NHS

Wrightington, Wigan and Leigh Teaching Hospitals

NHS Foundation Trust

Annual Report and **Accounts 2023/24**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Annual report and accounts 2023/24

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

Contents

Opening remarks from the Chair

I am delighted to be able to present my third annual report as the Chair of Wrightington, Wigan and Leigh Teaching Hospitals NHS FT (WWL). This year, I will begin by welcoming our new Chief Executive, Mary Fleming. Mary began working for WWL in 2008 as Operational Lead for the Division of Surgery and until her appointment in March, held the post of Deputy Chief Executive. She is a fantastic testament to the ethos which I have seen since joining the Trust myself; WWL's drive to invest in its people; support them to succeed and to grow its own talent.

WWL, Wigan Council and wider system partners across Greater Manchester continue to work together as an integrated care partnership, operating within an integrated care system (ICS). A key component of our current operating model is place-based leadership, which is based on collaboration between organisations which are responsible for arranging and delivering health and care services locally, through a local health care system. In Wigan, our place-based arrangements are chaired by Alison McKenzie-Folan, the Chief Executive of Wigan Council and our Place Based Lead for Health and Care Integration.

This year has been another difficult year for healthcare providers, our staff and our patients. A theme seen throughout this report is how service provision has been affected by the ongoing periods of industrial action which we have seen this year, being the longest in the history of the NHS. We have always expressed firm support for our medical and nursing colleagues, who have grappled not only with the personal implications of choosing to strike, but the operational challenges of having to backfill shifts and support rebooked procedures and ultimately the additional support which they have needed to provide to our patients during and following these periods.

Despite all of this, the results of the most recent NHS National Staff Survey show WWL to be ranked first within our ICS and 13th nationally for morale at work. In an industry where pressures are continually escalating, this provides myself and the board with tangible assurance that the work which we do to create a positive culture for our staff truly has an impact.

An exciting opportunity awaits us in in 2024. Last year, I reported upon WWL's difficulties in tackling the national increase in the number of patients residing in hospital beds, with many of these patients no longer requiring hospital care but needing additional support to be able to leave the hospital. Our position continued to worsen and in summer 2023, Wigan's local health care system was formally highlighted as requiring performance improvement measures to be put in place. To address the challenges we face the Trust has worked closely with the NHS Emergency Care Improvement Support Team (ECIST) on a clinically led programme that offers intensive practical help and support to urgent and emergency care systems. In addition this year, following a period of diagnostic work, in partnership with Wigan Council, we will move forward with our locality transformation programme. This will enable us to evolve and optimise our admissions avoidance services, enabling us to reduce corridor care and support the safe discharges of our patients to their home, or to intermediatory care or other long-term facilities.

This year saw us complete delivery of the Supporting Armed Forces in Acute Hospital Settings Programme, which helps us to develop better ways of supporting veterans and their families when they are in a hospital setting. The Wigan borough has the largest armed forces community in the North West and the seventh largest population of veterans in England, with circa 22,000 serving personnel, veterans and families. We are proud that we have been able to take steps forward to reduce the health inequalities experienced by this large group of patients, although acknowledge that this is just one group across a unique local demographic, amongst which health deprivation is heavily concentrated, particularly when compared with those of other trusts across Greater Manchester.

In November of 2023 we opened our new Community Diagnostic Centre at our Leigh site. This development was part of a national programme to increase the access to and capacity for key diagnostic tests including various types of scan, cardiac monitoring, blood pressure and lung function monitoring, sleep studies and phlebotomy. Offering these services in Leigh will help us to further reduce

health inequalities within our borough, by making it easier for more patients to physically access services.

Following a successful funding bid, we have also made significant progress this year in the transformation of our endoscopy services, with an increase in service capacity at the Leigh site and the opening of a new endoscopy unit at Royal Albert Edward Infirmary expected later in 2024, supporting us to achieve accreditation from the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

Finally, in terms of this year's capital developments, I am pleased to report that we have been able to increase theatre capacity at both our Leigh and Wrightington sites. Moving forwards, we aim to develop our Wrightington site as an orthopaedic hub for Greater Manchester, the North West and beyond.

WWL's Board of Directors is a unitary board, which comprises executive directors who lead the organisation operationally from day to day, as well as non-executive directors, who bring in external perspective and challenge. I am grateful to work with and be supported by such a talented and committed group of colleagues. This year we have welcomed two development non-executive directors who are working with us in a development and voluntary capacity; both are part of the NHS Leadership Academy's NExT Director Scheme, which supports the creation of a pipeline of strong and diverse potential candidates for non-executive director roles in the NHS. Currently it has a focus on supporting women, people from local BAME communities, and disabled people with senior level experience into board level roles.

The WWL board is also supported and held to account by our Council of Governors. They play a key role in appointing our non-executive board members and this year have supported us to make one new appointment. They remain engaged and committed and I am pleased to be able to say that their relationship with myself and my colleagues remains one of supportive and collaborative working.

Now as always, my final and most heartfelt thanks go to our staff, who work as one team to support the provision of health and care for our patients and the communities we serve. The last four years have been a persistent struggle for NHS providers but as WWL goes from challenge to challenge, we see our staff go from strength to strength. Their resilience, hard work and commitment to the patients of our borough is incredible and the pride that I take in being able to call myself WWL's Chair is a direct reflection of that.

Mark Jones

Chair

26 June 2024

Performance Report.

PERFORMANCE REPORT

Performance overview

The purpose of this overview of performance is to provide information on our organisation, its history and purpose. The Chief Executive also presents her perspective on our performance during the financial year 2023/24 and describes the key issues, opportunities and risks as determined by the board.

Who we are

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust is a major acute and community foundation trust in the North West of England, within the Greater Manchester footprint. On 1 April 2020 we changed our name to include reference to our commitment to education and training, as the first step towards our overarching aim of achieving university teaching hospital status, in partnership with Edge Hill University. Our Research Committee monitors our progress towards achievement of this aim, which is also one of our ongoing corporate objectives, against the University Hospital Association's recognition criteria and we have made significant progress towards this thus far.

We are registered with the Care Quality Commission without conditions and they rated us as “Good” at our last inspection in November 2019.

We serve a local population of 329,300 and we provide specialist services to a much wider regional, national and international catchment area. We provide our acute clinical services from our five main sites: Royal Albert Edward Infirmary, Wrightington Hospital, Leigh Infirmary, Thomas Linacre Centre and Boston House. Our community services are provided from a range of locations across the borough.

Royal Albert Edward Infirmary is our main district general hospital site and is located in central Wigan. Here you will find our accident and emergency department as well as the majority of our in-patient services. There has been a hospital on this site since 1873 and it was named after the then Prince of Wales who officially opened it in 1875. This site celebrated its 150th birthday last summer, with MP Lisa Nandy joining us on site for the unveiling of a commemorative mural, featuring some of the key milestones for the site.

Wrightington Hospital is a specialist centre of orthopaedic excellence and enjoys a world-acclaimed reputation. Situated just over the border in West Lancashire, it was from here that Professor Sir John Charnley developed the hip replacement in November 1962 and our surgeons of today have continued to enjoy a reputation for excellence. Last year our Wrightington site is celebrated its 90th birthday.

Leigh Infirmary is an outpatient, diagnostic and treatment centre in the south of the borough. It is now the home of the Jean Hayes Reablement Unit, which provides intermediate care to help patients recover before their return home and more recently, the Community Diagnostics Centre.

Thomas Linacre Centre is a dedicated outpatient centre in central Wigan and Boston House is a specialist ophthalmology unit, again in central Wigan.

Our Strategy 2030 sets out our vision to be a provider of excellent health and care services for our patients and the local community. In doing so, we see our current rating of ‘Good’ with the Care Quality Commission as the baseline and we want that rating to move to ‘Outstanding’ during the life of the strategy. To achieve that aim, we will support and empower our people to deliver high quality, patient-centred care. We will also develop our approach to continuous improvement and embed evidence-based methodologies as well as nurturing a culture of improvement to guide us our journey.

Review of the year

Once again there is much to be proud of at WWL this year. Following the global COVID-19 pandemic WWL, our partners within the Greater Manchester ICP and colleagues within the wider NHS faced the enormous challenge of recovery: the need to reduce the backlog in the provision of elective care and also the number of people on our waiting lists. This year has brought the additional challenge of ongoing industrial action which exacerbated existing workforce shortages and negatively impacted upon our performance, however, we remain keen to show our support for all of our staff who have taken part, in the same way that staff who have continued to work throughout these periods have supported us in ensuring the safety of our patients. We are one team - and we are unbelievably proud of each and every colleague who makes up our WWL family.

Whilst access times have not improved across the board in year, the length of time our patients are waiting for treatment has reduced. This year, trusts were asked to work to a 65 (rather than 18) week referral-to-treatment pathway and given the increasing pressures trusts are facing this year, the period for achieving this target was extended until September 2024. For WWL, this will require an increased focus on waiting times for patients waiting for genecology and endocrinology services.

Again this year, many trusts have seen an increase in the number of patients who no longer require hospital care continuing to reside in hospital, due to their support needs. WWL have cared for a consistently high number of these patients this year, frequently the highest number when compared with other trusts within the Greater Manchester Integrated Care Partnership. This has had a resultant effect on our ability to ensure a consistent flow of patients through our accident and emergency department and impacted our ability to meet the four-hour wait target. It has also contributed to an increase in mortality levels. We hope that our locality transformation programme, which we will take forwards next year will help us to tackle this issue and reduce admissions and the number of patients residing in hospital, where they could be better cared for outside of hospital, which will make more beds available for those who have a greater need for hospital care.

Whilst last year's metrics around access to services and quality are directly comparable with this year's, because of the unprecedented circumstances created by the global COVID-19 pandemic, we are still in a period of recovery and we ask that you bear this in mind when considering our performance.

A summary of our performance against key access and quality metrics is provided below:

 **Access headlines**	• **69.00%** performance against the Accident and Emergency four-hour wait target (target 95%; 2022/23: 68.64%) • **93.86%** performance against two-week wait from referral to date first seen for all urgent cancer referrals (target 93%; 2022/23: 93.71%) • **54.24%** performance against the 18-week referral-to-treatment pathway (target 92%; 2022/23 57.96%) • **72.75%** performance against 6-week diagnostic standard (target 99%; 2021/22: 78.01%)

Quality headlines

- **0** MRSA bacteraemia during the year (target 0; 2022/23: 1)
- **56** *C. difficile* infections against a target of 53, with **7** attributable to lapses in care (2021/22: 53 with 15 attributable to lapses in care)
- **3** never events against a target of 0 (2022/23: 4)
- Summary Hospital-level Mortality Indicator (SHMI) is **112.28** for rolling 12 months to December 2023 (average is 100) (Rolling 12 months to December 2022: 110.3)

As you will see from the staff report which begins on page 72, we place great importance on supporting our colleagues and we want to be an employer of choice in the local area. We take feedback from our workforce seriously and we undertake regular surveys to seek feedback. We have provided an analysis of the results of this year's national staff survey later in this report.

As well as commending our own staff, we also want to pay tribute to the staff from our partner organisations across Wigan. We believe that it is only through teamwork and joined-up ways of working that we will collectively be able to provide the right levels of care for our population. We are proud to be part of the Healthier Wigan Partnership, which is a collaboration between the NHS, local authority and other partners to make health and social care services better in Wigan.

The Healthier Wigan Partnership is working to create a simple, joined-up health and social care service which pledges to do the following for the people of Wigan:

1	2	3	4	5
Support you to be well and stay well	Help you live a full, active life, doing what you like to do	Offer easy access to more services in your community	Provide you with the right treatment when you need it	Offer the best possible care in the most efficient way

Following the creation of the ICS and with it the establishment of our Integrated Care Board (ICB), NHS Greater Manchester, we are delighted to have become a member of the Greater Manchester Integrated Care Partnership. The partnership is made up of trusts from across our ten boroughs, working together to offer better connected services. We now share delivery of several services with our partner trusts and will continue to take opportunities for partnership working where this will improve efficiency of service delivery and quality of patient care.

Our board members are highly involved at ICB level, regularly attending ICB level meetings with their counterparts from partner trusts. Our Chief Executive is joint Chair of both the Wigan Borough Integrated Delivery Board and the Greater Manchester Urgent and Emergency Care System Group.

At WWL, we firmly believe in continual improvement and we are committed to bettering ourselves in areas where we are not currently achieving the necessary standards. The board receives a performance report at each meeting which incorporates a clear dashboard to signpost directors to areas of concern.

Principal risks faced and impact

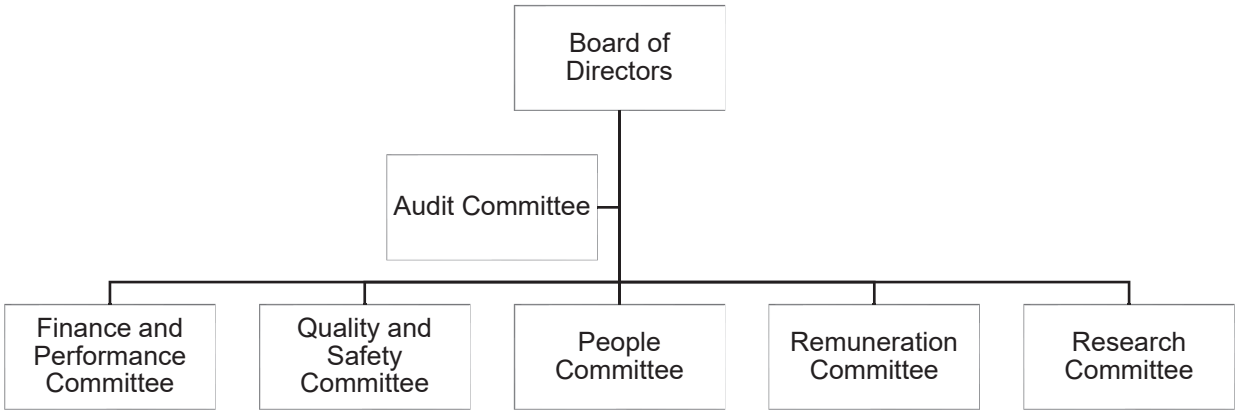
For more information on how we manage risk within the foundation trust, including the detail of the key risks that the organisation was exposed to during 2023/24 and those identified for 2024/25, please see the Annual Governance Statement which begins on page 100.

Mary Fleming
Chief Executive and Accounting Officer
26 June 2024

How we are run

The Board of Directors is responsible for the overall leadership and strategic direction of the organisation. The board is comprised of executive and non-executive directors and further information on the directors is available on pages 45 to 48.

The board operates a committee structure, with each committee responsible for seeking assurance on matters within its purview. The established committee structure and a summary of their roles is set out below:



Audit Committee

Responsible for oversight of the financial reporting process, obtaining assurance around the systems of internal control, internal audit, counter-fraud and other corporate governance matters

Finance and Performance Committee

Responsible for seeking assurance on and having oversight of the finance and performance elements of the business and reviewing high level risks allocated to the strategic objective of performance

Quality and Safety Committee

Responsible for seeking assurance on and having oversight of the quality and safety elements of the business and reviewing high level risks allocated to the strategic objective of patients

People Committee

Responsible for seeking assurance on and having oversight of the people elements of the business and reviewing high level risks allocated to the strategic objective of people

Remuneration Committee

A statutory committee, responsible for determining the remuneration, allowances and other terms and conditions of the executive directors

Research Committee

Responsible for oversight of our research activities and seeking assurance around delivery of the Research Strategic Plan. Established as part of our wider ambition to become a university teaching hospital.

The Council of Governors, made up of elected governors from our public and staff membership and appointed governors from our key stakeholders, has a number of statutory functions and two general duties – to represent the interests of members and the general public and to hold the non-executive directors to account for the performance of the board. More information on the Council of Governors is available on page 89.

Our Director of Corporate Affairs provides corporate governance leadership, advice and support to both the board and the council. The Director of Corporate Affairs has a dual reporting structure, reporting to the Chair professionally and to the Chief Executive on day-to-day matters. This ensures that the post holder is able to advise the collective board as well as the executive and non-executive directors separately when required. We have policies in place to deal with matters such as gifts and hospitality, declarations of interest and anti-bribery matters and we have a Freedom to Speak Up Guardian in place in line with best practice.

Our Chair holds regular private meetings with the rest of the non-executive directors, both virtually and in person at Trust Headquarters, without members of management present.

The executive directors collectively form the executive management team which provides day-to-day leadership and management of the organisation. Each director has a portfolio of responsibilities and is supported by dedicated support structures. We have a clear divisional management structure to coordinate and deliver high quality care across four clinical divisions, each headed by a divisional triumvirate comprising a Divisional Medical Director, a Director of Nursing and a Director of Operations. Other services are provided through our corporate and estates and facilities teams.

We employ 7,008 members of staff, all of whom play their part in delivering high quality, safe and effective patient care. Our Quality Account is published separately and provides much more detail on the quality improvements we are pursuing. Once completed, a copy will be able to be obtained from our website or on request from the corporate affairs team; please use the contact details on page 175.

Summary of our operational activity

The table below summarises our activity during 2023/24, and the figures for 2022/23 are provided for comparison:

		2023/24	2022/23*
Referrals	GP	90,302	84,068
	Other	96,613	94,292
	Total	**186,915**	**179,360**
In-patient activity	Elective/planned	5,581	5,966
	Day cases	33,334	33,991
	Non-elective	40,256	35,749
	Total	**79,171**	**75,706**
Outpatient activity	New appointments (attendances)	107,869	134,870
	Follow-up appointments (attendances)	261,047	320,278
	Total	**368,916**	**455,148**
Accident and emergency	**Total**	**100,052**(All) **88,078**(Type 1)	**101,434**(All) **96,066**(Type1)
Walk-in centre	**Total attendances**	**51,601**	**51,313**

Type 1 attendances are those made at the main emergency department, as opposed to attendances at the urgent treatment centre.

Social, community and human rights issues

We recognise the need to forge strong links with the communities we serve so that we are responsive to feedback and can develop our services to meet current healthcare needs.

We are committed to meeting our obligations in respect of the human rights of our staff and patients, which is closely aligned both to the NHS constitution and our values. As a public body, it is unlawful for us to act in any way which is incompatible with the European Convention on Human Rights unless required by primary legislation.

We have anti-fraud policies in place and further information is available within the staff report which begins on page 72 and within the annual governance statement which commences on page 100.

All our policies are reviewed on a regular basis and are subject to an equality impact assessment.

Equality of service delivery to different groups

WWL values difference and promotes equalities. All individuals whether staff or patients, should receive a high-quality caring experience of NHS services.

We are dedicated to developing an organisational culture that embraces difference, valuing everyone's contribution, treating people with dignity and respect and increasing our understanding what matters most for our patients by hearing about their lived experiences.

As an NHS organisation we aim to provide our services to all groups equitably and fully embrace the requirements of the public sector equality duty to eliminate discrimination, advance equality of opportunity and foster good relations. We recognise that people in our community have different needs and qualities. Understanding the diversity and needs of our local population can help us to plan and deliver services better. During 2023/24 WWL continued to enhance patient experience by continuing to engage with patients and their families.

WWL implemented the new framework requirements of the Equality Delivery System (EDS2022): a national improvement tool for patients, staff and leaders in the NHS. It supports NHS organisations in England, in active conversations with patients, the public, our staff, staff networks, community groups and trade unions to review and develop their approach in addressing health inequalities through three domains: services, workforce and leadership.

For domain 1, patient services, three separate engagement events were held during January 2024. Service users and members of the local community across all 9 protected characteristics were encouraged to attend. The events were promoted widely via various communication channels during November and December 2023 and stakeholders who were unable to attend were encouraged to review and provide feedback via our online feedback survey.

On 12 August 2023, Wigan Pride returned for an eighth year to Wigan Town Centre, celebrating equality and diversity. WWL were once again proud to be actively involved on the day. Our staff and supporters participated in the parade; advice and free sexual health testing was also provided by our health outreach and inclusion team; and our breast screening team were on hand to offer support on how to access their services. Our patient experience and engagement team actively engaged with the local community to ascertain their feedback about hospital services, reinforcing the message that WWL is an anchor institution which plays an active part in Wigan's local community and works continually to ensure that services are accessible.

During 2023/24, WWL continued to work with AccessAble (previously known as DisabledGo), which provides an online hospital accessibility checker service for our service users. During August 2023, AccessAble surveyors revisited all wards and departments on our Royal Albert Edward Infirmary site

to survey and update access guides accordingly. From October 2023, equality monitoring across all 9 protected characteristics was included within in-patient experience surveys (undertaken monthly by the patient engagement and experience team).

During 2023/24 WWL continued to review the provision of interpreter and translation services and an on-demand British sign language (BSL) video remote service was re-launched, providing patients with instant access to a BSL Interpreter. This is an essential communication aid, especially in emergencies where the need for a face-to-face interpreter is not known in advance. WWL continues to work towards meeting the core requirements of the Accessible Information Standard for everyone we serve and continues to undertake 3 yearly reviews of existing equality impact assessments (EIAs) across all patient services. All wards are now required to undertake EIAs as part of their work towards achievement of our ASPIRE Ward Accreditation Scheme standards. WWL's Equality, Diversity and Inclusion (EDI) Service Project Lead and patient experience and engagement team regularly participate in the ASPIRE accreditation ward visits.

Since December 2023, EDI has been featured at all monthly inductions for new starters. A 20 minute presentation is now delivered, raising staff awareness of the importance of EDI. Staff networks and the patient experience and engagement team now attended our 'induction marketplace', which provides an opportunity for new staff members to speak with members of various teams who have their own 'stalls' set up, to find out more about how those teams will work with and support them.

More information about our work on equality and diversity is available at:
wwl.nhs.uk/equality-and-diversity

Financial performance

The annual accounts included within this report provide detailed information for our financial performance in 2023/24.

We ended the 2023/24 financial year with a performance deficit of £10.4m; this is the key performance measure used to assess achievement of the financial plan for both the Trust and NHS Greater Manchester. The deficit of £10.4m was £3.9m adverse to the planned deficit of £6.5m but reflected the revised control agreed with NHS Greater Manchester in the second half of the financial year. The accounts report a deficit of £15.8m which includes technical items excluded from the performance deficit.

It was a challenging financial year with cost pressures associated with unfunded escalated bed capacity and disruption caused by industrial action. Despite this we worked hard to control our costs where possible, and delivered savings of £24.4m, delivering the cost improvement target (CIP) target in full.

Significant capital investment of £35.2m was made in 2023/24, including £15.8m of schemes funded through national public dividend capital which included building work at the Leigh site for the Community Diagnostic Centre (CDC) and a new laminar flow theatre, as well as replacement for current assets.

Income

We generated £523.1m of income in 2023/24 compared with £522.6m of income in 2022/23; an increase of £0.5m or 0.10%.

The 2023/24 financial year saw the introduction of the Aligned Payment Incentive (API) system. For all contracts we hold with commissioners over £0.5m, the payment is as per the API commissioning and comprises a variable and fixed element. Under the variable element, the Trust is paid according to actual activity delivered against the elective recovery and unbundled targets.

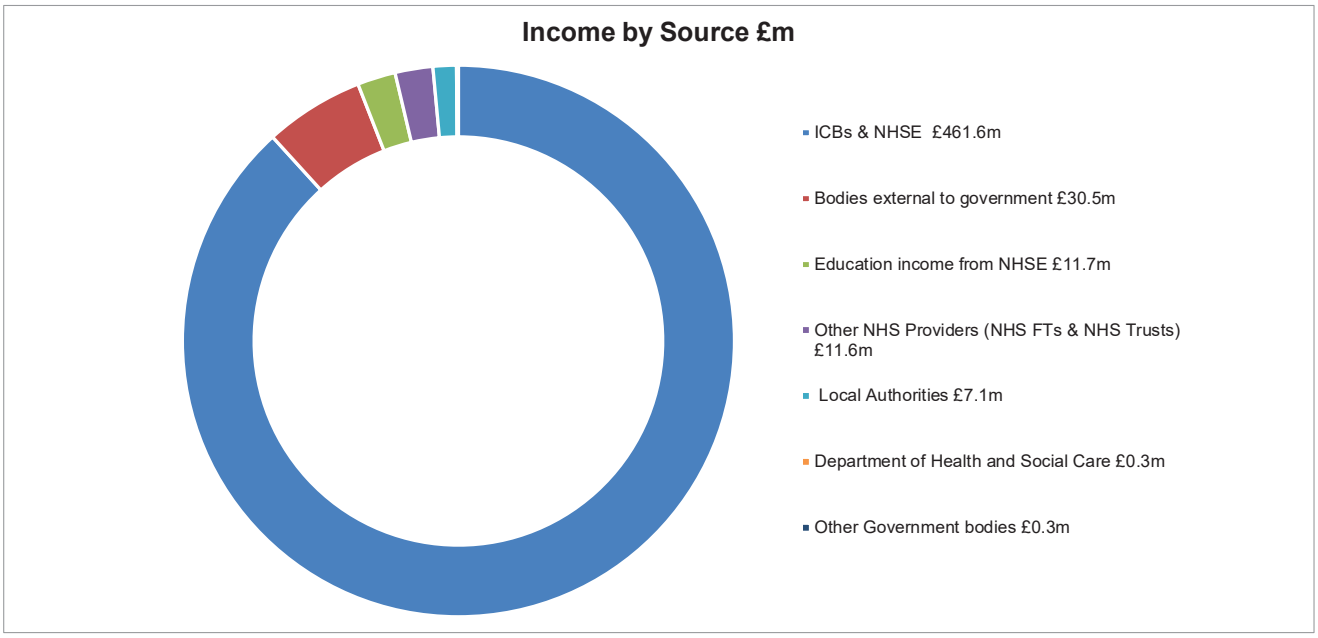
Our increased income of £0.5m compared to 2022/23 can be explained by several items. There was a £5.5m increase in funding from ICBs and NHS England which relates to increases in block income,

funding for industrial action and funding for the Community Diagnostic Centre. There was a reduction in local authority income of £5.8m due to the income from Wigan Borough Council. There was also an increase of £1.0m of education income from NHSE relating to funding for medical and non-medical education.

