NHS

North Cheshire and Mersey Healthcare Partnership

Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals









Full Business Case

Better Care Together

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1.0 Foreword

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) have long shared a commitment to delivering outstanding care for the communities of Warrington, Halton, and beyond.

As two organisations providing services across different parts of local patient pathways, we recognise that by coming together we can deliver even greater benefits for our patients, our people and our system partners.

Since 1 November 2024 we have taken significant steps towards closer collaboration, including the appointment of a joint chief executive and the establishment of joint governance arrangements. These include combined executive team and Board development meetings, alongside a dedicated integration steering group with representation from both Trusts and our system partners. These foundations have already enabled us to explore new opportunities to improve the quality, experience and sustainability of care.

This programme of integration is not simply about reducing duplication or addressing financial challenge, it is about transforming how we deliver healthcare for the future. By uniting acute, secondary, and community care into a single organisation, we can better respond to the evolving needs of our population and provide care that is truly centred on patients rather than organisational boundaries.

Our shared vision aligns closely with national priorities, including the government's 10 Year Health Plan for England to reshape the health service through integrated and patient-focused care. Together we are committed to tackling health inequalities, supporting older and frail people in the community, preventing avoidable hospital admissions, and accelerating safe and effective discharge. Above all, we aim to make the best use of our shared resources to deliver the highest standards of care.

A formal integration of WHH and BCH represents the next pivotal step in our journey. By bringing our organisations together as a single unified trust, we will be able to harness our combined expertise, strengthen our resilience and enhance our ability to provide safe, effective and compassionate care. This will create a stronger platform for innovation, integration and improvement, benefiting both our patients and our staff.

As we move forward our focus will remain on our communities, maintaining trust, communicating openly and working collaboratively to shape the next chapter in local healthcare. With strong foundations already in place through shared leadership and a united purpose, we are confident that we can move quickly to realise our vision: to create a new organisation that is greater than the sum of its parts.

Steve McGuirk

Chair of WHH

Martyn Taylor

Chair of BCH

Nikhil Khashu

Joint CEO of BCH and WHH

2.0 Executive summary

2.1 Our organisations

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) provide healthcare services to broadly the same population of 340,000 people in Warrington and Halton, and to a lesser extent, the surrounding areas.

Each organisation specialises in different parts of the clinical pathway, with WHH predominantly delivering acute and elective hospital-based services and BCH predominantly delivering community and domiciliary services.

Both trusts have underlying financial deficits and face increasing challenges relating to their ability to meet ever-growing demand and remain financially sustainable. The underlying deficit for financial year 2025/26 of WHH and BCH combined stands at an estimated £48.3m.

From the recent NHS oversight framework data, WHH has been placed in segment 4 of 5 in terms of overall performance and support needs, with BCH in segment 3. Both trusts currently perform well against numerous patient safety metrics. However, they have key challenges relating to access to services, performing poorly in terms of the number of people waiting more than 52 weeks for some services. WHH's performance relating to waiting times in the Emergency Department (ED) is currently amongst the worst in the country.

2.2 Background and history to the planned integration

The work to explore the integration of WHH and BCH dates back to 2018 and in February 2020, both trusts formally communicated their intent to integrate to NHS England. Within weeks of that decision, the COVID-19 outbreak impacted and discussions around integration ceased while both providers focused on the requirements of maintaining their own services through the pandemic.

Five years on, and all of the reasons why integrating the two partner organisations made sense in 2020, still apply. Therefore, the plans to bring together the two organisations have been reinvigorated and accelerated, supported by the NHS Cheshire and Merseyside Integrated Care Board.

2.3 Strategic rationale

The strategic case for integration is clear. The combined organisation will help address health inequalities, strengthen clinical sustainability, enhance patient experience and improve financial performance.

Both Warrington and Halton record ever-growing demand for services, static healthy life expectancy figures, an ageing population – often with multiple, complex and non-health related challenges, and system-wide inefficiencies. In order to tackle these challenges, the future will require unified leadership, a single, transformational vision for the future and an ability to deliver large-scale change at pace. Integration will deliver a single, resilient healthcare organisation capable of meeting both current and future population health needs.

Strategic direction locally, regionally and nationally (NHS 10 Year Health Plan) focuses on a 'left shift' of care out of hospital into community and from ill-health to prevention as a way to

manage future demand. The integration of WHH and BCH creates the perfect platform to make the required transformation of services happen.

2.4 Options appraisal

Following a robust appraisal process, the acquisition of BCH by WHH was approved as the most suitable and appropriate legal mechanism for integration. The acquisition of BCH was selected due to its lower risk, value for money and ability to deliver greater patient and staff benefits sooner.

2.5 Programme delivery and programme management

The trusts have established a detailed and wide-reaching programme of work to drive delivery and governance of the integration. The programme is entitled 'Better Care Together' and consists of 10 core workstreams, each with exec-level leadership and programme support.

The programme has been split into three phases:

- Phase one focuses on completing the legal transaction and setting up the critical infrastructure to ensure day one (1 April 2026) delivery and commence the integration of leadership, corporate services and some clinical support functions.
- Phase two (April 2026 to March 2027) focuses on embedding initial infrastructure changes and driving early benefits whilst commencing work on the longer-term clinical integration and priority services.
- Phase three (April 2027 onwards) will see the transformation of remaining clinical services and the shift towards a new model of care.

The three phased approach will help us to move at pace whilst keeping additional costs and disruption to clinical services to a minimum. The trusts have redirected significant internal resources to support delivery of the integration programme across its duration. Those resources will be deployed flexibly to ensure that priority workstreams are supported appropriately and at the right times.

2.6 Vision and strategies for integrated trust

Our vision for integration is to create a new single organisation which is greater than the sum of its parts, anchored with a core principle of **'Home first, community next and only then hospital'.**

Throughout the initial phases of the programme, we will develop a series of formal and connected strategy documents to help define our future clinical and operational model. Those documents will describe how the future model will meet the needs of our local populations and help address the strategic challenges we face now and in the future.

2.7 Organisation design

Plans are in place for a single Board to lead the integrated organisation, supported by elected governors and underpinned by a renewed trust constitution. Board committee structures and quality, financial, and people governance structures are detailed within the FBC to ensure robust governance from day one and beyond.

Draft transitional structures – effective from 1 April 2026 – have been developed for all teams, including clinical and corporate. These support the formal consultation around TUPE and organisational change, which commenced in November 2025.

2.8 Clinical model

The future clinical model of the integrated organisation will be shaped in line with national and local strategic direction and developed in full collaboration with local and regional partners. It will be clearly defined in a new clinical strategy to be published by the end of 2026. The clinical model will build on strong existing foundations of collaboration between the two organisations and a commitment to transforming clinical pathways and promoting localised, data-led health and wellbeing care.

Seven clinical priorities have been identified from initial engagement. These will form the basis of the initial integration work focused on clinical service redesign and improvement for patients. The service level clinical strategy and transformation will align to the core principle of 'Home first, community next and only then hospital'.

2.9 Corporate support functions

The most significant financial improvement opportunity that can be unlocked through integration is linked to corporate services. National benchmarking clearly demonstrates short-term benefits can be delivered through integration, unlocking improved economies of scale.

Our corporate services will come together from day one and draft transitional structures have been developed for consultation. Corporate teams have been working closely together, starting to align internal processes and streamline activities to make the transition as smooth as possible from day one.

2.10 Expected benefits and quality impact

There are a number of key areas that together, summarise the benefits of the integration to our patients and communities; a fundamental shift in care - Home first, community next and hospital only when needed, data-led local approaches to service design and delivery, streamlined clinical pathways, removal of organisational barriers, better use of resources, strengthening fragile services, and enhanced public and patient involvement.

2.11 Financial case

The combined planned deficit for the two organisations at the start of 2025-26 prior to in year savings and deficit support funding stood at £72m. The combined underlying deficit of the trusts is estimated to be £48.3m.

Recent historic financial performance illustrates a worsening financial position, largely in response to growing demand for services and a need to increase capacity to meet it. The integration programme presents financial improvement opportunities totalling up to £33m (both direct and indirect opportunities) and is therefore a fundamental part of the journey towards longer-term financial sustainability.

The estimated additional costs of the integration stand at around £1.1m, demonstrating the value in bringing the organisations together and the urgency to make this happen as quickly as possible.

2.12 Inequalities

Warrington and Halton have high levels of inequality across the populations, including significant variation in life expectancy and healthy life expectancy within each borough.

By aligning community and acute services, the new organisation will target the root causes of inequality, deliver prevention-focused care, and strengthen partnerships with local authorities, primary care and the voluntary sector to close health gaps across populations.

The integration between WHH and BCH creates opportunities for the development of seamless care pathways across hospital and community settings, with multidisciplinary teams delivering wraparound support closer to home, contributing to the development of neighbourhood health.

Increased collaboration with other local partners from across the sectors also creates opportunities to tackle the wider determinants of health that can help make a long-term and sustainable improvement in health outcomes and demand for statutory services.

2.13 Communications and engagement

Our new organisation will be known as North Cheshire and Mersey NHS Foundation Trust. We have commenced a large-scale programme of engagement with staff, patients, local stakeholders and the wider public around a number of elements of our approach to the integration. This will set the tone for how we aim to continue over the coming years as we bring the two organisations together.

We have support for the integration from our local MPs, NHS Cheshire and Merseyside ICB, both local authorities, GPs, voluntary sector partners and NHS England.

2.14 People Strategy

Between us, the two organisations employ more than 6,700 staff from over 80 different nationalities. The vast majority of our staff are also Warrington and Halton residents. The success of our integrated trust is important to them on many levels.

Our teams tell us that working closely together has already provided advancements in service delivery, and the energy and commitment to take the opportunity to make things better is tangible and a source of optimism.

We have already developed a joint culture plan and consulted with staff around our core trust values that we commit to keeping at the heart of our work as we progress.

2.15 Digital Strategy

Nationally, the NHS 10 Year Health plan sets out an ambition to shift care away from traditional analogue systems and processes and towards digitally enabled care. In order to maximise the benefits available to us through the integration, and truly seize the opportunity to transform services, digital services must be central to our ambitions.

We have set out a roadmap for the integration of our digital systems, including short-term interoperability of our EPR systems and a longer-term plan to move to a single EPR to support our clinical and operational vision.

2.16 Estates Strategy

Across both organisations our staff currently operate from approximately 98 sites within Warrington, Halton, Knowsley, St Helens and Greater Manchester. The quality of the estate varies greatly, creating variation in terms of staff and patient experience and financial efficiency.

The development of a new Clinical Strategy and the future vision for more services in community creates a platform for a transformational approach to the use of estate.

A new Estates Strategy will be developed to support the organisation's strategic long-term ambition to deliver more care locally and redevelop/modernise the acute hospital sites to enable the delivery of 21st century healthcare that meets the growing demands of our local population. It will be developed in collaboration with local partners and align to national and regional estates priorities.

2.17 Risks

The individual workstreams within the Better Care Together programme capture and record all operational and strategic programme-related risks. Robust governance is in place to ensure that programme risks feed into the existing organisational risk management processes within BCH and WHH.

Alongside this, appropriate and detailed due diligence has helped us to improve visibility of some of the key risks, issues and challenges associated with the acquisition. We have clarity around the most significant risks, and we have plans in place to mitigate and manage these as we progress through each phase of the integration programme, including those risks that are critical to manage as part of ensuring a successful day one.

2.18 Conclusion

The integration of BCH and WHH is essential to enable us to provide the seamless care our growing populations need and deserve. Joining together to form a single organisation allows us to deliver the left shift of care described in the national 10 Year Health Plan, as well as ensuring our services are clinically and financially sustainable for the future.

Put simply we will provide Better Care Together, for our patients, our staff and our partners and communities.

3.0 Our organisations

This section provides an overview of Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH), highlighting their shared purpose, complementary service portfolios and collective commitment to improving health outcomes across Warrington, Halton and neighbouring communities.

It describes how both organisations serve broadly the same population footprint through acute, community and specialist care, with WHH delivering mainly hospital-based services and BCH providing mainly community and dental care closer to home.

The section also sets out some of each organisation's key performance, workforce, estate, and service data to establish a clear baseline for integration. These details demonstrate the foundations upon which a single, integrated provider can build to deliver seamless, person-centred care, improve efficiency and equity of access, and create a sustainable model of care for the future.

Key message: Together, WHH and BCH represent a complementary partnership built on shared purpose and proven collaboration. Each organisation brings distinct expertise, WHH in acute and elective care, BCH in community and out-of-hospital services, creating a fully integrated care offer aligned with the 10 Year Health Plan's vision of prevention, digital transformation, and care closer to home.

This integration is a natural progression of our joint commitment to quality, efficiency, and equity of care across our shared populations.

3.1 Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH)

WHH comprises three hospital facilities delivering secondary care and acute services across two main sites in the boroughs of Warrington and Halton. It also provides a range of services across more than 30 community locations.

The Warrington Hospital site provides emergency care, general medicine, intensive and high dependency care, surgery, cardiac care, stroke care, cancer care, maternity, paediatrics, and support services like physiotherapy, pathology and pharmacy.

The Halton Hospital site in Runcorn specialises in elective and diagnostic care. It includes the Captain Sir Tom Moore Building and Nightingale Building, offering services including general surgery, urology, orthopaedics, endoscopy, cancer care and a broad range of outpatient clinics. The site is also home to the Delamere Macmillan Unit, Halton Clinical Research Unit, two phases of the Community Diagnostic Centre and Runcorn Urgent Treatment Centre.

All three facilities across the two main sites offer outpatient clinics and diagnostic services in a range of settings to ensure patients can access care close to home. In addition to hospitals, community hubs and mobile facilities, the trust also offers virtual options to improve access to quality care and reduce health inequalities.

WHH is rated 'Good' by the Care Quality Commission, and its workforce of nearly 5,000 staff comprises 80 different nationalities. The organisation's turnover in 2024-25 was £392m. Across 2024-25 the trust[1]:

- delivered 2,473 babies in hospital and in the community
- delivered 59,474 procedures and inpatient stays
- delivered 109,928 individual new outpatient appointments each year (face-to-face and telephone)
- operated 744 beds – assessment beds and trolleys – across both sites
- provided 144,951 episodes of emergency care – 84,816 episodes at the Emergency Department (ED), 22,842 at Warrington Same Day Emergency Care (SDEC) facility, and 37,293 at the Runcorn Urgent Treatment Centre (UTC)

3.2 Bridgewater Community Healthcare NHS Foundation Trust (BCH)

BCH provides community adult and children's nursing and therapy services in Halton and Warrington. It also provides specialised community dental services reaching more than 18,500 people across Cheshire, Merseyside and Greater Manchester. These services fall outside the two main boroughs but remain an important part of the partnership landscape, requiring close collaboration with local authorities, primary care networks, NHS providers and voluntary and community sector organisations. This wider footprint provides opportunities for shared learning and consistency in service delivery across localities, while ensuring that care is aligned with the priorities of each local Place.

As a dedicated provider of community services, the current trust strategy is to bring more care closer to home. Most services are delivered in patients' homes or from more than 60 community locations including health centres, GP practices, community centres and schools.

BCH employs approximately 1,700 people and has more than 100 apprentices working within its clinical and corporate teams.

The trust is rated 'requires improvement' by the Care Quality Commission and its turnover in 2024-25 was £108m. Across 2024-25 the trust[2]:

- administered 37,171 vaccinations to 32,045 children in schools and communities across Warrington and Halton
- delivered 201,410 district nursing care contacts in community across Warrington and Halton
- delivered 12,166 community matron care contacts in community across Warrington and Halton
- delivered 30,030 district nursing treatment room care contacts across Warrington and Halton
- provided 39,074 same day urgent care contacts at Widnes Urgent Treatment centre (unplanned activity only)
- delivered 40,917 dental appointments across Greater Manchester, and Cheshire and Merseyside

[1] Warrington and Halton Hospitals NHS Foundation Trust (2025) *Annual Report and Accounts 2024–25*. Available at: https://www.whh.nhs.uk/media/b12hznuj/whh-anual-report-and-accounts-2024-25.pdf

[2] Info sourced from BCH data warehouse

3.3 NHS oversight framework and current performance

The recent publication of trust league tables (September 2025)[3] following the launch of the new NHS oversight framework shows that WHH lies 118th out of 134 acute and specialist trusts in England. BCH is listed as 39th out of 61 non-specialist trusts.

WHH is in segment 4 of 5 in terms of overall performance and support needs, with BCH in segment 3.

Both organisations currently perform well against numerous patient safety metrics, as well as the metric assessing financial variance to agreed plans. However, they have key challenges relating to access to services, performing poorly in terms of the number of people waiting more than 52 weeks for some services. WHH's performance relating to waiting times in the Emergency Department (ED) is currently amongst the worst in the country.

The trusts also have challenges relating to longer term financial sustainability. The underlying deficit for the financial year 2025-26 of both WHH and BCH combined stands at £48.3m.

[3] NHS England (2025) *Acute Trust league table*. Available at: https://www.england.nhs.uk/long-read/acute-trust-league-table/

4.0 Background and history to the planned integration

This section outlines the journey that has led to the proposed acquisition of BCH by WHH, tracing the evolution of partnership working through the Better Care Together programme.

It highlights the shared challenges of fragmented care, workforce pressures and financial constraints that prompted greater collaboration between the trusts, alongside system drivers from the Cheshire and Merseyside Integrated Care System (ICS).

The section summarises how both Boards, supported by NHS England, have worked together to develop a structured, transparent and evidence-based case for integration. It demonstrates how early joint governance, shared leadership and collaborative service redesign have already improved outcomes and operational efficiency, providing proof of concept for a fully integrated model of care.

Key message: The proposed integration is the product of deliberate, incremental collaboration, not a reactive acquisition. Since 2023, both organisations have demonstrated a sustained commitment to collective problem-solving.

The integration represents the next logical step to achieve sustainable, system-wide benefits, aligned with national policy and the Cheshire and Merseyside ICS strategy.

4.1 Options for integration with other local partners

In November 2018, WHH and BCH entered into a Memorandum of Understanding (MoU). The MoU established a shared commitment to explore and implement opportunities for collaboration with the aim of enhancing service delivery, achieving mutual efficiency and effectiveness, and supporting the long-term sustainability of services. The MoU formalised the joint working that had already commenced between the two organisations.

At that time, both trusts had also considered the potential for merger or integration with other local acute and community providers.

4.1.1 BCH options

BCH had previously explored partnering with North West Boroughs Healthcare NHS FT (NWBH). The option was ultimately deemed not to deliver the same level of benefits to patients, staff and system financial recovery as the option to integrate with WHH. It was also felt that the option would be harder to deliver for a number of reasons, including:

- NWBH and BCH would have a prohibitively large, shared footprint
- NWBH had recently indicated its intention to be acquired by Mersey Care NHSFT
- a transaction between NWBH and BCH would not create opportunities to shift more acute care into the community and improve transition between hospital and community care, enabling more people to stay in the community and their homes for longer
- a transaction between NWBH and BCH would not help to address clinical and financial sustainability challenges faced by WHH

BCH did not consider partnering with other community service providers at that time, given the geographical constraints it would bring. BCH Board's view was that a formal transaction with NWBH, and therefore given the timing of the discussion, also with Mersey Care, would create an organisation with too large a geographical span. This would make it difficult and costly to ensure both strong quality governance and effective leadership to multiple place-

based services and would not realise the benefits required to offset the costs and disruption caused by an integration programme.

Furthermore, the Warrington population at the time was the fastest growing in Cheshire and Merseyside. A transaction with an organisation outside of Warrington would have potentially posed a risk to ensuring that the needs of the growing Warrington population were appropriately prioritised. The chairs and CEOs of BCH and NWBH met in December 2018 to discuss the option of the trusts formally collaborating, following which the BCH Board agreed it was not the preferred option. This was also reflected in NWBH's options appraisal completed as part of the process of them approaching NHSE/I to describe their intention to be acquired by Mersey Care.

4.1.2 WHH options

Prior to November 2018, WHH had worked closely with St Helens and Knowsley Teaching Hospitals NHS Trust (STHK)[4] and had successfully implemented a number of changes to enable sustainability of acute services. These included a new stroke pathway and joint on-call rotas for some smaller surgical specialties. However, a formal transaction between the two organisations was not considered a preferred option at that time for a number of reasons, including:

- learning and experience from previous transactions and national benchmarking, at that time, suggested that horizontal integration between large acute hospital trusts were likely to create further complexity rather than remedying it. However, there was evidence to suggest that there may be a role for vertical integration developing more coherent organisations[5]
- a formal transaction between STHK and WHH would not help to address the opportunities to shift care into the community and improve transition between hospital and community care
- the Warrington population was the fastest growing in Cheshire and Merseyside and again, integration with an organisation operating outside that area created a risk around WHH's ability to deliver on the specific needs of the local Warrington population
- a transaction between STHK and WHH would not help to address the clinical and financial sustainability challenges faced by BCH at that time

4.2 Initial proposal for integration of WHH and BCH in 2019

Following careful assessment, it was concluded that all other alternative integration options for both WHH and BCH would not deliver the same level of benefits for the organisations themselves or for the local populations they served.

Subsequently, a structured programme of work to start to bring the organisations together was developed and progressed through a series of joint executive team meetings. In parallel, both organisations held a number of Board-to-Board meetings and established a committee in common to consider the range of collaboration and transaction options available.

[4] The organisation is now known as Mersey and West Lancashire Teaching Hospitals NHS Trust following a recent merger between STHK and Southport and Ormskirk NHS Trust.
[5] The King's Fund (2015) *Foundation trust and NHS trust mergers: 2010 – 2015*. Available at: https://www.kingsfund.org.uk/insight-and-analysis/reports/foundation-trust-nhs-trust-mergers

In November 2019, a comprehensive options appraisal was presented and scrutinised at a Board-to-Board meeting. Following this appraisal, both Boards resolved in January 2020 that the preferred course of action was for WHH to acquire BCH. This decision was formally communicated to NHS England/NHS Improvement in February 2020 through a joint letter of intent.

The trusts commenced on a programme to recruit joint executive positions with the appointment of WHH's chief people officer into a joint role covering BCH between January 2019 and March 2020.

The full transaction was originally scheduled for completion in June 2021. However, the process was subsequently stopped as a direct result of the global COVID-19 pandemic and both organisations returned to focus on delivery of services as individual providers.

4.3 Revisiting previous plans

Five years later and a number of the sustainability challenges faced by WHH and BCH remain unresolved, demand for services across both providers has increased significantly, and the financial climate has grown ever more challenging. These circumstances have re-invigorated discussions between the WHH and BCH Boards about the possibility of integrating the two organisations.

The planned financial deficit for 2025-26 for the whole of Cheshire and Merseyside is £178.3m (before deficit support funding). This challenging financial situation has led to a number of detailed financial reviews across the ICS to explore financial improvement opportunities. Alongside this, the publication of trust league tables driven by the new NHS England oversight framework highlights the urgent need for performance improvement across both WHH and BCH.

Subsequently these factors have led to a direct request from the ICS for the two organisations to revisit the proposed integration plan, and if still feasible, explore how to make it happen as quickly as possible to drive required improvement.

5.0 Strategic rationale

The strategic rationale sets out the case for why integration is the only sustainable and logical next step for both organisations. It positions the proposal within the context of the national 10 Year Health Plan and the priorities of Cheshire and Merseyside ICS.

The section articulates the strategic need for integration, grounded in local population health need, financial and workforce sustainability, and alignment with regional and national NHS priorities; prevention, digital innovation, and out-of-hospital care. It identifies the challenges faced by both organisations independently, including fragmented pathways, duplicated support services and rising demand, and sets out how integration offers a viable, forward-looking solution.

Key message: The strategic case for integration is clear. This section explains how the combined organisation will address health inequalities, strengthen clinical sustainability, enhance patient experience and improve financial performance.

It highlights the growing demand for services, an ageing population, and system-wide inefficiencies that require unified leadership and delivery and ensuring both trusts remain sustainable contributors to the Cheshire and Merseyside system.

Ultimately, it establishes how integration will deliver a single, resilient healthcare organisation capable of meeting both current and future population health needs.

5.1 Our places

5.1.1 Warrington

Warrington is a large town and unitary authority area in Cheshire, England, situated on the banks of the River Mersey. Historically part of Lancashire, it became a significant industrial centre during the industrial revolution, known for its traditional industries including wire, textiles and brewing.

Today, Warrington is one of the fastest growing towns in the UK and has a diverse economy with strengths in logistics, advanced manufacturing and retail, all benefiting from its strategic location at the intersection of major motorways and railways. It serves as a key regional hub with a vibrant town centre, numerous business parks and a growing population, making it an important economic and residential area in the north west.

The population of Warrington is currently around 210,900[6].

5.1.2 Halton

Halton is a unitary authority and borough in Cheshire, England, comprising the towns of Runcorn and Widnes, along with several smaller parishes. Situated on either side of the River Mersey, it is perhaps best known for its industrial heritage – particularly in chemicals and engineering – and its iconic bridges including the Silver Jubilee Bridge and the more recent Mersey Gateway, which significantly improved regional connectivity.

[6] Office for National Statistics (ONS) (2022) *Population and household estimates, England and Wales: Census 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationandhouseholdestimatesenglandandwalescensus2021

Historically rooted in the ancient Barony of Halton, the area has transformed from industrial centres to a diversified economy with a focus on logistics, science and manufacturing, while also offering cultural attractions and green spaces. Since 2014 Halton has been part of the Liverpool City Region Combined Authority, playing a role in the wider regional development.

The population of Halton is currently around 128,200[7].

5.1.3 Regional differences and potential impact of devolution

Halton lies within the Liverpool City Region (LCR). Warrington sits outside of LCR and is preparing to join the Cheshire and Warrington Mayoral Combined Authority. Funding flows are different across each Place. Areas within LCR have access to devolved funding and regional initiatives that support health equity, digital inclusion, transport and access, and economic growth.

Both WHH and BCH are often required to navigate multiple commissioning geographies to secure funding to ensure consistent, equitable service delivery across both Places. This can occasionally lead to differences in service provision.

5.2 Local life expectancy and health inequalities

5.2.1 Life expectancy

Average life expectancy at birth for a female born in Warrington is 82 years, and for a male is 79 years. These figures are comparable to national averages.

Average life expectancy at birth for a female born in Halton is 81 years, and for a male is 78 years. These figures are below the national averages.

5.2.2 Health inequalities

Whilst overall life expectancy in Warrington may be close to national averages, there is significant variation in life expectancy within the borough itself. For example, a male born in the Latchford East ward would be expected to live up to ten years less than a male born in the Grappenhall ward. Latchford East and Grappenhall are separated only by the width of the Manchester Ship Canal.

There is a similar picture in Halton, where a male born in the Halton Lea ward would be expected to live 10 years less than a male born in Daresbury, Moore, or Sandymoor wards.

The wide variation in life expectancy across the two boroughs links strongly to levels of deprivation.

As of 2019, Warrington was considered the 148th most deprived of 317 local authorities in England[8]. In general, the more deprived areas lie in the central parts of Warrington, and the less deprived areas lie in the outer parts, particularly in the wards south of the canal.

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[7] ONS (2022) *Population and household estimates, England and Wales: Census 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationandhouseholdestimatesenglandandwalescensus2021

[8] Warrington Borough Council (2021) *Borough profile 2021 Warrington*. Available at: https://www.warrington.gov.uk/sites/default/files/2021-04/warrington_borough_profile_2021.pdf

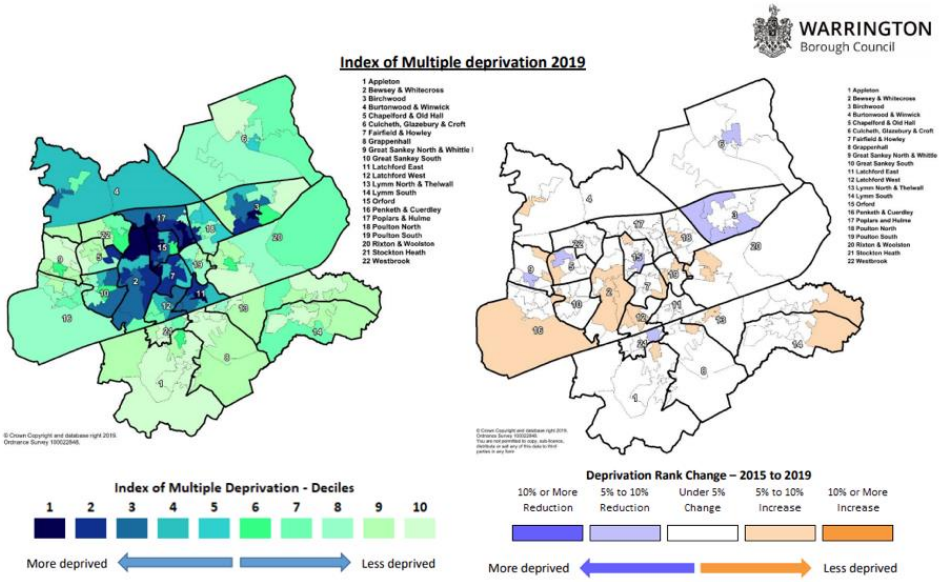

Figure 1: Map of deprivation within Warrington, WBC, 2019

Five wards within Warrington were amongst the 20% most deprived in England, equating to more than 35,000 residents or 17% of Warrington's population. It is these wards that also record many of the poorest health outcomes and therefore the lowest levels of life expectancy.

Warrington is less ethnically diverse than England as a whole, with a larger proportion of residents identifying as 'white' than England or the north west[9]. Levels of ethnic diversity in the town are also greater in the central, most deprived wards. Therefore, recorded inequalities linked to geography also correlate with inequalities in ethnic backgrounds.

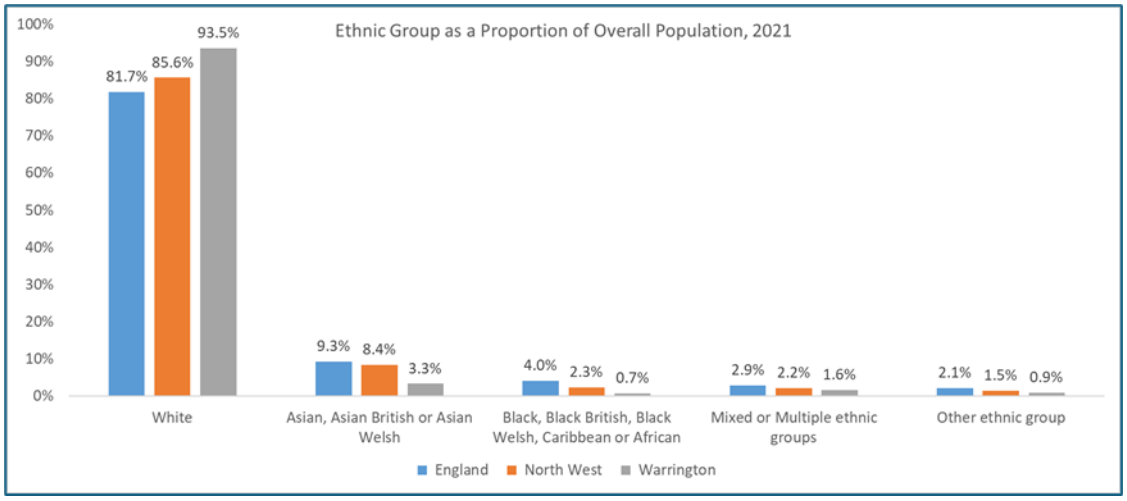

Figure 2: Ethnic group identification for Warrington as per 2021 census

Again, the picture is similar in Halton where the more deprived areas lie in the central parts of both towns of Widnes and Runcorn, and the less deprived areas lie in the outer parts.

[9] Warrington Borough Council (2025) *Warrington population - facts and figures 2025*. Available at: https://www.warrington.gov.uk/sites/default/files/2025-03/Warrington%20population%202025.pdf

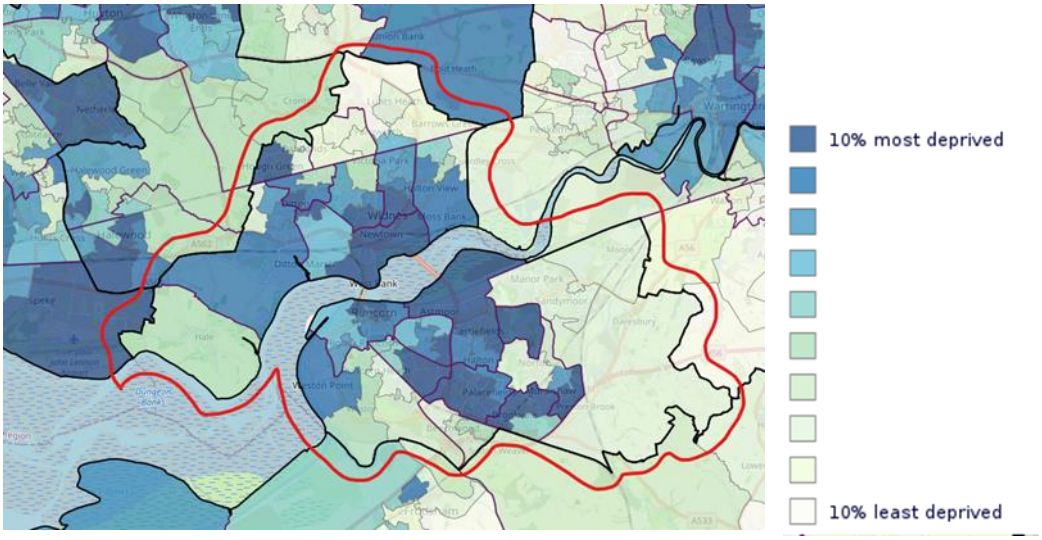

Figure 3: Deprivation within Halton

Statistics from 2019 show that seven wards within Halton were amongst the 20% most deprived wards in England, equating to more than 53,000 residents or 42% of Halton's population[10].

5.3 Healthy life expectancy

Healthy life expectancy is defined as 'a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health'. The healthy life expectancy at birth for people in Warrington is, on average, around 64 years[11]. In Halton, the figure is around 57 years[12].

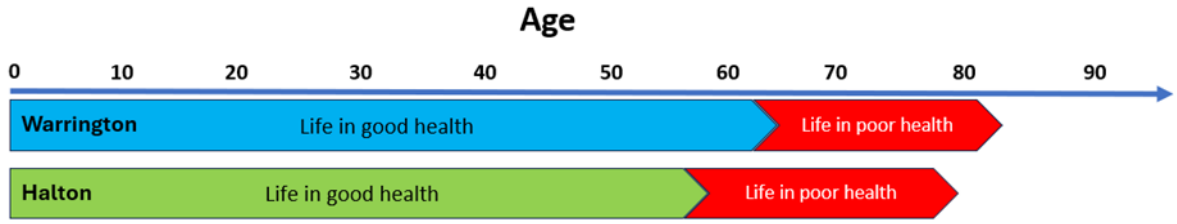

Figure 4: Average healthy life expectancy and overall life expectancy Warrington and Halton

On average, people in Warrington and Halton live approximately 17 to 23 years in poor health in the later years of their lives. It is these years lived in poor health that drive a significant amount of the demand for health and social care services across the boroughs. Estimates suggest that at least 50% of all healthcare demand and 65% of social care demand is driven by people aged 65 and above living with at least one long-term condition.

[10] English indices of deprivation (2019). Available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

[11] Office for Health & Improvement Disparities (2025) *Public Health Outcomes Framework - at a glance summary: Warrington*. Available at: https://fingertips.phe.org.uk/static-reports/public-health-outcomes-framework/at-a-glance/E06000007.html?area-name=Warrington

[12] Office for Health & Improvement Disparities (2025) *Public Health Outcomes Framework - at a glance summary: Halton*. Available at: https://fingertips.phe.org.uk/static-reports/public-health-outcomes-framework/at-a-glance/E06000006.html?area-name=Halton

5.4 Local health inequalities and wider determinants of health

Chapter 14 of this document describes the challenges within Warrington and Halton in relation to local health inequalities and stark differences between life expectancy within some of the more deprived areas of the boroughs compared to other more affluent areas. Data shows that residents in more deprived areas are more likely to access care through emergency departments and less likely to engage with preventative or planned services. These are some of the reasons why the more deprived parts of the towns record overall poorer health outcomes.

Research[13] also shows that health outcomes for an individual are determined by a wide variety of factors outside of direct healthcare. In fact, as little as 20% of what contributes to a person's health stems from access to, and quality of care. 30% links to lifestyle factors such as smoking, alcohol use, and diet and exercise. 10% links to physical and environmental factors such as air quality and housing. The remaining 40% links to socio-economic factors including education, employment, income, community safety, and social connections.

It is within these 'wider determinants of health' that the real opportunity to transform future healthcare possibly lies. By bringing acute and community services closer together, but also by bringing statutory health care services closer together with social care and wider community support, there is a huge opportunity to address some of the historically more difficult health challenges. That is the real prize for all organisations providing health and wellbeing support at Place.

For example, by supporting the population to live healthier lives for longer, empowering them to take greater responsibility for their own health and wellbeing, and helping them to access low-level support as soon as a need arises, it could be possible to see local healthy life expectancy figures increase. If residents lived in good health until 70 rather than 65, this would help materially reduce – or at least contain – future demand for health and care services. This could significantly improve access to essential services for patients, improve their experience of accessing health and care, and possibly even help break the constant cycle of increasing investment in acute and reactionary care.

5.5 Future population projections and demand for health and care services

The overall populations of both Warrington and Halton are expected to grow by around 1.3% and 3.9% respectively over the next decade[14]. These projections do not take into account the impact of any planned large-scale housing developments in either borough.

As a result of both a growing but also an ageing population, the expected changes to the demographic profile of the local population is more significant.

Table 1 below shows how the age profile of residents in both boroughs is projected to change over the coming years. By 2033, both Warrington and Halton are likely to have at least 20% more people aged over 65 than they do currently.

[13] Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, 2015
[14] ONS (2025) *Subnational population projections for England: 2022-based*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2022based?utm_source=chatgpt.com

Age group	England	NW	Warrington	Halton
0-19	-2.56%	-1.73%	-6.49%	-5.50%
20-64	+0.65%	-0.16%	-3.14%	-0.09%
65+	+21.44%	+19.11%	+22.72%	+20.20%

Table 1 : Estimated change in population by age, 2023 to 2033

Given that such a high proportion of demand for statutory health and care services stems from the older age groups, and without any change to average healthy life expectancy, it is clear that the future projections around age profiles of the local population are likely to significantly increase demand for services further.

5.6 Recent population changes and impact on demand for health and care services

By looking back at facts and figures from the year pre-COVID (2018-19), the impact of demand growth can be seen clearly. Between 2018-19 and 2024-25, the following changed:

- the overall population in Warrington and Halton increased by around 2%
- the population of residents aged over 65 increased by around 10%
- attendances at either the ED in WHH or the Urgent Treatment Centre (UTC) in Runcorn increased by around 8%
- non-elective activity at WHH increased by almost 29%
- the total number of patients on the WHH elective waiting list increased by 62%
- the total number of patients waiting more than 52 weeks for surgery at WHH increased from 47 to almost 600
- the total number of patients waiting more than 52 weeks for community services at BCH increased from zero to 1,429
- performance against the 4-hour ED target deteriorated from 85% to 69%
- funded posts within the unplanned care clinical and operational workforce increased by 28% (+320 whole time equivalents WTE)
- unplanned care pay budgets (adjusted for pay inflation) increased by 32% (+£16.8m)

Whilst overall performance and financial sustainability of NHS providers is a multi-layered challenge, it is clear that growing demand from the local population is a key factor in this.

5.7 Patient impact of current situation

The performance metrics and financial impact of continually increasing demand for healthcare services outlined in the section above makes for stark reading, but it is the impact of these figures on the experience of patients that creates the real reason change is required.

62% more patients are waiting for elective surgery now than they were six years ago. Within that figure, a significant number are now waiting more than a year for that surgery.

Almost 1,500 more patients are waiting over a year for a service in community than six years ago. 16% more patients are waiting more than four hours to be seen in ED. A significant number of them are waiting over 12 hours to be admitted to a hospital bed and an increasing number are being cared for on hospital corridors due to bed capacity constraints.

Additionally, local residents often experience significant challenges in getting an ambulance following a 999 call, accessing a routine appointment with their GP, or the length of time they may need to wait for some mental health services. It is no surprise to read that just 1 in 5 people (21%) in 2024 said they were satisfied with the way the NHS runs[15].

5.8 Managing demand and addressing performance and sustainability challenges

Both WHH and BCH acknowledge that the ability to manage future demand for statutory services, maintain access and quality of services, address local health inequalities and deliver financial sustainability of the organisations is severely limited if they continue to operate independently.

The integration of the two local providers will create new opportunities for improvement on numerous fronts. In the context of current organisational performance, the regional and national financial climate and ever-increasing demand, the proposal to bring the organisations together as soon as possible is of growing importance.

5.9 National strategic direction

5.9.1 Independent investigation of the NHS in England (2024)

Lord Darzi's 2024 independent review of the NHS[16] painted a clear picture: the NHS is in a critical condition, particularly due to the fragmentation of clinical services, lack of workforce planning, and inefficiencies in hospital-based care. One of the core recommendations of the review was to encourage 'group hospital networks and shared services' across multi-site collaborations that retain local accountability, while operating with a single strategic vision, unified leadership and standardised care models.

Lord Darzi identified that many single-site or smaller acute hospitals were no longer clinically or financially sustainable in isolation, particularly in the face of growing demand, ageing populations and increasingly specialist clinical workforce requirements.

5.9.2 NHS 10 Year Health Plan

NHS England acknowledged the findings from Lord Darzi's review and subsequently launched a large-scale consultation around the future of the NHS. The public and NHS staff were asked to help inform a new plan, which seeks to reshape healthcare in the UK.

The 10 Year Health Plan recognises that many of the challenges seen locally in Warrington and Halton are also reflected nationally. Advancement in medicine and technology is opening up increasing treatment options and ultimately leading to people living longer. The challenge over the coming decade is to ensure that the model of care adapts to support this positive change. The plan is built around three key strategic shifts in approach for the NHS:

- ill health to prevention
- analogue to digital
- hospital to community

[15] British Social Attitudes Survey 2024, Nuffield Trust and The King's Fund.
[16] Department of Health and Social Care (2024) *Independent investigation of the NHS in England*. Available at: https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

It also makes explicit the need for the NHS nationally to manage within its annual financial allocations, through both improved fiscal planning and day-to-day management.

The financial outlook for the NHS is under unprecedented pressure with NHS England's total revenue allocation only rising by 0.2% in real terms in 2024-25, placing demands on trusts to identify exceptional levels of efficiency savings.

In this context, incremental improvement is unlikely to deliver the size and scale of transformational change required to ensure the long-term sustainability and viability of high-quality health and care services.

Instead, it is incumbent on health and care commissioners, regulators and providers to deliver a 'quantum shift' in healthcare delivery if collectively we are to succeed at meeting tomorrow's needs and expectations.

The NHS 10 Year Health Plan sets out key priorities to transform healthcare over the next five to 10 years.

Table 2 below shows how the planned integration of WHH and BCH helps meet the strategic objectives set out in the plan.

10 Year Health Plan chapter	10 Year Health Plan objectives	How WHH / BCH integration delivers
Chapter 1 – a new service model for the 21st century	• boost 'out of hospital care' • further integrate primary and community services • reduce pressure on acute emergency services • focus on population health • maximise opportunities of working within integrated care systems	The integrated trust will create a seamless acute-community organisation across Warrington and Halton. This will enable new neighbourhood models of care, providing more services closer to home and reducing unnecessary ED attendances (already down 4% in 2024-25) and long lengths of stay. Closer alignment between secondary care services, primary care, and wider public and voluntary sector services will mean patients experience smoother transitions between hospital and community care. This will reduce overcrowding, improve discharge flow and enhance population health outcomes.
Chapter 2 – more NHS action on prevention and health inequalities	• strengthened focus on prevention • reduce health inequalities	The integrated trust will be able to take greater responsibility for larger parts of patient pathways, improving the emphasis on preventative care and managing more long-term conditions without the need for secondary care. With a 17 to 23-year gap between life expectancy and healthy life expectancy across Warrington and Halton, the integration allows for targeted intervention in the areas with the greatest need, improved outreach via community services, and closer partnership with local authorities, schools and voluntary groups.

Chapter 3 – further progress on care quality and outcomes	• address biggest causes of morbidity and mortality	Integration will allow the trust to review and optimise its clinical pathways across a wide range of services. A move towards more anticipatory care models will support more patients with long-term conditions to manage at home, preventing crisis admissions. Integration also enables fragile services across both providers to become more resilient and sustainable.
Chapter 4 – NHS staff will get the backing they need	• increase training opportunities for staff • make the NHS a better place to work (recruitment and retention)	Integration will create a combined single workforce of 6,700 staff and opportunities to create improved career pathways, rotational posts across community and acute, and shared training/education. Joint staff networks and a new joint strategic people committee will embed the NHS People Promise. Staff will benefit from stronger team resilience, shared wellbeing offers, harmonised pay structures (including bank rates), and reduced reliance on agency staff. This will improve retention and make the trust a more attractive employer both locally and regionally.
Chapter 5 – digitally enabled care will go mainstream	• use digital technology to make access easier • improve planning/delivery through better use of data • provide improved digital tools for clinicians	Integration creates the opportunity to align digital strategies across hospital and community care. A joint digital infrastructure will reduce duplication, streamline electronic patient records (EPR) and extend digital access for patients. Combined data sets will enable stronger use of population health analytics to plan services, reduce health inequalities and improve safety. Clinicians will benefit from access to shared digital tools, diagnostics, and estate infrastructure, enabling smoother care delivery across settings.
Chapter 6 – financial sustainability and productivity	• improve efficiency and value for money • ensure long-term financial sustainability of NHS providers	The WHH/BCH integration unlocks significant financial improvement opportunities for the organisations. By consolidating estates, corporate functions, leadership and senior management, and clinical support services in the short term, the integrated trust can achieve greater economies of scale. A single financial strategy will help tackle the current combined underlying £48.3m

		deficit, supported by joint cost improvement programmes, shared procurement and harmonised bank rates. This will strengthen the trust's ability to invest in patient care, workforce development and innovation.

Table 2: how the planned integration of WHH and BCH helps meet the strategic objectives set out in the NHS 10-year plan

5.10 Regional strategic direction – NHS Cheshire and Merseyside Integrated Care System (ICS)

5.10.1 NHS Cheshire and Merseyside ICS strategy

Cheshire and Merseyside ICS is made up of nine individual 'Places' – Cheshire East, Cheshire West and Chester, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, and Wirral. Cheshire and Merseyside has a population of approximately 2.7 million people, living across a mixture of urban centres, market towns and rural communities. The area is home to a diverse population with significant variation in levels of deprivation, health inequalities and ethnicity across its different Places.

Figure 5: Cheshire and Merseyside ICB Places and boundaries

NHS Cheshire and Merseyside ICS have four key strategic objectives, which are to:

- tackle inequalities in outcomes, experience and access
- improve outcomes in population health and healthcare
- enhance productivity and value for money
- help the NHS support broader social and economic development

The proposed integration of WHH and BCH will create the conditions to support delivery of these objectives over the coming years.

NHS Cheshire and Merseyside ICS has invested heavily in data and analysis tools to help improve knowledge and insight around health and social care challenges in local areas and communities.

The immediate challenge for organisations within the region is how to unlock the potential within the data by using it to drive meaningful change and improvement. The rich data available can support service redesign and shift towards a more proactive model of care. This will facilitate increasing volumes of activity being shifted away from hospital settings and into communities.

The financial challenges facing NHS Cheshire and Merseyside ICS at present are also significant. There are opportunities for improved productivity and efficiency across clinical pathways and estates and significant financial improvement opportunities available through integrating the corporate support functions between organisations. The integration programme will create the conditions to drive financial improvement as part of a medium to long-term financial sustainability plan.

The Cheshire and Merseyside ICS strategy sets out a clear ambition for providers of health and care to work more collaboratively, breaking down traditional organisational boundaries. Many of the objectives within the strategy will only be achieved at a local level through seamless service delivery, which the proposed integration will enable.

Table 3 summarises how the proposed strategic direction of the integrated organisation is aligned with the strategic objectives of NHS Cheshire and Merseyside ICS.

NHS Cheshire and Merseyside ICS strategic objective	Examples of how our integration will support delivery
Tackling health inequalities in outcomes, experiences and access	We will develop an integrated clinical model based on the principle of 'home first, then community and hospital only when needed', taking services closer to people's homes wherever possible. This will make it easier for people to access the support they need, as soon as they need it.
Improve outcomes in population health and healthcare	Our integration will enhance opportunities to work with local partners using a data-led approach to increase the focus on prevention, targeted early intervention and empowering people to take greater responsibility for their own health and wellbeing. Through increased collaboration across our Places we can work to address the wider determinants of health that drive longer-term, sustainable improvements in health outcomes.

Enhance productivity and value for money	We recognise that continuing to function as two individual providers severely restricts our abilities to deliver the care our populations require in a financially sustainable way. National benchmarking data and local insight identifies areas where we can improve our collective financial performance and protect investment in frontline clinical services by coming together as one single organisation.
Help the NHS support broader social and economic development	We know that we can work to address the wider determinants of health that drive longer-term sustainable improvements in health outcomes through increased collaboration across our Places. Closer collaboration, planning and service delivery alongside partners from across the sectors in Warrington, Halton and further afield can help us tackle broader challenges that can often lead to health issues later in life.

Table 3: The proposed strategic direction of the integrated organisation and how it is aligned with the strategic objectives of NHS Cheshire and Merseyside ICS

5.10.2 Cheshire and Merseyside provider blueprint

The majority of the provider trusts within Cheshire and Merseyside have identified long term financial sustainability concerns, with many forecasting rolling deficits in future years without significant organisational redesign or reduction of clinical services.

In addition, the ICS receives one of the highest per head of population NHS funding allocations in England, in comparison to other ICSs. Nationally, there is a move to review the funding allocation formulae and weighted capitation model, which could impact on the allocation of funding to NHS Cheshire and Merseyside ICS in future years.

Across the ICS there is also significant use of independent sector provision, primarily for surgical services, with a need to repatriate a large proportion of this activity to local NHS providers.

There is a clear need to deliver medium and long-term financial stability across C&M ICS and C&M provider trusts, enabling improved delivery of care to the C&M population.

Similarly, across the C&M ICS footprint, a number of NHS provider trusts have identified ‘fragile’ clinical services due to workforce constraints, scale, clinical expertise, infrastructure or location. This has become more apparent in the trusts providing clinical services outside of the Liverpool City footprint and includes services such as ENT, stroke, dermatology, cardiology, neonatology and maxillofacial surgery.

Cheshire and Merseyside Provider Collaborative (CMPC) has commenced work with NHS provider trusts to examine a number of these services. To date, there have been limited clinical service reconfigurations or moves across the C&M footprint. The move to reconfigure regional pathology services being one of the few, with WHH currently planning to TUPE affected pathology staff across to Mersey and West Lancashire Teaching Hospitals NHS Trust in 2026, subject to formal consultation.

There is a requirement to sure up fragile clinical services, networking and hosting services across providers to enhance service delivery, staff recruitment and retention and clinical expertise, as well as to improve patient outcomes.

In order to address the known challenges, the CEOs across Cheshire and Merseyside have supported the principles behind a new 'C&M blueprint' setting out a high-level strategic direction for NHS providers over the coming years. This is based around five key areas of focus, as shown in figure 6.

Figure 6: Key areas of focus for the C&M NHS provider blueprint

The integration of WHH and BCH is explicitly reflected in the C&M blueprint and is a key early part of a potentially much wider and longer-term reconfiguration of provider services across the region.

5.11 Local place strategic direction – Warrington and Halton

Both Warrington and Halton operate as distinct Place partnerships within the Cheshire and Merseyside ICS. These partnerships, known locally as Warrington Together and One Halton,

bring together health, care, local authority services, and voluntary sector organisations to co-design services and deliver more joined-up, sustainable and collaborative care.

The current health and wellbeing strategies for both Warrington[17] and Halton[18] identify the importance of partnership working and addressing the wider determinants of health and wellbeing to improve health outcomes for local populations.

The integration of WHH and BCH creates a unique opportunity to redesign how and where services are delivered and allow us to focus on the delivery of intervention and support into areas with the most significant challenges.

As both Warrington and Halton Places start to develop plans to deliver health and care on a neighbourhood basis, the integration of WHH and BCH brings the chance to develop a complimentary model of secondary and community care. Both organisations have been working in close collaboration with partners within both Places over recent years to co-create and embed a number of transformational health and care projects:

- Living Well Hub in Warrington town centre
- Living Well digital platform for health and wellbeing services in Warrington
- Well Runcorn multi-agency health and education hub, which is currently under construction
- Community Diagnostic Centres in Halton and the development of new AI-led dermatology pathways
- development of integrated urgent community response and hospital discharge teams along with the local authority social care teams

More detail on some of these projects can be found later in this document.

As we continue to integrate our services our local system partners will play an even greater role in shaping delivery, ensuring community services are aligned to primary care footprints, have seamless interfaces with acute services, and are delivered smoothly, coherently and collaboratively.

Details of the key system partners we work with at a local level can be found in the supporting documents accompanying this document.

5.12 Strategic commissioning context

Commissioning is how local integrated care boards (ICBs) and their partners ensure allocated public money is best used to improve health. Although commissioning is further away from patients' eyes than provision of care, it determines what services are delivered, by whom, for whom, where and why.

The Secretary of State has tasked ICBs to be 'pioneers of reform' through 'strategic commissioning', driving the three shifts for health services (see section 5.9.2) outlined in the 10 Year Health Plan. The intention is to help the NHS better manage rising demand for services without consuming an ever-growing share of national wealth.

[17] Warrington Borough Council (2024) *Living Well in Warrington Health and Wellbeing Strategy 2024-2028*. Available at https://www.warrington.gov.uk/sites/default/files/2024-02/Health%20and%20Wellbeing%20Strategy%202024-28.pdf

[18] One Halton (2022) *One Halton Health and Wellbeing Strategy 2022-2027*. Available at: https://onehalton.uk/wp-content/uploads/2022/12/One-Halton-strategy.pdf

In 2024-25, 88% of the combined turnover of WHH and BCH came from NHS England and local NHS commissioners. Less than 1% came from other NHS providers and 3.5% came from local authorities.

With such a significant proportion of the combined organisation's revenue flowing via the NHS commissioning route, it is imperative that our plans for integration reflect the changes happening outside our organisations. This will ensure that we are aligned and responsive to changing needs and priorities and able to sustain (and potentially grow) our revenue to support delivery of new models of care.

