induction which includes information on fraud, bribery and corruption and, all staff (new and existing) are required to complete mandatory fraud, bribery and corruption e-learning every three years, with the level of compliance maintained between 95% and 99%.Regarding prevention and detection, a number of activities have been undertaken including the review of Trust policies and procedures to ensure that they contain adequate anti-fraud, bribery and corruption measures, conduct of local and national proactive exercises to assist in identifying fraud and mitigating risk, and the circulation of local and national alerts in relation to specific identified fraud threats.

All allegations of fraud, bribery and corruption received by the Trust are dealt with and investigated in line with the Trust's Anti-Fraud, Bribery and Corruption Policy and all staff are

actively encouraged to report any concerns or suspicions to the LCFS or the national Fraud and Corruption Reporting Line.

Task force on climate related financial disclosures (TCFD)

Note for 2024-25 report:

NHS foundation trusts are required to follow the 'task force on climate-related financial disclosures' requirements on a comply or explain basis.

From 2024/25 entities should disclose how they identify, assess and manage climate related risks as part of the risk management pillar. Metrics and targets used in assessment and management of climate issues should also be disclosed.

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, risk management and metrics and targets pillars for 2024-25. These disclosures are detailed within the Environmental Management and Sustainability report.

Environmental Management and Sustainability

During 2024-25, the Trust has maintained its pathway to action, within the referenced timelines and the Trust Sustainability Objectives identified within the Board approved Green Action Plan.

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

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

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

The Trust, through its Emergency Preparedness Resilience and Response (EPRR), arrangements, receives regular climate monitoring in respect of seasonal weather forecasts, flood forecasts and other supporting data. This enables cascade of information to support

service planning. Any service, climate related incidents, are reviewed monthly and collated within the annual Estate Returns Information Collection.

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

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

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

Specific deliverables against Green Plan objectives include:

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

- Clinical models across services have been reviewed and the Trust is looking to reduce face to face visits, where appropriate, by utilising digital technology and the latest service to adopt this is the Trust's dermatology service.
- Processes continue to be reviewed to reduce resource consumption, and the Trust continues to roll out across services functionality such as hybrid mail, digital and text messaging, agile working practices and paper-light solutions in the context of digital technology.
- Electrical infrastructure has been upgraded at several sites to accommodate electric vehicle (EV) chargers.
- Promotion, through various payroll arrangements, of electric / low emission vehicles for Trust staff.
- Working with the Trust's dental network to review clinical delivery models alongside a targeted review of nitrous oxide infrastructure, usage, dispersal methods and sustainability.
- All A4 size paper continues to be purchased from recycled sources.
- Site surveys completed to support the potential fitting of solar panels at several of the Trust's freehold sites.
- Replacement of ageing, inefficient electric / gas heating systems with new, independently controlled air conditioning units.
- Exit of several leased buildings thereby reducing the organisations carbon footprint.
- Switched its electricity contracts, as part of the national negotiated arrangements, to a renewable source across all freehold sites.
- Continued submission of the NHS Green Plan dataset.
- Working with our clinical waste provider, the Trust continues to meet the NHS Clinical Waste strategy objective in terms of waste disposal types, this has included the procurement of reuseable plastic waste containers and the roll out of Tiger Waste bags, to reduce reliance on high temperature incineration waste processes. The Trust has met the NHSE ratio proportion objective of waste categorisation across the various waste classifications.
- The 2025-26 work programme will include the refresh of the Trust's Green Plan incorporating the primary focus area of workforce, sustainable clinical pathways, estates, travel, transport, digital transformation and procurement.
- The Board approved capital resources of £120k to support net zero programmes.

Social, community and human rights issues

The Trust recognises the importance of partnerships, engagement, and collaboration with our communities to meet our legal and moral obligations to reduce and eliminate the inequalities in health experienced by many people within our boroughs.

The Trust's 'Communities Matter' Strategy focuses on the importance of the NHS and of community health and dental services in the communities we serve. This is reflected throughout, in objectives for quality, health equity, resources, staff, partnerships, and equality, diversity and inclusion. Activities to support these strategic objectives are undertaken across the Trust through the enabling strategies for People, Health and Wellbeing, Equality, Diversity and Inclusion and others, and are reported regularly through governance to Board.

In 2024-25 the Trust has updated templates, policy and governance for reviewing the impact of activities, including policy, strategy, service redesign, and cost improvement or

transformation programmes, on protected characteristic and health inclusion groups. The new Equality and Health Inequalities Assessments also include human rights, the armed forces community, the requirement to address health inequalities in our areas, socio-economic deprivation, digital exclusion, low literacy, and many other factors that can influence or be influenced by health inequality.

A key element of the new assessment documents is impact on the Trust's commitments to be an anti-racist organisation, a commitment that underpins our legal equality duties and that has been of significance during 2024 and the civil unrest that affected communities across England. Throughout the year we have focused communications and activities on Choose Kindness, cultural change, Just Culture, and zero tolerance for racism, harassment, discrimination, bullying, and other acts that breach the human rights of our workforce or minoritised groups in our communities,

In March 2025 we submitted our bronze application for the NHS North West Anti-Racist Framework, seeking to evidence our commitments to racial equality and inclusion in our workforce and increasingly diverse communities. If successful the recognition will join our accreditation as Navajo LGBT+ Charter Mark holders, as Disability Confident Leaders, and as champions of armed force community inclusion through Veteran Aware accreditation, and Defence Employers Recognition Silver accreditation.

Tackling health inequalities

As an NHS community provider, we are committed to reducing health inequalities through our adoption of the Prevention Pledge, developing a role as an anchor institution and as part of the Trust's strategy, 'Communities Matter'. The strategy prioritises our commitment to the people and communities we serve and our collaboration with local partners. We have committed to providing person-centred care that improves health in its broader sense and reduces health inequalities.

Population health and health equity are key aspects of quality and as a Trust we take pride in our ability to innovate and to learn but we will only provide truly high-quality care if we reach everyone who needs us and ensure we deliver good outcomes for all who make up our communities.

Our strategic core commitments have been considered in line with commitments in the NHS Long-Term Plan, sub-regional prevention priorities and in particular the Cheshire and Merseyside Population Health Framework. These are key to influencing multi-agency action to address social determinants of health; to ensure that as an employer, a purchaser and a local anchor institution we can help moderate inequalities and to ensure that we tackle the relative disparities in access to services, patient experience and healthcare outcomes.

Working alongside the national Healthcare Inequalities Improvement Team and guided by Marmot principles, we have developed approaches to prevention, working with our partners 'at place', to address inequalities and deliver local priorities and prevention ambitions set out within the NHS Long Term Plan and in COVID-19 recovery plans.

As a Trust we work in partnership in the utilisation of common prevention pathways across our communities, to support secondary and tertiary prevention that reduces the impact of established disease through lifestyle advice and cardiac or stroke rehabilitation programmes. Examples of these are virtual wards, pathways in place with hospital trusts for cardiac and stroke, Making Every Contact Count and a staff health and wellbeing programme.

The Trust, as an Anchor Institution and a Prevention Pledge adoptee, contribute to the Cheshire and Merseyside Social Value principles; to positively impact on the wider determinants of health and the climate 'health' emergency when making decisions on recruitment, procurement, purchasing and through our organisation's corporate social responsibilities plus our Green Plan.

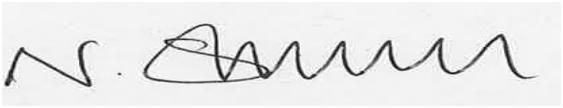
The five anchor institution pillars that as a Trust we are committed to, and are threaded throughout our Communities Matter strategy are:

1. Purchasing locally and for local benefit
2. Using buildings and spaces to support communities
3. Widening access to quality work
4. Working more closely with local partners, and
5. Reducing environmental impact

As we move towards becoming one organisation with Warrington and Hospital NHS Foundation Trust in 2027, we are already now bringing together our individual health equity plans, priorities and activity into a single strategic aim.

There are no overseas operations to declare.

The Performance Report for Bridgewater Community Healthcare NHS Foundation Trust was approved by the Board on 25 June 2025.



Accounting Officer, Nikhil Khashu (Chief Executive)

25 June 2025

3. Accountability Report

3.1 Directors' Report

Directors' statement

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

The Board of Directors

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

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

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

The directors of the Bridgewater Community Healthcare NHS Foundation Trust for the period 1 April 2024 to 31 March 2025 were as follows:

Karen Bliss **Chair** ***to 31 March 2025*** 	Karen qualified as a Chartered Accountant in 1991 after joining PricewaterhouseCoopers as a graduate trainee. She has held a variety of roles within the company at senior management level and has worked in audit, business assurance, due diligence and insolvency. She was originally appointed to the Board of Ashton, Leigh and Wigan Community Healthcare in 2008 and appointed to the Board of Bridgewater in 2010. She was appointed to the Chair role on 23 September 2019 for an initial three year tenure. In September 2022 Karen was re-appointed as Chair for a second three year tenure which concluded on 31 March 2025. <u>Qualifications</u> BA (Hons) Engineering, Cambridge University Fellow of The Institute of Chartered Accountants (FCA)

EXECUTIVE TEAM	
Nikhil Khashu **Chief Executive Officer** ***from November 2024*** 	Nik started as joint Chief Executive of Warrington and Halton Teaching Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust in November 2024. This followed his previous role at NHS England's North West regional team, where he served as Director of Finance from April 2022 and, more recently, as NHS England's national Deputy Chief Finance Officer. Nik joined the NHS in 1997, having started his career as a financial management graduate trainee. Throughout his career he has held senior leadership roles in prominent North West provider organisations, including Salford Royal, Alder Hey Children's Hospital, and St Helens and Knowsley Teaching Hospitals. He lived in Warrington for 20 years, with his twins born at WHH in 2010. Nik is deeply committed to driving positive change in equality, diversity, and inclusion, while actively working to reduce health inequalities across the communities he serves. He is dedicated to leading Warrington and Halton Hospitals and Bridgewater through a successful integration, to ensure the highest quality healthcare is delivered for the people of Warrington, Halton, and surrounding areas.
Prof Colin Scales **Chief Executive Officer** ***to September 2024*** 	Colin joined the NHS in 1994 after leaving university and has senior leadership experience in commissioning as well as several provider organisations. He has been an Executive Director in the NHS since 2003. Colin joined the Trust in 2011 as Chief Operating Officer and was appointed to the position of Chief Executive Officer on 1 April 2015. As well his Trust leadership role Colin undertakes a number of additional system roles including Chair of the Cheshire & Merseyside People Board and takes a lead role in several key areas in the development of the mental health and community services provider collaborative for Cheshire & Merseyside. He was appointed honorary professor in the School of Health, Social Work and Sport at the University of Central Lancashire in March 2024. <u>Qualifications and professional development</u> BA (Hons) Degree in Geography, University of Salford Cranfield University, School of Management, Strategic Leadership Executive Programme, May 2014 NHS Top Leaders Programme 2014/15

Dr Paul Fitzsimmons **Medical Director** ***from November 2024*** 	Paul joined Warrington and Halton Teaching Hospitals NHS Foundation Trust in December 2021 from Liverpool University Hospitals Foundation Trust where he was the Deputy Executive Medical Director for five years. He was appointed as joint Medical Director for Bridgewater Community Healthcare NHS Foundation Trust in November 2024. A consultant geriatrician and stroke physician by background, he studied medicine at Manchester University before undertaking postgraduate training in the north west. Paul is also the Caldicott Guardian and Executive Lead for Digital for both Trusts. Prior to joining Warrington and Halton Teaching Hospitals NHS Foundation Trust, Paul was a Healthcare Leadership Fellow at the Health Foundation and Ashridge University. He has extensive experience of delivering quality improvement, patient safety initiatives, digital clinical programmes and hospital service reconfigurations
Dr Ted Adams **Medical Director** ***to November 2024*** 	Ted joined the Trust in April 2020 as Acting Medical Director and was appointed in his substantive role from 1 July 2021. He joined us from Southport and Ormskirk NHS Trust, where he was Chief Clinical Information Officer and Clinical Director for Women's Health. Ted has worked across the North West including at NHS Northwest and has also spent a year at Kaiser Permanente in California as a Harkness fellow, learning about improvement methodology and implementation across large systems. <u>Qualifications</u> MRCOG (Member Royal College of Obstetricians and Gynaecologists) FFFMLM (Founding Fellow of the Faculty of Medical Leadership and Management) MSc (Health care ethics and Medical Law – University of Liverpool) PgDiP (Digital Health Leadership – Imperial College, London) MBChB (Bachelor of Medicine and Surgery – University of Liverpool)

Lynne Carter **Chief Nurse / Deputy Chief Executive Officer** **Acting Chief Executive** ***September 2024 to November 2024*** 	Lynne has been Chief Nurse in acute, community and integrated providers and has also been Head of Governance and Chief Operating Officer. She has extensive experience in developing new roles in order to meet the changing needs of healthcare including Advanced Clinical Practitioners, Nursing Associates, Consultant Nurse and Therapists. As an interim Lynne has delivered financial turnaround, safeguarding systems and new clinical pathways and is confident in all areas of leadership and management. Lynne remains a committed clinician with a strong professional perspective and belief in supporting healthcare services which meet the needs of local populations. Lynne joined the Trust on 23 March 2018 as an Interim Chief Nurse and was appointed in her substantive role from 1 May 2018. She was also appointed to the role of Chief Operating Officer from 13 July 2019 which she carried out until July 2020 when she assumed the role of Deputy Chief Executive Officer alongside of her role of Chief Nurse. <u>Qualifications</u> Post Graduate Diploma Medical Law Post Graduate Diploma Professional Studies in Management BSc (Hons) Nursing Studies Registered Nurse - Learning Disabilities Registered Nurse – Adult Lynne was the Acting Chief Executive from September 2024 to November 2024.
Daniel Moore **Chief Operating Officer** ***from December 2024*** 	Dan was appointed Chief Operating Officer of Warrington and Halton Teaching Hospitals NHS Foundation Trust in January 2021, having previously joined in 2018 as its Director of Operations and Performance. He is also Deputy Chief Executive. Dan was appointed as joint Chief Operating Officer for Bridgewater Community Healthcare NHS Foundation Trust in December 2024. As Chief Operating Officer his role is to oversee operational delivery and performance achievement across both Trusts. Prior to his current role, Dan held a number of senior operational positions within the NHS. During that time he worked in operations management across acute hospital trusts in Greater Manchester and Cheshire. <u>Qualifications</u> Masters in Business Administration (MBA) from Manchester Business School BSc in Operational Management from Lancaster University Management School.

Mark Charman **Acting Chief Operating Officer** ***from August 2024 to November 2024*** 	Mark started his NHS career as a student Audiologist in 1990 and qualified in 1992. Mark moved into Paediatric Audiology in 1994 and continued studying in this field, ultimately gaining his Master's Degree in Audiological Science in 2004. Following 20 years of clinical practice, Mark moved into a managerial role, taking up position as Assistant Director of Clinical Performance, Delivery, and Planning within the Ashton, Leigh, and Wigan Division of Bridgewater and, in 2014, moved into the role of Assistant Director of Transformation with Bridgewater. In August 2024, Mark was appointed as Acting Chief Operating Officer for Bridgewater and maintained this position until the end of November 2024.
Sarah Brennan **Chief Operating Officer** ***to August 2024*** 	A pharmacist by professional background, Sarah joined the Trust in May 2016 as the Head of Medicines Management. She became the Director of Operations Health and Justice in October 2018 and Director of Strategic Delivery, in November 2019. In July 2020 she was appointed as the Chief Operating Officer. As the Chief Operating Officer, she is responsible for ensuring that services operate in a safe and effective way and that they deliver care that meets the standard required. She also has an important role in developing and maintaining relationships with our key partners and reviewing how the Trust can deliver services in a more integrated way to achieve the best outcomes for the populations that we serve. <u>Qualifications</u> 2001 – De Montfort University, Leicester – Masters in Pharmacy 2014 - Diploma in Clinical Pharmacy (Community) – Bradford University 2015 – Pharmacist Independent Prescriber – Robert Gordon University

Nick Gallagher **Director of Finance** 	Nick is a member of the Chartered Institute of Management Accountants and started his career in the private sector in 1988. He has extensive NHS experience having worked in the NHS for over 30 years in numerous organisations including Primary Care Trusts, community providers and shared services. He was Interim Deputy Director of Finance for two years at Bridgewater before being appointed as Executive Director of Finance in January 2019. Married with three daughters, Nick has lived for over 43 years in the local borough of Warrington. Qualifications Chartered Institute of Management Accountants
Paula Woods **Director of People and Organisational Development** 	Paula has worked in the NHS since 2004. Prior to this, she worked for many years as an Assistant Director of Human Resources within the Housing Association sector in Merseyside. Paula was a Deputy Director of Workforce for many years within the NHS which included 'acting up' to the role of Director of Workforce, before securing the role of Director of People & Organisational Development at Bridgewater in June 2020. During her career, Paula has been involved in developing a range of 'people' services which improve work life balance, whilst ensuring quality and safe working practices for staff, patients and service users. She has project managed a range of national and regional 'people' initiatives and programmes of work, requiring extensive experience in leadership and people management. <u>Qualifications</u> Fellow of the Chartered Institute of Personnel & Development (FCIPD)

NON-EXECUTIVE TEAM*	
Gail Briers **Non-Executive Director** **& Vice Chair** ***from May 2024*** 	Gail joined the Trust as a Non-Executive Director in September 2020. Her appointment was renewed for a further three year tenure in August 2023. She is a registered mental health nurse with over 40 years' experience working within the NHS in a variety of clinical and leadership roles. Prior to taking up the NED role for Bridgewater, her most recent post was as Chief Nurse and Deputy Chief Executive within a neighbouring mental health and community trust. She has also worked as a NED within the quality improvement organisation Advancing Quality Alliance (AQuA). Gail was the Trust's Quality and Safety Committee Chair from 2021 to 2024.
Bob Chadwick **Non-Executive Director** 	Bob joined the Trust as a Non-Executive Director in February 2024, appointed for a three year tenure. His experience includes roles as an Executive Director of Finance in the NHS for over 20 years, holding many portfolios including finance, performance, information / IMT, procurement, estates and facilities. He has significant experience as an NHS leader in some of the most complex health economies in the UK with the delivery of key targets / objectives and strategies: • Pennine Acute Hospitals NHS Trust • Mid-Yorkshire Hospitals NHS Trust • Cardiff and Vale University Health Board Bob was born in Warrington and remained there for over 50 years before relocating to Wakefield / Leeds and then to Cardiff, returning on retirement to East Cheshire. <u>Qualifications</u> The Chartered Institute of Public Finance and Accountancy – CIPFA Bob became the Trust's Audit Committee Chair in 2024.

Linda Chivers **Non-Executive Director &** **Vice Chair** ***to May 2024*** 	Until its dissolution in June 2022, Linda was Audit Chair and a member of the Governing Body of Chorley and South Ribble CCG, having joined prior to its authorisation. Until June 2018 she was Chief Executive of Age Concern Central Lancashire, a post she held since 1997. She is a chartered management accountant with many years of experience working in the not-for-profit and service industries. During her time with Age Concern Central Lancashire, she was actively involved in developing collaborative approaches to working, ensuring services which supported people in later life were informed by and met their needs and was a Non-Executive Director of Age Concern Support Services (North West) and Age Concern Enterprises Ltd. Linda joined the Trust on 21 May 2018. Her appointment was renewed for a further three year tenure in May 2021. Linda held the position of Audit Committee Chair in the Trust and was also Deputy Chair. She left the Trust, on completion of her tenure, in May 2024. <u>Qualifications</u> BA Accountancy and Computer Science Member of the Chartered Management Accountants Associations – status – ACMA
Imam Abdul Hafeez Siddique **Non-Executive Director** 	Abdul joined the Trust as a Non-Executive Director in September 2020. His appointment was renewed for a further three year tenure in August 2023. He is a Muslim chaplain currently working at Category C prison in Lancashire. He possesses an MA in social work and MPhil in community cohesion as well as being a graduate of ILM leadership programme and Common Purpose streetwise MBA. Abdul has 15 years of engagement, advocacy experience with communities experiencing racial inequalities (CERI). He is the founder and CEO of Flowhesion that delivers wide-ranging commissioned research, training, consultancy and projects, programmes across the North of England with CERI communities. Abdul became the Trust's People Committee Chair in 2021.