Each year, the income we receive from the provision of goods and services for the purposes of the health service in England must be greater than the income we receive from the provision of goods and services for any other purpose. We have complied with that requirement in 2023/24.

Income by source

The chart below shows the split of our income by source during the year. Most of the Trust's income is received from government bodies with only 5.8% of income received from bodies outside of the government.



Income from patient care activities

Income generated from the provision of patient care totalled £494.6m in 2023/24, compared with £492.5m in 2022/23; an increase of £2.1m (0.4%). £5.9m of the increase relates to ICB block contract changes, funding for industrial action and for the Community Diagnostic Centre. Local authority income decreased by £6.2m due to non-recurrent funding to support delayed discharges and additional community funding. Private patient income increased by £1.7m in-year predominantly due to additional activity within the trauma and orthopaedics specialty.

NHS Greater Manchester is the largest commissioner of services, contributing 77% (£382.9m) of our patient care income compared to 75% (£368.7m) in 2022/23.

Income from patient care (by nature)

Income from patient care (by nature)	2023/24 £m	2022/23 £m
Acute services		
Aligned payment & incentive (API) income - Variable (based on activity)	102.7	0.0
Aligned payment & incentive (API) income - Fixed (not variable based on activity)	305.5	374.7
High cost drugs income from commissioners	1.0	1.7
Other NHS clinical income*	7.0	16.7
Community services		
Aligned payment & incentive (API) income	48.4	44.5
Income from other sources (e.g. local authorities)	6.3	6.5
All trusts		
Additional income for delivery of healthcare services	0.0	0.0
Private patient income	6.8	5.1
Elective recovery fund (comparative only)	0.0	10.2
Pay award central funding	0.2	12.1
Additional pension contribution central funding	13.1	12.0
Other clinical income**	3.6	9.0
Total income from patient care activities	**494.6**	**492.5**

* Other NHS clinical income includes funding for a range of services outside the block contract.
**Other clinical income includes income from Local Authorities and income relating to NHS injury recovery scheme, occupational health, and cross borders' income.

Other operating income

Other operating income received in year was £28.5m compared to £30.1m in 2022/23, which is a decrease of £1.6m (5.3%). This is predominantly due to a decrease in education funding of £3.1m offset by an increase of £1.0m in education income from NHSE and £0.5m mainly relating to income for staff recharges.

Expenditure

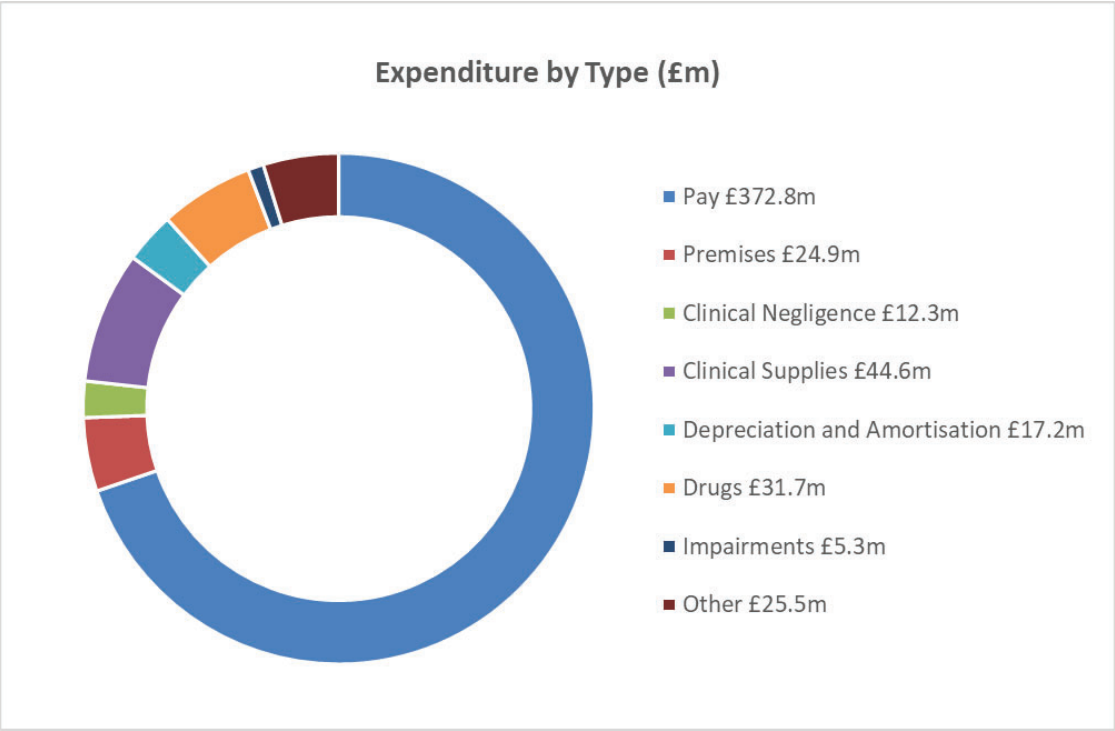
Operating expenditure for the 2023/24 financial year was £534.4m, compared to £524.7m for 2022/23, which was an increase of £9.7m (1.8%).

Employee expenses (pay) was the largest item at £372.8m (2022/23: £366.3m) which is 70% of operating expenditure. Within this figure, the amount spent on registered nursing, midwifery and health visiting staff was £108.3m (2022/23: £107.7m). Expenditure on medical staff was £88.2m (2022/23: £81.0m).

There is an increase in employee expenses of £6.5m. Pay expenditure has increased due the 2023/24 pay awards (£15.5m) which were funded nationally. There was a decrease of £8.2m associated with temporary staff which comprises bank and agency expenditure.

The largest items of non-pay expenditure included £31.7m spent on drugs (2022/23: £28.9m), £44.6m on clinical supplies (2022/23: £42.1m), £12.3m on the clinical negligence premium (2022/23: £12.9m) and £24.9m in premises costs (2022/23: £23.0m). Depreciation and amortisation of £17.2m and net impairments of £5.3m are included in the overall expenditure figure.

The following graph shows the main categories with the total reportable expenditure:



Cost improvement plans

In 2023/24, we achieved a cost improvement target of £24.4m, which supported our steps towards financial recovery and future sustainability.

Despite an exceptionally challenging start to the year, we delivered the full target with some divisions over-performing to support the wider Trust position. £13.2m (54%) was delivered through recurrent schemes ensuring that we are making improvements to our underlying position.

Although this was predominantly delivered through divisionally led efficiency schemes, the Trust has made good progress in the development of transformational programmes that reach into the longer term and will support CIP delivery in future years.

Particular areas of success in the delivery of 2023/24 CIP were a reduction in temporary premium pay spend and non-pay savings which were supported through enhanced grip and control measures. From a transformational perspective the Commercial Opportunities Programme delivered more than £1.5m towards CIP delivery.

Capital investment

During the year we invested £34.8m (2022/23: £25.1m) in the Trust's capital programme including £0.1m of donated assets (2022/23: £0.2m), which have significantly improved services for both patients and staff. A summary of the capital investments undertaken in the year is provided below:

Capital investment scheme	Investment benefits	£000k
Endoscopy	Expansion of endoscopy at Leigh to increase capacity from 3 rooms to 6 and the re-development of Endoscopy at Wigan to support increases in productivity.	5,002
Community Diagnostic Centre	Completion of a £10.2m scheme to refurbish and extend existing estate and provide additional diagnostic capacity on the Leigh site.	4,965
Leigh laminar flow theatre	Completion of works to create an ultra-clean theatre on the Leigh site increasing available theatres from 3 to 4.	4,738
Theatre 11 – Wrightington	Development of a new ultra- clean modular theatre and associated recovery rooms to create additional elective capacity.	4,782
Information technology	Continued investment in IT systems to raise digital maturity across the Trust sites	3,581
Medical equipment	The continued investment in medical equipment, including upgrades to scanners, x-ray and endoscopy equipment.	4,952
Site improvements, upgrades and maintenance	Electrical infrastructure works and improvements, upgrades, and general maintenance to improve our hospital environment.	7,187
Total (including donated assets)		**35,207**

Going concern

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

Mary Fleming

Chief Executive and Accounting Officer
26 June 2024

Performance analysis

The purpose of this overview of performance is to provide more detail on how we measure our performance.

We measure performance in a number of ways. We measure operational and clinical performance through key performance metrics, which are included in the performance report and presented to the board at each meeting for scrutiny. Copies of our board papers are available to download from our website, and we produce a dedicated Quality Account each year. This is published separately and available on our website.

Our Quality Account is available at: **wwl.nhs.uk/annual-report-and-accounts**

There is a clear link between our key performance indicators and the risks facing the organisation. For example, non-achievement of the four-hour wait target is a key risk to the organisation and non-achievement of the target can have quality and financial consequences. Similarly, increases in demand affect both our performance against our key performance indicators but can also contribute to our risks, such as a reduced availability of appropriate beds. There are a number of uncertainties in any organisation, and each month the board and its committees hold detailed discussions using contemporary data to identify emerging risks.

Operational and clinical performance: Division of Medicine

The Division of Medicine is a large multi-functional division comprising of four directorates. The four directorates are:

- General medicine (including cardiology, respiratory medicine, endocrinology and gastroenterology)
- Unscheduled care, which is further divided into emergency and acute medicine;
- Elderly care and specialist rehabilitation; and
- Therapy services

The division also incorporates pharmacy services on all sites.

Unscheduled care

Throughout 2023/24, we continued to see an increase the acuity of patients admitted through our accident and emergency department, which contributed to us being unable to maintain the delivery of the national 95% 4-hour accident and emergency department standard. In 2023/24, average daily attendances equated to 274 patients per day, compared to 277 average attendances per day in 2022/23, the higher complexity of patients combined with increased length of stay and a number of industrial actions throughout 2023/24 contributed to the pressures within the department and the number of patients waiting over 4 hours increased over the winter months in 2023/24. We use a business intelligence application which monitors hospital flow to monitor the acuity of patients attending. A patient's acuity level is based on how much care and treatment the patient is likely to need and whether they are likely to require admission.

Despite facing a challenging year, we achieved second position as a trust in achievement of the 4-hour target for accident and emergency department breaches across the Greater Manchester Integrated Care Partnership.

During the year we have continued to refresh our focus within the accident and emergency department and in relation to wider patient flow, this has included:

- Ensuring early ambulance handovers to our accident and emergency department, to make sure that we rapidly respond to patients with high clinical acuity as well as freeing ambulance crews up to attend other calls.
- The launch of our hospital discharge and flow programme which included the streamlining of referral processes, continuing transformation of our same day emergency care (SDEC) service, an improved frailty service at the front door and continuous improvement of the effectiveness of our 'white board ward rounds'.
- Implementation of our 'Home First' scheme for discharging patients to their own homes. Patients who are medically discharged are accompanied home by our 'Home First' therapy team and then met by members of our reablement team to agree a therapy plan. Risks within the patient's home environment are identified and mitigated then support measures are put in place to ensure a sustainable and safe continuation of care at home.
- The repurposing of Bryn North Ward as a Discharge Planning Unit. This new model of step-down care is supported by intensive therapy in combination with the 'Home First' scheme. This has helped us safely discharge up to an additional 28 patients per week.
- Continued focus on reducing delayed transfers of care in collaboration with our system partners.
- Work with system partners to publicly emphasise the need to continue to use services appropriately, signposting to other service such as NHS 111. We have continued to work with local partners to provide community-based services and early interventions to enable patents to be treated outside of the hospital setting when possible.
- Support provided by NHS England specialist teams – including ECIST - to improve the flow of patients across the emergency department and the rest of the hospital.
- Implementation of an electronic bed management system that will further support the flow of patients across the hospital and help us to manage bed capacity effectively.

Looking forwards to 2024/25, we will work towards improvements in our 4-hour accident and emergency performance, together with an improvement in the reduction of patients waiting 12 hours or more in the department and an improvement in ambulance handover and turnaround times. Through various continuous improvement initiatives, we will focus on improving the journey to recovery for our patients. This will be complemented by the ongoing working with system partners to support safe and timely discharge.

Further we will work to develop and implement a new model of care for the acutely unwell patients who present at our accident and emergency department. This will help us better utilise our resources while achieving the accident and emergency 4-hour target, reducing 12-hour delays and mitigate against the risk of having to care for patients on our corridors.

Scheduled care

Continuing the trend of the last few years, in 2023/24 we saw a further increase in referrals to many of our scheduled care services.

The medicine division maintained a focus on ensuring that new patients who were referred into our services were seen at the earliest opportunity as determined by their clinical need, whilst ensuring existing patients were scheduled appropriately. Despite the increasing demand, we ensured that no patient waited for longer than 65 weeks and therefore exceeded the national waiting list target for 2023/24.

To improve care for the significant number of diabetic patients within our borough, we launched a multidisciplinary diabetic foot clinic. We have increased the provision of diagnostic services through the Community Diagnostic Centre at our Leigh Infirmary site. We have also supported the development and delivery of the frailty service provided through our Community Assessment Unit.

For the coming year, our scheduled care teams will continue to focus on ensuring that we see patients based on their clinical need, whilst at the same time reducing the waiting lists for our services. We aim to meet the national target to see and treat patients within 65 weeks of referral. We will work with community partners and GPs to support a reduction in the number of referrals to hospital through community-based models of care and further expanding advice and guidance services.

Clinical governance

Despite the challenges seen throughout 2023/24, positive changes have been made to the division's clinical governance structure to improve the reporting and review of incidents, complaints and mortality and overall to improve patient outcomes. The clinical governance agenda within the division encompasses operational, medical and nursing colleagues as a triumvirate to deliver safe and effective care.

We also have a clear process to share learning through ward safety huddles, matron forums, speciality meetings, divisional newsletters, 'lessons learned forums' and our Divisional Clinical Cabinet, to ensure a safety culture is encouraged and that both the patient and staff voice are heard.

Widespread learning and review have led to tangible changes in our working methods, quality improvement projects monitored by the division empower staff to improve local areas and we have a clear focus on risk management and patient safety across the whole division.

Our clinical governance agenda also incorporates collaboration with our stakeholders and external partners, which promotes a holistic approach when reviewing risk and safety matters that involve cross-divisional issues, multi-disciplinary concerns and complex patient pathways.

Operational and clinical performance: Division of Surgery

The Division of Surgery is large and diverse, split into the following main areas:

- Emergency and elective surgery
- Theatres, anaesthetics and ICU
- Healthcare operations

- Maternity and child health

General Surgery including breast, colorectal, general and urology

The continued focus for our Division of Surgery this year remained the reduction in waiting times; we have been extremely successful, not just in reducing waiting times for our patients, but through offering mutual aid to other providers across Greater Manchester by allowing their long waiting patients to be transferred and treated by WWL. As a result, waiting times are now down to 65 weeks in all areas, save for gynaecology. This is a noteworthy achievement due to the lost capacity experienced due to this year's unprecedented industrial action and the need to ensure that our core emergency and acute services were maintained during these periods.

One of the enablers to help deliver this reduction in waiting times was the commissioning of an additional laminar air flow theatre along with increased theatre sessions at Leigh Infirmary. This additional capacity has been instrumental in our ability to allow other providers in Greater Manchester the resource to transfer patients. We are currently finalising our submission for surgical hub accreditation and are continuing to support the region as we continue to reduce overall waiting times. This remains part of our strategy to maximise the efficiency of Leigh Infirmary as well as enabling us to transfer cases from the acute site in Wigan.

Although the cancer position has improved over the year, there has been a significant increase in the number of patients referred on a cancer pathway. In colorectal services the introduction of faecal immunochemical testing (FIT testing) which is an effective way of identifying early stages of cancer, has not had the desired impact of reducing the number of referrals. Activity remains extremely high an although patients are being seen within 14 days, the volume of patients who then require further investigation continues to put immense pressure on the rest of the pathway, particularly within endoscopy. There are similar problems in the other surgical tumour areas such as urology.

It has been a particularly challenging year for obstetrics and gynaecology due to short term rota gaps resulting from industrial action; staff turnover and a significant increase in the number of patients to be seen within 14 days since before the pandemic period. All of these factors have put immense pressure on the department to achieve the cancer and 65 week targets. However, despite the pressures the department has faced, it has continued to treat more outpatients, mostly via one stop clinic, has successfully appointed three new consultants and has plans to recruit two more consultants in 2024/25.

To try and reduce first line pressures we are redesigning our pathways; one early example of this is within breast services, were we now have a GP who is streaming referrals away from limited one stop capacity into a mastalgia pain clinic.

Head and Neck surgery (including maxillo facial, ENT and ophthalmology)

The waiting times within our head and neck directorate continue to reduce and within ear, nose and throat (ENT) and oral surgery we have been able to see and treat hundreds of long waiting patients from across Greater Manchester. There are significant pressures across GM for these specialities, we are already working with the other providers to identify capacity and help facilitate the continued transfer of patients.

We have been able to do this due to the successful appointment of additional consultants. In ENT our new consultant has not only increased our capacity to see new patients; he has also introduced day surgery back into Leigh Infirmary. As part of our strategy for the Leigh site, we are looking to expand this further.

We have an additional orthodontic consultant, and we are now able to not only provide additional capacity for patients in Grater Manchester we are also taking patients from our neighbouring integrated care boards of Cheshire and Mersey, and Lancashire and Cumbria.

Recruitment in ophthalmology remains a national challenge. We have been able to mitigate some of the associated risks to this service through an alternative recruitment model focussed on attracting more non-consultant career grade doctors. Discussions are ongoing with Manchester Foundation Trust regarding development of a shared post to support more complex theatre cases, maximizing the theatre capacity at our Leigh day case unit; this is a priority for the next financial year.

Secondary care demand within ophthalmology will also reduce as local primary care optometrists are now able to treat lower-level glaucoma patients without a referral and we likewise are able to discharge some of our longstanding patients as they are suitable to be managed locally.

Theatres and anaesthetics

We were successful in securing investment to build a fourth theatre at our elective day case unit at Leigh Infirmary. This opened in November 2023 and has enabled us to facilitate breast surgery, including cancer, on our Leigh site. Whilst this increases the specialties that are provided on the site dedicated to day case surgery, we have also increased our sessions to increase activity. This allows us to dedicate services at our Wigan site to more complex surgery and paediatrics.
In the forthcoming year we will launch a project to support our pre-operative service, to facilitate maximising our elective theatre capacity thereby reducing patient waits for procedures. A range of specialties have also come together to collaboratively work towards making theatres more sustainable as part of our ‘Greener WWL’ agenda and there are a number of initiatives currently in the scoping and implementation phase, helping us to realise benefits which are both cost reducing and sustainable.

Maternity and child health

Maternity

Our maternity services are committed to acting on the recommendations within NHS England’s three-year delivery plan for maternity and neonatal services which sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable for mothers, babies and families. Over a three-year period, we will continue to concentrate on four high level themes.

Theme 1: Listening to and working with women and families with compassion.
Theme 2: Growing, retaining, and supporting our workforce.
Theme 3: Developing and sustaining a culture of safety, learning, and support.
Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care.

For the service to meet these ambitions we are currently growing our enhanced maternity care teams which provide care to the women and families within the lowest deciles of deprivation and those who do not speak English, in particular asylum seekers and refugees. One of our key priorities moving forward is to reduce health inequalities for those living in areas of deprivation and for marginalised groups of hard-to-reach families.

The service has introduced the role of a midwife lead for patient and staff engagement this role will focus on the voice of the woman and provide a single point of contact for those woman and families

who have suffered a poor outcome. They will also act as lead representative at the Maternity Voice Partnership meeting, which is a forum where maternity service users, providers and commissioners of maternity services come together to design services that meet the needs of local women, parents and families. The post holder will also engage with the Dad Matters Group, ensure that the recommendations following findings of Picker and CQC surveys are actioned and provide a link to the staff engagement team to provide feedback and support to staff.

We received funding from NHS England to support the recruitment and retention of midwives and maternity support workers. These posts have been very popular, and the attrition rate has remained low especially amongst newly qualified midwives, in respect of which attrition was previously a challenge. There are comprehensive preceptorship packages in place for all new starters, development plans and buddies for those new to the Trust who are working in leadership roles.

Multi-disciplinary training for maternity and obstetric teams is well embedded and follows the version 2 of NHS England's core competency framework to ensure that training is delivered to address significant areas of harm and to provide standardisation across all Trusts. Training and development opportunities are always supported and encouraged at WWL.

Developing and sustaining a culture of safety, learning and support remains a high priority across the service with ongoing work with the perinatal team to ensure that optimisation measures for the preterm infant are implemented and sustained. Our perinatal quadrumvirate leaders are currently studying in cohort 3 of the Perinatal Culture and Leadership Programme which is designed to create and craft the conditions for a positive culture of safety and continuous improvement.

NHS England's Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to improve maternity safety through the maternity incentive scheme which rewards trusts that meet the ten safety actions designed to improve the delivery of best practice in maternity and neonatal services. Year 5 of the scheme has been finalised with our maternity services meeting all 10 safety actions. Work remains ongoing in preparation for year 6 which will be published in April 2024.

Child health

The unit has made several improvements in respiratory care this year including purchasing new equipment to provide non-invasive ventilation support for babies from birth, optimising respiratory care, and recently centralised monitoring has been installed to improve surveillance of vital signs and identify any deterioration.

From a research perspective the unit is currently taking part in the 'FEED1' trial, co-ordinated by the Nottingham Clinical Trials Unit and recruiting babies born prematurely between 30-33 weeks, and aiming to find out the best way to feed babies born at these gestations. We are also an active participant in the NHS England 'MatNeoservice quality improvement project.

The neonatal unit has also implemented several quality improvement initiatives this year. We have achieved the highest accreditation level for Family Integrated Care (FICare) which is a model of neonatal care which promotes a culture of partnership between families and staff. The FICare model enables and empowers parents to become confident, independent primary caregivers. The service is also working towards baby friendly reaccreditation, offered for health visiting services that meet high standards designed to help parents to bond with their new baby, and feed their baby to support optimum health and development.

Rainbow Ward is our 35 bedded paediatric ward comprising 10 surgical ring-fenced beds (increasing by 5 in the busy winter months), 12 cubicles and 10 ward beds for the provision of medical, surgical, orthopaedic and children and adolescent mental health services for children (CAMHS), two high dependency unit (HDU) beds, one retrieval space within HDU for stabilisation and transfer of critically ill children and young people to tertiary centres for further treatment. Nationally there is a critical care review ongoing reviewing HDU capacity and the funding of HDU beds and activity which has a potential impact on our services going forward.

Surgical activity has increased following the lifting of pandemic restrictions and we provide ENT, urology, maxilla facial, ophthalmology, and orthopaedic elective surgery. We also support emergency orthopaedic trauma and general emergency surgery.

Our paediatric outpatient activity has achieved the 65-week national treatment target but remains a challenge in community paediatrics. We have successfully obtained funding for a substantive consultant community paediatrician which will increase capacity to address new and follow-up backlogs in children and young peoples' services, although demand continues to outstrip capacity. The ICP is undertaking a review of the neurodevelopmental pathways, which hopes to address these challenges and the WWL team are taking part in the associated working group.

Healthcare operations

It has been an extremely challenging year for members of the healthcare operations team. They have supported the scheduling of outpatient and elective admission activity to facilitate the elective recovery programme; supported us to transfer patients from other providers through the mutual aid process and facilitated the rebooking of the hundreds of appointments which were cancelled due to staff shortages during periods of industrial action.