5.13 Summary of national, regional and local system challenges

The challenges facing WHH, BCH, Cheshire and Merseyside ICS and the wider NHS at present are significant and complex.

Operational performance is deteriorating in terms of access to services and waiting times, demand is continually increasing from a growing and ageing population, and there is limited workforce availability and restricted revenue and capital resources.

These all combine to create an environment where a more radical and transformational approach is now required. The scale of the challenge is so large that it is unlikely it can be solved by individual organisations alone.

The government's 10 Year Health Plan sets out a vision for the development of a more collaborative, locally focused approach to the delivery of health and wellbeing services, that makes use of the wealth of data available and one that has digital services at its core.

This vision creates the opportunity to develop services alongside the local population and re-invigorate and engage a workforce that are desperate to see a brighter, more sustainable future emerge.

5.14 Conclusion: The next step is integration

The strategic rationale for the integration of BCH and WHH is clear – only by integrating acute and community services into a single provider can we sustainably meet the needs of our population, deliver on national and local priorities, tackle inequalities, and secure long-term clinical and financial sustainability.

Our aim is to formally bring together the two organisations as quickly and as simply as possible. This will unlock potential short-term financial improvement opportunities to help address urgent sustainability challenges.

Integration will remove existing organisational boundaries and simplify the processes needed to enable longer-term strategic transformation.

In the medium-term, we will develop a new and exciting vision for the future of our clinical services as part of the shift towards neighbourhood health at Place. This new integrated clinical strategy will bring together connected teams, join up clinical pathways between hospital and community, and facilitate the shift of care into community and domiciliary settings.

It is a time of significant change across the NHS and wider public services, but we believe the integration of the two organisations enables that change to happen at the level of speed required.

The integration of the two organisations aligns with the strategic direction of travel on a national, regional and local level, and creates increased opportunities for the organisations to address significant performance and sustainability challenges.

6.0 Options appraisal

This section describes the rigorous process undertaken by both executive teams and Boards to evaluate potential models for integration. It outlines the long list of options considered, from maintaining the status quo through to merger and acquisition. It summarises how the long list was evaluated to produce a shortlist of options and how each shortlisted option was assessed against agreed evaluation criteria covering patient impact, workforce, financial sustainability, and deliverability.

The section explains the transparent scoring methodology and stakeholder involvement, including clinical and system partners, and presents the rationale behind the recommended option.

Key message: Following an open, evidence-based appraisal involving both Boards, NHS England, and local system partners, the acquisition of BCH by WHH was identified as the most suitable option. This route offers the greatest patient benefit, best value for money and lowest delivery risk.

It enables continuity of leadership, legal simplicity, and the realisation of integration benefits at pace, providing the clearest route to long-term sustainability for both organisations.

It evidences how this route offers the greatest patient, staff and financial benefits, with manageable delivery risk, aligning fully with national and system priorities.

6.1 Long list of options for integrating BCH and WHH

In October 2024 a detailed 'long list' of the different legal options for the integration between WHH and BCH was developed. The long list was compiled with input from colleagues from NHSE's transactions team, local partners and external NHS organisations from across the country with recent experience of organisational integration. The long list was shared with both Trust's executive teams on 15 October 2024 and subsequently approved on 17 October 2024.

Table 4 details the long list of options in more detail.

Option number	Option title	Option description
1	Do nothing	Organisations remain as two separate legal entities and continue to operate independently.
2	Shared leadership with separate formal governance	Trusts could have a joint CEO, joint chair or both, as well as potentially a shared executive team and/or Board. However, no shared governance would be in place for formal decision making.
3	Shared leadership with joint strategic and/or limited remit formal governance	Trusts could have a joint CEO, joint chair or both, as well as potentially a shared executive team and/or Board. The trusts could make joint decisions via a joint committee.
4	Shared leadership with joint operational governance	Trusts could have a joint CEO, joint chair or both, as well as potentially a shared executive team and/or trust Board. The trusts could make joint decisions via a joint committee and implement shared governance via committees in common.
5	Merger between WHH and BCH	A legal transaction that sees the dissolution of two existing separate organisations and the creation of a new single organisation.

6	Acquisition of BCH by WHH	An acquisition involves the dissolution of the acquired trust and the wholesale transfer of its assets and liabilities to the acquiring trust. Under this option WHH would be the acquiring trust and BCH the acquiree.
7	Acquisition of WHH by BCH	As per option 6 but with BCH as the acquiring trust and WHH as the acquiree.

Table 4: Long list of integration options

6.1.1 Eliminated options

The long list of options was appraised by the joint executive teams to enable a shortlist of viable options to be recommended for more detailed appraisal and evaluation.

Following discussion and review of the long list, the following options were ruled out:

Option 1 – Do nothing

Rationale for exclusion: This option would see both organisations continue to operate as individual standalone providers. Given the scale of the current and future challenges facing both trusts, doing nothing was deemed not to be a feasible option. This option is also not aligned to the strategic direction across Cheshire and Merseyside.

Furthermore, the two organisations had already commenced a degree of integrated working meaning that this option would require both trusts to revert back to previous (separate) ways of working.

Option 2 – Shared leadership with separate formal governance

Rationale for exclusion: While this option would enable closer working between the two trusts, it was deemed unlikely to deliver the larger-scale transformational benefits that a formal integration via other options would achieve.

Option 3 – Shared leadership with joint strategic and/or limited remit formal governance

Rationale for exclusion: As per option 2 above.

The remaining four options were then taken forward as a shortlist for formal, detailed consideration. The retained options were deemed to deliver the most benefits from integration for our patients, staff, and stakeholders in the least complex way. On 5 November 2024 the executive teams from both organisations approved the shortlist, which was subsequently shared with and supported by both Boards on 6 November 2024.

6.2 Appraising the short list of options

In order to undertake a detailed and thorough appraisal of the remaining four shortlisted options, a number of steps were followed.

6.2.1 Creation of scoring panel

To ensure fairness and balance throughout the options appraisal process, a scoring panel was recruited from across both BCH and WHH executive and non-executive Board members.

The panel consisted of the joint chief executive and joint executive medical director, chief people officer (WHH), executive director of finance (BCH) and the chairs, senior independent directors, and chief nurses from both WHH and BCH. The trust Boards were given the opportunity to suggest members of the scoring panel, and these suggestions were taken into account when selecting the panel. The final panel was approved by both chairs and the joint CEO.

6.2.2 Agreement around assessment criteria

A framework for assessing each option was then developed by agreement with the Boards. Each of the four shortlisted options would be assessed against a total of 19 individual criteria grouped into the following six domains:

- patient impact and benefits
- patient care sustainability
- financial sustainability and value for money
- workforce and culture impact
- strategic alignment
- deliverability

The domains and the detailed criteria were compiled with significant input from colleagues within the NHS England transactions team and representatives from external trusts with recent integration experience.

The individual criteria were also allocated a weighting to ensure that scores for those areas that the Boards felt were more critical influenced the final outcome the most significantly.

6.2.3 Development of evidence and information pack to support evaluation and scoring process

A detailed evidence and information pack was then compiled to support the scoring process and circulated to the scoring panel on 10 December 2024.

All executives, key partners including local authorities, the ICB, voluntary sector and primary care colleagues, and NHSE contributed to the detailed evidence and information pack used to support the evaluation of options.

The guidance and template including the criteria and weighting are included within the supporting documents to the FBC.

6.2.4 Option evaluation

The options appraisal shortlist was then scored independently by each member of the scoring panel against the agreed detailed assessment criteria. The panel then met on 17 December 2024 to review individual and combined scores and make an agreed recommendation on the most suitable option.

As per guidance, assessment demonstrated impact on patients, finances, workforce and other stakeholders.

The final total scores and total weighted scores for each of the four shortlisted options are provided in table 5 below.

Score	Option 4 Shared leadership	Option 5 Merger	Option 6 Acquisition of BCH by WHH	Option 7 Acquisition of WHH by BCH
Total (unweighted)	326	470	611	513
Total (weighted)	1244	1785	2337	1937

Table 5: Total scores and total weighted scores for appraisal of short-listed options

The key outcomes of the options appraisal process, as agreed by the panel on 17 December, were as follows:

- All 10 panel members scored option 6, the acquisition of BCH by WHH – the highest.
- Option 6 had a total weighted score of 2,337 vs the next highest score of 1,937 for option 7.
- The process was agreed by both Boards, supported by NHS England, and was detailed, transparent and robust.

The result of the appraisal process was that **Option 6 – Acquisition of BCH by WHH** was judged to be the recommended option.

6.3 Approved option

Option 6 was unanimously selected as the first choice by all 10 panel members. The chosen option scored higher than or equal to option 7 against every one of the 19 criteria. The option was also deemed to enable delivery of broadly the same high levels of patient, staff and financial benefits as options 5 and 7, but provided the best value for money and did not present significant delivery risks against the Department of Health and Social Care's (DHSC) risk assessment process.

The Boards subsequently reviewed the outputs from the options appraisal exercise in February 2025 and formally approved the recommendation of progressing an acquisition of BCH by WHH.

7.0 Programme delivery and programme management

7.1 Chapter summary

This section sets out the governance, assurance and delivery framework for managing the integration process. It outlines the programme structure, including the role of the Better Care Together (BCT) delivery group, trust Boards, senior responsible officers (SROs), programme workstreams and underpinning reporting mechanisms.

It also highlights the clear governance arrangements already in place between the two trusts, such as joint executive leadership, and alignment with NHSE transaction oversight. Integration will progress in three phases: completing the acquisition and aligning systems by March 2026; operating as a single organisation with integrated leadership and integrated corporate infrastructure by March 2027; and fully embedding a long-term clinical model focused on 'home first, then community and hospital only when needed' from April 2027 onwards.

It explains the mechanisms for monitoring progress, managing interdependencies and mitigating risks. The section concludes by emphasising the disciplined, transparent and well-coordinated approach that underpins delivery of a safe and successful transaction.

Key message: A robust programme management framework underpins the integration, combining joint governance, system assurance and transparent reporting. The use of a shared Programme Management Office (PMO), aligned milestones and a structured Post-Transaction Integration Plan (PTIP) ensures the programme remains on track, accountable and outcomes-driven, reinforcing confidence among partners and regulators.

7.2 Governing our integration programme

Bringing the two organisations together is a complex and challenging programme of work involving multiple critical actions requiring input from every team across both Trusts.

We have set up a robust programme governance structure around this to help ensure accountability, clarity around requirements, and prioritise key actions and pieces of work. Our integration programme has been titled '**Better Care Together'** (BCT).

A BCT programme delivery group has been established to oversee the programme. The group is chaired by the joint CEO and consists of executive directors from both trusts alongside members of the BCT programme management team. Key responsibilities of the group include:

- overseeing delivery of integration workstreams and benefits
- managing programme risks and issues
- ensuring open communication between organisations
- delivery of strategic and full business cases
- maintaining commitment to the programme plan
- ensuring delivery of the programme within scope, time, cost, and quality
- reporting progress to trust Boards and key stakeholders

Key decisions relating to the integration are taken by both Boards, which have been provided with progress updates since October 2024. We have also kept both councils of governors (COG) informed of progress and engaged in programme development and delivery through the usual COG meetings.

We have used a workstream approach to develop the business case and support our planning for the date of acquisition and beyond. Each workstream has a senior responsible officer (SRO) and has identified specific projects determined by its key deliverables. We have also developed a robust risk management process for managing all risks associated with the integration programme (see chapter 19).

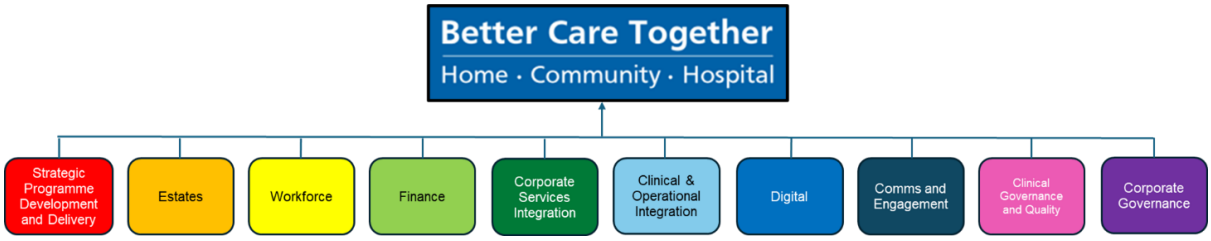

Figure 7 : The BCT integration programme and 10 core workstreams within the programme

A more detailed programme structure including the key sub-workstreams within each of the 10 core workstreams is included within the supporting documents to the FBC.

The table below details the SROs for each workstream alongside the designated support and operational leads.

Workstream	**SRO**	**Operational leads**	**Programme support**
Strategic programme development and delivery	Lucy Gardner	Steve Bennett	Lefteris Zabatis, Carolyne Ward
Estates	Dan Moore, Nick Gallagher	Val Doyle, John Morris	Carl Mackie
Workforce	Paula Woods, Michelle Cloney	Adam Harrison-Moran	Adam Harrison-Moran
Finance	Jane Hurst, Nick Gallagher	Janet Parker, Rachel Hurst	Jess Phillips, Paula Brereton
Corporate services integration	Jane Hurst, Nick Gallagher, Paula Woods, Michelle Cloney	Steve Bennett	Adam Harrison-Moran
Clinical and operational services	Dan Moore, Paul Fitzsimmons, Ali Kennah	Various	Hayley Heard, Rachel Moran, Mark Charman
Digital	Paul Fitzsimmons, Nick Gallagher	Tom Poulter, Dave Smith	Meg Wainwright, Bethan Savage
Communications and engagement	Kate Henry, Paula Woods	Hayley Smith, Mike Baker	Meg Wainwright
Clinical governance and quality	Ali Kennah, Jeanette Hogan	Susan Burton	Hayley Heard, Philip Mumberson, Carolyne Ward
Corporate governance	John Culshaw, Jan McCartney	John Culshaw, Jan McCartney	Kat Cornthwaite

Table 6: BCT workstream SROs and support

Figure 8 below illustrates how the overall integration programme is governed and the groups that report into/from the main programme governance structure.

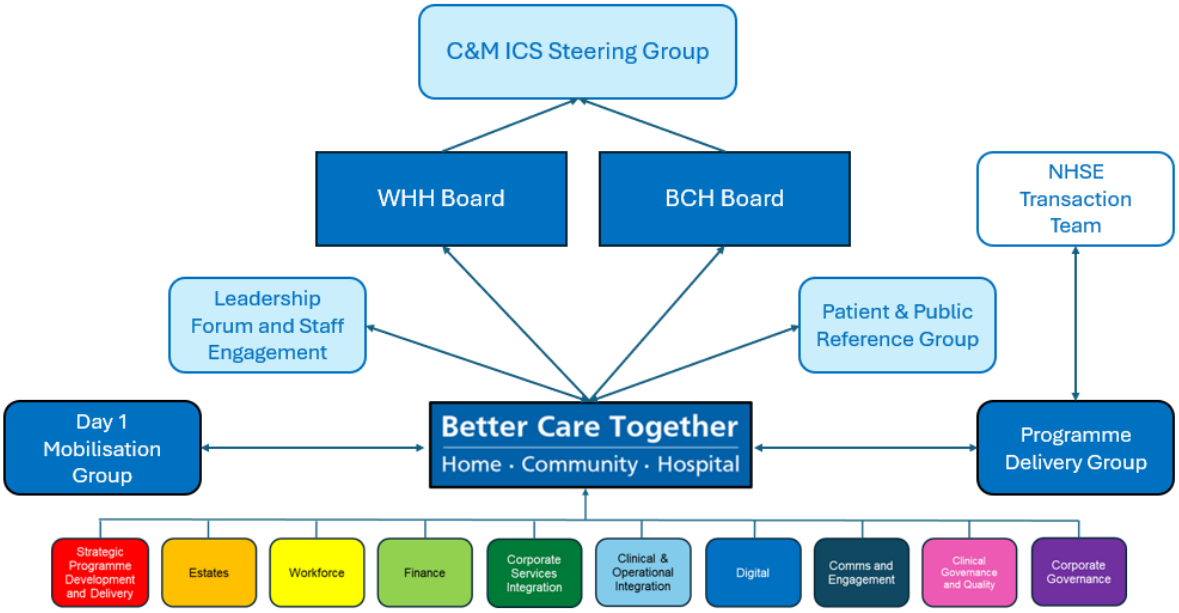

Figure 8: BCT programme governance

7.3 Ten core workstreams

The core workstreams, their main purpose and key milestones are detailed in table 7 below.

Workstream	Purpose/output	High-level key milestones
Strategic programme development and delivery	To co-ordinate and progress the core aspects of the overall integration programme in line with the required timeframes. This includes the production of required business cases and supporting information, progression of the legal transaction, development and co-ordination of programme/project support, engagement with external professional support and overall programme governance and reporting.	Develop the overall programme plan, governance and resources to deliver. Creation and approval of the strategic case. Creation and formal approval of the Full Business Case (with accelerated timeline). Oversee the transaction. Record, report and, where appropriate, manage all risks arising from the programme.
Workforce	The workforce workstream has the following responsibilities to: • enable staff from both organisations to work and behave as a single workforce	Develop an organisational change framework. Agree the required TUPE/organisational change measures and

	• establish the leadership and organisational structure • align the vision and cultural behaviours • support workforce transformation arising from integration workstreams • develop effective change management and staff transition plans	manage associated processes. Develop a joint culture plan. Develop a joint people strategy. Integrate workforce teams from WHH and BCH. Align all key systems and processes across the two organisations.
Communications and engagement	The communications and engagement workstream has the following responsibilities to: • maintain effective and appropriate communications around the programme with all key stakeholders • capture and respond to feedback from all stakeholders, but especially staff from both organisations • lead on public engagement and any required public consultation • develop a new organisational name and associated branding	Oversee all internal and external communications linked to the BCT programme. Support monthly staff engagement sessions. Ensure all stakeholders are appropriately engaged. Develop and monitor the communications and engagement plan for the BCT programme. Integrate the WHH and BCH comms teams.
Digital	This workstream will develop and deliver a strategy for the digital integration of WHH and BCH, ensuring the managed consolidation of systems and digital services to achieve quality improvements and efficiencies for both trusts.	Develop a joint digital strategy. Align all key systems and critical digital infrastructure. Integrate digital teams from WHH and BCH.
Finance	Aim to make both trusts more financially sustainable, create opportunities for efficiencies and productivity gains, and make the best use of our shared resources.	Develop a joint financial strategy. Integrate finance teams from WHH and BCH. Align all key systems, processes and financial governance policies.
Clinical and operational services	The clinical and operational workstream has been established to support the overall	Develop a joint clinical strategy.

	delivery of the integration programme, with a particular focus on: • managing emerging clinical and operational risks • integrating teams to create clinically improved models of care and better outcomes for patients • improving urgent and emergency care pathways and delivery of flow • developing sustainable services which are delivered in settings which are accessible, and which facilitate the delivery of optimum care and ensuring financial and clinical sustainability of services	Identify priority pathways and begin to integrate clinical and operational teams. Integrate all clinical and operational teams in line with phased plans. Develop the future organisational form. Work with Place partners to agree the future clinical vision. Work to improve key organisational performance metrics through integration opportunities.
Corporate services	Develop and then implement plans to create single services for each corporate function serving a new integrated organisation between WHH and BCH. Ensure the corporate functions of the integrated organisation will be cost effective, efficient and fit for the future.	Oversee the integration of all corporate services and delivery of financial improvement through corporate service integration.
Corporate governance	The programme is threefold, to: 1. ensure both trusts continue to remain Well Led during the integration programme 2. develop a strategy for greater collaboration between the trusts, focusing on joint/shared governance where appropriate 3. safely guide the trusts towards the formal legal mechanism and ensure the governance is in place post transaction	Agree the structure of the new Board for integrated organisation. Develop and implement committees in common for all key sub-committees of the Board. Oversee the new legal organisational form, membership of the new organisation, and governance arrangements.
Clinical governance and quality	The clinical governance and quality workstream has been established to support the overall delivery of the integration programme, with a particular focus on: • risk management, inclusive of complaints, incident management,	Integrate clinical governance teams from WHH and BCH. Align all key systems, processes and clinical policies across the two organisations.

	litigation and associated documentation, guidance and assurances • identifying opportunities and efficiencies for improvement in clinical governance services pathways and functions • managing emerging risks of integration from a functional and operational standpoint • integrating teams to create improved working models of care and safer outcomes for patients • developing aligned and sustainable services supporting patient experience such as bereavement, chaplaincy, and medical examiners • ensuring financial and clinical sustainability of services	Implement a single risk management system and supporting processes. Oversee the quality impact assessment (QIA) for the programme and quality assurance processes for the new organisation.
Estates	Integration of the estates department functions, contracts and sites of WHH and BCH to appropriately serve the population of Warrington and Halton and further afield.	Integrate estates teams from WHH and BCH. Ensure all 'business as usual' compliance, maintenance and estates safety issues are identified and addressed alongside the integration programme. Review and make recommendations on the rationalised use of estate.

Table 7: The 10 BCT workstreams and key milestones

7.3.1 Monitoring progress and assuring delivery

Each of the core workstreams detailed above has an individual 'delivery tracker' that is used to capture all key milestones across the various phases of the integration programme. Delivery of each milestone is supported by a number of more detailed actions, which are also recorded in the trackers. The list of actions and milestones have been compiled by the SROs and workstream leads, with support and advice from NHS England and other trusts nationally that have recent experience of integration.

Within the detailed actions, all workstreams have identified and flagged all tasks that are classed as 'critical day one' requirements. These include all relevant items of risk or potential risk to the organisation based upon the due diligence exercise undertaken in October 2025 (see chapter 19 for further details).

Delivery of all critical day one actions is monitored through a separate fortnightly 'day one mobilisation' meeting. This meeting has representation from all core workstreams and reports directly into the BCT delivery group (see figure 8).

An overview of all key programme actions and milestones is included in the supplementary information accompanying this document.

7.3.2 Monitoring workstream risks

Within the individual workstream delivery trackers, teams capture and record any risks associated with the workstream or the wider programme.

All risks relating to individual workstreams are recorded on the WHH Datix system and owned by the workstream teams, along with any required mitigating actions. They are also recorded on the BCH Ulysses system for completeness and to support dual reporting through the existing governance processes in the respective organisations.

All risks relating to the overall programme are recorded on the WHH Datix system and owned by the BCT programme team. They are also recorded on the BCH Ulysses system.

All risks are then monitored via the usual organisation risk monitoring processes, and they are also reported to the BCT delivery group on a monthly basis. An overview of the programme risks is included in chapter 19 of this document.

7.3.3 Monitoring workstream benefits – people, patients and productivity

Within the individual workstream delivery trackers, teams also capture and record any benefits relating to patients, people or productivity (non-financial benefits) that are expected to be delivered via the programme.

Progress against the delivery of these benefits is tracked via the BCT delivery group each month. A number of the more detailed people, patients and productivity benefits anticipated from the integration are described in later sections of this document.

7.3.4 Monitoring workstream benefits – financial

All workstreams also record and monitor the delivery of any anticipated financial benefits from the programme. These are detailed on the existing organisational central CIP trackers to ensure a single data source for all financial improvement across each trust.

Delivery of the respective trusts' financial improvement plans is reported each month via a range of meetings culminating in the joint finance and sustainability committee in common.

Progress against all anticipated financial benefits arising specifically from the BCT programme are reported to the BCT delivery group each month for information.

7.4 Senior programme leadership

The SRO for leading the integration programme is Lucy Gardner, chief strategy and partnerships officer at WHH. Lucy holds the executive portfolio for strategy at WHH, which includes the direct line management of the strategy team.

The WHH strategy team form the core of the BCT programme team, including the programme director role. The WHH strategy team are primarily responsible for the development and delivery of externally focused strategic change and improvement. Over

recent years the team have delivered a range of collaborative programmes of work across both Warrington and Halton Places, including:

- Halton Health Hub, a multi-million pound project to convert an unused retail unit in a local shopping centre in Runcorn into a multi-use health facility
- a £16m programme to create Community Diagnostic Centre facilities in three different locations in and around the trust's Halton site, including Halton Health Hub
- the Living Well Hub in Warrington, a £3m multi-agency health and wellbeing facility bringing together connected services from more than 30 different providers (including both WHH and BCH) from a range of sectors (referenced in section 10.3.1)

Lucy Gardner has prior experience of integrating organisations from her time at Ernst & Young. Her consultancy experience includes leading the advice and consultancy support to the Royal Free Hospital when it acquired Barnet and Chase Farm.

There is also substantial experience in mergers and acquisitions across the wider senior leadership teams:

- Joint chief executive Nikhil Khashu was the executive lead for the transaction of Calderstones to Mersey Care and worked on the early stages of the acquisition of Southport and Ormskirk Hospitals by St Helens and Knowsley. Nikhil also worked closely with the national transactions team as part of his previous role at NHS England.
- Joint medical director Dr Paul Fitzsimmons was previously deputy medical director at Liverpool University Hospitals NHS Foundation Trust (LUHFT) and was accountable for the reconfiguration of clinical services when Aintree University Hospitals acquired the Royal Liverpool to create LUHFT.
- Chief people officers from both WHH and BCH have extensive experience of leading TUPE transfers of staff into and out of organisations and creating an integrated workforce.
- WHH's chief finance officer supported the integration of Lancashire Ambulance Trust into North West Ambulance Service in her role as assistant director of finance at that time.
- WHH's director of communications and engagement was executive director of communications at South West Yorkshire Partnership NHS Foundation Trust and oversaw communications and engagement activities around TUPE of various community services in and out of the organisation.
- A number of the non-executive directors across both trusts have significant experience of transactions, including as NHS executives and commercial directors and lawyers.

7.5 Public Sector Equality Duty: Development and ongoing implementation

The integration programme is underpinned by a strong commitment to the Public Sector Equality Duty (PSED), ensuring that equality, diversity and inclusion are at the heart of organisational change. In 2024, both trust Boards formally agreed the Equality and Health Inequalities Impact Assessment (EHIA) process and governance arrangements, which have since been used to develop a combined EHIA for the integration. This comprehensive assessment is available as a supplementary document to the business case and provides assurance that potential impacts on protected groups and health inequalities have been thoroughly considered. The work continues and the EHIA will be a live document which continues to be reviewed post transaction as part of our implementation plans.

A standard operating procedure (SOP) has been established to ensure consistency and rigour in the EHIA process, and a bespoke combined EHIA training programme has been

developed for staff. This training aligns with statutory requirements for public consultation and engagement, equipping colleagues to identify, assess and mitigate equality impacts throughout the programme. In addition, assurance reviews are being developed in partnership with equality, diversity and inclusion leads from both trusts, providing ongoing oversight and challenge. This structured approach ensures that the PSED is not only met at the outset but will continue to be actively monitored and embedded as the new organisation moves forward.

7.6 A three-phase approach to integration

The scale and pace of change happening across the NHS, and public services nationally, is significant and unprecedented. As a result, it presents a challenge for our integration programme to be able to precisely define our long-term future operating model at this point in time. The main reason for this is because we know that the future success of our combined organisation will be based upon our ability to work collaboratively with our partners across the system. Therefore our future operating model needs to be developed as part of a much broader operating model across our local Places and region.

Whilst development and agreement around future operating models and the various Place vs regional aspects may require time, there are certainly elements that we can progress in the short-term to deliver improvement and create the foundations for future success. This is why we are following a three-phased approach to the integration programme as described in more detail in the following sections.

This phased approach will allow us to fully engage with the right partners at the right time to create the correct, sustainable, longer-term solutions, whilst simultaneously allowing us to progress critical improvement work that makes the most of the immediate opportunities created via the integration.

Figure 9 below illustrates the three planned phases of our programme, summarising the key work that will happen during each phase to bring together the respective elements of the two integrating partner organisations.

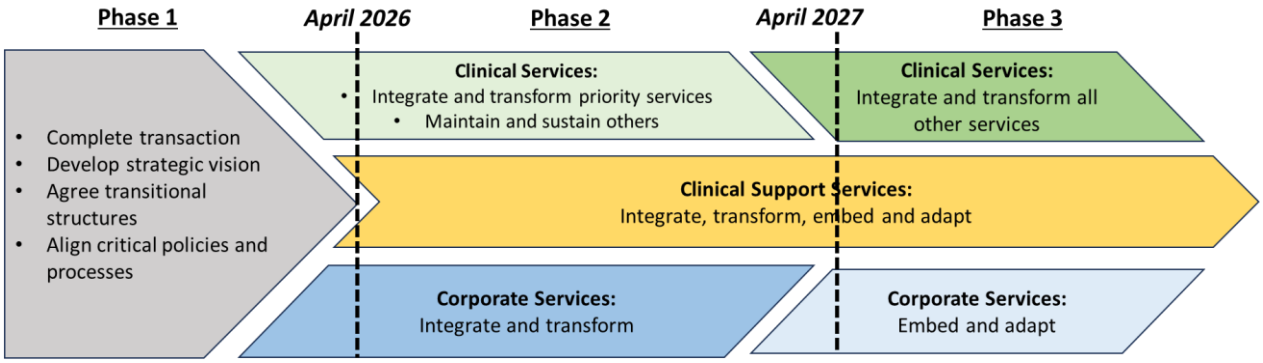

Figure 9: Three-phased approach to integration of services

7.7 Phase one: Period to 31 March 2026

In the short-term our aim is to bring BCH and WHH together through a formal acquisition as quickly as possible. We are aiming to complete the transaction in time to commence the new integrated organisation from 1 April 2026.

Completing the transaction quickly is more cost-effective, minimises disruption for patients and staff, creates the opportunities for improvement sooner and also makes them much easier to realise.

In the period leading up to the end of March 2026, we will focus on developing and agreeing initial integrated 'transitional' staffing structures for a number of services. These structures will create single teams and services across key parts of the organisation.

The structures will come into effect from the first day of our newly integrated organisation on 1 April 2026.

In addition, we will work to align all critical policies, processes and operating systems between the two partners to ensure the safe and seamless running of services from day one.

We will also continue to develop the strategic vision (along with supporting documents) and operating models for future services in collaboration with multiple local and regional partners, ensuring this is aligned to wider national strategic direction and the needs of our local communities.

7.7.1 Accelerating the transaction

Accelerating the process to complete the transaction and integrate the two organisations makes financial sense. It will reduce the costs associated with the transaction itself and also bring forward the date from which a number of key benefits can be delivered.

The benefits of the integration are detailed in later sections of this document but include financial benefits as well as benefits to patients and staff.

In terms of financial benefits, we estimate that accelerating our transaction will reduce the overall transaction costs by around £0.55m (see section 7.12). We also believe it will bring forward up to £4m in corporate savings by a year.

In terms of wider patient and staff benefits, formally bringing together the organisations sooner will help to simplify the process of service improvement, pathway redesign and makes it easier to divert resources between acute and community services to be more responsive to need.

We acknowledge that accelerating the transaction will also create new risks in terms of the time available to complete key tasks to support the integration. However, we believe that our phased approach to delivery will help us to mitigate that risk and allow us to divert the resources we have available to support the programme to the right projects at the right time.

7.8 Phase two: Period from 1 April 2026 to 31 March 2027

Figure 10 below illustrates the planned form of the integrated organisation, effective from 1 April 2026.

From this date, the organisation's senior leadership and senior operational management will operate as single integrated teams.

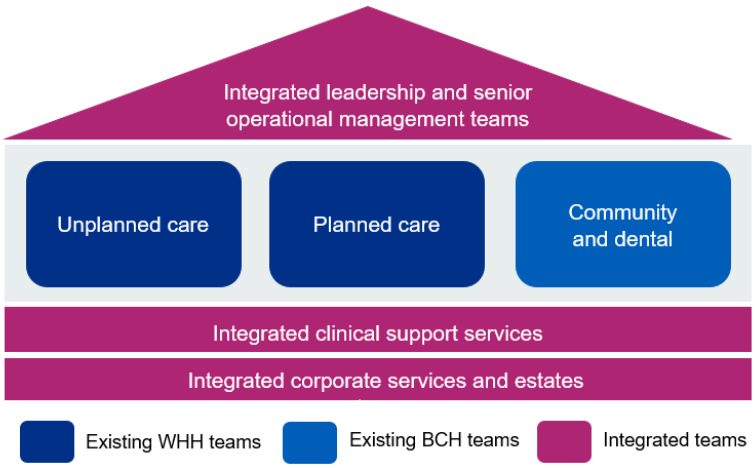

Figure 10: The proposed organisational form for integrated organisation, effective from 1 April 2026

The vast majority of clinical services from BCH will simply 'slot in' to the new integrated organisation, in the form of a new 'community and dental services' care group. This will operate alongside the existing WHH unplanned care and planned care groups.

The only exceptions will be where specific clinical services and pathways have been identified as priorities for integration and therefore the aim would be to deliver the required service redesign/transformation work in these areas during this phase of the programme. These clinical priorities are discussed in more detail in section 10.5.2 of this document.

The three main clinical care groups within the organisation will be supported by integrated corporate service and clinical support teams. More details on the plans to bring these teams together from 1 April 2026 is also included in later sections of this document (corporate teams in section 11.9 and clinical support teams in section 10.7).

Further detail on integration governance, risk management and delivery of the programme beyond the date of the formal transaction is set out in the post-transaction integration plan (PTIP). The PTIP is discussed further in section 7.10 below.

7.9 Phase three: Period from 1 April 2027 onwards

The third phase of our planned integration programme will see the remaining (non-priority) clinical services brought together and the delivery of our long-term vision for a new clinical model.

The rest of the organisational infrastructure, key systems and processes should be in place and embedded at this stage and therefore allows for the redirection of service change/transformation/organisational development resources to support the necessary clinical change work.

The future clinical model will be firmly based on the principle of 'home first, then community and hospital only when needed' and will be grounded in the national strategic direction around developing neighbourhood health and data-led intervention. More detail on the vision for the future clinical model is included in chapter 10 of this document.

7.10 Post-transaction integration plan (PTIP)

The post-transaction integration plan (PTIP) is developed alongside this Full Business Case and operates as a standalone, complementary document, setting out distinct milestones, objectives and governance arrangements that will guide the integration.

The PTIP outlines the approach and actions required to deliver the full integration of the two organisations following the formal transaction date of 1 April 2026. Therefore, it essentially sets out the plans for bringing together the services and teams across phase two and three of the BCT programme, ensuring all risks are managed and all benefits are realised along the way.

7.11 Accelerating the transaction

Figure 11 below illustrates the key steps and timeframes associated with the accelerated timeline for phase one of the integration programme.

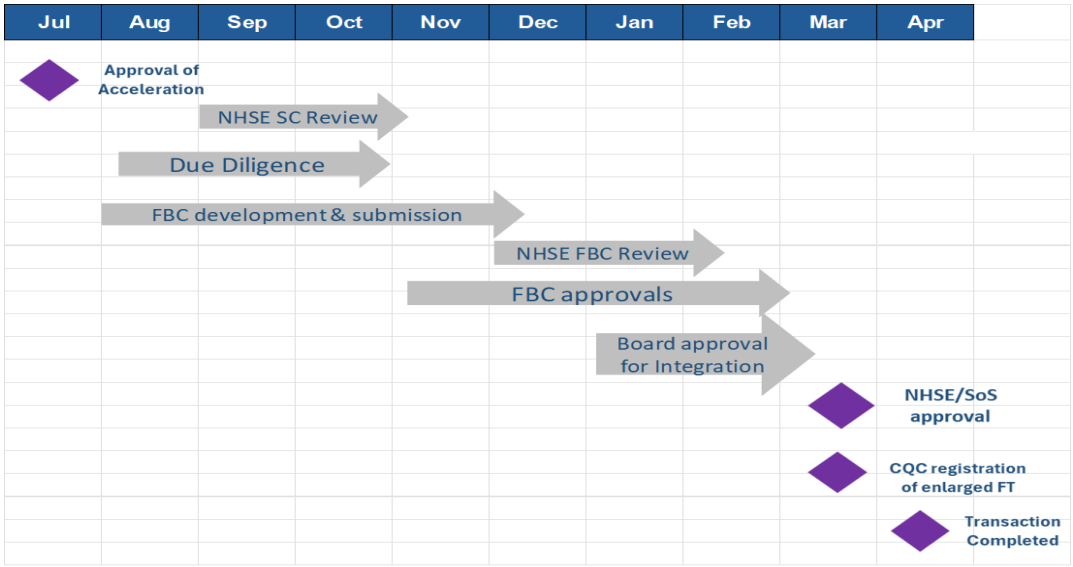

Figure 11: Timelines for key milestones as part of the accelerated transaction (phase one) of the programme plan

The key milestones achieved to date in relation to progressing the formal transaction for the integration is included in the supporting documents.

7.12 Resourcing the programme

Our ask of the ICS in terms of funding support to progress and complete the transaction was originally £1.65m spread across two years.

The current financial challenges across both WHH and BCH, but also across the wider ICS, present an urgent need for us to progress the accelerated timeline for the transaction. This should help to realise improvement opportunities sooner, reduce uncertainty and disruption for staff, and reduce the costs of the transaction itself.

The revised ask of the ICS to support the accelerated transaction has subsequently been reduced by £550,000. The partner organisations have agreed to realign internal resources wherever possible to deliver as much of the work required to support the integration as possible 'in house' and therefore reduce the costs. The overall revised ask is therefore just over £1.1m broken down as follows:

Funding support requested based on original transaction timeline	Programme requirement	Funding support requested based on accelerated transaction timeline
£32,000	Programme leadership and programme management support	£32,000
£120,000	Finance costs to support to the programme	£120,000
£90,000	Communications and engagement costs to support the programme	£90,000
£112,000	Dedicated clinical leadership to the programme	£112,000
£1,100,000	External consultancy support to the programme	£550,000
£200,000	Legal advice and support	£200,000
£1,654,000	Total funding support requested	£1,104,000

Table 8: Anticipated initial and revised programme costs

7.13 Programme costs and additional funding to date

Table 9 below details the known/estimated programme costs to date (as at the end of November 2025). Note that costs associated with operating a mutually agreed resignation scheme (MARS) are factored into profiled annual savings included in the finance section of this document (see section 13.3) and are therefore not included as additional costs below.

Table 51 in section 13.5 of this document details the anticipated annual additional programme costs profiled by year.

Programme requirement	Costs identified to date
Programme leadership and programme management support	£0
Finance costs to support to the programme	£140,000
Communications and engagement costs to support the programme (including signage)	£110,600
Dedicated clinical leadership to the programme	£0
External consultancy support to the programme	£415,000
Legal advice and support	£140,000
IT and system realignment costs	£97,500
Contingency	*£200,900*
Total funding support requested	£1,104,000

Table 9: BCT programme costs as at the end of November 2025

NHS Cheshire and Merseyside formally supported our strategic case, timeline and acceleration of the transaction in July, which included the £1.1m estimate of additional costs. A request for funding had also been submitted to the ICB prior to July's Board meeting. At the time the ICB agreed to make a 'modest sum' of funding available to support the integration programme and have so far confirmed £200k of this.

WHH have subsequently formally written to the ICB to confirm that unless the remaining £900k funding is allocated, the trust will potentially go off plan by up to £900k due to the additional costs of the integration programme in 2025-26. This is included as a key programme risk on the risk log (see table 58, section 19.2).

The funding requested of £1.1m is significantly less than that provided to other integrations completed locally in recent years. Our integration is forecast to deliver £2.4m of cashable financial benefits in 2025-26 (part of WHH/BCH internal CIP challenge), and cost up to £0.9m in 2025-26 (£1.1m in total), both costs and savings are reflected in our financial forecast.

7.13.1 Use of internal resourcing as programme support

In order to keep additional programme costs to a minimum, given the current financial challenges, both WHH and BCH have identified and diverted internal resources to support the core workstreams with managing the programme of work.

Table 10 below shows the total whole time equivalent (WTE) staffing released from a number of internal teams across the two organisations to date, and up to the end of 2026-27. Resource requirements beyond 2026-27 will be reviewed and agreed prior to the end of 2026-27.

Resource diverted from	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27	Q3 26/27	Q4 26/27
BCH - Digital team				0.20	0.20	0.20	0.20	0.20
BCH - Transformation team	0.20	0.20	0.20	0.20	0.20	0.05	0.05	0.20
WHH - Finance team		0.20	0.40	0.40	0.40	0.40	0.40	0.40
WHH - QI team	1.00	1.30	1.50	0.50	1.50	1.50	1.00	1.00
WHH - Strategy team	3.40	3.60	4.05	5.95	6.80	6.80	6.30	6.30
WHH - Transformation team				0.20	0.20	0.20	0.20	0.20
WHH - Workforce team	0.80	0.80	0.80	0.85	0.60	0.60	0.60	0.60
Grand Total	**5.40**	**6.10**	**6.95**	**8.30**	**9.90**	**9.75**	**8.75**	**8.90**

Table 10: Internal resource diverted from BCH and WHH to support the core workstreams

Figure 12 below illustrates how the internal resources quantified in table 10 are aligned to individual workstreams across each of the three phases of the BCT programme. We are planning to continue to resource the programme as required into 2027-28 and will review the resource requirements and ensure they are met prior to the end of 2026-27.

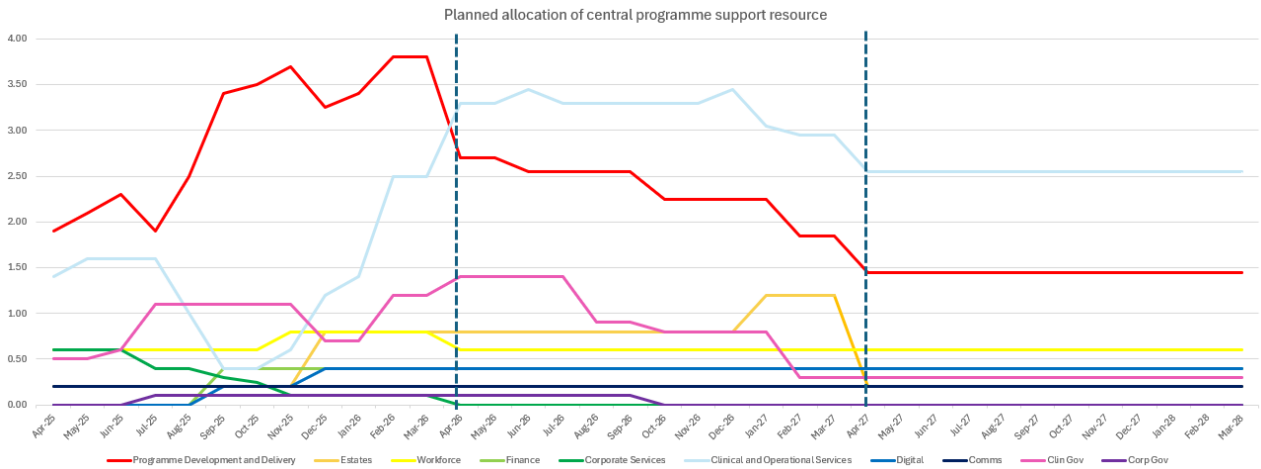

Figure 12: Alignment of central programme resource to support individual workstreams

7.13.2 Use of internal resourcing to support workstream delivery

In addition to the central programme support identified above, both BCH and WHH have diverted internal resources from teams within each of the core workstreams to support the delivery of all programme actions and milestones, including those classed as critical day one actions.

Table 11 below shows the total whole time equivalent (WTE) staffing released from a number of internal teams across the two organisations to date, and up to the end of September 2026 (midway through phase two of the programme). Resource requirements beyond September 2026 will be reviewed and agreed depending upon the outstanding actions within each workstream at that point.

Resource diverted from	Q1 25-26	Q2 25-26	Q3 25-26	Q4 25-26	Q1 26-27	Q2 26-27
BCH - Clin Gov team		1.10	4.65	4.65	4.65	4.65
BCH - Comms team	0.60	1.00	1.40	2.10	2.10	2.10
BCH - Corp Gov team	0.10	0.20	0.45	0.45	0.10	0.10
BCH - Digital team	0.10	0.20	0.51	0.51	0.51	0.51
BCH - Estates team	0.20	0.20	0.60	0.90	0.90	0.90
BCH - Finance team			0.10	0.10	0.10	0.10
BCH - Health visitors	0.30	0.30	0.30	0.30	0.30	0.30
BCH - IPC team			0.20	0.20	0.20	0.20
BCH - Management team			0.10	0.10	0.10	0.10
BCH - Med Mgmt team			0.10	0.10	0.10	0.10
WHH - Clin Gov team		0.50	1.40	3.02	3.02	3.02
WHH - Comms team	0.40	0.80	1.20	2.00	2.00	2.00
WHH - Corp Gov team	0.10	0.20	0.45	0.45	0.10	0.10
WHH - Digital team	0.20	0.20	0.91	0.91	0.91	0.91
WHH - Estates team	0.20	0.20	1.40	1.80	1.80	1.80
WHH - Finance team	0.05	0.10	0.50	0.50	0.50	0.50
WHH - IPC team			0.10	0.10	0.10	0.10
WHH - Management team			0.05	0.05	0.05	0.05
WHH - Pathology team			0.10	0.10	0.10	0.10
WHH - Pharmacy team			0.10	0.10	0.10	0.10
WHH - QI team			0.20	0.20	0.20	0.20
WHH - Radiology team			0.20	0.20	0.20	0.20
WHH - Workforce team			1.40	7.00	7.00	7.00
Grand total	**2.25**	**5.00**	**16.41**	**25.83**	**25.13**	**25.13**

Table 11: Internal resource diverted from BCH and WHH to support the delivery of actions within the 10 core workstreams

8.0 Vision and strategies for the integrated trust

8.1 Chapter summary

The integration of WHH and BCH seeks to establish a sustainable, high-performing organisation that delivers seamless acute and community care, meeting the evolving health needs of local people. This section articulates this shared vision, the mission and strategic priorities for the new integrated organisation.

It sets out how WHH and BCH will build on existing partnership work to deliver seamless care across the acute-community pathway, supporting the 'Start Well, Live Well, Age Well' principles of the Cheshire and Merseyside ICS, focusing on health equity, digital transformation, and population wellbeing.

Key message: The section details the trust's new vision, to deliver seamless, sustainable, person-centred care across hospital and community settings. It explains how the integrated trust will drive clinical excellence, workforce wellbeing, digital innovation and environmental sustainability, shaping a single, forward-thinking organisation built for the future.

It highlights how strategic alignment with the NHS 10 Year Health Plan will enable transformation at scale, improving access, prevention and continuity of care, and outlines the overarching outcomes framework through which success will be measured.

8.2 Our vision for the future

As described in chapter 5 of the case, the challenges we are aiming to address via integration are to:

- meet the current and future health and wellbeing needs of our local population
- manage future demand for statutory services within available resources
- deliver on national priorities and performance standards
- tackle known health inequalities
- secure long-term clinical and financial sustainability

In order to rise to these challenges, transformational change of our respective organisations is required.

Our vision for the organisation is to evolve into a thriving and responsive integrated acute and community provider delivering high-quality, effective services that meet the needs of residents. We will build sustainability and cost-efficiency into our pursuit of this vision.

Our clinical ambition, aligned closely to the principle requirements of the 10 Year Health Plan, is to achieve a fundamental shift in the delivery of care from an illness focused, hospital-based model to a more sustainable, community-based, collaborative model focusing on health promotion and prevention. As we develop the detail of what the future clinical model will look like alongside our local partners, there are a number of guiding principles we will follow that have been agreed by the senior clinical and operational leadership of both trusts. These are:

- **'Home first, then community and hospital only when needed' – this is our core principle**
- any changes to clinical service delivery should aim to improve access and reduce health inequalities
- service changes should aim to deliver the most cost-effective care possible

- clinical service delivery should align to ‘getting it right first time’ opportunities (GIRFT) and seek to achieve compliance with national, college and national institute for clinical excellence (NICE) guidance where applicable
- services should be delivered as close to home as feasibly possible and centralised when necessary
- services that are complex, specialised or small volume should be consolidated to enable future sustainability
- co-production should be considered wherever feasibly possible

8.3 Long-term planning and key organisational strategies

A number of documents are currently in development that together will set out how we aim to achieve our vision for the integrated organisation. Figure 13 below shows how the various documents align and connect with one another.

Figure 13: Alignment of trust strategies

8.4 Five-year organisational plan

The first draft of the five-year plan for the integrated organisation is due to be submitted to NHS England in December 2025. This plan will detail the organisation’s baseline position with regards its current performance and its capacity and capability to deliver on the challenges it faces. It will then describe the detailed plan for improvement over a five-year timeframe.

The integration of WHH and BCH will feature heavily in the plan as a critical enabler to improvement in terms of finance, performance, addressing health inequalities and managing future demand.

The five-year plan will incorporate the plan for financial and performance improvement.

8.5 Organisational strategy

8.5.1 Our strategy for an integrated organisation – 2026-2029

A joint strategy for the integrated organisation is currently in development with adoption expected at the end of 2026. It will describe in more detail our strategic vision to provide more joined-up care for people living in Warrington and Halton, with a greater focus on providing more of their care at home and in the community as set out in chapter 10. It will also align with national guidance to develop local neighbourhood health models which aim to strengthen collaboration between health and social care and wider public services.

The strategy will link closely with the organisation's five-year plan to help define a number of key strategic objectives and it will be underpinned by enabling strategies. These enabling strategies will provide greater depth around specific strategic objectives and start to demonstrate not just where we are going, but how we intend to get there.

A comprehensive engagement programme to ensure wide input into the new strategy for the integrated organisation has been developed. Implementation started in August 2025 with initial engagement on the values that our new integrated trust needs to demonstrate and uphold (section 8.6). The engagement programme will be ongoing throughout 2025 to 2026 until the new strategy for the integrated organisation is approved, as illustrated in figure 14.

We are following a five-stage process to develop our new strategy:

1. August to November 2025 – assess the relevance of existing strategies and engage on new values
2. December 2025 – define the scale and nature of change needed
3. January to April 2026 – develop the building blocks for our organisational identity, vision and mission
4. May to August 2026 – determine the final strategy and engagement
5. September to December 2026 – approve and launch the new strategy and agree ongoing governance and monitoring

Ongoing regular communication and engagement via digital channels, bulletins and forums will bring together people's experience, expertise and ideas to help shape our future plans.

We will engage internally through staff forums, equality, diversity and inclusion champions, staff network meetings, staff-side meetings and with our Freedom to Speak Up (FTSU) guardians. We will also seek external views from Place committees, voluntary sector partners, Healthwatch, local authority groups, our council of governors and members, and local councillors and MPs.

We will hold dedicated meetings with the GP leads from our Places – Warrington and Halton – and hold patient and public reference groups to help capture the views of our local population around what we are planning to do and what is particularly important to them.

The feedback received during this extensive programme of engagement will be vital in the development of our strategy and in shaping our plan for integration of clinical and operational services.

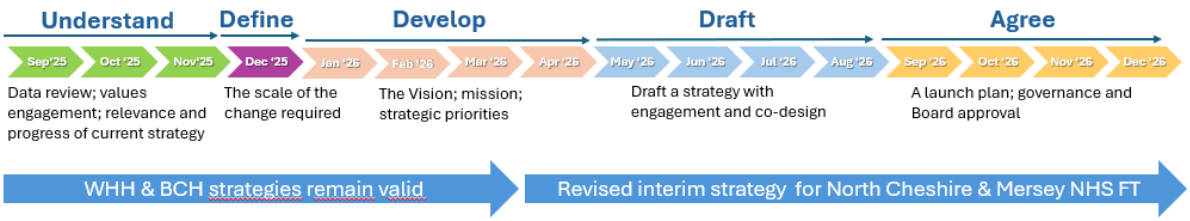

Figure 14: The timeline for the development, approval and publication of the new organisational strategy

8.5.2 Interim organisational strategy to 2026

Whilst the new strategy is in development, an interim strategy will be adopted by the new organisation from the date of the acquisition for the remainder of 2026. The interim strategy is based on the existing WHH strategy, which has been formally extended and approved by both WHH and BCH Boards with some amendments to reflect the priorities of BCH and opportunities realised through the integration.

Amendments to the WHH strategy include a change to the mission statement, which now states the ambition to be exceptional, our vision statement which previously referred to a great 'place' to receive healthcare and now refers to a great 'organisation providing healthcare'. Similarly, all three aims have had amendments to wording to incorporate phrases currently familiar within the BCH strategy as illustrated in figure 15.

Figure 15: Amended WHH organisational strategy

8.5.3 Interim strategic objectives

As part of the interim strategy for the integrated organisation, the current WHH strategic objectives will be adopted in the short term with one minor amendment to include belonging in 'our organisation' rather than belonging in WHH. Figure 16 below details the existing strategic objectives that are framed around the three strategic domains: quality, people and sustainability. These strategic objectives align to both WHH and BCH's existing strategies.

Figure 16: Amended interim strategic objectives

8.6 Trust values

Feedback received in staff engagement events suggested that the values of the integrated trust would be an important area for prioritisation and were something that staff were keen to input into. Refreshed organisational values will serve to guide the development of the wider strategy, and support work on culture and business planning such as a new behavioural framework and branding.

A three-week engagement exercise was undertaken across August and September 2025 via a short survey to staff which was shared widely within both trusts and with external partners. A total of 183 people completed the survey – 44% BCH, 55% WHH, 1% external.

8.6.1 Quantitative data

'Kindness' and related values (such as kind, caring and compassion) were the most frequently mentioned and resonated strongly with staff across both trusts, indicating a shared priority for a caring and supportive culture.

Many respondents expressed a desire for simplicity and clarity in organisational values, with comments suggesting that values should be memorable, collective and not overly numerous or complex. There was a notable emphasis on inclusivity, teamwork and openness, with staff highlighting the importance of working together, celebrating differences and maintaining honesty and transparency as the organisation moves forward.

8.6.2 Qualitative data

Qualitative information was gathered through discussions at various internal and external forums including Place partnership Boards and the joint trust leadership forum, which highlighted that:

- values should be concise, meaningful and reduced to around three to four in total
- there is an important link between the values and associated behavioural framework
- behaviours should additionally be engaged on, with communications clearly outlining the differences and similarities between old and new, to ensure they are embedded

Survey results and qualitative information were triangulated to develop the set of refreshed values, which will come into effect from 1 April 2026, described below.

Kind	Open	Fair	One Team

Table 12: Refreshed trust values for the integrated organisation

8.7 Supporting strategies and enabling strategies

Alongside the development of a new organisational strategy, there will be a need to develop a number of key supporting strategies and enabling strategies. These complimentary documents will provide further clarity and focus on specific areas of the integrated organisation's operations.

The clinical strategy will describe the future clinical model at service level and how it will enable the trust to realise the majority of the patient benefits of the integration. The content and principles within the clinical strategy are discussed further in chapter 10.