Dame Elaine Inglesby **Non-Executive Director** 	Dame Elaine Inglesby joined the Trust as a Non-Executive Director in March 2023, appointed for a three year tenure. Born in Orford, Elaine trained at Warrington General from 1977 to 1980 and qualified as a Registered Nurse. Elaine worked at Warrington for 14 years before taking up various posts across Merseyside, including Director of Nursing at the Walton Centre in Liverpool. Elaine was Director of Nursing and Midwifery at Stockport NHS Foundation Trust before taking up post at Salford Royal as Executive Nurse Director in 2004 and later held the positions of Executive Nurse Director and Deputy Chief Executive. She became Chief Nursing Officer for the Northern Care Alliance in 2016, an integrated hospital and community organisation which incorporated Salford Royal Foundation Trust and Pennine Acute NHS Trust. Elaine was a member of the Prime Minister's Nursing and Care Quality Forum and also the Berwick National Advisory Group on the Safety of Patients in England, following the Mid Staffordshire Report. In 2016, she became a Non-Executive Director of the National Institute of Care and Excellence. Elaine has been a strong advocate for both Safer Nurse Staffing and the quality and safety of patient care nationally. In 2015, Elaine was appointed a Commander of the Order of the British Empire for services to nursing. In 2019, Elaine became the first national recipient of NHS England's Chief Nursing Officers Gold Award for excellence in nursing. In October 2020, she was promoted to a Dame Commander of the Order of the British Empire in the 2020 Queen's Birthday Honours. She is also a Deputy Lieutenant for Merseyside. Elaine retired from full time roles in August 2022 following a period as interim Chief Nurse at Liverpool University Hospitals Trust. Elaine became the Trust's Quality and Safety Committee Chair in 2024.

Martyn Taylor **Non-Executive Director** **and** **Senior Independent Director** ***Appointed as Chair from 1 April 2025*** 	Martyn joined the Trust as a Non-Executive Director in February 2022, appointed for a three year tenure. His appointment was renewed for a further three year tenure in February 2025. Prior to joining Bridgewater Martyn was a NED, Deputy Chair and Senior Independent Director at Tameside and Glossop Integrated Care NHS FT, where he was also the Chair Quality and Governance Committee and a member of the Audit Committee. He was also the Lead NED for Freedom to Speak Up Guardian and also the Chair of the Organ Donation Committee. Before his retirement from a career in Banking he led a risk management team across the North of England, supporting businesses facing financial challenges. Prior to that he headed a UK national team of specialist relationship managers, who supported customers with mergers, acquisition, buy-outs etc. He graduated from senior management development programmes at Harvard Business School and the Wharton University of Pennsylvania, focusing on Strategy and Risk Management. Martyn was appointed to the role of Senior Independent Director (SID) in December 2022 and was appointed as Chair from 1 April 2025.
Tina Wilkins **Non-Executive Director** 	Tina joined the Trust as a Non-Executive Director in September 2020. Her appointment was renewed for a further three year tenure in August 2023. Tina chairs the Finance and Performance Committee and sits on the Audit Committee, the People Committee and the Nominations and Remuneration Committee. During her career Tina worked in Local Government, and the NHS within the fields of health, education and social care, in both operational and strategic roles. Tina holds a degree in Cultural Studies, a Masters in Education Policy Studies and a Post Graduate Diploma in Strategic Management.

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

Board's Responsibilities

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

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

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

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

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

Balance, Completeness and Appropriateness of Board Membership

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

Performance Evaluation of the Board

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

The Board meets on a bi-monthly basis, allowing the intervening month to be spent on a day of development as a team. During 2024-25 the Board spent some of these sessions developing the 'Better Care Together' programme, running a governance workshop and participated in the options appraisal process on the proposed integration with Warrington and Halton Hospitals NHS Foundation Trust (WHH). The Board met twice informally with the Board of WHH.

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

Throughout 2024-25, the Terms of Reference and Business Cycles for all Board Committees were reviewed. At the conclusion of each Board or Committee meeting, a review is conducted, and feedback is provided to enhance performance in the upcoming months. Each Committee submits an annual report on its effectiveness. This process is further supported by pre-meetings to set the agenda and optimise meeting functionality. Additionally, a formal evaluation is conducted annually through an assessment questionnaire distributed to all members, attendees and observers.

Register of Interests

The Foundation Trust has published an up-to-date register of interests on its website, including gifts and hospitality to 31 March 2025. (https://bridgewater.nhs.uk/aboutus/managing-conflicts-interest/). This applies to all decision-making staff, Band 7 with budgetary responsibility and staff who are Band 8A and above. This also includes all other members of staff with an interest to declare over within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance. For these purposes we have interpreted 'decision making staff' as:

- Executive and non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Band 7 staff with budget responsibility only and all Band 8a and over
- All registered doctors and dentists

- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions
- Governors of the Trust.

Board Committees

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

Audit Committee

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

In addition, the Audit Committee:

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

The Trust has a Finance and Performance Committee which looks at the challenges and issues associated with financial planning and forecasting, and the Audit Committee seeks assurances in respect of the processes and work undertaken.

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

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

The Trust maintains a Board Assurance Framework (BAF) which seeks to provide the Trust Board with a tool for the effective and focussed management of the risks which threaten the delivery of the strategic objectives. The Audit Committee supports the Trust Board regarding the management of the BAF by seeking assurance on the processes used to manage the risks on the BAF and Corporate Risk Register at each meeting. The Committee has consistently received the BAF throughout 2024-25 and provided direction where further information should be provided to the Trust Board.

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

Self-Assessment:

During the financial reporting period for 2024-25, the Committee has complied with 'good practice' recommended through:

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

Audit Committee Business

Anti-Fraud

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

Internal Audit

Throughout the year the Committee has worked effectively with the internal auditors to strengthen the Trust's internal control processes. The Internal Audit Plan has been delivered in accordance with the schedule of days agreed with the Committee at the start of the financial year. During the year, some agreed amendments to the plan were approved by the Audit Committee. The Committee Chair reported these amendments to the Board.

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

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

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

For 2024-25, MIAA completed 13 internal audit reviews covering both clinical and non-clinical systems and processes and formed a view on the level of assurance as follows:

	Review	Assurance Opinion	Recommendations Raised				
			Critical	High	Medium	Low	Total
1	Assurance Framework	N/A	-	-	-	-	-
2	Quality Impact Assessments	High	-	-	-	1	1
3	Freedom to Speak Up	High	-	-	-	1	1
4	Risk Management Core Controls	High	-	-	-	-	-
5	General Ledger	High	-	-	-	-	-
6	Accounts Payable	High	-	-	-	1	1
7	Accounts Receivable	High	-	-	-	1	1
8	Treasury Management	High	-	-	-	-	-
9	EPRR	Substantial	-	-	2	3	5
10	Dermatology Service	Substantial	-	-	1	1	2
11	PSIRF	Substantial	-	-	1	4	5
12	Quality Spot Checks (Patient Carer ID)	Moderate	-	1	3	-	4
13	Bank & Agency	Moderate	-	1	3	2	6
		TOTAL	-	**2**	**10**	**14**	**26**

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

External Audit

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

The Trust's external auditors for 2024-25 were KPMG, this is the sixth year using these auditors, following appointment in 2019-20. The scope of work for external auditors is set out in guidance issued by the National Audit Office.

Disclosure to Auditors

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

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

Category	2024-25 (£000)	2023-24 (£000)
Audit services	**170**	**167**
Further assurance services	**-**	**-**
Other services	**-**	**-**
Total	**170**	**167**

KPMG LLP does not provide any non-audit services.

Systems of Internal Control

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

Ongoing assurance that the Board is sighted on its key strategic risks is provided in the Board Assurance Framework (BAF) which was regularly reviewed by Committees and the Board in 2024-25. The quality of the content demonstrates clear connectivity with the Board agenda, the Trust's strategy and the external environment.

More detail is contained in the Annual Governance Statement.

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

Bridgewater has complied with the cost allocation and charging guidance issued by HM Treasury.

It has not made any political donations.

Better Payment Practice Code (BPPC)

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

	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	11,082	26,884	13,198	27,870
Total Non-NHS Trade Invoices Paid Within Target	10,910	26,464	12,667	26,988
Percentage of Non-NHS Trade Invoices Paid Within Target	98.5%	98.4%	96.0%	96.8%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	835	11,075	1,138	12,383
Total NHS Trade Invoices Paid Within Target	813	10,890	1,126	11,995
Percentage of NHS Trade Invoices Paid Within Target	97.4%	98.3%	98.9%	96.9%

Finance and Performance Committee

The Committee oversees the organisation's financial performance, ensuring the achievement of cash-releasing efficiency savings. Additionally, it ensures that any risks to quality are mitigated to an acceptable level.

The Committee's objectives are to:

- Advise the Board of Directors on all finance, performance, estates, and digital matters.
- Seek assurance regarding financial business planning.
- Ensure corrective actions are initiated and managed when gaps are identified in relation to risks within the Committee's portfolio.
- Scrutinise the Trust's financial plans, investment policy, and proposed digital business decisions, as well as those related to the Trust's estate which require Board approval.

Nominations and Remuneration Committee of the Board

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

Quality and Safety Committee

The Quality and Safety Committee ensures the Board receives assurance that the Trust provides high standards of care. Its objectives are to:

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

People Committee

The People Committee maintains a strategic overview of the Trust's human resources and organisational development arrangements, as well as staff communication and engagement. Its objectives are to:

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

CQC Well Led Framework

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

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

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

There are no material inconsistencies between:

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

Council of Governors and Membership

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

Governors are responsible for:

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

Further information can be found in the Constitution, the Council of Governors and Council of Governors Nominations Committee Terms of Reference on the Membership and Governors area of the Bridgewater website.

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

Many of our public members are patients and / or carers of service users. Our key means of communication is via our quarterly newsletter which is sent out electronically. We also post the newsletter and our Governor Focus newsletters are found on the Membership and Governors area of the Bridgewater website.

As a Foundation Trust we have a duty and responsibility to hold an Annual Members Meeting. In September 2024, this was held at Haydock Park Racecourse and invitations were issued electronically. We also utilised social media to advertise the event and again posted details via the Membership and Governor area of the website.

As in past years, the Annual Members Meeting was held on the same day as our Staff 'Thank You' awards. This event provides us with an opportunity to highlight some of the work that goes in within the Trust and reward / recognise those teams and individuals who have made a significant contribution to the Trust's work. This year we utilised animation to provide our membership with an insight into the diverse range of services and support provided by the Trust and our Deputy Lead Governor gave an overview of the work that has taken place within the Council during the previous year.

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

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

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

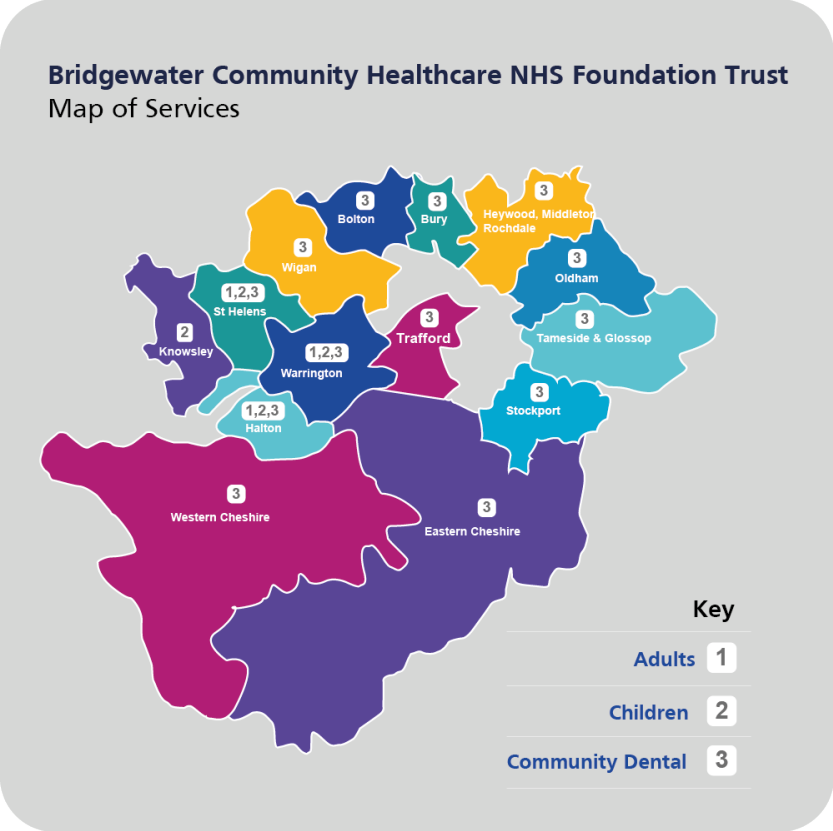
Building on the publication of the Trust's three-year strategy 'Communities Matter' in 2023, both Governors and the Trust have continued to engage in meaningful ways with members and the public. The Trust's Public and Community Engagement Group (PACE), chaired by the Chief Executive and reported to the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

In October 2024, the Trust Lead Governor supported the PLACE inspection of the Health Care Resource Centre, Widnes and the report of the inspection findings have been shared internally and externally.

Crucially, Governors have been actively involved in the proposals for the potential acquisition of the Trust by Warrington and Halton Hospitals NHS Foundation Trust from 1 April 2027 and have ensured that the voice of those the Trust serves is at the heart of this. As Bridgewater works more collaboratively with Warrington and Halton Hospitals, Governors will continue to be included in considering forward plans, including the strategy, priorities and objectives.

Governors have been encouraged to sign up to the Bridgewater mobile App that provides them with updates of all the key developments within the organisation.

Covering a significant geographic footprint across Cheshire & Merseyside and Greater Manchester, the Trust works hard to be inclusive and governors take every opportunity to engage with staff and patients when undertaking visits and attending events such as the 2024 Disability Awareness Day in Warrington. This event provided governors with an opportunity to actively sign-up new members to the Trust and explain to the public about the key developments in year.



If you wish to contact the Governors or Directors, you are welcome to do so by calling Membership on 01925 946400 or via email at Bchft.governors@nhs.net

Governors' Views, Meetings and Observation of Committees

During 2024-25, the Council of Governors considered the views of Governors with Non-Executive Directors routinely in attendance. The Council is constituted to require Executive Directors to attend to discuss specific items.

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

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

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

Governor views were captured at meetings including the Council of Governors and local governor meetings and minutes of the Council of Governors are available on request. In 2024-25, all minutes of the Council of Governors continued to be made available to staff and the public with the process led by the Lead Governor and the Trust Chair.

In the event of any conflict or disagreement between the Council of Governors and the Board, this would be addressed by the process laid out in the Trust's Constitution and in compliance

with the NHS Act 2006, Schedule 7, paragraph 10C. There had been no dispute during 2024-25 which required this process to be enacted.

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

In September 2024, the Trust Chief Executive, Colin Scales, left the organisation and Lynne Carter undertook the role of Acting Chief Executive. In November 2024, Nikhil Khashu was appointed as the Joint Chief Executive of both Bridgewater NHS Foundation Trust and Warrington & Halton Hospitals NHS FT.

In December of 2024, Karen Bliss, Chair of Bridgewater announced her intention to retire. It was the role of the Council to appoint a new Chair and at the February meeting of the Council the decision was formally announced to appoint Non-Executive Director Martyn Taylor as the organisation's new Chair for an initial period of 12 months. Mr Taylor will take up the role of Chair on 1 April 2025, and the Trust's Chair, Karen Bliss left the organisation on 31 March 2025.

Executive Directors regularly attend the Council providing, operational, strategic and financial updates. There has been a focus in the year on the engagement agenda. The Trust's Lead Governor and several governor colleagues are represented on key committees including the Bridgewater Engagement Group and the Public and Community Engagement Group (PACE) which was chaired by the Programme Director of Collaboration & Integration. The issue of member engagement is wrapped up within the organisation's wider ambitions to better engage with its communities, a part of these being members of the Trust.

The Trust's 'Time to Shine' sessions continued to be a source of great interest and whilst these were paused over the winter of 2024-25, they provide a useful insight into the diverse range of services provided by the Trust and hear about the everyday experiences of staff who deliver services and the views of patients / service. These sessions are delivered online via MS Teams.

As we look forward to 2025-26, we anticipate building upon the relationships made during the year, including those with fellow Governors at WHH and establishing further effective two-way communication between our governors and members.

We shall also be holding elections in the early summer of 2025 for a number of public / staff constituency areas to support the Trust during the integration process.

Constituencies, Membership Numbers and Governors' Responsibilities

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

The Trust has a total public membership of 6,219 which includes staff membership totalling 1655 as of March 2025.

We also have two partner governors representing the voluntary / third sector within the communities of Warrington and Halton and have a vacancy for a partner governor

representing the further / higher education sector following our partner governor from the University of Central Lancashire resigning.

The 2024-25 Council of Governors' membership is shown below:

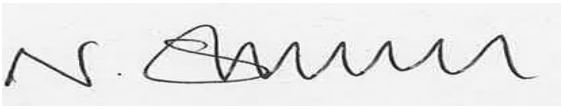
Constituency	Governor	Date of election
Public: Halton (1)	Peter Hollett	29/07/2022
Public: Halton (2)	Vacancy	
Public: Halton (3)	Vacancy	
Public: Halton (4)	Vacancy	
Public: Warrington (5)	Matt Machin	29/07/2022
Public: Warrington (6)	Andrew Mortimer **	29/07/2022
Public: Warrington (7)	Vacancy	
Public: Warrington (7)	Kevin Goucher	15/09/2023
Public: Warrington (8)	Vacancy	
Public: Rest of England (9)	Christine Stankus – Lead Governor (elected Sept 2022)	29/07/2022
Public: Rest of England (10)	Vacancy	
Public: Rest of England (11)	Vacancy	
Public: Rest of England (12)	Rita Chapman	15/09/2023
Public: Rest of England (13)	Arshad Ashraf	15/09/2023
Public: Rest of England (14)	Vacancy	
Staff Registered Nurses and Midwives (15)	Nicola Wilson	29/07/2022
Staff: Registered Nurses and Midwives (16)	Dr Suzanne Mackie	29/07/2022
Staff: Allied health professionals/other registered healthcare professionals (17)	Jillian Wallis	29/07/2022
Staff: Clinical Support Staff including Assistant Practitioners/ Healthcare assistants and trainee clinical staff (18)	Vacancy	
Staff: Registered Medical Practitioners or community dental staff (19)	Claire Barton	15/09/2023

Staff: Non-clinical support staff including managerial and administrative staff (20)	Sarah Power	29/07/2022
Constituency	**Governor**	**Date of election**
Partner: Higher Education (21)	Rachel Game,** UCLAN	29/09/2021
Partner: Statutory Borough based organisation (22)	Dave Wilson, Healthwatch Halton	19/04/2023
Partner: Borough based organisation (23)	Janet Hennessy, Signing Solutions, Warrington	01/06/2023

** resigned from office 2024

Directors' statement

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



Nikhil Khashu

Chief Executive 25 June 2025

3.2 Remuneration Report

The remuneration report includes:

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

Annual Statement on Remuneration

Nominations and Remuneration Committee

The **Nominations and Remuneration Committee** met on five occasions between 1 April 2024 and 31 March 2025. During the period, the Committee reviewed the appraisals and agreed the objectives of the Executive Directors, approved the appointment of Executives and approved the annual pay increase recommendations for Very Senior Managers (VSMs) of 5%.

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

Nominations Committee – Council of Governors

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

against these is then jointly assessed after the twelfth month elapses. The cycle is then repeated on an ongoing annual basis. The Nominations Committee appointed the Interim Chair and re-appointed one Non-Executive Director during this period.

Senior Managers Remuneration Policy

With the exception of Executive Directors and the CEO, all senior managers within the Trust are employed on Agenda for Change terms and conditions and associated salary scales. Bridgewater Community Healthcare NHS Foundation Trust has adopted the NHS VSM pay framework (PCT Band 4) as the salary scale for all Executive Directors. This provides a spot salary for each post, based on a percentage of the CEO salary. The Trust continues to follow national guidance on this matter.