One of our big challenges and also achievements of the year has been in the reduction of patients that did not attend their appointment, this has been a coordinated effort involving cross divisional working. The procurement of digital solutions such as DrDoctor Quick Question and Broadcast Messaging to support patient communication has been instrumental in helping us to achieve this, however, work undertaken by our business intelligence team to identify themes such as social deprivation; age and gender has had a tangible impact in identifying the patient demographics which need more support to aid their attendance. Likewise, this technology has also been used to validate the waiting lists; asking patients who have been on follow-up waiting lists if they still require their appointments through to contacting patients to see if they want to pick-up an appointment due to a last minute cancellation.

Operational and clinical performance: Specialist Services Division

Our Specialist Services Division is a large clinical division comprising of:

- Trauma and orthopaedics;
- Rheumatology;
- Radiology;
- Outpatients;
- Oncology (cancer services);
- Dermatology;
- Medical illustration; and
- Private patients and overseas visitors

The division's governance groups have been restructured to improve the clinical governance processes. These groups have a comprehensive work programme which allows scrutiny and monitoring of key areas, including incidents, compliments, patient stories, concerns and complaints, risks, lessons learned, and areas of good practice.

The division has commenced the implementation of the new NHS Patient Safety Incident Response Framework (PSIRF). This change means different ways of working and investigating incidents, which is already improving patient outcomes. As part of this process we have made improvements to our monthly governance processes to ensure the feedback from patient safety incidents is shared across the division through our governance groups.

All inpatient and outpatient areas in this division have retained accreditation through WWL's ASPIRE ward accreditation program, providing assurance that each area meets the standards set out in our organisational assessment framework. We are pleased that this has progressed with a silver award being achieved this year.

The division was pleased to see an increase in the number of staff participating in our staff survey this year and continues to focus on staff wellbeing, by working with staff to improve in problem areas, identified through themes which emerged from the survey feedback.

Equally, the division recognises the importance of patient feedback and continues to work closely with the patient relations team to ensure that feedback is used to support service improvements. The patient relations team supports the division to identify themes from complaints and discuss these with individual staff members, as well as to share experiences across the division and promote best practice communication, behaviours and attitudes.

Radiology

The radiology department undertakes all aspects of diagnostic imaging, including:

- General x-ray
- Computerised tomography (CT)
- Ultrasound
- Nuclear medicine
- Magnetic resonance imaging (MR)
- Breast screening and diagnostic
- Vascular and non-vascular interventional radiology
- Bone densitometry (DEXA)
- Medical illustration

Demand for diagnostic imaging continues to grow and we currently undertake over 330,000 examinations of increasing complexity per year. Throughout the last financial year, the service has expanded diagnostic facilities at Leigh Infirmary as part of the national community diagnostic centre (CDC) programme. This has delivered additional imaging capacity in CT, MR, X-ray and ultrasound. In addition to the CDC programme the service has also expanded breast imaging services to the Leigh site. This project made a transformational change to how diagnostic imaging services are delivered with a strong focus on providing these tests across all trust sites within a 7-day operating model. Patients have rapid access to diagnostic tests which has supported the work to deliver early diagnosis for patients referred with suspected cancer. In addition to this vital work, the service has been able to provide increased scanning availability for patients referred on elective pathways. Ther

CDC has also created a capacity gain at the Wigan site which has experienced the highest rate of growth in diagnostic demand specifically for CT and MR examinations requested as part of emergency or in-patient care. The CDC has provided new opportunities to re-design care pathways and has successfully implemented a one-stop service for patients that are referred with urological bleeding. The provision of additional MR capacity has permitted the service to commence MR guided breast biopsies which will allow patients to be investigated locally within a shorter timeframe that avoids potentially lengthy referrals to the tertiary hospital in Liverpool.

Performance of the service against the national diagnostic waiting time 6-week referral to exam target has been challenging as existing diagnostic services have exhausted capacity or have been restricted by obsolete technology. The additionality of CDC capacity and replacement of equipment has seen the elimination of 6-week wait breaches for CT and MR. The performance position for non-obstetric ultrasound has proven more challenging due to a national shortage of sonographers and competition from the independent sector. A recovery plan has been enacted which has seen a reduction in breaches and this will continue to be delivered throughout 2024/25.

The department supports clinical training for medical, obstetrics, gynaecology and radiology trainees and has an increasing portfolio of international trainees. We have created targeted training posts to support musculoskeletal intervention and breast imaging to contribute towards long-term resilience for specialities with identified skills deficiencies. Likewise, our successful sonographer training programme continues to expand, and reached a significant milestone in 2023/24 with the first students graduating as qualified sonographers. A dedicated ultrasound training hub is now established at Leigh Infirmary in collaboration with the University of Cumbria and other opportunities to expand undergraduate training are being explored with other higher education institutions. The service has engaged with the North-West Imaging Academy at Edge Hill University to participate in post-graduate education for radiologists and radiographers. The training portfolio is expected to expand to include training for support staff.

Radiographers who undertake general radiography training now rotate across 3, and in some cases, all 4 sites to ensure that there is a seamless service provision to match patient demand. Barriers to recruitment of radiographers, including a national high demand within the profession, have been mitigated by a wide range of recruitment initiatives including international recruitment, creation of apprentice radiographer posts. Two apprentice radiographers are now enrolled in training realising the directorate and trust ambition to act as an anchor institution, supporting people within our local communities to develop new skills and become registered health professionals. In addition to the apprentice radiographers, the service has noted that two former support staff have been accepted to undergraduate diagnostic training courses and the trust continues to provide support to these staff by allocating elective clinical experience as part of the training syllabus. Recognising the requirement to train a new workforce to replace the high number of staff that are due to retire has resulted in the service increasing the undergraduate intake from 7 to 10 students, meaning that we will have up to 32 radiographers in-training by the start of the 2025 academic year. Additional funding provided through the North West Imaging Academy will strengthen the wider need to develop clinical practice educators to support the training of the under and post graduate workforce.

The service has a strong focus on clinical governance and proactive approach to risk management has allowed it to operate safely in compliance with regulatory requirements. A new approach to clinical governance has recently been adopted, with a focus on quality and safety which links closely with a long-held ambition to bid for accredited service recognition by the Quality Standards for Imaging programme. The service successfully recruited a governance radiographer to support the arrangements for delivering clinical governance.

Several general x-ray equipment devices across our sites were installed more than 20 years ago. Throughout 2023/24 there has been good process to replace some of the oldest devices which has gone ahead at Wrightington Hospital through installation of a new general radiography room and a new fluoroscopy room. A new room has also been installed within the accident and emergency department, which replaces a room that was 20 years old.

The CT and MR departments are located at Royal Albert Edward Infirmary and Wrightington Hospital and perform around 54,000 CT and 23,000 MR examinations per year. The department comprises 4 CT and 4 MR scanners which operate over 7 days a week. To meet the increasing demand for acute CT the service was reconfigured to deliver a 24-hour on-site service which is responsive to the needs of clinicians and patients. Ther increasing demand for unscheduled CT scans and the emerging demand for MR scans in emergency clinical scenarios is likely to require a review of service arrangements to deliver increased capacity.

The CT department successfully developed a cardiac CT service which will negate the need for Wigan Borough patients to travel to Wythenshawe for investigations to be carried out. This examination is in high demand due to its safety profile and convenience. The expansion of diagnostic capacity within our Community Diagnostic Centre at Leigh Infirmary has allowed the service to expand which has been supported by the recruitment of a cardiothoracic radiologist and a consultant cardiologist with an interest in cardiac imaging.

The nuclear medicine department is located at Royal Albert Edward Infirmary and performs around 3000 examinations per year. We provide functional imaging for patients of Euxton Hall Hospital, with a large proportion of our work coming from orthopaedics, oncology, urology and cardiology.

The installation of a single-photon emission computed tomography CT scanner has increased both the sensitivity and specificity of imaging, which has improved diagnostic accuracy for orthopaedic imaging. The combination of functional and diagnostic imaging in one scan has reduced the need for patients to have further imaging, therefore reducing attendances.

Diagnostic and screening ultrasound services are provided within radiology for non-obstetric ultrasound services and obstetrics including the foetal anomaly screening service for approximately 3,600 deliveries.

Outpatient ultrasound scans are performed cross site over 14 hospital-based scan rooms and within community venues, typically within several GP surgeries across the Wigan Borough. Inpatient examinations are carried out at Royal Albert Edward Infirmary, Leigh Infirmary and Wrightington Hospital. A range of interventional procedures including biopsies and therapeutic injections are undertaken both the Wigan and Wrightington sites.

Trauma and orthopaedics

Challenges continued for the trauma and orthopaedics directorate throughout 2023/24. We have made significant progress against elective recovery following the pandemic, the current inpatient waiting list is approximately double pre-pandemic levels, at just under 5000. We have had a focus on reducing bottlenecks, developing pathways for more day case and ambulatory procedures. During the year we met the NHS England target for ensuring that no patient had been waiting for more that 65 weeks for surgery by 31 March 2024. Overall there remains an increasingly complex case mix, with a higher number of patients requiring more intensive support post operatively.

Wrightington has continued to succeed as a Greater Manchester trauma & orthopaedics elective hub since July 2021 and has been supporting a number of organisations through the Greater Manchester mutual aid programme, assistance has been provided to patients from neighbouring NHS Foundation Trust including Tameside and Stockport, Manchester Foundation Trust, Northern Care Alliance, East Lancashire Teaching Hospital and Bolton, helping to reduce inequities in access to healthcare across the region.

Since being identified as a major revision centre for knee surgery by the NHS Northwest England Specialised Commissioning Team in September 2021, our efforts have been focused on helping to improve knee revision surgery across Greater Manchester, Lancashire and South Cumbria.

During the year we have seen operational challenges primarily in our old main theatres which have continued to cause disruption to the running of planned lists. Our staff have worked tirelessly to mitigate the resulting impact on patients and loss of activity, by flexibly moving between any functional theatres on site. As part of the elective recovery programme, we are continuing to develop the elective ambulatory unit, increasing our ability to offer surgery on a walk-in walk-out basis for both upper and lower limb, reducing our waiting list times and increasing patient satisfaction. Since January 2024, our Wrightington site has expanded its capacity to see 16-17 year olds as overnight stays, reducing waiting list time and freeing up capacity at the main acute Wigan site. We have also seen the start in construction of theatre 11 to support the elective recovery programme, the aim is to commence surgery in November 2024.

During 2023/24, bed pressures within the system have continued to compromise our ability to consistently move patients with a fractured neck of femur in a timely manner to an orthopaedic ward. Additionally, the lack of sufficient dedicated orthopaedic beds on the Wigan site has led to patients in some cases residing on the wrong wards. Since January 2024, an improvement project has commenced to support fractured neck of femur patients being cared for on the right ward from the moment that they are admitted. To assist, where possible, trauma patients have been transferred for surgery at the Wrightington site which although impacts on the elective recovery programme, does ensure that trauma patients receive the appropriate care.

Over the coming year, the directorate is focused on moving to a position where no patient has waited for longer than 52 weeks for their surgery, commissioning additional facilities and supporting patients whilst they wait. A number of capital programmes have been identified for the upcoming financial year and beyond which will form part of the wider site redevelopment plan and strategy.

Rheumatology

The beginning of the year saw the recruitment of our third substantive rheumatology consultant which has strengthened service consistency and stability. Although the service has experienced significant challenges with capacity within our specialist nurse workforce due to periods of industrial action, the rheumatology team has managed to maintain minimal impact on its waiting lists and activity, for instance, having zero cancellations of day case procedures.

Despite the significant challenges which we have faced this year, we have managed to overachieve on our day case activity plan and our service has managed to maintain being open to out of area referrals. We have piloted group education sessions for our patients, which have been very positively received and we are keen to extend and expand these sessions which will support our patients and create further capacity for those waiting for follow-up appointments and medication prescriptions. We completed a review of all medical clinic templates to ensure that we are maximising our capacity and increasing efficiencies, this has resulted in an increase in new patient activity which will further

support our waiting list. A regular specialist osteoporosis clinic has been established to enhance patients' outcomes and reduce waiting times further.

Outpatient services

This year has seen an increase in demand for our outpatient services. We have facilitated extra clinics above our establishment to support our long waiting lists and responded quickly to challenges such those associated with industrial action.

The outpatient booking teams have implemented changes to booking processes and patient communication such as text reminder messages and have completed audits which have directly resulted in efficiencies such as a reduction in rates of non-attendance. We are keen to develop our workforce, increasing the retention rate of our staff, and providing opportunities for internal progression. With this in mind, we introduced our very first apprenticeship role within the outpatient booking team this year. We successfully validated all new and follow-up patients and continue to validate to ensure all capacity is utilised efficiently. We have completed audits on unrecorded outcomes and implemented processes to ensure timely completion, maximising our income.

Dermatology and plastics

The dermatology and plastics services have seen a very challenging year, with unprecedented rates of referrals of both general dermatology conditions and suspected skin cancer. Although we benefitted from the recruitment of our substantive clinical lead and dermatology consultant at the beginning of the year, we remain heavily reliant upon locum consultants to maintain the service due to a national shortage of dermatology consultants. Despite such challenges, we perform very well when benchmarked across our peers.

We completed a review of all medical clinic templates to ensure that we are maximising our capacity and increasing efficiencies, this has resulted in an increase in new patient activity which will further support our waiting list. We currently have no patients waiting over 65 weeks for either dermatology or plastics services.

We have implemented a tele-dermatology pilot whereby suitable patients referred on a suspected skin cancer pathway are triaged onto the tele-dermatology pathway. The pathway involves the patient attending an appointment in the tele-dermatology rapid access clinic within the medical illustration department at Leigh Infirmary, where high quality images are taken of the patient's suspected skin cancer. Following the photography appointment, a consultant dermatologist reviews the images taken and provides an outcome by letter to the patient and the referring healthcare professional. The pilot is proving to be highly successful, with a number of benefits realised, including excellent patient feedback and avoiding one face to face appointment for 73% of the patients reviewed. We are eager to extend and expand the tele-dermatology pilot subject to funding.

We have engaged with the Greater Manchester dermatology programme and await instruction regarding the model of care which the programme proposes.

Private patients and overseas visitors

With the continued length of wait some patients are encountering for elective procedures, private patient activity has seen significant growth. The growth in the number of patients seen and treated has been complemented by a high complexity of cases, leading to the income received by the service exceeding previous years. In general, increasing NHS waiting lists are a driver for patients seeking

private care and given the growth in NHS waiting times, a greater number of enquiries were received this year.

During the year there has referrals to the overseas visitors team have remained consistent and with the help of our transformation team, progress is being made in streamlining the processes for the management of overseas visitors.

Therapies

The musculoskeletal clinical assessment and triage service has continued to recruit successfully and the team is now fully staffed with no vacancies. As per the commissioned pathway, there is no waiting list for patients to access the service. The patient pathway has been streamlined by improved links to primary care via the first contact practitioner service and increasing opportunities for primary care colleagues to work alongside WWL and alternative secondary care providers. The service can now refer into Wrightington directly for hydro-dilatations.

The first contact practitioner service has continued to develop with a further increase to staffing numbers. The team continues to collect and analyse a significant amount of data about the service and has presented this at regional networking events. Pathway development for the practitioners continues, with the aim of streamlining the patient journey for those that require secondary care whilst effectively managing care at the point of initial contact in the primary care setting, for an increasing number of patients.

Our outpatient therapy team have worked extremely hard on a recruitment drive across services. They have collaborated with Johnson & Johnson and produced some promotional videos, posters and leaflets. We were delighted to receive a bronze HSJ award for this work. Members of the team have attended recruitment events at universities

Recruitment of physiotherapists has improved but there is a significant shortage of occupational therapists which is reflective of the national position. Therapies are hoping to welcome their first apprentice occupational therapists into post in September 2024. Therapies have over-achieved on their outpatient activity figures for the year, helping the division's overall position.

Trauma inpatient therapy services became part of our Specialist Services Division in August 2023. This change was necessary to ensure better communication between teams, patients being seen over seven days in line with Chartered Society of Physiotherapy standards, cross cover from Wrightington, an increased pool of staff for greater flexibility, improved training, supervision, peer support, increased continuity of care (particularly for outliers) and overall increased patient satisfaction. Overall length of stay for trauma has been reducing since the service transferred in August but there was a spike in January and February.

The orthopaedic practitioners have developed a service improvement to reduce the number of patients not attending our virtual clinics and are looking at increasing the number of new patients seen in their clinics to help with activity levels.

Cancer services and oncology

Improving cancer performance has been a major priority for the Trust, which has a strong focus on delivering early diagnosis. The Trust has responded by investing in diagnostic services by increasing imaging facilities and through the Community Diagnostic Centre at Leigh Infirmary and the approval for construction of expanded endoscopy units Wigan and Leigh.

Recovery to pre-pandemic performance levels remains challenging, although the impact of continuous improvement initiatives and investment are beginning to demonstrate tangible and sustainable performance gains. During the last 12 months the service has focussed on achieving compliant performance against the 28-day Faster Diagnosis Standard (FDS). The FDS was introduced in 2021 and measures the number of patients referred from their GP with suspected cancer to be given either a cancer or non-cancer diagnosis within 28 days of referral. A target to achieve a 75% performance target has been achieved for the 2023/24 planning period and this will be stretched to a 77% performance target throughout 2024/25. The service has confidence that this will be achieved by continuing to deliver improvement plans and by focussing attention on delivering improved compliance against the best practice timed pathways. To support this work the service has received funding to recruit a cancer transformation manager and additional pathway navigators.

The service has prioritised reducing the number of patients waiting more than 62 days on an open cancer pathway without receiving a decision as to whether they should be treated or given a non-cancer diagnosis. Good progress has been made to reduce long waits in line with the activity planning trajectory, but it has proved challenging to sustain consistent performance during periods when we have been operating under significant pressure. The service has delivered a decreasing trajectory throughout 2023/24 and although it did not achieve its year-end target it did get back to its pre-pandemic position. Despite removal of the national requirement to formally report the number patients waiting in this cohort, the Trust will continue to monitor these in 2024/25. The performance against the 62-day treatment standard (for patients with a confirmed diagnosis of cancer) has been predictable throughout 2023/24 with the Trust maintaining an average performance at 70% against the 85% target. The service will continue to seek improvements toward the 85% target but is confident that the 70% target identified within the operational planning guidance will be achieved. Cancer Services will support teams that are challenged by performance to increase the compliance against the combined target.

Substantial work has been undertaken to improve performance on the lower gastrointestinal pathway which has experienced considerable challenges. Working closely with colleagues in primary care has harmonised the compliance with FIT testing for patients with suspected bowel cancer. This has permitted the speciality to refine the referral pathway for patients with suspected colorectal cancer with a higher proportion of patients being referred straight to test for diagnostic procedures. The additional CT capacity provided by the new diagnostic centre has increased the monthly CT colonoscopy capacity from 70 to 100 patients which will deflect suitable patients away from endoscopy capacity.

Several other tumour specific pathways including prostate, lung and upper gastrointestinal tract have been involved in implementing best practice timed pathways to ensure a faster diagnosis which are intrinsically linked to the faster diagnostic standard. The rapid diagnostic service (RDS) continues to expand its scope to deliver improvements in the best practice times pathways and the management of patients with a negative FIT test but ongoing concerns of a possible cancer diagnosis.

The cancer services and RDS teams have continued to support the NHS Galleri trial which is using a novel blood test to detect positive cancer signals and aims to diagnose cancer before symptoms are evident. The trial has now entered the next stage of recruitment and follow-up. The early results demonstrate the potential for the test to be used to detect more cancers at an early stage which have a higher chance of cure.

The Trust continues to collaborate with primary care and teams within Greater Manchester to deliver comprehensive cancer prevention screening services including breast and cervical cancer screening. The Wigan locality took part in the second phase of targeted lung health checks in 2023 with promising results for patients with early-stage lung cancer which was detected before symptoms developed.

The team has also been working with tumour-specific teams to implement personalised stratified follow-up pathways which will enable patients to manage their conditions more effectively following treatment, having direct access back into the hospital system if required but reducing the reliance on attending routine follow up appointments which creates additional capacity for new patients.

The cancer peer review process for all tumour specific teams was completed in October 2023. The reviews allow teams to provide an overview of their services, describe the key achievements and challenges they had experienced over the previous 12 months and to identify key service developments they would like to focus on over the coming year. The 2024 peer review audit cycle is due to commenced in spring with a focus on delivery against the objectives identified in the operational planning guidance.

Cancer treatments are delivered within the dedicated cancer care unit, supported by bi-monthly meetings with The Christie NHS Foundation Trust (the Christie) to discuss operational issues and key performance indicators. Activity has been steadily growing and increased as more patients have required treatment in the early recovery phase. We have confidence in our ability to gradually increase the numbers of patients we can accept for treatment and to repatriate those patients that were transferred due to reduced capacity.

Our forward planning includes working with The Christie on ideas to extend our existing premises and we are currently meeting with them frequently to look at the increasing patient activity and how we can continue to provide a great quality service. Expanding treatment capacity requires re-purposing of the current estate, although the team working within the cancer care unit are developing plans to increase treatments delivered to patients in chairs, which has the potential to create increased capacity within the current footprint. The service was successful in a bid for funding to purchase new treatment chairs which are used to reduce bed occupancy on the unit and to allow more treatments to be administered within each session of work. Additional funding provided by charitable funds has been released to reconfigure the existing estate so that we have more treatment areas.

Patients undergo a holistic needs assessment at their pre-chemotherapy visit, enabling them to discuss any worries and concerns before they start their treatment. During the pandemic, pre-chemotherapy visits were performed virtually, presenting an unexpected opportunity for service improvement which the treatment team intend to continue beyond the pandemic. Results of the national patient cancer survey show how these improvements have been positively received by patients.

Operational and clinical performance: Division of Community

The Healthier Wigan Partnership set out a vision to radically transform local community-based health and care services. Across the borough, community based integrated health and social care services have been successfully built around seven neighbourhood areas. These areas have been based on naturally formed communities, each with a 30-50,000 registered population, and through these we plan delivery of our services to meet local needs. The neighbourhoods include health and care partners working closer together, including community nursing, therapies, and adult social care - we call these integrated community services - alongside schools, children's services, mental health, police, housing and other public and voluntary and community sector partners which are also aligned.

Our model has a strong emphasis on population health promotion, prevention, early intervention, self-care, and self-management. The model reduces demand for services and allows care and support to be increasingly delivered out of hospital, at the appropriate care level, contributing to safe and effective admission avoidance across the system. By working together across organisational boundaries as one team, we make better use of the combined skills and knowledge of all professionals co-located in a place. This has had a positive impact, enabling us to provide care for individuals more effectively at the first point of contact, ensuring that the most appropriate professional, or combined professionals, are able to deliver care and support at the right place and time. This improved care coordination has significantly reduced the number of hand-offs individuals experience across the system, with services feeling more connected and less fragmented for patients and residents.

The Healthier Wigan Partnership focuses on staff taking the time to understand people's goals, supporting them to connect to their community and be well. Keeping people well for longer is key to the success of our locality transformation programme; by addressing the wider determinants of health, such as social isolation, loneliness, housing issues and school readiness has led to a reduction in need for reactive and expensive hospital admissions and/or long-term social care.

Children and families

WWL's children and young peoples' 0-19 services successfully completed their planned move into the aforementioned Healthier Wigan neighbourhood areas. This move supports and enhances our ethos of integrated care, enabling the combined skills and knowledge of staff to be available to our population.

The public health contract for delivery of the health child programme for 0-19 years was directly awarded to WWL from Wigan local authority using the newly formed provider selection regime. This is extremely positive for WWL and is testament to the strong relationships between our leadership team and the local authority public health team.

Virtual Ward

Our Virtual Ward opened in January 2022 and has been expanding its capacity ever since. In 2022/23 we had 40 virtual beds, this increased to 150 at the end of 2023/24. The Virtual Ward is an initiative aiming to reduce pressure on acute services by providing alternative care out in the community, allowing patients to be cared for and clinically monitored in their own home/residence, instead of in an acute setting. The Virtual Ward aims to improve the experience for patients by minimising lengthy admissions into hospital and improving hospital discharge and flow. As well as patient and operational benefits, the service also provides WWL with value for money.

Intermediate care at home

Staying in hospital longer than necessary has a negative impact on our patients' opportunities to remain independent. As such, timely discharge from hospital is a key priority for our patients, our carers and for WWL. In order to enhance the support to our patients we have commenced an intermediate care (IMC) at Home service model which uses a 'Home First' approach,

The aim of the IMC at Home service is to provide short term health and/or social care interventions to adults, who need support after discharge from acute inpatient settings, to help them rehabilitate, re-able and recover. Previously there could be delays or gaps in patients receiving ongoing therapy at home following discharge from the acute or an intermediate care bed. IMC at Home offers a more immediate response for ongoing therapy with a higher frequency of input. This model provides therapy within the patient's own residence at an earlier stage than was previously available.

The first stage of this model was commenced in January 2024, when the first patients were accepted from our community bedded units. The intention is, where safe and appropriate, to offer earlier intervention to maintain patients in their own homes, improve their functional abilities and maximise their independence and well-being. This will also reduce inappropriate placements in long term care facilities and the need for permanent costly care/support packages.