The financial strategy will form part of the five-year organisational plan and demonstrate the plan to move the integrated organisation to a position of financial sustainability in the medium-term. The content and principles within the financial strategy are discussed further in chapter 13.

Other enabling strategies that will be produced include the estates strategy, the people strategy and the digital strategy. The content and key principles within these other enabling strategies are discussed in chapters 16 to 18.

Strategy	High-level description	Timeframe
Five-year organisational plan	Internal and regional use. Aligned to NHS 10 Year Health Plan, to set out the long-term objectives for the organisation including financial sustainability plans. Feeds into detailed operational plans on annual basis, including impact measures.	December 2025
Financial strategy	Internal and regional use. Plan to break even from current deficit position and maintain financial sustainability.	December 2025
Organisational strategy	Public facing. Vision, values and objectives and priorities to deliver strategic goals.	December 2026
Clinical strategy	Public and internal facing. Sets out vision for neighbourhood health. Includes responsibilities to address health inequalities and wider determinants of health. Supported by service level clinical priorities and plans.	December 2026
Estates strategy	Internal use. To describe estate requirements to deliver clinical strategy in fit for purpose facilities. Supported by detail to inform investment cases and deliver cost improvement.	October 2026
Enabling strategies incl. People strategy Digital strategy	Internal use. Approaches to provide support, resources and conditions to enable delivery of the overarching strategy and five-year organisational plan priorities.	December 2026

Table 13: Key organisational strategies and timeline for production

8.8 Strategy development timetable

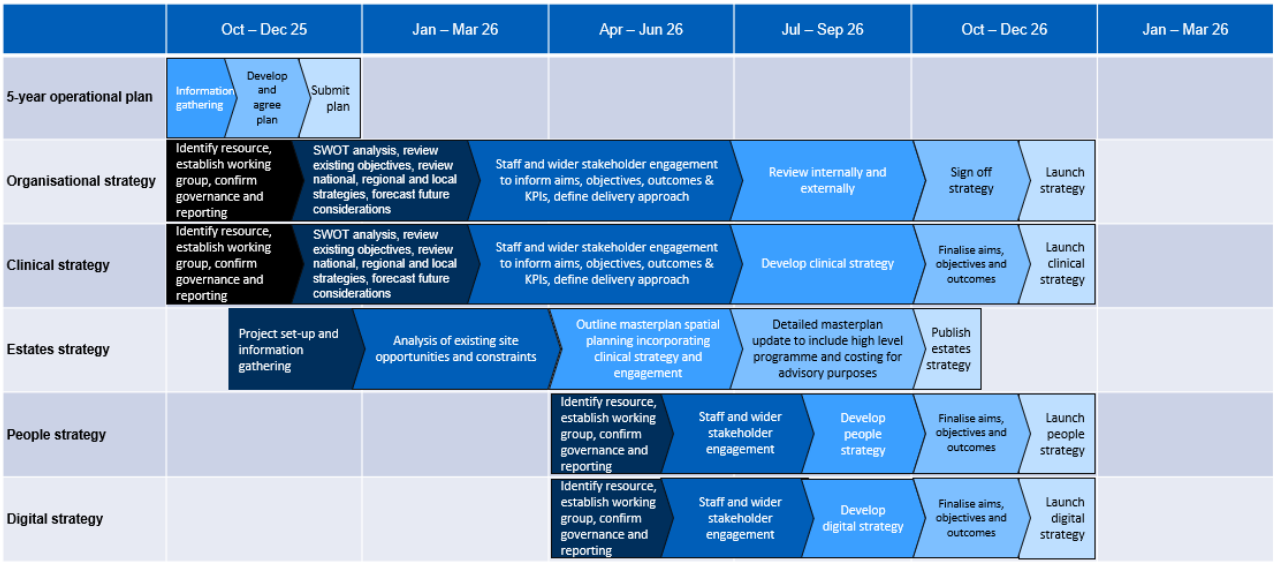

Figure 17: The timeline for development of various strategies for integrated organisation

8.9 Annual operating plans

Once the medium to long-term strategic direction of the new integrated organisation is set, the trust will need to translate this into clear, manageable objectives that can be monitored to ensure delivery. This will be achieved via annual operating plans that are agreed for each care group prior to the commencement of each new business year.

Through this process, all care groups are required to commit to a range of operational targets and goals aligned to the longer-term strategic objectives of the wider organisation.

Progress against the targets and goals set in the annual operating plans is monitored throughout the year by the trust senior leadership team to provide appropriate challenge and assurance, but also to identify risks to delivery and support required.

9.0 Organisation design

9.1 Chapter summary

This section outlines the proposed structure and governance of the new integrated organisation. It describes how leadership, clinical and corporate functions, the legal mechanism for the acquisition, Board committee structures, the quality and financial governance structures, and the operating model will be configured to support delivery of the Trust's strategic vision and operational priorities.

The section emphasises principles of simplicity, accountability and inclusivity, ensuring the new organisation's design supports integrated working and informed and timely decision-making.

It references early work undertaken through joint committees and collaborative working to ensure readiness for day one.

The section concludes by setting out the next steps for consultation, engagement and implementation of the future operating model.

Key message: The proposed design ensures a balanced, transparent and responsive structure, maintaining continuity while enabling innovation.

It integrates acute and community leadership, reflects the values of both organisations, and ensures accountability from Board to frontline services. This design positions the new organisation to deliver both local responsiveness and system-level impact.

9.2 Legal mechanism

The integration process between BCH and WHH has been driven by the need to improve services and achieve clinical and financial sustainability. As described in chapter 6, the chosen legal mechanism for achieving this will be through the acquisition of BCH by WHH.

Governance arrangements put in place to date include joint executive team meetings, joint Board development meetings, and the creation of an ICS steering group made up of senior representatives from both trusts, NHS Cheshire and Merseyside ICS and local system partner organisations.

As part of our BCT programme, BCH and WHH undertook a Board-to-Board session on 4 September 2024 to consider how BCH and WHH could effectively work together as a single organisation. This resulted in the options appraisal being undertaken as described in chapter 6.

Since November 2024, the trusts have been working together to introduce a joint executive team with a number of shared posts including chief executive, executive medical director, chief nurse, chief operating officer, and director of delivery to date.

At respective public trust Board meetings, on 5 and 6 February 2025, the recommendation of the options appraisal for BCH to be acquired by WHH was approved.

On 4 and 5 June 2025 respectively, it was agreed by both Boards to propose acceleration of the acquisition to 1 April 2026 to the C&M ICS Board. This happened on 24 July 2025, and the proposal was subsequently supported. Both Boards also approved the strategic case for our integration and acquisition at the same meetings on 4 and 5 June. The strategic case was also supported by the C&M ICS Board on 24 July 2025. The strategic case was then submitted to NHS England for review and feedback to be incorporated into this FBC.

9.3 Overall Board committee structure for WHH and BCH

Figure 18 below shows the current combined Board and sub-committee governance structure for WHH and BCH. Figure 19 and figure 20 show the current Board sub-committee structures for both BCH and WHH respectively. Finally, figure 21 shows the proposed Board sub-committee structure for the new integrated organisation.

The introduction of committees in common ensures that both Boards and the joint committee of the Boards have oversight of all domains of the two trusts and are able to balance information and appropriate challenge across shared agendas. This is complemented by integrated performance quality review reports for each trust with a single version across the two trusts scheduled to be produced ahead of day one.

As outlined in figure 18 below, committees in common for both people and finance and performance have already been established. Terms of reference for a joint committee of the Boards have also been approved, should they need to be stood up ahead of the acquisition date.

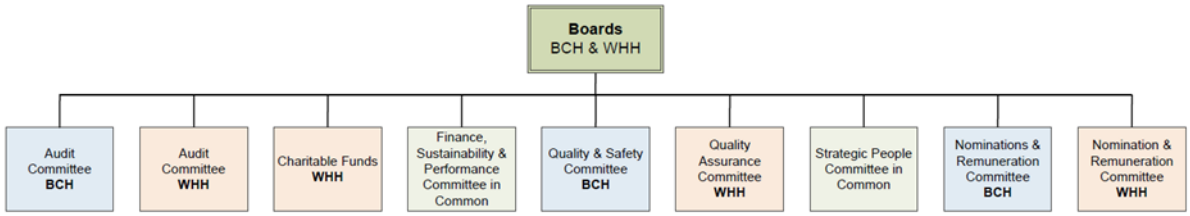

Figure 18: Current combined Board sub-committee governance structure

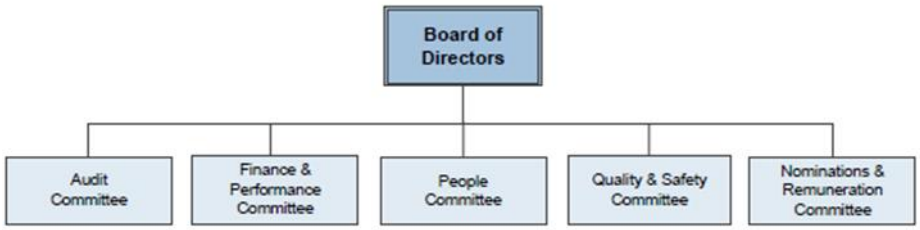

Figure 19: Previous BCH Board sub-committee structure

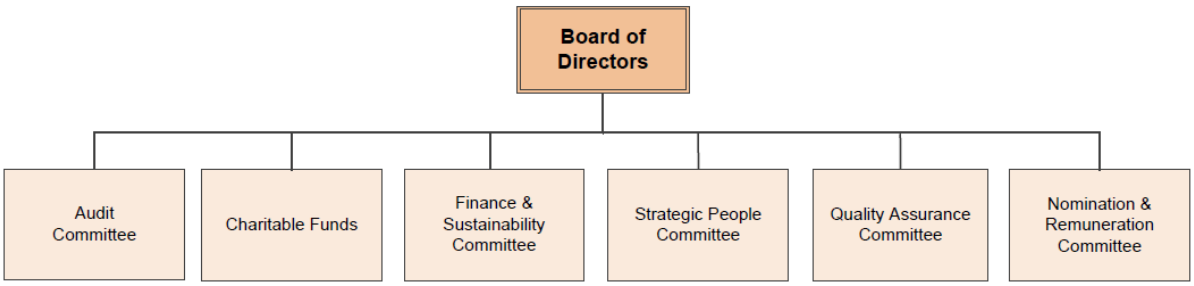

Figure 20: Previous WHH Board sub-committee structure

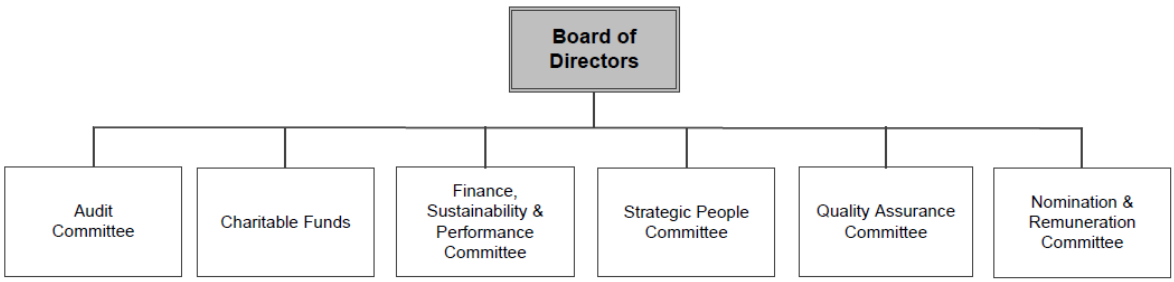

Figure 21: New Board sub-committee structure for integrated organisation

9.4 Board of integrated trust – day one proposed position

With the introduction of joint executive roles across both trusts since November 2024 and the establishment of committees in common, a significant amount of joint governance has been put in place ahead of the formal transaction.

Assurance on the progress of the acquisition has been reported through the BCT programme delivery group, which reports into both trust Boards directly. The delivery group will continue following the acquisition to provide assurance on the progress of delivery of the subsequent phases of the programme and further development and delivery of the PTIP.

Post acquisition, the Board committee structure will be further reviewed as part of the review of the constitution and self-evaluation against the well-led framework, to ensure the optimal balance of strategic development and assurance, and appropriate number of Board committees. This may lead to refinement of the committee structure for the integrated trust.

The terms of reference for the strategic people committee in common were approved separately by both Boards in April 2025. Similarly, the terms of reference for the finance, sustainability and productivity committee in common were approved in August 2025.

The remaining Board committees are currently reviewing their terms of reference, which will be submitted to both Boards for approval during the 2025-26 financial year.

From day one of the integrated organisation the following committees will also be in place:

- a single audit committee
- a single nomination and remuneration committee, comprised of all non-executive directors of the new trust
- a single quality assurance committee

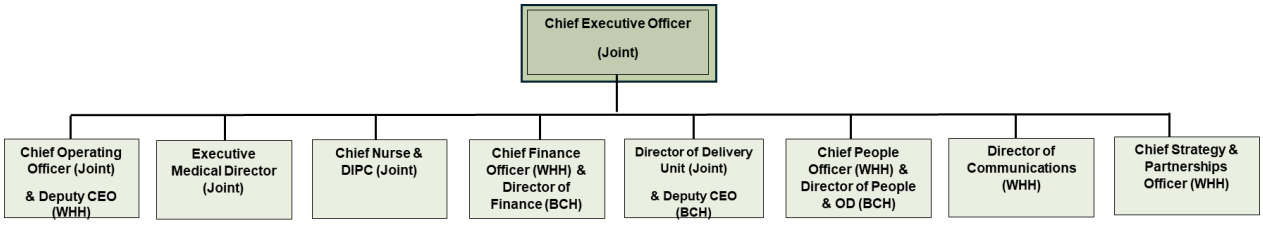

Figure 22: Current executive structure of both BCH and WHH

The integrated organisation will have a Board structure comprised of a single executive team and non-executive directors.

The trust will be led by an effective and diverse Board which is innovative and flexible and will support the delivery of the new organisation's strategy. The role of the Board of Directors will be to:

- provide effective and active leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed
- ensure compliance with the provider licence, the constitution, mandatory guidance issued by NHSE, and all relevant statutory requirements and contractual obligations
- set our strategic framework, taking into account the views of the council of governors, reviewing progress and managing performance
- assure the quality and safety of care, the reduction of health inequalities, education, training and research
- ensure that all functions are exercised effectively, efficiently and economically
- promote the long-term sustainability of the trust as part of the ICS, the local ICB and wider healthcare system in England, generating value for members of the foundation trust, patients, service users and the public
- help set the vision, values and standards of conduct and ensure obligations to members, service users and other stakeholders are understood, clearly communicated and met

The integrated organisation will have a newly appointed chair with a three-year term from April 2026-27 who will lead the organisation with the incumbent non-executive directors from WHH. The non-executive directors (NEDs) of WHH will continue their terms with the integrated organisation. The existing BCH NEDs will not automatically transfer to the new Board. However, as the terms of the current WHH NEDs come to an end, BCH NEDs will have the opportunity to apply for any forthcoming NED vacancies on the new Board, ensuring fair access to future roles within the integrated organisation.

The existing members of the WHH and joint executive team will transfer to the executive posts in the integrated organisation. The executive team structure was reviewed in 2024 as part of the appointments within the joint executive team. The required legal processes will be undertaken in line with the Transfer of Undertakings (Protection of Employment) regulations to establish the integrated Board.

Figure 23 below of the proposed executive team will support the integrated organisation with the capacity oversight and capability to deliver our integration programme and capital projects alongside business as usual.

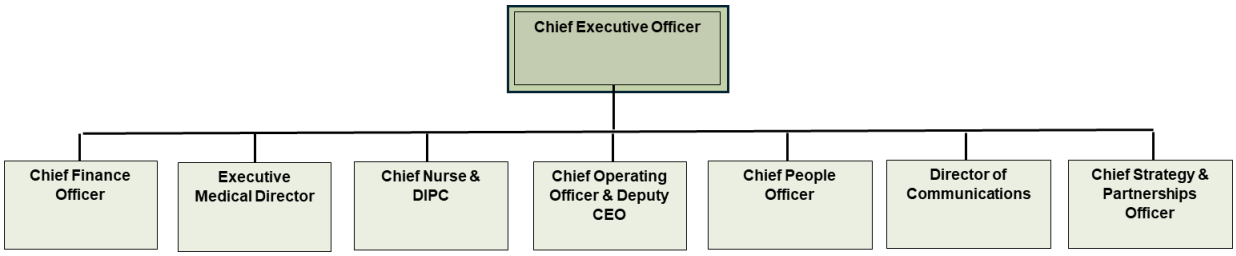

Figure 23: Executive team of the integrated organisation

In developing our structure, we have been mindful that the Board of the integrated organisation needs the necessary skills and experience to enable it to provide effective leadership and oversight of the new, integrated trust. This will help assure delivery of the

strategic objectives for the new organisation. The proposed Board will have the necessary skills to ensure that the integrated organisation delivers high quality, safe care to the populations we serve.

9.5 Constitution

An exercise will take place to review the constitutions of both WHH and BCH and align these where necessary for the integrated trust. Trust Boards and Governors will be engaged during the exercise. The updated constitution will be presented to the WHH Council of Governors and Trust Board for approval in February 2026.

Additionally, the Scheme of Reservation and Delegation (SoRD) and Standing Financial Instructions (SFIs) will be presented to the WHH Board for approval in February 2026.

9.6 Governors

WHH currently has 27 governors, while BCH has 24. As WHH is the acquiring trust, its council of governors will become the council of governors of the new organisation upon acquisition. The BCH council of governors will be dissolved.

Given that both trusts serve broadly the same population, work was undertaken during 2023-24 to align WHH's public constituencies with those of BCH. This resulted in the agreement of two public membership constituencies: Warrington and Halton, and rest of England, with governor representation from both. In 2023-24, the WHH constitution was updated to allow individuals to serve as governors at more than one trust encouraging cross-FT collaboration.

Staff constituencies across BCH and WHH are identical, therefore no changes are proposed. Partner governor positions are similar across both trusts. WHH currently has partner governors for all partner organisations specified by BCH, including statutory borough-based partner organisations, voluntary services and higher education.

Between September and November 2025, WHH will conduct routine elections to fill vacant seats or those with governors nearing the end of their term. Election results will be announced on 26 November 2025.

The newly formed governor engagement group in common (GEGiC) merges the WHH governor engagement group and the BCH communities matter public & community engagement group. Approved by both councils of governors in August 2025, GEGiC aims to strengthen collaboration between the two Trusts and align membership and engagement strategies to support the integration journey.

The statutory role of the council of governors is defined in the constitution. Governors work closely with non-executive directors through council meetings attended by all non-executive directors, with executive directors participating in specific agenda items as subject matter experts.

9.7 Membership

As of 31 March 2025, WHH had 3,062 public members and 4,790 staff members, and BCH had 1,655 staff members and 6,219 public members.

In the time leading up to the integration, efforts will be made to encourage BCH public members to become members of WHH, which will become the membership base of the new organisation. This message will be communicated through BCH and WHH member newsletters and media releases related to the 2025 WHH elections.

BCH members may submit nominations to become governors of WHH (and therefore the new trust), provided they submit a valid membership form. BCH membership will be dissolved upon acquisition. During the transaction period and beyond, the public will be encouraged to join WHH and the new organisation to ensure they can contribute to the strategic direction of the trust, stand in governor elections and vote for their representative governors.

BCH staff members will automatically become members of the new organisation following the transaction.

9.8 Quality governance structure for the integrated trust

The integrated organisation will adopt a unified quality governance framework that ensures safe, effective and person-centred care across acute and community settings. This framework will align with NHS England's quality governance principles and the requirements of the care quality commission (CQC), while supporting the trust's strategic objectives and ICS priorities.

A unified quality focused Board-level committee responsible for oversight of clinical quality, patient safety and experience will be established building on the existing quality governance framework form each trust. The committee will report directly to the Board of Directors having received briefing papers from a range of subcommittees covering areas such as patient safety, experience, safeguarding, infection prevention, medicines governance and risk review. The committee will also oversee the development and implementation of quality strategies, monitor compliance with regulatory requirements, and ensure effective communication and learning frameworks are in place across the trust.

The supporting documents show the proposed internal governance structure for the integrated organisation covering the three core strategic domains of quality, people and sustainability.

9.8.1 Integration of quality support functions

The integration of BCH and WHH will encompass all governance functions, including risk and incident management, central alerting system (CAS) alert management, policy, standard operating procedure (SOP) and guideline oversight, legal and claims management, and complaints and patient advice and liaison services (PALS).

More detail around the integration of clinical governance and quality teams can be found in section 11.15 of this document.

9.8.2 Clinical policies and procedures

To ensure safe and effective service delivery from day one, it is essential that all high-risk clinical policies and procedures are aligned and fully understood by all staff. Policies are categorised as high risk if they will potentially require a material change in practice or process for either WHH or BCH staff following the date of integration, and the change in practice or process, if not fully communicated and/or understood, could create a risk of harm.

Successful alignment of clinical policies will promote consistency in clinical practice, improve quality and safety standards, and enhance staff confidence in the new organisation's governance arrangements. It will also reduce duplication, streamline clinical decision-making

and lay the foundation for a more efficient, integrated and sustainable approach to patient care across the integrated trust.

The process of reviewing, prioritising and aligning all clinical policies ahead of the transaction date has already commenced. Relevant documents, SOPs and policies are being updated and consolidated to ensure clarity, accountability and robust governance structures. All processes will be concluded and fully communicated by 31 March 2026, with joint governance meetings commencing from 1 April 2026. Many activities will begin ahead of full integration to maintain continuity and safety. Where full alignment cannot be achieved by day one, clear interim arrangements and governance controls will be established and communicated to provide staff with definitive guidance on which policies to follow. This approach will safeguard patient care, maintain regulatory compliance and support a smooth transition to a unified clinical governance framework.

9.8.3 Incident management

Incidents will be managed collaboratively across both organisations on a daily basis. Clinical governance managers, aligned to each care group within the organisation, will provide daily escalations to the triage meeting chaired by the deputy director of governance. For any incidents of concern or interest, an SBAR report will be prepared and reviewed at the weekly executive-led safety oversight meeting (SOM), which is attended by ICB colleagues. During SOM, proportionate learning responses will be agreed and subsequently presented back for review. SOM currently reports into the WHH quality assurance committee (QAC) through relevant governance reports and escalates to the executive-led PSIRF group. It will report into the joint quality committee once this is established. Learning from incidents will be monitored through the sustained learning group, which will start in Q4 2025-26.

9.8.4 Risk management

The trust is currently undertaking a procurement exercise to purchase a single governance system across both organisations. It is proposed that training and rollout of the new system will commence from the first quarter of 2026-27. This will further strengthen integration, streamline reporting and enhance assurance across both organisations.

In the meantime we will ensure that risk management processes remain robust throughout the duration of the integration programme and beyond. WHH will continue to manage risk registers and incidents on the Datix system, while BCH will continue to utilise the Ulysses system for incidents and risk registers. Both systems will be governed and managed by a single data analyst governance team, which will produce joint reports for governance committees and care groups to ensure safe business continuity.

All risk registers will be overseen by a single risk review group, attended by the executive team, all care groups and the corporate secretary. This group will ensure that all risks are managed, reviewed and aligned with the corporate risk register and the Board assurance framework. The risk review group will report into the quality committee and Board by exception. The clinical governance managers/governance teams will be fully trained in both systems.

9.8.5 Health and safety management

Presently, the oversight of organisational health and safety resides within different portfolios across the two organisations. In the future integrated structure, health and safety will be managed and governed within the clinical governance portfolio to ensure clarity and consistency. BCH currently uses external contracted support to manage health and safety;

this was identified as a potential risk as part of the health and safety due diligence exercise (see section 19.3.2). It is envisaged this arrangement will continue temporarily while the capacity of the governance team is scoped and adequate resources are allocated to maintain all health and safety activity internally.

9.8.6 Legal and claims management

Legal and claims management currently sits within the corporate governance team at BCH, but with limited activity. This function will transfer to the WHH legal team at the point of integration, utilising existing WHH policies, procedures, and governance reporting frameworks.

9.9 Financial governance for the integrated trust

The new trust will operate under a robust financial governance framework, drawing on the existing structures of both organisations and aligning them through aligned policies and procedures.

While WHH and BCH remain separate legal entities until completion, both Boards have approved a 'committees in common' approach to provide unified oversight ahead of the legal transaction. For finance, this is the finance, sustainability and productivity committee in common (FSPCiC), replacing WHH's finance and sustainability committee (FSC) and BCH's finance and performance committee for joint scrutiny of plans, in year performance and strategic investments. FSPCiC reports via assurance reports to each sovereign Board and escalates as required to each trust's audit committee, operating within each scheme of reservation and delegation (SORD). The CiC oversees financial and operational planning, operational performance, strategic and business development, EPRR, estates and digital matters, and sustainability across both trusts, ensuring compliance with NHS regulations and local priorities.

Following integration, the CiC will revert to a single committee reporting within the internal governance structure illustrated in the supporting documents.

9.9.1 Individual elements of financial governance

The Board of Directors are the unitary Board responsible for stewardship of public funds, strategy, risk and assurance.

Audit committee – the independent committee that reviews and assures integrated governance, risk management, internal control, and the work of internal audit, external audit and counter fraud. It meets at least five times a year, with provision for private meetings with auditors, reports to the Board after each meeting, and supports the annual governance statement.

Finance, sustainability and performance committee – provides strategic oversight and scrutiny of financial planning, in year performance to plan/budget, efficiency and productivity, cost improvement programme (CIP), capital programme, cash and triangulation across performance and workforce. It also makes recommendations to the Board on plans, budgets and investments, and operates to an agreed cycle of business.

The governance model will be underpinned by a corporate governance manual and the annual governance statement which outline the control environment and responsibilities of key committees.

Furthermore, a single **delivery unit** has been established across both organisations to review and scrutinise productivity, non-pay, workforce and recruitment and overall financial grip and control.

9.9.2 Reporting lines and responsibilities

- The chief finance officer will be accountable for financial stewardship and reporting across the integrated entity.
- The audit committee reports to the Board and provides independent assurance on the adequacy of internal controls, risk management and governance processes.
- The finance, sustainability and productivity committee will report to the Board and is responsible for scrutinising financial plans, investment proposals and budget performance.
- The company secretary ensures governance compliance and supports committee operations, including documentation and escalation protocols.

9.9.3 Internal control system and lines of financial accountability

a) **Core instruments**

Standing financial instructions (SFIs) set out duties of all staff and the CFO to design and maintain internal financial controls, including segregation of duties, internal checks, record keeping and reporting – ensuring probity, accuracy, economy, efficiency and effectiveness.

The scheme of reservation and delegation (SORD) defines decision rights and delegated financial limits (revenue, capital, tendering/quotations, waivers), and clarifies who may commit, approve or vary budgets. Waivers of procurement processes are reported to the audit committee. Standing orders codify Board/committee composition and delegation, and requirements for conduct, declarations and meetings.

These documents will be reviewed and updated prior to the transaction to ensure they are fit for purpose for the new organisation.

b) **Budget accountability and reporting**

The CFO chaired finance resource group (FRG) reviews clinical business unit (CBU) and corporate financial performance monthly and reports to the non-executive led finance committee. The financial control group provides further grip and oversight of efficiency and controls. Quality impact assessments for CIPs are reviewed to ensure financial actions do not compromise quality.

c) **Assurance on segregation of duties**

The integration will maintain strict segregation of duties across financial processes, supported by standing financial instructions and scheme of delegation. These clearly define roles for budget holders, approvers and reviewers to prevent conflicts of interest and use financial systems with embedded controls to enforce separation of duties and prevent unauthorised transactions.

d) **Budget accountability**

Budget accountability will be embedded through:

- delegated budget responsibilities to operational leads and service managers
- regular financial reporting to the finance, sustainability and productivity committee and executive team

- integration of financial performance into the Board assurance framework (BAF) and risk registers

9.9.4 Internal audit, external audit and assurance alignment

Internal audit: The trust's internal audit provider (Mersey Internal Audit Agency – MIAA) delivers a risk-based annual plan approved by the audit committee. The 2024-25 cycle included mapping and follow up of actions with regular reporting to the committee, and the Head of Internal Audit (HOIA) opinion for 2024-25 concluded substantial assurance. As part of integration, MIAA is aligning annual plans and projects across WHH and BCH to ensure continuity of controls before and after the transaction.

Internal audit services will be aligned to ensure consistency and coverage:

- a unified audit plan will be developed in consultation with both legacy organisations' audit teams
- counter fraud activities will be aligned, with green ratings already achieved on fraud standards

External audit: External audit (statutory) provides independent assurance on the annual report and accounts, AGS and quality report. Following the planned acquisition on 1 April 2026, there will be a move to a single provider of external and the same for internal audit services to the integrated trust.

Audit committee oversight: Audit committee meets on a five times yearly cycle, receives internal/external audit and counter fraud reports, and tracks overdue actions; cycles of business are published and monitored.

9.10 People governance for the integrated trust

The new trust will operate under a robust people governance framework, drawing on the existing structures of both organisations and aligning them through harmonised policies and procedures. While Warrington and Halton Teaching Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust remain separate legal entities until completion, both Boards have approved a committees in common approach to provide unified oversight of people and organisational development ahead of the legal transaction.

For people governance, this is the strategic people committee in common (SPCiC), replacing WHH's strategic people committee and BCHT's people committee, to enable joint scrutiny of workforce strategy, organisational development, equality, diversity and inclusion, and staff wellbeing. The SPCiC provides assurance to each sovereign Board via formal assurance reports and escalates as required to each trust's audit committee, operating within each trust's Scheme of Reservation and Delegation (SORD) and standing financial instructions (SFIs). The committee oversees the development and implementation of joint people strategies, workforce planning, staff engagement and culture transformation across both trusts, ensuring compliance with NHS regulations and local priorities.

Following integration, the SPCiC will revert to a single committee reporting within the new internal governance structure, supporting the trust's ambition to be the best place to work, with a diverse and engaged workforce that is fit for now and the future. The committee will continue to monitor performance against national standards, oversee statutory and regulatory obligations in relation to equality, diversity and inclusion, and ensure that the trust attracts, develops, and retains its workforce in line with the principles of the NHS People Promise.

10.0 Clinical model

10.1 Chapter summary

This section describes the emerging joint clinical model that will underpin delivery of care across the new organisation. It demonstrates how acute, community and specialist services will be connected through integrated clinical pathways designed around patient need, not organisational boundaries.

The section explains how this model supports prevention, early intervention and reduced hospital admissions through multidisciplinary working, shared digital systems and community-based care.

The integrated clinical model transforms patient journeys by removing boundaries between hospital and community care. It strengthens clinical sustainability, reduces variation, and enables proactive, preventative care closer to home.

Key message: This section outlines the four priority areas for early integration – starting well, ageing well, urgent and emergency care, and long-term conditions, and the subsequent seven priority pathways of focus: frailty response, infant feeding, heart failure, chronic pain services, movement disorders, female urinary incontinence, and end of life care. It illustrates how these will improve outcomes and experience while ensuring long-term clinical and financial sustainability.

10.2 Clinical vision and strategy

Our vision for the future model of the integrated organisation has been set out clearly since the original strategic case for change document was produced in October 2024.

We will deliver new models of care, with the continued involvement of a wide range of partners and voices, including primary care, local authorities and people with lived experience. We want to provide care as close to home as feasibly possible and focus significantly on improving population health and reducing health inequalities.

The NHS 10 Year Health Plan provides a mandate to bring this vision to life and the integration programme between WHH and BCH becomes a key enabler to achieving that transformational change. Our aim is to play a lead role in the development and then the delivery of proactive neighbourhood health across our local places.

It also aligns with national guidance to develop local neighbourhood health models which aim to strengthen collaboration between health and social care and wider public services including the third sector.

As demonstrated in chapter 5, our current model of care results in too many people coming into hospital for inpatient and outpatient care. With a rapidly growing and ageing population, this model will contribute to unsustainable levels of demand for services in future. The 10 Year Health Plan sets out three strategic shifts and our medium to long-term vision for clinical services aligns perfectly with each of these:

1) **Sickness to prevention**
   We want to work more collaboratively with local system partners to address the wider determinants of health and drive forward an agenda of ill health prevention and earlier intervention. Increasing healthy life expectancy for current and future generations and reducing demand for statutory health and care services.

2) **Analogue to digital**
We want to be innovative and creative in our approach and make use of current and emerging technology to promote remote/virtual management of health conditions. We also want to promote self-care and empower the local population to take greater responsibility for their own health and wellbeing. Digital technology can be a key enabler in that aim.

3) **Hospital to community**
For those people who do require support from secondary care services, we want to rebalance the pathways so that increasing numbers are able to access those services in community settings, supported by secondary care clinicians, advice and expertise where required. The neighbourhood health agenda can be the vehicle to really make that happen.

10.3 Foundations for the clinical vision

WHH and BCH have been working closely for a number of years on a number of initiatives that demonstrate the three strategic shifts are realistic and achievable.

10.3.1 From sickness to prevention

10.3.1.1 Case study: Living Well programme in Warrington

WHH and BCH are two of the core partners leading the Living Well programme of work across Warrington over recent years. There are a number of projects within the programme that are focused on supporting prevention, early intervention and self-care.

The first of the Living Well projects was the Living Well Hub, which opened in March 2024 in Warrington town centre. The hub has rapidly established itself as a trusted, non-clinical access point for early help and wellbeing support. In its first 18 months of operation it recorded more than 30,000 attendances, with 50 per cent of people walking in on a drop-in basis rather than via referral – clear evidence of unmet demand for accessible, face-to-face support. Importantly, 88 per cent of visitors come from the town's most deprived central areas, and 9 per cent report they would not have accessed any help without the hub. Activity data shows that 15 per cent of visitors use more than one service per visit, and more than 5 per cent are actively signposted onwards, demonstrating the hub's role in diverting people away from crisis and into early, preventative support.

The co-location of WHH midwives, BCH community services, carers' support teams, dementia navigators, Home Start, job centre advisors, wellbeing teams and other statutory and voluntary providers enable seamless, multi-agency responses to complex social and health needs. Case studies from the project show tangible impact: vulnerable expectant parents receiving immediate financial and emotional support; unregistered carers identified early and connected into structured help; individuals with unmanaged long-term conditions brought into clinical pathways via informal engagement; and people in distress supported before reaching emergency services. Staff and people accessing services consistently report that these outcomes 'would not have been possible' without the shared hub model.

Alongside the hub, a wider network of 10 neighbourhood Talking Points delivered more than 900 visits in the first year and generated more than 2,000 requests for support, ensuring that early help is available close to where people live.

Building on this physical presence, the launch of the Living Well Warrington digital platform in March 2025 has created a 24/7 preventative 'front door' for residents and professionals.

Co-designed and governed by WHH, BCH, Warrington Borough Council and VCFSE partners, the platform consolidates previously fragmented information sources into a single, quality-assured resource. Early usage trends demonstrate that both clinicians and social prescribers are now routinely using it to connect patients to non-clinical support – further reducing unnecessary clinical contacts and strengthening community capacity.

The financial and system impact of the programme is significant: Living Well's face-to-face connections are estimated to have delivered £40m in system savings, while the digital platform has created £1m in social value within its first six months. The three projects to date operate at an annual cost of £490k – a fraction of the cost of a hospital ward. This demonstrates that the push towards community services and prevention creates opportunities to manage greater demand in a different way and support financial sustainability of the whole system.

Together, the Living Well Hub, Talking Points and digital platform represent a mature model of joint WHH and BCH population health working. They deliver measurable benefits in demand reduction, improved access, health equity and community resilience. Most importantly, they demonstrate that both trusts are already operating beyond organisational boundaries, jointly leading the cultural and operational shift from illness to wellness which this acquisition seeks to scale.

The Living Well Warrington programme was recently highly commended in the 'integrated care initiative of the year' category at the 2025 HSJ awards.

There are opportunities to go further with the collaborative work in Halton too, through the WELL Runcorn project, which will see a similar multi-agency health and education facility open in the town centre of Runcorn in early 2026.

10.3.2 From analogue to digital

10.3.2.1 Case Study: Skin analytics – AI-led dermatology service

April 2025 saw the launch of a new AI-led dermatology service, the result of three months of fast-paced collaboration between BCH, WHH and the software providers.

The new service uses revolutionary medical-grade artificial intelligence called DERM, which recognises skin cancer and common harmless skin conditions using photographic images instead of assessment by clinical staff. The results of the AI system are proven to be more accurate and the software also results in a faster diagnosis.

Using AI will reduce the number of hospital appointments for patients with benign lesions and allow faster care for more urgent cases, with treatment often performed on the same day, at the same location. In line with wider NHS aims, waiting times will be reduced and a rising demand better met.

The pioneering new service is delivered from Warrington and Halton Diagnostics Centre, located at Halton Health Hub, within Runcorn Shopping City. This is one of only a small number of Community Diagnostic Centres to be launched in a shopping centre in the country – and the first in Cheshire and Merseyside, making it easy for patients to access modern diagnostic services outside of a hospital environment.

There are exciting and rapidly expanding opportunities for service improvement and financial efficiency linked to the use of AI. This is an area that the integrated organisation will be focusing on over the coming years as the programme of clinical and operational transformation continues to develop and deliver.

10.3.3 From hospital to community

10.3.3.1 Case study: Urgent Community Response (UCR) Team

BCH's UCR teams across both Warrington and Halton work in close collaboration with the acute trust as well as Warrington and Halton borough councils. The UCR teams support people to get the care they need at home. The service receives a high volume of referrals and supports patients with high acuity to prevent unnecessary hospital admissions.

The urgent care improvement programme continues to work collaboratively with WHH, BCH and local authority colleagues, and benefits of integration are demonstrated with significant increased referrals to the UCR team as an alternative to ED. More than 120 more patients each month were referred to UCR in 2024 compared to 2023. Other improvements include a 4 per cent reduction in attendance at ED and a 17 per cent reduction in the length of time spent on the ED corridor from 2022-23 to 2024-25.

10.3.3.2 Case study: Frailty virtual ward

The Warrington Frailty Virtual Ward is a partnership between WHH and BCH. The aim of the virtual ward is to provide 'hospital at home' patient-centred care to patients over 65 with a frailty condition. The ward currently onboards patients who reside within both nursing and residential care homes, with an additional step-down pathway that was introduced early in spring 2024 to allow patients from the Frailty Assessment Unit to be stepped down to their own home. Moving forwards, plans are in place to introduce a step-up pathway to onboard patients from their own homes into the virtual ward.

New opportunities to shift work away from acute settings will arise from the proposed neighbourhood health agenda. The 10 Year Health Plan sets out a vision for more multi-disciplinary, neighbourhood health centres and these could potentially be facilities offering enhanced community services delivered by integrated community and acute specialty teams alongside primary care teams.

10.4 Clinical Strategy

The impact of delivering and sustaining these three shifts will ultimately see care provided closer to the patient's home and help prevent more people reaching poor health and crisis point. Over time, this shift of care will free-up clinical time within the acute trust, allowing secondary care clinicians to focus on complex care and potentially releasing resources that can be shifted back into the community.

By following the core principle of 'home first, community next and only then hospital', patients will only need to attend acute services as a last resort. This should free up professional time, reduce secondary care resource requirements, reduce waiting lists and ultimately increase the sustainability of the overall care model.

This principle will form the basis of a new clinical strategy for the integrated organisation, which is planned to be completed by December 2026. The new clinical strategy will provide further details about what the clinical model will look like across our local Places as the thinking and planning around neighbourhood health develops and matures with our partners.

The overall approach to clinical integration that will be captured by the strategy is based on principles of co-production, quality improvement and systems thinking. By creating the conditions for a culture of shared learning, collaboration and innovation we will facilitate the development of integrated pathways and services that lead to sustainable improvements.

Further detail around how our future integrated clinical model can support improvements in health outcomes and health inequalities can be found in chapter 14 of this document.

10.5 Clinical integration in phase two of the programme

We acknowledge that the development of a new Clinical Strategy and clinical model will take time (for context, the neighbourhood health plans on a national scale form part of the 10-year plan). But we also acknowledge there are opportunities for clinical improvement that exist without the longer-term, large-scale transformation described in the sections above.

Having established our principles for clinical and operational integration (see section 8.2), an initial workshop for senior clinical and operational leads was held in October 2024. Chaired by the chief strategy and partnerships officer at WHH and joint medical director, the aim of the workshop was to understand services across both trusts, to understand where we care for the same people, to identify clinical alignment and to make recommendations on priority themes for integration.

50 senior leaders from across both organisations and external partners including third sector organisations and primary care participated in the workshop and following two facilitated interactive sessions, the following themes emerged as priorities for integration:

Figure 24: Thematic priorities for clinical integration

- Starting well – women, children's and family services
- Ageing well
- Urgent and emergency care and discharge
- Long-term conditions

Subsequently, it was decided that urgent and emergency care already had a programme of work (ED improvement programme) being undertaken collaboratively between WHH, BCH and local authority colleagues, and a separate summit for this area was therefore not considered necessary.

It was also agreed that long-term conditions should be divided into two sub-groups to consider physical conditions and neurological conditions separately and similarly, women's health and children's services were separated too.

In total, five themes were agreed to be taken forward for further initial work. These themes then formed the basis for the next stage of the planning, which was to identify the priority

services for integration in phase two of the programme as part of a series of 'clinical summits'.

10.5.1 Clinical summits

Services falling within each of the five identified themes were grouped together and appropriate representatives from clinical and operational teams for each service from each trust invited to the relevant summit. Director level partners including local authority, primary care and voluntary sector representatives were also invited.

The clinical vision and ambition to move more care into the community were integral to the clinical summits. Discussion focused on high level pathways and opportunities to strengthen services rather than detailed plans or organisational structure.

Focused discussion was facilitated to:

- understand the pathways within each service and the challenges within them
- understand where patients would benefit most from integration and a shift of services into the community
- consider how integration could support improvement in pathways and the priority order for this integration

10.5.1.1 Clinical summit – long-term conditions (physical)

The specific services discussed at this summit were:

- podiatry and orthotics
- diabetes
- heart failure
- respiratory disease
- end of life care

The integration priorities agreed by the group were **heart failure, and end of life care**

10.5.1.2 Clinical summit – long-term conditions (neurological)

The specific services discussed at this summit were:

- neurological rehabilitation
- stroke
- movement disorders/Parkinson's disease
- chronic pain services

The integration priorities agreed by the group were **movement disorders/Parkinson's disease, and chronic pain services**

10.5.1.3 Clinical summit – women's health

The specific services discussed at this summit were:

- women and family services
- gynaecology, bladder and bowel
- breast screening and surgery

The integration priority agreed by the group was **female urinary incontinence.**

10.5.1.4 Clinical summit – children's services

The specific services discussed at this summit were:

- community paediatric and nursing care
- paediatric therapies
- antenatal and intrapartum care
- postnatal and neonatal care

The integration priority agreed by the group was **infant feeding.**

10.5.1.5 Ageing well

A seventh and final clinical priority was added following the completion of the clinical summit meetings in the summer of 2025.

Given the significance and the impact of the ageing and growing population locally, it was agreed that the clinical integration work also needed to include a focus on older adults.

More specifically, the system-wide management of people living with frailty syndromes and **frailty response services**.

10.5.2 Clinical priorities

Category	Priority Area
Acute & Community Care	Acute care closer to home – Frailty response
Cardiovascular Health	Heart failure
Pain Management	Chronic Pain Services
Maternal & Child Health	Infant feeding
Neurological Care	Movement Disorders / Parkinson's Disease
Women's Health	Female urinary incontinence
Palliative & Supportive Care	End of life care

Table 14: Seven services identified as priorities for integration as part of phase 2 of the programme

The following tables summarise the main outcomes from the initial meetings to discuss the identified clinical priorities.

Clinical priority 1: Frailty response	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
• No single community frailty service • Lack of senior frailty clinical support to BCH services meaning patients are often sent into ED for further assessment rather than positive risk-taking occurring • Services disjointed with no direct care pathways enabling flow to step in to secondary care or step down back to community – it means patients are often conveyed to ED for senior medical review when SDEC services may be more appropriate. Similarly, patients remain on wards for bloods to be repeated when this could occur in patients' own homes with medical input virtually if required. • Staffing constraints in both organisations with incorrect skill mixes • Limited therapy, nursing and specialist geriatric support in community • No provision of own home falls assessments for patients who are not housebound (despite gold stand falls assessment including an own home mobility/environmental review) • Digital fragmentation – usage of different clinical systems in WHH compared to BCH mean not all documentation is visible to both organisations – ACPs, CFS, 4AT delirium assessments, and care plans not consistently visible across hospital, community and GP systems. • No single governance structure for community and hospital-based frailty services, delaying service change /improvement and preventing optimal pathway design for patients • Care Home Integration – variable support for falls, infection management, and end-of-life care; inconsistent pathways to avoid unnecessary hospital admission.	• Early Frailty Identification and Comprehensive Geriatric Assessment (CGA) • Mandatory CFS assessment for all ≥65 in ED, FAU, and community referrals. • CGA delivered within 24 hours for moderate/severe frailty (CFS ≥6), including ANP/ACP support • CGA-lite offered in virtual ward or home for community-managed patients by community team • Admission avoidance and community integration • Expand virtual ward 'step-up' to prevent hospital admissions from ED, GP, ambulance, UCRS, community matrons and care homes • Strengthen links (both in and out of secondary care building) with community UCRS, ECHST and community matron teams to enable same-day or home-based care • Deconditioning and functional recovery • Mobilisation-first ethos organisation wide and in community (dress, sit up, move daily) • Therapy input coordinated across hospital and community to maintain function and independence • Delirium, falls, and bone health • Universal 4AT delirium screening in all hospital and community assessments • Standardised falls protocols across hospital, virtual ward, community and care homes • Osteoporosis risk assessment and post-falls rehabilitation offered in hospital and community settings. Therapy assessment for falls clinic patients to be completed in their own home • End of life care and advanced care plan • Routine ACP conversations across all hospital and community services with one standardised document to be shared between all. ReSPECT document is used nationally but not in Warrington/Halton • Shared digital records accessible to ED, FAU, virtual ward, community teams and GPs • Care home integration

	• Direct care pathways for hospital avoidance and early intervention with increased utilisation of virtual ward step up pathways • Standardised falls, infection and end-of-life protocols aligned with hospital services. Apply same formulary to community care as hospital-based care • Rapid access to specialist geriatric support without unnecessary hospital conveyance • Metrics, monitoring and digital integration • Dashboards to track: CFS completion, 4AT screening, admissions avoided, LOS, readmissions, functional outcomes • 75+ benchmarking to assess system performance and identify gaps • Fully integrated EPR system across hospital, community and GP networks to support shared decision-making • Clinical governance to be led medically by DMOP clinical lead with one centralised governance meeting for entire frailty service encompassing community and hospital provision
How will this look and feel better for patients?	**How will this look and feel better for staff?**
• More care delivered at home or in community • Reduced corridor waits in ED as increased direct conveyance to FAU • Reduced delirium and deconditioning rates • Reduced LOS as seen by right team at the front door and increased early supported discharge support back out into the community • Better end of life alignment with patient wishes • Improved flow of pathway for patients due to integrated service	• Increased support from senior frailty clinicians • Upskilling of community workforce • Increased awareness of community services for hospital-based staff • Right patient in right place; less duplication of assessment • Focused use of specialist staff for high-impact interventions

Table 15: Outcomes from initial discussions around clinical priority 1

Clinical priority 2: Heart failure	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
• Variation in practice for management of referrals and wider clinical practice by area • Too many patients wait too long for diagnosis and management leading to an increase in admissions • Availability of diagnostic tests varies by area and service • Variation in prescribing rights across WHH and BCH • Waiting times for outpatient appointments • Lack of clinical vetting for patients on the waiting list • Visibility of medical history and test results across disparate EPR systems • Waiting time for high complexity treatment e.g. intravenous diuretic medication • Suboptimal management of end-of-life heart failure patients leading to unnecessary admissions	• Have a single service serving patients across the heart failure pathway • Deliver a seamless integrated service to manage heart failure from diagnosis throughout the disease course – aiming to maximise the time patients are at home and minimise time and contact with the hospital. • Develop a community IV diuretics service • Establish community clinics for heart failure nurses shifting clinic workload into the community • Standardise the scope of practice of heart failure nurses including prescribing and referral right • Develop a one-stop approach to diagnosis and treatment in the community wherever possible • Reduce variation in practice between Halton and Warrington
How will this look and feel better for patients?	**How will this look and feel better for staff?**
• More access to specialist care closer to home, less unnecessary travel for certain types of heart failure care • Shorter waits for diagnosis and treatment • Care available will be less variable by patients' geographical location	• Staff will work in an integrated team across community and hospital with clear agreed structures • Staff will see their job roles and task standardised, making the best use of their skills. For example, specialist nurses in Halton can currently prescribe but those in Warrington cannot. This will change in the new model • An integrated team will allow for more resilience within the staffing model • Co-ordination of care for people living with heart failure will be easier, and staff will see the immediate benefits for the patients and families that they support

Table 16: Outcomes from initial discussions around clinical priority 2

Clinical priority 3: Chronic pain services	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
• Dated model of pain service provision in a predominantly hospital medical intervention-based model • Significant volume of pharmacological interventions for pain • Significant volume of day case invasive interventions for chronic pain – spinal injections etc • Lack of a joined-up approach to non-pharmacological interventions such as physiotherapy between acute trust and community trust • A focus on pharmacological management of pain rather than community-based therapies enabled	• We will move to an integrated model of community-based chronic pain service, shifting the focus from a dated hospital-based model relying on pharmacological and theatre-based interventions to manage pain symptoms, to a predominantly community and therapies-based model, with hospital intervention being limited to only the most complex cases
How will this look and feel better for patients?	**How will this look and feel better for staff?**
• Patients will be cared for in a model that will focus on rehabilitation and re-enablement (rather than pharmacological intervention) that will more effectively support their pain management and returning to the things they want to do • Reduced opioid and gabapentoid prescriptions, delivering significant patient and community benefits • Fewer invasive procedures will be required • Theatre capacity will be freed up to allow more procedures that deliver greater benefit to be undertaken – significantly reducing the number of procedures of limited evidence-based value taking place	• A reduction in opioid and gabapentoid prescribing will result in less work for primary care, both in prescribing burden and in the management of complications of these therapies • Theatre capacity will be freed up to allow more procedures that deliver greater benefit to be undertaken – this will allow staff to see greater benefits to patients from inpatient theatre and procedure room work • An integrated team will allow for more resilience within the staffing model • Co-ordination of care for people living with chronic pain will be easier, and staff will see the immediate benefits for the patients and families that they support

Table 17: outcomes from initial discussions around clinical priority 3

Clinical priority 4: Infant feeding	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
• Communication between services/departments (not being on the same IT systems). Not sharing an infant feeding policy. Pathways not embedded • Mixed messages and information provided across disciplines to parents	• Organisational-wide infant feeding policy covering all departments and services to ensure pathways are embedded and staff are aware of where to refer to for the right support

• Maternity and NNU UNICEF BFI accreditation challenges due to staffing levels and culture and finances • Staff training not provided in settings (paediatrics, ED, urgent care, GPs) where infants are presented with feeding issues as they do not currently have BFI standards as do maternity, NNU and community • Different service offer in each borough due to demographics and funding associated with this. Halton also has two local acute trusts where woman birth, which creates more complexities • Tongue tie services currently sit outside of women and children's services	• Multi-disciplinary staff training to ensure standardisation and relationship building between services • Pilot tongue tie service for Halton run by maternity and infant feeding using funding from Halton Family Hubs
How will this look and feel better for patients?	**How will this look and feel better for staff?**
• Consistent advice – trust in services/NHS • Assessed level of need will result in service users being directed to the appropriate practitioner via universal referrals/pathways • Improved patient outcomes and satisfaction • Reduced waiting times • More service users seen in the community where appropriate • Those that do need care from acute services or GPs will be seen more quickly	• Confidence in the information that they are providing for families • Evidence-based • Know how to escalate or refer • Build relationships between services • Improve culture and morale • Less patient complaints • Opportunities for upskilling

Table 18: outcomes from initial discussions around clinical priority 4

Clinical priority 5: Movement disorders/Parkinson's disease	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
• Disjointed pathway with multiple hand offs and clunky transfers of care when patients move between the hospital and community settings • 56 weeks' waiting time to see consultant • Deconditioning of patients whilst waiting for appointments and in hospital • Staffing capacity in community and hospital • Length of stay in hospital • Different IT systems • Variation in practice between Halton and Warrington	• Bringing together the multidisciplinary team across the hospital and community service will allow more effective use of capacity and shift the focus of care into the community supported by in-reach into the hospital setting • We will develop a Parkinson's passport to support holistic care • We will upskill our specialist and general workforce to manage movement disorders patients in an integrated model across the pathway • We will move to consolidate the movement disorders pathway onto (wherever possible) a single IT system • Forge closer links and working with community matrons and district nurses

How will this look and feel better for patients?	How will this look and feel better for staff?
• More joined up and effective care with fewer disruptions to care and medications when hospital care is required • Smoother discharges to community from inpatient stays • Reduced waiting times for clinic appointments and initial diagnosis	• Staff will provide care to people with Parkinson's/movement disorders in an integrated team across hospital and community • Job satisfaction will be increased seeing patient experience and outcomes across the pathway improve and knowing the most appropriate care is given to the people we serve.