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

The following Executive Directors were paid more than £150,000 during 2024-25, which was not pro-rated:

- Colin Scales – Chief Executive Officer to 17 September 2024
- Lynne Carter – as acting Chief Executive Officer from 18 September 2024 to 1 November 2024
- Lynne Carter – as Deputy Chief Executive / Chief Nurse

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

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

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

Explanations of how the components of remuneration operate	With the exception of Executive Directors and the CEO, all senior managers within the Trust are employed on Agenda for Change terms and conditions and associated salary scales. Bridgewater Community Healthcare NHS Foundation Trust has adopted the NHS VSM pay framework (Level 1, Band C) as the salary scale for all Executive Directors. This provides a spot salary for each post, based on a % of the CEO salary.
Maximum amount that could be paid in respect of the component	Maximum payable is the Executive Director's annual salaries as determined by the NHS VSM pay framework.
Explanations of any provisions for recovery	If an individual is overpaid in error, there is a contracted right to recover the overpayment.

There was no facility for performance related pay within the Trust's pay structure. As a Community Trust, with the requirement to travel across a wide geographical footprint, all Executive Directors are entitled to receive a lease car or take a car allowance equivalent to £5,700 pa.

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

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

Non-Executive Director Remuneration

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

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

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

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

The tables shown on the following pages provide information on the remuneration and pension benefits for Senior Managers for the period 1 April 2024 to 31 March 2025.

Governor and Director Expenses

During the reporting period, no Governors (out of 15 Governors) claimed expenses.

A total of six Directors (out of 20 directors Executive and Non-Executive) claimed a total of £2,095 in expenses.

	2024-25	2023-24
DIRECTORS (EXECUTIVE AND NON-EXECUTIVE)		
Total number of Directors in the year	**20**	**16**
Number of Directors who claimed in the year	**6**	**5**
Total number of expenses claimed by Directors in the year	**£2,095**	**£3,788**
GOVERNORS		
Total number of Governors in the year	**15**	**15**
Number of Governors who claimed in the year	**0**	**2**
Total number of expenses claimed by Governors in the year	**£nil**	**£454**

Salaries and Allowances

Salaries and Allowances 2024-25

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

Directors **Name and title**	**Salary at 31.3.2025 (note 2)** **Bands of £5,000 £'000s**	**Taxable benefits at 31.3.2025** **Total to nearest £100**	**Performance pay and bonuses at 31.3.2025** **Bands of £5,000 £'000s**	**Long term performance pay and bonuses at 31.3.2025** **Bands of £5,000 £'000s**	**All pension-related benefits at 31.3.2025 (1)** **Bands of £2,500 £'000s**	**TOTAL at 31.3.2025** **Bands of £5,000 £'000s**
Karen Bliss Chair In post to 31/03/25	45-50	-	-	-	-	45-50
Colin Scales Chief Executive In post to 17/09/24	85-90	-	-	-	5-7.5	90-95
Nikhil Khashu* Chief Executive In post from 01/11/24	35-40	-	-	-	32.5-35	70-75
Lynne Carter	155-160	-	-	-	-	155-160

Chief Nurse and Deputy Chief Executive Acting Chief Executive 18/09/24 to 31/10/24						
Ted Adams Medical Director In post to 21/11/24	65-70	600	-	-	-	70-75
Paul Fitzsimmons* Medical Director In post from 22/11/24	5-10	-	-	-	25-27.5	30-35
Nick Gallagher Executive Director of Finance	145-150	-	-	-	22.5-25	170-175
Sarah Brennan Chief Operating Officer In post to 08/09/24	60-65	-	-	-	5-7.5	65-70
Dan Moore* Chief Operating Officer In post from 09/12/24	20-25	-	-	-	45-47.5	65-70
Paula Woods Director of People and Organisational Development	140-145	8000	-	-	22.5-25	175-180
Robert Foster Programme Director - Collaboration & Integration In post to 30/06/24	20-25	-	-	-	-	20-25
Mark Charman Acting Chief Operating Officer In post from 09/09/24 to 08/12/24	20-25	-	-	-	32.5-35	50-55
Jeanette Hogan Acting Chief Nurse In post from 18/09/24 to 31/10/24	10-15	-	-	-	137.5-140	150-155
Linda Chivers Non-Executive Director In post to 24/05/24	0-5	-	-	-	-	0-5
Tina Wilkins Non-Executive Director	10-15	-	-	-	-	10-15

Abdul Siddique Non-Executive Director	10-15	-	-	-	-	10-15
Gail Briers Non-Executive Director	10-15	-	-	-	-	10-15
Martyn Taylor Non-Executive Director	10-15	-	-	-	-	10-15
Elaine Inglesby Non-Executive Director	10-15	-	-	-	-	10-15
Robert Chadwick Non-Executive Director	10-15	200	-	-	-	10-15

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

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

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

Nikhil Khashu 85-90

Paul Fitzsimmons 125-130

Dan Moore 160-165

Salaries and Allowances 2023-24

Period from 1 April 2023 to 31 March 2024.
(The following table has been subject to audit)

Directors						
Name and title	**Salary at 31.3.2024 (note 2)** **Bands of £5,000 £'000s**	**Taxable benefits at 31.3.2024** **Total to nearest £100**	**Performance pay and bonuses at 31.3.2024** **Bands of £5,000 £'000s**	**Long term performance pay and bonuses at 31.3.2024** **Bands of £5,000 £'000s**	**All pension-related benefits at 31.3.2024 (1)** **Bands of £2,500 £'000s**	**TOTAL at 31.3.2024** **Bands of £5,000 £'000s**
Karen Bliss Chair	45-50	-	-	-	-	45-50
Colin Scales Chief Executive	175-180		-	-	-	175-180
Lynne Carter Chief Nurse and Deputy Chief Executive	145-150	-	-	-	-	145-150

Ted Adams Medical Director	105-110	12	-	-	192.5-195	300-305
Aruna Hodgson Joint Medical Director In post to 30/4/23	5-10	-	-	-	-	5-10
Nick Gallagher Executive Director of Finance	140-145	-	-	-	-	140-145
Sarah Brennan Chief Operating Officer	135-140	-	-		55-57.5	190-195
Paula Woods Director of People and Organisational Development	135-140	77	-	-	25-27.5	165-170
Robert Foster Programme Director - Collaboration & Integration	95-100				20-22.5	120-125
Linda Chivers Non-Executive Director	10-15	1	-	-	-	10-15
Tina Wilkins Non-Executive Director	10-15	-	-	-	-	10-15
Abdul Siddique Non-Executive Director	10-15	-	-	-	-	10-15
Gail Briers Non-Executive Director	10-15	-	-	-	-	10-15
Martyn Taylor Non-Executive Director	10-15					10-15
Elaine Inglesby Non-Executive Director	10-15	-	-	-	-	10-15
Robert Chadwick Non-Executive Director In post from 5/2/24	0-5	-	-	-	-	0-5

All of the above Directors were in post for the year ended 31 March 2024 except where indicated.

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

Fair Pay Multiple

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

The mid-point of the banded remuneration of the highest paid director in Bridgewater Community Healthcare NHS Foundation Trust in the year ended 31 March 2025 was £217,500 which is a 22.5% increase from the previous year (2023-24: £177,500 an increase of 2.9%). The increase is due to the appointment of a new Chief Executive, a post which is shared between Bridgewater and Warrington & Halton Hospitals NHS FT and as such attracts a higher salary.

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

For employees of the Trust as a whole, the range of remuneration in 2024-25 was from £1,825 to £194,955*, (2023-24, £391 to £194,483). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years was -2.5% (2023-24: 3.22%). The decrease is as a result of a reduction in agency costs incurred during the year. No employees received remuneration in excess of the highest paid director in 2024-25.

* - Reflects annualised basic salaries.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

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

2023-24	25th percentile	Median	75th percentile
Salary component of pay	£26,876	£36,512	£46,019

Total pay and benefits (excluding pension benefits)	£26,876	£36,590	£46,438
Pay and benefits excluding pension: pay ratio for highest paid director	6.6:1	4.9:1	3.8:1

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

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

Exit Packages

There were no exit packages paid during 2024-25 (2023-24: none).

Service Contracts

Name and Job Title	Date appointed to Trust Board	Tenure	Notice Period	Left the Trust
Colin Scales, Chief Executive Officer	24 Oct 2011 *	Permanent	6 months	17 Sep 2024
Lynne Carter, Chief Nurse	23 Mar 2018 as Interim Chief Nurse and appointed in substantive role from 01 May 2018	Permanent	6 months	N/A
Nick Gallagher, Director of Finance	07 January 2019	Permanent	6 months	N/A
Dr Ted Adams, Medical Director	01 April 2020 as Acting Medical Director and appointed in substantive role from 01 July 2021	Permanent	6 months	21 Nov 2024
Mark Charman, Acting Chief Operating Officer	20 Aug 2024 to 30 Nov 2024	Temporary	N/A	N/A
Paula Woods, Director of People & Organisational Development	1 Jul 2020	Permanent	6 months	N/A
Sarah Brennan, Chief Operating Officer	1 Jul 2020	Permanent	6 months	8 Sep 2024

**Colin Scales became a member of the Board on 24 October 2011 before being appointed as Chief Executive Officer on 1 April 2015*

Pension Benefits

Period from 1 April 2024 to 31 March 2025

(the following table has been subject to audit)

Executive Directors

Name	Real increase in pension at pensionable age Bands of £2,500	Real increase in pension lump sum at pensionable age Bands of £2,500	Total accrued pension at pensionable age at 31 March 2025 Bands of £5,000	Lump sum at pensionable age related to accrued pension at 31 March 2025 Bands of £5,000	Cash Equivalent Transfer Value at 1 April 2024	Cash Equivalent Transfer Value at 31 March 2025	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Colin Scales Chief Executive (to 17/09/24)	0-2.5	-	50-55	125-130	1,066	1,174	6	-
Nikhil Khashu* Chief Executive (from 01/11/24)	2.5-5	2.5-5	60-65	155-160	1,125	1,334	34	-
Nick Gallagher Director of Finance	0-2.5	-	40-45	95-100	834	935	27	-
Lynne Carter Chief Nurse and Deputy Chief Executive	-	-	-	-	-	-	-	1
Sarah Brennan Chief Operating Officer (to 08/09/24)	0-2.5	-	25-30	-	334	379	2	-
Dan Moore* Chief Operating Officer (from 09/12/24)	0-2.5	2.5-5	35-40	90-95	535	712	38	-
Paula Woods Director of People and Organisational Development	0-2.5	-	35-40	90-95	795	891	25	-
Ted Adams Medical Director (to 21/11/24)	-	-	40-45	105-110	941	776	-	-
Paul Fitzsimmons*	0-2.5	0-2.5	40-45	105-110	726	852	21	-

Medical Director (from 22/11/24)								
Robert Foster Programme Director - Collaboration & Integration (to 30/06/24)	0-2.5	0-2.5	15-20	40-45	326	740	94	-
Mark Charman Acting Chief Operating Officer (from 20/08/24 to 08/12/24)	0-2.5	2.5-5	40-45	115-120	803	994	37	-
Jeanette Hogan Acting Chief Nurse (from 18/09/24 to 31/10/24)	5-7.5	17.5-20	50-55	145-150	57	93	2	-

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

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

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

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

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

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

Cash Equivalent Transfer Values (CETV)

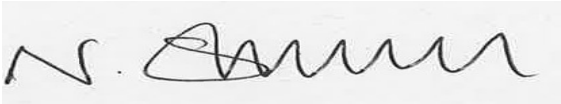
Cash Equivalent Transfer Values (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2024.

The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves a scheme and chooses to transfer the benefits accrued in their former

scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries

Real Increase in CETV

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



Nikhil Khashu

Chief Executive 25 June 2025

3.3 Staff Report

Staff Analysis

As of 31 March 2025, Bridgewater employed staff 1655 (1391 WTE), the majority of whom are clinically trained, including district nurses, health visitors, specialist nurses, occupational therapists, speech and language therapists, physiotherapists and clinical administrators.

The breakdown of male and female employees is as follows:

	Male		Female	
	Headcount	**WTE**	**Headcount**	**WTE**
Directors	3	2.8	8	7.5
Other Senior Managers	11	11	18	17.26
Employees	166	155.76	1449	1204.98
Total	180	169.56	1475	1229.74

Staff sickness

The sickness absence rate for the Trust for the period 1st April 2024 to 31st March 2025 was 6.22%.This equates to a Long Term Sickness Absence rate of 4.33% and Short Term Sickness Absence rate of 1.89%.

The top three reasons for sickness absence were:

Anxiety/stress/depression/other psychiatric illnesses	37.1%
Cold, Cough, Flu – Influenza	8.1%
Musculoskeletal problems	7.4%

Turnover

The Trust's turnover rate for the period 1st April 2024 to 31st March 2025 was 11.18% and includes all reasons for leaving.

The top three reasons for leaving were:

Voluntary Resignation / Not Specified Reason	27.41%
Retirement age	14.51%
Work / life balance	12.36%

Audited staff cost

Staff costs

	Permanent	Other	2024-25 Total	2023-24 Total
	£000	£000	£000	£000
Salaries and wages	54,191	2,415	**56,606**	52,808
Social security costs	5,047	222	**5,269**	5,191
Apprenticeship levy	256	11	**267**	260
Employer's contributions to NHS pensions	11,953	480	**12,433**	9,963
Pension cost – other	23	-	**23**	31
Temporary staff	-	3,010	**3,010**	5,133
Total gross staff costs	**71,470**	**6,138**	**77,608**	**72,658**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**71,470**	**6,138**	**77,608**	**72,658**
Of which				
Costs capitalised as part of assets	24	-	**24**	20

Average number of employees (WTE basis)

	Permanent	Other	2024-25 Total	2023-24 Total
	Number	Number	Number	Number
Medical and dental	51	5	**56**	64
Administration and estates	185	35	**220**	226
Healthcare assistants and other support staff	347	14	**361**	364
Nursing, midwifery and health visiting staff	473	48	**521**	501
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	269	9	**278**	261
Other	-	-	**-**	-
Total average numbers	**1,325**	**111**	**1,436**	**1,416**
Of which:				
Number of employees (WTE) engaged on capital projects		1	**1**	1

Reporting of compensation schemes - exit packages 2024-25

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

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

Reporting of compensation schemes - exit packages 2023-24

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

Exit packages: other (non-compulsory) departure payments

	2024-25		2023-24	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Mutually agreed resignations (MARS) contractual costs	-	-	-	-

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

Gender Pay Gap

To comply with the requirements of the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 we analyse and publish details of our gender pay gap results annually before 30 March 2025.

While we have seen continued improvements in results since the first publication in 2017, the Trust continues to work to eliminate the gender pay gap. Our actions look to understand and address the structural factors that may impact on gender pay, and to embed proactive and supportive workplace practices and offers that recognise the diversity of personal experiences that contribute to gender pay gaps.

Our published report and action plan can be found on our website: Equality, Diversity and Inclusion and on the Cabinet Office website: Gender Pay Gap Service

Modern Slavery Act

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

Our policies on slavery and human trafficking

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

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

Our guidance on Modern Slavery includes:

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

We will:

- Strive to incorporate modern slavery conditions or criteria in specification and tender documents whenever possible.
- Assess specifications and tenders, giving appropriate weight to modern slavery considerations.
- Encourage suppliers and contractors to take proactive measures and understand their obligations under the new requirements.
- Expect supply chain and framework providers to demonstrate compliance with their obligations in their processes

Trust staff must:

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

Procurement staff will:

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

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2025.

Equality, Diversity and Inclusion

Information on diversity and inclusion policies, initiatives, and longer-term ambitions

As public sector organisations, 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. At Bridgewater evidence of due regard to equality and inclusion in employment and service delivery is demonstrated through the annual Public Sector Equality Duty Report, which can be viewed on the Trust's website.

The Trust's local population and workforce are diverse, both in representation of individuals and communities identifying with protected characteristic groups, and in relation to other health inclusion groups such as carers, and communities in low socio-economic areas. The importance of equity and of inclusion for diverse and minoritised communities is a golden thread that runs throughout the overarching Communities Matter Strategy 2023 - 2026 and the six identified strategic objectives within the Strategy.

Bridgewater's strategic equality objective is to '*ensure that equality, diversity, and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for staff and patients.'* This strategic objective is delivered through enabling Strategies for People, and for Equality, Diversity, and Inclusion. These two strategies were informed by national requirements for workforce and equality, and through Trust data and evidence via regulated reporting and staff survey. Executive Directors have an equality objective, *'to actively promote equality, diversity, inclusion and anti-racism by creating the conditions that enable compassion and inclusivity to thrive'.*

Workforce equality governance in the Trust is aligned to delivery of the NHS Our People Promise, Long Term Workforce Plan, and Equality, Diversity, and Inclusion Improvement Plan. Delivery of related action plans is led by the Equality, Diversity, and Inclusion Working Group, reporting to the People Operational Delivery Council, and through the governance structure to Board for ultimate oversight, challenge, and approval. The group has two Non-Executive Director members.

Nationally, the 2024 Annual Staff Survey 2024 results showed staff experience of discrimination at work has increased, much based on ethnicity. We have examined and analysed our Survey results closely to identify opportunities for learning and improvement to support our staff, and in turn, deliver better care and outcomes for patients. It remains of concern that the experience of racially minoritised Staff in the NHS is still poorer than that of white colleagues.

Through our action plans, working group and Networks, we are focusing on career development, discrimination, civility and respect.

The Trust is committed to creating a culture of intentional anti-racism throughout the organisation. This is set out in our Anti-Racism Statement and Commitment and zero tolerance statement:

Bridgewater is committed to improving race equality for our staff and our communities, and to being actively anti-racist.

We are committed to improving awareness and understanding, from an individual to a Trust level, of the ways in which many of us have benefitted from privilege and systemic racial discrimination throughout our lives.

We will as a Trust demonstrate honesty and transparency; we will admit where we have gaps in knowledge, understanding, data, representation; we will be open and honest about where we believe we can do better; and we will actively facilitate and listen to the voices of our diverse workforce and communities, recognising that Black, Asian and minority ethnic groups are not a collective whole any more than 'White British' is a group with identical views, needs, aspirations and inequalities.

We will work in true partnership with our staff networks and with our wider communities to develop and deliver real and sustainable plans that address racism, discrimination, and inequality.

Our Zero Tolerance statement – We are compassionate and inclusive

Our 'Choose Kindness' way of working is a heartfelt initiative aimed at fostering a culture of compassion, positivity, civility and respect within the NHS and beyond.

It has been designed to remind colleagues, patients and the public of the profound impact that even the smallest acts of kindness can have.

It is also a reminder for individuals to think about their own behaviours and actions and what impact this can have on others.

Kindness is a choice we can make each and every day.

We will not tolerate, under any circumstances, any form of racial abuse, homophobia, biphobia, transphobia, ableism, sexism, sexual misconduct or any other form of discrimination by our patients, visitors or by our staff.

We will deal with any form of abuse or discrimination whenever and wherever it arises, directly or indirectly, in a kind, polite, and professional manner.

We are committed to working and delivering healthcare in an inclusive way which enables all to feel they belong here.

We will support staff where they are exposed to any form of abuse or discrimination and our staff are encouraged and supported to report such incidents, as soon as they occur.

Our teams work hard to deliver the very best care for our patients and their families regardless of their race, culture, belief or faith, gender or sexuality, age or if they have a disability. Please treat them with kindness.

In March 2025, the Trust submitted an application to the bronze level NHS North West Anti-Racism Framework. This mirrors our commitment to seek opportunities for external assessment and challenge on equality activities. Our submission included us focusing on the actions to achieve silver level accreditation.

Patient and community equality governance is aligned to legal, contractual and voluntary commitments. This includes the NHS Cheshire and Merseyside Prevention Pledge, the Green Plan, and NHS Anchor Institute. Oversight is through the Health Equity Group that reports through governance structures to Board.

The Equality, Diversity, and Inclusion Strategy places engagement and collaboration at the heart of all equality activities, and the Trust's staff networks are a key partner for this approach. The Trust has five active staff networks:

- Carers Support Network
- Enabled Network
- LGBTQIA+(lesbian, gay, bisexual, transgender, questioning, intersex, agender / asexual and other sexual and gender identities) Staff Network
- Menopause Support Network
- Race Inclusion Network

In November 2024, members from all networks, along with the Trust's Chief Executive and Executive Director sponsors for the networks, met to talk about next steps in 2025; how to further embed the safe space and support provided within the networks, and how to further establish engagement and the critical friend element of the networks to support continued equality and inclusion improvements in the Trust. The next phase for our Staff Networks is being implemented in 2025, including collaboration and partnership with network colleagues at Warrington and Halton Teaching Hospital NHS Foundation Trust.