Further expansion and embedding of the model will be implemented throughout 2024/25.

Community assessment unit

In 2023, a new frailty pathway was successfully implemented in our clinical assessment unit. Frailty SDEC is a Same Day Emergency Care service for patients over 65 years of age who are presenting from care homes or their own residence; and are presenting with one or more frailty related medical issues, such as delirium, Parkinson's Disease, a history of falls, immobility or incontinence.

The service assesses, diagnoses and treats referred patients with a view to discharging them on the same day. The team consists of Geriatricians, advanced care practitioners, specialist therapists, pharmacists, nursing staff and administrators. The number of patients seen via the frailty pathway has seen a significant increase throughout 2023/24, ensuring that our frailer patients are being cared for by a specialist frailty team, and wherever possible are able to maintain their independence for longer, in accordance with our Healthier Wigan Partnership vision.

Operational and clinical performance: Estates and facilities

The Estates and Facilities division continues to provide a wide range of non-clinical support services to all our sites, including:

- Capital Projects
- Car parking and security
- Catering
- Community equipment
- Community services administration support
- Domestic services
- Energy management
- Environmental and sustainability
- Fire Safety
- Trust general office services
- Estates and facilities governance and risk

- Linen services
- Medical electronics and equipment loan store
- Operational estates
- Portering services
- Residential accommodation
- Sterile services and decontamination unit
- Stores
- Switchboard
- Waste

Whilst quality, safety and our patient environment are equally important, we fully recognise the need to provide a cost-effective service and we utilise our estate as efficiently as possible.

The estates team provides an emergency breakdown repair and planned preventative maintenance (PPM) service which involves undertaking 13,333 PPM tasks each year. The estates team has supported wider estates and facilities activity across our sites. It also provides a technical out of hours emergency on-call service for the built environment and associated engineering services. The team continually assesses the most effective way to utilise its resources in this area.

The division also provides medical equipment management services, using an equipment database which includes more than 36,000 items. The database is a keystone to managing the servicing, maintenance and breakdown repair service that is delivered to all clinical departments and has been further enhanced in the last year by the addition of a new equipment database which will enable improvements in our record going forward.

In justifying the title of ‘cleanest acute hospital’ in the country the domestic services team complete around 4,600 deep cleans to infected areas.

The waste team manage around 370 tonnes of clinical waste and using at ‘point of use’ separation are able to effectively dispose of through the correct waste streams.

The trust’s catering department make around 1,000,000 sandwiches each year and provide patient meals to every in-patient during each day of their stay. To accommodate an in-patient stay, the Linen services handle around 240,000 items of linen during a year.

To effectively manage theatre and other clinical activities the sterile services and decontamination unit sterilise around 216,000 trays of surgical instruments.

These unprecedented times regarding the use of WWL services the trust’s switchboard answer around 480,000 calls per year.

To help provide a safe environment for patients, visitors and staff, the fire safety team provided around 2,000 staff with fire training which is rolled out each year to capture all staff within the Trust over a period of time.

As part of the NHS standard contract, all NHS organisations are required to monitor and report on compliance with the various requirements of the ‘Green NHS and sustainability’ clause. Our performance against the Standard Contract Service Provision 18 is provided in the table below:

Contractual requirement	Our performance 2023/24
In performing its obligations under this Contract the Provider must take all reasonable steps to minimize its adverse impact on the environment.	This is achieved through the Green Plan, Net Zero Strategy, Heat Decarbonisation Plan and moving forwards, will also be addressed by our Climate Change Adaptation Plan. We have carried out risk assessments in order to help mitigate the impacts of climate change and adapt to its effects. These are currently in the process of being compiled into a climate change action plan that will be integrated into decision making for any current or future developments.
The Provider must maintain and deliver a Green Plan, approved by its Governing Body, in accordance with Green Plan Guidance.	Our Green Plan was approved by the board and published on 30 March 2022. This document acts as the annual summary on delivery of the plan and is updated at the start of the financial year.
The Provider must nominate a Net Zero Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position.	WWL's Net Zero Lead is the Director of Strategy and Planning. The Operational Lead is the Environmental and Sustainability Manager.
The Provider must publish in its annual report quantitative progress data, covering as a minimum greenhouse gas emission in tonnes, emissions reduction projections and an overview of the Provider's strategy to deliver those reductions.	Included above.
As part of its Green Plan, the Provider must have in place clear, detailed plans as to how it will contribute towards a 'Green NHS' with regard to delivering a 'Net Zero' National Health Service commitments in relation to air pollution, and specifically how it will take action to reduce air pollution from fleet vehicles, transitioning as quickly as reasonably practicable to use exclusively zero and ultra-low emission vehicles;	We are engaged with our lease provider to review electric vehicle (EV) options. However, we have issues with available electrical capacity across our sites. To combat this we are in discussions with the Local Authority and the private sector regarding them provision of a charging hub. All leases are Euro 6 rated.
The Provider must take action to phase out fossil fuels for primary heating and replace them with less polluting alternatives.	The Trust has commissioned a heat decarbonisation plan and a bid for Public Sector Decarbonisation Scheme funding to address shortfalls in capital funding
The Provider must develop and operate expenses policies for Staff which promote sustainable travel choices.	The Trust operates an expenses policy that includes recompense for shared occupancy, bus, rail, electric vehicle, and bicycle travel.
The Provider must ensure that any car leasing schemes for staff (including salary sacrifice	We offer lease options on several EV vehicles and over 50% of all new leases are now EV

Contractual requirement	Our performance 2023/24
schemes) exclude high emission vehicles and promote zero and ultra-low emission vehicles.	
The Provider must develop plans to install electric vehicle charging infrastructure for fleet vehicles at the Provider's Premises.	Included above.
As part of its Green Plan, the Provider must have in place clear, detailed plans as to how it will contribute towards a 'Green NHS' with regard to delivering a 'Net Zero' National Health Service commitments in relation to climate change, and specifically how it will take action to reduce greenhouse gas emissions from the Provider's Premises in line with targets in Delivering a 'Net Zero' National Health Service.	We have a green plan, Net Zero Strategy and Net Zero steering group that all look to tackle the targets set out in delivering a Net Zero Health Service
In accordance with Good Practice, to reduce the carbon impacts from the use, or atmospheric release, of environmentally damaging gases such as nitrous oxide and fluorinated gases used as anaesthetic agents and as propellants in inhalers, reducing piped nitrous oxide waste, by clinically appropriate prescribing of lower greenhouse gas emitting inhalers, and by encouraging Service Users to return their inhalers to pharmacies for appropriate disposal.	We have completed nitrous oxide audits and are in the process of stopping use via manifolds. We have addressed use of metered dose inhalers and started to switch to dry powder Inhalers where clinically appropriate.
In complying with SC18.3.2.2 above, to reduce appropriately the proportion of desflurane to all volatile gases used in surgery to 2% or less by volume across 2023/24 as a whole (with a view to eliminating use of desflurane altogether, except as permitted by Guidance, with effect from 31 March 2024).	We have removed desflurane from use, to meet the 2024/25 deadline.
The Provider must adapt the Provider's Premises and the manner in which services are delivered to reduce risks associated with climate change and severe weather.	We are in the process of completing a climate change adaptation plan tool developed by Greener NHS. Alongside collation of exiting emergency preparedness, resilience, and response (EPRR) documentation, the output will be used to produce a Climate Change Adaptation Plan.
As part of its Green Plan, the Provider must have in place clear, detailed plans as to how it will contribute towards a 'Green NHS' with regard to delivering a 'Net Zero' National Health Service commitments in relation to single use plastic products and waste, and specifically how it will take action:	The Trust continually reviews its waste generation and adopts measures to reduce its impact. We have not signed up to the Plastics Pledge but are reviewing single use plastic cutlery/crockery in line with new guidance. This will be an ongoing process that requires feasibility studies to determine if we can switch to dishwashers or if we must purchase alternative non plastic disposables.

Contractual requirement	Our performance 2023/24
• to reduce waste and water usage through best practice efficiency standards and adoption of innovations; • to reduce avoidable use of single use plastic products; and • to make provision with a view to maximising the rate of return of walking aids for re-use or recycling and must implement those plans diligently.	Schemes to address waste and water usage are implemented through the Net Zero Estates Strategy Group. Progress is monitored through our sustainability project charter and savings are reported through our green plan. We are actively addressing single use plastic use through reviews of products purchased. Examples include a review of single use plastics included within theatre sets and replacement with reusables where feasible, and removal of single use plastics from our catering department. We operate a walking aid refurbishment scheme through the Local Authority.

Taskforce on climate related financial disclosures (TCFD)

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

The phased approach incorporates the disclosure requirements of the governance pillar for 2023/24. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

The Board of Directors has oversight of climate-related issues through the Finance and Performance Committee. Our Green Plan, its annual refresh and annual sustainability reports are all submitted to the board for approval.

Management assess and manages climate related issues within their divisions through several purpose established groups:

- Medicines and Sustainable Models of Care Group
- Estates Net Zero Group
- Digital Transformation Group

Where issues cannot be solved within these groups, they are fed up to the Net Zero Steering Group to address. Progress on Green Plan targets are also reported to the steering group by the sub-group leads. The Net Zero Steering Group provides monthly reports to Finance and Performance Committee detailing areas of assurance, progress and alerting it to any relevant risks. Progress is then reported through the Green Plan. The board monitors progress through our annual sustainability report.

Strategy

Climate related risks and opportunities will be addressed within our Climate Change Adaptation Plan which is currently in development. Opportunities and risks will also be addressed through our Green Plan which covers the period 2022-2025 and is currently being revised to extend to 2030. This updated version will be available from 1st April 2025.

The resilience of the organisation's strategy against different climate related scenarios is still being reviewed and is therefore not fully understood.

Risk Management

The Trust has long established risk management principles in place that consider the risks to meeting organisational objectives. The Board Assurance Framework details the risk of the Trust not meeting its net zero requirements and climate change having an impact on the Trust delivering services which cannot be mitigated.

Climate-related risks have not yet been collated into a dedicated plan outlining the associated opportunities presented by climate change. We intend to have a climate change adaptation plan in place by 31st March 2025.

However, using the national risk register as a base, the Trust has assessed how each risk will be affected by climate change and applied this assessment to internal emergency and business continuity plans that aim to ensure the continued achievement of organisational objectives and delivery of health services to provide the mitigation needed.

Metrics and targets

Metrics and targets used to assess and manage relevant climate related risks and opportunities can be found in the Trusts Green Plan. Our performance against the Standard Contract Service Provision 18 is provided in the table above.

Our Green Plan 2022-25 is available at: **wwl.nhs.uk/sustainability**

Joint forward plans and capital resource plans

During 2023/24, we continued to exercise our responsibilities on capital planning through robust governance, including a Capital Strategy Group, which met monthly. This allowed us to monitor capital spend during the year to ensure effective utilisation of capital resources. Progress reports from key programmes are received so that risks to delivery can be assessed and mitigations put in place where required. The Capital Strategy Group also provides oversight to the development of the five-year capital plan, ensuring this is appropriately aligned to our strategy. The annual capital programme is aligned to the business plan and identified risks, noting that we are operating within a highly constrained capital environment. Capital expenditure limits and bids for national capital are managed on at ICS level, to a large extent. We are represented at all ICS wide capital planning discussions to ensure that our capital requirements and risks are considered within the overall Greater Manchester plans. The Finance and Performance Committee routinely seeks and receives assurance on capital expenditure and planning.

Health inequalities

Our partnership working brings opportunities to focus not just on provision of health services, but also on tackling the wider determinants of health and reducing health inequalities. One key approach to this is our role as active participant in the Wigan Community Wealth Building partnership, as one of the anchor Institutions within the borough. Through this, we are actively engaged in supporting improvements in the socio-economics of the borough by leveraging the economic clout we have as

the largest employer and our significant spending power. Examples of tangible benefits include: development of a central training facility in partnership with Wigan and Leigh College, Edge Hill University, Wigan Council and WWL (the Rushton Building); an increase in the number of T-level placements at WWL and an increase in the number of apprentices.

An anchor institution landing page on our internet site has recently been developed:
wwl.nhs.uk/anchor-institution

In 2023/24, several reports have been commissioned to aid a greater understanding of health inequalities in relation to: patients who do not attend for appointments; attendances at our accident and emergency department; emergency admissions and waiting lists. These have been shared with locality partners, and the Healthier Wigan Partnership Integrated Delivery Board (IDB) is planning to focus on health inequalities, including reducing inequity of access to care moving forwards. A workshop was held with IDB members, with wider representation from across the locality, to inform development of a plan to reduce inequity of access to care; this will lead into targeted improvement projects within the locality during the coming year. These insight reports and the recommended actions have also been discussed by our Board of Directors.

WWL will continue to progress the national requirements for health inequalities outlined within the 2023/24 priorities and operational planning guidance[1] by delivering key actions within our Health Inequalities Analytics Action Plan. The plan outlines next steps; such as embedding protected patient characteristics into core reporting and agreeing equity data priorities for 2024/25 and recommendations for wider collaborative inequalities reporting.

Operational compliance: emergency preparedness, resilience and response

Compliance for emergency preparedness, resilience and response (EPRR) within the Trust is assessed using the NHS EPRR Core Standards Self-Assessment Tool. This tool uses the following definitions for this self-assessment:

Overall EPRR assurance rating	Criteria
Fully compliant	The organisation is 100% compliant with all core standards it is expected to achieve. The organisation's board has agreed with the position statement.
Substantial compliance	The organisation is 89%-99% compliant with the core standards it is expected to achieve. For each non-compliant core standard, the organisation's board has agreed an action plan to meet the compliance within the next 12 months.
Partial compliance	The organisation is 77%-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's board has agreed an action plan to meet the compliance within the next 12 months.

[1] https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/

Non-compliant	The organisation is compliant with 76% or less of the core standards it is expected to achieve. For each non-compliant core standard, the organisation's board has agreed an action plan to meet the compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

EPRR activity across the Trust operates using established emergency planning life-cycle principles which embed continual review and learning principles into planning and response. This ensures that the Trust has a process of continuous improvement for EPRR.

In areas that we assess ourselves as being non-compliant to the NHS core standards for EPRR, we engage with all internal departments and with external partners to review performance and develop improvement plans to improve compliance. These improvement plans are regularly monitored until compliance is achieved.

For 2023/24, we have assessed ourselves as having an EPRR assurance rating of 'partially compliant' against the core standards. This was agreed by the Board of Directors at its meeting on 6 December 2023.

Accountability Report.

ACCOUNTABILITY REPORT

Directors' report

Our Board of Directors operates according to the highest corporate governance standards. It is a unitary board and has a wide range of skills and experience. The non-executive directors have wide-ranging expertise and experience, including backgrounds in finance, primary care and education. The board considers that it is balanced and complete in its composition, appropriate to the requirements of the organisation and that each of its non-executive members is independent. The directors are responsible for preparing the annual report and accounts each year.

Mark Jones, Chair | Appointment 1 Nov 2021 to 31 Oct 2024

Mark joined WWL after a long and respected international and domestic career in the pharmaceutical industry and after a previous Non-Executive Director role at a local foundation trust. Mark has previously worked as Company President for national companies in Germany, Canada and the UK and later served as the Regional Vice-President for Southern Europe for AstraZeneca. He was also Non-Executive Director of the Kids Brain Health Board of Canada and worked with the Canadian government to help launch a charitable foundation for children's mental health. Mark was also advisor to the board of the North American consultancy Syntegrity, working with global companies faced with strategic challenges.

Mary Fleming, Chief Executive | Permanent post

Mary was previously appointed as Deputy Chief Executive, having been our Chief Operating Officer prior to this. Mary worked in the private sector before moving into healthcare and has worked in acute provider organisations across Greater Manchester and Yorkshire. Her experience in working across both the private and public sector brings a strong focus on ensuring services are organised around the needs of the patient with the goal of improving cost and quality. Mary joined the flagship Nye Bevan Aspiring Director Leaders' Programme and successfully completed the Executive Health Care Leadership Programme with the NHS Leadership Academy. She has studied social history and sociology and has a post graduate certificate in Managing Health and Social Care.

Prof Sanjay Arya, Medical Director | Permanent post

Sanjay is a consultant cardiologist by background, with interests in coronary artery disease, heart failure, arrhythmia, syncope and cardiac assessment for non-cardiac surgery and professional footballers. Sanjay was appointed Honorary Professor in Health and Wellbeing at the University of Bolton and is also the Undergraduate Clinical Lead for Edge Hill University's Medical School.

Prof Clare Austin, Non-Executive Director (Independent) | Appointment 1 May 2019 to 30 Apr 2025

Clare is Pro Vice-Chancellor and Dean of the Faculty of Health, Social Care and Medicine at Edge Hill University. Prior to this, she was Associate Dean for Research and Innovation and Director of the Edge Hill University Medical School. Clare holds a BSc and PhD in Pharmacology and has worked in a number of different North West Universities.

Lady Rhona Bradley, Senior Independent Director (Independent) | Appointment 1 Dec 2019 to 30 Nov 2025

Rhona has 25 years' experience in the criminal justice system with the National Probation Service in Greater Manchester and Cheshire and in local government in the region, where she undertook director-level roles in children and family services. She has recently retired after 14 years as the Chief Executive of the charity ADS, Addiction Dependency Solutions, which has provided innovative substance misuse services for almost 50 years. Rhona continues her involvement with the charity as a trustee of the board.

Before joining ADS, Rhona was seconded by HM Inspectorate of Probation to work for what is now the Care Quality Commission as a service inspector, conducting multiagency statutory inspections of Youth Offending Teams and local authority children's services. Rhona was appointed a Deputy Lieutenant for Greater Manchester in 2010.

Tabitha Gardner, Chief Finance Officer | Permanent post

Tabitha brings a vast amount of knowledge and experience to the role having worked in NHS finance at various different Trusts in the North West. From 2019, Tabitha held the role of Director of Finance at the Rochdale Care Organisation, part of the Northern Care Alliance NHS Foundation Trust (NCA), where she delivered significant investment into the organisation as part of the Rochdale elective surgical offer. Prior to this, Tabitha spent eight years working as the Deputy Director of Finance for the North West branch of NHS England and during this time she led the financial management for Specialised Services which delivers numerous rare and complex services.

Julie Gill, Non-Executive Director | Appointment 1 Apr 2023 to 31 Mar 2026

Julie has worked in senior roles across the public sector, including local government, housing, regeneration, policing and education and is currently a Chief Officer at Cheshire Constabulary, taking the lead on Business Services for Cheshire Police as part of the Chief Constable's leadership team. She has many years of experience at board level covering finance, commercial and property management, change and digital strategy and HR workforce planning, across the various roles. Prior to working with the police, she has held Director of Resources roles at Cheshire West and Stoke councils, as well as wide ranging roles within the education sector and a national housing provider.

Ian Haythornthwaite, Non-Executive Director (Independent) | Appointment: 9 Apr 2018 to 31 Oct 2024

Ian was previously the Chief Finance and Operating Officer for BBC Nations and Regions with overall responsibility for the effective delivery of all BBC operations outside of London, and before this he was the BBC's Director of Finance. Ian is a Fellow of the Chartered Institute of Management Accountants, with extensive public sector management experience and chairs our Audit Committee. He is also Chair of the Countess of Chester Hospital NHS FT, a trust which does not operate within the same ICS as WWL, thereby maintaining Ian's status as an independent non-executive board member.

Paul Howard, Director of Corporate Affairs | Permanent post

Paul began his NHS career in 2001 with the then Greater Manchester Ambulance Service, qualifying as a paramedic and undertaking a range of clinical roles before taking up the role of Corporate

Governance Manager with North West Ambulance Service. Paul went on to work in Company Secretary roles within the acute health sector and in the education sector and in 2014 he was named not-for-profit Company Secretary of the Year by the Institute of Chartered Secretaries and Administrators. In the same year, Paul coordinated the development of new national rules on behalf of NHS Providers which allowed votes in elections to FT councils of governors to be cast online or by text message to increase participation and engagement.

Lynne Lobley, Vice Chair | Appointment 26 Mar 2018 to 31 Dec 2024

Lynne's background is in education and most recently she was a member of the Senior Management Team at the Cheshire and Mersey Deanery. She has also been a member of the Deanery Integration Board and the Local Workforce Action Board. She has 20 years' experience as a NED in four very different trusts. Lynne is passionate about creating a joined up, sustainable health and social care service for the future.

Anne-Marie Miller, Director of Communications and Stakeholder Engagement | Permanent post

Anne-Marie has 15 years' experience in senior communications and engagement roles at acute and community NHS provider organisations across the North West. During this time, she led the complex communications and engagement for the merger of University Hospital of South Manchester NHS FT and Central Manchester University Hospitals NHS FT to create Manchester University NHS FT, the largest foundation trust in the country. Prior to joining the NHS, Anne-Marie held stakeholder engagement roles at UNITE Group plc and was Vice-President of Liverpool Students' Union. Anne-Marie holds an Executive Award in Health Care Leadership following completion of the Nye Bevan programme and is a Member of the Chartered Institute of Public Relations.

Mary Moore, Non-Executive Director (Independent) | Appointment 1 Dec 2023 to 30 Nov 2026

Mary is a retired Executive Chief Nurse having spent 44 years on an NHS career trajectory from Bedside to Board. Mary's experience was primarily in acute settings until commencing national improvement roles with the Department of Health and Social Care from 2000 – 2010. Returning to NHS acute and commissioning organisations in her executive roles in recent years.

Richard Mundon, Director of Strategy and Planning | Permanent post

Richard is an experienced public servant who has spent the majority of his career in the health sector. He spent 25 years with the Department of Health across a range of policy, management and corporate disciplines. He has experience of leading large change processes and developing performance management and planning regimes, including his role as Project Manager on the 2000 NHS Plan

Kevin Parker Evans | Chief Nurse | Permanent post

Kevin joined the Trust as Interim Chief Nurse in January 2024 from Tameside and Glossop Integrated Care NHS Foundation Trust where he was Deputy Chief Nurse from 2020. Kevin is a registered adult nurse and has had several clinical, operational, and senior leadership roles within his 20-year nursing career, and completed an MBA in 2023, he is also Chartered Manager (CMgr). Kevin has a passion to develop nursing, midwifery and AHP teams to be able to lead on the delivery of excellent patient and service user care, developing and utilising technology to support the care we deliver to release clinical teams 'time to care' to the bedside.

Juliette Tait, Chief People Officer | Permanent post

Before joining us at WWL, Juliette, worked at Greater Manchester Mental Health NHS Foundation Trust (GMMH), undertaking a variety of roles in Human Resources (HR) and Organisational Development (OD). In 2019, Juliette was the Deputy Director of HR and OD before taking on the role of Executive Director of Human Resources. Juliette started her career journey as an apprentice and, over the years, has completed a range of professional qualifications, most recently being awarded Chartered Member status of the Chartered Institute of Personnel and Development.

Francine Thorpe, Non-Executive Director (Independent) | Appointment 1 May 2021 to 30 Apr 2027

Francine is a physiotherapist by background and until March 2021 was the Director of Quality and Innovation at Salford Clinical Commissioning Group. She brings significant experience of working at board level as well as the development of integrated health and care services. Over the past 12 months she has been leading some work around mortality reviews to understand the impact of COVID-19 on widening inequalities and how this can be minimised. As well as her commissioning expertise, she has experience of working across both acute and community health services.

Claire Wannell | Interim Chief Operating Officer | from 8 Jan 2024 to 30 Jun 2024

Claire has worked in the NHS for the last 14 years, 12.5 of those spent at WWL. She holds an LLB in Law, an MSc in Human Resources and has also completed the NHS Graduate Management Scheme and Kings Fund Programme. Before stepping in to the role of Interim Chief Operating Officer, Claire was a WWL Shadow Board member.

The following individuals were also directors of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust during 2023/24:

- Tracy Boustead (Chief People Officer from 1 Jan 2023 to 31 July 2023)
- Dr Steven Elliot (Non-Executive Director to 30 Apr 2023)
- Dr Terence Hankin (Non-Executive Director from 1 Jul 2023 to 30 Nov 2023)
- Silas Nicholls (Chief Executive to 7 Jan 2024)
- Rabina Tindale (Chief Nurse to 1 Jan 2024)

More information about our directors and the work of the board is available at:
wwl.nhs.uk/board-and-board-papers

All directors are required to comply with the requirements of the fit and proper persons test and are required to make an annual declaration of compliance in this regard.

Appointment and removal of non-executive directors (including the Chair)

Appointment and, if appropriate, removal of non-executive directors is the responsibility of the Council of Governors. When appointments are required to be made, usually for a three-year term, a Nomination and Remuneration Committee of the council oversees the process and makes recommendations as to appointment to the full council. The procedure for removal of the Chair and

other non-executive directors is laid out in our constitution which is available on our website or on request from the corporate affairs team.