Table 19: Outcomes from initial discussions around clinical priority 5

Clinical priority 6: Female urinary incontinence	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
• Women, particularly older women, may under report symptoms. Integrating UI care ensures equitable access to assessment, diagnosis, and treatment, reducing health inequalities • Lack of appropriate clinic room space at hospital sites for pelvic health physio • Waiting list for gynae appointments • Variable and complex pathways, with complex referral processes and rules that make accessing services challenging at times and can delay care • Commissioning variance driving inequality of service access and provision across Warrington and Halton • Complex prescribing arrangements spanning clinical pathways across primary, community and secondary care elements of the pathway • Availability of female clinicians to support pathways in all settings	• More collaborative working and alignment of care pathways to deliver seamless care across acute trust and community settings • A joint MDT (hospital and community) to discuss complex patients • A single referral pathway and direct referral into services • Improved access to IT systems to improve visibility of lab results and blood tests • Develop community-based clinics shifting care out of the hospital. Review pathways/contracts. Review capacity and demand. Streamline referral pathways to pelvic health physiotherapy so comparable for each site • Consider of 'one-stop-shop' for patients i.e. consultant, physio, nurse to provide timely treatment
How will this look and feel better for patients?	**How will this look and feel better for staff?**
• Prioritising UI management allows timely interventions that restore confidence, independence and participation in work, social and family life • Early identification/treatment of UI can reduce secondary complications such as UTIs, skin breakdown and falls (from urgency or rushing to the toilet) • Access to conservative management (bladder training, pelvic floor exercises, weight management) and specialist interventions improves long-term continence outcomes	• Staff will be empowered to ensure patients get the right care in the right place • By making prescribing rights equitable across the service staff will get to utilise their skills and qualifications to best effect and gain increased work satisfaction from this. Better job satisfaction – seeing patients earlier in symptom journey, increased rehab potential to improve, less requirement on further medical/surgical support • Easier to support patients with navigating referral pathway system

• Managing UI proactively in the community can prevent hospitalisation related to complications, improve discharge from acute care and reduce re-admissions • Providing UI care as part of a community-focused, integrated pathway promotes co-production, empowering patients to be involved in treatment decisions, self-management and goal setting • Better patient experience • Reduced waiting times to receive NICE recommended treatment	• Will free up consultant time for more complex patients

Table 20: Outcomes from initial discussions around clinical priority 6

Clinical priority 7: End of life care	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
• Too many patients are not dying in their preferred place with their preferences met • Too often patients do not receive timely, responsive access to face-to-face support, whether from generalist or specialist palliative care	• Strengthen our integrated MDT approach with accessible electronic solutions to share clinical information • Up to date personalised care planning discussions and decisions will be available, accessed and updated wherever the patient is met on their journey (EPaCCs) • Build our 'palliative care at the front door' model, working to integrate with Rapid Response in the community • Work towards an enhanced integrated hub model to ensure needs are met by the right people at the right time • Further integrate to work alongside primary care to improve effectiveness of the Gold Standards Framework process • Standardise the multidisciplinary process for the transition of young people to adult services • Develop a smoother, integrated discharge process • Integrate education for non-specialists across sectors • Work towards a 7/7 face to face specialist service within all settings • Strengthen our integrated governance processes to streamline the patient journey across the whole pathway • Align our 'learning from deaths' process across acute and community settings, including evaluation of whether the five priorities of care for the dying person are met

How will this look and feel better for patients?	How will this look and feel better for staff?
• More patients will have the opportunity for timely discussions about personalised care planning at the end of life • Patients will be more likely to have their needs and preferences met and their symptoms managed • Fewer avoidable hospital admissions in the last year of life, whilst ensuring necessary admissions are not unnecessarily prolonged	• Increased team morale, with effective administration enabling more time spent with patients • Feeling part of an integrated team and having a shared influence over the whole patient experience, throughout an integrated pathway • Greater understanding of the whole system, sharing responsibility for overcoming challenges • Non-specialist staff to feel valued and more confident in managing patients' generalist palliative needs, with improved timely access to specialist support

Table 21: Outcomes from initial discussions around clinical priority 7

10.5.3 Clinical priorities – next steps

A number of 'quick wins' and smaller scale improvement projects have been identified via the initial clinical summits to be taken forward by clinical teams with minimal support from the central project management team. A standardised process has been developed to ensure consistency and transparency including information collection template, a standardised equality and health inequality impact assessment (EHIA) process and governance structure. Clinical and operational integration projects undertaken by service teams will require authorisation from the executive management team and progress and benefits realisation will be reported through the clinical and operational services integration workstream to the BCT delivery group.

The larger scale clinical priorities will need project management support to mobilise and maintain progress, and the pace of delivery will be dependent on available resource. Delivery plans will be developed for each project and managed through the workstream, also reporting to the BCT delivery group. We will aim for the first three priority pathways to be integrated by July 2026 with further prioritisation of remaining pathways. Public, patient and partner involvement will be crucial in the next steps of the integration process. The plans around public and patient engagement are discussed further in chapter 15.

The BCT delivery group approved the recommendation for the priority order of pathways for integration in May 2025 as illustrated in figure 25 below. Next steps include:

- integration projects already in progress, e.g. 0-19 and maternity services should continue with regular reporting to the BCT delivery group
- small scale integration projects should be taken forward by clinical and operational teams with approval from the executive management team, standardisation of data collection and routine reporting
- heart failure, infant feeding and chronic pain management pathways should be prioritised as larger scale integration projects with allocated project management support

- urgent and emergency care integration should continue through the ED improvement programme

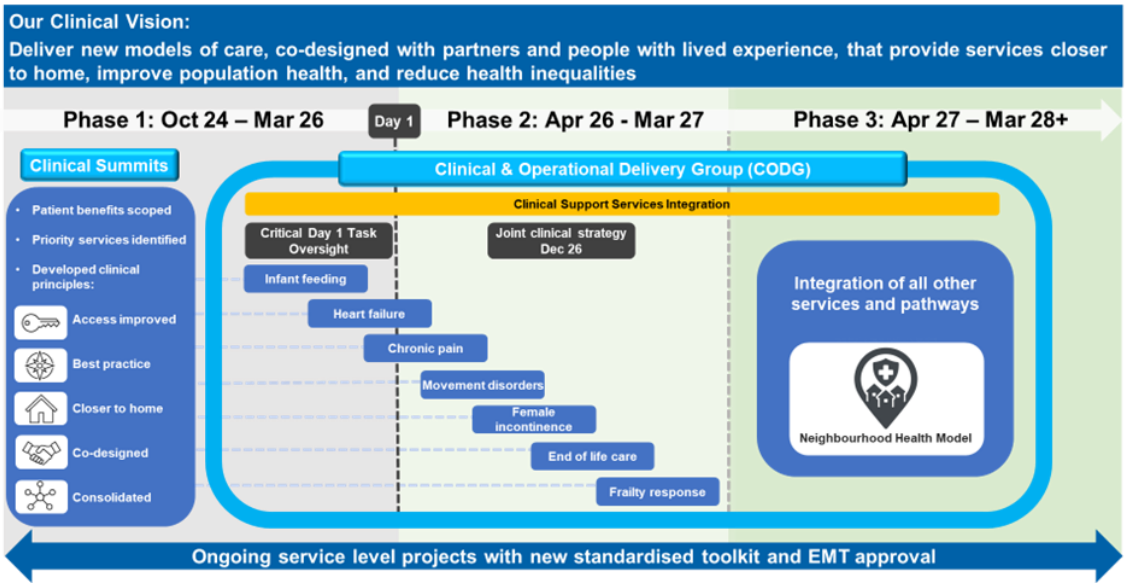

Figure 25: Next steps and timeframes around clinical priority workstreams

10.6 Urgent and emergency care

As noted in section 10.5, the work to more closely align and eventually integrate urgent and emergency care services is covered by the well-established ED improvement programme, which has involvement and engagement from both WHH and BCH teams.

Achievements of this programme of work as of early summer 2025 include a **4 per cent reduction in ED attendances** from people aged over 65 years, from 7,359 per month in 2022-23 to 7,060 in 2024-25 and a **17 per cent improvement to the length of time patients spend on the ED corridor** (from 8.2 hours in 2022-23 to 6.8 hours in 2024-25). Referrals to the urgent community response team in Warrington have increased by 126 patients per month compared to 2023 and more people are being referred to the same day emergency care (SDEC) department (246 more each month compared to 2023). On average patients are spending 1.5 days less in hospital than they were in 2023 (12.2 days compared to 13.7 days).

A workshop held in May 2025 agreed to revise the structure of the programme to establish three distinct workstreams: pre-hospital, in-hospital and post-hospital as illustrated in figure 26 below.

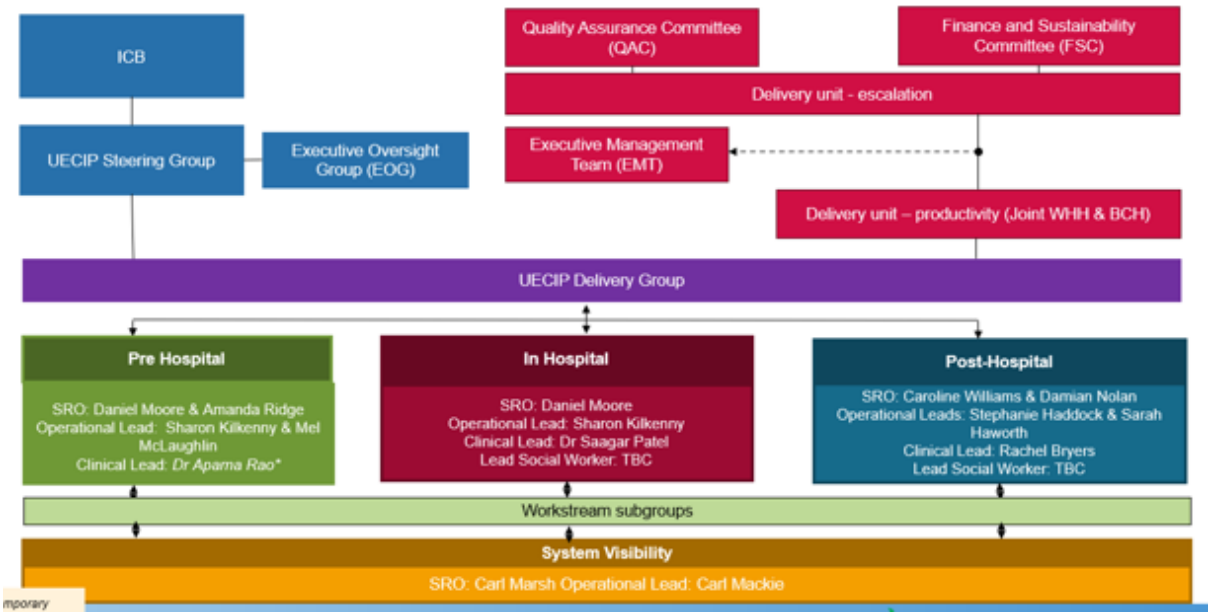

Figure 26: UEC/ED improvement programme of work

Each workstream has an SRO and clinical lead to deliver their work plan. Key areas of focus are outlined in the table below.

ED improvement programme: Key areas of focus		
Pre hospital	**In hospital**	**Post hospital**

• Alternatives to ED:
  ○ UCR*
  ○ FAU
  ○ SDEC
• Education/training on alternatives to ED
• Decision to refer GP/111
• Conveyances – NWAS
• Single point of access
• Palliative/end of life care
	• Frailty
	• 4 and 12-hour waiting times
	• Non-elective length of stay
	• Transfer of care (discharge)
	• Decision to admit
	• Front door UTC
		• ICAHT* single assessment
		• In Reach (pull model)
		• Flow through ICAHT / bed bases
		• Standardisation and optimisation of information
		• NCTR*

Table 22: Key areas of focus of the ED improvement programme

**UCR = urgent community response*
FAU = Frailty Assessment Unit
SDEC = Same Day Emergency Care
ICAHT = Intermediate Care at Home Team
NCTR = no criteria to reside

The ED improvement programme will work closely with the clinical and operational integration workstream with shared SROs and alignment of delivery plans.

10.7 Integration of clinical support services

The integration of the clinical support services (CSS) clinical business unit (CBU), bringing WHH and BCH services together, represents a key enabler for delivering high-quality, efficient and seamless care across acute and community settings. The approach to bringing these teams and services together has been aligned with the overarching objectives of the initial phases of the integration programme. Namely, ensuring safe transition at day one, maintaining continuity of service, and realising longer-term clinical and operational benefits through unified service models.

10.7.1 Integration approach and principles

The integration of CSS will follow a structured, risk-managed approach underpinned by clear governance and engagement. The key principles are:

- service continuity and patient safety during transition
- alignment of governance and quality systems under established clinical governance frameworks
- operational efficiency through unified management structures and shared resources
- Improved patient pathways through more consistent diagnostic, therapeutic and support service delivery across community and acute settings
- workforce alignment and engagement to ensure staff feel supported and valued during change

10.7.2 Service-specific CSS integration plans

10.7.2.1 Pharmacy

We intend for WHH pharmacy services and BCH medicines management services to be fully integrated from day one, adopting a new operational structure that brings together acute and community pharmacy functions under a single governance and leadership model. This will be achieved through meaningful consultation.

10.7.2.2 Radiology/imaging services

Radiology services will remain within the pre-existing CSS structure and form part of the new integrated CSS CBU. BCH imaging colleagues will join WHH's established radiology safety meetings from day one, ensuring alignment of clinical governance, safety standards and reporting processes. This will support consistent diagnostic quality and more efficient cross-site reporting.

10.7.2.3 Pathology

Regional pathology service transformation is progressing through the Cheshire and Merseyside pathology network. As noted in section 5.10.2, WHH and Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) plan to deliver a single, integrated pathology service for the local geography, including an essential service laboratory (ESL), collectively referred to as the East Hub.

Non-patient-facing pathology staff from WHH are planned to transfer via TUPE to MWL, which will deliver the service on behalf of both organisations. Oversight will be provided by the east hub pathology service committee, with TUPE transfers scheduled to complete in 2026 and full implementation of the regional model, including integration of the laboratory information management system (LIMS), by April 2027.

It is anticipated that regulatory responsibilities for laboratory quality and safety will transfer to MWL, while the new integrated CSS will operate under a shared clinical governance structure. Oversight will be provided by the joint executive medical director, ensuring effective coordination of regional and local priorities.

Within WHH, clinical haematology (consultants, nursing and administrative teams) will remain locally managed within the integrated CSS, ensuring continuity of specialist services. Phlebotomy services are also included in the CSS integration, with BCH staff phased into the new CBU. A draft PID is being developed to confirm accountability, timelines and delivery plans for a single, efficient and patient-centred phlebotomy service.

Despite the organisational and contractual changes, there will be no material impact on patient experience or clinical service delivery, ensuring continuity of safe, high-quality pathology services throughout the transition.

10.7.2.4 Breast screening

The breast screening service will remain within CSS in its current form. The mobile screening unit, which operates under regional branding, will continue to deliver screening services on behalf of the wider programme, maintaining current governance and operational arrangements.

10.7.2.5 Therapies

WHH therapy services, including physiotherapy, occupational therapy, speech and language therapy, orthotics, dietetics, heart failure and stroke nursing, exercise physiology, and support staff, will continue within the CSS CBU at day one to maintain continuity of care. BCH therapy services will transfer to the new Community and Dental CBU on 1 April 2026.

As part of the phased approach, there is significant opportunity over time to review, optimise, and realign therapy structures and pathways in line with the NHS 10 Year Health Plan and emerging neighbourhood health models. From April 2026, a structured programme of full integration will focus on developing seamless acute-community therapy pathways and management structures that enhance patient flow, reduce duplication and improve rehabilitation and reablement outcomes.

10.7.2.6 Infection prevention and control (IPC)

IPC services across WHH and BCH will be fully integrated from day one under a single operational and governance structure. This will ensure consistent infection control standards across all care settings, strengthen outbreak management and surveillance, and enhance audit, education and assurance processes across the merged organisation.

10.7.3 Summary and overview of clinical pathway integration

Figure 27 provides a high-level overview of the proposed alignment of services within the two new clinical business units (CBUs): the new Community and Dental CBU and the integrated Clinical Support Services (CSS) CBU. It sets out the proposed structure from day one and highlights the phased opportunities for service integration that will support more seamless care delivery across community and acute settings.

The new Community and Dental CBU will bring together a range of existing community-based and specialist nursing services currently delivered by BCH. These include adult community and district nursing, children's specialist and paediatric services, health visiting and school nursing, audiology, and wellbeing services. The formation of this CBU

establishes a coherent framework for the delivery of integrated community care, strengthening local provision and supporting population health management.

Building on this foundation, the diagram identifies phase one priority clinical pathways where integration offers the greatest immediate impact and will be considered as part of priority pathway workstreams. These include services such as heart failure, dermatology, infant feeding, specialist palliative care, and bladder and bowel care. Each of these pathways represents a highlighted key area where improved coordination between community and acute teams can deliver tangible benefits for patients through more consistent management, reduced duplication, and enhanced continuity of care.

Further phase two opportunities for integration are also illustrated. These encompass multidisciplinary services such as falls and rehabilitation, single point of access, urgent community response (UCR), adult and children's therapies, and neurorehabilitation. These areas will be explored in subsequent phases once the foundational integration work is embedded, enabling the model to evolve in a controlled and sustainable way whilst maintaining continuity of existing services.

The integrated clinical support services (CSS) CBU will consolidate cross-cutting clinical support functions that underpin both community and acute delivery. Specific services situated within BCH will be integrated from day one, including pharmacy, infection prevention and control, pathology and radiology. The other pre-existing CSS services operating with WHH will continue into the new CSS CBU. Their integration under the CSS CBU will further strengthen consistency, efficiency and quality across organisational boundaries.

It should be noted that the service list presented in the diagram is not exhaustive, and certain services have been grouped together to provide a high-level strategic overview. There are likely to be specific complexities relating to contracting and commissioning arrangements that will need to be addressed as the integration develops, for example the transfer of some pathology staff to MWL. As the integration programme progresses, further detailed mapping and analysis will be undertaken to confirm the inclusion of additional services and to refine the associated operational, governance and workforce arrangements.

This phased approach ensures that the development of the CBUs is both pragmatic and progressive, enabling early wins through targeted pathway integration, while establishing a robust framework for longer-term transformation across the wider clinical and community system.

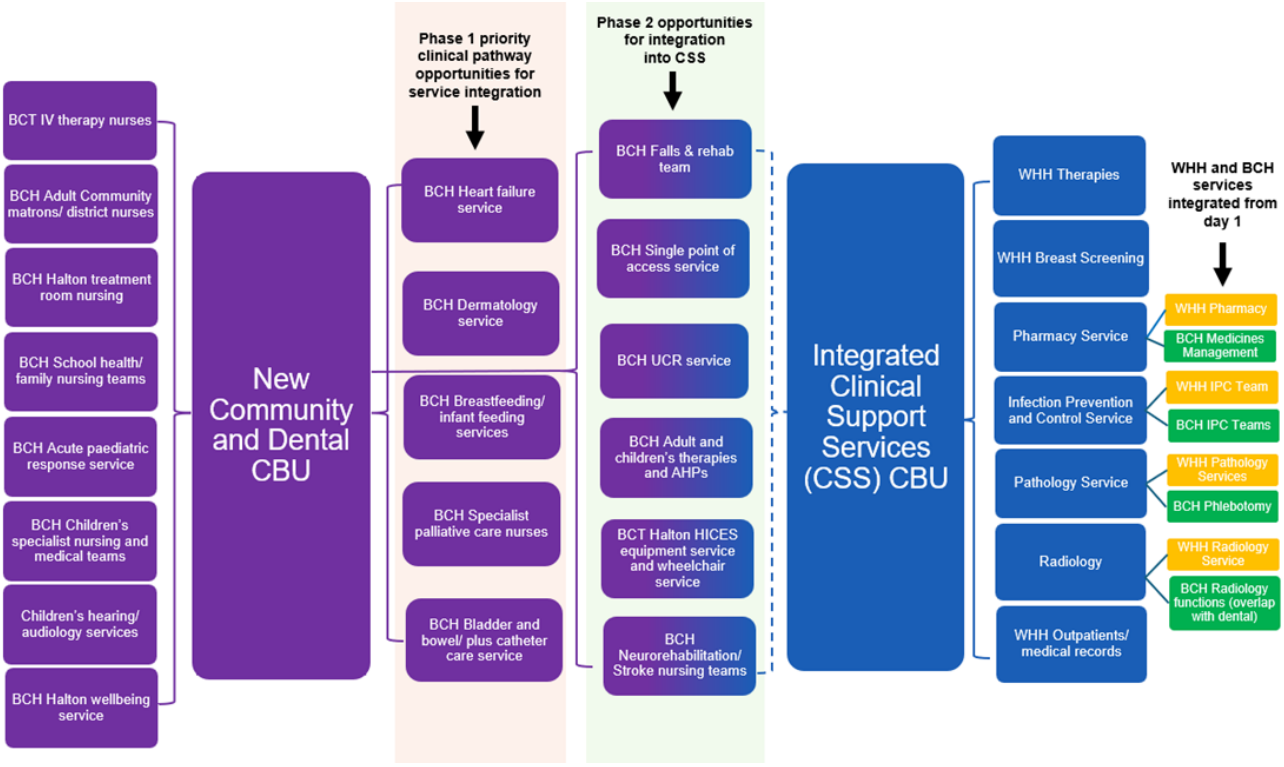

Figure 27: Visual showing planned integration of clinical support services

10.8 Research and development

As part of our integration programme we are establishing a joint research growth strategy designed to strengthen, expand and align research capability across acute and community settings. The integration represents a key opportunity to create a single, system-wide approach to research delivery that enhances patient outcomes, attracts investment and supports long-term sustainability.

The integration presents multiple opportunities to expand and enhance the research capabilities of the new organisation through:

- **expanding patient access** to clinical research opportunities across both hospital and community settings, ensuring equitable participation for all populations, including underserved groups
- **improving the ability to apply for and deliver a greater volume of clinical trials**, supported by integrated governance, streamlined processes and shared expertise
- **developing multidisciplinary staff** to increase the number of qualified principal investigators and strengthen the overall research leadership pipeline
- **growing the academic portfolio** to support recruitment, retention and professional development of clinicians, nurses, midwives and Allied Health Professionals
- **expanding the research footprint** by leveraging WHH's infrastructure such as the Halton Clinical Research Unit (HCRU), alongside BCH's access to diverse community populations
- **increasing the number of HCRU-delivered trials** and extending capacity to host high-value, phase two and three studies
- **growing annual commercial research income**, enabling continued reinvestment into infrastructure, workforce and study delivery

WHH brings a proven track record in commercial research, having generated more than £4.8m since 2021 through delivery of large-scale industry-sponsored trials across specialties including gastroenterology, respiratory medicine, rheumatology and maternity.

BCH complements this with recognised expertise in community-based and oral health research, as well as strong engagement of NMAHPs in early-career research and education. Together, these complementary strengths create a balanced and scalable platform for future growth.

The partnership also aligns strategically with the newly established **NIHR Commercial Research Delivery Centre (CRDC)** hosted by the University Hospitals of Liverpool Group. Participation in the CRDC will enable WHH and BCH to attract prestigious commercial trials, enhance visibility across the Cheshire and Merseyside region, and increase access to cutting-edge research for local patients.

Integrated governance and risk management structures will ensure regulatory compliance, operational resilience and financial stability. Shared infrastructure, joint governance frameworks and coordinated staffing models will reduce duplication, optimise use of resources and create capacity for larger, more complex studies.

Ultimately, the integration will deliver a more connected and equitable research ecosystem that drives innovation, improves patient outcomes and contributes to workforce development across the health system.

The combined strengths of both organisations will enhance the position of the new trust in clinical and applied research, capable of delivering sustainable income growth, supporting national NIHR priorities, and embedding research as a core component of high-quality patient care.

11.0 Corporate support functions

11.1 Chapter summary

This section details the approach to integrating the corporate services that underpin effective delivery across the new organisation. It outlines the benefits of unified functions in areas such as finance, workforce, digital, estates, governance, and communications, and demonstrates how alignment will create efficiencies, eliminate duplication and strengthen resilience.

The section also highlights the importance of maintaining continuity during transition, supported by joint governance structures and shared best practice from both trusts.

Key message: Integration of support functions creates a unified backbone for the new organisation – improving efficiency, reducing duplication and enhancing service quality.

By standardising systems and processes, the new organisation will deliver greater value for money and ensure a consistent, high-quality service across all operational areas.

11.2 Corporate support integration – our approach

The integration of all corporate functions across both WHH and BCH will be guided by principles of safety and efficiency. Alongside this, we will ensure that future services are fit for purpose and able to provide the appropriate corporate support to clinical teams and the wider organisation, and respond quickly to changing demands and needs.

The approach to integration will follow the phased plan as set out in section 7.6, ensuring that both short-term continuity (from day one) and medium to long-term transformation are achieved.

The work to integrate all support functions is overseen by the corporate services integration workstream within the Better Care Together programme governance (see section 7.2).

11.3 Financial opportunities within corporate service

The latest 2024-25 data from the NHS Model Health System website highlights the significant opportunities that exist for financial improvement through the integration of the corporate functions across WHH and BCH. Bringing two sets of corporate teams together formally unlocks economies of scale that are not available to the organisations in their current form.

The supporting documents provide further detail at corporate sub-function level but in total there is estimated to be around £8m of recurrent financial improvement to be achieved if the combined corporate service costs of the two trusts were to reduce to the median levels recorded across the country (see section 13.3.1 for links to overall financial benefits).

If the integrated organisation was to be able to go beyond this and deliver costs in line with national lower quartile performance, there would be further potential savings of around £9m (in addition to the £8m) to be achieved. It should be noted that the vast majority of providers reporting lower quartile corporate costs are much larger organisations (£1bn+ turnover).

11.4 A three-phased approach to integrating corporate services

Section 7.6 details the three-phased approach to the integration programme, the following sections detail how the plan for integrating corporate services will follow that approach.

11.4.1 Phase 1 – the period up to 31 March 2026

In the pre-transaction period, the focus of the work around integrating corporate services will be around planning and preparing the future service models. The key part of this will involve bringing the teams from the two partner organisations together to start to familiarise themselves with each other's services, processes and ways of working. All corporate teams will work to align business-critical systems and processes as part of phase one, to ensure a smooth transition into a single service supporting both acute and community services immediately following the transaction date.

Alongside the work to align processes, initial transitional structures for each service that will become effective immediately following the formal transaction date, will be developed and agreed following formal consultation.

11.4.2 Phase 2 – 1 April 2026 to 31 March 2027

In the 12-month period following the transaction, the challenge for all corporate services will be to embed all immediate changes and ensure smooth and effective delivery of all corporate support functions to the newly integrated organisation. In addition, each service will be expected to start to unlock the known financial opportunities and begin to bring the combined corporate costs down to median national performance (as a minimum). The launch of mutually agreed resignation scheme (MARS) across both BCH and WHH in November 2025 will help to expedite this.

11.4.3 Phase 3 – 1 April 2027 onwards

By April 2027 it is expected that the integrated corporate services will be running smoothy and cost-effectively, and working towards national median cost performance based on model health benchmarking.

From this date onwards, the challenge will be to review the latest national benchmarking information each year to check progress and drive further efficiency if required. Corporate teams should also start to consider the implications of moving further towards lower quartile national benchmarking levels in future years. In order to achieve this, it is likely that shared service corporate models may need to be explored, potentially as part of the work around the Cheshire and Merseyside provider blueprint (see section 5.10.2).

11.5 Transitional arrangements and target operating models

Transitional arrangements will be put in place to ensure a smooth transition from legacy structures to the new integrated model. This will involve the establishment of a transitional structure for both governance and staffing by day one of the transaction, in line with TUPE law. Much of the transition will be a 'lift and shift' process, ensuring minimal disruption to ongoing operations. Following this, a wider service redesign will be completed once the clinical structures have been finalised, ensuring that support functions are reflective of the organisation's needs and aimed at delivering high-quality patient outcomes.

11.6 Organisational change framework

An organisational change framework has been developed to ensure that the integration processes reflect our legal and statutory requirements. This framework includes comprehensive governance arrangements to ensure compliance and oversight. The ambition is to have a transitional structure in place for both governance and staffing by day one of the transaction, ensuring continuity and stability.

11.7 Governance arrangements

Governance arrangements are being incorporated into the integration process to ensure that all legal and statutory requirements are met. This includes the establishment of clear governance structures and processes to oversee the integration and ensure accountability across the length of the programme.

11.8 Staff consultation

Formal staff consultation around the initial integration of services will commence in November 2025 and run for a period of 3-4 months to ensure that it is meaningful and inclusive. During this period, transitional structures may adapt based on feedback and evolving needs. However, governance arrangements will remain in place to ensure stability and compliance throughout the transition.

11.9 Integration of corporate governance services

11.9.1 Vision for an integrated corporate governance service

The vision for the integrated corporate governance service is to create a single, resilient team that supports the integrated organisation with robust governance, compliance and assurance. By bringing together the expertise and resources of WHH and Bridgewater, the new service will enable effective decision-making, transparency and accountability across all levels of the trust. The integrated team will foster a culture of continuous improvement, partnership working and shared learning, ensuring that governance arrangements are fit for the future and aligned with the strategic objectives of the new organisation.

This approach will help the trust to meet statutory and regulatory requirements, support the Board and its committees to facilitate high-quality services to patients and communities. The integrated governance service will also play a key role in supporting transformation, risk management and stakeholder engagement. The draft transitional structure is included within the supplementary information to this document.

11.9.2 Scope of corporate governance services

Service area	Description
Board and committee support	Secretariat, agenda planning, minute-taking, action tracking
Statutory compliance	Annual reporting, regulatory submissions, licence management
Risk management (BAF)	Board assurance framework management
Corporate governance policy and procedure	Development, review, alignment of policies and procedures
Corporate records management	Information governance, records retention, FOI coordination
Stakeholder engagement	Governor and member support, public engagement, communications
Legal and transactional support	Due diligence, co-ordination of legal advice
Training and development	Governance training for staff and Board members

Table 23: Core duties of the integrated corporate governance team

11.9.3 The key integration objectives for the integrated corporate governance team include:

- ensure effective and compliant governance across the new organisation
- support the Board and committees with timely, accurate information and assurance
- align policies, procedures, and systems to enable seamless operations
- align Board Assurance Framework
- facilitate stakeholder engagement and transparent communications
- enable continuous improvement and shared learning
- deliver efficient, cost-effective corporate governance services

WHH and BCH already have a number of Board sub-committees working as joint committees in common and a number of shared executive director posts in place.

11.9.4 Current challenges and opportunities for corporate governance

Challenges:

- aligning different governance cultures, policies and systems
- managing capacity and workload during transition
- ensuring continuity of statutory compliance and assurance
- integrating digital systems and records management
- addressing resource gaps and vacancies in both teams

Opportunities:

- streamlining processes and reducing duplication
- sharing best practice and expertise across both organisations
- enhancing resilience and flexibility of the governance function
- improving stakeholder engagement and communications
- supporting transformation and innovation in corporate governance

11.9.5 Success criteria for corporate governance

- ✓ seamless transition to a single, integrated governance team with minimal disruption to statutory compliance and Board assurance
- ✓ alignment of policies, procedures, and governance systems across the new organisation within agreed timescales
- ✓ improved efficiency and effectiveness of Board and committee support, evidenced by timely agendas, accurate minutes and clear action tracking
- ✓ enhanced risk management, with a unified risk register and robust incident reporting processes
- ✓ positive feedback from Board members, governors, and stakeholders regarding the quality and responsiveness of governance support
- ✓ achievement of regulatory and accreditation standards, with no adverse findings from external audits or inspections
- ✓ establishing an effective Board assurance framework (BAF)
- ✓ increased staff engagement and participation in governance training and development
- ✓ delivery of cost savings or resource efficiencies through streamlined processes and reduced duplication
- ✓ evidence of continuous improvement, innovation, and shared learning within the governance function

11.10 Digital services integration

11.10.1 Vision for an integrated digital service

Our vision is to establish a fully integrated digital service that brings together acute and community capabilities under a single, collaborative digital team structure. Creating a single, seamless digital service that connects acute and community care, enabling our workforce to access the right information in the right place at the right time, delivering safer, more coordinated, and patient-centred care across the system.

The integrated service will deliver a unified digital infrastructure, shared data environment and support services with a consistent user experience, allowing staff across all care settings to work as one team. By aligning technology, information and processes we will improve care continuity, efficiency and population health outcomes, while reducing duplication and operational silos.

Through this approach the digital service will function as an enabler for transformation, supporting the move towards integrated care delivery, data-driven decision-making, and a sustainable, paper-light trust.

The transitional structure is included within the supplementary information to this document.

11.10.2 Scope of digital services included

Service area	Description
Digital strategy and governance	Development and delivery of the trust's digital strategy, ensuring alignment with organisational priorities, national digital standards and ICS integration initiatives. Oversees governance, compliance and benefits realisation.
Clinical Systems/EPR	Management, optimisation and support of clinical systems including Electronic Patient Record (EPR) and associated clinical applications across the trust. Ensure interoperability and continuity of care.
Data and analytics	Provision of data warehousing, reporting, business intelligence and advanced analytics. Supports operational performance, population health and decision-making through accurate and timely information.
Infrastructure and networks	Delivery and maintenance of core IT infrastructure including data centres, cloud services, network connectivity, Wi-Fi and device management. Ensure resilience, scalability and business continuity.
Desktop Support	Management of user devices, desktop/laptop provisioning, mobile device management, and end user support via service desk and field engineering teams. Focus on user experience and responsiveness.

Service area	Description
Cyber security and information governance	Protection of information assets through cybersecurity monitoring, risk management and compliance with NHS DSPT and IG standards. Works in partnership with information governance whilst ensuring digital clinical safety.
Unified communications and collaboration	Delivery of communication and collaboration tools (email, telephony, MS Teams, video, messaging) to enable flexible and efficient working across acute and community settings.
Records management and scanning services	Delivery of EDMS, records digitisation, retention and destruction policies, and digital archiving to support the trust's transition to paper-light working and BS 10008 compliance.
Programme and project delivery	Oversight and delivery of digital projects and programmes, ensuring alignment with trust strategy, governance compliance, and benefits realisation.
Service management and performance	End-to-end service management including SLAs, incident/ problem management, capacity planning, and continual service improvement across all digital functions.
Training and digital enabled workforce	Ensuring confident digitally literate staff, digital skills assessments, learning and development and support from digital advocates.

Table 24: Core duties of digital services included

11.10.3 The key integration objectives for the integrated digital team include:

The integrated digital team will deliver a unified, system-wide digital service that supports safe, efficient, and joined-up care for all stakeholders across acute and community settings.

The key integration objectives are to:

- create a single, unified digital service – establish one integrated digital operating model with shared leadership, governance and standards
- enable seamless care through shared systems and data – align clinical, corporate, and data systems to support continuity of care and improved access to information across all sites
- optimise resources and reduce duplication – consolidate contracts, infrastructure and support functions to improve efficiency, enable transformation and maximise value for money
- provide a consistent user experience – deliver standardised support, digital tools and processes to ensure all staff receive the same high-quality service, empowering patients with access to their information
- strengthen data, security, and compliance – align data governance, cyber security and information management standards to ensure resilience and compliance

- drive innovation and digital maturity – create capacity for innovation and transformation, supporting continuous improvement and readiness for AI and wider future system integration

11.10.4 Current challenges and opportunities for digital services

Challenges

- fragmented digital teams and systems – separate acute and community digital services lead to duplicated effort, inconsistent processes, and limit interoperability between systems
- inconsistent user experience and support – variability in service levels, IT support and capabilities reduces efficiency and hinders adoption across BCH and WHH teams
- limited data integration for patient pathways – disconnected systems make it difficult to share patient information, track outcomes across care settings, or analyse population health effectively
- resource and capacity constraints – recruitment and retention challenges with limited digital staff capacity and competing priorities make it challenging to deliver the integration, manage infrastructure changes and deliver the new service
- financial pressures and contract inefficiencies – multiple contracts for infrastructure, hosting and applications increase costs, duplication and limit flexibility for shared EPR's and digital service models
- change fatigue and cultural differences – differences in organisational culture, process maturity and readiness for digital change could slow integration and adoption of shared systems

Opportunities

- integrated acute and community digital service – consolidating digital teams and governance across WHH and BCH will streamline delivery, reduce duplication and improve accountability.
- EPR convergence and shared instance – moving towards common EPR systems allows consistent workflows, enables further interoperability and real-time access to patient information across acute, community services and wider place partners.
- enhanced data, analytics, and reporting – integrated data platforms enable population health management, pathway optimisation and system-wide insights for decision-making
- consistent user experience across our services – standardised tools and processes improved digital adoption and productivity, and user satisfaction across our pathways services
- efficiency and financial sustainability – rationalising infrastructure, contracts and support services will reduce costs, free investment capacity, and support a sustainable integrated digital model
- acceleration of digital innovation – a shared digital service facilitates the adoption of digital transformation initiatives, automation and innovative technologies to improve care delivery and patient outcomes

11.10.5 Success criteria for digital services

- ✓ integrated service delivery – single integrated digital team operational adherence to agreed governance framework
- ✓ EPR and system availability – shared EPR instances offer reliable, easy access with standard workflow experience
- ✓ data availability and quality – >95% data quality, seamless information sharing between acute and community services, analytics driven decisions new FDP functionality
- ✓ user adoption and satisfaction – >85% staff adoption positive user satisfaction ratings; support tickets reduced over baseline
- ✓ operational efficiency and cost optimisation – reduction in duplicated systems/contracts measurable cost savings achieved

11.11 Workforce team integration

11.11.1 Vision for an integrated workforce service

The integration of workforce services across BCH and WHH is designed to deliver a comprehensive and consistent approach to people management, supporting the NHS People Plan, statutory requirements and organisational priorities. The integrated service will continue to be responsible for providing core HR, organisational development, staff engagement, workforce planning, recruitment, education and training, EDI and wellbeing functions, ensuring a positive and inclusive working environment for staff and high-quality care for patients.

Both organisations operate within a robust governance framework, with clear reporting lines, performance monitoring and a commitment to equality and health inequalities impact assessments. The integration will align systems, key performance indicators and leverage best practices from both organisations, ensuring efficient use of resources, improved service delivery and enhanced staff experience.

The transitional structure is included within the supplementary information to this document.

11.11.2 Scope of workforce services

Service area	Description
Apprenticeships and widening participation / Talent for Care	Supporting and implementing government and local initiatives in relation to apprenticeships, work experience and work placements.
Employment Services	End-to-end recruitment support to managers, managing return to practice process for AHPs and nursing, supporting international recruitment for nurses and clinical fellows, running the medical bank and non-nursing agency requirements. In addition, supporting the effective running of rostering services.
Human Resources (HR)	Working in partnership with the organisation on a wider range of people management, employee relations, deployment and development matters. Providing managers and employees with specialist expertise, information, guidance and advice.

Service area	Description
Learning and Development	Supporting mandatory and role specific training as well as corporate induction across the organisation.
Medical Job Planning	Supporting and facilitating the job planning process for medical staff across the trust. Providing specialist advisory support regarding the job planning framework and system.
Mental Wellbeing Hub	In-house staff counselling and wellbeing services to support the mental wellbeing of the workforce.
Occupational Health and Wellbeing	Specialist clinical service providing a targeted, proactive and accredited support system for staff.
Organisational Development (OD)	Specialists in developing interventions and programmes to support leaders and teams in creating a compassionate and inclusive culture to enable individuals to thrive in the workplace.
ESR Helpdesk	Manage ESR data quality ensuring information is accurate, managing expenses system and processing payments. In addition, project manage the transition to the new national workforce system.
Culture and Equality, Diversity and Inclusion (Workforce)	Supporting staff networks and statutory duties relating to workforce equality, diversity, inclusion and human rights related issues and developments.
Culture and Staff Engagement	Lead and support staff voice, feedback, reward and recognition and staff experience initiatives across the organisation.
Workforce Information	Manage and create trust level reporting for the Workforce Dashboard with key people metrics, manage the infrastructure of these reporting systems and provide other daily, weekly and monthly reporting for both national returns and locally required reports.
Clinical Education and Resus Services	Leads the development of a skilled, confident and compassionate clinical workforce capable of delivering outstanding patient care. This multi-professional team provides structured education and training across the career lifecycle, from student placements to post-registration development, ensuring staff have the clinical and non-clinical competencies required to thrive in their roles.
Medical Education	Leads the development of a skilled, confident and compassionate medical workforce capable of delivering outstanding patient care. This dedicated team provides structured education and training across the career lifecycle, from undergraduate placements to postgraduate specialty training, ensuring doctors have the clinical and professional competencies required to thrive in their roles.

Table 25: Core duties of the workforce services

11.11.3 The key integration objectives for the integrated workforce team include:

- inclusive recruitment and retention – become a local employer of choice, attracting and retaining talent to deliver the new organisation's aims
- development of a robust people strategy to meet the future priorities of the organisation and national 10 Year Health Plan
- development of a robust workforce equality, diversity and inclusion strategy which achieves the NHS equality, diversity and inclusion improvement plan
- development of a leading career development programme, ensuring our workforce have the skills, behaviours and capability to respond positively to a changing health and social care environment
- create a pre and post-integration organisational development and organisational design programme which supports managers and leaders to have the skills for their teams to thrive through change
- integration of the two electronic staff records systems and project manage the transition to the new national workforce system
- delivery of the joint culture plan to support all our workforce to have a good day at work

11.11.4 Current challenges and opportunities – workforce services

From a workforce and people perspective, the integration presents both challenges and valuable opportunities. One of the key challenges lies in balancing the delivery of transformational change alongside maintaining business-as-usual activity. Current workforce capacity is limited and there is a risk that progress on transformation could impact the quality and consistency of ongoing operational services. This has been carefully managed and a dedicated role has been put in place to support the workforce and HR elements of integration.

High levels of sickness absence across the workforce continue to affect productivity, service continuity and staff wellbeing. Sustained organisational change also carries risks of change fatigue, with potential impacts on morale, engagement and retention of critical roles.

Despite these challenges, the integration offers considerable opportunities to strengthen the workforce function and enhance organisational effectiveness. By bringing together people and workforce teams, the integration can enable more collaborative and efficient ways of working, improve coordination and reduce duplication. There is a significant opportunity to develop and share deeper expertise in organisation development and design, supporting a more strategic and evidence-based approach to shaping services. This includes alignment with the new organisation's values and behavioural framework.

The programme has already demonstrated the value of shared learning, collaboration and professional partnership across teams. Building on this foundation will enable the organisation to make better use of its collective expertise in HR, workforce planning, organisational development, design and leadership, enhancing both capability and capacity. Over time, the integration can also help create a more flexible and resilient workforce model, enabling the more agile deployment of staff and improved alignment of resources with organisational priorities.

Finally, through a more cohesive and connected approach to people management, learning and wellbeing, the integration provides a platform to improve the overall employee experience. This will help strengthen engagement, support retention and contribute to

reducing sickness absence levels over time, while embedding a culture of collaboration, learning and continuous improvement across the organisation.

11.11.5 Success criteria – workforce services

The success of the workforce integration will be evidenced by:

- ✓ continued improvement in response rates and NHS staff survey results through aligned action plans which consider the quantitative and qualitative results
- ✓ improved employee engagement and satisfaction scores which demonstrate improvement in areas relating to communication, leadership and change management
- ✓ sickness rates to achieve the trust target and maintain performance
- ✓ achievement of the integrated workforce plan and interdependencies in reporting
- ✓ ensure alignment of workforce key performance indicators which consistently achieve the trust targets
- ✓ programme of organisation design developed to support the clinical and corporate transformation programme, as highlighted within this business case
- ✓ achievement of statutory returns and requirements for the new organisation
- ✓ develop and prepare our workforce to deliver care and services at a system level

11.12 Finance integration

11.12.1 Vision for an integrated finance team

Our vision is to become one team delivering expert financial advice and stewardship to the integrated organisation as efficiently and effectively as possible. We also want to use the integration of our two organisations to reduce or eliminate single points of service failure (for example capital management processes) across both trusts.

Both teams currently use the same ledger (SBS) which will be merged from 1 April 2026, along with the capital (CARS) and costing system (CIVICA). For the first three months post-integration the teams will work independently to produce the audited accounts for the individual trusts whilst coming together to undertake a combined month 1 position. Following the production of the accounts the team will become co-located and continue to work flexibly with hybrid working. Integration and culture change takes time, and the senior team will support this with staff training and development, regular communication and away day sessions. The team will work towards becoming an award-winning level 3 accredited team.

The draft transitional structure is included within the supplementary information to this document.

11.12.2 Scope of finance services

Service area	Description
Financial planning	Strategic financial planning using patient-level costing and national benchmarking to inform strategic decision-making.
Improvement and performance	Relentlessly exploring commercial development and financial improvement opportunities to support long-term sustainability.

Service area	Description
Management accounting	Budget setting, management and monthly reporting to keep the organisation on track financially and identify emerging financial challenges as early as possible.
Financial services	Treasury management of organisation including cash flow, capital and all external financial reporting.
Procurement	Constantly ensuring value for money through commercial contracts and purchasing. Also, includes stores, receipts and distribution.
Clinical coding	Ensuring the accurate and timely coding of all recorded clinical activity to support appropriate income maximisation and external reporting.

Table 26: Core duties of the finance services

11.12.3 The key integration objectives for the integrated finance team include:

- annual accounts for external submission
- monthly submissions to ICS and NHS England
- contribution to internal Board performance and finance committee reporting
- charity accounts for external submission
- national cost collection for external submission
- contribute to system working across Cheshire and Merseyside and the north west
- working collaboratively across all teams in the integrated trust and supporting operational teams
- contribute to sustainability plans and ensure value for money
- develop and maintain a highly professional and competent team

11.12.4 Current challenges and opportunities – finance services

Challenges:

- requirement to complete two separate sets of accounts whilst coming together and simultaneously producing a joint month one position and reports
- two separate audit processes (with two sets of auditors) to be managed
- possible increased absence, retirement and leavers in teams. Potential for loss of local knowledge

Opportunities:

- economies of scale and reduce single point of failure
- learning from each other, sharing skills and best practice

11.12.5 Success criteria – finance services

- ✓ unqualified accounts
- ✓ positive internal audit reviews
- ✓ all key deadlines achieved
- ✓ working with one single ledger from 1 April 2026 and all information feeds working
- ✓ accreditation for new trust
- ✓ feedback from away days / staff survey

- ✓ new Board agrees operational plan and budget setting
- ✓ new contracts in place for SBS, CARs, CIVICA, auditors, insurance etc
- ✓ successful transition to new location(s)

11.13 Estates integration

11.13.1 Vision for an integrated estates team

Our integrated estates and facilities team will provide operational support across the expanded organisation, ensuring that services are provided from clean, safe and efficient spaces across our portfolio. The team will be responsive to the needs of our staff across acute and community sites and ensure that all sites are accessible and welcoming for our patients. Strategically, our integrated team will work across our expanded geography, supporting the trust's aim of home first, community second and hospital only when necessary.

The transitional structure is included within the supplementary information to this document.

11.13.2 Scope of estates services

Service area	Description
Management and maintenance of new and existing trust assets	Maintenance and repair of trust physical assets, management of major trust capital projects (strategic and infrastructure), management of backlog maintenance, and overall estates portfolio.
Leadership and management of environmental sustainability	Management of overall environmental sustainability and development and delivery of green plan.
Compliance with all statutory and mandatory requirements	Fire safety, cleaning standards, waste management and recycling, grounds and gardens maintenance.
Management of the trust's catering service	Including all patient, staff and retail catering offers across the sites.
Management of site access and security	Including car parking, site security, staff ID badges and associated access control.
Management of patient movement and transport services	Including portering, patient and staff transport, and equipment logistics services.
Management of equipment maintenance and storage	Including medical engineering and maintenance and distribution of medical devices.
Management of linen and laundry services	Including all site linen and laundry services and staff uniforms.
Management of inbound telephony services	Including hospital and community site switchboard.

Table 27: Core duties of the estates services

11.13.3 The key integration objectives for the integrated estates team include:

- align the estate to the clinical strategies and underpin the trust's values and objectives
- reduce backlog maintenance and critical infrastructure risks
- enable the delivery of clinical and operational services and sustainability
- improve functional suitability and net zero target
- improve utilisation of estate
- improve compliance with health building notes and health technical memorandums
- provide a solid platform to prioritise investment and prepare for future opportunities
- support the ambitions of Warrington and Halton as growing boroughs, focusing on regenerating built and natural environment and reducing health inequalities

11.13.4 Current challenges and opportunities – estates services

Challenges:

- WHH estates services are predominantly focused on a small number of larger sites with many facilities management services delivered in-house. BCH estates services are predominantly focused on a large number of smaller sites with many facilities management services delivered via external contracts. The two estates teams function in different ways and therefore need to understand each other's challenges and ways of working
- some opportunities for financial benefits through bringing externally contracted services in-house may prove not to deliver benefits due to NHS terms and conditions

Opportunities:

- evolving neighbourhood health plans across both Warrington and Halton create the opportunity to review and potentially rationalise use of estate
- underutilisation of space across both organisations is an opportunity to review and either improve use or rationalise

11.13.5 Success criteria – estates services

- ✓ all staff have access to sites as required
- ✓ operation of a unified estates helpdesk
- ✓ singular reporting as an integrated organisation from 1 April 2026
- ✓ integrated estates contracts and asset registers in place
- ✓ approved single capital programme agreed for integrated organisation
- ✓ consolidation of sites and reduction in spend on leases wherever appropriate
- ✓ reduced spend on external facilities management contracts

11.14 Communications and engagement team integration

11.14.1 Vision for an integrated communications and engagement team

Our vision is to work together and in partnership with our colleagues, patients and communities to deliver a proactive and strategic communications and engagement service that supports better care, stronger relationships and has a lasting impact.

The draft transitional structure is included within the supplementary information to this document.

11.14.2 Scope of communications and engagement services

Service Area	Description
Public affairs	Manage relationships with the government, policymakers and regulatory bodies to support organisational goals.
Patient and public engagement and consultation	Involve patients/public in relation to new services and service change.
Stakeholder engagement	Build and maintain positive relationships with key individuals/groups.
Brand and reputation management	Protect and enhance the trust's identity and profile internally and externally.
Campaign development	Create targeted comms initiatives to raise awareness and promote services.
Internal communications	Ensure staff are informed, engaged and support trust values and priorities.
Strategic communications	Plan and deliver comms that support long-term organisational objectives.
Media relations	Manage relationships with media outlets to achieve positive and accurate coverage.
Digital communications	Use online platforms to share information and engage audiences.
Patient information	Produce accessible materials to help patients understand their care, treatment and services.
Film, photography and design	Create visual content to support trust communications.
Communications and engagement strategy	How the organisation communicates and supports future strategic plans.
Staff awards event management	Organise annual staff awards to recognise and honour achievements.
Hospital charity communications and engagement support	Comms and engagement support for the organisation's WHH Charity.

Table 28: Core duties of the communications and engagement services

11.14.3 The key integration objectives for the integrated communications and engagement team include:

- provide communications and engagement support for the overall BCT integration programme and subsequent integrated organisation. This includes the trust rebrand and associated communications
- provide support to engage patients, trust governors, carers and communities in Warrington, Halton and surrounding areas, to ensure their voice is used to help influence decisions on service design and strategy development. This includes public consultations, managing patient reference groups and forums, and attending events when required
- develop accessible and inclusive patient information, leaflets and resources
- keep staff updated and engaged via internal communications channels, news bulletins and digital platforms

- manage the reputation and brand of North Cheshire and Mersey NHS Foundation Trust/handle crisis communications
- promote the trust's services and initiatives externally through the media, social media, websites, stakeholders and events
- develop a proactive and strategic approach to the communications and engagement service, objectives and growth
- develop communications and public relations campaigns for the trust
- support other teams and departments with their communication needs, e.g. campaigns, digital work, essential branded materials, governance requirements. This also includes our external services when needed
- provide briefings, speeches and presentations for our trust executives and Board members as required
- maintain and uphold NHS and trust identity guidelines (e.g. branding and style guide), statutory accessibility requirements and health literacy standards
- support system-level communications including ICS/NHS North West
- manage the communications for WHH Charity

11.14.4 Current challenges and opportunities – communications and engagement services

Challenges:

- due to the differences in acute and community requirements there are likely to be variations in communications support and the level of service provided to other departments by each team that need to be worked through. Prioritisation of communications requests across acute and community services may be different to previous expectations. Any variances will be considered and an aligned comms offer agreed
- effective segmentation of staff groups will be required to achieve effective internal communications across a larger and more dispersed workforce
- team members will need to adapt to different working styles and patterns
- ensuring communications reach patients and service users with limited access to mainstream communication channels
- ensuring communications reach staff working with underserved populations, including those in outreach, safeguarding, and community-based roles, will be critical to maintaining equity in messaging and engagement

Opportunities:

- ability to pool resources and share skills and individual specialisms where they will be of the greatest benefit
- reduced duplication – both internally within the team, and externally e.g. patient engagement approaches (our organisations largely cover the same communities)
- creation of a new joint communications and engagement strategy and service model offer that truly meets the needs of a modern, integrated acute and community health provider aligned with the 10 Year Health Plan priorities
- a stronger, more unified voice across acute and community services, improving clarity and consistency in messaging to patients, staff, stakeholders and local communities
- improved stakeholder engagement through coordinated campaigns
- enhanced internal communications that support a more connected and informed workforce

- ability to co-design messaging with communities experiencing health inequalities, ensuring that campaigns are culturally relevant, accessible, and emotionally safe
- potential to improve responsiveness in managing media relations and crisis communications, as well as capacity to be more proactive in generating positive comms for the benefit of the trust
- further opportunities will be explored as the team integration progresses

11.14.5 Success criteria – communications and engagement services

- ✓ a unified team delivering a single high quality service offer
- ✓ communications channels will be fully integrated to reduce duplication, and engagement with our patients and public will happen in a coordinated manner

Key communications metrics to evidence success are highlighted in the communications section of this case (see chapter 15).

11.15 Clinical governance team integration

11.15.1 Vision for an integrated clinical governance team

The vision for the integrated clinical governance team is to create a unified, transparent and accountable infrastructure where teams collectively ensure safety, quality, and excellence in patient care. A single leadership structure bringing teams together reduces variation, promotes effective, sustainable coordinated services and excellence in delivery of clinical governance across the trust.

The draft transitional structure is included within the supplementary information to this document.

11.15.2 Scope of clinical governance services

Service area	Description
Risk and Patient Safety	Management of the incident reporting system and leads on the approach to patient safety in the trust i.e. patient safety incident reporting framework (PSIRF). Monitoring central alert system alerts, management of risk registers.
Clinical Governance	NICE compliance and clinical policies. Compliance – CQC and accreditation.
Complaints/Pals	Management of complaints and compliments.
Patient Experience	Coordination of systems including friends and family test (FFT) and patient-reported outcome measures (PROMS). Translation and interpretation. Management of volunteers.
Legal Services/ Claims	Manage and respond to legal claims, including clinical negligence and personal injury. Liaise with NHS Resolution and external legal counsel. Support staff involved in litigation or inquests. Prepare documentation and represent the hospital at coroner's inquests. Advise clinicians and staff on giving evidence and legal implications.