Embedding engagement with communities is ongoing in the Trust. The Bridgewater Engagement Group provides oversight and challenge for the patient experience and feedback provided in the Talk To Us forms, and patient stories are regularly presented to Board. Local Healthwatch representatives support the group, providing insight into patient and community experiences when accessing Trust services; their support and insight is invaluable and appreciated. Further work to develop patient and community representation and voice is being undertaken through the Public and Community Engagement Group and through collaboration with Warrington and Halton Teaching Hospital NHS Foundation Trust through the Health Equity Group.

Through the engagement and collaboration approach the Trust is honoured to hold the following equality accreditations, and the Equality, Diversity, and Inclusion Working Group lead on action plans to continually improve employment offers and experiences for these accreditations:

- Disability Confident Leader
- Navajo Charter Mark for LGBT+ inclusion in Cheshire and Merseyside and Greater Manchester
- Defence Employer Recognition - Silver
- Veteran Aware

To embed the requirement of due regard to equality the Trust has policy and process for equality impact analysis of activities related to staff or to patients and communities. In 2024 the Trust refreshed this approach through implementation of new equality and health inequalities assessment templates. These require all proposals (policy, strategy, cost improvement or transformation plans, and service redesign or changes) to be thoroughly assessed before final decision making for potential positive or negative impacts on protected characteristic groups and other health inclusion groups:

- Looked after children and young people
- Carers
- Homeless and vulnerably housed
- People in the criminal justice system.
- People experiencing substance misuse issues
- Social factors such as low socio-economic status, rural locations, deprivation, and low literacy
- Refugees, asylum seekers, and victims of trafficking and modern slavery

The new templates also focus very specifically on the three aims of the General Equality Duty, on the principles of the Human Rights Act 1998, on health equality requirements, and on impact and support for the Trust's anti-racism commitments.

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.

The Trust considers the element of 'due regard' associated with the Armed Forces Act 2021 in the new equality and health inequalities assessment templates and process, and in 2024 published a new Reservists Policy and Armed Forces Toolkit for workforce, including a new offer of 10 additional paid leave days (pro rata) for reservists and cadet force adult volunteers in our workforce to attend annual camp.

Further information on equality work undertaken by the Trust in 2024-25, and plans for the future can be viewed in our annual reports.

Equality Reporting

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

There are processes within the NHS that support delivery of duties of due regard to equity. These include the Equality Delivery System 2022, and Workforce Disability and Race Equality Standards.

All current equality reports, including the annual Public Sector Equality Duty annual reports and Gender Pay Gap reports, can be found on the Trust's website at: Equality, Diversity and Inclusion – Bridgewater Community Healthcare NHS Foundation Trust

Internal Communications and Staff Engagement

Integration Programme

The Communications Team plays a crucial role in the integration programme between Bridgewater Community Healthcare (BCH) and Warrington and Halton Teaching Hospitals (WHH). A unified narrative and coordinated communications approach are essential for success. The Communications and Engagement Workstream meets monthly to address short and medium-term actions. As integration progresses, Trust communications will evolve, reflecting closer collaboration between the two Trusts.

Media attention about the partnership has caused some uncertainty among colleagues. It remains vital to maintain open and transparent internal communication to ensure messaging is delivered internally before reaching external audiences. As discussions with the Cheshire and Merseyside Integrated Care Board and other stakeholders increase, the integration programme will demand high priority from the Communications team.

Business as Usual

Despite the integration programme, regular business as usual communications activity continues. One such example is the weekly staff bulletin called MyBridgewater. This is a popular communication channel and will often result in staff open rates of 70% and higher. Another credible communications channel is our month end 'Feel Good Friday' bulletin. This is a platform to spread team and individual joy across the organisation.

CQC Inspection Preparation

As a CQC inspection could happen at any time, the Communications team developed a CQC guide to help colleagues understand inspection expectations and support the Trust's goal of delivering high-quality care. This guide is readily available in key locations throughout the Trust as well as on the MyBridgewater extranet.

Flexible Working Campaign

Launched in April 2024, the 'Making Flexible Work' campaign promotes flexible working, improving recruitment and retention. In response to the People Promise theme of ‘We work flexibly’ dipping slightly in the NHS Staff Survey in 2023, this campaign has proved to be an embedded success in the 12-months it has run.

Choose Kindness Campaign

Launched in July 2024, the 'Choose Kindness' campaign encourages colleagues and the public to act with kindness. The campaign has been integrated into various Trust initiatives

and shared as good practice across NHS Cheshire and Merseyside. The updated Behavioural Framework has also been promoted under this campaign.

Sexual Safety and Speak Up Campaigns

Bridgewater is committed to zero tolerance for sexual misconduct. The 'We say no to sexual misconduct' campaign, launched in September 2024, highlights the new Trust Sexual Misconduct Policy. During 'Speak Up' month in October 2024, the Communications and Engagement Team promoted Freedom to Speak Up throughout Bridgewater.

Seasonal and Reactive Campaigns

Seasonal campaigns, such as the Winter Flu and COVID campaign, continue to be implemented. The team is ready to react to changing situations, as demonstrated during the civil unrest in Southport in which the Choose Kindness campaign was heavily promoted.

Core Communication Channels

In addition to the regular MyBridgewater Bulletin and the month end ‘Feel Good Friday’, the Trust's core internal communication channels also include the MyBridgewater Extranet, Staff App, Global emails, and joint partnership Team Brief. Newly introduced in 2024, Trust screensavers have proved an additional way to push key Trust campaigns and messaging, via colleague laptops and desktop devices. After much testing, the rollout of the screensaver messaging continues have a dramatic and visual impact.

Joint Communications

The ‘Good Morning’ message from joint CEO Nikhil Khashu and the joint Leadership Forum are examples of increasing partnership communications between WHH and BCH. These efforts aim to reduce duplication and foster greater collaboration.

Ongoing Projects

The team supports various projects, including creating animations for the Three Boroughs Infection Prevention and Control Team, improving the Neurodevelopment Pathway, and communicating the Heart Failure Pathway.

Staff Engagement

Integration with Internal Communications

Internal communications and staff engagement are closely linked. Despite the Staff Engagement function transitioning to the Organisational Development Team in November 2024, the Communications Team maintains a close working relationship with Staff Engagement colleagues and its workings.

NHS Staff Survey

The NHS Staff Survey is a key listening tool. Following the 2023 survey results, the Staff Engagement Team met regularly with relevant colleagues to address areas of concern. 'You said… We did… We are doing' document was communicated Trust-wide to demonstrate actions taken based on feedback.

2024 NHS Staff Survey Results

The 2024 survey revealed a steady performance despite a challenging year. Bridgewater received an equal best-ever 62% response rate. The survey assessed nine elements, including the NHS People Promise components, staff engagement, and morale. Bridgewater showed positive increases in three elements, static performance in four, and slight decreases in two.

National Quarterly Pulse Survey (NQPS)

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

Integration Programme Engagement

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

People Promise Champions

In May 2024, the Trust refreshed its Staff Engagement Champions into People Promise Champions and Ambassadors. These roles support the delivery of the NHS People Promise and promote existing mechanisms to support staff on various issues. Champions also help shape and deliver annual Staff Survey Action Plans.

Key Internal Events

Significant internal events focused on quality, such as the Communities Matter – Start of Year Event and the Leader in Me event. The #TeamBridgewater 'Thank You' Awards, held in September, celebrated staff recognition. Due to financial challenges, the 2025 awards will not be held in-person, but alternative recognition methods will be explored.

Adapting to Change

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

Health, Safety, Fire and LSMS Performance

Health, Safety, Fire and LSMS work undertaken during period April 2024 – March 2025.

This includes:

- Review and updated Policies and guidance:
    - Health and Safety Policy
    - Fire Policy
- Undertake and monitoring of Fire Drills in freehold sites and specific leasehold sites and gathering of Fire Drill/Evacuation Reporting form
- Attendance at Fire Drills at Community Health Partnerships (CHP) sites and National Health and Performance Safety (NHSPS) sites

- Provide comment, recommendations on various Safe Operating Procedures (SOP) and policies for services
- Advice and support on completing Risk Assessments – for lone working, violence and aggression
- Provide advice, support in review of Ulysses Incident Reporting system, regarding application of 'Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) as per Health and Social Care guidance
- A range of communications has been produced via the internal bulletin and Team Brief, plus the following were provided directly to freehold premises, specific leasehold managers, and sites:
    - Fire safety
    - Legionella – water safety – flushing infrequently used outlets
    - Personal Emergency Evacuation Plans (PEEP's)
    - Thefts and Security
    - Electrical safety
- Update Trust regarding Counter Terrorism (CT) and actions required and national initiatives. Promotion of 'Action Counters Terrorism' (ACT) training. Meetings with Education and Professional Development (EPD) and Safeguarding. Proposal to EMT for implementation and Education Governance – rollout across the Trust
- Development of and provision of, training for warehouse operatives. Six sessions, 'Health and Safety in the Warehouse'
- Interpretation and application of new Building Safety Act, Martyn's Law, and Fire Regulations and updated Health Technical Memoranda documents
- Application of the 'Sexual safety in healthcare – organisation charter' to the Trust and its undertakings. Attendance at meetings to progress implementation of the Charter, training requirements and Policy
- Production of contract reports twice yearly
- Advice, support, and promotion of first aid provision. Level of training required to suit needs of the Trust
- Advice, support, and promotion of evac-chair/ski-pad training
- Advice and support in development of Personal Emergency Evacuation Plans (PEEPS) – for patients and staff
- Advice regarding asbestos removal and staff/patient safety
- Review of the Violence & Aggression Prevention and Reduction Standards detailing the Trust's responsibilities to manage violence and aggression. This is supported by the 'Sexual safety in healthcare – organisation charter'
- Development of new violence and aggression posters, (for staff and patients) in line with Trust's 'Choose Kindness' campaign
- Support and advice to Warehouse manager, and monitoring of warehouse action plan
- Assisted with investigations of accidents, incidents, thefts, and security and generation of reports detailing recommendations
- Liaison and meetings with local with Police Officers (LPCSO)
- Advice and support regarding temporary fire safety measures and upgrade of fire alarm system and advice on new fire alarm system

- Advice and assistance to managers regarding RIDDOR reporting to the Health and Safety Executive (HSE) for both staff incidents and patients/members of public incidents/accidents
- Dissemination and communication of 'external warning notices' regarding violent patients
- Project – staff panic alarm systems and local procedures in place and / or to be developed. Raising awareness of staff panic alarm systems that are already installed. Liaising with managers, landlords (CHP/NHSPS/GP Practices) regarding maintenance of such. Development of 'local' procedure for recording testing of staff panic alarms
- Lone Working Devices - Contract meetings with provider, RELIANCE for lone worker devices. Monitor staff usage of equipment and training accessed and completed. Highlighting areas of weakness and recommendations. Weekly reports generated and provided to senior managers for actioning
- Risk assessments with reports and action plans produced:
    - 21 Fire risk assessments (freehold and leasehold sites)
    - 21 Security risk assessments (freehold and leasehold sites)
    - Additional 19 Fire risk assessments (leasehold sites)
- Six fire warden training sessions - (delivered face-to-face)
- Development of stress risk assessment sessions and delivery of approximately four sessions to managers and staff

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

- Advice and assistance with, slips, trips and falls – staff and patients
- Manual handling – staff
- Violence and aggression – staff and patients
- Unauthorised access to premises
- Suspicious telephone call – incident at school. Liaised with site landlord and meeting with head teacher

Attendance at:

- Attendance at Contract meetings four times year
- Health, Safety, Fire and Security Committee meetings, three per year and production of minutes
- Estates meetings – weekly
- Stress Working Group meetings – stress risk assessments and compliance issues
- Community Health Partnerships (CHP) Building User Group meetings
- Community Health Partnerships (CHP) Water Safety Groups
- Dental health and safety meetings
- HR Project Operational Development (POD) meetings
- Quality Council, including providing reports for discussion and highlighting areas for improvement and areas of strength
- Multi-Disciplinary Team meetings in relation to specific incidents of violence and aggression
- Medical Gasses Group meetings and actions required as per ALERT issued
- CCPG Policy meetings

- Security meetings with UNISON Health and Safety Representative
- Accessibility working group

Support, advice, and assistance has been provided to managers and staff, including liaison with Trade Union Representatives where appropriate for:

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

Seminars:

- Safeguarding
- Violence Prevention and Reduction Standards
- Stress Management
- Martyn's Law – PROTECT UK
- Right Care, Right Person (RCRP)

Occupational Health

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

PAM offer a fully consolidated Occupational Health Service including:

- Occupational health appointments via management referral
- Support and advice for musculoskeletal issues
- Physiotherapy, both management referral and employee led via the Physiotherapy Information Line (PhIL)
- Pre-employment screening
- Vaccinations and health surveillance for staff
- Needlestick injury support
- Stress management support
- Ergonomics advice
- PAM Assist (Employee Assistance Programme) – a 24-hour / 7 days per week confidential helpline providing advice and support on a range of issues including bereavement, divorce, addiction and stress

- Ill health retirement application assessments
- Counselling and cognitive behavioural therapy
- Trauma support

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

- Hosting a Wellbeing fortnight during October 2024, where staff could attend a range of workshops and one to one interventions and access information to support their health and wellbeing.
- Collaborating with the North West Leadership Academy to develop an implementation toolkit.to deliver the North West Staff Partnership Forum Wellbeing Policy at a local level, with the aim of fundamental culture change to support person-centred wellbeing.
- A Health and Wellbeing Leaders Programme was implemented to develop leaders' skills and knowledge to support the health and wellbeing of their teams as part of creating a wellbeing culture within Bridgewater.

NHS Staff Survey 2024

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

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

62% of Bridgewater staff completed the survey last year, equalling the best response rate ever for the Trust also achieved in 2023. The survey period was open between September and November 2024.

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

The fieldwork for the 2024 NHS Staff Survey was carried out between September and November 2024 and results were published in March 2025.

The 2024 NHS Staff Survey benchmark report showcases a mixed journey for the organisation. When considering another challenging and turbulent year ahead for the NHS, it is important that we continue to listen to and look after our staff and do all we can to maintain focus on delivery of the NHS People Promises.

Overall Trust Responses – 2024-25, 2023-24 and 2022-23

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

	2024-25		2023-24		2022-23	
	Trust score	**Community Trust benchmarking score**	**Trust score**	**Community Trust benchmarking score**	**Trust score**	**Community Trust benchmarking score**
We are compassionate and inclusive	7.79	7.76	7.8	7.8	7.6	7.6
We are recognised and rewarded	6.4	6.42	6.4	6.5	6.1	6.4
We each have a voice that counts	7.17	7.11	7.2	7.2	7.1	7.1
We are safe and healthy	6.53	6.49	6.5	6.4	6.3	6.3
We are always learning	5.79	5.97	5.9	6.0	5.3	5.9
We work flexibly	6.95	6.91	6.8	6.9	6.4	6.7
We are a team	7.27	7.2	7.2	7.2	7.0	7.1
Staff engagement	7.21	7.23	7.3	7.3	7.2	7.2
Morale	6.24	6.26	6.3	6.2	6.1	6.1

When viewing the 2023-24 response, five out of the nine elements and themes show an improved score when compared to the Community Trust average for the year. Four elements and themes show a very slight decrease. These will result in the target areas that the Trust will work closely on as part of its organisation-wide action planning.

The areas showing a decrease compared to the Community Trust average are as follows:

- We are recognised and rewarded (-0.02)
- We are always learning (-0.18)
- Staff Engagement (-0.02)
- Morale (-0.02)

The following table highlights the journey of the Trust between the 2023 results and the 2024 results.

We have improved in 4 areas, stayed the same in 1 and deteriorated in 4 areas. The score differentials between 2023 and 2024 are not statistically significant as such, but there is a sustaining and only very slight improvement in our scores and we have some work to do to over the coming year to listen to our staff and do all that we can to make improvements where we can.

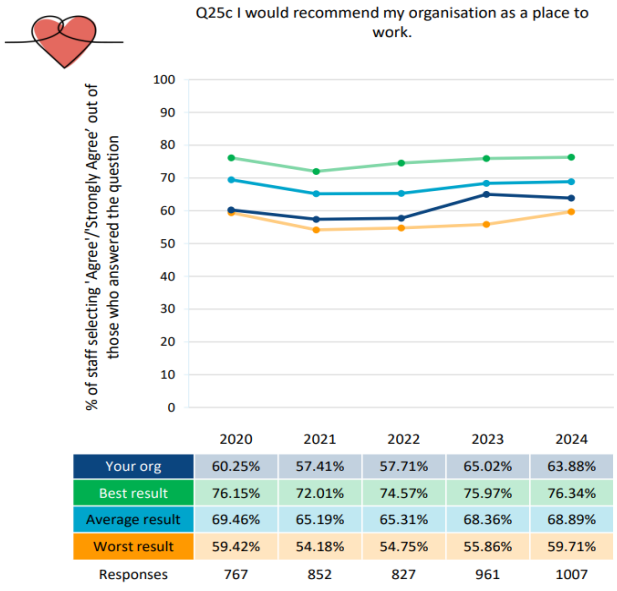
People Promise Element / Theme	2023 score	2024 score	Trust scores - 2024 vs 2023 Green - improvement Red - Deterioration
We are compassionate and inclusive	7.76	7.79	0.03
We are recognised and rewarded	6.35	6.40	0.05
We each have a voice that counts	7.18	7.17	-0.01
We are safe and healthy	6.53	6.53	0 - SAME
We are always learning	5.92	5.79	-0.13
We work flexibly	6.76	6.95	0.19
We are a team	7.20	7.27	0.07
Staff engagement	7.29	7.21	-0.08
Morale	6.27	6.24	-0.03

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

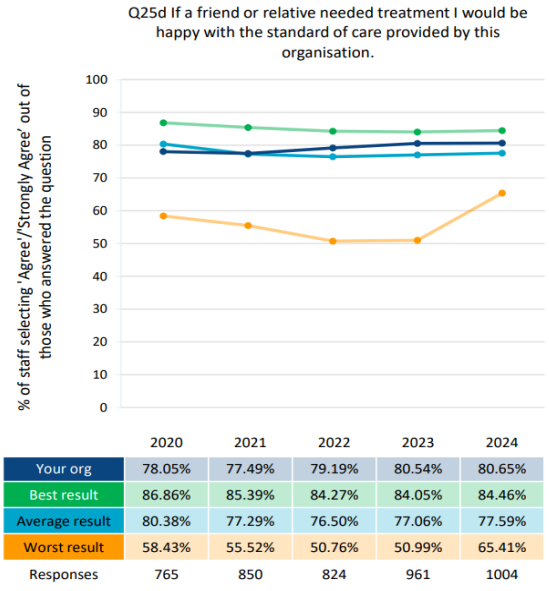
a. Q25c: I would recommend my organisation as a place to work

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

The five-year trajectory shown in this image has shown promising improvement in both questions; however in 2024 Q25c has seen a 1.14% decline since last year. Q25d has seen a 0.11% increase. This is an area that we focus on during our Time to Talk sessions, asking staff those two questions as often as possible.



	2020	2021	2022	2023	2024
Your org	60.25%	57.41%	57.71%	65.02%	63.88%
Best result	76.15%	72.01%	74.57%	75.97%	76.34%
Average result	69.46%	65.19%	65.31%	68.36%	68.89%
Worst result	59.42%	54.18%	54.75%	55.86%	59.71%
Responses	767	852	827	961	1007



	2020	2021	2022	2023	2024
Your org	78.05%	77.49%	79.19%	80.54%	80.65%
Best result	86.86%	85.39%	84.27%	84.05%	84.46%
Average result	80.38%	77.29%	76.50%	77.06%	77.59%
Worst result	58.43%	55.52%	50.76%	50.99%	65.41%
Responses	765	850	824	961	1004

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

Similar to the 2023 staff survey, the Engagement Team will continue to work closely with the Trust directorates on their latest Staff Survey Action Plans for 2024-25 year. A Trust-wide action plan will also be created and embedded into the organisation.