Division of responsibility

There is a clear division of responsibilities between the Chair and the Chief Executive which is set out in writing as part of a statement of responsibilities within the foundation trust and has been approved by the board. The Chair ensures that the board has a strategy which delivers a service that meets and exceeds the expectations of the communities we serve and that the organisation has an executive team with the ability to deliver the strategy. The Chair facilitates the contribution of the non-executive directors and their constructive relationships with the executives. The Chief Executive is responsible for the leadership of the executive team and for implementing our strategy and delivering our overall objectives, and for ensuring that we have appropriate risk management systems in place.

Declarations of interest

All directors have a responsibility to declare relevant interests as defined within our constitution. These declarations are made via our electronic system, MES Declare and reported formally to the board, and available on our electronic register which is available to the public. A copy of the register is available on our website or on request from the corporate affairs team.

The statement of responsibilities within the foundation trust and the register of directors' interests can be found at **wwl.nhs.uk/corporate-governance and https://wwl.mydeclarations.co.uk/**

Independence of directors

The non-executive directors bring strong, independent oversight to the board and all non-executive directors are currently considered to be independent. We are committed to ensuring that the majority of the voting members of our board is made up of independent non-executive directors who objectively challenge management.

The Council of Governors is responsible for all decisions to reappoint non-executive directors and is supported in its consideration by the recommendations it receives from the Nomination and Remuneration Committee. Any recommendation to reappoint a non-executive director beyond six years follows detailed scrutiny to ensure the continued independence of the individual director and, generally speaking, such terms of office are avoided unless there are exceptional grounds for them to be considered. Any non-executive director appointed beyond six years is subject to annual reappointment and the maximum term of office is nine consecutive years.

The board has reserved certain powers and decisions to itself; these are set out in the Schedule of Matters Reserved to the Board of Directors. This details the roles and responsibilities of the Board of Directors, the Council of Governors and committees of the board.

The foundation trust is able to make arrangements for the exercise of any of its powers by a committee of directors or by individual directors, subject to such restrictions and conditions as the board thinks fit. Standing Orders set out the arrangements for the exercise of such powers under delegation.

Attendance summary

The tables below show the attendance at meetings for all directors in post during 2023/24.

Board of Directors

Name of director	A	B	Percentage attendance
Mark Jones, Chair	9	10	90%
Sanjay Arya, Medical Director	8	10	80%
Clare Austin, Non-Executive Director	8	10	80%
Tracy Boustead, Interim Chief People Officer (to 31 Jul 2023)	3	3	100%
Rhona Bradley, Non-Executive Director	9	10	90%
Steven Elliot, Non-Executive Director (to 30 Apr 2023)	0	1	0%
Mary Fleming, Deputy Chief Executive (to 7 Jan 2024) Chief Executive (from 8 Jan 2024)*	10	10	100%
Tabitha Gardner, Chief Finance Officer	9	10	90%
Julie Gill, Non-Executive Director (from 1 Apr 2023)	8	10	80%
Ian Haythornthwaite, Non-Executive Director	6	10	60%
Terence Hankin, Non-Executive Director (from 1 Jul 2023 to 30 Nov 2023)	3	4	75%
Paul Howard, Director of Corporate Affairs†	10	10	100%
Lynne Lobley, Non-Executive Director	8	10	80%
Anne-Marie Miller, Director of Communications and Stakeholder Engagement†	9	10	90%
Mary Moore, Non-Executive Director (from 1 Dec 2023)	3	4	75%
Richard Mundon, Director of Strategy and Planning	9	10	90%
Silas Nicholls, Chief Executive (to 7 Jan 2024)	5	7	71%
Kevin Parker-Evans, Interim Chief Nurse (from 8 Jan 2024) Chief Nurse (from 12 Jun 2024)	3	3	100%
Juliette Tait, Chief People Officer (from 14 Aug 2023)	6	6	100%
Francine Thorpe, Non-Executive Director	9	10	90%
Rabina Tindale, Chief Nurse (to 1 Jan 2024)	7	7	100%
Claire Wannell, Interim Chief Operating Officer (from 8 Jan 2024 to 30 Jun 2024)	3	3	100%

A: number of meetings attended
B: number of meetings the director could have attended

† Indicates non-voting director

* Mary Fleming acted as Interim Chief Executive from the date that Silas Nicholls left the trust up to her substantive appointment on 7 March 2024.

Evaluating performance and effectiveness

During 2021/22, we commissioned Deloitte LLP to undertake an external review of our leadership and governance using the NHS well-led framework, in line with best practice. In commissioning Deloitte to undertake the work, the board was satisfied that the firm did not have any other connection with the foundation trust or with individual directors. No major concerns were identified during the review and throughout 2022/23 we monitored completion of the resulting action plan through our public board meetings.

A robust appraisal process is in place for all directors. The Chair appraises the Chief Executive, and the Chief Executive carries out performance reviews of the other executive directors. These reports are then submitted to the Remuneration Committee for consideration.

The Chair undertakes the performance review of non-executive directors using our non-executive director competency framework and the outcomes of these appraisals are reported to the Council of Governors. During 2023/24, as in previous years, the performance review of the Chair was led by the Senior Independent Director in accordance with national guidance. The outcome was then reported to the Council of Governors by the Senior Independent Director. In 2024/25, we will move to adopt the recently published national NHS leadership competency framework for board members, by way of our appraisal process.

Understanding the views of governors and members

Directors develop an understanding of the views of governors and members about the organisation through attendance at members' events, attendance at Council of Governors meetings and attending the annual members' meeting. The Chair also has regular discussions with the lead governor and two-way communication is facilitated, either directly or through the corporate affairs team.

Mandatory declarations required within the directors' report

- We have complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.
- A statement describing adoption of the Better Payment Practice Code is included within the accounts.
- No interest or compensation was paid under the Late Payment of Commercial Debts (Interest) Act 1998 during 2021/22 or 2022/23.
- More information on the arrangements that are in place to ensure that services are well-led can be found in our annual governance statement.
- Income disclosures as required by section 43(2A) of the National Health Service Act 2006 are included within the performance report.
- Fees and charges levied by the foundation trust did not exceed £1m and were not otherwise material to the accounts.
- Each director has taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

In making these declarations, the directors confirm that they have made such enquiries of their fellow directors and of the foundation trust's auditors for that purpose and taken such steps (if any) for that purpose, as are required by their duty as a director of the foundation trust to exercise reasonable care, skill and diligence.

REMUNERATION REPORT

I am pleased to present the remuneration report for the financial year 2023/24 on behalf of the foundation trust's two remuneration committees.

As set out in legislation, the Remuneration Committee has been established by the Board of Directors to determine the remuneration, allowances and other terms and conditions of office of the executive directors.

Whilst the Council of Governors is ultimately responsible for determining the remuneration, allowances and other terms and conditions of office of the non-executive directors, it has established the Nomination and Remuneration Committee to consider these matters in detail and to present recommendations to the full Council for consideration at a general meeting.

Within this report, the term "senior manager" is used. Guidance issued by NHS England defines senior managers as "those who influence the decisions of the NHS foundation trust as a whole rather than the decisions of individual directorates or sections within the NHS foundation trust". As a result, only members of the Board of Directors have been treated as senior managers for the purpose of this report.

In accordance with the requirements of the HM Treasury Financial Reporting Manual and reporting requirements issued by NHS England, this report has been divided into three parts:

- the **annual statement on remuneration**, which sets out the major decisions on senior managers' remuneration as well as any substantial changes to senior managers' remuneration which were made during the year and the context in which those changes occurred and decisions have been taken;

- the **senior managers' remuneration policy**, which sets out information about our policy in a standardised format across the sector; and

- the **annual report on remuneration** which includes details about the directors' service contracts and sets out other matters such as committee membership, attendance and the business transacted.

Annual statement on remuneration

The two remuneration committees aim to ensure that both non-executive and executive directors' remuneration is set appropriately, taking into account relevant market conditions. As Chair of the foundation trust, I chair both of these committees except when my own remuneration or terms of service are under consideration, at which point I withdraw from the meeting and take no part in the discussions or decision-making.

Non-executive directors

NHS England has published guidance on the remuneration of chairs and non-executive directors of NHS foundation trusts and NHS trusts. This guidance acknowledges that whilst there are 150 foundation trusts in existence, they are not necessarily the largest or most complex NHS organisations. The guidance argues that there is essentially no distinction between the services provided by NHS trusts and NHS foundation trusts, nor in their respective responsibilities, yet there was significant variation in the level of remuneration paid to non-executive directors. The guidance

was therefore issued in an attempt to standardise remuneration across the NHS and for the level of chairs' remuneration to be informed by the size of the organisation's turnover.

Whilst recognising that as an autonomous foundation trust there is no requirement to comply with the guidance, the Council of Governors has nonetheless agreed to follow it and regards this as the market-tested remuneration information required to be considered at least once every three years. As a result, no in-year increases were applied to the remuneration of the non-executive directors.

For non-executive directors appointed before the guidance was published, the recommendation is that their remuneration should be aligned to the national approach at the time of reappointment. The Council of Governors has previously agreed that it would consider this on a case-by-case basis, taking into account the need to retain talented individuals and to ensure an appropriate skill mix around the board table. Following consideration by the Council of Governors, the three non-executive directors who were reappointed in-year, two being by way of a short contract extension to maintain continuity, retained their previous level of remuneration.

Executive directors

We have developed an executive remuneration framework which applies to all executive director posts. There is no guarantee of receiving an increment and any increase is based on performance in post.

Our outgoing Chief Executive was appointed in 2019 on a spot salary which was set at the median average of NHS England's established pay range for medium-sized acute NHS organisations. We reviewed that salary in-year and uplifted it to take account of performance in post and comparative data.

Our current Chief Executive was appointed this year on a spot salary which was set in line with our executive remuneration framework and NHSE guidelines, following review and scrutiny of the job description for this post by the Remuneration Committee, guidance and acceptable pay ranges.

As a Consultant Cardiologist, the Medical Director is employed in accordance with the 2003 Consultant terms and conditions. He receives a management allowance for his non-clinical responsibilities which include acting as Medical Director, and this was uplifted by £1316 (4.8%) to £27621 per annum from 1 April 2023.

The remaining executive directors are employed on set scales of remuneration, which operate in the same way as Agenda for Change does for other staff. Under the framework there are four pay scales on which all new appointments will be made, as well as a legacy pay scale for those executive directors in post as at 31 August 2019. Appointments made after November 2020 are subject to contractual earn back provisions.

The four executive director pay scales, all of which are based on benchmarking data provided by NHS England, are:

- Non-voting director
- Voting director
- Chief Finance Officer
- Deputy Chief Executive

The executive remuneration framework seeks to replicate the arrangements in place for the majority of our people who are employed under Agenda for Change terms and conditions and to provide additional transparency around executive remuneration. Each pay scale comprises three pay points and postholders remain on each pay point for two years, or longer in the event that necessary performance objectives are not met.

Progression to the next pay point also requires the following:

- Completion of all mandatory training for the previous financial year by 31 March;
- Satisfactory completion of a fit and proper person declaration in respect of the current financial year;
- Satisfactory Disclosure and Barring Service Check dated within the current financial year for those posts subject to this requirement;
- A completed declaration of interests in line with the foundation trust's policy or a nil declaration dated within the current financial year; and
- A completed declaration of gifts and hospitality received in the previous year, or a nil declaration where this is not applicable.

Those executive directors in post as at 31 August 2019 retain their historic pay arrangements. Each pay scale is uplifted each year; usually by the nationally recommended uplift for posts subject to Very Senior Manager pay arrangements. For 2023/24, an uplift of 5% was applied in line with national guidance to all pay scales.

We have included earn back arrangements in contracts for all post holders who commenced employment after November 2020 and will continue to incorporate this for all new appointments. Under this scheme, up to 10% of the post holder's remuneration each year is subject to earn back arrangements in line with the foundation trust's policy. This means that if their performance in post is not satisfactory, their remuneration may be reduced by up to 10% in the following year. The post holder would need to return to satisfactory performance to earn back that element of salary for the next financial year.

Those executive directors who have remained on historic pay arrangements are entitled to an additional car allowance payment of £6,945. This has been discontinued for all new appointments and there is now only one executive director who receives this benefit.

This year our remuneration committee reviewed and amended our executive remuneration framework so that that the periods of acting-up into executive roles are now paid at the substantive rate for the post, rather than at a percentage rate as had historically been the case, given that the acting post holders have responsibility for areas within their portfolios in the same way as for substantive post holders.

Mark Jones
Chair
26 June 2024

Senior managers' remuneration policy

The table below sets out the component parts of our remuneration package for senior managers which comprises the senior managers' remuneration policy.

Element of pay	Purpose and link to strategy	How operated	Maximum opportunity	Description of performance metrics	Changes from previous year
Executive directors' base salary	To help promote the long-term success of WWL and retain high calibre executive directors	Salary scales set out in the executive remuneration framework Progression to next pay point based on performance in post and other criteria Annual increases in line with national VSM pay recommendations or, if appropriate, in line with other local NHS organisations	Pay scales are based on established pay ranges published by NHS England and these are reviewed periodically. Post holders move one point every two years, subject to satisfactory performance in post.	Personal objectives are set at the start of each year.	No change.
Executive directors' taxable benefits	To help promote the long-term success of WWL and retain high calibre executive directors	Benefits for executive directors include: Personal car allowance for those on historic pay arrangements Pension-related benefits (annual increase in NHS pension entitlement).	There is no formal maximum	N/A	No change
Executive directors' pension	To help promote the long-term success of WWL and retain high calibre executive directors	We operate the standard NHS pension scheme without any exceptions	As per standard NHS pension scheme	N/A	No change

Element of pay	Purpose and link to strategy	How operated	Maximum opportunity	Description of performance metrics	Changes from previous year
Non-executive directors' fees (including the Chair)	To attract and retain high quality and experienced non-executive directors	The remuneration of the non-executive directors is set by the Council of Governors having regard to guidance issued by NHS England. Non-executive directors do not participate in any performance-related schemes nor do they receive any pension or private medical insurance or taxable benefits	As determined by the Council of Governors, based on national guidance.	N/A	No change
Other fees payable to Non-Executive Directors or other items that are considered to be remuneration in nature	To attract and retain high quality and experienced non-executive directors	Prior to 2019/20, enhancements to the standard Non-Executive Director remuneration were paid for to the Vice-Chair, the Senior Independent Director, the Audit Committee Chair and those who chaired committees. Existing post holders will retain enhancements until they are considered for reappointment; decisions for new appointments will be made in line with national guidance.	Vice Chair: £4,490 Senior Independent Director: £4,490 Audit Committee Chair: £3,360 Committee chairs: £350	Enhancements were applied on appointment to the additional role. New appointments will be made in line with national NHS guidance on the remuneration of chairs and non-executive directors.	No change

Our remuneration package is not performance based. During the year, three senior managers were paid more than £150,000. Benchmark salary information for comparable jobs within the NHS was considered at the time of appointment and it was concluded that the remuneration agreed was appropriate and reasonable for the current post holder.

There are currently no provisions within directors' terms and conditions of employment to allow for the recovery of any sums paid to directors or for withholding the payments of sums to senior

managers. Earn back arrangements are in place for all VSM contracts entered in to from 1 November 2020.

Policy on diversity and inclusion

We are committed to the principles of diversity and inclusion and we recognise the importance of having a board that is made up of people from different backgrounds and with varied characteristics. We have a policy in place on board diversity and inclusion, which both the Remuneration Committee and the Nomination and Remuneration Committee use when considering board-level appointments.

The policy has at its heart the objective of ensuring that diversity and inclusion are taken into consideration when evaluating the skills, knowledge and experience needed for each board-level vacancy and that our recruitment processes encourage the emergence of candidates from diverse backgrounds. This is in line with our wider organisational strategy which gives a firm commitment that everyone will have the opportunity to achieve their purpose.

During 2023/24 we have appointed three substantive female executive director posts, two being internal promotions, and one male executive director post. We also appointed one female non-executive director; which followed a male interim appointment in respect of the same post. As a result, the board is now made up of 11 (64.7%) female directors and 6 (35.3%) male directors (2022/23 62.5% female and 37.5% male). One of our directors (5.88%) is from a black, Asian or minority ethnic background.

Service contract obligations

The contracts of employment for the majority of executive directors are permanent, continuation of which is subject to regular and rigorous reviews of performance. There are no obligations on the foundation trust which could give rise to, or impact on, remuneration payments or payments for loss of office not disclosed elsewhere in this report.

Policy on payment for loss of office

All executive directors' contracts contain a notice period of three months, with the exception of the Chief Executive's contract which contains a six-month notice period. If loss of office were to be on the grounds of redundancy, this would be calculated in line with Agenda for Change methodology and consistent with NHS redundancy terms and maximum caps. Loss of office on the grounds of gross misconduct would result in summary dismissal without payment of notice.

Statement of consideration of employment conditions elsewhere in the foundation trust

In setting the remuneration policy for senior managers, consideration was given to the pay and conditions of employees on Agenda for Change and relevant national guidance. In determining non-incremental pay uplift for executive directors and other senior managers, consideration is given to any national pay award decisions and to appropriate national guidance.

Annual report on remuneration

Information on each senior manager's service contract, correct as at the date of signing, is provided in the tables below:

Executive directors

Name	Role	Start date	Unexpired term	Notice period
Mary Fleming	Chief Executive	8 Jan 2024	Permanent contract	6 months
Sanjay Arya	Medical Director	1 Apr 2017	Permanent contract	3 months
Tabitha Gardner	Chief Finance Officer	2 Mar 2023	Permanent contract	3 months
Paul Howard‡	Director of Corporate Affairs	1 Apr 2020†	Permanent contract	3 months
Anne-Marie Miller‡	Director of Communications and Stakeholder	1 Mar 2021	Permanent contract	3 months
Richard Mundon	Director of Strategy and Planning	28 Sep 2015	Permanent contract	3 months
Kevin Parker-Evans	Chief Nurse	12 Jun 2024	Permanent contract	3 months
Juliette Tait	Chief People Officer	14 Aug 2023	Permanent contract	3 months
Claire Wannell	Interim Chief Operating Officer	8 Jan 2024	TBC	3 months

* Mary Fleming's employment as Chief Executive commenced on 7 Mar 2024 following her appointment as Interim Chief Executive on 8 Jan 2024, however she was first appointed to the Board of Directors as Chief Operating Officer on 1 April 2016.

† Paul Howard's employment as Director of Corporate Affairs commenced on 1 April 2020, however he was first appointed as Company Secretary on 7 June 2017.

‡ Indicates non-voting director

Non-executive directors

The chair and non-executive directors are appointed for a period of office as decided by the Council of Governors. Subject to satisfactory performance, they are able to serve a maximum term of nine years, although in accordance with the NHS Foundation Trust Code of Governance any term beyond six years is subject to rigorous review and annual re-appointment.

The "maximum term end date" shown in the table below is the point at which the nine years' maximum service will have been reached and is not an indication that the contract will continue until this date. The Council of Governors is particularly mindful of the need to ensure independence and the progressive refreshing of the Board of Directors and takes this into account when making decision as to the reappointment of non-executive directors.

Name	Start date in role	Start date of current contract	Unexpired portion of current contract	Maximum term end date	Notice period
Mark Jones Chair	1 Nov 2021	1 Nov 2021	5 months	31 Oct 2030	3 months
Clare Austin Non-Executive	1 May 2019	1 May 2022	11 months	30 Apr 2028	1 month
Rhona Bradley Non-Executive	1 Dec 2019	1 Dec 2022	1 year, 6 months	30 Nov 2028	1 month
Julie Gill Non-Executive	1 Apr 2023	1 Apr 2023	1 year, 10 months	31 Mar 2032	1 month
Ian Haythornthwaite Non-Executive	9 Apr 2018	10 Apr 2024	4 months	31 Mar 2027	1 month
Lynne Lobley Non-Executive	28 Mar 2018	1 Apr 2024	6 months	27 Mar 2027	1 month
Mary Moore Non-Executive	1 Dec 2023	30 Nov 2026	2 years 5 months	30 Nov 2032	1 month
Francine Thorpe Non-Executive	1 May 2021	1 May 2021	2 years 10 months	30 Apr 2030	1 month

The work of our nominations and remuneration committees

The Remuneration Committee established by the Board of Directors to consider matters relating to the remuneration, allowances and terms and conditions of office of the executive directors is made up of all the non-executive directors and is chaired by Mark Jones.

Attendance during 2023/24 was as follows:

Name of director	A	B	Percentage attendance
Mark Jones	8	8	100%
Clare Austin	6	8	75%
Rhona Bradley	7	8	88%
Julie Gill	6	8	75%
Terence Hankin	3	5	60%
Ian Haythornthwaite	7	8	88%
Lynne Lobley	6	8	75%
Mary Moore	1	2	50%
Francine Thorpe	6	8	75%

A: number of meetings attended
B: number of meetings the director could have attended

The Chief Executive attends the committee in relation to discussions around board composition, succession planning and the remuneration and performance of executive directors. The Chief Executive is not present during discussions relating to her own performance, remuneration or terms and conditions of office.

The Chief People Officer and the Director of Corporate Affairs attend meetings to provide support and advice. They withdraw from the meeting during consideration of their own performance, remuneration or terms and conditions of office.

The Nomination and Remuneration Committee established by the Council of Governors to consider matters relating to the appointment, remuneration and other terms and conditions of service of the non-executive directors is also chaired by Mark Jones. During the year, committee members met on several occasions as part of the process of appointing several new board members. The committee also held one formal meeting during the year, to consider the reappointment of one executive director and the extension of the terms of office fortwo other non-executive directors, which it was agreed would support retention of corporate memory and a smooth transition once their replacements had been identified,

The committee's membership and attendance information is given below:

Name of committee member	A	B	Percentage attendance
Mark Jones, Chair	2	3	67%
Les Chamberlain, Public Governor	2	3	67%
Andrew Haworth, Public Governor	3	3	100%
Julie Hilling, Public Governor	2	3	67%
Andrew Savage, Staff Governor	3	3	100%
Bryonie Shaw, Appointed Governor	2	3	67%

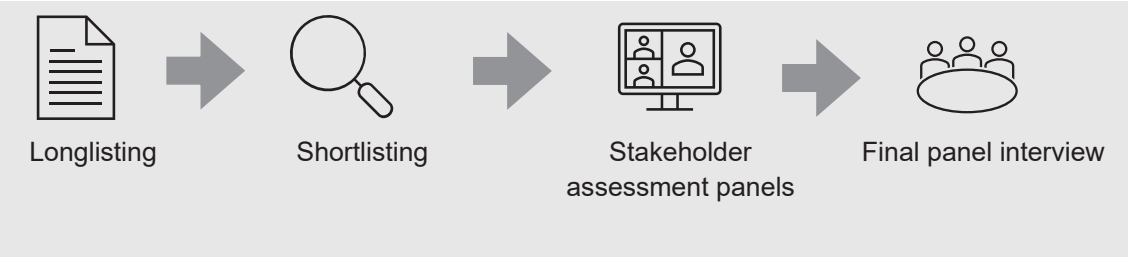
A: number of meetings attended
B: number of meetings the member could have attended

The Director of Corporate Affairs or a member of his team attends each meeting to provide advice and support to the committee. The chair withdraws from the meeting when his own reappointment, remuneration, allowances and other terms and conditions of office are under discussion.

One substantive non-executive director post was appointed to during 2023/24. The committee was assisted with this appointment by Seymour John, a recruitment consultancy with significant experience in recruiting non-executive directors. In determining which firm to use to support the processes, a competitive pricing exercise was undertaken to ensure value for money. The committee was satisfied that the services received were objective and independent and a total fee of £8,750 was paid. Seymour John does not have any other connection with the foundation trust or individual directors.

One additional 6-month interim appointment was also made.

Our appointments process which was followed for the substantive appointment is summarised below:



The appointments process is also supported by training issued for all of our nominations and remuneration committee members, which focuses on the importance of recognising unconscious bias in recruitment.

The committees also supports our succession planning work. This year we have run two initiatives which have helped us to develop our succession pipelines. Our Shadow Board Programme supported 15 of our senior managers to gain experience of working at board level by both practically shadowing our board and also undertaking taught leadership modules. Two participants went on to accept interim positions on our board and one took up the post of our Chief Clinical Information Officer. Our participation in the NHS Leadership Academy's NExT Director Scheme supports the creation of a pipeline of strong and diverse potential candidates for non-executive director roles and has a current focus on supporting women, people from local BAME communities, and disabled people with senior level experience into board level roles. We now have two colleagues working with us through this programme as development non-executive directors.

Remuneration for the year to 31 March 2024

The following tables and the fair pay multiple, which are subject to audit, show directors' remuneration for the year.

	Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
Mark Jones, Chair	45 - 50	0	0	45 - 50
Silas Nicholls, Chief Executive (to 7 Jan 2024)	155 - 160	1400	0	155 - 160
Mary Fleming, Chief Executive (from 8 Jan 2024; Deputy Chief Executive to 7 Jan 2024)	170 - 175	0	10 - 12.5	180 - 185
Sanjay Arya, Medical Director†‡	305 - 310	0	0	305 - 310
Clare Austin, Non-Executive Director	10 - 15	0	0	10 - 15
Tracy Boustead, Chief People Officer (to 31 July 2023)	40 - 45	0	45-47.5	90 - 95
Rhona Bradley, Non-Executive Director	10 - 15	0	0	10 - 15

Steven Elliot, Non-Executive Director (to 30 Apr 2023)	0 - 5	0	0	0 - 5
Tabitha Gardner, Chief Finance Officer	150 - 155	0	127.5 - 130.0	280 - 285
Julie Gill, Non-Executive Director (from 18 Apr 23)	10 - 15	0	0	10 - 15
Terence Hankin, Non-Executive Director (from 1 July 2023 to 30 Nov 2023)	5 - 10	0	0	5 - 10
Ian Haythornthwaite, Non-Executive Director	15 - 20	0	0	15 - 20
Paul Howard, Director of Corporate Affairs	105 - 110	2200	25 – 27.5	135 - 140
Lynne Lobley, Vice-Chair and Non-Executive Director	15 - 20	0	0	15 - 20
Anne-Marie Miller, Director of Communications and Stakeholder Engagement	110 - 115	1200	12.5 – 15	120 - 125
Mary Moore, Non-Executive Director (from 1 Dec 2023)	0 - 5	0	0	0 - 5
Richard Mundon, Director of Strategy and Planning‡	115 - 120	600	0	115 – 120
Juliette Tait, Chief People Officer (from 14 Aug 2023)	85 - 90	0	95 -97.5	180 - 185
Francine Thorpe, Non-Executive Director	10 - 15	0	0	10 - 15
Rabina Tindale, Chief Nurse (to 31 Dec 2023)	110 - 115	0	0 – 2.5	110 - 115
Claire Wannell, Interim Chief Operating Officer (from 8 Jan 2024 to 30 Jun 2024)	95 - 100	2100	20 – 22.5	120 - 125
Kevin Parker-Evans Chief Nurse (from 8 Jan 2024)^	35 - 40	0	127.5 – 130	165 - 170

** Remuneration excludes the value of salary sacrificed in exchange for a lease vehicle.

† The above remuneration includes clinical duties of £166k that are not part of the individual's management role.

‡ During the period, Sanjay Arya undertook the role of Undergraduate Clinical Lead at Edge Hill University Medical School. His salary in the above table excludes the element of salary recharged to Edge Hill University.

Richard Mundon undertook a role in support of the Provider Federation Board, hosted by Manchester University NHS Foundation Trust, to provide strategy and policy input to providers in Greater Manchester. His salary in the above table excludes the element of salary recharged to Manchester University NHS Foundation Trust.

^ Kevin Parker-Evans is seconded from Tameside NHS Foundation Trust, the salary in the above table the total cost paid by Wrightington, Wigan and Leigh NHS Foundation Trust.

All of the above directors were in post for the 12-month period to 31 March 2024 except where indicated. No annual performance or long-term performance-related bonuses were paid during the period. Taxable benefits relate to car lease benefit in kind.

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

being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Remuneration for the year to 31 March 2023

The following tables and the fair pay multiple, which are subject to audit, show directors' remuneration for the year.

	Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
Mark Jones, Chair	45 – 50	0	0	45 – 50
Silas Nicholls, Chief Executive**	200 – 205	6,800	0	205 - 210
Sanjay Arya, Medical Director†‡	265 – 270	0	90 – 92.5	360 – 365
Clare Austin, Non-Executive Director	10 – 15	0	0	10 – 15
Alison Balson, Chief People Officer (to 31 Dec 2022)	105 – 110	0	15 – 17.5	120 – 125
Ian Boyle, Chief Finance Officer (to 30 Nov 2022)**	90 – 95	0	17.5 – 20	110 – 115
Rhona Bradley, Non-Executive Director	10 – 15	0	0	10 – 15
Steven Elliot, Non-Executive Director	10 – 15	0	0	10 – 15
Tabitha Gardner, Chief Finance Officer (from 2 Mar 2023	10 – 15	0	2.5 - 5	15 - 20
Mary Fleming, Deputy Chief Executive	150 – 155	0	37.5 – 40	185 – 190
Mick Guymer, Non-Executive Director (from 13 Dec 2022)	0 – 5	0	0	0 – 5
Ian Haythornthwaite, Non-Executive Director	15 – 20	0	0	15 – 20
Paul Howard, Director of Corporate Affairs**	100 – 105	0	25 – 27.5	130 – 135
Kelly Knowles, Acting Chief Finance Officer (from 1 Nov 2022 to 28 Feb 2023)**	35 – 40	0	0	35 - 40
Lynne Lobley, Non-Executive Director	15 – 20	0	0	15 - 20
Anne-Marie Miller, Director of Communications	110 – 115	0	27.5 – 30	140 – 145
Richard Mundon, Director of Strategy and Planning‡	110 – 115	0	35 – 37.5	145 – 150
Tracy Boustead, Chief People Officer (from 1 Jan 2023)	30 – 35	0	0	30 – 35
Rabina Tindale, Chief Nurse	130 – 135	0	25 – 27.5	155 – 160

Francine Thorpe, Non-Executive Director	10 – 15	0	0	10 – 15
Alison Tumilty, Non-Executive Director (to 25 Nov 2022)	5 – 10	0	0	5 – 10

** Remuneration excludes the value of salary sacrificed in exchange for a lease vehicle.

† The above remuneration includes clinical duties of £166k that are not part of the individual's management role.

‡ During the period, Sanjay Arya undertook the role of Undergraduate Clinical Lead at Edge Hill University Medical School. His salary in the above table excludes the element of salary recharged to Edge Hill University.

Richard Mundon undertook a role in support of the Provider Federation Board, hosted by Manchester University NHS Foundation Trust, to provide strategy and policy input to providers in Greater Manchester. His salary in the above table excludes the element of salary recharged to Manchester University NHS Foundation Trust.

^ Kevin Parker-Evans is seconded from Tameside NHS Foundation Trust, the salary in the above table the total cost paid by Wrightington, Wigan and Leigh NHS Foundation Trust.

All of the above directors were in post for the 12-month period to 31 March 2023 except where indicated. No annual performance or long-term performance-related bonuses were paid during the period. Taxable benefits relate to car lease benefit in kind.

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

Pension entitlements for year-ended 31 March 2024

Non-executive directors do not receive pensionable remuneration, therefore there are no entries in respect of pensions for non-executive directors.

In accordance with guidance issued by the NHS Business Services Authority, an increase of 10.1% CPI on the opening cash equivalent transfer value at 31 March 2024 has been applied. The following pension entitlement tables are subject to audit.

	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 as at 31 March 2024 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2024 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2024 £000	Cash Equivalent Transfer Value at 31 March 2023 £000	Real increase in Cash Equivalent Transfer Value £000
Silas Nicholls^ Chief Executive	0	0	0	0	0	0	0
Sanjay Arya Medical Director	0	0	85 – 90	235 - 240	131	85	10
Juliette Tait Chief People Officer	5 – 7.5	0	25 - 30	0	389	187	104
Tabitha Gardner Chief Finance Officer	5.0 – 7.5	45.0 – 47.5	40 - 45	115 - 120	977	606	289
Mary Fleming Chief Executive	0	35 – 37.5	55 – 60	155- 160	1,471	1,126	208
Paul Howard Director of Corporate Affairs	0 – 2.5	0 – .2.5	20 - 25	35 - 40	364	252	72
Anne-Marie Miller Dir. of Communications	0 – 2.5	0	25 - 30	0	407	268	97
Richard Mundon Director of Strategy and Planning	0	0	25 – 30	0	515	402	54
Tracy Boustead^^ Chief People Officer	2.5 - 5	0	15 - 20	0	246	99	40
Rabina Tindale Chief Nurse	0 – 2.5	0	60 - 65	165 - 170	1552	1,298	78
Claire Wannell Interim Chief Operating Officer	0 – 2.5	0	5 - 10	0	62	0	11
Kevin Parker-Evans* Chief Nurse	5 – 7.5	12.5 - 15	25 - 30	60 -65	479	0	107

^ bgtgbgr565Silas Nicholls chose not to be covered by the pension arrangements during the reporting year.

Pension entitlements for year-ended 31 March 2023

Non-executive directors do not receive pensionable remuneration, therefore there are no entries in respect of pensions for non-executive directors.

In accordance with guidance issued by the NHS Business Services Authority, an increase of 3.1% CPI on the opening cash equivalent transfer value at 31 March 2023 has been applied.

	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 as at 31 March 2023 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2023 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2023 £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Real increase in Cash Equivalent Transfer Value £000
Silas Nicholls^ Chief Executive	0	0	0	0	0	0	0
Sanjay Arya Medical Director	5.0 – 7.5	5.0 – 7.5	80 – 85	220 – 225	85	1,760	0
Alison Balson Director of Workforce	0 – 2.5	0	20 – 25	15 – 20	276	245	4
Ian Boyle Chief Finance Officer	0 – 2.5	0 – 2.5	50 – 55	105 – 110	968	888	22
Mary Fleming Deputy Chief Executive	2.5 – 5.0	0	50 – 55	105 – 110	1,126	1,026	47
Paul Howard Director of Corporate Affairs	0 – 2.5	0	15 – 20	30 – 35	252	221	10
Anne-Marie Miller Dir. of Communications	0 – 2.5	0	25 – 30	0	268	234	12
Richard Mundon Director of Strategy and Planning	2.5 – 5.0	0	25 – 30	0	402	343	29
Tracy Boustead Chief People Officer	0 – 2.5	0	5 – 10	0	99	88	0
Kelly Knowles Interim Chief Finance Officer	0 – 2.5	0 – 2.5	15 - 20	25 - 30	233	216	0
Tabitha Gardner Chief Finance Officer	0 – 2.5	0 – 2.5	35 – 40	65 - 70	606	525	4

Rabina Tindale Chief Nurse	0 – 2.5	0	50 – 55	155 – 160	1,298	1,198	45

^ Silas Nicholls chose not to be covered by the pension arrangements during the reporting year

Cash Equivalent Transfer Values

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

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31st March 2024.

Following the government's announcement that all public sector pension schemes will be required to provide the same indexation on the Guaranteed Minimum Pension (GMP) as on the remainder of the pension, NHS Pensions has revised its method of calculating CETVs. The real increase in CETV will therefore be impacted as it will include any increase in CETV due to the change in GMP methodology.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

During the period there were no compensation payments made to former senior managers nor any amounts payable to third parties for the services of a senior manager.

Directors' and governors' expenses

The total number of governors in office as at 31 March 2024 was 26 (2023: 27).

The total number of directors in office as at 31 March 2024 was 17 (2023: 17)

Expenses paid to directors include all business expenses arising from the normal course of business and are paid in accordance with our policy.

The total amount of expenses reimbursed to 4 directors during the year was £1,294 (3 directors, £3,441 in 2022/23).

The total amount of expenses reimbursed to 5 governors during the year was £265 (4 governors, £471 in 2022/23).

Fair pay multiples

NHS Foundation Trusts are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust in the financial year 2023/24 was £305-£310k (2022/23: £265-£270k). This is an increase of 15.0%. The relationship to the remuneration of the organisation's workforce is disclosed in the below table, which is subject to audit.

2023/24	**25th percentile**	**Median**	**75th percentile**
Salary component of pay	£25,125	£37,350	£56,007
Total pay and benefits excluding pension benefits.	£29,124	£40,273	£58,320
Pay and benefits excluding pension: pay ratio for highest paid director.	10.6	7.6	5.3

2022/23	**25th percentile**	**Median**	**75th percentile**
Salary component of pay	£24,990	£36,103	£49,975
Total pay and benefits excluding pension benefits.	£28,057	£38,502	£51,914
Pay and benefits excluding pension: pay ratio for highest paid director.	9.7	7.1	5.1

For employees of the Trust as a whole, the range of remuneration in 2023-24 was from £13k to £381k (2022-23 £13k to £320k). The percentage change in average employee remuneration (based on total for all employees, including bank and agency staff, on an annualised basis divided by full time equivalent number of employees) between years is 10% (2022-23, 8%). 6 employees received remuneration in excess of the highest-paid director in 2023-24, (2022-23,1).

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

Mary Fleming
Chief Executive and Accounting Officer
26 June 2024

STAFF REPORT

The financial wellbeing of our staff remains a key focus for us in 2024/25. We continue to develop and promote our Financial Wellness Hub and the financial wellbeing partners we work with to support those staff who find themselves in a state of economic hardship. The programme includes but is not limited to:

- Financial advice webinars;
- Low-cost loans, savings schemes, advance salary payments, and grants;
- Meal deals available from our dining facilities and on-site shops;
- Savings and discounts available on the “high street”

Other avenues of support that we can provide to our staff as part of this programme will be explored and during 2024/25 we will build on our people programmes by:

Looking after our people

- Offering leadership development opportunities in line with our People and Culture Strategy - formally our ‘Our Family, Our Focus, Our Future’ programme;
- Developing a new appraisal strategy to support high quality conversations about personal development and career progression;
- Offering a coaching programme to develop leadership capability at all levels;
- Launching our People & Culture Strategy which will provide structured organisational development solutions for teams and leaders to support them in strengthening engagement, teamworking or culture.

Supporting our people

- Further developing the resource and intervention offers within the staff psychological support service (a non-crisis service for staff with mild to moderate concerns relating to their mental wellbeing) to meet the increased demand for support with complex and longer-term mental health difficulties;
- Continuing to offer advice and guidance to line managers and HR representatives, ensuring staff mental health is supported and increasing understanding of mental health needs and reasonable adjustments;
- Providing psychoeducation and group-based support for staff with long-term conditions, neurodiversity and learning difficulties;
- Offering holistic, proactive health and wellbeing support to staff, including screening tools, health checks and physiotherapy services;
- Continuing to work with local services and community mental health teams, to provide appropriate support for staff when their needs go beyond those provided by our in-house services;
- Continuing to provide Trauma Risk Management (TRiM) as part of our Supporting People After Critical Events (SPACE) service. Our TRiM practitioners provide support to colleagues who have experienced a traumatic incident at work and can refer into other services if needed.

We have continued to maintain and promote positive partnerships both internally, with our divisional and staff side colleagues, and externally with boroughwide health and social care partners and

neighbouring NHS organisations. Together we have worked to provide the best possible healthcare for the population that we serve.

Learning and development

Our new and revised appraisal approach was launched in June 2023 and initial feedback suggests that this is supporting a more positive appraisal experience for staff members. The focus for 2024 will be to continue to evaluate and enhance staff experience in relation to appraisal and to migrate the process onto a digital platform.

The launch of our new Learning Management System (Learning Hub) in March 2024 has provided our staff with an enhanced user experience and will enable us to highlight mandatory learning requirements and opportunities in a more efficient way.

In November 2023, we launched our 'Welcome to WWL' event for all our new staff members. This is an in-person, full day event to welcome our new starters and highlight key organisational information and services to support them in the early days and beyond.

Our Talent for Care Strategy continues to provide young / unemployed / disadvantaged people from across the borough with opportunities to develop essential skills and training whilst on a placement at WWL, with a view to securing future employment. This is key in supporting our commitment to attract the next generation of NHS workers and fulfilling associated obligations as an anchor institution across the locality. We are currently exploring the opportunity of a funded Talent for Care post with Wigan and Leigh College to enable us to continue to deliver and support this agenda.

Leadership development will be an area of focus throughout 2024 with a revised approach which will be linked to the People and Culture Strategy.

Staff experience and engagement

At WWL, we want to enable our staff to have positive staff experience and feel supported throughout their career. We provide an array of opportunities to listen to our staff's voice including the staff survey, staff networks, trust-wide forums, the Freedom to Speak Up Guardian service, as well as regular listen events and focus groups.

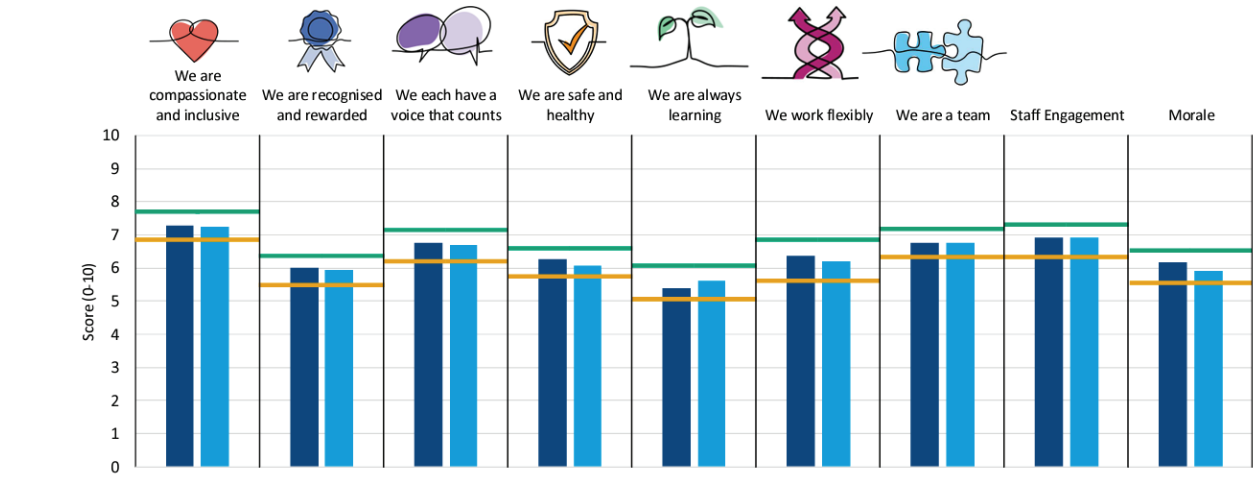
One of our main staff feedback mechanisms includes the annual National Staff Survey and National Quarterly Pulse Surveys. All staff are invited to share their views and experiences in an anonymous survey with results being broken down by division, subdivision, staff group and protected characteristics to allow insight into where changes is most needed. The staff survey results are shared with the board to set strategic Trust-wide priorities for areas for development and cascaded to divisional leadership teams to develop divisional annual actions plans to improve staff experience within their areas. In 2023/24, we strengthened the governance structure to ensure that our action plans in response to staff feedback are monitored routinely through the '*Our Family, Our Future, Our Focus'* steering group led by executive sponsors and through divisional assurance processes. Any trust-wide key areas of improvement have also been included in our People and Culture strategy 2024/25.

We also routinely engage with staff via our communication channels, including weekly newsletter, Exec vlogs and monthly forums chaired by the CEO. At these forums, staff will be informed of key strategic programmes of work, invited to showcase their own projects and have opportunities to share their feedback. Staff are also encouraged to speak up about any concerns through our usual reporting routes either via our Freedom to Speak Up Guardian, our people services team, staff side or chaplaincy.

Our various staff networks are another key routes for our staff to have their voice heard and be represented when developing new strategies, policies or processes. This includes our diversity staff networks (True Colours Network, Disability and Long-Term Health Condition Network and For All Minority Ethnicities 'FAME' network) as well as our wellbeing champions and staff engagement associates whose membership has increased in 2023/24, with over 500 staff members being actively involved in at least one of these networks.

We continue to improve feedback mechanisms to ensure that we regularly learn from our staff on how to improve staff experience. In 2024/25, we aim to increase the visibility for staff to speak up about concerns by better utilising our communication channels and encouraging staff to provide feedback on key programmes of work. Another key objective is to strengthen our learning culture by organising learning events as a direct outcome of someone, or a team, having raised a concern.

The NHS staff survey



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.29	6.02	6.76	6.28	5.38	6.37	6.77	6.92	6.17
Best result	7.71	6.37	7.16	6.59	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.09	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	2656	2650	2620	2624	2472	2627	2647	2657	2658

Note: 2023 results for 'We are safe and healthy' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

We achieved a 37.0% response rate (2,664 respondents) in the 2023 National Staff Survey, a 2% increase from 2022 and a 7.5% increase since 2021. Whilst there is still work to do to increase the response rate in future surveys (sector average 45%), this is excellent progress and the highest response rate we have achieved in over 5 years.

The results from the National Staff Survey revealed that there have been significant improvements in three People Promises, including "we are recognised and rewarded", "we are always learning" and "morale" and four People Promise scores and themes have remained stable compared to 2022. This suggests a trend of improvement over the past 12 months which can be viewed positively, given the wider context we are working in.

The majority of our People Promise scores were above national average in the benchmarking group of acute and acute & community trusts and broadly in line with the sector scores for similar organisations.

Two People Promise scores are significantly better than the sector 'we are safe and healthy' (6.26) and morale (6.13). 3 sub-scores are significantly better than the sector.

As in 2022, the highest scoring People Promise for 2023 is 'we are compassionate and inclusive' (7.29) and the lowest 'we are always learning' (5.38), with the latter being the only significantly worse

People Promise score compared to the sector. However, there has been a significant increase in staff accessing the right learning and development opportunities and perceptions of higher quality appraisal conversations in the past 12 months, demonstrating that we have made progress in both areas and that work should continue to further improve this score.

Staff engagement (6.92) is also in line with scores for similar organisations.

Staff recommending the Trust as a place to work is higher than the sector (WWL 63%; sector 61%). Staff feeling happy with the standard of care if a friend or relative needed treatment, has stayed the same but this year is significantly worse than the sector (WWL 62.5%; sector 65.2%).

We are most proud of:

- The scores which indicate levels of morale are significantly better than the sector;
- Scoring significantly higher than the sector for staff recommending WWL as a place to work;
- Improvements in the appraisal process, and we will continue to develop this to ensure appraisals are inspiring, motivating and support career development.

Areas for focus in 2024

We can see that we need to be better at:

- Creating an inclusive environment for everyone, in particular those from a black, Asian and minority ethnic background, as well as staff with long-term health conditions;
- Supporting our staff with long-term health conditions to ensure they feel valued and that we are making reasonable adjustments to support them in their roles.
- Eliminating discrimination, bullying and harassment, particularly for black, Asian and minority ethnic staff;
- Ensuring pathways to jobs with greater responsibility are clear and give all staff equal opportunity to progress.

During 2023/24, the '*Our Family, Our Future, Our Focus'* culture and engagement programme continued to be the mechanism through which we audited and drove forwards our engagement initiatives through executive sponsorship.

The tables below show our top 5 and bottom 5 ranking scores and comparative performance:

	2023/24		2022/23		Improvement/ deterioration
	WWL	Sector average	WWL	Sector average	
Response rate	37%	45%	35%	43%	Improvement
Top 5 ranking scores					
(13b) In the last 12 months I have personally experienced physical violence at work from managers.	0.4%	0.8%	0.4%	0.8%	No change
(13c) In the last 12 months I have personally experienced physical violence at work from other colleagues.	1.0%	2.0%	1.3%	2.0%	No change

(17b) In the last 12 months, I have personally been the target of unwanted behaviour of a sexual nature in the workplace from a manager / team leader or other colleagues	3.2%	3.9%	n/a	n/a	n/a
(16c03) Experienced discrimination on grounds of religion.	5.3%	5.4%	5.6%	4.9%	No change
(17a) In the last 12 months, I have personally been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public.	5.6%	8.0%	n/a	n/a	n/a

	2023/24		2022/23		Improvement/ deterioration
	WWL	Sector average	WWL	Sector average	
Bottom 5 ranking scores					
(23b) The appraisal/review helped me to improve how I do my job	22.6%	26.6%	19.7%	22.7%	Improvement
(12e) I often / always feel worn out at the end of my working day / shift.	38.9%	43.1%	41.0%	47.0%	No change
(12c) My work often / always frustrates me.	35.6%	36.5%	35.8%	40.4%	No change
(12a) I often / always find my work emotionally exhausting	31.1%	33.9%	33.9%	37.3%	Improvement
(5a) I have unrealistic time pressures (never / rarely)	29.3%	22.6%	27.7%	22.6%	No change

At question level, most scores are in the intermediate-60% range of similar organisations. There are 21 scores that are in the top 20% and 9 scores that sit in the bottom 20% range clustered around effectiveness of appraisal conversations, development opportunities, experience of discrimination and support with reasonable adjustments. There are 36 scores that are significantly better than the sector average and only 9 that are worse.

2023/24, 2022/23 and 2021/22

Scores for each indicator together with that of the survey benchmarking group (Combined Trusts) are presented below.