Table 29: Core duties of the clinical governance services

11.15.3 The key integration objectives for the clinical governance team include:

- develop an integrated leadership hierarchy structure
- ensure clinical functions, systems and processes are coordinated and delivered across the organisation
- align and synchronise portfolios of the teams from each organisation into one cohesive team

11.15.4 Current challenges and opportunities – clinical governance team

Challenges:

- establishing a single risk management system
- standardising clinical governance systems and processes and sub-committee meetings across the organisation
- capacity of clinical staff to align relevant clinical policies by end of March 2026 in line with phase one of the integration programme

Opportunities:

- create efficiencies and reduce duplication
- improved resilience of clinical governance teams
- improved communication and responsiveness
- improved outcomes – sharing of knowledge and skills

11.15.5 Success criteria – clinical governance team

- ✓ seamless high-quality care. Patient-centred decision making and outcomes
- ✓ responsive clinical governance team that supports delivery of organisational strategy
- ✓ collaborative and engaged workforce
- ✓ clear data driven reporting, transparency of decision-making providing assurance to the Board and sub-committees of the Board
- ✓ sustainable system integration

11.16 Data, BI and performance team integration

11.16.1 Vision for an integrated data, BI and performance team

Our vision is to provide a single, trusted source of data and insight to support safe, efficient, and high-quality care, operational excellence, and strategic decision-making. The goal is to unify data, embed analytics in decision-making, and enable improvement at every level – from ward to Board.

There are five core components of our vision:

Integrated data platform

- single data environment (data warehouse) that consolidates data from:
  - EPR and PAS systems
  - Workforce, finance, estates, digital systems
  - National datasets (SUS, HES, Model Hospital, etc.)
- automated data pipelines to reduce manual collection
- common data model and definitions – a ‘single version of the truth’

Business Intelligence (BI) Layer

- modern BI tools (Power BI, Qlik) used across the trust
- self-service dashboards with governed access for different user groups:
    - executives: Board performance, quality, financial sustainability
    - operational teams: patient flow, bed occupancy, RTT, theatre utilisation
    - clinicians: outcomes, safety metrics, clinical effectiveness
- dashboards aligned to national priorities (elective recovery, UEC, CDS quality, workforce)

Real-time and predictive analytics

- integrate live feeds from EPR and other operational systems
- deploy predictive tools for:
    - patient flow and discharge planning
    - demand and capacity modelling
    - infection or readmission risk

Data governance

- strong information governance framework: role-based access, privacy, audit trails
- data quality framework: regular checks, automated monitoring, feedback loops
- transparency: clear ownership of data and metrics

Culture and capability

- build a data-literate workforce:
    - training for staff in data interpretation and use
    - clinical and operational teams empowered to use self-service dashboards
    - encourage data-driven conversations at all performance and quality meetings
- promote collaboration between business intelligence, digital, performance, clinical and improvement teams

The draft transitional structure is included within the supplementary information to this document.

11.16.2 Scope of data, BI and performance team services

Service area	Description
Business Intelligence (BI)	Modern BI tools (Power BI, Qlik) used across the trust. Self-service dashboards with governed access for different user groups: • executives: Board performance, quality, financial sustainability • operational teams: patient flow, bed occupancy, RTT, theatre utilisation • clinicians: outcomes, safety metrics, clinical effectiveness • dashboards aligned to national priorities (Elective Recovery, UEC,CDS Quality, Workforce)
Real-Time and Predictive Analytics	Integrate live feeds from EPR and other operational systems. To support: • patient flow and discharge planning • demand and capacity modelling • infection or readmission risk

Service area	Description
Data governance	Strong IG Framework: role-based access, privacy, audit trails. Data Quality Framework: regular checks, automated monitoring, feedback loops. Transparency: clear ownership of data and metrics.

Table 30: Core duties of the data, BI and performance team services

11.16.3 The key integration objectives for the integrated data, BI and performance team include:

- ✓ to be able to report nationally via integrated sit reps from day one
- ✓ to move to new operating model within 12 months of integration

Level	Function	Example deliverables
Trust Board / Execs	Strategic insights, benchmarking	Integrated Board Report; IPR national KPI tracking
Care Group / Directorate	Operational and quality management	Divisional dashboards; service line reports
Frontline / Clinical Teams	Local improvement and safety	Real-time ward metrics, SPC charts
Corporate Services	Finance, workforce, digital	Integrated resource and productivity dashboards

Table 31: Key integration objectives for the integrated data, BI and performance team

11.16.4 Current challenges and opportunities – data, BI and performance team

Challenges:

- ensuring that integrated data systems can support population health management and track progress on reducing health inequalities across both Places
- aligning data definitions and metrics across acute and community settings to enable consistent reporting on equity, access, and outcomes

Opportunities:

- integration will increase skills pool within the team as different products are currently being used in each organisation prior to integration
- enable intelligent procurement exercise to arrive at future BI platform of choice taking into account affordability, usability and scalability
- streamlining of dashboards to provide the right information, in the right format, at the right time for the new organisation
- enhanced use of CIPHA data, which includes trust level health inequalities dashboards, will enable targeted analysis of variation in access, outcomes and experience – supporting Place-based planning and equity focused decision-making

- opportunity to embed population health metrics into core performance reporting, ensuring that system transformation is informed by real-time insights into deprivation, long-term conditions, and service reach

11.16.5 Success criteria – data, BI and performance

- ✓ integrated sit reps to be submitted from day one
- ✓ ability to provide access to relevant dashboards to executive team, trust Board and clinical/operational management teams from day one.

12.0 Expected benefits and quality impact

12.1 Chapter summary

This section summarises the expected clinical, operational, workforce and financial benefits of integration. It highlights how joining acute and community care will improve patient outcomes, enhance workforce satisfaction, and deliver long-term sustainability.

The section provides an overview of the benefits realisation framework and the approach for monitoring and evaluation. It reinforces that integration will result in better continuity of care, reduced duplication, improved access and greater equity across populations, ensuring that quality and safety remain central to every element of transformation.

Key message: The benefits of integration are significant and measurable. Patients will experience more consistent, joined-up care; staff will benefit from expanded opportunities and shared learning; and the system will achieve greater efficiency and resilience. The benefits realisation framework ensures delivery is tracked, quantified and sustained over time.

This section covers the expected patient benefits; scale of those benefits and the realisations measured as identified through the initial ideas and seven early priorities developed through collaborative clinical workshops.

12.2 Key points supporting the patient benefits case

1. **A fundamental shift in care – Home first, then community and hospital only when needed:** The integration will enable holistic, joined-up care closer to patients' homes, with a strong emphasis on prevention and early intervention. This shift supports population health goals by addressing needs upstream and reducing avoidable hospital admissions – particularly for those in deprived or underserved communities.

2. **Enhanced clinical model implementation:** The joint clinical model prioritises seven service areas that span acute and community care. These priorities are designed to reduce unwarranted variation, improve continuity, and ensure that care is tailored to the needs of populations experiencing the greatest health inequalities.

3. **Overcoming operational barriers:** Integration will remove longstanding obstacles such as fragmented IT systems, commissioning arrangements and governance structures that currently hinder equitable service delivery. A unified approach will enable better coordination and more efficient use of resources, ensuring that patients receive consistent care regardless of geography or provider.

4. **Cross-cutting patient benefits:** Integration will improve the patient experience by simplifying pathways and reducing fragmentation. It will also enhance equity of access, directly addressing health inequalities through better use of pooled resources and more consistent service offers, helping to eliminate postcode lotteries and ensure that care reaches those who need it most.

5. **Financial and professional advantages:** The integration is expected to generate financial benefits for the integrated trust and the wider healthcare system. Without sustainability clinical services will not thrive. Additionally, it will create expanded

professional opportunities for staff, drawing on the strengths of both organisations and improving job satisfaction.

6. **Specific clinical improvements:** Building on the seven clinical priorities, integration will strengthen coordination between hospital and community settings, improving outcomes for patients with complex needs and those at risk of exclusion:

    - Frailty services will shift focus to earlier, community-based interventions – reducing crisis admissions and supporting independence, especially in areas with high deprivation and multimorbidity.
    - Infant feeding support will be consistent and specialist-led, improving outcomes for mothers and babies, particularly in communities with lower breastfeeding rates and limited access to early years support.
    - Heart failure services will offer greater access to specialist care closer to home, reducing travel barriers and improving outcomes in areas with high cardiovascular risk.
    - Chronic pain management will be enhanced through coordinated, multidisciplinary pathways – reducing delays and improving quality of life for patients often marginalised in traditional models.
    - Movement disorders and Parkinson's disease care will be more joined-up, ensuring reliable access to medication and continuity of support, especially for those with mobility or transport challenges.
    - Urinary incontinence services will offer timely assessment and treatment, reduce stigma and improve daily functioning, particularly for women in communities where access to pelvic health services is limited.
    - End-of-life care will be strengthened through better coordination and personalised support, often delivered closer to home ensuring dignity and compassion regardless of socioeconomic status or setting.

7. **Patient and public involvement:** Patient and public voices are central to service design and monitoring, with engagement already underway through clinical workshops and summits. This is described in further detail in section 10.5.1.

8. **Benefits realisation:** As the programme advances, progress will be tracked through specific indicators and milestones, ensuring accountability for delivery. All workstreams within the BCT programme maintain a detailed tracker recording actions, milestones, risks and benefits. These are updated periodically and reported monthly through to BCT delivery group for assurance around progress.

In summary, the integration of BCH by WHH is predicted to deliver substantial improvements in healthcare delivery and patient outcomes. By addressing current operational barriers and clinical inefficiencies, the integration aims to create a more efficient, equitable, and patient-centred healthcare system.

The comprehensive approach outlined in the document underscores the commitment to transforming health services, through vertical integration, for the benefit of the population we serve.

12.3 Summary of patient benefits

12.3.1 Introduction to patient benefits

This section summarises the patient benefits we expect to achieve from integration. Becoming a single organisation will enable us to implement our clinical model, deliver improvement in our clinical priorities, and realise substantial patient benefits.

We are ambitious on behalf of the population we serve and want to transform the way we deliver services to improve the health of Warrington and Halton. Together with our local partners we want to better meet our patients' health needs now and in the future. We will do this by providing integrated, holistic care, closer to patients' homes, with a focus on prevention and early intervention: **Home first, then community and hospital only when needed.**

Although we have seen some early benefits from partnership working to date as part of the Better Care Together programme, integration enables us to take forward more opportunities at a much greater scale and pace than is possible while we are two separate legal entities. The Boards strongly believe that integration is an essential enabler to making these planned changes a reality within the timescale required.

The planned integration will deliver substantial and lasting improvements to the health outcomes and experiences of our local populations as we move to transform our model of care locally. Integration at scale and pace will also expand the professional opportunities available to colleagues, drawing on the strengths of both organisations and improving staff satisfaction. The single organisation will achieve these benefits while also reducing costs for the combined trust and the wider system.

Although some BCH and WHH services are already working closely together, different IT systems, commissioning arrangements, employment contracts, governance arrangements and fractured clinical pathways limit this collaboration. Integration offers the opportunity to overcome these barriers and secure significant patient benefits in terms of better care and experience. It also enables us to streamline processes and remove duplication to free up clinicians' time for frontline care and to work more effectively with system partners.

12.3.2 Cross-cutting patient benefits

Integration presents the opportunity to create a new and exciting joint clinical strategy for the combined organisation.

The seven clinical priorities identified by the clinical and operational integration workstream outline clear patient and population benefits, and the approach taken with these priorities will be used as a future blueprint for all the clinical integration work. As the wider corporate and clinical services identify their integration scope, vision, key milestones and opportunities, they will also define their benefits.

The table below details the cross-cutting benefits that the trusts have identified as critical benefits from integration:

Benefit	Measure
Patient and population benefits	Improved equity of access to health and care services across our places; pooling our resources to remove existing 'post-code lotteries', particularly where current disparities and/or

Improved patient experience by creating services that are less fragmented, across both clinical pathways and geographic areas.	health inequalities exist because of historic commissioning decisions.
	Improved patient experience by simplifying pathways and reducing hand-offs.
	Improved accessibility of our services by reducing the number of interfaces encountered by patients and their carers that can act as barriers to the provision of fast and easy access to care.
	Improved continuity of care by aligning the geographic coverage of our service teams and reducing the number of interfaces across care pathways.
	Improved communication with patients, their carers, and across clinical teams by reducing the inter-organisational boundaries along patient pathways that can act as barriers to the provision of consistent and complete information.
Patient and population benefits Improvements to patient safety and outcomes	Working with primary care and other partners to support multi-disciplinary team working, so that when people do require care this is delivered at home or as close to home as possible through a model that has the benefit of 'acute oversight' where required, allowing a greater degree of clinical risk to be managed locally. **Home first, then community and hospital only when needed**.
	Establish a universal, trust-wide approach to quality improvement (QI) and transformation that utilises our combined expertise and recognises the importance of both standardisations to reduce unwarranted variation, and adaptation to meet the needs of Warrington and Halton.
	Improving the quality of patient care by improving clinical information sharing, enhancing access to specialists in community settings and reducing gaps in specialist clinical knowledge by sharing resources more widely and improving knowledge transfer within teams.
	Sharing resources more effectively to maintain sustainable staffing levels, service delivery integrity and reducing gaps in specialist clinical knowledge, particularly of smaller services.
Wider benefits to health and care system	Simplifying and integrating our care pathways and making it easier for primary, social care and other partner colleagues to access and work with our services to support people in the

	community to avoid unnecessary deterioration and admissions to hospital.
	Reducing A&E attendances and avoidable admissions to secondary care through reducing the complexity and duplication of our care pathways to always care for patients in community settings when appropriate.
	Inform and shape future system and place strategy development, particularly neighbourhood models, from an integrated acute/community trust perspective.
	Simplify governance and commissioning arrangements with place and ICB with a single trust being held accountable for the delivery of equitable safe and high-quality acute and community services.

Table 32: Anticipated public and patient benefits from integration

12.4 Patient and population benefits aligned to clinical priorities

In addition to the cross-cutting benefits described above, the integration will enable delivery of specific patient and population benefits aligned to the seven clinical priorities identified as the start point for the clinical and operational integration workstream. These priorities represent the areas where integration is expected to have the greatest or most urgent impact on outcomes, experience, and sustainability of services.

The benefits identified in this section are grounded in evidence and practice. They draw on the extensive clinical engagement process described in chapter 10, a review of published literature, and insights from clinical integration leads and the clinical summits.

It is important to note that the benefits presented here are initial ideas and early priorities developed through collaborative clinical workshops. They should be regarded as the starting point for a programme of work that will continue to evolve.

As the integration progresses, each priority will be supported by detailed delivery plans, refined benefit realisation measures, and evaluation frameworks that will be tested and adapted in practice.

Accordingly, the measures and outcomes set out in the following six tables should not be considered final or fixed. They will develop iteratively through co-design with patients, staff, and partners, and will be subject to ongoing scrutiny and oversight by the Better Care Together delivery group.

This flexible approach ensures that the programme remains responsive to patient needs, local system capacity, and emerging evidence, while retaining clear accountability for the delivery of benefits.

Clinical priority 1 – frailty response services			
Change enabled by integration	**Patient benefit**	**Scale of benefit – how many people benefit**	**Benefit realisation measures**
Establishment of a single, integrated frailty response model across Warrington and Halton. Brings together acute, community, and primary care teams under shared clinical governance and pathways. Enables rapid, multi-disciplinary assessment and response in the community, reducing duplication and delays.	Improved access to timely and coordinated care for people living with frailty. Reduction in avoidable hospital admissions and length of stay. Enhanced patient experience through continuity of care and care closer to home. Improved support for carers and families.	c. 27,500 people aged 65+ living in Warrington and Halton with moderate to severe frailty.[19]	Reduction in non-elective admissions for frail older adults. Reduction in average length of stay for frailty-related admissions. Increase in same-day/within 2-hour community response rates. Improved patient and carer experience scores. Reduction in repeat attendances to ED or UCC within 30 days. Increased proportion of people dying in their preferred place of care.

Table 33: Clinical priority 1 – frailty response services benefits

Clinical priority 2 – heart failure			
Change enabled by integration	**Patient benefit**	**Scale of benefit – how many people benefit**	**Benefit realisation measures**
Develop an integrated heart failure model with a single team serving patients across the	An integrated service can create more cohesive care pathways, reduce transitions, and improve continuity of care.	Based on NW England HF prevalence rate of 1.22% estimated HF cases are Warrington	Increase in early HF diagnosis rates. Improved recognition of terminal heart failure

[19] CIPHA ICB Frailty Dashboard

pathway and shifting care closer to home. Developing a community diagnostic service for heart failure including standardisation of referral criteria. Developing a community IV diuretics service. Establishing community clinics for heart failure nurses Increasing the scope of heart failure nurses and access to blood results. Developing a one stop approach to diagnosis and treatment. Reducing variation in practice between Halton and Warrington.	Being treated at home rather than in hospital helps with recovery, improves outcomes, and provides a personalised service. Better communication and data sharing between teams can ensure a more personalised and responsive care provision, reducing waiting times for appointments, tests and treatments leading to faster diagnosis and commencement on an appropriate treatment plan. Better and more equitable access to specialised services, expertise, and treatment modalities. Provides patients with more opportunities for education, support and engagement in their care improving their quality of life and self-management of their care pathway. Timely interventions and supportive care reduce mortality risk and need for hospital admission.	2,600 people and Halton 1,600 people[20]. In the UK approx 385k people are living with undiagnosed and untreated HF and modelling suggests more than 1,200 are in Warrington and Halton[21] [22]. HF accounts for 5% of all emergency hospital admissions in the UK[23]. Since April 2023 784 attendances at WHH ED with HF as primary diagnosis were admitted to a hospital bed. RTT stats: 1,940 patients waiting for new cardiology OP appointments and 6,534 waiting for follow up. In Warrington, on average around 39% of all cardiovascular disease mortality in people aged under 75 is considered preventable[24].	and initiation of appropriate management plan. Improved quality of life indicators and qualitative patient feedback scores.

Table 34: Clinical priority 2 – heart failure benefits

[20] Department for Health and Social Care (no date) *Health trends in England: Cardiovascular disease in the North West*. Available at: https://fingertips.phe.org.uk/static-reports/health-trends-in-england/North_West/cardiovascular_disease.html

[21] British Heart Foundation (2020) *Heart Failure: A Blueprint for Change*. Available at: https://www.bhf.org.uk/-/media/files/health-intelligence/heart-failure-a-blueprint-for-change.pdf?rev=f89dedb7c933452e8086cc063ff98c26

[22] Lippi, G. and Sanchis-Gomar, F. (2020) 'Global epidemiology and future trends of heart failure', *AME Medical Journal*, 5(15), doi:10.21037/amj.2020.03.03

[23] NHS Cheshire and Merseyside (2023) *Expanding the use of virtual wards to support heart failure patients in Liverpool*. Available at: https://www.cheshireandmerseyside.nhs.uk/posts/expanding-the-use-of-virtual-wards-to-support-heart-failure-patients-in-liverpool/#:~:text=Heart%20failure%20NHS%20virtual%20wards%20in%20Liverpool&text=Allowing%20patients%20to%20recover%20in,been%20successfully%20treated%20this%20way. (Accessed: 28 November 2025)

[24] Warrington Borough Council (2025). Joint Strategic Needs Assessment Warrington 2024–May 2025.

Clinical priority 3 – chronic pain services			
Change enabled by integration	**Patient benefit**	**Scale of benefit – how many people benefit**	**Benefit realisation measures**
We will move away from the current hospital-based model to an integrated, community-based chronic pain service. The focus will shift from a service that relies on pharmacological and theatre-based interventions to manage pain symptoms, to a predominantly community and therapies-based model, with hospital intervention being limited to only the most complex cases.	Patients will be cared for in a model that will focus on rehabilitation and re-enablement (rather than pharmacological intervention) that will more effectively support their pain management and returning to the things they want to do. Reduced opioid and gabapentoid prescriptions, delivering significant patient and community benefits. Fewer invasive procedures will be required. Theatre capacity will be freed up to allow more procedures that deliver greater benefit to be undertaken – significantly reducing the number of procedures of limited evidence-based value taking place.	National evidence shows ~34% of adults live with chronic pain and ~12% with high-impact chronic pain. In Warrington and Halton this equates to ~90,000 with chronic pain and ~30,000 with high-impact chronic pain[25] [26]. Around 84% of chronic pain cases are musculo-skeletal in nature, meaning community-based rehabilitation models could directly target the majority of cases[27]. Published average waiting time for pain management treatment at WHH is currently 25 wks. c. 700 people on waiting list for the specialist pain management service in Warrington and Halton[28].	Improved function, participation in meaningful activities, reducing pain impact and enhancing quality of life as measured by patient-reported outcomes such as the Patient-Specific Functional Scale (PSFS). Increased physical activity levels as assessed through patient supported outcomes. Decreased rates of opioid and gabapentoid prescription. Decreased rates of pain-related invasive interventions such as spinal injections.

Table 35: Clinical priority 3 – chronic pain services benefits

[25] Versus Arthritis (2021) *Chronic pain in England: Unseen, unequal, unfair*. Available at: https://www.arthritis-uk.org/media/23739/chronic-pain-report-june2021.pdf

[26] Fayaz, A. *et al*. (2016) 'Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies', *BMJ Open*, 6(6), p.e010364. doi: 10.1136/bmjopen-2015-010364

[27] Versus Arthritis (2021) *Chronic pain in England: Unseen, unequal, unfair*. Available at: https://www.arthritis-uk.org/media/23739/chronic-pain-report-june2021.pdf

[28] CIPHA, Elective recovery database (in pilot).

Clinical priority 4 – infant feeding			
Change enabled by integration	**Patient benefit**	**Scale of benefit – how many people benefit**	**Benefit realisation measures**
Provision of an integrated service model reducing inequality across the population served. Consistency with regional priorities as outlined in the Cheshire and Mersey Infant Feeding Strategy to include: - consistent referral criteria - equitable advice and support - coherent and joined up approach Policy alignment. Closing service gaps between hospital and community care.	Seamless support in various formats Equality and accessibility Consistent information and education	c. 2500 in accordance with birth rates recorded for Warrington and Halton Hospital	Increase breast feeding rates at 6 to 8 weeks equal to or exceed the national average of 52.7%. Increase first feed of breast milk equal to or exceeding the national average of 71.3%. Increase in women's satisfaction with breastfeeding support.

Table 36: Clinical priority 4 – infant feeding benefits

Clinical priority 5 – movement disorders / Parkinson's			
Change enabled by integration	**Patient benefit**	**Scale of benefit – how many people benefit**	**Benefit realisation measures**
Bringing together the MDT caring for patients with movement disorders across the hospital and community service will allow more effective use of capacity and shift the focus of care into the	Patients will receive earlier diagnosis of Parkinson's disease and other movement disorders. Patients will receive a greater proportion of their care in the community with fewer	4,925 admissions to hospital for people with Parkinson's (planned or unplanned) in Cheshire and Merseyside in FY 2024-25 compared to a national average of 2,625.	Reduced waiting list times for first appointment and follow up. Reduction in hospital based follow up appointments.

community supported by in-reach into the hospital setting. Develop a Parkinson's passport to support holistic care. Upskill our workforce to manage movement disorders patients in an integrated model across the pathway. Move to consolidate the movement disorders pathway onto (wherever possible) a single IT system. Forge closer links and work with community matrons and district nurses to identify deterioration and changes in treatment requirements in Parkinson's patients earlier.	visits to hospital clinics. Care will be better coordinated across primary, community and secondary care, with fewer missed does of medication when patients have an acute admission.	10% of these admissions were to WHH with an excess bed day cost to the trust of nearly £160k[29]. Approx 114 new cases of Parkinson's diagnosed in Warrington and Halton every year (based on NICE prevalence rates)[30]*. In Warrington and Halton 831 are currently registered as having Parkinson's disease[31].	Fewer missed doses of medication following admission.

Table 37: Clinical priority 5 – movement disorders/Parkinson's benefits

[29] Parkinson's UK (2021) *Hospital admissions for people with Parkinson's*. Available at: https://parkinsonsuk.hsj.co.uk/hospital-admissions-people-parkinsonss

[30] National Institute for Health and Care Excellence (NICE) (2025) *Parkinson's disease: How common is it?* Available at: https://cks.nice.org.uk/topics/parkinsons-disease/background-information/prevalence/

*Actual diagnosis rates and numbers of people living with Parkinsons and other movement disorders will be available via a local GP database review

[31] CIPHA ICB Population Explorer tool

Clinical priority 6 – female urinary incontinence (UI)			
Change enabled by integration	**Patient benefit**	**Scale of benefit – how many people benefit**	**Benefit realisation measures**
More collaborative working and understanding of care pathways. A joint MDT (hospital and community) to discuss complex patients. A single referral pathway and direct referral into services. Seamless care. Improved access to IT systems to improve visibility of lab results and blood tests. Development of community-based clinics.	Prioritising UI management allows timely interventions that restore confidence, independence and participation in work, social and family life. Early identification and treatment of UI can reduce secondary complications such as urinary tract infections, skin breakdown and falls (from urgency or rushing to the toilet). Access to conservative management (bladder training, pelvic floor exercises, weight management) and specialist interventions improves long-term continence outcomes.	It is estimated that 34% of UK women are living with UI[32]. Using local age/sex data and applying plausible prevalence rates, ~34,500* women aged 18+ across Warrington and Halton may currently experience urinary incontinence and could benefit from improved diagnostic and treatment pathways[33, 34, 35].	Reduction in complications such as urinary tract infections, falls, or skin breakdown related to incontinence. Reduced waiting times for assessment and treatment. Increased number and proportion of women receiving assessment and treatment within community settings. Reduction in acute hospital admissions related to complications of UI. Increased patient satisfaction and symptom control.

[32] NICE (2025) *Incontinence – urinary, in women*. Available at: https://cks.nice.org.uk/topics/incontinence-urinary-in-women/

[33] Based on ONS (2024) *Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2023*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2023

[34] Warrington Borough Council. (2025) *Joint Strategic Needs Assessment (JSNA)*. Available at: https://www.warrington.gov.uk/jsna

[35] Halton Borough Council. (2024) Joint Strategic Needs Assessment: Population Overview. Runcorn: Halton Borough Council. https://www3.halton.gov.uk/Pages/health/publichealthinfo.aspx

*While an estimated 34,500 women across Warrington and Halton may be affected, a clearer picture of the true unmet need (as not all women with UI will present for treatment) and target population can be built over time by triangulating GP coding data, continence service referrals, prescribing patterns, and local survey insights as the integration programme develops.

	Women, particularly older women, may underreport symptoms. Integrating UI care ensures equitable access to assessment, diagnosis and treatment, reducing health inequalities. Managing UI proactively in the community can prevent hospitalisation related to complications, improve discharge from acute care, and reduce re-admissions. Providing UI care as part of a community-focused, integrated pathway promotes co-production, empowering patients to be involved in treatment decisions, self-management, and goal setting.		

Table 38: Clinical priority 6 – female urinary incontinence (UI) benefits

Clinical priority 7 – end of life care			
Change enabled by integration	**Patient benefit**	**Scale of benefit – how many people benefit**	**Benefit realisation measures**
Multi-disciplinary, electronic and	Increased opportunity for timely	Approx 3,370[36, 37] people each year	Improved experience including symptom

[36] Stopford (2024) *Analysis: Deaths registered in England and Wales 2022*. Available at: https://stopford.com/analysis-deaths-registered-in-england-and-wales-2022/

[37] Warrington Borough Council (2021) *Joint Strategic Needs Assessment Summary 2021*. Available at: https://www.warrington.gov.uk/sites/default/files/2022-01/Joint%20Strategic%20Needs%20Assesment%20Summary%202021.pdf

governance processes will be streamlined across sectors to deliver an integrated pathway. All staff will view and use the personalised care plans. Access to specialist palliative care across the whole week and including at the front door will be strengthened. Integration of education to specialists and non-specialists will continue.	personalised care planning. More likely to have preferences met, including preferred place of care and preferred place of death. Timely access to appropriate generalist and specialist palliative care with improved symptom management across the patient journey, across the whole week and equitable across patient groups.	across Warrington and Halton likely to be in last year of life (for Halton estimated based on available data), expected to rise by 25.4% by 2040 with an increase of 42.4% in those needing specialist palliative care services[38]. Using population data in England over a two-year period, it has been estimated that 69-82% of people who die need palliative care[39].	management, reduced avoidable admissions and safely reduced lengths of stay measured by: - Integrated Palliative Care Outcomes Scale (IPOS) - key performance indicators and clinical audits including re: front door and gold standards framework (GSF) - national audit of care at the end of life - CODE™ survey - Cheshire and Merseyside palliative end of life care population based needs analysis - palliative care activity dashboard (including GSF data for front door attendances and admissions)

Table 39: Clinical priority 7 – end of life care benefits

12.5 Why integration is essential

The case studies presented in section 10.3 illustrate how colleagues and teams from BCH and WHH have already worked together pre-transaction to secure tangible benefits for patients.

These examples show that integration of individual services can be achieved through collaboration, given sufficient resource, effort and commitment. However, this approach is inherently limited. With finite resources and competing demands on clinicians and operational leaders, relying on workarounds is unsustainable and cannot deliver the scale or pace of change that patients need.

Integration provides the essential lever to unlock systemic transformation across all services. It removes dependence on self-selecting groups of clinicians driving change in isolation and instead embeds integration as a strategic, organisation-wide and system-wide priority.

[38] Sue Ryder (2021) *Modelling demand and costs for palliative care services in England: A final report for Sue Ryder*. Available at: https://media.sueryder.org/documents/Modelling_Demand_and_Costs_for_Palliative_Care_Services_in_England_1.pdf

[39] Murtagh, F. E. *et al.* (2013) 'How many people need palliative care? A study developing and comparing methods for population-based estimates'. *Palliative Medicine*. 28(1), pp. 49-58. doi:10.1177/0269216313489367

This enables improvement efforts to be aligned with the areas that clinicians, partners and patient representatives have identified as offering the greatest benefits. It also ensures that resources are used most effectively, accelerating transformation while maintaining safety and quality.

The wider evidence base on integration highlights well-documented barriers to delivery of clinical improvement[40, 41] including:

- a lack of organisational commitment
- insufficient resources
- misaligned payment mechanisms
- poor information sharing between professionals
- weak coordination across services
- limited focus on patient needs and preferences
- workforce pressures and role uncertainty
- conflicting priorities and resistance to change

Conversely, research identifies clear enablers of success, such as well-defined and evidence-based service models, collaborative working between general practices, adequate resourcing, shared values, effective digital communication, and robust monitoring of quality and outcomes.

Integration directly addresses many of the barriers while embedding the recognised enablers. Although the national evidence integration is complex, NHS case studies demonstrate that bringing acute and community services together within a single organisation can accelerate transformation. Staff working in combined acute-community trusts report that integration strengthens teamwork, speeds up service redesign, and improves continuity and coordination of care, all of which are critical to achieving the fundamental shift in focus required for our population[42].

12.6 Patient and public involvement in clinical integration

A communications and engagement plan has been developed for the overarching BCT programme to inform and engage a broad audience about the integration of the organisations and clinical pathways.

This plan sets out an approach that will cover both engagement and involvement, and public consultation where required, across both BCH and WHH stakeholders and services. This is based on a 'start with people' approach and a commitment to ensuring effective engagement with staff, stakeholders and communities, including people with lived experience of services.

Chapter 10 of this business case describes early engagement with staff and wider stakeholders, including Healthwatch which informed the priority areas for clinical transformation.

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[40] Ling, T. *et al.* (2012) 'Barriers and facilitators to integrating care: experiences from the English Integrated Care Pilots'. *International Journal of Integrated Care*, 12(5), pp. e129. doi: 10.5334/ijic.982

[41] Kozlowska, O. *et al.* (2018) 'Barriers and facilitators to integrating primary and specialist healthcare in the United Kingdom: a narrative literature review'. *Future Healthcare Journal*, 5(1), pp. 64-80. doi: https://doi.org/10.7861/futurehosp.5-1-64

[42] The King's Fund (2015) *Acute hospitals and integrated care: From Hospitals to health systems*. Available at: https://www.kingsfund.org.uk/insight-and-analysis/reports/acute-hospitals-and-integrated-care

The next steps to support this activity and to ensure meaningful patient and public engagement informs any changes to services will be the involvement of Healthwatch Halton and Healthwatch Warrington, to provide independent chairing and project coordination of feedback from a BCT patient and public reference group (PPRG).

The PPRG will formally report into the BCT programme delivery group and will tap into wider engagement networks, helping to ensure that the voice of our patients and local public is heard.

The inaugural meeting will be held in December 2025 to agree the format and terms of reference and will be followed by three further monthly meetings, progressing to bi-monthly meetings focused on topic areas including seven areas of clinical pathway transformation.

Provisional meeting timetable:

Meeting date	Area of focus
December 2025	Overview of BCT integration plans, the case for change, understanding engagement and feedback to date, and agree PPRG terms of reference
January 2026	Infant feeding pathway
February 2026	Urgent and emergency care/self-care
March 2026	Heart failure pathway
May 2026	Chronic pain management/frailty services
June 2026	Movement disorders/end of life care
September 2026	Female urinary incontinence

Table 40 – PPRG provisional meeting timetable

Members of the group will be expected to share information and engage with their respective networks / communities on behalf of the PPRG, feeding back into the group with community responses about the wider integration programme, to inform clinical integration plans.

In addition, we will incorporate engagement on clinical integration priorities through our established engagement networks and activity across both BCH and WHH. This will include those with lived experience of both community and hospital services in the priority workstream task and finish groups as required.

It will also include engagement attendees at community events in Halton and Warrington and through those services delivered across a wider footprint. We will provide opportunities for local people to hear about our integration plans from senior leaders through established forums and groups so that people can ask questions, make suggestions and share thoughts and concerns.

12.7 Benefits realisation

The evidence base to support the tangible benefits resulting from integrated care is complex, but systematic reviews report that integration can enhance patient satisfaction, increase perceived quality of care, and enable access to services.

Examples of where expected benefits of integration have failed to be delivered often link to one or more of the following:

- poor design of the integrated service model
- problems with implementation of the model
- problems with evaluation of the benefits of integration

Mitigating design and implementation challenges has been addressed in the above section on our approach to clinical integration. As described, our approach has been designed with reference to the insight drawn from the evidence base, best practice guidance and expert advice.

Realising the benefits of integration through integration therefore relies on the successful delivery and evaluation of three key elements:

- new or changed capabilities (e.g. new or redesigned pathways, operating models, digital technologies, roles or infrastructure)
- adoption of the changed capabilities (e.g. the behaviour change by staff, patients and the public required to make use of the new capabilities)
- measuring the outcome of the change process (e.g. capturing the benefits that should be accrued with successful delivery)

Our plan for clinical integration will empower teams to take a systematic approach to the design and delivery of new or transformed services.

Each of the clinical priority areas detailed in section 10.5.2 will have key performance indicators, visible to staff and regularly reviewed, which will provide the ‘leading’ measures of improvement at team level.

This will allow us to clearly communicate performance improvements from integration, alongside any risks to performance that may emerge. By empowering our clinical teams in this way, we provide an engine for frontline change that is focused on the things that matter most to our staff, patients and populations.

True benefit measures will typically be ‘lagging’ measures – outcomes that impact directly on people and that may accrue over a longer period after change has taken place and may be more challenging to measure.

Our evaluation of the benefits of integration will be managed and monitored via the Better Care Together programme governance structure in 2025-26 and then via our post transaction integration programme governance structure from 2026-27 onwards.

13.0 Financial case

13.1 Chapter summary

This section presents the financial evidence supporting the integration, including baseline and projected future financial positions of the partner organisations, financial improvement opportunities associated with the acquisition, and the anticipated additional costs incurred as a result. It sets out the medium-term financial plan for the integrated trust to support financial sustainability that will help protect resources allocated to frontline patient care.

Key message: Integration will create significant opportunities for financial improvement for both WHH and BCH. Without integration, the ability of both providers to reach a position of financial sustainability and maintain clinical quality and effectiveness is severely restricted.

By removing duplication, optimising resources and leveraging shared investment, the new organisation will deliver better value for money and greater system resilience.

In this section we detail how integration will deliver economies of scale, streamline services and unlock up to £33m in financial opportunities, helping to significantly improve the current combined underlying deficit of £48.3m across the two organisations (projected as at the end of 2025-26). Opportunities for financial improvement identified to date far outweigh the anticipated £1.1m additional costs of the integration programme. This aligns with NHSE's expectations for integrated, financially sustainable care systems.

13.2 Historic financial performance

13.2.1 I&E performance

WHH and BCH financial performance over the three years to 2024-25 is set out below. Both organisations have historically achieved their ICS agreed risk adjusted plans/forecasts each financial year for both revenue and capital and CIP delivery has improved year on year.

Note: The WHH 2024-25 position includes deficit support funding of £16.5m.

£m	Actual	Actual	Actual
I&E – WHH	2022-23	2023-24	2024-25
Income	347.1	356.1	392.0
Pay	(255.0)	(275.8)	(293.8)
Non-pay	(95.1)	(103.8)	(117.6)
Non-operating expenditure	(4.5)	(4.7)	2.3
Surplus / (deficit) as per accounts	**(7.6)**	**(28.2)**	**(17.2)**
Adjustments to financial performance	(0.3)	(1.7)	0.3
Adjusted surplus / (deficit)	**(7.9)**	**(30.0)**	**(16.8)**
Exclude deficit support funding (DSF)	0.0	0.0	(16.5)
Adjusted surplus / (deficit) excluding DSF	**(7.9)**	**(30.0)**	**(33.3)**
Planned surplus / (deficit)	(16.8)	(19.9)	(27.8)

Table 41: WHH recent historic financial performance (I&E)

£m	Actual	Actual	Actual
I&E – BCH	2022-23	2023-24	2024-25
Income	97.0	101.9	107.6
Pay	(69.1)	(72.6)	(77.6)
Non-pay	(27.5)	(30.6)	(31.2)
Non-operating expenditure	0.6	1.3	(0.0)
Surplus / (deficit) as per accounts	**1.0**	**0.0**	**(1.2)**
Adjustments to financial performance	0.0	0.0	0.0
Adjusted surplus / (deficit)	**1.0**	**0.0**	**(1.2)**
Planned surplus / (deficit)	0.0	0.0	2.1

Table 42: BCH recent historic financial performance (I&E)

Delivery of the financial plans has become more challenging for both organisations, as shown by the deteriorating financial positions of both WHH and BCH over recent years. There has been increasing requirement for additional CIP due to growth in staffing (see section 5.6) and reduction in productivity post-COVID.

WHH in particular has a historic underlying deficit position. Drivers of underlying financial deficit at WHH are predominantly operational and structural factors:

- Operational
    - outpatient and inpatient activity case mix changes are driving higher costs
    - authorised but unfunded pay increases to meet patient safety standards and increased clinical activity
    - savings being achieved non-recurrently
    - impact of workforce challenges
    - high levels of premium pay spend due to vacancies and recruitment.
    - winter
    - acuity of patients post COVID
    - infrastructure challenges

- Structural
    - decrease in recurrent income, increased depreciation and amortisation costs due to significant levels of investment in plant and machinery and software in response to COVID. In 2021-22 and 2022-23 non-recurrent income was supporting recurrent costs. This income reduced in 2023-24 and further reduced in the 2024-25 plan
    - reduced out of hospital support facilitating timely discharge and care in the community
    - block contracts / PBR
    - PBR tariffs for DGH without specialist activity more likely to have a deficit
    - the reliance on non-recurrent income
    - impact of industrial action

A number of the drivers behind the deficit position, such as infrastructure costs and reduced out of hospital support, can be addressed and improved through the integration programme.

13.2.2 Balance sheet positions

WHH and BCH balance sheet positions at the end of each year over the three years to 2024-25 are set out below.

Balance sheet WHH – £m	2022-23	2023-24	2024-25
Non-current assets	192	211	207
Current assets	58	35	30
Current liabilities	(55)	(53)	(48)
Non-current liabilities	(11)	(10)	(9)
Net assets employed	**184**	**182**	**180**
PDC	215	240	264
Revaluation reserves	41	41	36
I&E reserve	(71)	(98)	(120)
Total taxpayers and others' equity	**184**	**182**	**180**

Table 43: WHH balance sheet positions at the end of each of the most recent three years

Balance sheet BCH – £m	2022-23	2023-24	2024-25
Non-current assets	51	51	48
Current assets	33	27	23
Current liabilities	(22)	(15)	(14)
Non-current liabilities	(37)	(37)	(33)
Net assets employed	**26**	**26**	**25**
PDC	33	34	34
Revaluation Reserves	3	3	3
I&E Reserve	(10)	(11)	(12)
Total taxpayers and others' equity	**26**	**26**	**25**

Table 44: BCH balance sheet positions at the end of each of the most recent three years

BCH balance sheet position is largely unchanged over the period.

WHH balance sheet position has changed as a result of:

- investment in WHH asset portfolio to deliver and improve patient care, and address mandated and business critical requirements linked to dated estate

- current assets have declined as the cash position has followed the challenging I&E performance of the trust
- main movement to note is the I&E reserve due to the deficit position which is offset by the PDC reserve

Again, some of the negative balance sheet movement for WHH is a result of the deficit I&E position. This is something that the integration programme can help improve.

13.2.3 Cost improvement (CIP) delivery

Historic CIP performance for both WHH and BCH is shown below.

BCH has achieved CIP in recent years albeit with the use of non-recurrent items.

WHH has increased CIP delivery year on year with a significant shift to recurrent delivery.

		WHH			BCH		
		Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
2022-23	recurrent	15.7	1.5	(14.3)	1.9	1.6	(0.3)
2022-23	non recurrent	0.0	13.4	13.4	2.3	2.6	0.3
2022-23	**Total**	**15.7**	**14.9**	**(0.9)**	**4.2**	**4.2**	**0.0**
2023-24	recurrent	17.9	7.3	(10.6)	5.2	1.7	(3.5)
2023-24	non recurrent	0.0	8.2	8.2	0.0	3.6	3.6
2023-24	**Total**	**17.9**	**15.5**	**(2.4)**	**5.2**	**5.2**	**0.1**
2024-25	recurrent	19.4	12.7	(6.8)	4.9	1.7	(3.2)
2024-25	non recurrent	0.0	4.3	4.3	0.0	3.3	3.3
2024-25	**Total**	**19.4**	**17.0**	**(2.5)**	**4.9**	**5.0**	**0.1**

Table 45: WHH and BCH CIP delivery since 2022-23

13.2.4 Capital spend

Historically, both organisations have spent their planned capital allocation (see table 46 below).

Spend in WHH capital in previous years has been higher than plan due to additional national and regional funding received during the course of the year, including for the Community Diagnostic Centre (CDC) scheme, Targeted Investment Fund (TIF) schemes and IFRS16.

Actual spend in 2024-25 was lower than plan due to a deferral of frontline digitisation funds to 2025-26.

	WHH			BCH		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
2022-23	22.7	27.4	4.7	2.1	2.3	0.2
2023-24	26.9	31.6	4.7	2.4	2.4	0.0
2024-25	25.0	21.9	(3.1)	2.3	2.2	(0.1)

Table 46: WHH and BCH historic capital spend v plan

Future capital investment will be delivered through existing CDEL levels, no additional funding is assumed, except if targeted funding becomes available to support specific schemes.

13.3 Financial opportunities through integration

As individual standalone organisations, both WHH and BCH will have limited opportunities to deliver services more efficiently. Continuing to deliver annual CIP targets at current levels is not realistic unless the model of service provision is transformed and ongoing/future demand managed more effectively.

Table 47 below summaries the anticipated financial benefits from the integration over the coming years. This includes:

- £2.39m of recurrent financial benefits already realised during 2025-26 (at month 7)
- a further £9.75m of recurrent financial benefits that can be realised across the next four years directly as a result of bringing the organisations together (£8.4m between 2026-27 and 2028-29)
- a further £21m of recurrent financial benefits that are *enabled* via the integration over the next four years (£18.2m between 2026-27 and 2028-29)

Note that a number of the financial opportunities linked to integration are profiled to deliver in later years. This aligns with the fact that we have limited transformation/programme support resources (see section 7.12) to deliver large-scale clinical change at pace.

Delivery of some aspects of clinical redesign will be limited by our ability to divert programme resources away from other aspects of the programme, as and when they come to a conclusion (e.g. completion of the transaction, integration of corporate and clinical support teams as part of phase one and phase two of the programme).

	2025/26	2026/27	2027/28	2028/29	2029/30	Total
Direct financial benefits of integration						
Corporate services integration	0.30	1.05	3.30	2.75	0.60	8.00
Clinical service redesign	0.29	-	-	0.75	0.75	1.79
Re-align bank rates	1.80	-	-	-	-	1.80
Contract alignment (excl corporate)	-	0.05	0.05	-	-	0.10
Corporate hub	-	-	0.15	-	-	0.15
Operational management restructure	-	-	0.10	-	-	0.10
Community estates rationalisation	-	-	0.20	-	-	0.20
Community treatment rooms	TBC	TBC	TBC	TBC	TBC	0.00

	2.39	**1.10**	**3.80**	**3.50**	**1.35**	**12.14**
Indirect financial benefits of integration						
Place-based demand management	-	2.80	2.80	2.80	2.80	11.20
UEC improvement	-	0.39	-	-	-	0.39
CDC phase 4	-	-	0.96	-	-	0.96
Commercial clinical services	-	-	0.50	-	-	0.50
GIRFT productivity	-	0.86	0.84	-	-	1.70
Fragile service restructure	-	-	-	1.40	-	1.40
Car parking charges for BCH staff	-	0.45	-	-	-	0.45
BCH block contract review	-	-	2.20	2.20	-	4.40
	0.00	**4.50**	**7.30**	**6.40**	**2.80**	**21.00**
Grand total	**2.39**	**5.60**	**11.10**	**9.90**	**4.15**	**33.14**

Table 47: £33m of financial benefit opportunities identified to date from integration (both direct and indirect)

13.3.1 Corporate services integration

National benchmarking information from the NHS Model Health System data identifies financial improvement opportunities that can be delivered through the integration of corporate functions between the two organisations. By reducing overall costs in line with national median levels, the potential financial improvement would equate to around **£8m** recurrently.

Both WHH and BCH have already launched mutually agreed resignation schemes (MARS) in order to create required vacancies across affected corporate services. The costs in the table above account for the payment of MARS costs, hence the delayed profiling of the main benefits into 2027-28.

The integration of WHH and BCH, and particularly the increased organisational scale that is created via the integration, is critical in terms of realising this benefit. The ability of both organisations to reduce corporate costs down to national median levels is restricted as standalone organisations.

Nationally, the best performing trusts in terms of corporate costs are those with the larger turnover. As figure 28 below shows, organisations with 19 times the revenue of BCH only report corporate costs to be around five times those of BCH. This is simply due to economies of scale within corporate teams.

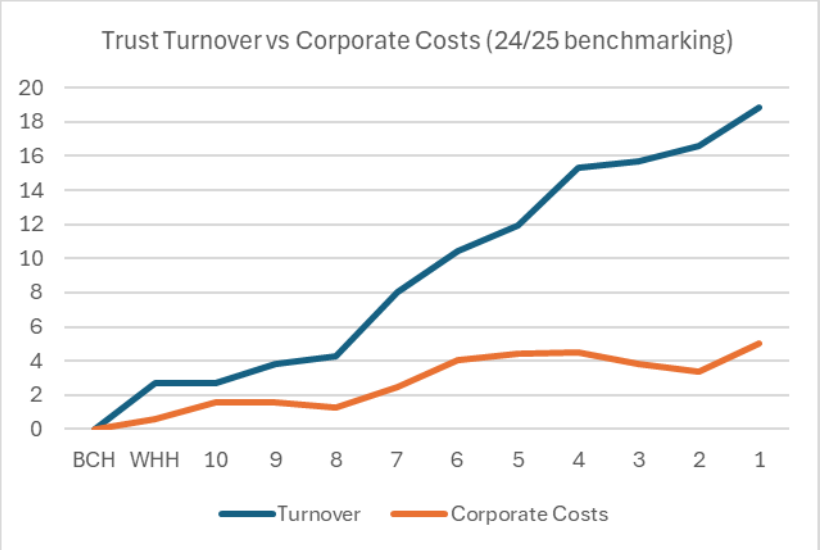


Figure 28: Total corporate service costs vs trust turnover based on a sample range of trusts from the NHS Model Health System benchmarking data

13.3.2 Clinical service redesign

There are a wide range of opportunities for financial improvement via the integration of clinical services. The opportunities are all dependent upon transforming delivery of services aligned to the principles set out in chapter 10 of this document.

For example, the current model for the chronic pain management service at WHH is predominantly secondary-care based and consultant-led. Other similar services locally are predominantly community-based and non-consultant-led. The difference in cost between these two models of care is significant. The integration of BCH and WHH creates the opportunity to shift the acute model to one delivered out in the community. This would reduce costs and align with the national strategic direction.

Similarly, evidence from the Getting It Right First Time (GIRFT) programme suggests that up to £2,000 of savings can be made by the organisation for every frailty admission to the hospital bed base that can be avoided. Based upon volumes of current (increasing) admissions for this group of patients, potentially between **£1.5m and £2m per year** could be saved if we were to avoid 10 to 15% of admissions. The management of frailty is a key clinical priority and the development of a multi-agency, community-based model has significant potential to deliver the transformation required to unlock the financial improvement.

According to the NHS Model Health System data, the average cost of a weighted unit of activity (WAU) for dentistry at WHH is the highest in the country, as demonstrated by figure 29 below. Given the scale of the community dentistry service delivered by BCH, there is likely to be a number of opportunities created through integration of the services to drive financial improvement through accessing economies of scale.

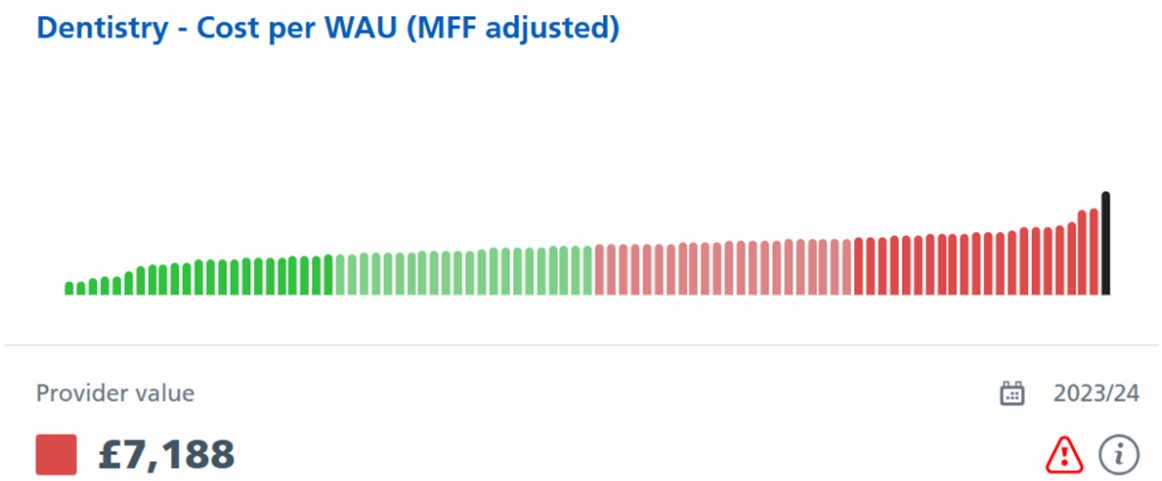


Figure 29: Cost per WAU for dentistry at WHH

The launch of the BCH AI-led dermatology service at WHH (see section 10.3.2.1) has already generated additional revenue of **£0.3m** in 2025-26, which demonstrates that the opportunities to deliver services differently and improve profitability at the same time are real.

13.3.3 Realign bank rates

More than **£1.8m** of pay cost savings have been delivered by WHH in 2025-26 as a result of reviewing the payment of bank rates for temporary shifts and aligning them to the rates paid by BCH to their staff. The integration of BCH and WHH will help increase the volume of staff able to support with temporary staffing cover across both community and acute services. This will help the integrated organisation to provide greater resilience to the workforce numbers and keep temporary staffing costs as low as possible into the future.

13.3.4 Contract alignment

An initial review of the current contract registers across both BCH and WHH indicates approximately 34 'matched' clinical or estates contracts between the two organisations[43]. These are contracts that appear to be for the same or similar goods and/or services. The total value of these matched contracts is around £2.8m. A 10% improvement in total cost as a result of the combined purchasing power of the integrated organisation and reduced duplication should be achievable and would equate to **£0.28m per year**.

13.3.5 Corporate hub

As part of the work to integrate corporate services (see section 13.3.1 above), there is a parallel piece of work to explore the creation of a single corporate hub as the central 'home' location for all corporate services in the integrated organisation.

Spencer House in Birchwood, Warrington, is the current BCH corporate headquarters. At present the building is under-utilised and regularly has significant space to accommodate more staff. Initial data and analysis suggests that the facility could accommodate all

[43] There are a further 36 'matched' contracts across corporate services but the cost, and therefore the opportunity, for financial improvement through these is included within the identified corporate services integration opportunity.

corporate teams from both WHH and BCH with minimal or no significant redesign. This would be achieved through a combination of expanding the current number of desk spaces at the facility and formalising agile working arrangements across all corporate teams. It would also require the creation of a small corporate 'hot desk' facility on the Warrington hospital site. This is described in more detail in section 18.6.1.

Co-locating all corporate functions would promote improved communication and connection between the various teams but it would also allow significant parts of the Kendrick wing space at Warrington hospital to be 'mothballed' in order to save money.

The impact of closing those spaces in Kendrick wing has been estimated to be around **£0.15m per year.** This is currently profiled as a financial opportunity in 2027-28.

13.3.6 Operational management structure

Phase two of the integration programme will see the integration of operational management structures currently overseeing the clinical services across both WHH and BCH.

The current annual budget (2025-26) for operational management teams across both trusts totals around £10m and includes 122 WTE staff.

A prudent estimate of financial improvement that can be made through the integration of the operational management structures would be **£0.1m per year**.

As mentioned above, both WHH and BCH have already launched MARS schemes to help create required vacancies across affected services. The true financial value and profile linked to this opportunity will be known when the MARS schemes in early 2026.

13.3.7 Estates rationalisation

Chapter 18 of this case illustrates the current use of estate by both WHH and BCH across Warrington and Halton. In line with the development of the new clinical strategy, phased estates plan (see section 18.9) and the emergence of a local vision for neighbourhood health, there will undoubtedly be opportunities for the integrated organisation to look at rationalising the use of its current hospital and community estate over the short to medium term.

As leases for community facilities come up for renewal, our intention would be to review the requirements for every facility. We will look at whether our use of estate can be rationalised to deliver improved financial efficiency without compromising on the need to maintain core acute services on the hospital sites whilst also looking to move more non-acute care services away from the hospital and into community and domiciliary settings.

The initial financial benefit associated with the rationalisation of estate is estimated to be **£0.2m per year** from 2027-28.