Monthly Staff Survey Action Plan meetings take place with key personnel. There will be a key focus on addressing the areas flagging as red as well as continuous improvement.

Trust-wide and directorate action plans will be closely monitored and will be updated / reported to various internal groups for assurance and governance purposes. Some groups will undertake individual action plans and other groups will receive a highlight report on how the staff survey action planning is progressing.

We will also continue to feedback and communicate with our staff by way of our well-established, "You said… We did… We are doing" approach.

Our Staff Engagement Framework for 2024-25 will include engagement activities that align to the feedback we have received to further support the fulfilment of the seven elements of the NHS Our People Promise.

Trade Union Facility Time

1st April 2023 – 31st March 2024

This document details the statutory submission for the period April 2023 to March 2024 as per the Trade Union (Facility Time Publication Requirements) Regulations 2017, which took effect from 1 April 2017.

The purpose of these regulations is to promote transparency and allow for public scrutiny of facility time.

Facility time data is data that the Trust is required to collect, report and publish under the Trade Union Facility Time Publication Requirements Regulations 2017.

Facility time can be broken down as follows:

Trade union duties

- duties connected with collective bargaining – for example, on terms and conditions of employment, redundancy, allocation of work
- taking part in a negotiation or consultation process – including meeting and corresponding with managers, and informing union members of progress and outcomes
- attending a disciplinary or grievance hearing, with trade unions, including allowing reasonable time to prepare
- attending training for the trade union representative role

Trade union activities

- discussing internal union matters
- dealing with internal administration of the union – for example, answering union correspondence meetings other than as part of the negotiating or consultation process

Details of the statutory submission are contained within tables 1-4 below.

Table 1 – Relevant Union Officials

What was the total number of your employees who were relevant union officials during 2023-24?

Number of employees who were relevant trade union officials during the relevant period	*Total full-time equivalent of trade union officials*
13	10.75

Table 2 - Percentage of Time Spent on Facility Time

How many of your employees who were relevant union officials employed during 2023-24 spent a) 0%, b) 1% - 50%, c) 51% - 99%, or d) 100% of their working hours on facility time?

Percentage of time	*Number of employees*
0%	2
1 – 50%	9
51% - 99%	0
100%	2

Table 3 – Percentage of Pay Bill Spent on Facility Time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during 2023-24.

	Figures
Provide the total cost of facility time	£54,703.89
Provide the total pay bill	£67,834,000.00
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.08%

Table 4 – Paid Trade Union Activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

	Figures
Provide the total hours spent on paid trade union activities	398.85
Provide the total paid facility time hours	2915.75
Time spent on trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during 2023/24 / total paid facility time hours) x 100	13.68%

Expenditure on consultancy

The Trust spent £0.33m (2023-24: £0.5m) on Consultancy, of which £0.06m (2023-24: £0.1m) was in respect of hosting the Provider Collaborative for NHS Cheshire and Merseyside. A significant proportion of the costs for this are recharged to member organisations. A further £0.2m was spent on consultancy to support the development and implementation of Business Intelligence and Information Technology solutions. There was a further £0.07m spent on consultancy in respect of specialist VAT advice.

Off-payroll engagements

The Trust had the following highly paid off-payroll engagements as at 31 March 2025, earning £245 per day or greater:

No. of existing engagements as of 31 March 2025	13
Of which:	
No. that have existed for less than one year at time of reporting	11
No. that have existed between one & two years at time of reporting	0
No. that have existed between two & three years at time of reporting	0
No. that have existed between three & four years at time of reporting	0
No. that have existed for four or more years at time of reporting	2

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater:

Number of off-payroll workers engaged during the year ended 31 March 2025	11
Of which:	
Not subject to off-payroll legislation*	11
Subject to off-payroll legislation and determined as in scope of IR35*	0
Subject to off-payroll legislation and determined as out of scope of IR35*	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which:	
Number of engagements that saw a change to IR35 status following review	0

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

Off-payroll engagements of board members, and / or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2025:

No. of off-payroll engagements of board members, and / or senior officials with significant financial responsibility, during the financial year.	3
No. of individuals that have been deemed "board members, and/or senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	12

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

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

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

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

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

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

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

3.5 Regulatory Ratings

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

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

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; 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.

Segmentation

The Trust is currently placed in segment '2' which means that the Trust is offered targeted support by NHSE for the areas of concern, but the Trust is not obliged to take advantage of this support.

This segmentation information is the Trust's position as of 31 March 2025. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: NHS England » NHS oversight framework segmentation

Finance and use of resources

Reporting against use of resources continues to be suspended in 2024-25.

3.6 Statement of Accounting Officer's Responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Bridgewater Community Healthcare NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require [name] NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Bridgewater Community Healthcare NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

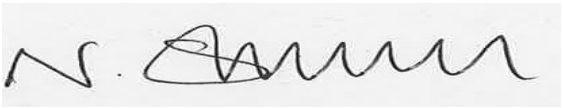
- In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:
- observe the Accounts Direction issued by NHS England, including the relevant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

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

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

aware of that information.

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



Chief Executive Date: 25 June 2025

The Accountability Report for Bridgewater Community Healthcare NHS Foundation Trust was approved on behalf of the Board on 25 June 2025

Accounting Officer Nikhil Khashu (Chief Executive)

25 June 2025

3.7 Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Bridgewater Community Healthcare NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Bridgewater Community Healthcare NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Directors oversaw all aspects of organisational performance and foreseeable risk, including challenges in achieving financial duties, ongoing financial sustainability, service pressures and maintaining key relationships and partnerships across the wider local health economy and with our commissioners, including engagement with integrated commissioning plans and the sustainability and transformation plans. Executive Directors' performance appraisals were undertaken by the Chief Executive, and personal objectives were set. The Nominations and Remuneration Committee of the Board oversees the outcome of these meetings.

The Chief Nurse / Deputy Chief Executive has delegated authority for the risk management framework and is the Executive Lead for maintaining the Board Assurance Framework and its supporting processes. They also have responsibility for clinical governance and clinical risk, including incident management.

The Chief Nurse / Deputy Chief Executive also has responsibility for patient safety and patient experience, and joint responsibility with the Medical Director for quality.

The Head of Risk Management and Patient Safety is responsible for ensuring that the Trust has suitable and sufficient systems and processes for the effective management of risk.

The Medical Director's portfolio provided leadership as the Responsible Officer (RO) and has responsibility, together with the Chief Nurse, for monitoring and improving clinical service delivery, safety, and quality and is responsible for the process for revalidation of medical staff (doctors) across the Trust.

The Chief Nurse, together with the Medical Director, has responsibility for monitoring and improving clinical service delivery, safety, and quality. This includes ensuring mechanisms are in place for reporting clinical incidents and identifying opportunities for service improvement as identified from incident investigations. They have responsibility for monitoring of Trust achievement against the Care Quality Commission (CQC) standards, supported by sound clinical governance systems across the Trust. The Chief Nurse is responsible for the process for revalidation of nursing staff across the Trust and holds the role of Executive Lead for Safeguarding. The Medical Director's role encompasses the role of Controlled Drugs Accountable Officer (CDAO) as set out in the Medicines Policy and provides the Executive Lead on medical equipment as set out in the Medical Devices Policy, they are also responsible for the revalidation of doctors. The Chief Nurse holds the role of the Caldicott Guardian as set out in the Information Governance Policy.

Directors and managers were supported by the Head of Risk Management and Patient Safety who offered specialist advice and leadership on risk register and incident system management and facilitated training for all managers with responsibility for risk management within their service and to support to their staff.

The Risk Management Framework and the Incident Reporting Policy contained the mechanisms for staff to employ to identify and manage risk. The web-based Ulysses 'Safeguard' Risk Management system accommodated the Risk Register, incident reporting, medical equipment, and central alert management functions. The system also hosted safeguarding, complaints, and Freedom of Information data.

Lessons Learned were identified by the Patient Serious Incident Review Framework and Learning Panel (PSIRFaLP) to identify and cascade areas of improvement across the Trust using electronic bulletins, intranet, and Team Brief from the Executive Team. Recommendations from investigations into serious incidents also fed directly back to local teams and services.

The risk and control framework

The Risk Management Policy (which is known as the 'Risk Management Framework') differentiates between strategic risk (the principal risks to the strategic objectives of the organisation as set out by the members of the Board) and operational risk (risks to the delivery of safe and high-quality care on a day-to-day basis as identified by operational staff).

It sets out the range of sources for risk identification, where these are documented, the responsibility and authority, expected responses, and escalation by managers to different levels of risk, and a consistent methodology for prioritising and reviewing risks based on the NHS standard 5 x 5 matrix for risk scoring.

The documented risk assessments set out in policy, whether manual or electronic (using the Ulysses 'Safeguard' risk module), require the assessor to document primarily:

- the foreseeable hazard placing an objective at risk,
- the potential impact should the hazard occur,
- existing controls that are currently mitigating the likelihood or impact,
- means of assurance on the efficacy of those controls,
- gaps in controls or assurance that have increased the level of risk,
- a plan to address any identified gaps

Policies, procedures, and clinical guidelines and associated staff training/implementation are the most common form of control for most of both strategic and operational risks. The Clinical and Corporate Policy Group (CCPG) has delegated responsibility for reviewing and approving policies, procedures, guidelines, and pathways.

Built into the process for policy development, each document can only be approved, once evidence of an Equality Impact Assessment has been completed.

The Risk Management Policy (also known as the 'Risk Management Framework') also sets out the threshold of the Board's appetite (strategic and operational) for tolerating what it deems to be high risk based on a 5 x 5 scoring matrix:

- any risk with an overall score greater than or equal to 12, or
- any overall score below this but retaining a potential severity score of '4 - Major'

The Trust's appetite towards its strategic risks is documented on the Board Assurance Framework (BAF).

All risks which score 12 or higher, are managed as part of the Corporate Risk Register.

Any risk that reaches this threshold is escalated to the monthly Risk Management Council for support and constructive challenge as these are seen as exceptional.

All risks (irrespective of risk scores) can be linked to the Board Assurance Framework, using the Trust's risk management system.

Operational risks are monitored monthly by the Directorate Associate Directors via the Risk Management Council meetings. Controls and assurance that affected local operational process were managed and recorded by managers at an operational level within the Directorate / service. All risks scoring 12 and over were escalated to the relevant Board Committee. Each of the Board Committees took a role in oversight of key risks pertaining to their remit and considered them in detail at each meeting. The Audit Committee considered the systems and processes of Risk Management at each of its meetings.

During the year, the Trust implemented the Patient Safety Incident Response Framework and Learning Panel (PSIRFaLP), this included the continuation of weekly Directorate Incident Review and Learning Groups, which provide additional scrutiny and control of the impact of patient safety incidents.

The Trust employs specialists (Health and Safety, Medicines Management, Information Governance, Security, and Equality and Diversity etc.) to maintain Trust adherence to regulations and additionally offer advice to staff and management on expected operational controls and assurances to mitigate and monitor risks.

The Digital Information Governance and Information Technology (DIGIT) group is well established and continues to meet on a bi-monthly basis. This group combines members from both the Information Governance (IG) and the Information Technology (IT) steering groups into one group. The group was chaired by the Medical Director, who was also the Chief Clinical Information Officer. Also in attendance was the Director of Finance in their role as Senior Information Risk Owner (SIRO) and the Director of Corporate Governance in their role of Data Protection Officer (DPO). The group reported to the Finance and Performance Committee. The DIGIT group is responsible for developing and implementing the Trust's Digital Strategy to ensure it is delivered in a safe, secure, and cost-effective manner. The group ensures the Digital strategy is underpinned by a comprehensive information governance framework and

IT and reporting infrastructure. An audit plan was established to ensure that the Data Security Protection Toolkit (DSPT) requirements were evidenced and fully embedded into the Trust. The DSPT is a mandatory requirement for all who handle personal information. It is "*to measure their performance against the National Data Guardian's 10 data security standards*" (NHS Digital 2020).

All managers across the Trust maintained a responsibility for the safety of their staff and patients, and the safe and effective delivery of care as part of the Trust objectives. Foreseeable hazards were risk assessed and documented on the risk register residing on the Ulysses 'Safeguard' Risk Management System or, if something adverse occurred it was recorded on the same system as an incident.

Risks, complaints, and incidents were monitored and triangulated by the Risk Management Council with any thematic lessons to be learned for Trust-wide dissemination reported via the 'MyBridgewater' bulletin and via the Trust extranet.

Monthly operational performance, finance, human resource, incident, and patient experience information was collated by the Information and Performance Team for reporting to the Board in a single Integrated Quality Performance Report (IQPR). As gatekeepers of all contributions to the IQPR, the Performance Team only included data on the understanding that local quality checks by services had taken place, and that figures and supporting narratives had been reviewed by the relevant director before publication. This data was aggregated against Key Performance Indicators (KPIs) and submitted back to services for explanatory narrative. Additionally, specific reports were collated for the Board monthly and quarterly encompassing infection control, incidents, complaints and clinical audit etc.

The Board of Directors continued to be accountable for the establishment and ongoing delivery of services within the requirements of the Provider Licence, risk assessment framework, and maintaining regulatory compliance, including against CQC ratings and feedback from inspections. As a committee of the Board, the Quality and Safety Committee obtained routine assurance on compliance with CQC registration requirements. As a Committee of the Board, the Finance and Performance Committee monitored and challenged the robustness of financial controls and escalates significant risks and actions where they did not appear robust.

Operational risks as identified by operational staff and managers within Directorates and services are risks which may foreseeably impede the safe delivery of high-quality services to patients on a day-to-day basis. Significant operational risks could adversely affect a service's ability to meet organisational objectives.

Operational risks are identified, assessed, and documented at service level and monitored by the Directorate Leadership Teams with any significant issues escalating to the Performance meetings, the Risk Management Council, and all risks scoring 12+ are escalated to the relevant Board Committee or Board as a standing agenda item. The Committees consider the Risk Register and IQPR to identify areas of concern and routinely request detailed papers on specific risks.

To provide the Trust with assurance that risks have been identified and are being managed correctly, the Risk Management Council meets monthly. The Council reviewed the Corporate Risk Register and received reports from Directorate and Service leads regarding the risks within their respective portfolios. This occurred every month during 2024-25.

During 2024-25 the Trust recognised the most routinely reported significant operational risks likely to remain the focus of risk treatment during 2025-26. These risks relate to:

- Demand and capacity issues within both clinical services and corporate support functions. This remains a strategic issue and systems are in place which are referred to in the strategic risk referred to below.
- Potential breaches of waiting times for assessment and treatment. As these breaches occur, they are now being reported via Ulysses as incidents to establish whether any harm has occurred and form part of monthly monitoring via the IQPR. This clinical harm review process did not identify any significant harm to patients.
- Performance and delivery of KPI's.
- Information technology issues. These were identified as symptoms of more strategic issues and systems put in place. The oversight of risk relating to Information Technology was strengthened by consolidating the meeting structure, for Information Technology and Information Governance.

Operational finance risks. These were acknowledged and reported to the Finance & Performance Committee during 2024-25. However, it should be noted that due to the changed NHS finance regime as a result of the pandemic, the risk profile of all Finance risks has reduced and there are none with a risk score of 12 or above.

Strategic risks are those principal risks recorded on the Board Assurance Framework (BAF) that may foreseeably impede the ability of the organisation to deliver its objectives. Each of these retains controls, assurances and any gaps that are the responsibility of a lead director and are assigned to a Board Committee which oversees the actions of each strategic risk. The assurances are within those documents received by the Board.

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

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

If the Trust fails to deliver on its strategy or fails to make the expected contribution by not meeting the needs of partners, commissioners or the Integrated Care Board, it could lose its identity as a key system contributor and place partner. This may reduce the Trust's influence within the Integrated Care System or provider collaborative which could result in services being assigned to other providers and the Trust would become financially and clinically unsustainable.

Quality. Failure to deliver quality services and continually improve.

If we fail to deliver quality services and consistently strive for improvement in a safe and inclusive environment, it could lead to potential harm to patients, an increase in complaints and claims, and ultimately, a poor patient experience.

Health Equity. Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients.

If we fail to understand health inequity with our communities, we may fail to deliver services equitably, which could contribute to health inequity and our patients abilities to improve their health.

Staff. Failure to sustain an environment for staff to develop, grow and thrive.

If we fail to maintain a safe and inclusive environment where staff can develop, grow, and thrive, it may lead to low staff morale, ineffective teamwork, reduced compliance with policies and standards, high levels of staff absence, and high staff turnover rates.

Resources. Failure to use our resources in a sustainable and effective way.

Failure to utilise our resources efficiently, effectively, and sustainably could negatively impact the quality and safety of the services we provide. These resources include workforce, finance, estates, and digital assets.

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

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

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

Partnerships. Failure to work in close collaboration with partners and staff in place and across the system.

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

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

The Board met on a bi-monthly basis and delegated to the Committees of the Board. The Trust Chair was responsible for the leadership of the Board and ensured that members of the Board had access to relevant information to assist them in the delivery of their duties. Records of Board attendance are reported in the Annual Report, and these confirm that their attendance ensured that all the meetings of the Board and Committees of the Board were quorate. The Non-Executive Directors actively provided scrutiny and contributed challenge at Board and Board Committee level. The Board and its Committees comprised membership and representation from appropriate staff and Non-Executive Directors with sufficient experience and knowledge to support the Committees in discharging their duties. The Board was well attended by all Executives and Non-Executives throughout the year, ensuring that the Board was able to make fully informed decisions to support and deliver the strategic objectives.

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

In 2024-25 the Trust completed a Corporate Governance Statement (required under NHS foundation trust condition 4(8) (b)). The Board was satisfied that systems and standards of

corporate governance are sound. The Director of Corporate Governance engaged with the NHS Providers Company Secretaries Network and routinely checked the NHS England website and publications to ensure the Trust remained compliant and responsive to any new information or requirements. Terms of Reference of all the Board Committees were reviewed during 2024-25. External audit reports supported the annual financial accounts. The Finance and Performance Committee, as a Committee of the Board, routinely scrutinised the Trust's financial decision-making, management, and control. There continues to be an Integrated Quality Performance Report (IQPR), Accountability Framework and Performance Framework in place to ensure the Board is sighted on significant issues and risks in an appropriate manner. The Trust undertook a range of engagement with its stakeholders, through Governors and Patient Partners via Healthwatch. A Trust-wide staff engagement programme was in place, and directors regularly undertook drop-ins to team meetings, both virtual and face-to-face.

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

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

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

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

The Audit Committee oversaw a programme of counter fraud arrangements, including the contract with Mersey Internal Audit Agency (MIAA) for an Anti-Fraud Specialist. An MIAA Internal Audit Plan was developed and produced to address and ensure coverage of key risk areas of the Trust, with reference to strategic risks identified within the BAF, management requests into areas of potential gaps and weaknesses etc. along with mandated reviews. The overall opinion from MIAA, internal auditors, for the period 1st April 2024 to 31st March 2025 provides Substantial Assurance that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

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

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

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

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality. This applies to all decision-making staff, budget holding staff of Band 7 and above, all Band 8As and above, and any other member of staff with an interest to declare over the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

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

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

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

NHS organisations were required to deliver efficiencies during 2024-25.

The Trust's Finance and Performance Committee oversaw delivery of the Trust's efficiency programmes and provided appropriate assurance directly to the Board.

Cost savings requirements were identified in the planning guidance and were followed up with an additional stretch target identified by the ICS of £2.0m for integration savings.

This results in total savings of £6.94m (Trust plan of £4.94m 4.9% plus the stretch target of £2.0m) in line with ICB instruction.

The Trust plan to month twelve is £6.94m, against which achievement of £5.00m is reported, which includes £0.08m relates to integration savings. Of this achievement, £1.76m has been achieved recurrently.

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

Information Governance

Information Governance provides the framework to enable staff to deal consistently with the various rules, laws, and guidance in relation to how information is handled. Ensuring the security of Trust information requires engagement from individuals, teams, services, and departments, including information asset owners, service/department managers, Estates, Facilities, and Procurement.

Information Governance encompasses the processing of all information, including personal information such as patient and employee data, as well as corporate information such as financial and accounting records, policies, and contracts.

To ensure our staff, patients, and service users are informed about how we handle their information, we maintain up-to-date Privacy Notices for both patients and staff, including a bespoke Privacy Notice for the children who attend our services. These Privacy Notices are available in different formats to accommodate various needs.