		2023/24		2022/23		2021/22	
		WWL	Combined trusts	WWL	Combined trusts	WWL	Combined trusts
People Promise 1:	Diversity and equality	8.2	8.1	8.2	8.0	8.2	8.0
People Promise 2:	Recognition	6.0	5.9	5.8	5.7	6.0	5.8
People Promise 3:	Raising concerns	6.5	6.4	6.4	6.4	6.6	6.4
People Promise 4:	Health and safety climate	5.7	5.5	5.5	5.2	5.6	5.2
People Promise 4:	Burnout	5.2	5.0	5.1	4.8	5.1	4.8
People Promise 4:	Negative experiences	7.9	7.8	7.8	7.6	7.7	7.6
People Promise 5:	Appraisals	4.4	4.7	4.0	4.4	3.6	4.2

		2023/24		2022/23		2021/22	
		WWL	Combined trusts	WWL	Combined trusts	WWL	Combined trusts
People Promise 6:	Flexible working	6.3	6.1	6.2	5.9	6.1	5.9
People Promise 7:	Team working	6.7	6.7	6.6	6.6	6.3	6.5
People Promise 7:	Line management	6.9	6.8	6.7	6.6	6.7	6.8
Theme 1:	Morale	6.2	5.9	6.0	5.7	6.3	6.2
Theme 2:	Staff engagement	6.9	6.9	6.89	6.76	7.1	7.0
Staff Engagement:	Advocacy	6.8	6.7	6.7	6.6	7.0	6.8

2020/21 and 2019/20

Scores for each indicator together with that of the survey benchmarking group (Combined Trusts) are presented below.

	2020/21		2019/20	
	WWL	Combined trusts	WWL	Combined trusts
Equality, diversity and inclusion	9.2	9.1	9.2	9.2
Health and Wellbeing	5.9	6.1	5.9	6.0
Immediate Managers	6.7	6.8	6.9	6.9
Morale	6.3	6.2	6.5	6.5
Quality of Appraisals	N/A	N/A	5.0	5.5
Quality of care	7.7	7.5	7.8	7.5
Safe environment – bullying and harassment	8.0	8.1	8.3	8.2
Safe environment – violence	9.6	9.5	9.6	9.5
Safety culture	6.7	6.8	6.9	6.8
Staff engagement	7.1	7.0	7.3	7.1
Team Working	6.3	6.5		

National Staff Survey: improvement plans

As part of the communication and engagement plan for the National Staff Survey, there are specific Trust-wide and local activities to share and respond to staff feedback including:

- Infographics and communications of key areas of strengths and improvement shared via WWL global email, newsletters, and staff forums;

- Organisational development support to encourage leaders to make improvements in their area;
- Development of Trust-wide people actions and divisional People Promise action plans to improve staff experience with particular focus on Equality, Diversity and Inclusion (EDI) this year;
- Workforce Race Equality and Disability Equality Standards action plans to reduce inequalities in staff experience and eliminate discrimination and bullying, harassment or abuse;
- Monitoring of action planning via divisional assurance processes and the newly established EDI Strategy Group;
- Regular assurance reports submitted to People Committee;

Key strategic actions to respond to our people's feedback in the National Staff Survey 2023/24 include:

- Corporate people objectives 2024/25 launch with focus on eliminating discrimination, strengthening inclusion and staff voice;
- Launch of WWL Trust values to support development of inclusive, compassionate culture in Q1 in 2024/25;
- All divisional action plans to include at least one EDI objective to support our ambition to be intentionally inclusive for all from Q4 2023/24;
- Strengthened EDI governance and launch of new EDI Strategy Group to oversee delivery of improvement plans to address disparities in staff experience for those with protected characteristics in Q1 2024/25;
- Set up of strategic EDI workstreams to respond to staff survey results and ensure compliance with NHS EDI Improvement plan, including plans on inclusive recruitment practices, equity in career progression, reasonable adjustments for staff with long-term health conditions, and supporting our internationally educated colleagues;
- WWL to launch Anti-Racist Organisation Statement in June 2024 and commit to becoming an Anti-racist organisation as part of the North West Black and Minority Ethnic (BAME) Assembly Anti-Racist Framework;
- WWL's commitment to the NHS Sexual Safety Charter principles by July 2024;
- New People and Culture Strategy to be launched in Q1 2024/25 which follows a three-year timeframe to strengthen the staff voice and speak up culture; develop leadership capabilities to empower leaders to create positive workplace cultures; to become intentionally inclusive in everything we do; and commit to growth and development of our people and supporting our local community by widening access to opportunities within WWL.

For 2024/25, we aim to continue to improve our staff feedback mechanisms by:

- Embedding the new arrangements for Freedom to Speak Up, including a review against the NHS board self-assessment framework;
- Aligning our quarterly pulse survey methodology with the one used for the National Staff Survey from July 2024 to increase response rate and yield better data breakdown to support divisional action planning;
- Encouraging informal feedback processes by implementing a streamlined and supportive approach to line manager and staff conversations;
- Strengthening the partnership with staff networks and staff side to co-design new programmes of work under the new People and Culture Strategy.

Equality, diversity and inclusion

Our 2022-26 Equality, Diversity and Inclusion Strategy is centred around increasing diversity and accessibility, eliminating inequality, and improving experience for protected groups. We will continue

to ensure that our staff and service users are in a safe, inclusive and accessible environment where there is a true sense of belonging and that our services are accessible to all communities across the borough of Wigan.

We have signed up to the NHS Sexual Safety Charter Standards and the Northwest BAME Assembly Anti-Racist Framework to ensure we are improving the experience of staff with protected characteristics, reducing race disparities, particularly for staff from black, Asian and minority ethnic backgrounds and adopting a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace.

Our EDI strategy, alongside the NHS EDI Improvement Plan provide us with a framework for taking action to improve through key programmes of work that promote an inclusive culture including:

- Active bystander training to empower our staff to challenge poor behaviours that may have become normalised over time;
- Supporting our disabled colleagues through activities that address the implementation of reasonable adjustments as a supportive and compassionate approach to employment;
- Creating safe and inclusive spaces for staff to speak up through the provision of our Freedom to Speak Up Guardian and a Speak up Safely Campaign;
- Creating a cultural development plan to support our internationally educated staff, ensuring their employment experience provides a sense of belonging and inclusion and eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur;
- Promotion of WWL's EDI Calendar to celebrate and raise awareness of key religious festivals, cultural and spiritual beliefs that reflect the diversity of our staff;
- Empowering our Board members to have an EDI objective aligned with improving inclusion and reducing inequality;
- Continuing to provide EDI training for our Governors, Board and the Executive Team.

We have a full suite of workforce policies which are developed and reviewed in partnership with staff side representatives. These include recruitment and selection (including how applications for employment by those with disabilities will be given full and fair consideration), learning and development, attendance management, conduct and standards and performance management. These policies link with frameworks and systems that provide opportunity for disabled employees and their leaders to agree reasonable adjustments to support them within the workplace throughout their career. These policies would also be used in the event that a member of staff becomes disabled during their employment. Our staff networks representing protected and minority groups are included within the approval process of our workforce policies and procedures. We publish weekly news bulletins on priority items and topics of interest to our workforce, inclusive of updates such as information governance and counter fraud. We also publish weekly vlogs from our executive team, including our Chief Executive, covering key items of interest to our workforce. Our executive directors lead monthly all staff briefings and leadership forums. We have long established executive led forums with staff side colleagues which focus on topics of concern to our workforce. These forums are used to share and answer concerns, showcase both positive and developmental staff stories leading to proactive steps and continuous improvement in our policies and processes. They are also an opportunity to consult and negotiate with our staff side representatives on new and existing initiatives affecting our workforce.

WWL staff inclusion and diversity networks

We are proud to have three diversity and inclusion staff networks that provide a supportive and welcoming space for colleagues to share their lived experience. Our staff networks offer valuable expertise on matters relating to EDI, ensuring they have a voice in influencing strategies to improve staff experience.

The True Colours Network is WWL's LGBTQIA+ Network. Members and allies of the network last year successfully headlined Wigan Pride and will continue to have an important presence at this event to celebrate diversity but also to address health inequalities of the LGBTQIA+ community. The network has also helped to support transgender staff and develop our gender identity policies.

Our Disability and Long-Term Health Conditions+ Network has been a major influence on programmes of work to raise awareness of hidden disabilities amongst staff and are soon to launch the Sunflower Scheme which promotes inclusivity, acceptance and understanding of those that may have a hidden disability.

Our FAME (For All Minority Ethnicities) Network has over 100 members and allies and has gone from strength to strength. The network continues to celebrate cultural diversity and has been involved in international nurse welcome events and creating a diversity wall on one of our hospital sites that celebrates the 62 different countries and nationalities that represent our staff.

Gender pay gap report

Our most recent pay gap report and those submitted in previous years can be found at: **https://gender-pay-gap.service.gov.uk**

Mandatory disclosures within the staff report

Workforce gender profile as at 31 March 2024

Directors:	11 female (64.7%), 6 male (35.3%)
Senior managers:	254 female (70.95%), 104 male (29.05%)
Employees:	5683 female (81.09%), 1,325 male (18.91%)
(by headcount, senior managers are band 8a and above)	

Workforce diversity profile as at 31 March 2024 (per indicator nine of the NHS Workforce Race Equality Standard)

Directors:	16 white (94.22%), 1 BME (5.88%)
Senior managers:	329 White (90.14%), 28 BME (7.67%), 8 Not Stated (2.19%)
Employees:	5768 White (82.55%), 1069 BME (15.3%), 150 not stated (2.15%)
(by headcount, senior managers are band 8a and above)	

In the most recent 2021 Census, 95.0% of people in the Wigan borough identified their ethnic group within the "white" category, while 1.3% identified their ethnic group within the "mixed or multiple" category. We therefore consider that the board reflects the ethnic diversity of the communities which the trust serves, as well as its workforce, as set out above.

Sickness absence data

Sickness absence data for NHS organisations is published online by NHS Digital. The table below shows the figures for January to December 2023 which is required to be disclosed in an organisation's annual report:

Figures converted by the Department of Health and Social Care to best estimates of required data items		Statistics produced by NHS Digital from the Electronic Staff Record data warehouse		
Average FTE 2022	Adjusted FTE days lost to Cabinet Office definitions	Average FTE 2022	Adjusted FTE days lost to Cabinet Office definitions	Average FTE 2022
6,232	73,258	6,232	73,258	6,232

Our most recent sickness absence data is available at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff turnover

NHS Digital publishes monthly information about staff turnover for all organisations. The most up to date data for WWL can be found by typing the following address into a web browser and visiting the 'resources' section towards the bottom of the page:

Staff turnover information is available at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Consultancy

We did not incur any consultancy fees during the year.

Occupational health

Occupational health services are provided by Wellbeing Partners, a joint venture organisation between Lancashire Teaching Hospitals NHS FT and us. Performance is monitored on a quarterly basis by each partner organisation and via a governance board. An occupational health representative attends our Occupational Safety and Health Group and Infection Prevention and Control Group meetings.

Counter-fraud and corruption

We employ our own Accredited Fraud Specialist Manager who is qualified to investigate fraud to a criminal standard, we have a fraud, corruption and bribery policy and response plan in place which has been developed in line with NHS Counter-Fraud Authority requirements and the expectations detailed in the Government's Functional Standard (GovS 013) relating to fraud, bribery and corruption. All staff are required to successfully complete a mandatory e-learning anti-fraud module

every three years and continuous fraud awareness campaigns are undertaken via the intranet, news articles and presentations.

Health and Safety

The statutory Health and Safety Committee, known as the Occupational Safety and Health Group (OSHG), seeks assurance and monitors organisational compliance with statutory health and safety requirements. The Director of Corporate Affairs chairs the group and has delegated responsibility for health and safety within Wrightington, Wigan and Leigh Teaching Hospitals.

The group is accountable to the Quality and Safety Committee, which is in turn, is accountable to the Board of Directors. It meets quarterly and receives reports from its sub-committees as a way of monitoring and seeking assurance of compliance with statutory requirements.

In May 2023 the Trust was inspected by the Health and Safety Executive (HSE) specific to the management and prevention of sharps injuries. A notice of contravention was issued. Although the Trust was able to evidence availability of training, the inspection found it was not robust enough to cover the information and training requirements set out in the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. A programme of training was implemented to satisfy the notice, which was signed off in July 2023.

The Trust continues to observe the HSE HSG65 model “Managing for Health and Safety”. The key components are the Plan, Do, Check, Act (PDCA) cycle. This year, the health and safety risk assessment and risk management framework has been reviewed and updated to internally strengthen this cycle and better complement the corporate risk management framework.

Health and safety incident reporting remains an important role for the health and safety team, along with the investigation of incidents which were reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, as does working with our legal team where issues with employer’s liability arise.

Health and safety training has continued, with excellent attendance. The annual programme of inspection has also continued with strong engagement and ongoing management of action plans by all of our divisions to ensure environments remain safe for all.

Health and safety audits have focused on hazardous substances which made recommendations to support improvements in storage arrangements. One improvement measure included the review and relaunch of the in-house Control of Hazardous Substances to Health Awareness Training Course.

Time off for trade unions

The tables below outline the facilities that we have provided for trade union colleagues during the year and collectively they constitute our facility time report for 2023/24.

Relevant union officials

Number of employees who were relevant union officials during the relevant period:	39
Full-time equivalent employee number:	35.61

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	4
1-50%	32
51-99%	0
100%	3

Percentage of pay bill spent on facility time

Total cost of facility time:	£154,000
Total pay bill:	£335,468,000
Percentage of total pay bill spent on facility time:	0.05%

Paid trade union activities

Total paid facility and union time hours	6,743

Employee costs (subject to audit)

	Permanent £000	Other £000	2023/24 Total £000	2022/23 Total £000
Salaries and wages	262,824	1,646	264,470	256,041
Social security costs	27,350		27,350	24,888
Apprenticeship levy	1,343		1,343	1,153
Employer contributions to NHS pension scheme	29,701		29,701	27,257
Employer contributions paid by NHSE	13,115		13,115	11,987
Termination benefits	67		67	0
Temporary staff - external bank / agency /contract	0	38,744	38,744	46,955
Total staff costs	334,400	40,390	374,790	256,041
Costs capitalised as part of assets	1,162	832	1,994	2,032

Average number of employees (based on whole-time equivalents; subject to audit)

	Permanent (Number)	Other (Number)	**Total 2023/24** (Number)	Total 2022/23 (Number)
Medical and dental	607	79	686	632
Administration and estates	1,520	23	1,543	1450
Healthcare assistants and other support staff	714	12	726	680
Nursing, midwifery, and health visiting staff	2,647	408	3,055	2,819
Scientific, therapeutic and technical staff	966	37	1,003	918
Healthcare science staff	4	1	5	4
Other	11	0	11	12
Total average numbers	6469	560	7029	6515
Number of employees (WTE) engaged on capital projects	28	7	35	26.15

Reporting of compensation schemes: exit packages 2023/24 (subject to audit)

Exit package cost band (including any special payment element)	Total number of exit packages
<£10,000	41
£10,001 to £25,000	1
£25,001 to £50,000	2
£50,001 to £100,000	0
Total number of exit packages by type:	44
Total resource cost:	£228,000

During 2023/24, 41 exit packages related to payments made in lieu of notice.

Reporting of compensation schemes: exit packages 2022/23

Exit package cost band (including any special payment element)	Total number of exit packages
<£10,000	40
£10,001 to £25,000	3
£25,001 to £50,000	1
£50,001 to £100,000	
Total number of exit packages by type:	44
Total resource cost:	£201,612

During 2022/23, 42 exit packages related to payments made in lieu of notice.

Reporting of high-paid off-payroll arrangements earning more than £245 per day

Highly paid off-payroll worker engagements as at 31 March 2024, earning £245 per day or greater	
Number of existing engagements as at 31 March 2024:	33
Of which, the number that have existed:	
For less than one year at time of reporting:	8
For between one and two years at time of reporting:	5
For between two and three years at time of reporting:	7
For between three and four years at time of reporting:	6
For four or more years at time of reporting:	7

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2024 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2024:	50
Of which:	
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	47
Subject to off-payroll legislation and determined as out-of-scope of IR35*	3
Number of engagements reassessed for compliance or assurance purposes during the year:	0
Of which, number of engagements that saw a change to IR35 status following review:	0

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

Off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2024	
Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year:	0
Number of individuals that have been deemed board members and/or senior officials with significant financial responsibility during the financial year. (This figure includes both off-payroll and on-payroll engagements)	22

Our use of off-payroll arrangements is limited to occasions when it is deemed unavoidable and subject to close scrutiny. We recognise that, on an exceptional basis, it is necessary to use the services of individuals who are only available as self-employed or provide services through an intermediary ('off-payroll'). This may reflect particular market sectors, or the choice of individuals on how to structure their careers. Whilst the preference is to employ our own staff, the need may arise to cover areas of work for which the necessary skills or specialist experience are not available on an employed basis. In such cases, a determination is made is to which method of resourcing is most appropriate.

We apply rigorous controls to all aspects of discretionary expenditure, including the use of off payroll arrangements. We follow rules from His Majesty's Revenue and Customs (HMRC) surrounding off-payroll working, commonly known as IR35. For tax purposes, an assessment is carried out on a case-by-case basis, and IR35 compliance is confirmed prior to commencement.

Mary Fleming
Chief Executive and Accounting Officer

26 June 2024

Disclosures set out in the Code of Governance for NHS Provider Trusts

We have applied the principles of the Code of Governance for NHS Provider Trusts, which came in to force in April 2023, on a comply or explain basis.

The NHS Foundation Trust Code of Governance contains guidance on good corporate governance. NHS England recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for any non-compliance with the code should be explained. This "comply or explain" approach has been in successful operation for many years in the private sector and within the NHS foundation trust sector. There are no provisions within the NHS Foundation Trust Code of Governance that we did not comply with during 2023/24.

The NHS Foundation Trust Code of Governance also sets out a number of disclosure requirements and these are provided below.

Council of Governors

The Council of Governors continues to play a key role in the work of the foundation trust, representing the interests of our membership and the general public.

It has a number of statutory duties, including appointing the chair and the non-executive directors, determining their remuneration and other terms and conditions of service and approving the appointment of the Chief Executive.

The Council of Governors holds the non-executive directors to account, both individually and collectively, for the performance of the board. It also receives the annual report and accounts and contributes to our annual business planning process, including our objectives, priorities and strategy, by canvassing the views of foundation trust members, the public (and if they are appointed, their appointing body)on our forward plan and communicating these to the Board of Directors. This is mainly done through our formal governor meetings, facilitated by a regularly scheduled item which is led by governors, who provide feedback from these groups for the board.

Decisions made by our Council of Governors include:

- Appointment or removal of the Chair and the other Non-Executive Directors;
- Approval of the appointment (by the Non-Executive Directors) of the Chief Executive;
- Remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;
- Appointment or removal of the Foundation Trust's Financial Auditor;
- Appointment or removal of any other external auditor appointed to review and publish a report on any other aspect of the Foundation Trust's affairs;
- Approval of significant transactions and applications by the Foundation Trust to enter into a merger, acquisition, separation or dissolution;
- Whether the Foundation Trust's non-NHS work would significantly interfere with the fulfilment of its principal purpose or the performance of its other functions;
- Approval of amendments to the constitution;

We support effective mechanisms for communication between governors and members from our constituencies through a regularly scheduled membership magazine and engagement events. The contact details for members who wish to communicate with governors and/or directors are made available on our website and throughout this report.

The public and staff members of the Council of Governors are elected from and by the foundation trust membership to serve for three years. They may stand for re-election at the end of their term of office, subject to a maximum of 9 years' service.

Our Council of Governors comprises 28 governor posts:

- 4 public governors from the Wigan constituency;
- 4 public governors from the Leigh constituency;
- 4 public governors from the Makerfield constituency;
- 4 public governors from the Rest of England and Wales constituency;
- 1 medical and dental staff governor;
- 2 nursing and midwifery staff governors;
- 2 staff governors from the 'all other staff' constituency; and
- 7 appointed governors for across our key stakeholders.

The following table provides detail of the attendance during 2023/24 of those governors who remain in post as at the date of writing:

Name	Constituency/organisation	Term of office ends (see note 1)	Attendance 2023/24 (see note 2)
Public governors			
Peter Allard	Public: Wigan	2025	87.5%
Alan Boardman	Public: Leigh	2025	37.5%
Alan Baybutt	Public: Wigan	2024	67%
Andrew Bullen	Public: Makerfield	2026	62.5%
Les Chamberlain	Public: Makerfield	2025	87.5%
Ken Griffiths	Public: Makerfield	2026	37.5%
Andrew Haworth	Public: Leigh	2024	100%
Julie Hilling	Public: Rest of England and Wales	2024	37.5%
Mustapha Koriba	Public: Rest of England and Wales	2025	75%
Lisa Lymath	Public: Rest of England and Wales	2025	37.5%
Catherine Martindale	Public: Wigan	2024	62.5%
Malcolm Ryding	Public: Rest of England and Wales	2024	62.5%
Susan Spibey	Public: Leigh	2024	66.7%
Philip Woods	Public: Makerfield	2026	87.5%
Staff governors			
Ali Al-Chalabi	Staff: All other staff	2026	100%
Julie Barrett	Staff: Nursing and Midwifery	2026	50%
Emily Cooper	Staff: Medical and Dental	2024	50%
Michelle Hartley	Staff: Nursing and Midwifery	2024	100%
Andrew Savage	Staff: All other staff	2026	87.5%
Appointed governors			

Name	Constituency/organisation	Term of office ends (see note 1)	Attendance 2023/24 (see note 2)
John Cavanagh	Foundation Trust volunteers	2027	75%
George Davies	Wigan Council	2026	80%
Dawne Gurbutt	University of Central Lancashire	2024	50%
David Humphries	Local Medical Committee and CCG	2026	80%
Axel Kaehne	Edge Hill University	2026	100%
Bryonie Shaw	Age UK Wigan Borough	2027	50%

Notes:

1. The term of office of all governors ends at the conclusion of the annual members' meeting in the year shown.
2. There were six formal meetings of the Council of Governors during 2023/24 in addition to informal workshops and briefing sessions. The attendance figures above are calculated on the basis of formal meetings only. Two of these meetings were called at short notice and this may have impacted on governors' ability to attend on those occasions.

The Council of Governors appoints a lead governor each year. Andrew Haworth was appointed to this role for the third time on 11 January 2023.

Council of Governors' register of interests

All governors are required to comply with the Code of Conduct for Governors and to declare any interests which may result in a potential conflict of interest in their role as a governor. A copy of the register of governors' interests can be obtained from the corporate affairs team, using the details on page 175.

Nomination and Remuneration Committee

The Nomination and Remuneration Committee makes recommendations to the Council of Governors on the appointment and remuneration of the chair and the other non-executive directors. This year, the committee has led on the recruitment of three substantive non-executive directors on behalf of the Council of Governors, as outlined on page 61.

Training and development for governors

During 2023/24, we provided our governors with access to a number of training and development opportunities to further support them in their role. These included externally provided training and development such as the GovernWell programme offered by NHS Providers and workshops provided by Mersey Internal Audit Agency and internal workshops and induction sessions

Communicating with governors

There are a number of easy ways for members of the public to communicate with the Council of Governors:

Email

governors@wwl.nhs.uk

Telephone

0800 073 1477

This is a freephone service and a 24/7 answerphone is available

Post

Council of Governors
c/o Corporate Affairs Team
Trust Headquarters
Royal Albert Edward Infirmary
Wigan Lane
Wigan, WN1 2NN

The board's relationship with the Council of Governors and members

The board and the council work together closely throughout the year. Non-executive directors are invited to attend all meetings of the council and the aim is for all non-executive directors to attend at least one meeting per year although many do attend more. As required by legislation, the chair of the Board of Directors is also the chair of the Council of Governors.

The following directors have attended a Council of Governors meeting during 2023/24:

- Clare Austin
- Rhona Bradley
- Mary Fleming
- Tabitha Gardner
- Julie Gill
- Terence Hankin
- Ian Haythornthwaite
- Paul Howard
- Mark Jones
- Lynne Lobley
- Anne-Marie Miller
- Richard Mundon
- Kevin Parker-Evans
- Silas Nicholls
- Francine Thorpe
- Juliette Tait
- Claire Wannell

The Council of Governors receives copies of the agendas of all board meetings in advance and copies of the minutes once approved. Some of our governors also choose to attend public board meetings where they can see the board at work. This allows them to gain a good understanding of the unitary nature of the board and to see at first hand the challenge and scrutiny undertaken by the non-executive directors.

Governors are also in attendance at each of our assurance committee meetings. This to help the Council of Governors to undertake its role of holding the board to account through the non-executive directors.

A clear dispute resolution procedure, set out in our constitution, details how disagreements between the Council of Governors and the Board of Directors will be resolved.

The types of decisions taken by each body are set out within our constitution and within the core governance documents of the organisation. Decisions around strategy, significant investments and those which are considered to have a potentially significant impact on the organisation's reputation are made by the board and its committees, whilst operational matters and decisions relating to the day-to-day running of the trust are handled by our executive directors.

More information about the Council of Governors and its work is available at:
wwl.nhs.uk/council-of-governors

Our membership

Our membership is an essential and valuable asset. There are two membership categories: public and staff. Anyone who lives in Wigan, Leigh or Makerfield is eligible to apply for membership of the foundation trust as a public member of the respective constituency. We also welcome applications for membership from individuals who live outside of these areas to the Rest of England and Wales constituency.