13.3.8 Other, as yet unquantified, opportunities for financial benefits

13.3.8.1 Community treatment rooms

BCH currently delivers a range of low-risk elective procedures directly from treatment rooms across both Warrington and Halton. A review of capacity and demand for these facilities could help identify opportunities for procedures currently undertaken in theatres or outpatient clinics on the hospital sites to be more appropriately undertaken in these community

facilities. This would create a financial opportunity around the use of the facilities potentially vacated by the shift of activity away from the acute setting.

13.4 Forecast medium-term financial outlook following integration

The table below shows the forecast abridged financial statements for the integrated organisation over the next three years assuming delivery of financial benefits as detailed in table 47 (above) and in line with all assumptions made in subsequent tables below.

£m	Actual	Actual	Actual	Underlying Position	Forecast	Forecast	Forecast
Abridged Income and Expenditure	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**
Income	444.06	458.05	499.55	491.70	478.68	498.60	505.34
Pay	(324.17)	(348.46)	(371.42)	(368.43)	(363.09)	(360.18)	(356.93)
Non pay	(122.53)	(134.42)	(148.80)	(147.90)	(144.64)	(143.22)	(140.24)
Non-operating expenditure	(3.89)	(3.45)	2.30	(5.85)	(7.16)	(8.39)	(8.70)
Surplus / (deficit) as per accounts	**(6.53)**	**(28.29)**	**(18.37)**	**(30.48)**	**(36.22)**	**(13.18)**	**(0.54)**
Adjustments to Financial Performance	(0.32)	(1.66)	0.39	0.56	0.56	0.56	0.56
Adjusted Surplus / (deficit)	**(6.85)**	**(29.95)**	**(17.99)**	**(29.92)**	**(35.66)**	**(12.62)**	**0.02**
Exclude Deficit Support Funding (DSF)	0.00	0.00	(16.50)	(18.33)	0.00	0.00	0.00
Adjusted Surplus / (deficit) Excluding DSF	**(6.85)**	**(29.95)**	**(34.49)**	**(48.25)**	**(35.66)**	**(12.62)**	**0.02**
Planned Surplus / (deficit)	(16.80)	(19.86)	(25.65)	(30.25)			

Abridged Balance Sheet							
Non-current assets	243.31	261.46	255.38	292.62	257.22	244.22	244.22
Current Assets	91.31	62.27	52.95	45.96	45.96	45.96	45.96
Current liabilities	(76.72)	(68.44)	(61.99)	(70.65)	(70.65)	(70.65)	(70.65)
Non-current Liabilities	(47.73)	(47.06)	(41.49)	(38.68)	(38.68)	(38.68)	(38.68)
Net Assets Employed	**210.17**	**208.22**	**204.85**	**229.25**	**193.85**	**180.85**	**180.85**
PDC	248.05	273.34	297.87	336.73	336.73	336.73	336.73
Revaluation Reserves	43.42	43.28	38.79	43.64	43.64	43.64	43.64
I&E Reserve	(81.31)	(108.41)	(131.81)	(151.11)	(186.77)	(199.39)	(199.36)
Total taxpayers and others' equity	**210.17**	**208.22**	**204.85**	**229.25**	**193.60**	**180.98**	**181.00**

Abridged Cashflow Statement							
Cash flows from operating activities	11.34	(9.19)	(1.14)	16.07	22.32	31.83	40.11
Cash flows from investing activities	(24.33)	(27.27)	(21.33)	(50.29)	(50.29)	(50.29)	(50.29)
Cash flows from financing activities	1.42	12.18	11.66	24.29	51.29	57.41	53.39
Net cash flow for the period	**(11.57)**	**(24.27)**	**(10.81)**	**(9.92)**	**23.32**	**38.95**	**43.22**
Cash and cash equivalents at start of period	70.81	59.24	34.97	24.15	14.24	37.56	76.51

Cash and cash equivalents at end of period	**59.24**	**34.97**	**24.15**	**14.24**	**37.56**	**76.51**	**119.73**

Table 48: Abridged summary forecast financial position post-integration

As shown by table 48, the integration is expected to support a reduction in the deficit in 2026-27 and 2027-28 and deliver a small surplus in 2028-29.

The joint BCH and WHH 2025-26 underlying position of £48.3m deficit (see blue cell in table) for the combined organisation is driven by:

- BCH position of £4.5m deficit
- WHH position of £43.8m deficit

Note: By taking the £48.3m combined underlying deficit figure above, adding back the delivery of internal and system-supported CIP in year 2025-26 (£21.5m WHH and £5.35m BCH) and then adjusting to reflect £3.1m of non-recurrent changes, you will arrive at the combined £72m planned 2025-26 deficit figure included in the strategic case for integration.

Table 49 below showing the key assumptions underpinning the financial modelling for the proposed integrated organisation is shown below.

Assumption	Assumption scope	2025-26	2026-27	2027-28	2028-29
Weighted inflation	Income	2.2%	0.0%	0.0%	0.0%
	Pay	3.3%	2.1%	2.1%	2.1%
	Drugs	0.0%	0.6%	0.6%	0.6%
	CNST	0.0%	0.5%	0.5%	0.5%
	Non-pay	0.6%	2.2%	2.2%	2.2%
	Capital charges	0.2%	1.7%	1.7%	1.7%
CIP Efficiency	Opex	5.0%	5.0%	5.0%	5.0%

Table 49: Key financial assumptions for the modelling of the integrated organisation

Table 50 below shows the assumed level of CIP delivery for the combined organisations within the future financial modelling.

£m	2025-26	2026-27	2027-28	2028-29
Recurrent CIPs				
Pay cost	16.1	14.7	12.3	13.2
Non-pay cost	3.6	5.5	5.3	5.1
Income	4.3	5.2	18.1	6.6
Total recurrent CIPs	**24.0**	**25.4**	**35.7**	**24.9**

Non-recurrent CIPs				
Pay cost	0.5			
Non-pay cost	1.0			
Income	1.5			
Total non-recurrent CIPs	**3.0**	**-**	**-**	**-**
Total CIPs	**27.0**	**25.4**	**35.7**	**24.9**

Table 50: Assumed level of CIP delivery for the combined organisations over medium term

Figure 30 below shows the summary financial bridge diagram illustrating how the integrated organisation plans to move from a position of a £48.3m underlying deficit at the end of 2025-26 to a small surplus/break even position by the end of 2028-29.

The blue bar on the diagram constitutes the £8.4m anticipated financial improvement to be made as a direct result of the integration.

The orange bars illustrate where some of the non-direct benefits of the integration programme will support delivery of further financial improvement.

The integration of WHH and BCH is a critical enabler to both organisations' journey to financial sustainability over the coming years.

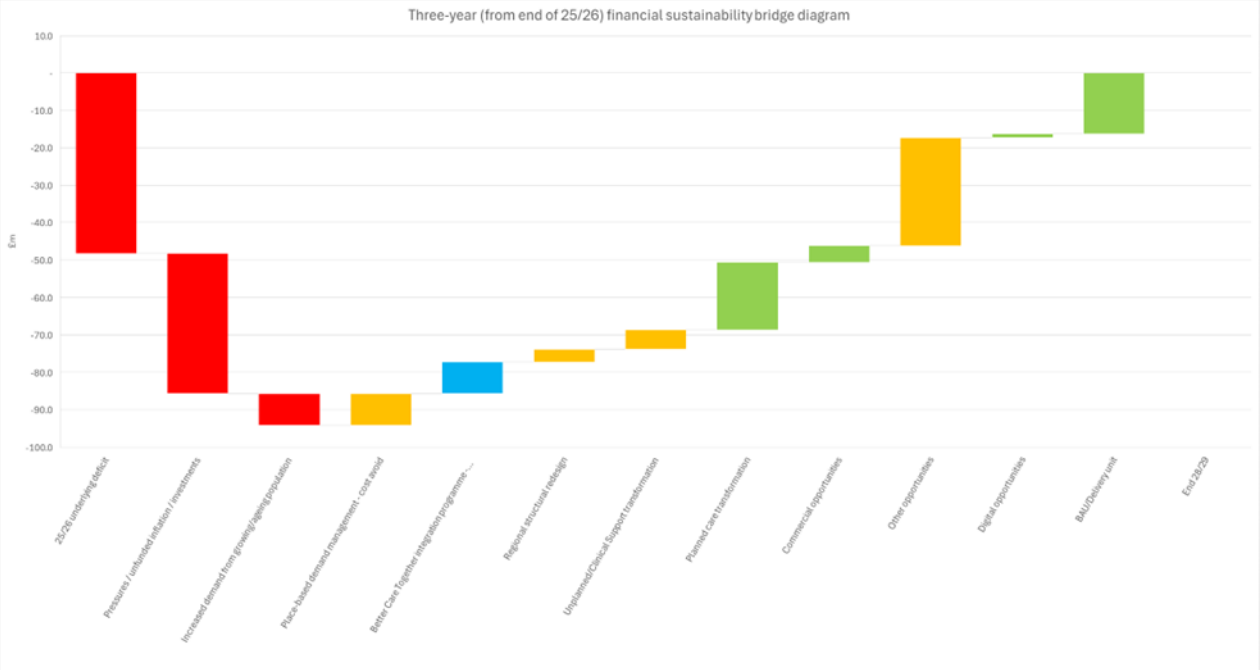


Figure 30: High-level financial sustainability bridge for the integrated organisation from the end of 2025-26 to the end of 208-29

13.5 Costs associated with integration

Table 51 below details and profiles the total additional anticipated costs (i.e. not absorbed by the trusts) associated with the integration programme totalling **£1,104,000**.

Programme requirement (additional)	Costs to be incurred during phase one of integration programme (2025-26)	Costs to be incurred during phase two of integration programme (2026-27)	Total additional costs anticipated
Programme leadership and programme management support	£0	£0	£0
Finance costs to support to the programme	£100,000	£40,000	£140,000
Communications and engagement costs to support to the programme (including signage)	£86,000	£24,600	£110,600
Dedicated clinical leadership to the programme	£0	£0	£0
External consultancy support to the programme	£415,000	£0	£415,000
Legal advice and support	£90,000	£50,000	£140,000
IT and system realignment costs	£97,500	£0	£97,500
Other costs	£80,000	£120,900	£200,900
Total anticipated additional programme costs	£868,500	£235,500	£1,104,000

Table 51: Estimated programme costs associated with each phase of the integration programme vs total costs identified to date

14.0 Inequalities

14.1 Chapter summary

This section highlights the trusts' joint commitment to tackling health inequalities across Warrington, Halton and the wider system, addressing six priority areas:

- Restoring NHS services inclusively – after the COVID-19 pandemic
- Mitigating against digital exclusion
- Ensuring data sets are complete and timely
- Accelerating preventative programmes
- Strengthening leadership and accountability
- Tackling workforce inequalities

It identifies the current variation in health outcomes and access to services across communities and outlines how integration will enable targeted, data-driven interventions.

The section aligns with the NHS Core20PLUS5 framework, focusing on reducing unwarranted variation, improving prevention and supporting inclusive workforce practices.

It reinforces how integration provides the platform to address structural barriers to equity and deliver measurable improvements in population health outcomes.

Key message: Integration is a powerful enabler of equity and local data has suggested significant challenges across our local population including a growing number of children and young people requiring mental health support; a growing ethnic minority population with language barriers and digital exclusion hindering preventative treatments; and bullying, isolation, and unmet mental health needs within the LGBTQ+ community to name a few.

By aligning community and acute services, the new organisation will target the root causes of inequality, deliver prevention-focused care, and strengthen partnerships with local authorities and the voluntary sector to close health gaps across populations.

14.2 Overview

This section outlines how the trust is identifying and responding to health inequalities, using national dashboards and local data to target interventions in priority wards. It summarises variation in avoidable hospital admissions (ACSC rates) and inequality gradients (AGI values) across Halton and Warrington, highlighting areas of greatest need and opportunity for impact. This insight is being used to inform service redesign and transformation programmes as part of the clinical integration workstream.

System-wide opportunity through integration:

- The integration of WHH and BCH enables a more cohesive, place-based approach to tackling inequalities, particularly through stronger integration with primary care networks, community assets and neighbourhood teams.
- The most recent joint strategic needs assessments (JSNAs) for Warrington and Halton emphasise the importance of joined up working across sectors to address complex and overlapping health needs. This creates opportunities to align transformation efforts and reduce duplication across acute and community settings.

Population contrasts:

- Warrington is growing and becoming more diverse, with 11.9% of residents from minority ethnic backgrounds and notable growth in eastern European communities. This demographic shift highlights the need for culturally responsive services and inclusive communication strategies.
- Halton has higher levels of deprivation, poorer health outcomes and lower ethnic diversity (~4.5%), with multiple communities ranked among the top 10% most deprived nationally. This reinforces the need for targeted interventions in priority wards and tailored support for communities facing multiple disadvantages.

Unplanned vs planned care:

- Both Warrington and Halton Joint Strategic Needs Assessments (JSNAs) highlight that residents in more deprived areas are more likely to access care through emergency departments and less likely to engage with preventative or planned services. This pattern reflects barriers to early intervention and continuity of care, particularly in areas with lower health literacy or limited access to primary care.
- The trend is especially pronounced in Halton, where urgent care use is higher and avoidable admissions are more frequent. This underscores the importance of proactive, community-based approaches to reduce reliance on emergency services and improve long-term outcomes.

The creation of an integrated trust serving both Warrington and Halton must navigate divergent health needs, access patterns and community assets. The integration presents a strategic opportunity to:

- align acute and community services to reduce fragmentation and improve continuity of care
- target resources proportionately, recognising Halton's deeper deprivation and Warrington's growing diversity
- embed equity into service design, ensuring that care models reflect local population profiles and lived experience
- leverage combined data intelligence to identify risk, predict demand, and personalise interventions

As an integrated trust (with a reach across both community and acute) we will seek to create seamless pathways and work more closely with the neighbourhood teams and our PCNs. We know this will provide a more holistic service for our populations and we will take strides to reduce inequalities in relation to access and prevention.

As NHS organisations it is very easy to talk about 'hard to reach' groups, or communities that are not 'engaging' in healthcare, or accessing in the ways it has been designed. However, these communities more often than not know what it is that they need, and have made a very valid decision based on their circumstances about how they are going to access care, and whether they have the resources or the time to engage in healthy living activities.

Both organisations are already involved in advancing focused work with our communities, and we expect that this progress will be advanced as we become a single organisation.

14.3 Key priority areas for reducing inequalities

NHSE sets out five key priority areas for reducing inequalities in healthcare which underpin the work of the National Healthcare Inequalities Improvement Programme (HiQiP). These were reinforced through the 2024-25 NHSE priorities and operational planning guidance, and they include:

- Restoring NHS services inclusively – after the COVID-19 pandemic
- Mitigating against digital exclusion
- Ensuring data sets are complete and timely
- Accelerating preventative programmes
- Strengthening leadership and accountability

Through our joint Health Equity Group we agreed to add a sixth priority area:

- Tackling workforce inequalities

These six priorities provide a useful framework for our plan to reduce inequalities in our local population, with the BCT programme a key enabler for positive change.

We are working closely with NHS Cheshire and Merseyside ICS, and both WHH and BCH are key stakeholders in the Warrington and Halton Place Boards. These Boards are driving transformative change in services and patient outcomes, informed by insights from the Marmot altogether fairer report and Core20PLUS5 framework in Cheshire and Merseyside.

WHH and BCH are also making use of resources from public health teams at Cheshire and Merseyside ICS, local authorities, and national tools such as the CIPHA dashboards and the NHS England health inequalities improvement dashboard, to guide and focus our programme of work on reducing inequalities and improving outcomes.

14.4 Deprivation and links to health service use

Details about our local populations and some of the high-level statistics about deprivation and life expectancy are included in chapter 5 of this document. These deprivation patterns are also heavily reflected in health service use.

Ambulatory care sensitive conditions (ACSCs) are health conditions such as asthma, diabetes or heart failure that can often be managed safely at home or in the community, without needing emergency hospital care. The rate of ACSCs tells us how many people per 100,000 population were admitted to hospital for these conditions.

AGI (absolute gradient of inequality) shows how unevenly avoidable hospital admissions are spread across different neighbourhoods. A higher AGI means a bigger gap between the most and least deprived areas.

Halton has an ACSC rate of 3,236 per 100,000 population and an AGI of 4,389, indicating both a high burden of avoidable hospital admissions and a steep inequality gradient. This means that in Halton, people in more deprived areas are far more likely to be admitted for ACSCs than those in better-off areas. Halton has both a higher overall burden of avoidable hospital admissions and greater inequality in who is affected.

Warrington's ACSC rate is 1,921 per 100,000, with an AGI of 1,309, suggesting lower overall demand and moderate inequality in access and outcomes.

In both areas, but particularly in Halton, there is a strong case for targeted health and wellbeing interventions – such as neighbourhood primary care interventions, health literacy support, and outreach in priority wards.

As outlined earlier in the section describing the clinical vision, the integration of the community and acute trusts will allow us to accelerate work in this area, including through the adoption of neighbourhood hubs as a vehicle for intervention.

14.5 Priority wards for intervention

The national health inequalities dashboard has identified small areas (wards or neighbourhoods) within Warrington and Halton where people are more likely to experience avoidable health problems – especially those that lead to emergency hospital visits. These areas are flagged as a priority because they show:

- high rates of unplanned hospital admissions, especially for conditions that could be managed earlier or in the community (like asthma, diabetes, or heart failure)
- wider health inequalities, often linked to deprivation, ethnicity, or access to care

In Warrington, these areas include:

- Fairfield and Howley
- Birchwood
- Poulton North
- Burtonwood and Winwick

In Halton, these areas include:

- Halton Lea
- Appleton
- Ditton, Hale Village and Halebank

The areas above include a number of the most deprived areas within our local catchments. Deprivation is strongly linked to mental health need, substance misuse, housing insecurity, and child poverty – all of which compound health inequalities.

Deprivation intersects with other factors – ethnicity, gender, disability, LGBTQ+ identity and age – to deepen exclusion and reduce access to care.

Residents in deprived areas often feel disconnected from mainstream services, citing lack of trust, cultural relevance and continuity. This disconnect reinforces cycles of poor engagement and unmet need, particularly in areas with high AGI and ACSC rates. The opportunity to create a new community-focused model of care to provide greater reach into these areas is both exciting and also necessary.

14.6 Local challenges around health inequalities

The following sections detail some of the most significant health and wellbeing challenges across our local populations in Warrington and Halton. The opportunities to transform how care is delivered and make a significant impact on the lives of the local population are clear to see.

14.6.1 Children and young people (CYP)

- Halton has higher levels of child poverty, with several wards in the top decile of deprivation nationally. This is linked to poorer educational outcomes, increased safeguarding concerns, and higher rates of mental health need.
- Warrington shows growing diversity among CYP, particularly in urban wards, with increasing demand for culturally responsive services.
- CYP in both Places face rising mental health needs, including anxiety, depression, and self-harm – exacerbated by post-pandemic disruption and digital pressures.
- Halton reports higher rates of obesity, dental decay and hospital admissions for asthma and respiratory conditions.
- Warrington's JSNA highlights gaps in neurodevelopmental pathways, including ADHD and autism diagnosis delays.
- CYP from deprived backgrounds are less likely to access early help and more likely to present in crisis.
- SEND services face pressure across both Places, with long waits and fragmented transitions to adult care.
- Young carers, care-experienced children, and those from minority ethnic groups often fall through the cracks of mainstream provision.

14.6.2 Men

- The JSNAs and supporting public health intelligence indicate that men are less likely to engage with preventative services, have lower health-seeking behaviours, and are overrepresented in emergency care settings.
- In Halton, men have lower life expectancy and higher rates of premature mortality, particularly from cardiovascular disease and cancer.
- Non-attendance patterns are not always broken down by gender in JSNA summaries, but broader NHS data and local audits suggest that men are more likely to miss outpatient appointments, especially in deprived areas.

14.6.3 Women

- In both Places, women live longer than men but spend more years in poor health, especially in later life.
- Healthy life expectancy for women is lower in Halton (~62.1 years) than in Warrington (~64.8 years), and both trail national averages.
- Women in deprived areas experience earlier onset of long-term conditions, including musculoskeletal disorders, mental health issues and cardiovascular disease.
- Women are more likely to be primary carers, which can limit their ability to attend appointments or prioritise their own health.
- In Halton, women in deprived areas are less likely to engage with preventative services (e.g. cervical screening, contraception reviews).
- In Warrington, language barriers and digital exclusion affect access for women from minority ethnic backgrounds, especially in Eastern European, Black African and Caribbean and South Asian communities.
- Halton JSNA highlights gaps in perinatal mental health support, especially for younger mothers and those experiencing domestic abuse.
- Warrington's JSNA notes rising demand for fertility, menopause, and gynaecological services, with variation in access by geography and ethnicity.

14.6.4 Ethnic minorities

- Warrington has a growing ethnic minority population, with 11.9% of residents identifying as non-White British. This includes significant Eastern European, South Asian, and Black African communities, particularly in central and southern wards.
- Halton remains less diverse, with around 4.5% of residents from minority ethnic backgrounds. However, Gypsy, Roma, and Traveller (GRT) communities are specifically noted in the JSNA as experiencing entrenched inequalities and poor access to services. Whilst Warrington JSNA does not specifically highlight Gypsy, Roma and Traveller communities, recent outreach to two sites in Warrington has highlighted similar levels of inequalities and poor access to services.
- Ethnic minority residents in both Places face disproportionate barriers to accessing care, including:
    - language and literacy challenges
    - digital exclusion
    - cultural stigma around certain conditions (e.g. mental health, reproductive health)
    - lower trust in services, especially among newly arrived or marginalised groups
- These barriers contribute to a lower uptake of screening, higher rates of late diagnosis, and a greater reliance on urgent care pathways.
- Many services do not consistently record ethnicity, limiting our ability to tailor care and track outcomes.
- Ethnic minority communities are often underrepresented in patient feedback, co-production panels, and strategic decision-making forums.

14.6.5 LGBTQ+

- LGBTQ+ residents in both Places face disproportionate health inequalities, often rooted in stigma, discrimination and systemic exclusion.
- National and local evidence shows higher rates of:
    - mental health challenges (e.g. anxiety, depression, self-harm)
    - substance misuse
    - barriers to accessing primary and preventative care
- Trans and non-binary individuals experience particularly poor outcomes, including delays in gender-affirming care and lack of inclusive service environments.
- Sexual orientation and gender identity (SOGI) data is inconsistently recorded across services, limiting visibility and accountability.
- LGBTQ+ communities are often underrepresented in patient feedback, engagement panels, and strategic decision-making forums.
- LGBTQ+ people who are also ethnic minorities, disabled or living in deprivation face compounded barriers to care. Young LGBTQ+ people in Halton and Warrington report bullying, isolation and unmet mental health needs, especially in school and family contexts.

14.6.6 Veterans

- Warrington and Halton are home to a significant number of Armed Forces veterans, including older adults, reservists and those recently discharged.
- Many veterans live in deprived areas, and some face challenges related to housing, employment, mental health and physical rehabilitation.

- Veterans may not always self-identify in healthcare settings, leading to under-recognition of their needs.
- Veterans are more likely to experience:
    - mental health conditions, including PTSD, depression, and anxiety
    - musculoskeletal injuries and chronic pain
    - substance misuse and social isolation
- Access barriers include:
    - stigma around help-seeking
    - fragmented care pathways between military and civilian services
    - limited awareness among staff of veteran-specific entitlements and needs

14.7 Integrated, Place-based care as an enabler for change

The integration between WHH and BCH creates opportunities for the development of seamless care pathways across hospital and community settings, with multidisciplinary teams delivering wraparound support closer to home.

Our medium to long-term clinical vision (described in chapter 10) is to develop neighbourhood-based models of care, building on the successes of collaborative projects like the Living Well Hub and looking to expand this approach into other localities. This allows us to embed trauma-informed, culturally competent, targeted care for disadvantaged groups closer to where they live and help prevent deterioration of health conditions and reduce the number of people reaching crisis point.

The following sections describe how the integration programme can become a key enabler for change linking back to the priorities outlined in section 14.3:

14.7.1 Priority 1: Restore NHS services inclusively

We will review opening hours, locations and transport links to ensure services are accessible, especially for those in deprived areas. We will consider delivery of services from community hubs across all of our places, as these develop as part of a neighbourhood health agenda locally. We will consider public transport routes and work with local authority partners to ensure access to locations is as good as possible.

We will adopt a population-health approach to service planning and delivery, looking to deliver targeted services in locations where specific health outcomes are notably worse than other areas. Where possible, we will look at ways to extend access for particular groups living in the most deprived areas, where engagement tells us that those communities experience difficulties in accessing services in certain facilities or at certain times.

The two trusts are already working closely in partnership in delivering from shared community spaces, including the Living Well Hub in Warrington.

14.7.2 Priority 2: Mitigate against digital exclusion

Increasing the use of our patient portal will be a priority for the integrated trust – but also giving patients help to access and use it, regardless of language need. In order to support patients with accessing the portal, we will explore an on-site presence in our clinics to show patients how to access appointments, letters and test results.

We will ensure we make full use of text reminders for appointments, but also give patients the ability to change/cancel appointments via the patient portal – so they don’t have to spend

money waiting for a long time on the phone to speak to someone, to cancel or re-arrange an appointment that they cannot make because it doesn't fit with when their carer is available, or their working hours, for example.

Alongside partners at Place, we have recently invested UK Shared Prosperity Fund (UKSPF) funding to upgrade digital infrastructure in a number of community locations across Warrington. This ensures residents have places they can use to access digital health and wellbeing services if they are unable to access them at home.

14.7.3 Priority 3: Ensuring datasets are complete and timely

We are working with other NHS trusts across Cheshire and Merseyside to create a dashboard on the CIPHA platform (a Cheshire and Merseyside specific population health database) that is transparent and easy to use. It will combine our acute and community datasets to build a richer, place-based understanding of need – enabling predictive modelling, targeted outreach, and real-time monitoring of Core20PLUS5 populations.

Shared analytics will support proactive identification of patients at risk of poor outcomes, especially those facing digital exclusion, housing insecurity, or multiple long-term conditions. For example, we are trialling using the data we have available to carry out active case finding of undiagnosed COPD patients to enable early outreach and support.

14.7.4 Priority 4: Accelerate preventative programmes

The integration enables seamless care pathways across hospital and community settings, with multidisciplinary teams delivering wraparound support closer to home.

We will look to expand the model of co-locating connected services, making early support easier to find and easier to access for those who may need it.

In March 2025, we launched the Living Well Warrington digital platform[44] in partnership with numerous stakeholders from across Warrington. The new platform further strengthens the local offer around prevention, early intervention and empowering self-care through a 'community-led' approach. It empowers users to navigate their health and wellbeing journey more independently as the single digital entry point for any health and wellbeing-related enquiries for the whole of Warrington.

As at the end of September 2025 the platform included almost 700 individual support services and events on offer across the town and had received over 93,000 individual views.

14.7.5 Priority 5: Strengthen leadership and accountability

Each executive director in the new integrated organisation will have personal objectives to tackle health inequalities. This is a model that WHH executive directors currently follow.

We will explore the new integrated trust Board taking responsibility for overseeing the health inequalities plan, and the chair and each non-executive director will oversee components of the strategy.

The integration strengthens our role as an anchor institution within Warrington and Halton, deepening collaboration with local authorities, voluntary sector partners and the ICS.

[44] Living Well Warrington (2025) *Live well in Warrington*. Available at: www.livingwellwarrington.org

We will co-deliver population health programmes, support inclusive economic development, and embed community voice into governance and service design.

14.7.6 Priority 6: Tackling workforce inequalities

Working as an integrated organisation, the combined trust will extend already developed programmes supporting staff in a variety of areas, including:

- mental health and wellbeing – counselling placements within mental health wellbeing hub to support staff
- occupational health and support – occupational health pre-employment process updated to reflect workforce needs aligned to the workforce equality and diversity and inclusion strategy
- reasonable adjustments – signposting to Maximus, an access to work mental health provider to support individuals with long term mental health conditions. Implementing a passport to support staff with the resources to remain in work and thrive
- prevention programmes – multiple prevention programmes and packages delivered focused on cardiovascular disease, menopause, mental wellbeing and musculoskeletal conditions

15.0 Communications and engagement

15.1 Chapter summary

This section describes the comprehensive engagement undertaken with staff, patients, system partners and the public throughout the integration process.

It demonstrates how both trusts have embedded transparency, inclusivity and co-production into all communications activity, aligned with the Better Care Together communications and engagement plan.

The section evidences the ongoing collaboration with local authorities, primary care, voluntary and community sectors, and NHS England. It highlights the success of staff engagement sessions, leadership forums and stakeholder briefings in building shared understanding and support for the transaction, ensuring that change is developed with, not for, our people.

Key message: Continuous open communication has been fundamental to this programme's success. Alongside the patient experience team, we are working in partnership with Health Watch to ensure service users and partners have their voice heard and that it is central to our developing clinical integration workstreams and joint strategies.

We are continuing with stakeholder engagement meetings, events and activities, ensuring that the insight we gather informs our integration plans. This has been carried out through a wide variety of channels, including websites, video content, case studies, social media channels, patient and public engagement sessions and surveys to ensure local people are aware of our plans to integrate, our name change, and the key messages that support our future as one organisation.

15.2 Approach to communications and engagement

There is a programme for ongoing two-way stakeholder communication and engagement regarding our partnership and the planned integration of the two organisations. An established and embedded communications and engagement plan has been developed and is being implemented to help us achieve the following:

To communicate proactively and inclusively about the integration to help both trusts come together as one new organisation, supporting colleagues and ultimately improving patient care.

This plan will therefore enable audiences to:

- engage with or understand changes in patient pathways and service improvements
- participate in or be informed about the integration process
- recognise integration benefits and have opportunities to ask questions and receive answers

Our communications and engagement objectives are to explain how, in collaboration with local partners, patient pathways are being improved to deliver integrated, comprehensive care that meets identified needs. This is achieved by the following:

- outlining how integration supports this
- detailing anticipated impacts of the integration for staff and communities
- summarising the steps taken toward integration and noting key milestones

Further to the points mentioned above, we will also:

- share information transparently about emerging issues and respond to stakeholder queries
- ensure stakeholders understand how they can contribute their views, and clarify actions taken in response to feedback
- offer stakeholders accessible information and opportunities for engagement through appropriate channels
- make certain that patient and public perspectives are included in the development of patient pathways, and that they participate in changes affecting them

Our communications and engagement plan can be found within the supporting documents to the FBC.

15.3 Communication and engagement principles

At the heart of the developed communications and engagement plan, several well-established communication principles known to the NHS are used and embedded. These are as follows:

1. **Clarity and trust**

With the need to engage a broad audience, clarity and trust are essential to achieving our communication goals. Alongside the 'Seven Cs of effective communication' – clear, concise, concrete, correct, coherent, complete, and courteous – our messaging about Better Care Together must be strongly aligned with our key messages and personalised for different audiences.

We must be open and honest in line with our values to help build trust, communicating as much as we can, as soon as we can.

2. **Compassionate and reassuring language**

Change can often feel unsettling. A new partnership like this one may raise concerns about forced changes or, in the worst case, job security. Our language should reassure both colleagues and patients that they play a vital role in our mission and that we are working with them and for them, not against them.

We should select language that resonates with each audience, avoiding a one-size-fits-all approach. For internal communications with staff, consistency in language across both organisations is imperative.

3. **Aspirational yet realistic**

Our language should inspire hope and a sense of purpose, using active terms like 'building', 'strengthening', 'combining', and 'flourishing' to convey positivity, dynamism and purpose.

While Better Care Together is ambitious, aimed at long-term sustainability for our colleagues and patients, our communication must strike a balance between being aspirational and realistic. We should communicate our goals and processes in a way that is inspiring, beneficial and grounded in reality.

4. **Accessible and timely**

Information about Better Care Together should be available in various formats to ensure that all audiences can access it in the way that suits them best. Urgent or important information

must be communicated internally within both organisations at the same time. Less important information should be timed to be issued as closely together as possible.

We commit to communicating internally with our staff before we communicate externally, so that staff hear news from us first, and not from external sources.

5. **Start with people**

Collaborative and meaningful partnerships should start with people and focus on what really matters to our communities and staff. There are clear benefits to working in partnership with people and communities:

- better decisions are made about service changes and how money is spent
- reduced risks of legal challenges
- improved safety, experience and performance
- helps address health inequalities by understanding communities' needs and developing solutions with them

It is about shaping a sustainable future for the NHS that meets people's needs and aspirations. We commit to effective engagement with staff, stakeholders and communities, including people with lived experience.

6. **Close the loop**

Clear and consistent communication is essential for effective engagement. Beyond encouraging staff and patients to voice their opinions, our communications and engagement activity should also 'close the loop', clearly demonstrating how their input has influenced the outcomes of this new way of working together.

This applies not only when feedback has been implemented but also when we cannot make changes in line with the feedback received.

Our communications and engagement work is further guided by the following ideologies:

- leadership is demonstrated through visible executive and clinical involvement
- messaging remains consistent across both trusts
- we maintain openness about each stage, acknowledging challenges honestly
- patient and public feedback informs integration plans
- we clearly communicate the benefits of change

Our communications and engagement plan aims to keep staff, stakeholders, patients and the public informed about our joint work, including:

- progress in partnership arrangements with real-life benefits
- options considered for moving forward and reasons for integration, focusing on patient, community and staff advantages
- impact of changes on colleagues, services and local residents
- support for teams and individuals during adjustments, especially with new working arrangements
- integration of strengths from both trusts to maintain excellent care

Our staff engagement initiatives are designed to further cultivate a unified organisational culture by facilitating consistent communication on integrated working, as well as coordinating collective events and activities such as the annual staff Thank You Awards, health and wellbeing programmes, and streamlined internal communications.

We are committed to actively listening to our staff, patients, the public and stakeholders, ensuring that the insights gained through our communications and engagement efforts directly inform the development of our integration strategies.

15.4 Key messages for the integration

Strong narrative and key messages are fundamental to all communication activity relating to our integration programme. Overarching messages form the basis of our communication with different stakeholder groups and are tailored as the integration progresses and for specific audiences and different communication channels/formats.

In line with our communications and engagement principles, the key messages (as outlined below) need to:

- be repeated often so that they become embedded in people's minds
- be simple and memorable so that they can be recalled and repeated

	Key message 1 (why) We want to provide better care together	Key message 2 (what) We are joining forces and working as one	Key message 3 (how) With shared leadership, we are integrating our services
Supporting messages	Warrington and Halton need strong and resilient clinical services	Together we will improve healthcare services for our communities	We have a joint CEO and shared executive team
	Our healthcare system must be sustainable for the future	We'll involve staff, partners and people with lived experience	We've established an integration programme called Better Care Together
	We can achieve more together for patients and staff	We will work and behave as a single organisation	We need your support to make it a success

Table 52: Our key message grid

This is articulated in narrative form as:

We want to provide better care together. Warrington and Halton need strong and resilient clinical services, and our healthcare system must be sustainable for the future. We know that we can achieve more together for both our patients and staff.

We are joining forces and working as one. Together we will improve healthcare services for our communities. We'll involve our staff, partners and people with lived experience and we will work and behave as a single organisation.

With shared leadership, we are integrating our services. We have a joint chief executive and a shared executive team. We've established an integration programme called Better Care Together and we need your support to make it a success.

In addition to the key message grid, early messaging related to integration was published on our respective websites.

As the integration journey progresses, a dedicated partnership website has also been created and is available at NHS North Cheshire and Mersey Partnership.

A full staff microsite for the partnership has also been created for WHH and BCH colleagues. Like the partnership website, the dedicated staff microsite also contains a wealth of information from the latest integration news to frequently asked questions.

Over the past year we have engaged extensively with colleagues, partners, governors, patients and members of our local community regarding our strategic direction and the role our integration plans will play as a catalyst for positive transformation.

Our focus is now shifting towards a comprehensive information and awareness campaign designed to ensure that our integration into a new single organisation, its forthcoming name change and supporting key messages reach as many local residents as possible in the wide-ranging communities we serve.

This campaign will incorporate a variety of communication channels, including website updates, social media posts, digital screens, media releases, posters and short-form video content to name but a few. Any campaign will continue to be fluid in nature and will adapt as the need requires.

15.5 Clinical integration workstreams: Patient engagement and involvement

An early deep dive into patient engagement and involvement of each trust was undertaken at the very beginning of this integration journey. This helped set a benchmark of any potential gaps in assurance so these could be focused on quickly and efficiently.

From a BCH perspective, engagement and involvement is currently overseen by the Bridgewater Engagement Group. This includes patient, carer, public and staff engagement and includes public governors and representation from both Healthwatch Halton and Healthwatch Warrington. The main vehicles for supporting and facilitating co-design and involvement in projects within clinical services are through local patient partner projects.

Within WHH, engagement and involvement activity is co-ordinated within the Communications and Engagement Team, in partnership with clinical and corporate teams. Assurance on patient and public engagement and involvement activity is also provided through bi-monthly high level briefing papers to the WHH patient experience and inclusion sub-committee and reporting to Board.

The main vehicle for supporting and facilitating co-design and involvement of service users, carers and advocates within projects and future developments is WHH's lived experience volunteer programme (Experts by Experience).

Foundation trust public governors are engaged through the respective Council of Governor meetings, WHH's Governor Engagement Group and BCH's Public and Community Engagement Group and via sharing information with foundation trust members through regular member newsletters.

Taking the above sovereign engagement channels into account, a community stakeholder mapping exercise has been completed, with the following being identified as key patient and public stakeholders.

People and carers:

- patients / people
- carers / guardians
- advocates
- families

- patient groups
- advocacy / support groups representing people with protected characteristics
- WHH Charity
- Warrington League of Friends
- Voluntary, Community, Faith and Social Enterprise (VCFSE) networks
- community groups
- Patient Advice and Liaison Service (PALS)
- volunteers
- Experts by Experience / Patient Partners
- Patient Safety Partners
- veterans / armed forces members
- wellbeing services (local authority commissioned)
- hospital radio stations (ref HWH segment on Radio Halton)
- Wheelchair Users Group (St Helens)
- local authority engagement networks, including those for marginalised/under-served communities

Influencers:

- Healthwatch organisations (Warrington and Halton)
- MPs
- councillors
- media/comms colleagues
- public and partner governors
- foundation trust members

Following this stakeholder mapping exercise, our approach to patient engagement and involvement is clear:

1. We have established a BCT patient and public reference group (PPRG), independently chaired by our local Healthwatch partners, which will formally report into the BCT programme delivery group. This group will tap into wider engagement networks and will help act as a critical friend to ensure that the voice of our patients and local public is heard. The first meeting of the PPRG is to take place in November 2025.

2. We will provide wider opportunities for local people to hear about our integration plans directly from senior leaders. We will support opportunities to ask questions, make suggestions and share thoughts and concerns, ensuring these are shared across the wider integration programme. Feedback received to date from our local public about the integration programme can be found later in this chapter and in the supporting evidence.

3. We will engage and consult as required on specific changes to clinical services which impact on how people and communities in the core areas of Warrington and Halton access services across both BCH and WHH.

4. We will engage with people and communities regarding services delivered outside of Warrington and Halton and over our wider geographical footprint:

    - BCH Community Dental Services (Bolton, Bury, East Cheshire, Halton, Heywood, Middleton, Oldham, Rochdale, Sandbach, St Helens, Stockport, Tameside and Glossop, Trafford, Vale Royal area of Cheshire, Warrington, Western Cheshire and Chester and Wigan Borough)

- WHH Breast Screening Services (Warrington, Halton, St Helens and Knowsley)
- BCH services delivered in St Helens (paediatric audiology/hearing screening, Community IPC, Community Equipment Service, Occupational Therapy for Assistive Technology, Wheelchair Service)
- BCH Drive Ability North West

15.6 Integration of clinical and operational pathways

The progress to date around identifying priority clinical services for integration is described in detail in section 10.5.2. Public, patient and partner involvement will continue to be crucial in the next steps of the integration journey.

To support this activity and to ensure meaningful engagement informs any changes to services, patient and public engagement support will be provided via the BCT communications and engagement workstream. This will involve:

- support to inform the completion of an Equality and Health Inequalities Impact Assessment for each element of proposed change
- delivering a programme of in person and online awareness sessions for staff: 'Engagement, involvement and public consultation duties in service change'
- updated online 'equality and health inequalities assessment (EHIA)' training to include engagement, involvement and public consultation duties in service change
- identification of key partners and stakeholders to involve in the development of proposals for change
- benchmarking of patient experience metrics
- identification and facilitation of appropriate mechanisms for engagement and involvement of patients and communities using the approaches outlined earlier in this section

15.7 Stakeholder communication and engagement methods

Keeping in line with our communication principles and overarching communications and engagement plan, our stakeholder map helps us to ensure we are communicating and engaging regularly with stakeholders.

15.7.1 Engagement tools

We have kept colleagues, partners and the public informed about our vision to improve health outcomes by removing and respective organisational barriers to integration.

In addition to using our usual and well-established communication channels, we continue to develop new resources to keep everyone updated and expand our audience reach where possible. A joint communications channel matrix can be found in the supporting documents to this FBC.

In addition to the matrix, several channels are highlighted in greater detail as follows:

a) Public website

As integration progresses, and communication becomes more coordinated between both organisations, a dedicated partnership website has been created.

This website contains a wealth of information to the public and wider stakeholders, such as information about the integration journey, frequently asked questions (FAQs) and latest

news. The NHS North Cheshire and Mersey Partnership address will subsequently transform into our newly integrated public-facing website once the transaction is complete.

During this time of transition, each sovereign organisation will continue to promote the partnership website and will signpost to it from their respective site.

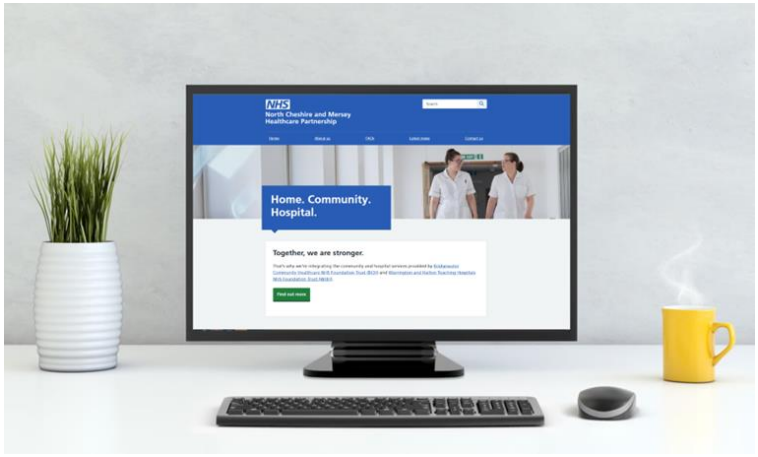


Figure 31: The public facing partnership website

b) Staff microsite

A bespoke staff microsite was created at the very beginning of our integration journey. Its purpose was to reduce duplication of resources and stop any potential misinformation between the two organisations, but more importantly a sole microsite would mean us having one consistent and strong message.

The staff microsite continues to grow in popularity and is very much the ‘go to’ destination for the latest information on integration. As such, it is promoted heavily at every opportunity.

The site contains sections such as information about the integration, details about the various programme workstreams, frequently asked questions, case studies and resources.

Alongside the joint staff microsite, a communication channel matrix has been developed to document the existing sovereign channels for each organisation and outline intended steps to integrate these channels. This matrix can be found in the supporting evidence section of this document.

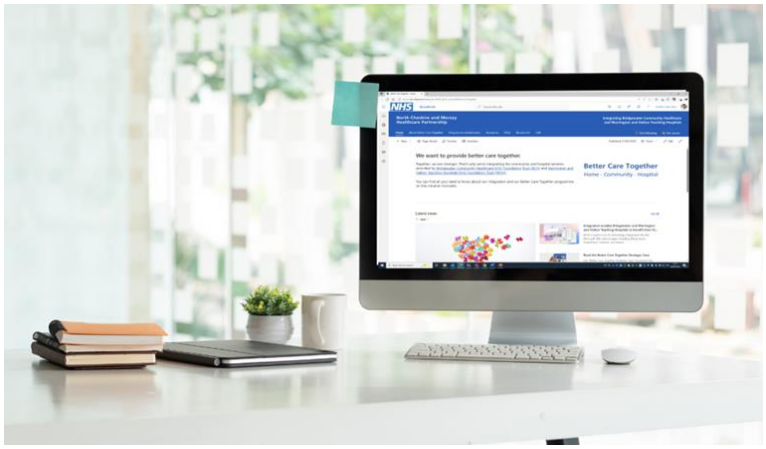


Figure 32: The staff facing microsite

c) Monthly staff engagement briefings

Since February 2025, we have held monthly one-hour staff engagement sessions to update staff on the Better Care Together programme and provide a forum for questions.

These well-attended sessions now include spotlights on relevant topics such as the joint culture plan and organisational change framework. Event details and joining links are shared in advance on the staff microsite and promoted through all communication channels.

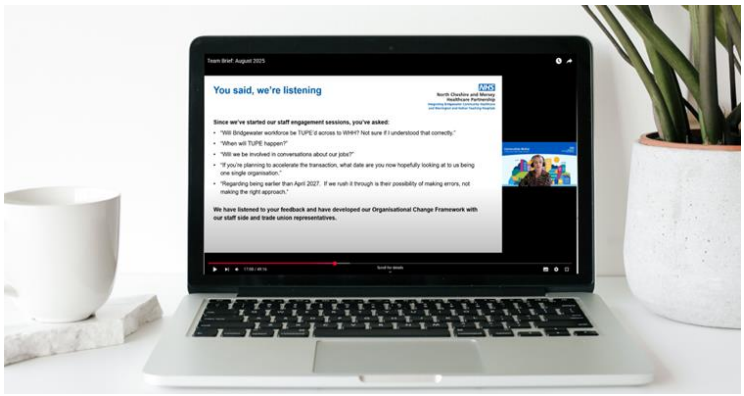


Figure 33: An example of the monthly staff engagement session

d) Partnership stakeholder update

Our joint partnership newsletter is continually evolving and distributed to stakeholders on a monthly basis.

In addition to providing updates regarding the progress of our integration efforts, the newsletter highlights broader initiatives and demonstrates areas where services and pathways have started to converge to enhance patient care and expand staff development opportunities.

This regular communication serves to illustrate the value of integration by presenting concrete examples of the advantages associated with collaborative working, thereby offering stakeholders insight into how these changes may positively influence both the provision and experience of care.

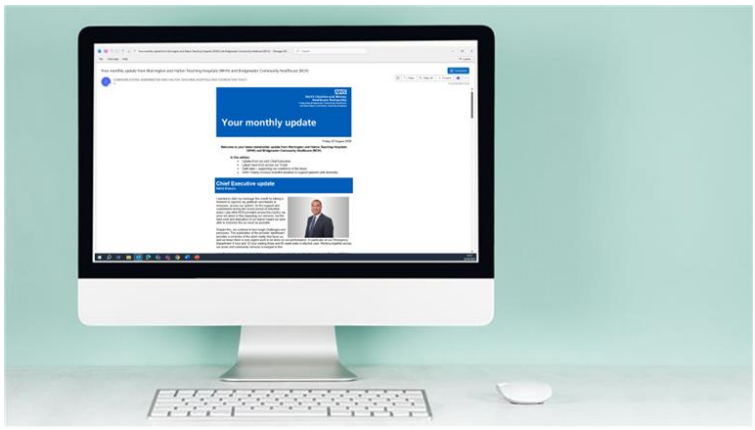


Figure 34: An example of the monthly stakeholder update

e) 60-second animation explainer

A 60-second animation has been produced to further explain the reasons for integration and its benefits. This short video is intended as a method to communicate the process in a clear and accessible manner. Additional animation and explainer videos will be created to provide further information about the advantages of integration for the public and stakeholders as we head ever closer to the proposed transaction date. This animation is prominent on the home page of the new partnership website (NHS North Cheshire and Mersey Partnership). It has also been shared on respective organisational websites, social media channels and in our joint stakeholder bulletin.

f) Community engagement activity

Our respective organisations coordinate attendance by a range of services at annual community engagement events. In addition to raising awareness of specific services, these have been used as an opportunity to seek feedback from our communities on our integration proposals and to identify any key themes or considerations which have been detailed in section 15.8. A flavour of this community engagement activity is outlined as follows:

Figure 35: Public engagement at Disability Awareness Day 2025 (above left)

Figure 36: Public engagement at Warrington Pride 2025 (above right)

Figure 37: Public engagement at Chinese Lunar New Year Fun Day 2025

15.8 Staff engagement

Aligned to the Better Care Together workforce workstream, our approach to staff engagement will help ensure that staff feel valued, informed and engaged:

1. Collaborative engagement through joint staff engagement channels – we will establish joint engagement groups where this is appropriate, including

representatives from both trusts to collaborate on integration goals and share feedback. By involving staff in decision-making processes, we will ensure that integration respects and reflects the insights of our workforce.

2. Open and transparent communication forums – we will conduct regular, open forums with programme leadership, offering clear, transparent updates on the integration process. These sessions will include Q&A opportunities where staff can voice concerns and ask questions directly. The aim of this is to ensure that our staff remain informed and confident in the integration progress and are given a platform to express their views openly.

3. Consistent mechanisms to gather and act on staff feedback – we will establish reliable, easy-to-use feedback channels, such as surveys, suggestion boxes and focus groups, to continuously gather staff input. Feedback will be reviewed and outcomes shared to demonstrate how staff input informs integration decisions. With mechanisms such as the quarterly people pulse and staff surveys in place, the review of this information will be themed and aligned to inform engagement plans.

4. Continuous and accessible communication channels – we will ensure that staff have access to regular engagement mechanisms in a variety of formats, ensuring all staff can access them and feel informed. Ensuring an open engagement approach when even if there are no new updates, we will maintain these channels to reassure staff and share progress reminders.

5. Taking a diversity and inclusivity approach – we will take an inclusive approach to engagement which respects the diversity of our workforce, the perspectives, roles, and contributions within both trusts. Celebrating shared successes and addressing personal challenges collectively, aiming to create a positive environment where staff from all backgrounds feel welcomed and integral to our unified future.

15.9 Internal stakeholder analysis

A comprehensive stakeholder mapping exercise has been conducted, resulting in the identification of key internal stakeholders, *see below*, relevant to both organisations, unless otherwise specified. Additionally, it should be noted that communications and engagement activities – both internal and external – are systematically coordinated and aligned.

- Trust Boards
- Executive Management Team
- Council of Governors
- Trade unions
- Culture Champions (WHH)
- People Promise Champions (BCH)
- Culture, Inclusion and Engagement Teams (WHH)
- Staff Engagement Lead (BCH)
- Equality, Diversity and Inclusion Manager (BCH)
- People Promise Manager (WHH)
- HR Business Partners
- Staff network leads
- Operational and clinical managers who lead staff forums
- People Directorates' senior leadership teams

- Wider senior leadership teams – clinical and corporate
- Operational and clinical managers
- Line managers
- Better Care Together programme workstream leads / delivery groups

15.10 Meeting governance

The following have been identified as key internal meetings / groups / forums that will need to be involved and engaged to varying degrees (applicable to both organisations unless otherwise stated):

- Trust Board meetings
- Board People Committees
- Sub-Board level People Committees
- Executive Management Team meeting
- Council of Governors meetings
- Better Care Together programme delivery group, executive delivery group and workstream delivery groups
- Joint Negotiation and Consultation Committee (JNCC)
- Joint Local Negotiation and Consultation Committee (JLNC)
- People Promise Champion meetings (BCH)
- Culture Champion Chats (WHH)
- Staff network meetings
- Staff network chairs and executive meetings (WHH)
- Staff Voice Forum (WHH)
- Leadership Forum
- Staff health and wellbeing groups
- People directorate forums
- Executive-led engagement groups (e.g. Chief Nurse Check-In forum)

15.11 Stakeholder engagement on the integration

15.11.1 Stakeholder analysis

As outlined in section 15.5, an external stakeholder mapping exercise has been completed. To further expand on this, a large number of stakeholders and forums have been identified as key stakeholder to keep informed and engaged at the appropriate level required.

15.11.2 Our approach

We regularly produce presentations for partner organisations and forums to keep them informed of our integration plans and progress made. This ensures that consistent messaging is being given across the range of external forums attended, and that it is aligned to our internal communications.

Partner organisations have been involved as required throughout the duration of our integration, e.g. by attending clinical and operational services workstream workshops, or engagement events for our shared communities.

Key partners continue to be represented on the BCT ICS steering group, and we continue to discuss integration as part of our routine trust stakeholder engagement meetings, with MPs for example.

In October 2025 we reintroduced and refocused our monthly strategic stakeholder meeting to concentrate on integration and strategic estates developments. This meeting includes our local authority chief executives, MPs and councillors, and provides a forum for sharing updates, answering questions and receiving feedback.

Our respective governors have been kept informed and updated on the integration programme and progress through various forums including the WHH governor engagement group, council of governors and BCH public and communities' engagement group.

Following agreement at the BCH public and community engagement group and WHH governor engagement group in summer 2025, proposals were approved by the respective council of governor meetings to bring together BCH governors with WHH governors in a 'governor engagement group in common'. A draft terms of reference and cycle of business for the combined group was developed with input from both sets of governors and membership engagement leads.

15.12 What we have heard so far – key themes

Alongside the approach for individual clinical pathways set out earlier in this chapter, feedback is collected on an ongoing basis from multiple sources. This includes from public discussions at community engagement events such as Disability Awareness Day, Armed Forces Day, and Warrington Mela. The BCT communications and engagement workstream reviews this feedback and has identified the following areas of feedback.

Trust-wide benefits include:

- improved convenience and accessibility
- better communication and coordination
- enhanced service efficiency and quality

Location improvements include:

- central hub locations for multiple services
- more venue choice and provision
- local venues with adequate parking / public transport links

Service improvements include:

- operational improvements
- improved patient experience
- reduced waiting times
- reduced travel time, costs and parking

Concerns include:

- resources and funding limitations
- staffing levels / workload pressures
- implementation challenges

Most staff and public feedback is positive, but concerns remain around implementation, especially staffing and capacity. Respondents want assurance the integration programme will be adequately resourced and managed without harming staffing levels. This assurance will continue to play a part of our overall communications and engagement activity.

Feedback received informs the communications and engagement activity we undertake, with targeted communications implemented where required.

It also contributes to our frequently asked questions, which are regularly updated, and is fed back to other integration workstreams where required for action.

15.13 New name for our joint organisation

An engagement exercise was carried out over four weeks from 10 January to 9 February 2025 to gather feedback on a new name for the trust. The consultation included staff, members, governors, partners, and Experts by Experience panel members. Healthwatch networks and voluntary, community and faith groups in Halton and Warrington were also invited to participate, along with attendees at events during the engagement period.