The Digital Information Governance and Information Technology (DIGIT) group is responsible for ensuring the Trust's Digital Strategy is achieved.

The Trust, like all organisations that process health information, must be registered with NHS England’s Data Security Protection Toolkit (DSPT). The DSPT is an essential tool for maintaining high standards of data security and protecting patient information. Since 2022, we have consistently achieved the “standards met” status and ensure that our third-party suppliers also achieve the DSPT.

The Trust, like other health organisations, must be registered with NHS England's Data Security and Protection Toolkit (DSPT). This toolkit is indispensable for upholding high standards of data security and safeguarding patient information. The Trust has consistently achieved the "standards met" status since 2022. It exemplifies the Trust's steadfast commitment to data security. As a data controller, we also ensure that our third-party suppliers also comply with DSPT requirements, thereby ensuring comprehensive data protection.

The Data Security and Protection Toolkit (DSPT) is governed by the Department of Health and Social Care (DHSC). It serves as the platform on which health organisations also report serious data security breaches. When a breach affects the rights and freedoms of individuals, it is investigated by the Information Commissioner's Office (ICO).

Data Security Incidents 2024-25

In accordance with DHSC requirements, all serious incidents are reported through the DSPT. In , we reported one significant incident involving our third-party supplier. During this incident, a delivery van was looted resulting in the loss of delivery details for our patients. The matter was thoroughly investigated by the police, and the Trust ensured that the supplier implemented a rigorous action plan to prevent future occurrences.

Data quality and governance

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

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

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

The Trust remains proactive in improving data quality by providing:

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

Review of effectiveness

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

During the year, the Audit Committee undertook a review of its effectiveness, which reported an overall satisfaction score of 4.67 out of 5. The Trust has used a combination of internal subject matter experts and external development support. All Board members have an appraisal with the Chair or Chief Executive, the results of which are reported to the Remuneration Committee or the Governors' Nominations Committee. The Council of Governors oversee the performance review of the Chair and the Non-Executive Directors of

the Trust to help inform their decisions on the re-appointment or termination of Non-Executive Directors as necessary.

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

The focus of an Audit Committee's work is related to internal financial control matters, the maintenance of proper accounting records, the reliability of financial information, and a wider focus on the safety and quality of patient care.

During the financial reporting period for 2024-25 the Audit Committee have complied with 'good practice' recommended through:

- Agreement of Internal and External Audit and Anti-Fraud plans.
- Regular review of progress and outcomes in relation to internal audit and counter fraud.
- Private meetings with External, Internal Audit and Anti-Fraud.
- Regular review of the Audit Committee work plan.
- Review of the Committee's Terms of Reference.

The overall opinion from the Director of Internal Audit for the period 1st April 2024 to 31st March 2025 provides Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

This opinion is provided in the context that the Trust, like other organisations across the NHS is facing a number of challenging issues and wider organisational factors particularly with regards to the ongoing elective recovery response, workforce challenges, financial challenges and increasing collaboration across organisations and systems.

In providing this opinion we can confirm continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. We also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

The purpose of our Head of Internal Audit (HoIA) Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. As such, it is one component that the Board takes into account in making its Annual Governance Statement (AGS). The opinion does not imply that we have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework.

During the year MIAA has completed 13 internal audit reviews, covering both clinical and non-clinical systems and processes and formed a view on the level of assurance as follows:

	Review	Assurance Opinion	Recommendations Raised				
			Critical	High	Medium	Low	Total
1	Assurance Framework	N/A	-	-	-	-	-
2	Quality Impact Assessments	High	-	-	-	1	1
3	Freedom to Speak Up	High	-	-	-	1	1
4	Risk Management Core Controls	High	-	-	-	-	-
5	General Ledger	High	-	-	-	-	-
6	Accounts Payable	High	-	-	-	1	1
7	Accounts Receivable	High	-	-	-	1	1
8	Treasury Management	High	-	-	-	-	-
9	EPRR	Substantial	-	-	2	3	5
10	Dermatology Service	Substantial	-	-	1	1	2
11	PSIRF	Substantial	-	-	1	4	5
12	Quality Spot Checks (Patient Carer ID)	Moderate	-	1	3	-	4
13	Bank & Agency	Moderate	-	1	3	2	6
		TOTAL	**-**	**2**	**10**	**14**	**26**

These audits were presented to the Audit Committee for oversight and to provide assurance. Individual Committees take responsibility for tracking progress against recommendations and

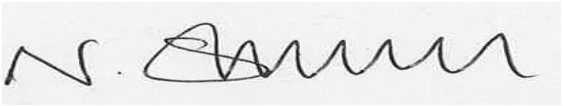
action plans. The Quality and Safety Committee were also in receipt of the progress of Clinical Audit programmes across the Trust.

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

Conclusion

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

Signed



Nikhil Khashu

Chief Executive Date: 25 June 2025

4. Annual Accounts for year ended 31 March 2025

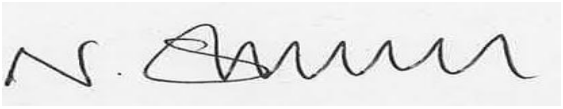
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 March 2025

FOREWORD TO THE ACCOUNTS

These accounts, for the period ended 31 March 2025, have been prepared by Bridgewater Community Healthcare NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed:



Name: Nikhil Khashu
Job title: Chief Executive
Date: 25 June 2025

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Bridgewater Community Healthcare NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Bridgewater Community Healthcare NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

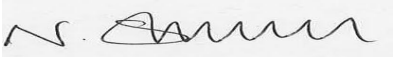
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

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

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

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

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

Signed:  Chief Executive Date: 25 June 2025

Statement of Comprehensive Income for year ended 31 March 2025

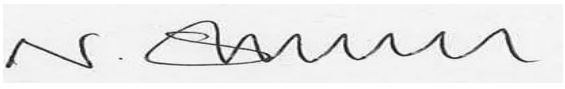
	Note	**2024/25 £000**	2023/24 £000
Operating income from patient care activities	3	**104,365**	98,864
Other operating income	4	**3,221**	3,059
Operating expenses	6,8	**(108,756)**	(103,240)
Operating (deficit)/surplus from continuing operations		**(1,170)**	(1,317)
Finance income	10	**729**	1,054
Finance expenses	11	**(369)**	(408)
PDC dividends payable		**(386)**	(139)
Net finance (costs)/income		**(26)**	507
Other (losses)/gains	12	**-**	(14)
(Deficit)/surplus for the year from continuing operations		**(1,196)**	(824)
(Deficit)/surplus for the year		**(1,196)**	(824)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	**-**	(165)
Revaluations	15	**139**	259
Total comprehensive (expense)/income for the year		**(1,057)**	(730)

Statement of Financial Position as at 31 March 2025

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets:			
Intangible assets	13	**1,013**	1,090
Property, plant and equipment	14	**10,879**	10,048
Right of use assets	16	**36,524**	39,484
Receivables	18	**80**	74
Total non-current assets		**48,496**	50,696
Current assets:			
Inventories	17	**799**	40
Receivables	18	**14,254**	9,671
Cash and cash equivalents	19	**8,179**	17,334
Total current assets		**23,232**	27,045
Current liabilities			
Trade and other payables	20	**(9,194)**	(9,884)
Borrowings	22	**(4,484)**	(3,567)
Provisions	23	**(172)**	(215)
Other liabilities	21	**(61)**	(1,472)
Total current liabilities		**(13,911)**	(15,138)
Total assets less current liabilities		**57,817**	62,603
Non-current liabilities:			
Borrowings	22	**(32,944)**	(36,848)
Total non-current liabilities		**(32,944)**	(36,848)
Total assets employed		**24,873**	25,755
Financed by:			
Public dividend capital		**33,996**	33,821
Revaluation reserve		**2,659**	2,593
Income and expenditure reserve		**(11,782)**	(10,659)
Total taxpayers' equity		**24,873**	25,755

The notes on pages 137 to 170 form part of this account

The annual accounts on pages 131 to 170 were approved by the Board on 25 June 2025 and signed on its behalf by:



Chief Executive: **Date: 25 June 2025**

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

	Public Dividend Capital	Revaluation Reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 – brought forward	**33,821**	**2,593**	**(10,659)**	**25,755**
Deficit for the year	-	-	(1,196)	**(1,196)**
Other transfers between reserves	-	(73)	73	**-**
Impairments	-	-	-	**-**
Revaluations	-	139	-	**139**
Public dividend capital received	175	-	-	**175**
Taxpayers' and others' equity at 31 March 2025	**33,996**	**2,659**	**(11,782)**	**24,873**
Taxpayers' and others' equity at 1 April 2023 – brought forward	33,477	2,567	(9,903)	**26,141**
Surplus for the year	-	-	(824)	**(824)**
Other transfers between reserves	-	(68)	68	**-**
Impairments	-	(165)	-	**(165)**
Revaluations	-	259	-	**259**
Public dividend capital received	344	-	-	**344**
Taxpayers' and others' equity at 31 March 2024	**33,821**	**2,593**	**(10,659)**	**25,755**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows for the year ended 31 March 2025

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating (deficit)/surplus		**(1,170)**	(1,317)
Non-cash income and expense:			
Depreciation and amortisation	6	**6,296**	6,348
Net impairments	7	**-**	787
(Increase) in receivables and other assets		**(4,528)**	(663)
Decrease in inventories		**(759)**	41
(Decrease) in payables and other liabilities		**(2,240)**	(5,888)
(Decrease) in provisions		**(43)**	(524)
Other movements in operating cash flows		**8**	-
Net cash flows (used in)/from operating activities		**(2,436)**	(1,216)
Cash flows from investing activities			
Interest received		**729**	1,054
Purchase of intangible assets		**(788)**	(207)
Purchase of property, plant, equipment and investment property		**(1,280)**	(1,871)
Sales of property, plant, equipment and investment property		**-**	-
Initial direct costs or up front payments in respect of new right of use assets (lessee)		**-**	(61)
Net cash (used in) investing activities		**(1,339)**	(1,085)
Cash flows from financing activities			
Public dividend capital received		**175**	344
Capital element of finance lease rental payments		**(4,730)**	(4,488)
Interest paid on finance lease liabilities		**(369)**	(407)
PDC dividend (paid) / refunded		**(456)**	(130)
Net cash (used in) financing activities		**(5,380)**	(4,681)
(Decrease) in cash and cash equivalents		**(9,155)**	(6,982)
Cash and cash equivalents at 1 April – brought forward		**17,334**	24,316
Cash and cash equivalents at 31 March	19	**8,179**	17,334

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. The Trust is also required to disclose material uncertainties in respect of events or conditions that may cast significant doubt upon the going concern ability of the Trust and the Trust does not consider that there are any such events or conditions requiring disclosure. However, details have been provided below in respect of future potential core activity changes.

The Trust reported a deficit of £1.196m in 2024-25. However, this includes adjusting items such as the net impact of Department of Health and Social Care (DHSC) procured inventories. Excluding these items, the Trust's adjusted financial position for 2024-25 is a deficit of £1.156m.

The Trust has submitted a 2025/26 plan to both NHS Cheshire and Merseyside ICB and NHS England (NHSE) showing a deficit of £1.53m. The Board has approved the plan.

The Trust continues to actively seek new business opportunities with Commissioners either through tendering opportunities being advertised or collaborative working.

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

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to

receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

Revenue from NHS contracts

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

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

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

NHS injury cost recovery scheme

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

claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from Commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the 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 apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Subsequent expenditure

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

Measurement

Valuation

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

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service

potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

Revaluation gains and losses

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Min life Years	**Max life Years**
Land	-	-
Buildings, excluding dwellings	5	99
Plant & machinery	3	24
Information technology	2	9
Furniture & fittings	10	20

Note 1.8 Intangible assets

Recognition

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

Software

Software, which is integral to the operation of hardware, e.g., an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software, which is not integral to the

operation of hardware, e.g. application software, is capitalised as an intangible asset, where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Min life Years	Max life Years
Intangible assets - purchased		
Software	2	8
Other	4	5

Note 1.9 Inventories

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

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the

date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% 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 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2024:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% 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 23.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed, 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 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set

out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax

The Trust has determined that it has no corporation tax liability as it does not operate any commercial activities that are not part of core health care delivery.

Note 1.18 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.19 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

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

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

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

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

Note 1.20 Third party assets

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

Note 1.21 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 1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

Other standards, amendments and interpretations

IFRS 17 Insurance Contracts - The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 was issued in April 2024 and applies to periods beginning on or after 1 January 2027. The standard has not yet been adopted by FRAB for inclusion within the FREM and therefore it is not yet possible to confirm how this will impact on the Trust's accounts in the future.

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 1.25 Critical judgements in applying accounting policies

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

- In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision only affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

- Non-consolidation of the Trust's element of the registered charity Mersey Care NHS Foundation Trust Charity (charity number 1191576). In making this judgement the Trust has made reference to the DHSC GAM 2024/25. The Trust's element of this fund is managed under a Service-level agreement with Mersey Care NHS Foundation Trust. Whilst the Trust is able to requisition expenditure from this fund within the constraints of the fund objective,

corporate Trusteeship of the fund remains with Mersey Care NHS Foundation Trust. Where a body acts as a corporate Trustee, there is a presumption that the body possesses 'control' of the fund. Therefore, there is no need for the Trust to consolidate; and

- Valuation of the Trust's land and buildings. In making this judgement the Trust has engaged with an independent RICS Registered Valuer, 'DVS - Property Services arm of the VOA' which performs a full revaluation of the Trust's land and buildings every 5 years. The Trust considers this to be of sufficient regularity to ensure that the carrying values of land and buildings are not materially misstated and further confirms this by (i) requesting the DVS to perform a desktop revaluation exercise in the intervening years; and (ii) performing an annual impairment review of the asset register (including land and buildings).

Note 1.26 Sources of estimation uncertainty

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

Accounting for Impairments

The Trust accounts for impairments using an adaptation of IFRS as per the FReM and Department of Health and Social Care Group Accounting Manual (GAM). Details of impairments are included in note 7.

Actuarial assumptions for costs relating to the NHS Pension Scheme

The Trust reports as operating expenditure employer contributions to staff pensions. These contributions are based on an annual actuarial estimate of the required contribution to meet the scheme's liabilities.

Accruals

Accruals are largely based on known commitments and are assessed accurately. Where estimates are made, they are based on historical records, precedence and officers' knowledge and experience. In all cases, the Trust adopts a prudent approach to avoid overstating its resources.

Asset valuations and lives

The value and remaining useful lives of land and building assets are estimated by DVS - Property Services arm of the VOA, who provide professional valuation services. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the DHSC and HM Treasury. Valuations are carried out primarily on the basis of Depreciated Replacement Cost based on the Modern Equivalent for specialised operational property (property rarely sold on the open market) and Current Value in Existing Use for non-specialised operational property.

Note 2 Operating Segments

The Trust operates in a single segment, the provision of community healthcare services. There are therefore no reportable segments.

Income from transactions with the following organisations is in excess of 10% of total income:

	2024/25	2023/24

	£'000	£'000
CCGs and NHS England	**5,966**	4,880
Integrated Care Boards	**78,722**	75,041
Local Authorities	**16,338**	16,133
	101,026	96,054

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

Note 3.1 Income from patient care activities (by nature)

	2024/25	2023/24
	£000	£000
Community services		
Income from commissioners under API contracts*	**79,933**	76,889
Income from other sources (e.g. local authorities)	**19,512**	18,943
All services		
Additional pension contribution central funding**	**4,920**	3,023
National pay award central funding***	**-**	9
Total income from activities	**104,365**	98,864

*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. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% 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.

***Additional funding was made available directly to providers by NHS England in 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 3.2 Income from patient care activities (by source)

	2024/25	2023/24
	£000	£000
NHS England	**5,966**	4,880
Integrated care boards	**78,887**	75,041
Department of Health and Social Care	**68**	-
Other NHS providers	**2,226**	2,030
Local authorities	**16,338**	16,133
NHS injury cost recovery scheme	**51**	73
Non-NHS: other	**829**	707
	104,365	98,864
Of which:		
Related to continuing operations	**104,365**	98,864
Related to discontinued operations	**-**	-

Note 4 Other operating income

	2024/25	2023/24

	£000	£000
Other operating income from contracts with customers:		
Education and training (excluding notional apprenticeship levy income)	**1,368**	1,490
Non-patient care services to other bodies	**1,282**	1,112
Other contract income	**-**	8
Other non-contract operating income		
Education and training	**555**	345
Charitable and other contributions to expenditure	**-**	104
Other non-contract income	**16**	-
	3,221	3,059
Of which:		
Related to continuing operations	**3,221**	3,059
Related to discontinued operations	**-**	-

Note 5 Income from activities arising from commissioner requested services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25 £000	2023/24 £000
Income from services not designated as commissioner requested services	**104,365**	98,864
	104,365	98,864

Note 6 Operating expenses

	2024/25 £000	2023/24 £000
Purchase of healthcare from NHS and DHSC bodies	**2,522**	2,707
Purchase of healthcare from non-NHS and non-DHSC bodies	**2,444**	1,923
Staff and executive directors costs	**77,156**	72,638
Remuneration of non-executive directors	**140**	137
Supplies and services – clinical (excluding drugs costs)	**5,240**	5,791
Supplies and services - general	**573**	436
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**3,501**	2,420
Consultancy	**335**	537
Establishment	**3,329**	3,531
Premises	**4,208**	4,562
Transport (including patient travel)	**238**	289
Depreciation on property, plant and equipment	**5,794**	5,846
Amortisation on intangible assets	**502**	502
Net impairments	**-**	787
Movement in credit loss allowance: contract receivables/contract assets	**82**	(813)
Movement in credit loss allowance: all other receivables and investments	**3**	14
Increase/(decrease) in other provisions	**(3)**	3
Fees payable to the external auditor		
- audit services - statutory audit*	**209**	211
Internal audit costs	**108**	89
Clinical negligence	**870**	715
Research and development	**61**	-

Education and training	**1,421**	836
Losses, ex gratia & special payments	**1**	-
Other	**22**	79
	108,756	103,240
Of which:		
Related to continuing operations	**108,756**	103,240
Related to discontinued operations	**-**	-

* Fees payable to the external auditor of £209k include VAT and additional costs incurred relating to the statutory audit for the financial year ended 31 March 2024. The fee payable to the external auditor for the statutory audit for the financial year ended 31 March 2025 is £203k excluding VAT.

Fees payable to the external auditor of £211k include VAT and additional costs incurred relating to the statutory audit for the financial year ended 31 March 2023, and forecast additional costs relating to the statutory audit for the financial year ended 31 March 2024. The fee payable to the external auditor for the statutory audit for the financial year ended 31 March 2024 is £167k excluding VAT

Note 6.1 Limitation on auditors' liability

An obligation to indemnify is no longer appropriate in an audit relationship. The limitation on auditors' liability in 2024/25 for external audit work carried out was £1 million.