Feedback was collected through an online survey, accessible via a link or QR code displayed on posters in clinic spaces and waiting rooms, and through printed surveys distributed to community clinics. The survey was also shared internally via a chief executive message, regular staff bulletins and monthly joint Team Brief meeting.

The survey presented five possible name options, inviting respondents to comment on each and suggest alternatives. There were 370 individual responses. Analysis of the results included sentiment assessment and identification of common themes. Key themes identified included the challenge of representing the integrated trust's entire geographical area and concerns about names implying takeovers rather than partnerships, as well as potential confusion with existing organisations.

A review of the 178 alternative suggestions showed many did not meet NHS identity guidelines for naming conventions. After considering all feedback, the partnership name 'North Cheshire and Mersey Healthcare Partnership' was chosen, with the future name of the integrated organisation to be **'North Cheshire and Mersey NHS Foundation Trust'**.

To represent Bridgewater's community dental services provided outside the core trust area, a standalone service name, 'North West Community Dental Service', was agreed, in line with the naming approach used for other services covering a wider area.

Further details on the feedback analysis are available in the presentation which went to both trust Boards. This can be found in the supporting documents.

15.14 Measuring the impact of our work

The communications and engagement team continues to track and analyse metrics to inform engagement efforts. These include:

- webpage and microsite visits
- attendance at events and meetings
- readership of online newsletters (where possible) e.g. membership / staff news
- social media engagement (where appropriate)
- responses to surveys
- feedback from rolling programme of internal and external engagement

An example of a recent communication and engagement activity log is included within the supporting evidence section of this business case. This is updated on a monthly basis and is discussed as a standing agenda item at the Communications and Engagement Workstream Delivery Group.

Risks identified through communication and engagement activities are communicated via the appropriate channels and reported to the Better Care Together Delivery Group as they arise.

Our communications and engagement approach is designed to provide thorough support throughout each phase of the integration process. We recognise that our approach needs to remain dynamic, allowing for ongoing review and necessary adjustments to ensure continued effectiveness.

15.15 Supporting evidence

The following evidence supports this section of the business case and is all included in the supporting documents:

- BCT – Communications and engagement plan
- BCT – Joint communication channels (November)
- BCT – Partnership name engagement and recommendations
- BCT – Integration activity – engagement and communication update (October 2025)
- BCT – Summer 2025 Public feedback
- BCT – Engagement and communications activity log (November 2025)

16.0 People Strategy

16.1 Chapter summary

This section sets out the vision for a single, empowered workforce that underpins the success of the new organisation.

It highlights how integration will strengthen recruitment, retention, training and career development through shared education pathways, joint policies and aligned workforce planning.

The section describes work already underway to develop a joint People Strategy, organisational development framework, and culture plan, ensuring a positive, inclusive and resilient workforce and discusses the two-phased approach to organisational development, both pre and post transaction.

It reinforces that our people are at the heart of integration, and that by uniting teams, aligning terms and embedding shared values, we will build an organisation where everyone can thrive.

Key message: The People Strategy section details the workforce approach to integration. It discusses the plans and activities already in place for staff engagement, with more than 1,500 staff having attended joint engagement sessions since February 2025.

A combined workforce planning approach has been adopted which will recognise and embrace innovation, develop a robust workforce supply chain and incorporate demand forecasting.

Training and development elements such as a joint corporate induction have already been introduced and a continued collaborative and co-production approach will continue to build a foundation for one inclusive, empowered workforce.

16.2 Our people

For the past 18 months staff across WHH and BCH have been working together more closely to enhance healthcare services for our communities, improve patient experience and drive forward benefits for our workforce.

Our organisations employ around 6,700 staff who reflect the diverse communities of Warrington, Halton, Cheshire, Merseyside and Greater Manchester. We deliver services across 98 sites, including our hospital sites, local clinics and dental clinics, out in community locations and through care provided directly in service users' homes.

We recognise the commitment of our staff to deliver high-quality, compassionate care. Consequently, improvements in patient and service user care will further our objective to transition care from hospital settings to locations closer to service users' homes, thereby making roles more rewarding for our teams as we achieve the ambitions of the 10 Year Health Plan for England[45].

Integration will also create expanded opportunities for career progression by providing shared training and educational resources, supporting workforce development and retention.

[45] Department of Health and Social Care (2025) *Fit for the Future: 10 Year Health Plan for England*. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

This initiative will facilitate opportunities for individuals seeking career advancement, new challenges or internal movement within our organisations.

Acknowledging that organisational culture shapes behaviours, our integration aims to unify and leverage the strengths of both trusts. The NHS staff survey remains an important measure of workforce experience and fostering a shared culture at both organisational and team levels is essential to ensuring a positive work environment. This has been a priority during our transition period, utilising the strengths of our workforce to deliver service transformation for the future which is reflective of the 10 Year Health Plan as we prepare to transition into our new organisation.

These developments will enable us to optimise and realign resources, enhancing our attractiveness to prospective employees and supporting retention of current talent. This approach encompasses both clinical and support team roles across WHH and BCH and establishes the foundation for collaborative work throughout the region. Through these improvements, we will ensure staff have access to the necessary support and resources to provide exceptional care, whether in patients' homes, the community or in hospital settings.

Our workforce spans 80 nationalities, mirroring the diversity of our communities. We aim to strengthen equality of opportunity and tackle health inequalities for those we serve and employ. Our vision is to build an inclusive, empowered team where everyone feels they belong, enjoys their work and consistently delivers excellent care in line with the NHS People Promise.

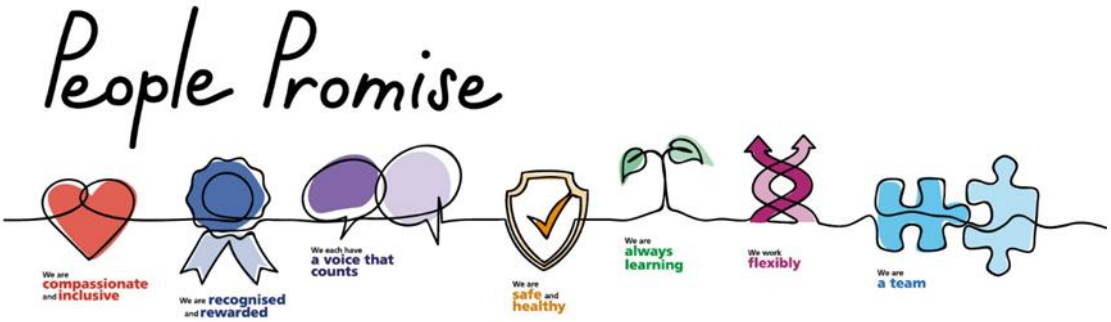


Figure 38: NHS People Promise

As a combined organisation delivering acute, elective, community and dental services, the integration offers a wide range of opportunities for the workforce to deliver effective care which impacts all areas of health. From listening to our workforce during our clinical summits, they tell us they are excited by the opportunities that working closely together will bring. From seeking efficiencies in service delivery, proactively supporting health improvements and providing opportunities 'to do things once', our teams tell us that working closely together has already provided advancements in service delivery.

16.3 Staff engagement

Staff engagement is a key element of our integration plans; this is demonstrated in our Better Care Together communications and engagement plan. Our commitment is to be open, transparent and inclusive in how we communicate, engage and co-create our future as one trust.

Since February 2025 we have run staff engagement sessions across both WHH and BCH, with more than 1,500 attendees so far. These sessions form the backbone of our

engagement strategy providing a consistent, large-scale platform to share updates, answer questions and gather feedback. They also allow managers to cascade key messages to their teams, ensuring alignment across the organisation while respecting employment law requirements and supporting staff through change.

In addition, we've held a monthly joint staff side meeting since December 2024, which has allowed us to engage in partnership and develop plans such as our organisational change framework, joint culture plan and discuss key matters which our workforce have raised.

In addition to these sessions, we've embedded engagement into our existing structures via:

- joint team briefs have spotlighted our progress on integration
- leadership forums have hosted dedicated sessions on the development of our organisational change framework and other key developments
- staff network meetings have been vital in sharing messaging and gathering views to inform our plans and are now evolving into a staff network in common approach
- we've actively involved our Culture Champions (WHH) and People Promise Champions (BCH) to listen and respond to staff voices and build momentum
- we've used people pulse survey data to understand how staff are feeling and identify areas for support
- walkarounds across departments have provided invaluable anecdotal insights into how people are experiencing the integration process.
- our Freedom to Speak Up guardians have been working collaboratively, increasing awareness of the processes under freedom to speak up
- the BCH deputy CEO has held a series of sessions to allow BCH staff to ask specific questions they may have relating to any potential or anticipated changes at BCH

These multi-channel efforts ensure we're engaging with our wider workforce, not just through formal sessions but also through everyday conversations and feedback loops.

Each staff engagement session includes a Q&A segment, with questions submitted in person or anonymously resulting in 142 questions, which have been themed and compiled into a monthly FAQ sheet. This helps us respond meaningfully and transparently to the concerns and questions from our people.

We know that meaningful engagement is not a one-off, it's a continuous dialogue. Therefore we will continue to evolve our engagement plans and ensure these principles are embedded into consultation.

16.4 Workforce planning

As a combined organisation we will establish a single, coordinated approach to workforce planning that aligns directly with our operational plans and long-term trust strategic priorities. By bringing together expertise, systems and planning methodologies across the organisation, we will create an approach that ensures our workforce is optimally structured and equipped to deliver safe, effective and sustainable services.

This integrated approach will:

- embed workforce planning as a core pillar of our people strategy – ensuring that our people agenda is not developed in isolation but is fully aligned with patient outcomes, service transformation, quality and financial sustainability
- recognise and embrace innovation – including the deployment of automated intelligence (AI), automation and digital tools to enhance service delivery, support

staff and create new roles that will reshape how care and support are delivered in the future
- develop robust workforce supply pipelines – through targeted recruitment, retention and career development strategies that address current shortages, secure future talent and ensure a balanced skill mix across clinical and non-clinical roles
- incorporate demand forecasting and skills modelling – to ensure that our strategic workforce plan anticipates and responds to service demand, demographic change and evolving clinical models, rather than reacting to pressures as they arise

By adopting this combined workforce planning approach we believe the organisation will be well-positioned to meet the future demands of our population and drive forward clinical service transformation. It will provide clarity on how our people strategy directly enables operational delivery and ensures we are proactively shaping the workforce of today, not just meeting the challenges of today.

16.5 People services operating model

Work is underway to develop people service operating models for the new organisation as part of the corporate services integration workstream (see chapter 11). This will include structures, functions and principles for integration. It is recognised that this will involve meaningful consultation with our workforce and we anticipate this to take place between November 2025 and March 2026.

Our priorities since July 2024 have included scoping policy development and governance arrangements. By working collaboratively we have already had opportunities to share best practice and implement policy improvements, including national policy frameworks, such as the sexual misconduct in the NHS policy[46]. This work is continuing through the introduction of our joint staff side meeting on a monthly basis.

In addition, since April 2025, we have implemented a joint strategic people committee in common. This has allowed for opportunities to do things once where possible, align governance procedures and share the commonalities between both trusts. This creates efficiencies as well as support the workforce at WHH and BCH in tandem.

The integration of the two organisations represents a key milestone in advancing the People Strategy and Workforce Equality, Diversity and Inclusion Strategy, as it will facilitate staff engagement and support the definition of new organisational ambitions which reflect the ‘workforce standards’ within the 10 Year Health Plan.

16.6 Organisational culture – values for the new organisation

Since commencing our staff engagement sessions, we've had the opportunity to hear the thoughts and feedback of our workforce on our integration journey. Their insights have been important in guiding our principles as we come together.

In August 2025 we launched a values engagement exercise as an opportunity to co-create the values that will define our future as an organisation with effect from 1 April 2026. We recognise how our values lie at the heart of our trust; shaping how we work, how we care and how we support each other. The aim of this exercise is to recognise the current values

[46] NHS England (2024) *NHS England sexual misconduct policy*. Available at: NHS England » NHS England sexual misconduct policy

held by each organisation as well as seek an opportunity to develop something new which represents our future ambitions.

Our new values (detailed in section 8.6) will serve as the foundation for our future organisational strategy, culture and core business planning. We will actively embed them into a refreshed behavioural framework, our staff induction programme and organisational branding. By doing so, we will ensure that these values not only define who we are today but also guide our aspirations for the future, shaping how we work together and deliver care across the trust.

Work to establish a new behavioural framework for the integrated organisation is progressing, building on the values developed through a staff engagement exercise. Feedback gathered from staff has been instrumental in shaping these values, which now serve as the foundation for the behavioural framework. To ensure the framework is meaningful and relevant a working group is being set up, drawing on the involvement of staff side representatives, staff networks and champions from across the two trusts. This collaborative approach ensures broad engagement and ownership.

A review of behavioural frameworks from other NHS trusts and the private sector has been undertaken to identify best practice and avoid unnecessary duplication, with a clear focus on expanding and bringing our new values to life rather than reinventing them. The framework will be concise, memorable and simple, reflecting staff feedback and aligning with kindness research completed locally. It will also be designed to support the implementation of the NHS England Leadership and Management Framework, while ensuring alignment with Medical Internal Professional Standards (MIPS).

The framework will be developed with reference to workforce policies, ensuring it supports standards of conduct and addresses misconduct appropriately. The plan is to ensure this goes through governance processes and has a soft communications launch ahead of a formal go live on 1 April 2026. This structured and inclusive approach provides assurance that the new behavioural framework will be robust, relevant and ready to underpin the culture of the integrated organisation from day one.

Work to continue to build on the organisational culture, how this resonates with staff and new starters is noted within the post transaction integration plan (PTIP).

16.7 Organisational culture – organisational development (OD)

16.7.1 Phase one of integration – pre-transaction

Supporting our people through periods of change is fundamental throughout the integration. Creating our future organisational culture has so far been focused on understanding the cultures of both organisations. Since August 2024, the organisational development (OD) teams across both WHH and BCH have worked collaboratively to design packages which aim to build psychological safety and strengthen resilience to prepare people for a time of change.

The work of our people teams will continue to play a crucial role in supporting integration, transformation and cultural alignment. By developing behaviours, skills and culture, they will enhance the organisation's overall effectiveness, leading to better performance, employee experience, enjoyment and patient care.

This will create a workplace where both people and the business can thrive, promoting effectiveness and efficiency. To support our teams in their integration journey, OD has created a number of resources including a change management guide, team engagement

strategies and a session facilitation toolkit. These initial management resources will help engage teams in the integration journey.

For teams anticipating high levels of change through the integration programme, OD offers facilitated sessions, including:

- Introduction to leading integrated teams: Building trust and creating a shared purpose and vision to strengthen integrated teams
- Team integration and managing change: Exploring change and its impact on teams, using reflective thinking to enhance team integration
- Creating kinder cultures: Developing professional workplace behaviours and fostering a culture of kindness within teams

Additionally, OD will focus on leadership development, team building and resilience. Plans include measuring and evaluating culture over time to ensure continuous improvement and alignment with our organisational goals. Transition support will be provided to ensure a smooth integration process, helping our teams adapt and thrive in the new organisational structure.

To strengthen our OD plans, in July 2025 the trusts implemented their first joint culture plan. As we move forward in our programme to become one trust, we have taken a commitment to develop a shared culture that reflects the best of both organisations. Our plan sets out a clear and ambitious vision: to create one inclusive, empowered team where everyone has a good day at work.

To support this, cultural due diligence is already underway, with a strong focus on organisational development practices that help people navigate change. This includes exploring:

- how decisions are made across teams and services
- what motivates our people and how we can harness that energy
- the subcultures within teams, recognising that each has its own strengths and dynamics

This work is not being done in isolation. We plan to continue to embed focus groups into the process to ensure that staff voices are central to shaping our future through channels such as the Culture Champions (WHH) and People Promise Champions (BCH), Freedom to Speak Up Champions as well as staff networks ‘in common’. These groups provide rich insights into lived experiences and help us understand what matters most to our workforce.

We’re also aligning our approach with the NHS cultural assessment toolkit, which has been used as a foundation for developing our joint culture plan (attached). This ensures our work is grounded in best practice and supports our ambition to deliver better care together.

Our staff survey results, with input collectively from more than 3,000 colleagues, along with other engagement activities over the past 12 months, have shaped the three phases of our culture plan. We’re currently focused on ‘doing the basics brilliantly’, laying strong foundations for long term cultural transformation. We know this takes time and we’re not imposing a fixed timeline. Instead, we’re meeting teams where they are, recognising that different services will progress at different paces with a clear ambition for all our workforce to have a great day at work.

Ultimately, the aim of this has been about recognising the power of our people across both organisations. The culture we create together will not only shape our working lives, but it will also directly impact patient safety, experience and the success of our integration.

16.7.2 Phase two of integration programme – post-transaction

We anticipate that our targeted OD programmes will continue to run post-transaction for 18 to 24 months, ensuring that we have supported our workforce to thrive in the new organisation. We believe this will impact on:

- **leadership development**
  Supporting our leaders and future leaders to have the skills to lead integrated teams. This will be focused on enhancing the current programmes which we offer to align with the needs of our workforce.

- **structural change**
  As we review our structures to ensure that they work in an optimum manner, creating efficiencies whilst delivering high-quality patient outcomes, we recognise that targeted organisational design support is required post transaction. This will be strengthened by reviewing governance arrangements to develop transitional structures in the first instance, potentially followed by wider organisational change through trust policies and procedures.

- **Clinical pathway redesign**
  In addition to structural change, we recognise that our services and clinical pathways will be required to transform to meet the needs of our communities. This work has already commenced with early scoping through our clinical summits which were held in early 2025. We recognise it is imperative that OD support is provided through this process, strengthening the skills and abilities of our workforce to deliver this through quality improvement, designing services which work across the boundaries of healthcare.

16.8 Culture plan and development of the new clinical operating model

The joint culture plan is integral to the development and delivery of the trust's new operating model, ensuring that cultural alignment underpins organisational effectiveness. It utilises key metrics, including workforce data and NHS staff survey results, broken down by service and department, to provide a robust evidence base that aligns with the operating framework. This approach reflects the analysis undertaken across both trusts and acknowledges the need to continue to develop the future organisational cultures post-transaction, aligning community and acute services.

The workforce due diligence exercise (see section 19.3.2) has included a review of staff survey performance and quarterly people pulse data, with clear actions for improvement to maintain alignment. The forthcoming results of the 2025 staff survey will inform further refinements to priorities, and the post-transaction implementation plan will be updated accordingly to embed cultural objectives within the wider operating model.

From April 2026, work aligned to cultural alignment and transformation will be completed and this will be reported through trust governance processes.

16.9 Training and development

The integration of WHH and BCH provides a significant opportunity to align and strengthen our approach to training and development. By working collaboratively, we can enhance the staff experience, maximise efficiency and ensure our workforce is fully supported to deliver safe, high-quality care. Key developments and anticipated opportunities are outlined below:

- **Joint corporate induction**
  Colleagues from both trusts have worked together to design a new joint corporate induction programme. This will reduce duplication in content, enable more efficient use of staff time and resources and provide all new starters with a consistent and high-quality introduction to our organisation. Implementing this ahead of the transaction will ensure alignment of existing and future values, as described in section 8.6 of this paper, and will support a unified organisational culture from day one. The first joint corporate induction took place on 3 November 2025.

- **Apprenticeship Levy**
  Integration creates opportunities to expand our widening participation agenda, using the Apprenticeship Levy to support both current staff development and future workforce supply. Since September 2025 we have aligned levy funding and resources across both trusts. We will maximise investment in skills development, strengthen workforce planning and reinforce our role as an anchor institution for the communities we serve. This will further enhance access to healthcare careers.

- **Continuing professional development (CPD)**
  Our clinical and medical education teams are already working together to maximise CPD opportunities across the trusts. Through our People Strategy and Workforce Equality, Diversity and Inclusion Strategy, we will embed clear and inclusive processes to ensure that staff from all protected characteristics can access CPD activities equitably. This will support personal development, improve retention and strengthen workforce capability across all areas.

- **Learning and development offers**
  We will align and refresh leadership development resources to create a comprehensive and accessible package that supports individuals at all career stages to progress and thrive in their roles. This consistent leadership framework will help embed shared values, build resilience and ensure our leaders are well-equipped to manage change and deliver improvement across the new organisation.

- **Mandatory training review**
  A joint review of mandatory training requirements will be undertaken to ensure compliance with national standards while reducing duplication and unnecessary burden on staff. This will support a more streamlined approach, enabling staff to move between sites and services with minimal disruption and enhancing workforce flexibility and efficiency.

The integration of our organisation provides a clear opportunity to strengthen our training and development infrastructure.

By aligning induction, development pathways and mandatory requirements, we can create a more efficient, inclusive and supportive environment for our workforce. This investment will underpin delivery of our People Strategy and ensure we are well positioned to meet the future needs of our patients and communities.

16.10 Managing organisational change

Staff feedback gathered through engagement has played a role in shaping the development of our Organisational Change Framework and its supporting materials.

The questions raised particularly around the process and implications of change have informed a co-development approach with staff side and trade union representatives, ensuring the principles of organisational change are meaningfully applied and clearly understood by those affected.

The framework is split into three phases:

- **Phase One:** Development of change readiness tools to support staff and managers in preparing for change – completed in January 2025
- **Phase Two:** Development of an easy-read framework to support people in understanding the processes aligned with TUPE and organisational change – completed in August 2025
- **Phase Three:** Development of a mirrored organisational change policy with dedicated resources to support Transfer of Undertakings (Protection of Employment) [TUPE] processes – planned to be finalised in December 2025

Through the development of our resources, we have created a statement of transparency:

“The Trust is committed to managing organisational change in a fair, transparent and consistent manner in accordance with the principles of the NHS Constitution. The framework outlines the procedures for managing change processes affecting staff employed under Agenda for Change and Medical and Dental Terms and Conditions of Service, ensuring compliance with employment legislation and national NHS frameworks.”

In doing so, we have outlined six key principles agreed with our staff side colleagues which we will follow in accordance with staff consultation:

1. Early and meaningful consultation with staff
2. Engage and work in partnership with staff side and trade union representatives
3. Transparency and timely communication on the transaction through the provision of staff engagement sessions
4. Minimising adverse impact on staff through training and redeployment, if required
5. Quality / equality and health inequalities impact assessments conducted for all organisational change
6. Compliance with national guidance, legal and statutory requirements

Dedicated workforce support has been aligned to the programme in addition to business-as-usual support through the respective HR Business Partnering Teams at WHH and BCH. The workforce team are piloting tailored, face-to-face NHS leading for wellbeing sessions at WHH, offering leaders a space to reflect, share experiences and gain practical tools to support team wellbeing. Focused on services identified as ‘developing’ or ‘fragile’ within the culture plan, the pilot targets first-line managers and supervisors to strengthen leadership and integration.

We aim to take a person-centred approach to the organisational change process by adapting to the needs of our workforce. To support this, staff engagement sessions will continue to be held monthly throughout the period, ensuring ongoing engagement and involvement with individual consultation meetings also in place.

As a result, we believe that we have developed a framework which will support consistency in approach, whilst meeting legal requirements as part of our TUPE processes. We anticipate that the TUPE consultation will commence in November 2025 and run to 31 March 2026.

17.0 Digital Strategy

17.1 Chapter summary

This section outlines the digital transformation required to support integrated care delivery across acute and community settings. It highlights how digital alignment will improve data quality and clinical efficiency.

The section sets out how shared systems, electronic patient records and data analytics will underpin joined-up care, empowering clinicians and patients alike. It also aligns with national ambitions for digitally enabled care, supporting remote monitoring, virtual wards and population health management.

Integration provides the platform for a single, modern digital infrastructure that enhances safety, efficiency and patient experience.

Key message: The approach for digital integration has two underpinning focuses; technical integration (systems, data flows, interoperability) and the organisational integration (governance, culture, clinical workflows) and will cover six key areas:

- Governance and strategic alignment
- Current state assessment
- Data and technical enablers
- Clinical and operational engagement
- Programme management
- Risks and mitigations

A single digital ecosystem will unite the new organisation, enabling real-time data sharing, smarter decision-making, and more personalised care. Integration accelerates delivery of the 10 Year Health Plan's 'analogue to digital' ambition, ensuring technology enhances, not replaces, human care.

17.2 Our vision for digital services

We will deliver highly effective, interconnected digital services that enhance care, communication and operational efficiency across our health and care system. This vision directly supports the delivery of our developing clinical strategy by enabling integrated, patient-centred care across acute and community settings.

Our digital transformation will underpin the clinical strategy by:

- enabling seamless care pathways across acute and community services
- improving access to real-time data for clinical decision-making and care coordination
- empowering patients to manage their health proactively, reducing unnecessary hospital visits
- supporting workforce efficiency and collaboration, freeing up clinical time for direct care
- creating resilient infrastructure that supports service continuity and future growth

More details on how this will be achieved are included in the supporting documents.

While these aims set out a clear direction, it is important to acknowledge that progress will need to be incremental. These ambitions will not be realised immediately as they represent a

progressive journey that will require time, investment and continued collaboration across partners in the system.

A structured plan is being developed to phase implementation carefully, ensuring that each step is achievable, sustainable, and aligned with the needs of local communities.

17.3 Digital Strategy

The development of our digital strategy for the integration of the two organisations is a cornerstone for delivering new models of care, supporting population health and realising the ambitions of the national 10 Year Health Plan which places digital transformation at the heart of healthcare delivery.

Our new joint digital strategy will be aligned with national, regional and local priorities, ensuring digital transformation underpins clinical and operational excellence. The strategy will be shaped by the 10-year plan, the new strategy for the integrated organisation and the clinical strategy.

It will bring to life the strategic plans to support the shift from analogue to digital services. The strategy will detail how digital services can support the delivery of one-stop neighbourhood health models, digital-first care, advanced EPR implementations, AI, and the NHS app as a 'front door' for patients.

It will also reflect our aim to wrap care around the holistic needs of individuals at the neighbourhood level, working in partnership with primary care networks (PCNs) and wider community services.

Our strategy will be further informed by:

- our developing clinical and operational model and priorities
- digital maturity assessment
- model hospital system analysis
- due diligence findings

Our strategic digital programmes that will form a core part of the strategy are described below:

	Programme
1.	Acute EPR Procurement (MWL Partnership)
2.	WHH & BCH integration : Digital Services, Systems & Infrastructure
3.	Acute EPR Readiness Programme (inc. Clinical Data Repository)
4.	Community EPR Procurement & Integration, C&M Shared Care Record
5.	Digital Diagnostics & Clinical AI (PACS,LIMS, "other ologies")
6.	AI, Automation & Employee Productivity Tools
7.	NHS App, Patient Engagement Platforms (PEPs) & Wearables
8.	FDP- Patient Flow, Data Warehouse & Real-time Analytics
9.	Network Convergence, Real-time location tracking & Device Integration
10.	IG, Cyber Security, Clinical Safety & Service Continuity

Table 53: Strategic digital programmes that will form a core part of the strategy

17.3.1 Digital strategic objectives

Key strategic objectives for the digital future of the integrated organisation will include:

- empowering patients to manage their own health through digital tools such as the NHS App and personal health records
- delivering care closer to home, supported by remote diagnostics, virtual consultations, and community-based services
- improving clinical outcomes and operational efficiency through AI-enabled diagnostics, shared care records, and streamlined digital workflows
- enhancing workforce capability with mobile access, digital training and clinical decision support tools
- strengthening data sharing and interoperability to reduce duplication and ensure a single, accurate view of patient status across care pathways
- leveraging population health intelligence to target interventions, improve equity, and support proactive care planning
- ensuring cybersecurity and data governance to protect patient information and maintain public trust

Our digital strategy will be delivered through a phased implementation plan, supported by robust governance, stakeholder engagement and continuous evaluation. It will represent a bold step forward in our journey to become a digitally mature, patient-first organisation that is fit for the future.

17.3.2 How the Digital Strategy will enable the delivery of our clinical strategy

In an evolving healthcare landscape, our main goal is to transform how digital systems support clinical excellence. Our focus is clear: digital integration must not exist in isolation, but it must directly serve and enhance our clinical priorities. To achieve this, we are adopting an **Enterprise Architecture (EA) approach** which provides a structured methodology for modelling, aligning and optimising our digital platforms, systems, devices and data assets.

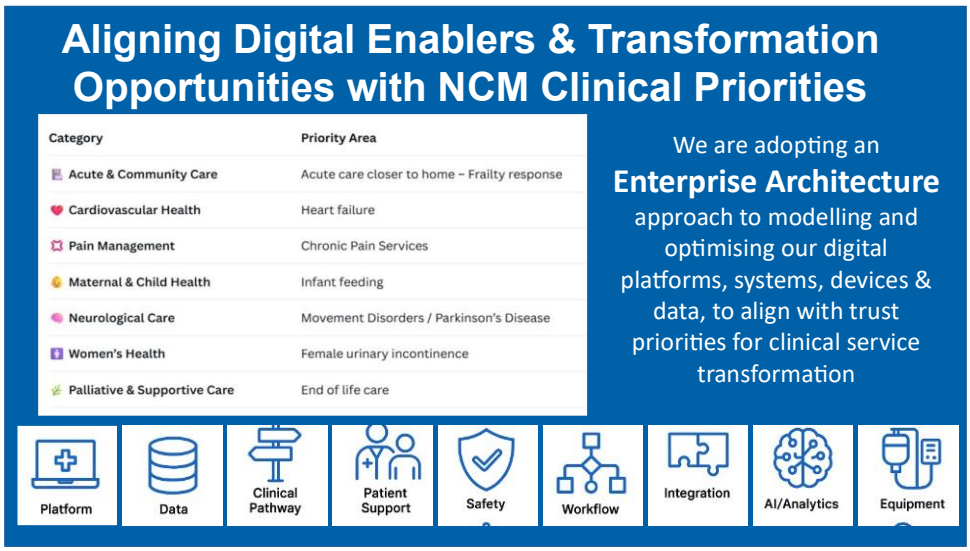


Figure 39: Adoption of enterprise architecture to support delivery of the Clinical Strategy

The EA framework enables the trust to establish clear linkages between digital capabilities and the organisation's overarching clinical transformation objectives.

Through this integrated approach, the trust seeks to create a coherent and sustainable digital ecosystem that:

- supports safe, effective, and efficient delivery of clinical services
- enhances interoperability and information flow across departments and care settings
- enables clinicians to access timely, accurate, and relevant data at the point of care
- provides a robust foundation for innovation, analytics, and continuous improvement

For our new organisation, digital services will support integrated care delivery, workforce enablement, and improved patient outcomes. By implementing unified digital services such as shared electronic patient records, leading to the implementation of a new combined EPR in the longer-term, patient engagement portals, and AI-driven tools like Ambient Voice Technology (AVT), we will ensure continuity of care, empower both staff and patients, and reduce administrative burdens whilst supporting efficiencies and reducing cost.

These digital initiatives will not only streamline access to information and enhance clinical decision-making but also foster innovation and resilience, aligning with national NHS priorities and the broader move towards community-based, preventative care. Our focus on digital skills development and clinical safety frameworks will further ensure that technology adoption will translate into safer, more effective and patient-centred services for the new organisation.

By aligning digital enablers with clinical transformation goals the trust aims to reduce operational fragmentation, streamline workflows, and enhance decision-making processes. This alignment not only facilitates improved clinical outcomes but also underpins organisational resilience, cost-effectiveness and compliance with national digital health strategies.

Importantly, this approach is designed to underpin and accelerate progress across the Trust's seven clinical priorities. The EA framework ensures that each clinical priority is supported by fit-for-purpose digital infrastructure and integrated data flows. By embedding interoperability, standardised data models, and advanced analytics capabilities, the trust will enable each clinical area to measure performance, identify variation and implement evidence-based improvements more effectively. More details on how this will be delivered are provided in the supporting documents.

17.4 Supporting neighbourhood health centres

The development of the new neighbourhood health centres offering diagnostics, treatment, rehab, mental health and pharmacy services will be digitally enabled to provide truly integrated, patient-centred care within local communities. A unified digital infrastructure will ensure that clinicians across all disciplines can access and share real-time information securely.

Interoperable electronic health records, digital appointment management, and shared care planning tools will enable seamless coordination and reduce duplication across pathways. Virtual consultation capabilities and remote monitoring technologies will extend access to specialist input and support ongoing care beyond the clinic setting. Data analytics and population health tools will inform proactive management of local health needs, while digital prescription and dispensing systems will improve safety and efficiency.

Collectively, these digital enablers will make neighbourhood health centres a cornerstone of the integrated, preventative and accessible care that our new trust will deliver, bringing diagnostics and treatment closer to home and improving patient outcomes across the continuum of care.

17.5 Digital integration

Successful digital integration between an acute and community NHS trust is about creating clinically useful, interoperable pathways, underpinned by national standards, shared governance and cultural alignment.

Integrating the digital systems of WHH and BCH will be a complex process, and its success will depend on both the technical integration (systems, data flows, interoperability) and the organisational integration (governance, culture, clinical workflows).

Our integration approach is summarised below:

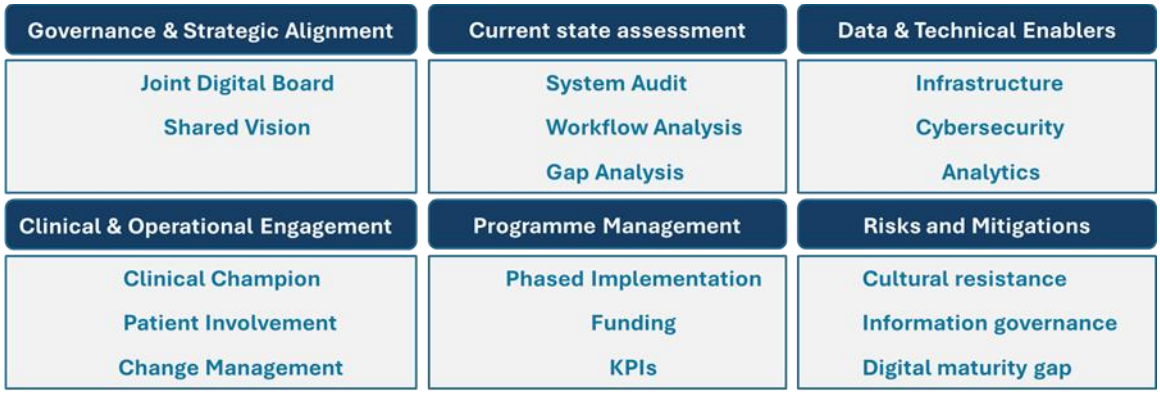


Figure 40: Digital integration approach

The key milestones for the digital integration and implementation of our digital strategy are described in more detail in the PTIP, section 5.8.

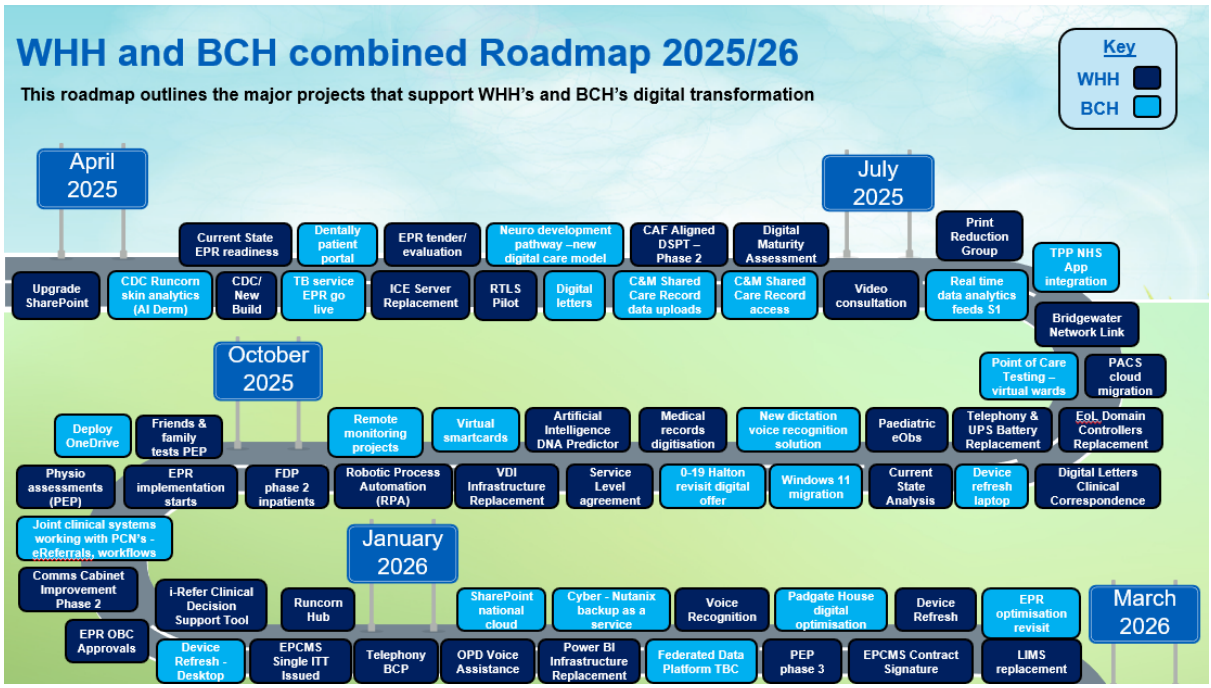


Figure 41: Above illustrates the short-term digital roadmap for the two organisations

17.6 Access to EPR systems

17.6.1 Day one information sharing and communication plan

From the outset, staff in acute and community services will leverage existing reciprocal access arrangements to each trust's systems, such as TPP SystmOne and Lorenzo. Additional/new user accounts will be provided as needed and within current license limits. Clinical teams will continue to share access where necessary, ensuring that information follows the clinical service and supports robust clinical decision-making and pathway redesign.

Immediate actions for the digital teams include reviewing policy statements and processes to accommodate any increase in user base and investigating technical solutions like click-through capabilities for launching alternative system views in context. Regional access to the CareCentric C&M shared care record will be prioritised, providing a broader platform for information sharing beyond the two EPRs, and supporting wider clinical collaboration.

17.6.2 Long-term vision to 2030

Looking ahead to 2030, the combined digital strategy is to progressively enhance interoperability using standards, enabling seamless exchange of records and discharge information between systems. The goal is to transition to a common system by 2030. In the interim, digital solutions will be aligned with evolving clinical strategies, with investments dependent on national funding allocations and a strong organisational commitment to digital transformation.

The plan includes deploying tools like Optima One (Federated Data Platform) for multi-agency bed management and discharge planning, expanding the use of patient portals and wearables, and standardising data structures to the NHS data dictionary. Ongoing refreshes of the digital strategy will ensure alignment with clinical priorities and organisational operating models, supporting effective communication and information sharing across acute and community services.

17.7 System functionality

WHH completed a £3m IT network replacement in March 2025, providing a modern, cyber-secure and high-speed connectivity infrastructure for our hybrid cloud portfolio of applications, imaging modalities and medical devices. During 2025-26 we will migrate to the Cheshire and Merseyside regional PACS Cloud, providing consolidated, secure storage and improved data sharing in radiology. In preparation we are trialling medical imaging AI solutions, including Annalise.AI for chest X-rays, to enhance diagnostic speed and accuracy.

As part of our EPR Readiness Programme we are commissioning a Clinical Data Repository (CDR) solution to facilitate digitisation of paper medical records and to provide a consolidated clinical data archive for legacy system data storage. This approach will facilitate consolidation of patient-related documents from multiple source systems and the transition to digital outpatients and digital wards in preparation for core EPR replacement.

As we continue our Federated Data Platform (FDP) programme, following the successful implementation of theatres scheduling we will onboard a PLICS solution as an early adopter, rename the WHH FDP tenant to NCM, and onboard community services, creating a shared secure data environment. We are assessing the viability of using the FDP tenant for future organisation-level data warehousing, alongside other options for an integrated data

warehouse and BI reporting platform for NCM. Future reporting requirements include near-real time dashboards with a range of data visualisations and patient flow optimisation dashboards, linked to bed management and RTLS-based resource tracking.

Our Electronic Patient Record (EPR) strategy is focused on procurement of a new shared instance solution in partnership with Mersey and West Lancashire NHSFT. This strategic investment will facilitate convergence of digital systems at scale, enabling the standardisation of clinical workflow processes via a flexible EPR platform. Following replacement of current core EPR systems, in 2030 we will re-tender the community EPR contract with an option for full consolidation into a single EPR platform for the integrated organisation.

17.8 Governance and assurance

We have established joint governance structures, robust risk management, and cyber assurance processes. Investments in network architecture and cyber security, SIRO/DPO registrations, and Board assurance on information risk ensure regulatory readiness and resilience. Our integrated digital service desk and technical support model underpin operational continuity. Key digital pre-requisites for go live in 2026 include integrated governance, service desk, updated policies, and technical architecture.

Maintaining robust cyber security defences throughout the transition period is critical to the safe and successful integration of the trusts' IT network and business-critical systems. We have established a joint Change Advisory Board (CAB) in advance of the transaction, to facilitate technical knowledge transfer and integration of IT service management processes, ensuring access, security and availability of systems used to support frontline service delivery.

We are also designing a new digital activity and performance framework as an integrated reporting platform, providing a consolidated view of our service desk, systems, data, cyber defences, and other key digital metrics.

17.9 Digital improvement programme

We are consolidating our IT service management toolsets and administration products, reducing variation by standardising items in the digital service catalogue. The introduction of a new digital customer portal for digital support, live system and incident status and self-service service requests will further streamline support processes and improve user experience.

These actions, combined with ongoing collaboration at the Cheshire and Merseyside level including consortium procurements, are enabling us to deliver more effective use of digital capital monies, reduce duplication, and ensure that cost savings are realised and sustained.

Our portfolio of digital transformation programmes also contributes to several trust-wide productivity and improvement programmes, for example DNA reduction via PEP and digital correspondence, and theatres utilisation metrics via the FDP Theatres Scheduling system.

Our digital cost reduction programme is delivering sustainable efficiencies and maximising value from digital investments across the integration. We have already consolidated onto the same supplier contracts for mobile data, achieving immediate savings and simplifying management. Plans are in development to converge onto a single managed print service (MPS), which will contribute to sustainable savings as part of a wider Print Reduction Strategy.

This approach ensures that digital transformation is not only innovative but also financially responsible, supporting the long-term sustainability of our services.

17.10 Building our digital culture

We are committed to digital upskilling, staff engagement and supporting patients at risk of digital exclusion. NHS App uptake is above both national and C&M averages (Warrington 65%, Halton 62%), demonstrating strong population digital readiness.

Our Digital Champions, Information Asset Owners and MDT-style digital teams foster a culture of inclusion, capability and continuous improvement. Digital inclusion is a recognised priority, with targeted support for vulnerable groups and ongoing engagement with Place partners.

17.10.1 Population digital readiness and inclusion

We are proud of our above-average NHS App uptake and are committed to supporting patients at risk of digital exclusion through digital champions, assisted access and tailored communications. Our digital inclusion work is recognised at place and system level, with ongoing engagement and support for vulnerable groups. Our updated digital skills and culture programme will ensure our frontline clinicians are equipped to use digital systems efficiently, with a focus on data quality and continuous improvement.

WHH has an established Patient Engagement Platform (PEP) with above average NHS App uptake. Through our communications and stakeholder engagement activities, with the support of Warrington Together and One Halton partners, we have developed a digital inclusion plan based on population health data including the Digital Exclusion Index (DEI). According to the DEI, Warrington is ranked as the most digitally inclusive place in Cheshire and Merseyside.

To ensure all our community patients can benefit from digital healthcare, we will focus on improving both digital readiness and digital inclusion. We will work with local councils, voluntary sector organisations, and community groups to help patients build digital skills and confidence through training, digital champion schemes, and accessible support hubs.

We will also address barriers to access by providing support for devices, connectivity and local WiFi-enabled spaces, ensuring patients can engage digitally regardless of the circumstances. All new digital tools will be designed to be simple, accessible and inclusive by default, with alternatives such as phone or face-to-face options for those who prefer them.

By combining inclusive design, practical support and ongoing community engagement, we will ensure everyone has the opportunity, skills and confidence to participate in digital health services, helping to reduce health inequalities and improve access to care.

17.11 Patient benefits

Our emerging Digital Strategy will deliver a comprehensive set of benefits to patients by using digital innovation to improve care quality, accessibility and experience. Key patient-focused benefits and outcomes include:

- **holistically supporting people throughout their lives** – patients receive continuous, personalised care that adapts to their evolving health needs throughout life

- **faster diagnosis and streamlined pathways** – advanced technologies such as AI-enabled imaging and integrated shared records accelerate diagnostic processes and improve clinical decision-making
- **enhanced patient empowerment and access** – tools like the NHS App and personal health records (PEP) enable patients to manage appointments, view health information and actively participate in their care
- **care delivered closer to home** – diagnostic services and routine tests are made more accessible by decentralising delivery, reducing travel and improving convenience
- **improved data sharing and reduced duplication** – cloud-based electronic patient records (EPR) and shared care records ensure seamless information flow across providers, minimizing repetition and enhancing continuity of care
- **workforce enablement and digital inclusion** – patients benefit from a digitally confident workforce and inclusive services that ensure equitable access to care, regardless of digital literacy or socioeconomic status
- **measurable improvements in experience and outcomes** – the strategy will drive quantifiable gains in operational efficiency, clinical effectiveness and overall patient satisfaction

17.12 Priorities for day one and transitional arrangements

As part of the integration process, we are developing a comprehensive digital transition plan to ensure that core systems and digital services are fully aligned and capable of supporting a single, integrated organisation. The transition is being designed to prioritise patient safety, continuity of clinical services and minimal disruption to staff.

The plan is directly informed by findings from IT due diligence, ensuring that risks are addressed, legacy issues are managed, and opportunities for digital improvement are realised. Robust transition plans will be in place for all critical systems, including electronic patient records, clinical applications, risk management, workforce systems and financial ledgers.

A phased implementation approach is being adopted, focusing first on areas where integration is most urgent and impactful, while carefully balancing available resources. This ensures a safe and controlled transition, with appropriate fallback measures where required.

On day one the trust's digital priorities will centre on ensuring continuity and reliability of all critical clinical/operational systems, such as the electronic patient records (EPR), finance and human resource systems, analytics platforms, and the supporting secure infrastructure. This will include updating organisational identifiers (ODS codes, trust names etc), harmonising cyber security and governance processes, and maintaining staff access to essential digital tools. Minimising changes with clear communication to our staff about necessary changes will be vital to maintain confidence and operational stability.

Future transitioning to any new systems will require detailed migration plans that map existing platforms, sets milestones for updates, and ensures secure data migration with robust quality checks. Stakeholder engagement will be crucial – forming transition teams with clinical, operational, IT and governance leads to oversee the process and ensure buy-in. Comprehensive training and ongoing support for staff, alongside retaining access to legacy systems for a defined period, will help minimise disruption and support continuity.

Finally, aligning all policies, documentation and registrations to the new organisation will ensure ongoing compliance with national standards requirements. This strategic, collaborative and patient-centred transition will provide the basis for our integrated, future-ready digital services and ongoing operational resilience.

17.13 Resourcing and funding

The delivery of the digital integration plan is being resourced in a way that balances delivery of the digital transition with the need to maintain safe and effective business-as-usual (BAU) operations. Capacity has been freed up through reprioritisation of internal workloads, and additional temporary capacity may be sought through external recruitment and interim appointments where required. This ensures that transition activities do not compromise day-to-day service delivery.

We are currently completing a review of long-term contracts and licensing arrangements to fully understand any cost implications and build these into forward planning. Where opportunities exist to exit, consolidate or renegotiate contracts, these are being pursued to release savings.

Achieving the digital transformation ambitions will require structured investment across multiple domains. Initial costs include capital funding for new platforms (such as EPR and AVT solutions), infrastructure upgrades and integration efforts, while ongoing costs cover staff training, process change and adoption, system maintenance, compliance, and governance.

All one-off and ongoing costs associated with the digital integration transition are aligned to the broader integration plans. Assumptions will be validated against sector benchmarking data to ensure cost estimates are both realistic and defensible.

We will utilise national and regional funding opportunities, whilst also ensuring we maximise the benefits of our existing systems, developing standardised configurations throughout to control costs. We will ensure all investments are aligned with local, ICS and national programmes and supported by robust business cases, showing clear return-on-investment tracking, and sustainable resourcing plans to ensure long-term value and impact for the new organisation.

18.0 Estates Strategy

18.1 Chapter summary

This section describes how the combined estate of WHH and BCH will be optimised to support integrated service delivery, future sustainability and support the production and delivery of the joint Clinical Strategy. It sets out the current estate footprint, utilisation levels and opportunities for rationalisation, co-location and community access.

The section highlights how integration enables a single estates plan aligned with clinical priorities and the NHS Net Zero agenda. It details how modernisation, investment and disposal strategies will ensure the estate is efficient, fit for purpose and environmentally responsible, providing high-quality care environments for patients and staff.

Key message: This section shows how the full extent of the new community and acute estate is being considered in relation to delivery of services. Outpatient locations, corporate spaces and relocation of corporate staff are a particular focus, looking at where best to deliver services across the 98 sites comprising 75 buildings, including 45 leased spaces across Warrington, Halton, Knowsley, St Helens and Greater Manchester.

This section addresses the age and declining condition of the current estate, the increasing cost of backlog and impending backlog maintenance costs. Works identified include:

- replacements to infrastructure including replacement windows
- aged site drainage
- building management system
- ventilation systems
- water distribution
- electrical systems

Through robust risk management and future-focused planning, the integrated trust will provide the right environments for patients and staff while safeguarding long-term value.

18.2 Estates Strategy – supporting the integration

Estates has been identified as one of the key enablers to support the delivery of the joint strategic goals which forms the basis of the plan for the integration of WHH and BCH. The developing Estates Strategy will describe a vision for an integrated estates service to support the delivery of the clinical strategy through the effective supply of high-quality space for both clinical and non-clinical functions.

The strategy will be developed prioritising effective space utilisation, with the goal of providing a place of delivery as close to the service user as possible. This is in line with several local, regional, and national strategies including the 10 Year Health Plan. The benefit of the integration is being able to consider all the estate of an integrated organisation as one, and make informed decisions on space allocation which best suits the needs of patients and the services they are accessing.

Currently there are areas of estate across both organisations which require development to support the joint Clinical Strategy of the trusts, and the delivery of the integration programme.

We know we can make more efficient use of the joint estate between WHH and BCH, taking a strategic approach based on patient, clinical and organisational need to optimise the use of estates and capital expenditure.

Across both organisations, our staff currently operate from approximately 98 sites, comprising around 75 buildings which includes 45 leased spaces across Warrington, Halton, Knowsley, St Helens and Greater Manchester, that deliver a mixture of clinical, community, administrative and support functions. This reflects the breadth of our combined estate, spanning hospitals, health centres, community clinics and office accommodation.

Nationally since 2016, while the NHS estate has grown by 3 per cent, patient attendances have risen by 11 per cent, highlighting the need for efficient space management to meet rising demand and provide a safer and more compliant care environment for patients[47]. This provides an opportunity to align investment with clinical pathway transformation, identifying suitable and potential under-utilised space across our boroughs.

The condition and functionality of NHS estates are often constraints for NHS trusts, with significant investment required to modernise and make the aging estate fit-for-purpose. This is certainly true of the hospital estate, where half of our buildings are more than 40 years old, and as such the case for new acute estate remains strong.

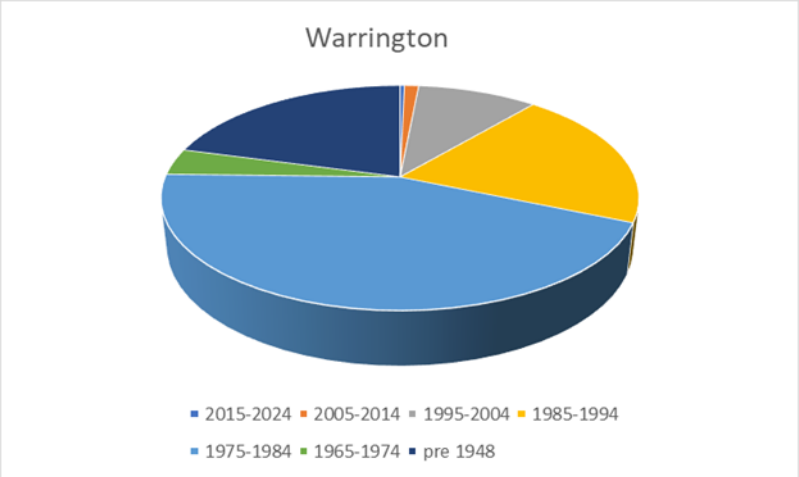
71 per cent of the buildings occupied by WHH and/or BCH teams have been constructed within the past 30 years, including properties leased from other NHS sectors. That includes NHS Property Services, community health partnerships and GPs. Through integration, we will ensure that our portfolio across our boroughs aligns with our clinical strategy and national policy.

The focus of the Estates Strategy will be to support the delivery of a transformational clinical strategy and enable the integration of corporate services.

18.3 Current state

18.4 Age and condition

The buildings within the WHH estate portfolio vary in age as illustrated by figure 42 and figure 43 below.



[47] as per NHS England (2024) *Delivering productivity through NHS estate*. Available at: https://www.england.nhs.uk/publication/delivering-productivity-through-the-nhs-estate/

Figure 42: Age profile of buildings at Warrington Hospital

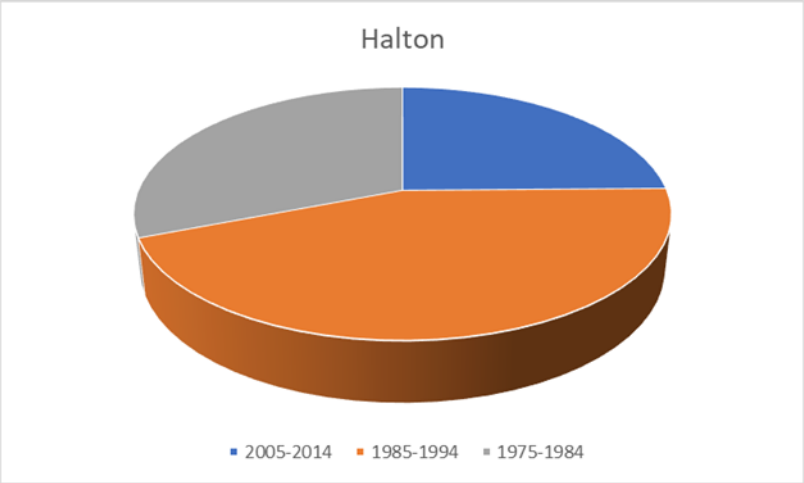


Figure 43: Age profile of buildings at Halton Hospital

These figures can be compared with NHS England age data using the NHS Estates Return Information Collection (ERIC) – the latest release covers the period 2023-24.

Comparatively, WHH estate is older than equivalent NHS estate when looked through 'trust type' and regional averages (56 per cent of WHH estate is now aged more than 40 years old, compared with 43 per cent nationally):

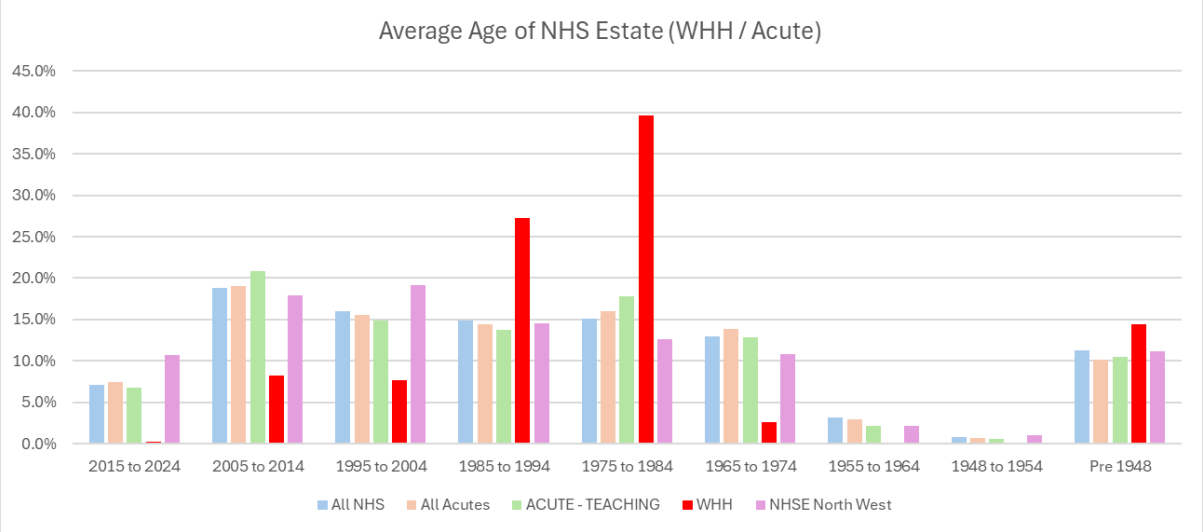


Figure 44: Average age of WHH estate compared to NHS averages

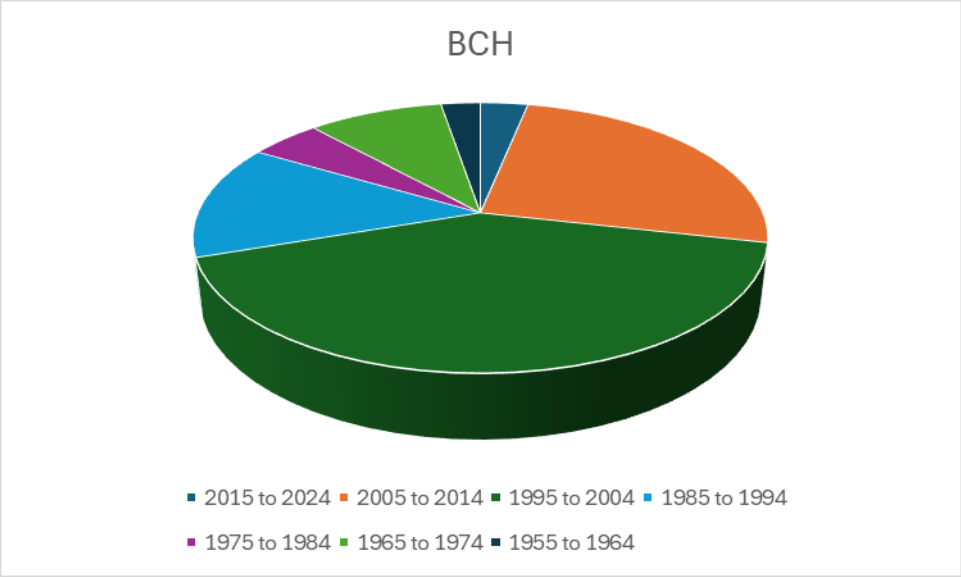


Figure 45: Age profile of buildings operated by BCH as reportable through to ERIC

In contrast, the age of BCH estate compares more favourably against peer organisations:

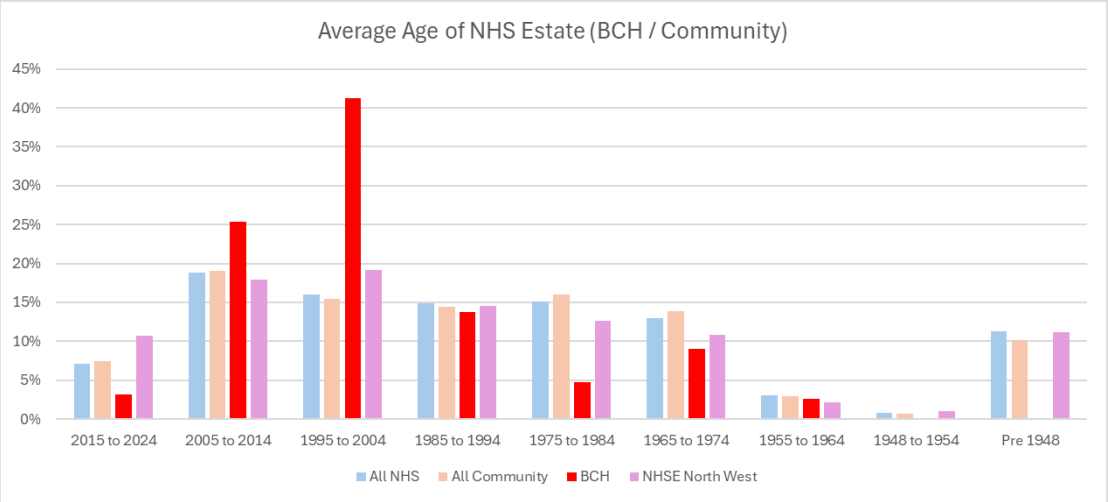


Figure 46: Average age of BCH estate compared to NHS averages

18.4.1 Backlog maintenance

Backlog maintenance cost (backlog) is the cost to bring estate assets that are below a certain standard and make them operationally sound in terms of their physical condition, and/or compliance with mandatory fire safety requirements and statutory safety legislation.

Backlog and statutory compliance costs are classified as either low, moderate, significant or high risk.

The NHS Estates Guide 'A Risk-Based Methodology for Establishing and Managing Backlog[48]' is used to calculate the risks for each defect highlighted within the physical condition and statutory compliance.

[48] NHS Estates (2004) *A risk-based methodology for establishing and managing backlog*. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/05/Backlog_costing.pdf

Table 54 below shows a breakdown of the backlog costs (i.e. costs required to bring elements currently below condition grade 'B' up to condition grade 'B' immediately) by risk. As per Department of Health definitions, grade 'B' describes estate as 'sound, operationally safe and exhibits only minor deterioration', and is the nationally recognised standard used by the Department of Health.

In November 2024, the total backlog cost in relation to physical condition and statutory compliance was **£44,665,099** as per table 54.

Backlog by site	Low	Moderate	Significant	High	Total
Halton Hospital	£1,787,588	£4,014,238	£7,218,212	£459,479	**£13,479,517**
Warrington Hospital	£5,084,047	£8,601,945	£16,201,756	£1,297,834	**£31,185,582**
Total	**£6,871,635**	**£12,616,183**	**£23,419,968**	**£1,757,313**	**£44,665,099**

Table 54: WHH backlog maintenance costs by category

Most of the facilities within the BCH portfolio are leased and therefore the majority of backlog liabilities fall with the property landlords. However, as per the latest (2024-25) ERIC returns, the total value of backlog liability for BCH is £350,000. 91 per cent of this liability falls within the 'low' or 'moderate' categories.

18.4.2 Impending backlog maintenance costs

Impending backlog relates to elements of the estate currently in condition grade B that will fall below condition grade B within five years, assuming no major investment in the interim.

The total impending backlog costs, for condition (including costs for site infrastructure) as of November 2024 were:

£10,266,918 – Warrington Hospital site

£7,931,512 – Halton Hospital site

The backlog figures in table 54 are likely to increase by the figures above (i.e. this is estate that is likely to deteriorate below condition grade B across the next reporting period with no investment).

In addition to backlog costs relating to physical condition and statutory compliance, WHH also calculates costs relating to the following facets on an annual basis:

- functional suitability
- space utilisation
- quality of the environment
- environmental management
- Equality Act

Some of these facets are difficult to address due to the nature of a building, the historical design and layout of rooms and wards, or the infrastructure unable to support new methods

of building. It is therefore less likely that the costs will be addressed, and the organisation will focus primarily on the physical condition and statutory compliance.

The estimated costs to address these facets of backlog is currently £25.5m at Warrington Hospital and £4m at Halton Hospital.

Works identified include:

- replacements to infrastructure including replacement windows
- aged site drainage
- building management system
- ventilation systems
- water distribution
- electrical systems

It is estimated that to effectively eradicate the total backlog, the integrated organisation will need to spend upwards of **£100m** over the next 10 years.

Whilst addressing the backlog can limit development and growth elsewhere, statutory compliance items will be addressed first, followed by high-risk backlog items under physical condition, followed by significant then moderate and low risk items. Future costs should be addressed as appropriate by risk as described for backlog items above.

This will be actioned in tandem with a review of current estate needs of the integrated organisation, identifying any opportunities to safely relocate services to improved environments where there is no or minimal impact on patient experience and care.

18.5 Outpatient space

The growth in demand for services over recent years has put increasing demand on the existing estate across both organisations, particularly in terms of ward and urgent care estate within the hospital. Space is in short supply, budgets are under pressure, and current access for patients needs to be improved.

To meet these demands and deliver on the clinical vision for the integrated organisation, changes will need to be made at the point of delivery for outpatient services. The integration presents an opportunity to transform the delivery of key services to shift away from a hospital-centric model towards a community-first model and ensure that the organisation's estates strategy meets evolving needs, whilst making appropriate and efficient use of all available space.

Outpatient space is a consistent challenge at WHH, particularly when space is needed for additional clinics to help flexibly manage RTT and cancer standards. BCH has several community locations that can be factored into the wider underpinning Estates Strategy, supporting the workstreams identified from the new joint Clinical Strategy.

Approaches the strategy will take for the transformation of outpatient services include the following examples:

- Redesign how we deliver virtual and face-to-face outpatient clinics, making best use of available space.
- Make full use of the estates available across both community and acute to ensure point of delivery for outpatient services in the most appropriate location and ensure the most efficient use of space.

- Consider community locations within specific neighbourhoods and how clinical estate in those locations can best be used to deliver services targeted and the needs of the local populations in those neighbourhoods.
- Review utilisation of all current clinic space.
- Consider which services are best delivered in an outpatient community setting and which need to be on an acute site, for critical adjacencies.

Table 55 below shows the current delivery locations for outpatient services at WHH.

Specialty	Acute	Community	Primary Care	Telephone	Home	Appointments
650 – PHYSIOTHERAPY	38%	22%	0%	5%	35%	61,681
651 - OCCUPATIONAL THERAPY	69%	20%	1%	9%	1%	45,139
130 – OPHTHALMOLOGY	99%	1%	0%	0%	0%	42,685
110 - TRAUMA AND ORTHOPAEDICS	82%	0%	0%	18%	0%	32,472
320 – CARDIOLOGY	79%	2%	0%	19%	0%	25,494
120 – ENT	70%	27%	0%	2%	0%	21,086
560 - MIDWIFE EPISODE	89%	0%	0%	11%	0%	20,770
324 - ANTICOAGULANT SERVICE	75%	25%	0%	0%	0%	17,290
420 – PAEDIATRICS	81%	1%	0%	18%	0%	15,549
100 - GENERAL SURGERY	100%	0%	0%	0%	0%	13,743
658 – Orthotics	46%	53%	0%	1%	0%	13,231
340 - RESPIRATORY MEDICINE	88%	0%	0%	7%	5%	12,725
341 - RESPIRATORY PHYSIOLOGY	38%	54%	0%	7%	0%	12,655
307 - DIABETIC MEDICINE	88%	1%	0%	11%	0%	11,947
101 – UROLOGY	74%	0%	0%	26%	0%	11,689
422 – NEONATOLOGY	96%	0%	0%	4%	0%	9,067
103 - BREAST SURGERY	100%	0%	0%	0%	0%	7,876
327 - Cardiac rehabilitation	7%	91%	0%	0%	1%	7,497
104 - COLORECTAL SURGERY	68%	0%	0%	31%	0%	7,269
301 – GASTROENTEROLOGY	75%	0%	0%	25%	0%	7,253
652 - SPEECH AND LANGUAGE THERAPY	100%	0%	0%	0%	0%	6,925
502 – GYNAECOLOGY	100%	0%	0%	0%	0%	6,630
143 – ORTHODONTICS	100%	0%	0%	0%	0%	5,733
812 - DIAGNOSTIC IMAGING	100%	0%	0%	0%	0%	4,875
140 - ORAL SURGERY	100%	0%	0%	0%	0%	4,178
655 – ORTHOPTICS	32%	48%	0%	20%	0%	3,710
302 – ENDOCRINOLOGY	52%	0%	0%	48%	0%	3,450
303 - CLINICAL HAEMATOLOGY	79%	0%	0%	21%	0%	2,896
361 – NEPHROLOGY	15%	0%	0%	85%	0%	2,335
840 – AUDIOLOGY	92%	0%	0%	8%	0%	1,991
191 - PAIN MANAGEMENT	96%	0%	0%	4%	0%	1,967
328 - Stroke Medicine	13%	0%	0%	87%	0%	1,788
306 – HEPATOLOGY	93%	0%	0%	7%	0%	1,694
214 - PAEDIATRIC TRAUMA AND ORTHOPAEDICS	100%	0%	0%	0%	0%	1,567
300 - GENERAL MEDICINE	100%	0%	0%	0%	0%	1,491
144 - MAXILLO-FACIAL SURGERY	83%	0%	0%	17%	0%	1,397

Table 55: Current delivery locations for outpatient services at WHH

The estate locations currently utilised by WHH and BCH within Warrington and Halton are depicted in figure 47 below.

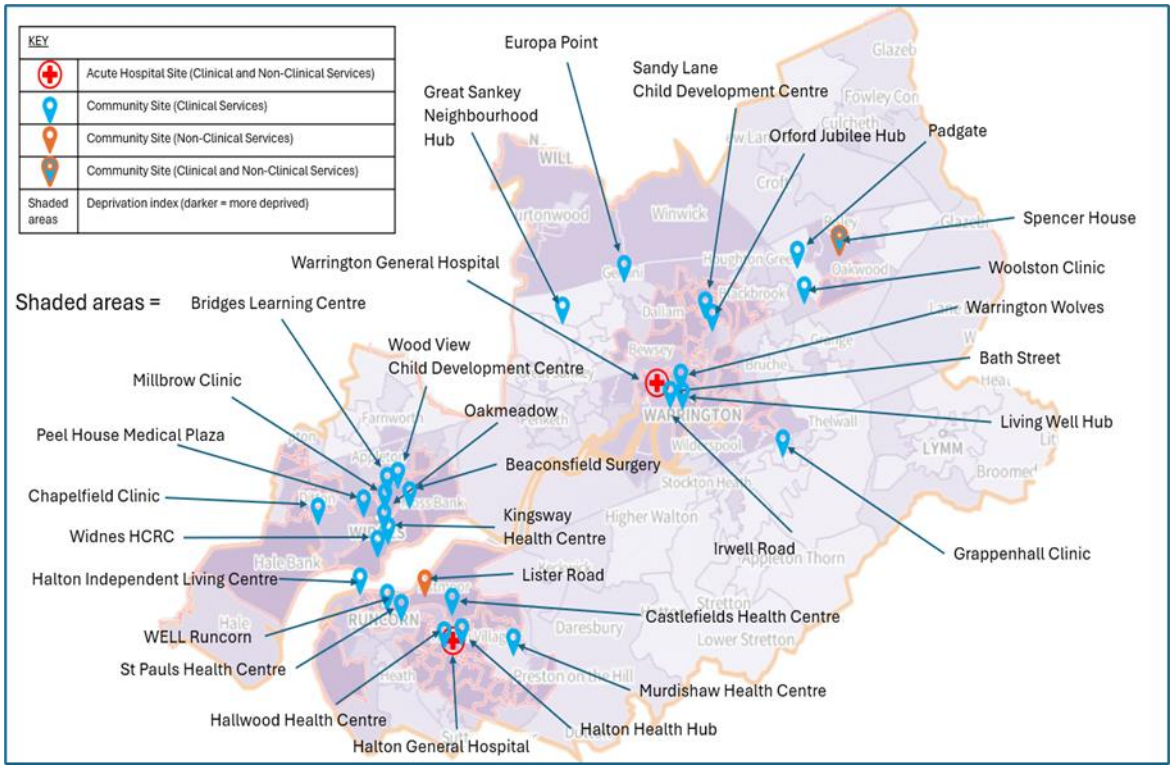


Figure 47: Current Warrington and Halton estate locations across both WHH and BCH

18.6 Estates integration priorities – outpatient spaces

There are several challenges to be taken into consideration when planning a transformation of outpatient estate across both trusts:

- Main outpatient department capacity on the hospital sites is lacking for smaller specialties to expand and address growing waiting times.
- There is limited capacity in primary and community care settings to move activity from the acute site at present.
- A corresponding cultural shift may be required for some staff to deliver services away from the acute site.
- IT links and software functionality may need developing and upgrading in some facilities.

The draft Estates Strategy must support the requirements of the new integrated Clinical Strategy as it develops and estates will be a key enabler to the delivery of any future clinical model.

18.7 Estates integration priorities – corporate spaces

To support efficient delivery of a combined corporate service, changes are likely to be required with regards to the location of corporate teams. The integration presents an opportunity to ensure that corporate services support the integrated organisation, whilst making appropriate and efficient use of all available space.

Approaches the strategy will take for the transformation of corporate services include the following examples:

- Support digital transformation, making best use of available space for the delivery of corporate services.

- Make full use of the estates available across the combined organisation to ensure corporate teams can work in appropriate locations and make the most efficient use of space.
- Review utilisation of all current office space.
- Consider which corporate services are best delivered in a non-acute setting and which need to be on an acute site, for critical adjacencies and supporting operational teams.

18.7.1 Corporate space case study – relocation of corporate staff

The relocation of services from Kendrick Wing on the Warrington Hospital site has long been a strategic intent of WHH due to the poor condition of large parts of the building and high running costs of the buildings.

Relocating significant numbers of staff away from Kendrick Wing would also help address another long-standing challenge around car parking for patients and visitors, as it would reduce demand for parking spaces for staff on the site.

There is currently significant under-utilised space at Spencer House, the BCH corporate HQ. It is therefore prudent to explore whether the use of Spencer House as a main corporate hub for the integrated organisation would be feasible and beneficial. Several other trusts locally have adopted an off-site base model for corporate functions without significant issues arising.

Consolidating corporate functions from both WHH and BCH in the same corporate base location will support improved integrated working, connection between staff and teams, and create opportunities for future financial efficiency as noted in section 13.3.7.

The impact of COVID-19, and subsequent increase in agile working and virtual meetings, has created an environment for change that perhaps did not previously exist when off-site working solutions were tentatively explored.

At a high level, it appears that the current demise of Spencer House would be sufficient to use as a potential base location for all appropriate corporate teams from both WHH and BCH.

The analysis assumes current agile working patterns are not changed in any way. Although if the estimated desk demand proves to be significantly greater than calculated, there remains an option to review current working arrangements and promote/mandate increased working from home.

There would be a requirement to retain a corporate hot desk facility on the Warrington Hospital and possibly the Halton Hospital site. Further work is required to estimate the required size of this. There would also be a need to consider workforce implications associated with this exercise before proceeding any further.

The potential re-location of corporate staff out of Kendrick Wing will not facilitate the full closure of that part of the hospital estate. There will be a further need to explore re-location of other non-corporate teams and services (e.g. stores).

However, closing large sections of the building would enable delivery of cost savings through energy usage and facilities management services.

18.8 Developing an Estates Strategy

As illustrated in section 8.7, we will develop an Estates Strategy for the integrated organisation, which will align to the overall organisational, clinical, and financial strategies. It will also align to most recent NHS Cheshire and Merseyside ICS Estates Strategy.

The eight principles of the current C&M Estates Strategy are detailed in figure 48 below:

Figure 48: 8 principles of the Cheshire and Merseyside Estates Strategy

The NHS 10 Year Health Plan has several strategic estates implications, primarily driven by a planned shift in healthcare delivery from hospitals to community-based services. Supporting this, the trust will undertake a review of its combined estates to ensure that its assets are able to align with this intent, identifying areas for investment (and routes to secure that investment), as well as opportunities for efficiencies across the portfolio.

Aligned with this, the integrated trust must ensure that the areas from where care is delivered are not putting communities across Warrington and Halton at a disadvantage, especially when there are significant areas of deprivation across our catchment.

Supporting the focus on a move to community health, there will be a need to re-evaluate existing hospital assets to ensure that they support the move of services into appropriate infrastructure in community settings. The trust must be well integrated into evolving governance at the Department of Health and Social Care, and at a local level through the devolution of Warrington and Cheshire, to ensure inclusion on local capital pipelines, and able to influence capital spending decisions in support of its programme.

The delivery of the estates objectives below will support the strategic aims which collectively underpin achievement of the integrated trust's strategic objectives:

- align the estates and clinical strategies and underpin the trust's values and objectives
- support the ambitions of Warrington and Runcorn as growing towns, focusing on regenerating built and natural environment and reducing health inequalities
- improve compliance with health building notes and health technical memorandums
- provide a solid platform to prioritise investment and prepare for future opportunities

- reduce backlog maintenance and critical infrastructure risks
- secure additional capital resources to fund the backlog maintenance program
- enhance the tactical estates group (TEG) to provide oversight on the capacity
- enable the delivery of clinical and operational services and sustainability
- improve functional suitability and net zero target
- improve utilisation of estates capacity
- aid in the achievement of the financial plan

18.9 Green plan

Climate change plays a huge part in the future of our estate. The work towards achieving net zero across both organisations is underpinned by Board-approved green plans, which outline the objectives and goals to help us achieve this ambition. This plan is delivered through 117 actions across key priority areas, including governance and sustainable models of care.

We are committed to reducing our carbon footprint and continue to pursue a wide range of projects and initiatives to make this happen, with an updated plan due to be launched in 2026. From an estates perspective, this ambition will be supported through a focus on the areas in details in figure 49 below:

Figure 49: Key areas of focus for the NHS green plan

The Estates Strategy will be finalised and presented as a key enabling strategy as part of the overall programme of strategy development following the integration of the two organisations. We expect the final strategy to be signed off in Q3 2026-27, as per figure 17, showing the high-level timeline for the development of the joint strategies.

18.10 Estates Strategy – next steps

In order to assist with the development of a cohesive plan to deliver the strategic estates objectives, WHH has appointed a third party to help create a refreshed strategic estates development plan for both main hospital sites. This plan will be developed in line with the principles of the emerging clinical strategy across the combined organisation and follow the principle of ‘home first, then community and hospital only if needed’. Since the development of WHH’s previous strategic estates development plan in 2015, much of the strategic landscape has changed, requiring a refreshed medium-term vision to be developed.

In 2022 WHH submitted a bid to the national Hospital Infrastructure Programme to create a new hospital in Warrington town centre and to undertake a major reconfiguration of the Halton Hospital site. This bid was ultimately unsuccessful and given likely constraints upon NHS capital resources across the medium term, a more flexible and adaptive approach to the future provision of health care within our boroughs is required.

Additionally, WHH has seen significant site and service development in the intervening years, within both hospital and community settings. These developments are broadly in line with the principles of the 10 Year Health Plan, as well as the emerging clinical strategy resulting from the integration of the acute and community trusts.

Resultingly, the updated strategic estates development plan must reflect these developments and provide a blueprint for our future estate requirements, ensuring a focus on:

- utilisation of land and buildings already in use (including opportunities of an expanded estate via the integration programme)
- development of agile, business-case-ready proposals, enabling the integrated trust to respond promptly to calls for investment from the Department for Health and Social Care and other potential funders

19.0 Risks

19.1 Chapter summary

This section provides a comprehensive overview of the key risks associated with the integration and the mitigation measures in place to manage them. It identifies clinical, financial, workforce, operational and reputational risks, and demonstrates how these are being monitored through established governance frameworks.

The section highlights the proactive approach taken by both trusts to risk management, ensuring issues are identified early, owned at the right level and mitigated effectively.

It concludes by affirming that, while risks exist, the robust governance, engagement and assurance mechanisms already established provide confidence in a successful transaction and future integrated delivery model.

Key message: This section outlines the approach to identifying and managing any potential risks that may arise as a result of the integration programme. An overarching programme risk register has been developed and a summary of key integration risks and mitigations scoring 9 or above are discussed.

Extensive and appropriate due diligence has been undertaken by WHH as the acquiring trust as part of the process for compiling the FBC. A number of key areas of due diligence have been conducted primarily by KPMG as an external consultancy partner. Other areas of due diligence have been undertaken internally by trust representatives and then subsequently reviewed by KPMG. Hill Dickinson solicitors completed the legal due diligence.

The due diligence findings were compiled into a single list and reviewed by both trust Boards before appropriate mitigating actions were agreed and documented to address any agreed risks associated with the transaction.

19.2 Programme risk management

A robust risk management process is in place across the BCT programme with all 10 core workstreams using the individual delivery trackers (as referenced in section 7.3.2) to capture, record, report, manage and monitor all risks arising as a result of the integration work.

All workstreams capture and record both operational risks (risks within the workstream itself) and strategic, programme-level risks.

The risks being recorded and managed have been identified through a range of sources, including:

- programme management team
- Better Care Together programme delivery group
- executive management team (EMT) and trust Boards/sub-committees
- workstream leads
- due diligence findings
- risks arising from other organisations that have undertaken a similar form of integration

The standards, methodology and operating principles applied to risk management within the programme are aligned with the recognised WHH organisational risk management strategy. The integration risk register mirrors the format and scoring methodology used in both trusts'

corporate risk registers. Risks are initially captured within the delivery trackers, including any mitigating actions, risk scoring and relevant risk owner. Table 56 below sets out the risk assessment and scoring criteria applied to programme risks based on likelihood and impact of risk.

		Likelihood				
		1. Almost never	2. Unlikely	3. Likely	4. Highly likely	5. Almost certain
Consequence	1. Insignificant	1	2	3	4	5
	2. Minor	2	4	6	8	10
	3. Moderate	3	6	9	12	15
	4. Severe	4	8	12	16	20
	5. Catastrophic	5	10	15	20	25

Table 56: Risk assessment criteria

Overall risk score	
1-3	Very low risk
4-6	Low risk
8-12	Moderate risk
15-25	Extreme/high risk

Table 57: Risk scoring/grading

The current version of the transaction risk register is included within the supporting documents accompanying this document. A summary of the highest risks (i.e. those scoring 15 or above before mitigation) and the associated mitigations is presented in table 58 below. This excludes the highest rated due diligence risks, which are summarised in section 19.3.2.

Workstream	Risk description	Initial overall score	Please provide controls and assurance details	Current overall score
Digital	If the trusts do not have a single EPR system in place from 1 April 2026, then this will present challenges to clinical teams around accessing the information required, resulting in potentially sub-optimal clinical decision-making.	20	The phased approach to the integration programme includes a 'lift and shift' approach for clinical services, meaning that there are no significant changes to pathways or clinical systems scheduled for day one of the integration. This should minimise risk and disruption for clinical teams in the short-term. Staff with existing access to Lorenzo/SystmOne/EMIS will continue to have that access and additional access will be granted if required within existing licencing limitations. Click-through capabilities to launch alternative systems from within others will also be	8

			explored. There is a high-level roadmap in place to progress towards a single EPR system for the integrated trust by 2030.	
Strategic programme management	If the ICB do not agree to fully fund our request for additional resources to support the programme, then the programme will either need to be paused or any unfunded costs met from internal trust resources, resulting in either a material delay to the programme or a material risk to delivery of the trusts' in-year financial plan.	16	The ICB Board formally supported our strategic case, timeline and acceleration of the transaction in July, with full knowledge of the likely costs, which we had submitted a request for funding for to the ICB prior to July's Board meeting. The ICB have so far confirmed allocation of £200k to support delivery of our integration. We have formally written to the ICB to confirm that unless the remaining £900k funding is allocated, we will potentially go off plan by up to £900k due to integration in 2025-26. The funding we have requested of £1.1m is significantly less than that provided to other integrations completed locally in recent years. Our integration is forecast to deliver at least £2m CIP in 2025-26 and cost up to £1.1m in 2025-26, both costs and savings are reflected in our financial forecast.	16
Strategic programme management	If the transaction is accelerated, then there will be less time available; to complete a number of critical programme tasks, resulting in increased pressures on already stretched corporate teams (e.g. workforce colleagues supporting OD, staff engagement and TUPE processes).	16	In order to manage the additional workload created, corporate teams will look to reduce or reschedule as much existing work as possible in order to create capacity. Furthermore, we have agreed a phased approach to the integration programme that will allow us to delay commencement of some elements that will require more resource (such as clinical service integration). When the initial transaction phase of the programme is complete, we will look to divert programme support to other workstreams to allow them to commence in full.	8

Strategic programme management	If NHSE do not approve the transaction to proceed as planned on 1 April 2026, then the programme will be delayed for a period of time, resulting in significant additional costs being incurred and a material level of operational uncertainty across both organisations.	16	We will review all critical day one actions recorded within the programme in early January 2026 to help identify those that will be impacted negatively by a delay to the completion of the transaction. Those that will, will require a 'plan B' mitigation to be drawn up and agreed with the consequences fully identified and communicated. In the meantime, the trusts are in close dialogue with NHSE around timeframes for approval and relevant detail and assurance required to ensure the transaction is approved and completed in time for 1 April 2026.	8
Clinical and operational	If high-risk policies across both organisations are not consistently updated, stored centrally in SharePoint, and effectively communicated to staff, there is a risk that staff may use outdated documents, potentially compromising patient, staff, and organisational safety.	16	The process of reviewing, prioritising and aligning all clinical policies ahead of the transaction date has already commenced. Relevant documents, SOPs and policies are being updated and consolidated to ensure clarity, accountability and robust governance structures. All processes will be concluded and fully communicated by 31 March 2026. All policies have been reviewed and categorised. All high-risk policies are now detailed on the clinical governance workstream delivery tracker with expected dates for revision of policies, approval of amendments and communication/training with staff.	8
Strategic programme management	If the transaction is accelerated, then there will be less time available to engage and consult with our staff, our local communities and our wider stakeholders, resulting in less understanding and trust in the process.	16	The communications teams from both BCH and WHH have diverted significant internal resources onto the integration programme to ensure all stakeholder communications are maintained and are thorough. We have included some designated additional resource to our communications teams as part of the Better Care Together programme resourcing plan to support regular and frequent	6

			engagement and two-way communication with multiple groups to ensure all stakeholders to the programme are kept informed and able to feed in their views. The public and patient reference group will commence in December 2025 and will be independently led by Healthwatch.	
Strategic programme management	If the transaction is accelerated then there will be less time available prior to the transaction date to plan and engage with stakeholders, resulting in a less effective integration of clinical services.	16	In order to mitigate the associated risk, it is proposed to bring BCH services across as a standalone care group within the existing WHH management structure in the short term (aka lift and shift). This will mean minimal or zero disruption and/or change to key clinical services in the short term.	4
Strategic programme management	If the integration programme timescales are accelerated then there will be less time to complete key actions and activities for regulatory and legal readiness such as consultation with staff re: TUPE transfer, organisational change processes, due diligence etc, resulting in a potential risk to legal compliance for the programme.	15	We have secured senior ICB and national support for the proposal in the short term to allow us to commence these actions. All required due diligence has now been completed and the results and risks identified have been fed back into our day-to-day planning via the workstream delivery trackers. Any decision to proceed with the transaction will need to be approved by both Boards and verified by the Council of Governors who will need to be assured that a robust and appropriate legal process has been followed. As noted in other identified risks, there has been significant work undertaken to review current workloads and divert internal resources to support and prioritise the core tasks within the programme wherever required.	8
Estates	If a contracted service is brought in house without proper evaluation of TUPE risks, then there is potential for the trust to be in breach of law, resulting reputational and financial damage to the trust.	15	Workforce representatives are invited to all project meetings to ensure that due consideration is given by project leads regarding TUPE and staff implication. Issues are highlighted to SROs and workstream leads where appropriate.	5

			Governance is in place to reduce likelihood of occurrence	

Table 58: A summary of key integration risks and the associated mitigations

Figure 50 below illustrates the process for programme risk management, which was approved by the BCT programme delivery group.

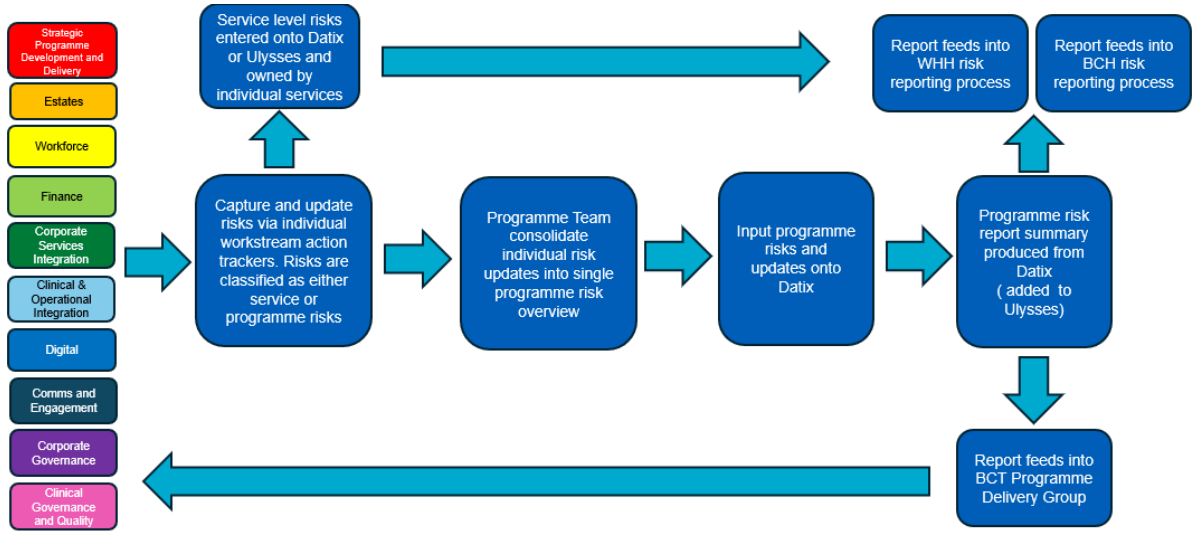


Figure 50: Process for capturing and reporting/managing risk associated with the BCT programme

All operational risks are added to the WHH Datix system and the BCH Ulysses system by the relevant operational/corporate teams. From there, they are managed via the established organisational risk management processes in place within both BCH and WHH.

All strategic programme-level risks are added to the WHH Datix system and the BCH Ulysses system by the BCT programme team and again, managed through established processes. These risks are also reviewed monthly at the BCT programme delivery board.

The integration risk register is reviewed as a standing agenda item at the BCT programme delivery group, ensuring visibility, challenge, mitigation, and escalation. Where significant risks are identified, these are reported up to the trust Boards.

19.3 Due diligence

All NHS trusts undertaking a material transaction are required to complete a due diligence process. NHS England guidance makes clear that the scope of due diligence should be proportionate to the nature of the transaction.

The primary purpose of due diligence is to identify potential areas of risk, enabling the trusts to make informed decisions about proceeding with the transaction and, where appropriate, embedding mitigation measures into integration planning.

In this case, as WHH is acquiring BCH, the due diligence exercise was unidirectional, with WHH conducting due diligence on BCH only.

To support this process, external consultants KPMG were engaged to conduct a detailed due diligence review, providing independent assurance and insight into operational, financial, and regulatory risks. Legal due diligence was undertaken by Hill Dickinson solicitors, ensuring all legal and contractual matters were fully assessed. Internal subject matter experts from WHH also reviewed specific areas of due diligence, offering in-depth knowledge and validation of findings. The outputs from their work were subsequently reviewed by KPMG.

A blended, proportionate approach was adopted, combining external assurance with internal expertise:

- **General due diligence (WHH on BCH):** Led by KPMG, supported by internal WHH teams, delivering external guidance, advice and recommendations
- **Legal due diligence (WHH on BCH):** Conducted by Hill Dickinson

19.3.1 Due diligence process

The due diligence (DD) process was undertaken in line with NHS England requirements to ensure that all material risks associated with the integration were fully understood and assessed and could therefore be appropriately managed. Due diligence was completed across a range of areas, including financial, IM&T, estates, legal, health and safety, workforce, and clinical and operational. The following structured approach was applied:

1. **Reviewed NHSE mergers and acquisitions DD guidance**

The programme team completed a detailed review of NHSE's DD guidance to ensure the scope, methodology, and outputs of the process met all national expectations for transactions of this scale.

2. **Integrated specialist recommendations from external advisors**

Areas of focus recommended by **KPMG** (operational/financial/regulatory) and **Hill Dickinson** (legal) were incorporated, ensuring that the DD scope was comprehensive and aligned with recognised best practice for NHS transactions.

3. **Designed tailored DD questionnaires**

Bespoke DD questionnaires were developed for each corporate, clinical and operational area.

These were designed to ensure systematic collection of information relating to clinical governance, performance, compliance, risk, contracts, workforce, estates, digital, quality, and finance.

4. **Supported workstreams through guidance and engagement sessions**

Introductory briefings and support sessions were delivered to workstream teams to ensure clarity of expectations, consistency of responses and timely provision of evidence.

The programme team provided ongoing guidance throughout the data-gathering stage.

5. **Factual accuracy review of initial DD reports**

Once KPMG and Hill Dickinson produced their draft DD reports, trust leads and workstream SROs conducted a detailed factual accuracy review. This ensured that all findings, assumptions and interpretations were correct and aligned with internal records.

6. **Finalisation of DD reports**

All amendments arising from the factual accuracy review were incorporated into the final DD reports by KPMG and Hill Dickinson. The final outputs provide an accurate and validated assessment of risks.

7. **Risk review, scoring and mitigation planning**

All identified risks were reviewed systematically RAG-rated in line with trust risk management frameworks.

For each risk, mitigation actions were developed collaboratively with workstream SROs and recorded within the integration risk registers.

8. **Identification of day one critical actions**

Specific high-priority actions required for day one readiness were extracted from the DD findings.

These actions are reflected in the workstream delivery plans and flagged as critical day one actions in relevant delivery trackers to ensure clear accountability, monitoring and timely implementation as part of the day one mobilisation meetings.

This comprehensive approach has enabled the identification, assessment and planned mitigation of risks; informing our integration planning and ensuring that the new trust will maintain strong governance, operational effectiveness and patient safety throughout the transaction and beyond. By addressing risks proactively, the trusts are positioned to deliver safe, sustainable and high-quality services within the new integrated organisation.

Of the 151 identified DD risks across all categories, 111 require a further review or mitigating action to be taken forward. These actions have therefore all been incorporated back into the individual workstream delivery trackers to ensure visibility. Of those 111 actions, 81 have been classified as critical day one.

19.3.2 Due diligence findings

Full details of each risk identified through the due diligence exercise, including the original and residual risk scores, are documented in the supporting documentation for reference and assurance.

A summary of the top risks by each area is presented below:

Clinical and operational risks			
Risks identified	**33**	**DD Completed By**	**KPMG/Hill Dickinson**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG057	Based on the 2025-26 Q1 NOF data, BCH has been assigned to segment 3 ('below average and/ or financial deficit'). For two domains, Access to Services and Finance and Productivity, BCH has been assigned to segment 4 ('low performing'). The access to services segment 4 ('low performing') rating includes one indicator – the percentage of patients wating over 52 weeks for community services.	20	Targeted improvement plans are in place to address contributing to segment 3 rating, specifically within finance (strengthened recovery plans), productivity and efficiency action plans and access to services, validation of waiting list and action plans to ensure there are no patients waiting over 52 weeks by March 2026. Performance is monitored through performance council and trust committees/Board. Robust improvement plans are in place to progress to segment 2 of the NOF.	16
KPMG065	Five services have been described as 'fragile' in part due to staffing-related reasons. However, the action to support these services is not consistently reported to the quality and safety committee.	20	Fragile services are identified within the organisation, service leads are developing targeted workforce and resilient plans, including recruitment, retention and skill mix plans to support performance and activity. Harmonising approach to fragile services reporting to quality committee in common pre transaction and QAC post transaction.	8

KPMG069	Difficulties recruiting to certain posts is creating fragile services.	20	Harmonising approach to fragile services reporting to quality committee in common pre transaction and QAC post transaction.	8
HD034	BCH has confirmed it has taken one case to the Court of Protection over the last three years. This related to a patient with severe learning difficulties who required dental treatment under general anaesthetic. The outcome of this and whether any claim is likely to arise is unclear/not specified.	20	Background: Concerns were raised by independent mental capacity advocate (IMCA) regarding proposed dental treatment. The Trust sought legal advice and initiated a court of protection application to ensure compliance with statutory requirements and safeguard best interests. Outcome: Dental treatment authorised by the court of protection. Conveyancing plan agreed and scheduled. Solicitor noted deprivation of liberty concerns, which commissioning bodies will address. Official solicitor visit completed following signed undertakings. Treatment successfully completed and patient recovered well. Patient now not showing any signs of pain. No risks identified and therefore no further action required.	6

Table 59: Summary of the top clinical and operational due diligence risks

Commercial risks			
Risks identified	**12**	**DD Completed By**	**KPMG**

	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG072	Cost reduction opportunities have been identified from the integration of corporate functions. The quantification of this opportunity has been based on benchmark data from the national model health system and represents a move to national median or lower quartile performance.	9	MARS scheme launched in November 2025 to help create early opportunities for reduction in headcount.	4
KPMG073	The population across Warrington and Halton is projected to grow by 11,300 between 2021 and 2033 (2.4%) due to population growth and inward migration. While this level of net population growth is modest, the age distribution is forecast to shift significantly. The working age population (20 to 64) will decline over the 12-year timeframe, at the same time the number of people aged 65+ will increase by 23% for Warrington and 20% for Halton over the same period. These demographic changes will result in increased demand for community services provided under the block contract. There is a risk that it may not be possible to gain additional funding for projected increases in activity.	9	Action covered by KPMG023.	1

KPMG074	Anticipated changes in demography will not only increase the demand for community services, but at the same time will result in increased demand and greater pressure on acute services. A key aspect of trust plans for the integration, in alignment with wider NHS and ICB priorities, is to develop models of care with the aim of increasing care in communities and at home. This will have the effect of further increasing the level of demand for community services within the integrated trust. However, clinical integration planning has not yet reached the point where the specific impact of new models of care has been fully quantified, in terms of additional demand on community services.	9	As part of year 2 of the 5-year plan, we will undertake robust capacity and demand analysis covering both acute and community services.	3
KPMG078	There has been a high level of increase in overall expenditure over the medium term. BCH's total expenditure rose by 12.7% between FY23 and FY25 from £96.5m to £108.8m. This increase is primarily driven by rising employee expenses and increased spending on drugs and healthcare purchases.	9	No action required. Financial planning assumptions in FBC are based upon combined 2025-26 planned deficit (before CIP) as a start point. Significant work has been undertaken to identify cost reduction opportunities and the integration programme is a key enabler to unlocking many of those opportunities.	1
KPMG079	A key strategic aim for the planned integration of WHH and BCH is to transform how and where services are delivered, with more care delivered at home or closer to home. However, there are currently significant pressures on community services. There are just under 8,500 adults and children currently on community waiting lists and almost 8,000 patients waiting for dental services. BCH also performs worse than peers for waiting list performance based on NHS Oversight Framework ('NOF') metrics. BCH receives the lowest provider score of 4 (low performing) for percentage of people waiting over 52 weeks for community services.	9	No immediate action. Risk will be covered through the development of the detailed clinical strategy and the new integrated clinical model that will underpin it.	1

Table 60: Summary of the top commercial due diligence risks

Digital risks			
Risks identified	**22**	**DD Completed By**	**KPMG/Hill Dickinson**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG030	Certain bespoke applications are managed solely by individual staff members, resulting in key person dependency within the IT team.	12	Code and configuration knowledge: There are three resources with knowledge of clinical systems code and configuration but within individual systems. BI & Qlik: Business Intelligence, Qlik applications and Infrastructure are highlighted as areas of expertise with key person dependency. Joining the BW/WHH teams provides more resiliency for key skills areas. Also, BCH CSOC operations are disseminated as it is more cost-effective than employing multiple cyber analysts.	9
KPMG031	Certain roles/vacancies are being held due to cost improvement targets and uncertainty surrounding the potential integration. This creates instability in workforce planning and delays in recruitment.	12	Limited current vacancies exist. Categorise new vacancies by criticality to service continuity and digital transformation. Prioritise VAF's recruitment for roles essential to integration projects, digital operations and compliance (e.g. EPR, cybersecurity, IT support). Monitor throughout until new org models are completed.	9
KPMG037	Completeness and currency of the disaster recovery documentation are not fully confirmed	12	Yes, DR Run books for all critical systems do exist and are regularly reviewed at CABIT meetings as part of their workplans. Updates are reported to the DIGIT governance group. BC testing needs to be more frequent.	8

Table 61: Summary of the top digital due diligence risks

Environmental risks			
Risks identified	**10**	**DD Completed By**	**Senior WHH estates manager**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KB002	No evidence that the air conditioning F-Gas survey reports are available.	8	Surveys have been completed. Request copies of the survey reports and confirmation from FM provider for all sites.	2
KB003	Energy certificates are not displayed in all BCH sites.	8	Check lease status for Europa and Newton Road sites.	4

Table 62: Summary of the top environmental due diligence risks

Estates risks			
Risks identified	**11**	**DD Completed By**	**KPMG/Hill Dickinson**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG045	10 contracts are due to expire within 12 months and a further 2 operate on a month-to-month basis. Discussions are underway between BCH and incumbent suppliers about renewing/rolling these contracts.	8	Work with WHH and procurement to novate/extend contracts at risk. PID documents submitted to programme delivery group.	4

Table 63: Table of the top estates due diligence risks

Finance risks			
Risks identified	**38**	**DD Completed By**	**KPMG/Hill Dickinson**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG003	BCH's FY26 forecast outturn includes delivery of £5.5m of CIPs, of which £5.4m has been assumed to be delivered on a recurrent basis. We understand from BCH management that delivery against these schemes is in line with plan and BCH have identified £6.5m of schemes, including £4.8m of schemes already implemented for FY26. However, we note that there is an additional CIP target of £2.4m including in month 12 of the FY26 plan for FY26 (and forecast outturn) not reflected in the CIP plan, for which with schemes are yet to be identified.	15	Continue to work with ICB to identify schemes to achieve stretch target.	12
KPMG004	There is an additional £0.5m of CIP which was previously delivered by BCH, by reducing dermatology appointments. However, the realised saving has since been offset by an additional cost pressure (additional cancer appointments to reduce wait times).	15	Action covered by KPMG003.	12

KPMG015	We note that £0.7m of CIP schemes are planned to start delivering savings from month six onwards. We also note that an additional savings target of £2.9m has been embedded in the month 12 expenses out of which £0.5 million savings have been achieved but now offset by additional expenditure.	15	Action covered by KPMG003.	12
KPMG017	The plan was prepared based on the forecast outturn for FY25 (as at month 11), rather than actual deficit as reported at month 12.	15	No action required. Financial planning assumptions in FBC are based upon 2025-26 planned deficit (before CIP) as a start point. Whilst there will undoubtedly be some areas of spend within the plan that are underestimated, there are also elements that are undoubtedly overestimated. Overall we are confident that the opening plan is an accurate reflection of the true position of BCH.	6
KPMG020	BCH's planned other operating expenses for FY26 at £3.5m are significantly lower than actual spend of FY25 at £6.8m. This is due to removal of one-off items in FY25 spend and inclusion of a £2.9m **additional savings** offset against the month 12 expenditure. Out of the £2.9m savings target, £2.4m has savings schemes yet to be identified, while £0.5m has been assumed to be delivered. However, the realisation of the £0.5m savings is dependent on successfully negotiating income of £0.5m from the ICB.	15	Action covered by KPMG003.	12

Table 64: Summary of the top finance due diligence risks

Health and safety risks			
Risks identified	**11**	**DD Completed By**	**Senior WHH health and safety manager**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
HW008	Incidents are managed by operational managers and reports are collated by the head of risk management and patient safety.	9	Need to confirm there is a process in place at BCH for managing and monitoring incidents, and also confirm that a regular report on incidents is shared with the relevant H&S committee at BCH. Note that post-integration the process will become aligned.	3
HW009	Hazardous substances are managed via an electronic word template. Under the COSHH regulations the trust is required to ensure all individual substances are risk assessed, have safety data sheets in places with details of any precautionary requirements and PPE required, and training is in place.	9	Need to confirm there is a process in place at BCH for safe management of hazardous substances and confirm that a regular report is shared with the relevant H&S committee at BCH. Also need to confirm there is a process in place and review whether we will adopt a different system.	3

Table 65: Summary of the top health and safety due diligence risks

Workforce risks			
Risks identified	**14**	**DD Completed By**	**Senior WHH people manager**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
AHM004	High sickness absence could impact assurance; off-plan absence may affect targets.	12	Work at a system level to address sickness absence and implement a new approach to supported attendance. This action is aligned to system controls outside of integration. Collaborative work to develop a new policy framework.	8
AHM010	Requires management of long-term absence and alignment of processes and policies post-transaction.	12	Aligned with risk 2: Work at a system level to address sickness absence and implement a new approach to supported attendance. This action is aligned to system controls outside of integration. Collaborative work to develop a new policy framework. Review of sickness absence and management processes from April onwards to support timely and consistent case management post Regulation 11 timeframes in line with WHH information. Development of a policy roadmap for all people policies pre-April 2026 to support management of policy consistency (within TUPE frameworks).	8
AHM011	Contract may cease after six months; increased usage could create cost pressures.	12	**Occupational health:** Development of a combined in-house OH service for all staff within the cost envelope of the current external contract. Development of PID pre-integration to ensure a streamlined day one offer. Development of plan B option for continuity should the OH service contract not end in March 2026.	8

			Resus: Development of a plan to align resus provisions for day one to support effective clinical services in the community and acute. Development of combined governance procedures for resus monitoring and reporting.	
AHM012	Declining scores may increase sickness/turnover and bank/agency reliance.	12	Implementation of the Joint Culture Plan collaboratively based on NSS results for 2025. Targeted triangulation of OD activity and programme of activity aligned to staff survey results/OD activity at a local level. Alignment of sub-committee governance to ensure oversight and management of cultural alignment post integration.	8
AHM013	Tribunal awards can be unlimited; high disciplinary ratio (WRES) may impact future performance.	12	Review of employee relations and management processes from April onwards to support timely and consistent case management post Regulation 11 timeframes. Complete a review of casework capacity and themes for management.	8

Table 66: Summary of the top workforce due diligence risks

19.4 Risk management in the integrated organisation from day one

Risk management processes will remain robust throughout the integration period. WHH will continue to manage risk registers and incidents on the Datix system, while the new community and dental care group (BCH clinical services) will utilise the Ulysses system for incidents and risk registers. Both systems will be governed and managed by a single data analyst governance team, which will produce joint reports for governance committees and care groups to ensure safe business continuity.

All risk registers will be overseen by a single risk review group, attended by the executive team, all care groups, and the corporate secretary. This group will ensure that all risks are managed, reviewed and aligned with the corporate risk register and the Board assurance framework. The risk review group will report into quality committee and trust Board by exception. The clinical governance managers/governance teams will be fully trained in both systems.

20.0 Conclusion

The integration of WHH and BCH marks a pivotal moment in our shared ambition to deliver a single, high-quality, sustainable healthcare system for the people of Warrington, Halton and the surrounding Cheshire and Merseyside footprint. This business case sets out a compelling strategic, clinical, operational and financial rationale for the transaction and demonstrates how our integration directly aligns with the national 10 Year Health Plan's three overarching priorities: shifting the focus from treatment to prevention; analogue to digital transformation; and integrated, personalised care from the hospital into the community.

Over the past 18 months, significant work has already been undertaken to lay the groundwork for a successful transaction. The appointment of a joint chief executive and executive team provides strong and consistent leadership across both organisations. Joint governance and decision-making structures are now embedded, including shared Board meetings, a strategic people committee in common, and a single BCT delivery group overseeing all aspects of the integration. Clinical leadership has been pivotal to the outcomes of the joint clinical summits to develop our clinical priorities and will be even more crucial as we progress the integration of the clinical services further. The national strategic direction to develop neighbourhood health models of care in collaboration with multiple partners across Place creates the perfect environment for our integration to drive improvement through a transformed clinical model and associated pathways. The opportunities to deliver sustainable and measurable benefits for patients, staff and the wider regional NHS are huge.

Early progress and collaborative working between the two organisations is already delivering benefits and demonstrating the potential impact of integration on a larger scale. Our patients will experience smoother, more effective and compassionate care. We will be much better placed to manage demand for unplanned and planned care in future, and our combined organisational costs will reduce. This business case builds on early successes, setting out a roadmap for achieving a successful transaction by April 2026 and a firm foundation for fully integrated services and systems thereafter.

While the foundations for success are strong, further work is required to continue to develop our plans in partnership with stakeholders and then realise the full benefits of the opportunities that exist. The second phase of our programme will see us move into completion and delivery of our post-transaction implementation plan (PTIP), the production of new joint clinical and estates strategies and the continued alignment of digital infrastructure, workforce systems and governance frameworks. Continuous engagement with staff, system partners and our communities will remain critical to maintaining trust and ensuring delivery remains responsive to local needs and challenges.

Ultimately, this integration is not simply an operational necessity, it is the only sustainable route to delivering the safe, high-quality, equitable and financially viable services that our local population expect and deserve. The case for change is clear; by coming together as one organisation we create an environment for change and improvement, a platform from which we can deliver on the transformational vision of future collaborative care, and an opportunity to drive significantly improved value. Put simply, we will deliver better care together.

21.0 Index of tables in FBC

22.0 Index of figures in FBC