Note 7 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus/(deficit) resulting from:		
Other	**-**	787
Total net impairments charged to operating surplus / deficit	**-**	787
Impairments charged to the revaluation reserve	**-**	165
Total net impairments	**-**	952

Note 8 Employee benefits

	2024/25	2023/24
	£000	£000
Salaries and wages	**56,606**	52,080
Social security costs	**5,269**	5,191
Apprenticeship levy	**267**	260
Employer's contributions to NHS pensions	**12,433**	9,963
Pension cost - other	**23**	31
Temporary staff (including agency)	**3,010**	5,133
Total gross staff costs	**77,608**	72,658
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**77,608**	72,658
Of which:		
Costs capitalised as part of assets	**24**	20

Note 8.1 Retirements due to ill health

During 2024/25 there were 4 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £140k (£62k in 2023/24).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the Scheme can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both the 1995/2008 and 2015 schemes 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 31 March 2024, 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 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 10 Finance income

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

	2024/25	2023/24
	£000	£000

Interest on bank accounts	**729**	1,054
Total	**729**	1,054

Note 11 Finance expenditure

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

	2024/25	2023/24
	£000	£000
Interest on lease obligations	**369**	408
Total interest expense	**369**	408
Total finance costs	**369**	408

Note 12 Other gains

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	**-**	-
Losses on disposal of assets	**-**	(14)
Total (losses)/gains on disposal of assets	**-**	(14)
Total other (losses)/gains	**-**	(14)

Note 13 Intangible assets

Note 13.1 Intangible assets – 2024/25

	Software Licences £000	**Intangible assets under construction £000**	**Other (purchased) £000**	**Total £000**
Valuation/gross cost at 1 April 2024	**1,968**	**-**	**63**	**2,031**
Additions	426	-	-	**426**
Reclassifications	-	-	-	**-**
Disposals / derecognition	(699)	-	(63)	**(762)**
Valuation/gross cost at 31 March 2025	**1,695**	**-**	**-**	**1,695**
Amortisation at 1 April 2024	**879**	**-**	**62**	**941**
Provided during the year	502	-	-	**502**
Disposals / derecognition	(699)	-	(62)	**(761)**
Amortisation at 31 March 2025	**682**	**-**	**-**	**682**
Net book value at 31 March 2025	**1,013**	**-**	**-**	**1,013**
Net book value at 1 April 2024	1,089	-	1	1,090

Note 13.2 Intangible assets – 2023/24

	Software Licences £000	Intangible assets under construction £000	Other (purchased) £000	Total £000
Valuation/gross cost at 1 April 2023	4,958	-	63	5,021
Additions	448	121	-	569
Reclassifications	121	(121)	-	-
Disposals/ de-recognition	(3,559)	-	-	(3,559)
Valuation/gross cost at 31 March 2024	1,968	-	63	2,031
Amortisation at 1 April 2023	3,940	-	52	3,992
Provided during the year	492	-	10	502
Disposals / derecognition	(3,553)	-	-	(3,553)
Amortisation at 31 March 2024	879	-	62	941
Net book value at 31 March 2024	1,089	-	1	1,090
Net book value at 1 April 2023	1,018	-	11	1,029

14 Property, plant and equipment

Note 14.1 Property, plant and equipment – 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 – brought forward	**903**	**5,345**	**-**	**2,576**	**4,125**	**372**	**13,321**
Additions	-	537	41	522	690	-	**1,790**
Impairments	-	-	-	-	-	-	**-**
Reversal of impairments	-	-	-	-	-	-	**-**
Revaluations	-	139	-	-	-	-	**139**
Reclassifications	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(212)	(1,144)	(128)	**(1,484)**
Valuation/gross cost at 31 March 2025	**903**	**6,021**	**41**	**2,886**	**3,671**	**244**	**13,766**
Accumulated depreciation at 1 April 2024 – brought forward	**-**	**52**	**-**	**882**	**2,101**	**238**	**3,273**
Provided during the year	-	212	-	268	593	18	**1,091**
Revaluations	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(205)	(1,144)	(128)	**(1,477)**
Accumulated depreciation at 31 March 2025	**-**	**264**	**-**	**945**	**1,550**	**128**	**2,887**
Net book value at 31 March 2025	**903**	**5,757**	**41**	**1,941**	**2,121**	**116**	**10,879**
Net book value at 1 April 2024	903	5,293	-	1,694	2,024	134	10,048

Note 14.2 Property, plant and equipment – 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023 – brought forward	**880**	**4,537**	**290**	**2,318**	**4,112**	**353**	**12,490**
Additions	-	720	242	381	488	19	**1,850**
Impairments	-	(526)	(5)	-	-	-	**(531)**
Reversal of impairments	-	23	-	-	-	-	**23**
Revaluations	23	64	-	-	-	-	**87**
Reclassifications	-	527	(527)	-	-	-	**-**
Disposals/de-recognition	-	-	-	(123)	(475)	-	**(598)**
Valuation/gross cost at 31 March 2024	**903**	**5,345**	**-**	**2,576**	**4,125**	**372**	**13,321**
Accumulated depreciation at 1 April 2023 – brought forward	**-**	**35**	**-**	**714**	**1,924**	**217**	**2,890**
Provided during the year	-	189	-	283	652	21	**1,145**
Revaluations	-	(172)	-	-	-	-	**(172)**
Disposals/de-recognition	-	(248)	-	(413)	(1,296)	(120)	**(2,077)**
Accumulated depreciation at 31 March 2024	**-**	**52**	**-**	**882**	**2,101**	**238**	**3,273**
Net book value at 31 March 2024	**903**	**5,293**	**-**	**1,694**	**2,024**	**134**	**10,048**
Net book value at 1 April 2023	880	4,502	290	1,604	2,188	136	9,600

Note 14.3 Property, plant and equipment financing – as at 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	903	5,757	41	1,941	2,121	116	**10,879**
Net book value at 31 March 2025	**903**	**5,757**	**41**	**1,941**	**2,121**	**116**	**10,879**

Note 14.4 Property, plant and equipment financing – as at 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned	903	5,293	-	1,694	2,024	134	10,048
Net book value at 31 March 2024	**903**	**5,293**	**-**	**1,694**	**2,024**	**134**	**10,048**

Note 14.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	903	5,757	41	1,941	2,121	116	**10,879**
Total net book value at 31 March 2025	**903**	**5,757**	**41**	**1,941**	**2,121**	**116**	**10,879**

Note 14.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	903	5,293	-	1,694	2,024	134	**10,048**
Total net book value at 31 March 2024	**903**	**5,293**	**-**	**1,694**	**2,024**	**134**	**10,048**

Note 15 Revaluations of property, plant and equipment

All of the Trust's owned Land and Buildings have been revalued at 31 March 2025 based on a desktop revaluation exercise. The last full revaluation was carried out on 31 March 2024. The revaluation was carried out independently by:

DVS - Property Services arm of the VOA (DipSurv MRICS RICS Registered Valuer)
Crewe Valuation Office
2nd Floor Wellington House
Delamere Street
Crewe
CW1 2LQ

The revaluation was undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the Annual Reporting Manual. The assumption has been made that the properties valued will continue to be held for the foreseeable future having regard to the prospect and viability of the continuance of occupation. The basis of valuation is Current Value which has been interpreted as market value for existing use.

For those properties where there is market-based evidence to support the use of ‘Existing Use Value’ (EUV) to arrive at Current Value the comparative method of valuation has been adopted.

For those properties where there is no market-based evidence to support the use of EUV to arrive at Current Value, the Depreciated Replacement Cost (DRC) approach has been used.

Note 16 Leases - Bridgewater Community Healthcare NHS Foundation Trust as a lessee

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

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

The Trust leases properties from a wide range of landlords - whilst some landlords issue longer term leases, NHS Property Services and Community Health Partnerships, in particular, historically only issued short-term arrangements. For these properties, the Trust adopted a lease term, on transition to IFRS 16, of either:

- **10 years**, where the services delivered from these properties were 'core services' provided by the Trust and there was no intention to cease that provision nor vacate the property.
- **5 years**, where the services delivered from these properties were 'core services' provided by the Trust and there was no intention to cease that provision however the location of the service provision was being reconsidered as part of the Estates Strategy and was not known with certainty.

The Trust has confirmed with NHS Property Services and Community Health Partnerships that this assessment of lease term, where a signed lease is not in place, is appropriate.

The Trust also leases pool vehicles with contract terms of 3 to 5 years.

Information about leases for which the Trust is a lessee is presented below:

Note 16.1 Right of use assets - 2024/25

	Property (land and buildings)	Plant & Machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**47,654**	**301**	**47,955**	**36,153**
Additions	893	-	**893**	893
Remeasurements of the lease liability	850	-	**850**	**850**
Disposals / derecognition	(407)	-	**(407)**	**(407)**
Valuation / gross cost at 31 March 2025	**48,990**	**301**	**49,291**	**37,489**
Accumulated depreciation at 1 April 2024 - brought forward	**8,406**	**65**	**8,471**	**7,132**
Provided during the year	4,608	95	**4,703**	**3,814**
Disposals / derecognition	(407)	-	**(407)**	**(407)**
Accumulated depreciation at 31 March 2025	**12,607**	**160**	**12,767**	**10,539**
Net book value at 31 March 2025	**36,383**	**141**	**36,524**	**26,950**
Net book value at 1 April 2024	**39,248**	**236**	**39,484**	**29,021**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	26,950

Note 16.2 Right of use assets - 2023/24

	Property (land and buildings)	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**44,070**	**274**	**44,344**	**32,442**
Additions	-	146	146	-
Remeasurements of the lease liability	4,116	-	4,116	3,735
Impairments	(468)	-	(468)	-
Reversal of impairments	24	-	24	-
Revaluations	(64)	-	(64)	-
Disposals/ derecognition	(24)	(119)	(143)	(24)
Valuation / gross cost at 31 March 2024	**47,654**	**301**	**47,955**	**36,153**
Accumulated depreciation at 1 April 2023 - brought forward	**3,893**	**84**	**3,977**	**3,378**
Provided during the year	4,601	100	4,701	3,778
Revaluations	(64)	-	(64)	-
Disposals/ derecognition	(24)	(119)	(143)	(24)
Accumulated depreciation at 31 March 2024	**8,406**	**65**	**8,471**	**7,132**
Net book value at 31 March 2024	**39,248**	**236**	**39,484**	**29,021**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	29,021

Note 16.3 Revaluation of right of use assets

For the majority of right of use assets. the Trust has applied the 'IFRS 16 cost model' as an appropriate proxy for current value in existing use. The Trust has identified right of use assets where the rental paid on the properties was not indicative of market value and for those leases the revaluation model under IFRS 16 is required and has been supplied as at 31 March 2025 by DVS (Property Services arm of the VoA). Refer to Note 15 for further details regarding the valuer.

Where the revaluation model under IFRS 16 has been adopted, the valuer has identified the current market rental value for existing use that could be achieved for the right-of-use asset as at the valuation date and used an appropriate yield as at the valuation date for the full remaining lease term (as defined in IFRS 16). For right-to-use specialised assets, the DRC method of valuation has been applied to arrive at the current value for existing use to the lessee.

Note 16.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 22.

	2024/25 £000	**2023/24 £000**
Carrying value at 31 March	**40,415**	**40,701**
Lease additions	893	85
Lease liability remeasurements	850	4,116
Interest charge arising in year	369	408
Lease payments (cash outflows)	(5,099)	(4,895)
Carrying value at 31 March	**37,428**	**40,415**

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.

Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.5 Maturity analysis of future lease payments

	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000	**Total 31 March 2024 £000**	Of which leased from DHSC group bodies: 31 March 2024 £000
Undiscounted future lease payments payable in:				
- not later than one year;	4,847	4,001	3,940	2,950
- later than one year and not later than five years;	19,438	16,004	19,390	15,697
- later than five years.	15,192	8,664	19,033	11,773
Total gross future lease payments	**39,477**	**28,669**	**42,363**	**30,420**
Finance charges allocated to future periods	(2,049)	(1,370)	(1,948)	(1,144)
Net lease liabilities at 31 March 2025	**37,428**	**27,299**	**40,415**	**29,276**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		**27,299**		29,276

Note 17 Inventories

	31 March 2025	31 March 2024

	£000	£000
Consumables	-	40
Other	799	-
Total inventories	799	40
Of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £40k (2023/24: £145k). Write-down of inventories recognised as expenses for the year were £0k (2023/24: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2024/25 the Trust received £0k of items purchased by DHSC (2023/24: £104k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Due to the impending acquisition of the Trust by Warrington & Halton Hospitals NHS FT, the Trust has sought to align accounting policies and therefore has included items of stock held by the Community Equipment Service as inventory.

Note 18 Trade and other receivables

Note 18.1 Current and non-current trade receivables and other receivables

	31 March 2025	31 March 2024
	£000	£000
Current		
Contract receivables*	13,442	8,609
Capital receivables	49	49
Allowance for impaired contract receivables/assets	(351)	(291)
Prepayments (non-PFI)	511	717
PDC dividend receivable	61	-
VAT receivable	304	286
Other receivables	238	301
Total current trade and other receivables	14,254	9,671
Non-current		
Provision for impaired receivables	(32)	(29)
Other receivables	112	103
Total non-current trade and other receivables	80	74
Of which receivables from NHS and DHSC group bodies:		
Current	4,977	3,693
Non-current	-	-

The majority of the Trust's revenue comes from contracts with other public sector bodies and therefore the Trust has low exposure to credit risk.

Note 18.2 Allowances for credit losses

	Contract receivable and contract assets	All other receivables
	£000	£000
Allowances as at 1 April 2024 – brought forward	**291**	**29**
Net allowances arising	**82**	**3**
Reversals of allowances	**-**	**-**
Utilisation of allowances (write offs)	**(22)**	**-**
Allowances at 31 March 2025	**351**	**32**

	Contract receivable and contract assets	All other receivables
	£000	£000
Allowances as at 1 April 2023 – brought forward	1,355	15
Net allowances arising	151	29
Reversals of allowances	(964)	(15)
Changes in existing allowances	(251)	-
Allowances at 31 March 2024	291	29

Note 18.3 Exposure to credit risk

The majority of the Trust's revenue comes from contracts with other public sector bodies and therefore the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2025 are in receivables from customers, as disclosed in the table above.

Note 19 Cash and cash equivalent movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024/25	2023/24
	£000	£000
At 1 April	**17,334**	24,316
Net change in year	**(9,155)**	(6,982)
At 31 March	**8,179**	17,334
Broken down into:		
Cash at commercial banks and in hand	**4**	4
Cash with the Government Banking Service	**8,175**	17,330
Total cash and cash equivalents as in SoFP and SoCF	**8,179**	17,334

Note 20 Trade and other payables

	31 March 2025	31 March 2024
	£000	£000

Current		
Trade payables	**3,916**	3,311
Capital payables	**1,351**	1,203
Accruals*	**1,630**	3,054
Social security costs	**1,253**	1,316
PDC dividend payable	**-**	9
Pension contributions payable	**1,015**	964
Other payables	**29**	27
Total current trade and other payables	**9,194**	9,884
Of which: payables to NHS and DHSC group bodies:		
Current	2,480	1,475
Non-current	-	-

Note 21 Other liabilities

	31 March 2025	31 March 2024
	£000	£000
Current		
Deferred Income: contract liability	**61**	1,472
Total current borrowings	**61**	1,472

Note 22 Borrowings

	31 March 2025	31 March 2024
	£000	£000
Current		
Lease liabilities	**4,484**	3,567
Total current borrowings	**4,484**	3,567
Non-current		
Lease liabilities	**32,944**	36,848
Total non-current borrowings	**32,944**	36,848

Note 22.1 Reconciliation of liabilities arising from financing activities – 2024/25

	Lease liability	**Total**
	£000	**£000**
Carrying value at 1 April 2024	**40,415**	**40,415**
Cash movements:		
Financing cash flows – payments and receipts of principal	(4,730)	**(4,730)**
Financing cash flows – payments of interest	(369)	**(369)**

Non-cash movements:		
Additions	893	**893**
Lease liability remeasurements	850	**850**
Application of effective interest rate	369	**369**
Carrying value at 31 March 2025	**37,428**	**37,428**

Note 22.2 Reconciliation of liabilities arising from financing activities – 2023/24

	Lease liability £000	Total £000
Carrying value at 1 April 2023	**-**	**-**
Cash movements:		
Financing cash flows – payments and receipts of principal	(4,488)	(4,488)
Financing cash flows – payments of interest	(407)	(407)
Non-cash movements:		
Additions	85	85
Lease liability remeasurements	4,116	4,116
Application of effective interest rate	408	408
Carrying value at 31 March 2024	**40,415**	**40,415**

Note 23 Provisions for liabilities and charges analysis

	Legal Claims £'000	Other £'000	Total £'000
At 1 April 2023	15	200	**215**
Arising during the year	9	-	**9**
Reversed unused	(12)	(40)	**(52)**
At 31 March 2025	**12**	**160**	**172**
Expected timing of cash flows:			
- not later than one year	12	160	**172**
Total	**12**	**160**	**172**

The provision for legal claims as at 31 March 2025 relates to the Liabilities to Third Parties Scheme "LTPS" provision.

Other provisions include:

- Liability for VAT repayable of £150k to HMRC and employees relating to car leasing schemes following a VAT Tribunal case brought by Northumbria Healthcare NHS FT. The provision is calculated based on previous VAT returns and payroll information. Payment is expected to be made in the year ending 31 March 2026, but the amount and timing of payments is dependent on the Trust's success in contacting former employees; and
- Liability for injury claim of £10k. A solicitor's letter was received in March 2023 confirming that a personally injury case has been brought against the Trust and therefore a provision has been recognised for the excess payable. Payment is expected to be paid in the year ending 31 March 2026, but the amount and timing of payment is dependent on the outcome of the case.

Note 23.1 Clinical negligence liabilities

At 31 March 2025, £2,587k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Bridgewater Community Healthcare NHS Foundation Trust (31 March 2024: £3,987k).

Note 24 Contingent Liabilities

	31 March 2025	31 March 2024
	£000	£000
Other	465	-
	465	-

In 2024 the Trust had expressed interest in a contract opportunity advertised by Salford City Council for its 0 to 19 service. The Trust withdrew from the process following due diligence. In September 2024 the Trust received a claim from the Council for costs of £465k which was immediately rejected by the Trust following legal advice.

No further communication or correspondence has been received from the Council.

Note 25 Contractual capital commitments

	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	-	2
Total	-	2

Note 26 Financial Instruments

Note 26.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS England, Clinical Commissioning Groups and Local Authorities and the way NHS England, Clinical Commissioning Groups and Local Authorities are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Department of Health and Social Care. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2025 are in receivables from customers, as disclosed in the Receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with other NHS bodies, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated resources. The Trust is not, therefore, exposed to significant liquidity risks.

Note 26.2 Carrying values of financial assets

	Held at amortised cost
	£000
Carrying values of financial assets as at 31 March 2025	
Trade and other receivables excluding non-financial assets	**13,378**
Cash and cash equivalents at bank and in hand	**8,179**
Total at 31 March 2025	**21,557**

	Held at amortised cost £000
Carrying values of financial assets as at 31 March 2024	
Trade and other receivables excluding non-financial assets	8,668
Cash and cash equivalents at bank and in hand	17,334
Total at 31 March 2024	26,002

Note 26.3 Carrying values of financial liabilities

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2025	
Obligations under leases	**37,428**
Trade and other payables excluding non-financial liabilities	**6,923**
Total at 31 March 2025	**44,351**

Carrying values of financial liabilities as at 31 March 2024	
Obligations under leases	40,415
Trade and other payables excluding non-financial liabilities	8,420
Total at 31 March 2024	48,835

Note 26.4 Maturity of financial liabilities

	31 March 2025	31 March 2024
	£000	£000
In one year or less	**11,770**	12,360
In more than one year but not more than five years	**19,438**	19,390
In more than five years	**15,192**	19,033
Total	**46,400**	50,783

Note 27 Losses and special payments

	2025		2024	
	Total number of cases	Total value of cases £000	Total number of cases	Total value of cases £000
Losses				
Bad debts and claims abandoned	**3**	**12**	24	246
Total losses	**3**	**12**	24	246
Special payments				
Ex-gratia payments	**-**	**-**	1	-
Total special payments	**-**	**-**	1	-
Total losses and special payments	**3**	**12**	25	246

Note 28 Related parties

The Trust considers the Department of Health and Social Care as its parent department and the following provides a list of the main entities within the public sector with which the body has had dealings:

- Department of Health and Social Care ministers
- Board members of the NHS foundation Trust
- The Department of Health and Social Care
- Other NHS providers
- ICBs and NHS England
- Other health bodies
- Other Government departments
- Local authorities
- NHS charitable funds (where not consolidated)

During the reporting period none of the Department of Health Ministers has undertaken any material transactions with Bridgewater Community Healthcare NHS Foundation Trust.

During the reporting period, the following Trust board members or members of the key management staff, or parties related to any of them, have undertaken material transactions with Bridgewater Community Healthcare NHS Foundation Trust.

In the reporting period, the Trust appointed 3 joint Executive Roles split with Warrington and Halton Hospitals NHS Foundation Trust. This is part of the strategic collaboration and board approved acquisition of the Trust by Warrington and Halton Hospitals NHS Foundation Trust by April 2027. The roles appointed were Chief Executive Officer (Nikhil Khashu), Chief Operating Officer (Daniel Moore) and Medical Director (Paul Fitzsimmons). During 2024/25, the Trust has recognised Income of £403k and £918k Expenditure with the Hospital Trust. As at 31st March 2025, there was a receivable of £487k and a payable of £293k. These balances relate to equipment purchase and recharge and contracts for healthcare services delivered throughout the reporting period and is consistent with prior years.

The sister-in-law of the Trust's Chair, Karen Bliss, is a member of the governing body of NHS Liverpool Place (NHS Cheshire and Merseyside ICB), the lead commissioner for Cheshire and Merseyside. During 2024/25, NHS Cheshire and Merseyside ICB has remitted income of £67,164k to the Trust for the delivery of NHS commissioned services by the Trust. At 31 March 2025, the Trust recognises a contract receivable of £2,159k. The Trust also recognised expenditure of £29k in the year related to salary recharges.

One of the Trust's Non Executive Directors, Tina Wilkins, is an Associate Consultant at Mersey Internal Audit Agency ("MIAA"), the Trust's internal auditors. MIAA is hosted by Liverpool University Hospitals NHS Foundation Trust. During 2024/25, the Trust has recognised expenditure with Liverpool University Hospitals NHS Foundation Trust of £108k for internal audit and counter fraud services and as at 31

March 2025. All invoices were paid giving a contract payable at 31 March 2025 of £nil.

Further related parties also include (i) NHS Providers which has invoiced the Trust £24k for the 2024-25 annual membership and this balance was paid giving a contract payable at 31 March 2025 of £nil; and (ii) NHS Confederation which has invoiced the Trust £9k primarily for the 2024-25 annual membership and this balance was paid giving a contract payable at 31 March 2025 of £nil.

Note 29 Events after the reporting period

There were no events after the reporting period requiring disclosure.

Note 30 Adjusted financial performance (control total basis)

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

For the financial reporting year ended 31st March 2025, Bridgewater Community Healthcare NHS Foundation Trust has reported a deficit of £1.196m (2023/24: £0.82m deficit) and this is the same figure as in the summarisation schedules that underpin the accounts.

However, it should be noted that the surplus for 31 March 2025 includes technical adjustments for impairments, assets transferred by absorption, and DHSC centrally procured inventories to give an adjusted financial position of £1.156m deficit (2023/24: £0.004m surplus).

	2024/25	2023/24
	£000	£000
(Deficit) / surplus for the period	**(1,196)**	(824)
Remove net impairments not scoring to the Departmental expenditure limit	**-**	787
Remove net impact of inventories received from DHSC group bodies for COVID response	**40**	41
Total	**(1,156)**	4

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Bridgewater Community Healthcare NHS Foundation Trust ("the Trust") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity, Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in 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 (as amended).

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Trust's accounting policies.

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

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

We identified a fraud risk that liabilities and related expenditure for the purchase of goods or services are not completely recorded in the correct accounting period. The commitment to a financial plan can create an incentive for management to understate the level of relevant expenditure compared to that which has been incurred. There is a risk that relevant manual, non-NHS, non-pay expenditure, excluding depreciation and impairment, may be manipulated in order to report that their agreed target has been met and/or improved to facilitate the delivery of their own and system level plan. We consider this would be most likely to occur through understating manual non-NHS, non-pay expenditure, excluding depreciation and impairment, via pushing back relevant expenditure into 2025-26 to mitigate financial pressures in 2024-25.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included inspecting journals posted as part of the year end closedown procedures that reduce expenditure via the non-NHS accruals General Ledger codes in order to critically assess whether there is an appropriate basis for posting the journals and that the values can be agreed to supporting evidence;
- Inspecting a sample of non-NHS expenditure invoices and expenditure related bank transactions, which occurred in April 2025, in order to determine whether expenditure has been recognised in the correct accounting period; and
- Comparing the items that were accrued at 31 March 2024 to those accrued at 31 March 2025 in order to assess whether any items of expenditure accrued for in the 2023-24 financial year have been excluded from the 2024-25 financial statements; and
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.

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

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

We gained an understanding of the Complaints and Freedom to Speak Up ('whistleblowing') policies, which included investigating examples, to allow us to assess the appropriateness of the policies and confirm they are being followed.

We tested examples of legal expenditure to gain an understanding as to what they related, so as to confirm if the expenditure was in line with expectations based on discussions with the Accounting Officer and other management, and our understanding of the sector.

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

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

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

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

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

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

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

Other information in the Annual Report

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

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

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

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 114, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

We have nothing to report in this respect.

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

As explained more fully in the statement set out on page 114, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

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

Statutory reporting matters

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

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a

director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

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

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

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Bridgewater Community Healthcare NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

James Boyle

for and on behalf of KPMG LLP

Chartered Accountants

1, St Peter's Square
Manchester
M2 3AE

27 June 2025

6. Key Contacts

Your views

We welcome your comments and feedback on our Annual Report and Accounts.

Please email bchft.global@nhs.net if you:

- have any further questions or need help understanding any aspect of this document
- would like to view this document in another language or format such as Braille or audio
- would like us to send you a printed copy of this document or parts of this document

Giving feedback on our services

If you wish to tell us about your experience of our services, please contact Patient Services:

Email: bchft.patientservices@nhs.net

Telephone: 0800 587 0562

Membership

If you would like to have a say and help us to develop our services to meet local needs, then please consider becoming a member. Membership is open to anyone aged 14 years or over who lives in England. Please contact us to find out more:

Email: bchft.governors@nhs.net

Want to know more about us? You can:

- find out more about us on our website: www.bridgewater.nhs.uk
- follow us on X: www.x.com/WeAreBCHFT
- 'like' us on Facebook https://www.facebook.com/WeAreBCHFT/
- contact our Headquarters:

Bridgewater Community Healthcare NHS Foundation Trust

Spencer House 1st Floor

89 Dewhurst Road, Birchwood, Warrington, WA3 7PG

Telephone: 01925 946400 or

Email: bchft.enquiries@nhs.net

Acknowledgements

Thank you to all the staff and teams who contributed to this document.

7. Appendices

Appendix 1: Board and Committee Attendance Register

Board and Committee Attendance Register – April 2024 to March 2025

KEY: **AP** – apologies **A** – absent (no apologies) * closed and/or extraordinary meeting ** two meetings in a month, some closed		Apr	Jun	Jun *	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar *	Total
Board of Directors														
Karen Bliss	**Chair**	✔	✔	✔		✔		✔		✔		✔		**7/7**
Nikhil Khashu	**Chief Executive**									✔		✔	✔	**3/3**
Colin Scales	**Chief Executive**	✔	✔	✔		✔								**4/4**
Gail Briers	**Non-Executive Director**	✔	✔	✔		✔		✔		AP		✔		**6/7**
Bob Chadwick	**Non-Executive Director**	✔	✔	✔		✔		AP		✔		✔	✔	**7/8**
Linda Chivers	**Non-Executive Director**	✔												**1/1**
Elaine Inglesby	**Non-Executive Director**	✔	✔	✔		AP		AP		✔		✔		**5/7**
Abdul Siddique	**Non-Executive Director**	✔	✔	AP		✔		✔		AP		✔	✔	**6/8**
Martyn Taylor	**Non-Executive Director/ SID**	✔	✔	✔		✔		✔		✔		✔	✔	**8/8**
Tina Wilkins	**Non-Executive Director**	✔	✔	AP		✔		✔		✔		✔	✔	**7/8**
Ted Adams	**Medical Director**	✔	✔	✔		✔		✔						**5/5**
Sarah Brennan	**Chief Operating Officer**	✔	✔	✔										**3/3**
Lynne Carter	**Chief Nurse / Dep Chief Exec / Acting Chief Executive**	✔	AP	✔		✔		✔		✔		AP	✔	**6/8**
Paul Fitzsimmons	**Medical Director**									✔		✔	✔	**3/3**
Nick Gallagher	**Director of Finance**	✔	✔	✔		✔		✔		✔		✔	✔	**8/8**
Daniel Moore	**Chief Operating Officer**											✔	✔	**2/2**
Paula Woods	**Director of People and Organisational Development**	✔	✔	✔		✔		AP		✔		✔	✔	**7/8**
Susan Burton	**Associate Chief Nurse**		✔ #											**1/1**
Mark Charman	**Acting COO**							AP		✔				**1/2**
Jeanette Hogan	**Acting Chief Nurse / Dep CN**							✔				✔ #		**2/2**
Joanne Waldron	**Dep Director People & OD**							✔ #						**1/1**

Linda Chivers left the Trust 24 May 2024
Colin Scales left the Trust 23 September 2024. Nikhil Khashu in post from 1 November 2024.
Ted Adams left the Trust 21 November 2024. Paul Fitzsimmons in post from 18 November 2024.

Sarah Brennan left the Trust 17 August 2024. Mark Charman, Acting Chief Operating Officer 21 August to 1 December 2024. Daniel Moore in post from 1 December 2024. Lynne Carter, Acting Chief Executive Officer 18 September – 1 November 2024. Jeanette Hogan, Acting Chief Nurse for this period.
[#] where a deputy has attended on behalf of an Executive

KEY: **AP** – apologies **A** – absent (no apologies)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Nominations & Remuneration Committee 2024-25 (ad-hoc)														
Karen Bliss	**Chair**				✔		✔	✔	✔		✔			**5/5**
Gail Briers	**Non-Executive Director**				✔		✔	AP	AP		✔			**3/5**
Bob Chadwick	**Non-Executive Director**				✔		✔	AP	✔		✔			**4/5**
Linda Chivers	**Non-Executive Director**													**0/0**
Elaine Inglesby	**Non-Executive Director**				✔		✔	✔	AP		✔			**4/5**
Abdul Siddique	**Non-Executive Director**				AP		AP	✔	AP		✔			**2/5**
Martyn Taylor	**Non-Executive Director/ Senior Independent Director**				✔		✔	✔	✔		✔			**5/5**
Tina Wilkins	**Non-Executive Director**				✔		✔	✔	✔		✔			**5/5**

Linda Chivers left the Trust 24 May 2024

KEY: **AP** – apologies **A** – absent (no apologies) * extraordinary meeting		Apr	May *	Jun *	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Audit Committee														
Linda Chivers	**Non-Executive Director** Chair to May 2024	✔	✔											**2/2**
Bob Chadwick	**Non-Executive Director** Chair from May 2024	✔	✔	✔	✔			✔			✔			**6/6**
Gail Briers	**Non-Executive Director**	✔	✔	✔	✔			✔			✔			**6/6**
Elaine Inglesby	**Non-Executive Director**	✔	✔	✔	AP			✔			✔			**5/6**
Abdul Siddique	**Non-Executive Director**	✔	AP	AP	✔			✔						**4/6**
Martyn Taylor	**Non-Executive Director/ Senior Independent Director**	AP	✔	✔	✔			✔			✔			**5/6**
Tina Wilkins	**Non-Executive Director**	✔	✔	AP	✔			✔			✔			**5/6**
Colin Scales	**Chief Executive**		✔											**1/1**
Sarah Brennan	**Chief Operating Officer**	✔	✔	✔	AP									**3/4**
Lynne Carter	**Chief Nurse / Dep Chief Exec / Acting Chief Executive**	✔	✔	✔	✔			✔			✔			**6/6**
Mark Charman	**Acting Chief Operating Officer / Acting Deputy Chief Operating Officer**							✔			✔			**2/2**
Nick Gallagher	**Director of Finance**	✔	✔	✔	✔			✔			✔			**6/6**
Jeanette Hogan	**Acting Chief Nurse / Dep CN**							✔ #			✔			**2/2**
Daniel Moore	**Chief Operating Officer**										✔			**6/6**

Linda Chivers left the Trust 24 May 2024
Ted Adams left the Trust 21 November 2024. Paul Fitzsimmons in post from 18 November 2024.
Sarah Brennan left the Trust 17 August 2024. Mark Charman, Acting Chief Operating Officer 21 August to 1 December 2024. Daniel Moore in post from 1 December 2024.
Lynne Carter, Acting Chief Executive Officer 18 September – 1 November 2024. Jeanette Hogan, Acting Chief Nurse for this period.
 # where a deputy has attended on behalf of an Executive

KEY: **AP** – apologies **A** – absent (no apologies) * extraordinary meeting		24 Apr *	23 May	Jun	25 Jul	Aug	19 Sep	31 Oct *	21 Nov	Dec	2 Jan *	30 Jan	20 Feb *	20 Mar	Total
Finance & Performance Committee															
Tina Wilkins	**Non-Executive Director** Chair	✔	✔		✔		✔	✔	✔		✔	✔	✔	✔	**10/10**
Gail Briers	**Non-Executive Director**	✔	✔		✔		✔	✔	✔		✔	✔	✔	✔	**10/10**
Bob Chadwick	**Non-Executive Director**	✔	✔		✔		AP	✔	AP		✔	✔	✔	✔	**8/10**
Linda Chivers	**Non-Executive Director**	AP	✔												**1/2**
Martyn Taylor	**Non-Executive Director/ Senior Independent Director**	✔	✔		✔		✔	✔	✔		✔	✔	✔	✔	**10/10**
Sarah Brennan	**Chief Operating Officer**	✔	✔		✔										**3/3**
Lynne Carter	**Chief Nurse / Dep Chief Exec / Acting Chief Executive**	✔	✔		✔		✔	✔	AP		✔	AP	✔	✔	**8/10**
Mark Charman	**Acting Chief Operating Officer / Acting Deputy Chief Operating Officer**						✔	✔	✔		✔ #	✔ #	✔ #	✔	**7/7**
Nick Gallagher	**Director of Finance**	✔	✔		✔		✔	✔	✔		✔	✔	✔	✔	**10/10**
Jeanette Hogan	**Deputy Chief Nurse / Acting Chief Nurse**								✔ #						**1/1**
Daniel Moore	**Chief Operating Officer**										AP	✔	AP	✔	**2/4**

Linda Chivers left the Trust 24 May 2024
Sarah Brennan left the Trust 17 August 2024. Mark Charman, Acting Chief Operating Officer 21 August to 1 December 2024. Daniel Moore in post from 8 December 2024.
Lynne Carter, Acting Chief Executive Officer 18 September – 1 November 2024. Jeanette Hogan, Acting Chief Nurse for this period.
 # where a deputy has attended on behalf of an Executive

a

KEY: **AP** – apologies **A** – absent (no apologies) * meeting deferred		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov** *	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
People Committee 2024-25														
Abdul Siddique	**Non-Executive Director** Chair		✔		✔		✔			✔	✔		✔	**6/6**
Linda Chivers	**Non-Executive Director**		✔											**1/1**
Bob Chadwick	**Non-Executive Director**		AP		✔		AP			✔	AP		✔	**3/6**
Elaine Inglesby	**Non-Executive Director**		✔		AP		✔			✔	✔		✔	**5/6**
Tina Wilkins	**Non-Executive Director**		✔		✔		✔			✔	✔		✔	**6/6**
Paula Woods	**Director of People and Organisational Development**		✔		AP		✔			✔	✔		✔	**5/6**
Ted Adams	**Medical Director**		AP		✔		✔							**2/3**
Sarah Brennan	**Chief Operating Officer**		✔		AP									**1/2**
Mark Charman	**Acting Chief Operating Officer**						✔			AP				**1/2**
Lynne Carter	**Chief Nurse / Dep Chief Exec / Acting Chief Executive**		✔		✔		✔			✔	AP		✔	**5/6**
Paul Fitzsimmons	**Medical Director**									AP	AP		AP	**0/3**
Jeanette Hogan	**Deputy Chief Nurse**										✔ #			**1/1**
Dan Moore	**Chief Operating Officer**										AP		AP	**0/2**

Linda Chivers left the Trust 24 May 2024
Ted Adams left the Trust 21 November 2024. Paul Fitzsimmons in post from 18 November 2024.
Sarah Brennan left the Trust 17 August 2024. Mark Charman, Acting Chief Operating Officer 21 August to 1 December 2024. Daniel Moore in post from 1 December 2024.
Lynne Carter, Acting Chief Executive Officer 18 September – 1 November 2024. Jeanette Hogan, Acting Chief Nurse for this period.
 # where a deputy has attended on behalf of an Executive

KEY: **AP** – apologies **A** – absent (no apologies)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Quality & Safety Committee 2024-25														
Gail Briers	**Non-Executive Director** Chair to December 2024	✔		✔		AP		✔		✔		✔		**5/6**
Elaine Inglesby	**Non-Executive Director** Chair from December 2024	✔		✔		✔		✔		✔		✔		**6/6**
Abdul Siddique	**Non-Executive Director**	AP		✔		AP		AP		✔		✔		**3/6**
Martyn Taylor	**Non-Executive Director/** **Senior Independent Director**	✔		✔		✔		✔		✔		✔		**6/6**
Ted Adams	**Medical Director**	✔		✔		AP		✔						**3/4**
Sarah Brennan	**Chief Operating Officer**	✔		✔										**2/2**
Lynne Carter	**Chief Nurse /** **Deputy Chief Executive**	✔		✔		AP		AP		✔		✔		**2/4**
Mark Charman	**Acting Chief Operating Officer**					✔		✔		✔ #		✔ #		**4/4**
Paul Fitzsimmons	**Medical Director**									✔		AP		**1/2**
Jeanette Hogan	**Acting Chief Nurse**					✔ #		✔						**2/2**
David Mills	**Deputy Medical Director**					✔						✔ #		**2/2**
Daniel Moore	**Chief Operating Officer**									AP		AP		**0/0**

Ted Adams left the Trust 21 November 2024. Paul Fitzsimmons in post from 18 November 2024.
Sarah Brennan left the Trust 17 August 2024. Mark Charman, Acting Chief Operating Officer 21 August to 1 December 2024. Daniel Moore in post from 1 December 2024.
Lynne Carter, Acting Chief Executive Officer 18 September – 1 November 2024. Jeanette Hogan, Acting Chief Nurse for this period.
 # where a deputy has attended on behalf of an Executive

KEY: **AP** – apologies **A** – absent (no apologies)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Council of Governors 2024-25														
Karen Bliss	**Chair**	AP		✔		✔		✔		✔		✔		**5/6**
Gail Briers	**Non-Executive Director**	✔		✔		AP		✔		✔		AP		**4/6**
Bob Chadwick	**Non-Executive Director**	AP		AP		✔		✔		A		✔		**3/6**
Linda Chivers	**Non-Executive Director**	✔												**1/1**
Elaine Inglesby	**Non-Executive Director**	✔		AP		✔		✔		✔		✔		**5/6**
Abdul Siddique	**Non-Executive Director**	✔		✔		✔		✔		AP		AP		**4/6**
Martyn Taylor	**Non-Executive Director/ SID**	✔		AP		✔		✔		✔		✔		**5/6**
Tina Wilkins	**Non-Executive Director**	✔		AP		✔		✔		AP		✔		**4/6**
Arshad Ashraf	**Public Governor – Rest of England (ROE)**	✔		A		A		A		A		✔		**2/6**
Claire Barton	**Staff - Dental**	✔		✔		✔		✔		✔		A		**5/6**
Rita Chapman	**Public Governor – ROE**	✔		✔		AP		✔		✔		✔		**5/6**
Rachel Game	**Partner Governor – Higher Education**	AP		AP		AP		AP		AP				**0/5**
Kevin Goucher	**Public Governor – Warrington**	AP		AP		AP		AP		✔		✔		**2/6**
Bill Harrison	**Public Governor – ROE**	A		A										**0/2**
Janet Hennessy	**Partner Governor – Signing Solutions Warrington**	A		A		✔		AP		A		✔		**2/6**
Peter Hollett	**Public Governor – Halton**	AP		A		A		A		AP		A		**0/6**
Matt Machin	**Public Governor – Warrington**	✔		✔		✔		AP		✔		✔		**5/6**
Sue Mackie	**Staff – Nursing**	A		A		A		A		A		A		**0/6**
Andrew Mortimer	**Public Governor – Warrington**	✔		AP										**1/2**
Sarah Power	**Staff – Non-Clinical**	✔		AP		AP		AP		✔		AP		**2/6**
Christine Stankus	**Public Governor – ROE & Lead Governor**	AP		✔		✔		✔		✔		✔		**5/6**
Jilly Wallis	**Staff – Allied Health Professionals**	✔		✔		AP		✔		✔		AP		**4/6**
David Wilson	**Partner Governor - Healthwatch Halton**	A		A		✔		✔		AP		A		**2/6**
Nicola Wilson	**Staff – Nursing**	AP		AP		AP		AP		A		✔		**1/6**

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