Our staff automatically become members of the foundation trust if they have a contract of employment which has either no fixed term, or a fixed term of at least 12 months, or they have been continuously employed by us for at least 12 months, unless they choose to opt out.

Our constitution places a small number of restrictions on membership, and these are as follows:

- it is only possible to be a member of one constituency at any one time;
- a member of staff may only be a member of a staff constituency whilst they are employed by us (they cannot choose to be a member of the public constituency instead);
- individuals must be at least 16 years of age to become a member; and
- the criteria set out in the constitution which prevent an individual from becoming or continuing as a member must not be satisfied

The table below provides a summary of our membership as at 31 March 2024 and comparative figures for the previous year have also been provided:

Constituency	No. members as at 31 Mar 2024	No. members as at 31 Mar 2023	Change
Public: Leigh	1,764	1,797	-33
Public: Makerfield	1,919	1,938	-19
Public: Wigan	2,377	2,404	-37
Public: Rest of England and Wales	2,507	2,548	-41
Staff: Medical and Dental	406	541	-165
Staff: Nursing and Midwifery	2108	2,071	+37
Staff: All other staff	4652	4,625	+27
Total members:	**15,733**	**15,924**	**-231**

In order to monitor the representativeness of our membership, we have access to a membership profiling tool which is provided by Civica Election Services on our behalf. We can confirm that our membership remains broadly representative of the communities we serve.

If you would like to become a member of the foundation trust, please visit:
wwl.nhs.uk/become-a-trust-member

The Audit Committee

The role of the Audit Committee is to provide independent assurance to the board on the effectiveness of the governance processes, risk management systems and internal controls on which the board places reliance for achieving its corporate objectives and in meeting its fiduciary responsibilities. It is authorised by the board to investigate any activity within its terms of reference and to seek any information it requires from staff.

The committee considers both the internal and external audit work plans and receives regular updates from both the internal and external auditors. The committee also receives an anti-fraud update at each of its meetings. The local anti-fraud function is very important in identifying and preventing fraud and operational risks to the organisation. We have a zero-tolerance policy in respect of fraud, corruption and bribery and investigations are carried out if evidence supports this. We have a mandatory training e-learning anti-fraud module which has been rolled out across the foundation trust and all staff are required to complete this on a bi-annual basis. Our Fraud Specialist Manager works with staff and management in identifying areas of potential fraud risk and coordinates this work with external partners.

In addition to these areas which are routinely considered throughout the year, the other significant areas that the committee considered in relation to the financial statements, wider operations and organisational compliance were:

progress with the implementation of actions arising from an internal audit review of waiting list management and medical e-rostering, which received limited assurance during 2022/23. Updates were also provided to the Board of Directors and confirmation was provided in-year by the internal auditors that Trust had made good progress with the implementation of recommendations; limited assurance internal audit reports around the Global Training and Education Centre; escalation of deteriorating patients and sepsis; discharge planning; data quality in community services; safe medical staffing and job planning for specialty, specialist and locally employed doctors, on which the committee was briefed during the year. High assurance levels were allocated to internal audits of safeguarding; general ledger, accounts payable, accounts receivable, treasury management and risk management core controls

KPMG became our external auditors during 2022 following a tender exercise which was conducted in 2020/21. The contract was awarded for an initial term of two years, with an option to extend for one or two further years. The Council of Governors consider the matter at its meeting in October 2023 and agreed to reappoint KPMG for a further two-year period. This was based on feedback from market testing, a review of the auditor's performance and consideration of their independence. No non-audit services were provided by KPMG during 2023/24.

A key aspect of the Audit Committee's work is to consider significant issues in relation to financial statements and compliance. As part of the preparation for the audit of financial statements, KPMG undertook a risk assessment and identified a number of risks including management override of

controls, valuation of land and buildings and a fraud risk from expenditure recognition. These are relatively standard audit risks prescribed by professional auditing standards and do not imply any particular control issues within the foundation trust. They also undertook a value for money risk assessment, which identified no significant risks in respect of financial sustainability, governance and improving economy, efficiency and effectiveness.

Mersey Internal Audit Agency (MIAA) carries out our internal audit function. The executive team works with MIAA to agree the internal audit plan and key performance indicators for assessing their performance and effectiveness, and this is reviewed and approved by the Audit Committee. MIAA provides us with benchmarking data, updates on assurance frameworks and briefing notes on a range of current issues. In particular, MIAA provide good briefing sessions for chairs of audit committees, governors and staff.

Audit Committee membership and attendance during 2023/24 was as follows:

Name	A	B	%
Clare Austin	4	5	80%
Rhona Bradley	5	5	100%
Terence Hankin	2	2	100%
Ian Haythornthwaite (Chair)	5	5	100%
Mary Moore	1	1	100%

A: Number of meetings attended
B: Total number of meetings the director could have attended

More information about the Audit Committee is available at:
wwl.nhs.uk/audit-committee

The Remuneration Committee

The Board of Directors has established a Remuneration Committee. Its responsibilities include consideration of matters relating to the remuneration and terms and conditions of office of the executive directors. The committee comprises all non-executive directors and is chaired by Mark Jones. Attendance information is provided on page 60.

In order to help us assess the diversity of our board, we carry out an annual board composition survey, allowing us to capture data relating to the board's balance of skill, knowledge and experience as well as ethnicity, disability, age and gender. The results influence board composition, allowing us to identify which areas we are unrepresentative in and we work with our recruiters to ensure that they understand our board diversity goals, keeping these in mind when providing us with potential candidates.

The committee also supports our succession planning work. This year we have run two initiatives which have helped us to develop our succession pipelines. Our Shadow Board Programme supported 15 of our senior managers to gain experience of working at board level by both practically shadowing our board and also undertaking taught leadership modules. Two participants went on to accept interim positions on our board and one took up the post of our Chief Clinical Information Officer. Our participation in the NHS Leadership Academy's NExT Director Scheme supports the creation of a pipeline of strong and diverse potential candidates for non-executive director roles and

has a current focus on supporting women, people from local BAME communities, and disabled people with senior level experience into board level roles. We now have two colleagues working with us through this programme as development non-executive directors.

The Chief Executive attends the committee in relation to discussions around board composition, succession planning, remuneration and performance of executive directors. The Chief Executive is not present during discussions relating to her own performance, remuneration or terms of service.

More information about the Remuneration Committee is available at:
wwl.nhs.uk/ remuneration-committee

The Nomination and Remuneration Committee

The Council of Governors has established a Nomination and Remuneration Committee. Its responsibilities include consideration of matters relating to the appointment, remuneration and other terms and conditions of service of the non-executive directors and providing recommendations to the Council of Governors for consideration. Membership and attendance information is provided on page 61.

More information about the Nomination and Remuneration Committee is available at:
wwl.nhs.uk/nomination-and-remuneration-committee

Assurance Committees

The Finance and Performance Committee met six times during 2023/24 and membership and attendance was as follows:

Name	A	B	%
Rhona Bradley	4	6	67%
Tabitha Gardner	6	6	100%
Julie Gill (Chair)	5	6	83.3%
Mary Fleming	3	3	100%
Ian Haythornthwaite	4	6	67%
Richard Mundon	6	6	100%
Francine Thorpe	5	6	83.3%
Claire Wannell	2	3	67%

A: Number of meetings attended
B: Total number of meetings the director could have attended

The People Committee met five times during 2023/24 and membership and attendance was as follows:

Name	A	B	%
Clare Austin	3	5	60%

Sanjay Arya	4	5	80%
Julie Gill	4	5	80%
Terence Hankin	2	2	100%
Lynne Lobley (Chair)	5	5	100%
Mary Moore	1	1	100%
Kevin Parker-Evans	1	1	100%
Juliette Tait	3	3	100%
Rabina Tindale	2	4	50%
Tracy Boustead	2	2	100%

A: Number of meetings attended
B: Total number of meetings the director could have attended

The Quality and Safety Committee met seven times during 2023/24 and membership and attendance was as follows:

Name	A	B	%
Sanjay Arya	6	7	85.7%
Rhona Bradley	6	7	85.7%
Terence Hankin	2	2	100%
Lynne Lobley	7	7	100%
Mary Moore	3	3	100%
Kevin Parker-Evans	2	2	100%
Francine Thorpe (Chair)	7	7	100%
Rabina Tindale	5	5	100%

A: Number of meetings attended
B: Total number of meetings the director could have attended

The Research Committee met four times during 2023/24 and membership and attendance was as follows:

Name	A	B	%
Sanjay Arya	1	4	25%
Clare Austin (Chair)	4	5	80%
Terence Hankin	1	1	100%
Anne-Marie Miller	4	5	80%
Richard Mundon	4	4	100%
Kevin Parker-Evans	0	1	0%
Lynne Lobley	3	4	75%
Rabina Tindale	2	3	66.7%
Francine Thorpe	3	4	75%

A: Number of meetings attended
B: Total number of meetings the director could have attended

NHS England's system oversight framework

NHS England's System Oversight Framework provides the framework for overseeing systems, including providers, and identifying potential support needs. The framework looks at five national themes:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- Finance and use of resources
- People
- Leadership and capability

Based on information from these themes, providers and Integrated Care Boards are segmented from 1 to 4, where 4 reflects providers receiving the most support and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

WWL is currently placed in segment 2 of NHSI's Single Oversight Framework (providers offered targeted support; potential support needed in one or more of the five themes but not in breach of licence and/or formal action is not needed) as notified by NHS England. This segmentation information represents the position as at 31 May 2024. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website.

For current segmentation, please visit **https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/**

Statement of the Chief Executive's responsibilities as the Accounting Officer of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

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

NHS England, in exercise of the powers conferred on Monitor by the National Health Service Act 2006, has given Accounts Directions which require Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

Responsibility for preparing the annual report and accounts sits with the Board of Directors. In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

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

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

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

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

Mary Fleming
Chief Executive and Accounting Officer
26 June 2024

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, I am primarily responsible on behalf of the board for WWL's risk management arrangements. Our Director of Corporate Affairs holds the portfolio for risk management and with a dedicated Head of Risk, has day-to-day responsibility for this function.

Our Board of Directors is responsible for monitoring our strategic risks, which are defined as risks which pose a threat to our achievement of our corporate objectives. These objectives are set annually by the board and each categorised in line with one of our four principle objectives: patients, people, performance and partnerships. Once set by the board, the corporate objectives form the basis of our board assurance framework, which logs all corresponding risks; existing risk controls and assurances; gaps in control and assurance and the proposed risk treatments. This document is reviewed at every board meeting and each principle objective is monitored by the most appropriate board sub-committee. The risks identified assist us in shaping our meeting agendas and ensuring that additional assurance is sought where the board note concerns with specific risks.

As part of their onboarding, all board members receive training from the Head of Risk on how to use the board assurance framework and once again this year our internal auditor confirmed that our approach fully meets the expectations of an effective NHS board assurance framework.

Following the introduction of the integrated care model, along with nine other trusts in our region, WWL became a member of the Greater Manchester Integrated Care Partnership (GMICP). We also continue to be a member of our local care organisation, the Healthier Wigan Partnership (HWP), along with other key health and care providers across primary, community, mental health, social care. Both of these organisations are developing their own assurance frameworks which will work similarly to our own in monitoring achievement of and risks related to our wider regional and local objectives. In 2024/25, we will work to adapt our risk management arrangements to ensure that our

board are regularly sighted on risks relating to both of these frameworks. Currently, our board receives both a partnerships report and a system partnerships report annually, facilitating oversight of how we work collaboratively with our regional and local partners. These documents, along with the 'partnerships' section of our board assurance framework, inform our board of any risks around partnership working.

Our risk management policy and risk management framework document our leadership arrangements for risk management, these documents are approved and their implementation monitored by our Audit Committee. The senior operational risk group reporting to the Audit Committee is our Risk Management Group, which is chaired by me as Chief Executive and is routinely attended by over half of our executive board members. Chairing the Risk Management Group allows me to get a good oversight of our arrangements and also allows me and other executive colleagues to reinforce the importance of this issue and the need for clear line of sight to the executive team. The group reviews all risks scoring 15 and above (more information on the scoring methodology used is provided below) and identifies where a risk or collection of risks may impact upon achievement of our corporate objectives, thereby escalating risks for inclusion on our board assurance framework. The Audit Committee receives a biannual deep dive in to risks scoring 15 and above, as selected by the Committee Chair.

After each Risk Management Group meeting, a summary of the business transacted at that meeting is presented to the executive team for information and for escalation as required. This in turn helps to ensure that risk drives the agenda of our key meetings.

Our risk management policy also defines what risk related training our staff are required to undertake with risk management training delivered for all staff through mandatory training modules and supported by compliance monitoring dashboards. Our LMSx manager dashboard allows managers to check their team's compliance and see what training is due to be undertaken. All risk related incidents are reported through Datix, our incident management system and a 'Datix Risk Register Workshop' hosted via our online learning hub is available for all staff to take part in. Our training is designed to provide an awareness and understanding of the risk management strategy, the risk management process and to give practical experience of completing risk assessment paperwork.

We expect all of our leaders to support us in the management of risks and individual job descriptions set out appropriate requirements for each role.

We aim to learn from good practice and hold a clinical audit conference each year. The purpose of this event is to showcase best practice and the positive impact that our improvement work has had on patient care. Colleagues are invited to submit any audit work they have done for shortlisting, and 4 projects are chosen which are presented on the day.

Risk management core controls are included in our internal audit plan cycle, with our 2023 audit result being one of high assurance.

The risk and control framework

The risk management framework supports the consistent and robust identification and management of opportunities and risks within desired levels across the trust, supporting openness, challenge, innovation and excellence in the achievement of objectives. The trust board is corporately accountable for ratifying, adhering to, and delivering the risk management framework. The board determine and continuously assess the nature and extent of the principal risks that the trust is

exposed to and is willing to take to achieve its objectives - its risk appetite – and ensure that planning and decision-making reflects this assessment.

Identification of risk

Risk identification activities provide an integrated and holistic view of risks, organised into categories relating to the four principal objectives: patients, people, performance and partnerships. The trust has established risk management activities which cover all types and sources of risk. The aim is to understand the trust's overall risk profile. The trust uses a range of techniques for identifying specific risks that may potentially impact on one or more objectives. Risk prioritisation is supported by risk assessment, which incorporates risk analysis and risk evaluation.

Evaluation of risk

The evaluation of risk is undertaken to determine whether the risk level is within risk appetite or whether the risk requires further control measures to reduce its level, known as risk treatment. The evaluation process involves considering the level of risk and the time, cost and effort involved in reducing the risk rating further.

We use a 5 x 5 risk matrix, where both the consequence and the likelihood of a risk materialising are allocated a score and multiplied to provide an overall risk score. Risks scoring 15 or above are escalated to the Risk Management Group. The trust's willingness to accept a risk above the risk appetite will depend on which of the principal objectives is at risk and the positive or negative impact that the risk would have on objectives, should it materialise. Therefore, risk evaluation is completed by managers with sufficient knowledge and authority. Those managers and groups that should be involved in deciding if a risk level is acceptable are identified in the standard operating procedure to enable the trust to make an informed decision on accepting levels of risk.

Control of risk

Selecting the most appropriate risk treatment option(s) involves balancing the potential benefits derived in enhancing the achievement of objectives against the costs, efforts, or disadvantages of proposed actions. Justification for the design of risk treatments and the operation of internal control is broader than solely economic considerations and considers all the trust's obligations, commitments and partner views.

This corporate approach sets out five ways in which risks can be managed:

- A risk can be **treated** by taking mitigating action to reduce it to a tolerable level as identified through a target risk score;
- It may be that, in line with the foundation trust's risk appetite statement approved by the board, a risk can be **tolerated** – either in its initial form or following mitigation to reach the target risk score;
- We may take the decision to **transfer** the risk, such as by taking out an insurance policy or commissioning the services from a third-party supplier;
- Where risks are of such significance that there are no other alternatives, we may decide to **terminate** the risk by stopping the associated activities or

- We may **take the opportunity** associated with the risk for the benefit of the foundation trust

As part of the selection and development of risk treatments, the trust specifies how the chosen option(s) will be implemented, so that arrangements are understood by those involved and effectiveness can be monitored. Where appropriate, contingency, containment, crisis, incident and continuity management arrangements are developed and communicated to support resilience and recovery if risks crystallise. Monitoring plays a role before, during and after implementation of risk treatment. Ongoing and continuous monitoring supports understanding of whether and how the risk profile is changing and the extent to which internal controls are operating as intended to provide reasonable assurance over the management of risks to an acceptable level in the achievement of the trust's objectives. The "three lines of defence" model sets out how these aspects operate in an integrated way to manage risks, design and implement internal control and provide assurance through ongoing, regular, periodic and ad-hoc monitoring and review. Importantly, the accounting officer and the board receive unbiased information about the trust's principal risks and how management is responding to those risks.

Risk appetite

Risk appetite is defined as the level of risk with which the trust aims to operate (optimal level). Too great a risk appetite can jeopardise a project or activity whilst too little could result in lost opportunity. Risk tolerance is the level of risk with which the trust is willing to operate, given current constraints. This balances the funding position with the position outlined in trust's objectives. Above this threshold, the trust actively seeks to manage risks and prioritises time and resources to reduce, avoid or mitigate these risks. The Trust Board agrees the risk appetite and risk tolerance levels for the trust as part of the annual strategic planning process.

A risk leader from the executive team is designated for each high-level risk on the board assurance framework. Appropriate managers are designated for all other risks. Risk leaders ensure that their risk management plan addresses the risks identified and are required to monitor the status of their risks through the relevant meetings.

The current risk appetite statement, correct as at the date of signing this report, is summarised by risk category and principal objective in the following matrix:

Risk category and link to principal objective		Threat		Opportunity	
		Optimal	Tolerable	Optimal	Tolerable
	Safety, quality of services and patient experience	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
	Data and information management	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
	Governance and regulatory standards	≤ 3	4 - 6	≤ 6	8 - 10

		Minimal	**Minimal**	**Cautious**	**Cautious**
	Staff capacity and capability	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
	Staff experience	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 15 Eager**	**≤ 15 Eager**
	Staff wellbeing	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 15 Eager**	**≤ 15 Eager**
	Estates management	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
	Financial Duties	**≤ 3 Minimal**	**4 - 6 Minimal**	**≤ 6 Cautious**	**8 - 10 Cautious**
	Performance Targets	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
	Hospital Demand, Capacity and Flow	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
	Sustainability / Net Zero	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
	Technology	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
	Adverse publicity	**≤ 3 Minimal**	**4 - 6 Minimal**	**≤ 6 Cautious**	**8 - 10 Cautious**
	Contracts and demands	**≤ 3 Minimal**	**4 - 6 Minimal**	**≤ 6 Cautious**	**8 - 10 Cautious**
	Strategy	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
	Transformation	**≤ 6**	**8 - 10**	**≤ 15**	**≤ 15**

		Cautious	Cautious	Eager	Eager

Our key quality governance committee is the Quality and Safety Committee, chaired by a non-executive director, which is a subcommittee of the Trust Board of Directors. The committee comprises of Non-Executive Directors, the Trust Executive Medical Director and the Trust Executive Chief Nurse and Director of Infection Prevention and Control, with representatives from each Division and corporate governance team. This committee seeks assurance that the highest standards of care is provided by our staff and ensures that there are adequate and appropriate quality assurance governance systems, processes and controls in place across the organisation. Dedicated groups report to this committee to manage and seek assurances on key subjects such as patient safety, patient experience, medicines management, infection control and health and safety. These groups all report up to the Quality and Safety Committee, providing assurances and highlighting risks. The Quality and Safety Committee can then provide assurances up to the Board of Directors on these quality governance areas, as well as highlighting key areas of risk and how these are being managed.

Quality of performance information is assessed at clinical divisional and corporate levels through local governance assurance structures and clinical divisional quarterly performance reviews. Information data quality is reviewed by our Data Quality Group.

Our last full inspection by the Care Quality Commission was in October and November 2019, with the report published in February 2020 We also underwent a focused inspection within the Maternity Services at the Royal Albert Edward Infirmary by the CQC and the service retained ‘Good’ status.

We are proud that our overall provider level remains ‘Good’ with all sites being rated as either Good or Outstanding. Regular contact is maintained with the Care Quality Commission relationship team and regular engagement meetings are held, where emerging issues can be discussed and addressed at an early stage. Inspectors remain in contact should they receive any enquiries in between these meetings and responses are always submitted on these enquiries.

Our major risks are included on the board assurance framework and included the following for 2023/24:

Patients:	• Sepsis Recognition, Screening and Management • Preferred place of death • Harm free care - avoidable pressure ulcers • Complaint response rates
People:	• Workforce Sustainability • Staff Engagement • Internationally Educated Nurses
Performance:	• Financial performance: failure to meet the agreed investment and expenditure position

	• Financial sustainability: efficiency targets and balance sheet • Estates Strategy - capital Funding • Elective services • Urgent and emergency care
Partnerships:	• Supporting widening access to employment for local residents • Partnership working - CCG changes • Estate Strategy - net carbon zero requirements • University Teaching Hospital - University Hospital Association criteria

These risks are likely to remain the same during 2024/25.

We have now fulfilled all recommendations made by Deloitte LLP in our 2021/22 well-led review. The team commented that we follow good practice in several areas, including the development of our strategy, the launch of initiatives aimed at positively influencing culture and the refreshing of our risk management arrangements described earlier in this statement. Our committee structure was acknowledged to be in line with good practice, although some suggestions to improve effectiveness were shared. Since then, we have facilitated better oversight of the digital agenda at board and committee level; strengthened the accountability and performance framework within which our divisional leaders operate and developed a more structured approach to quality improvement, which will support organisational transformation and ultimately cost savings. We work to continuously develop the skills of our board members and this year have held workshops on 'inclusion with humanity' and 'making data count', as well as a session on integrated working, at which we were joined by leaders from our local care organisation. This year saw us welcome several new board members to WWL and we will soon be beginning a board development programme delivered by the NHS Leadership Academy to support the strong cohesion that I can already see developing within our new team. In line with best practice guidance from NHS England, our next review will be scheduled to take place in 2026.

Principal risks to compliance with the NHS foundation trust licence condition

The board has not identified any principal risks to compliance with provider licence condition NHS2. This condition covers the effectiveness of governance structures, the responsibilities of directors and committees, the reporting lines and accountabilities between the board, its committees and the executive team.

The board is satisfied with the timeliness and accuracy of information to assess risks to compliance with the foundation trust's licence and the degree of rigour of oversight it has over performance. This is supported by the conclusion of our external auditor as part of their value for money work, which concluded that there were no identified risks in relation to our governance arrangements.

At WWL, risk management is an integral part of all organisational activities to support decision-making in achieving objectives. For example, equality impact assessments are integrated into our

core business. Control measures are in place to ensure compliance with our obligations under equality, diversity and human rights legislation. We continue to demonstrate compliance with the general and specific duties of the Public Sector Equality Duty on an annual basis through publishing relevant equality information as part of our annual inclusion and diversity monitoring report. We also undertake an assessment of current performance against the criteria stated in the national equality delivery system on an annual basis. We have continued to review and assess performance in collaboration with staff and local stakeholders, using this framework as well as identifying priorities going forward.

Progress against our action plan and equality objectives is monitored by our Equality, Diversity and Inclusion (EDI) Steering Group on a bi-monthly basis and is overseen by our People Committee. The EDI Steering Group has the following workstreams reporting it, all of which are aligned to the NHSE high impact EDI actions, and will be fully developed over 2024/25:

Workstream	Link to NHS England Plan	Chair
Disability Confident Scheme	NHS England High Impact Action 6	Deputy Chief People Officer
Anti-Racist Framework, including civility & respect	NHS England High Impact Action 6	Chief People Officer
Inclusive Recruitment	NHS England High Impact Action 2	Deputy Chief People Officer
Supporting international colleagues	NHS England High Impact Action 5	Chief Nurse
Pay Equality	NHS England High Impact Action 3	Medical Director
Health equality	NHS England High Impact Action 4	Health Inequality Lead
Patient access and experience	NHS England High Impact Action 4	Deputy Chief Nurse

Our EDI Strategy has the following key aims:

The EDI lead will ensure the EDI workstreams are aligned to the EDI Strategy People and Patient aims and objectives to ensure consistency of strategic priorities and to allow monitoring progress through the EDI Strategy group. This action provides an assurance to the People Committee that all key EDI actions are being overseen and implemented by the EDI Strategy Group and workstreams.

From 1 April 2015, all NHS organisations were required to demonstrate how they are addressing race equality issues in a range of staffing areas through the nine-point Workforce Race Equality Standard metric. This standard has been fully embedded within current practice. We continue to work closely with our GM Integrated Care Partnership colleagues to implement the Accessible Information Standard.

During the year we continued to undertake equality impact assessments on all policies and practices to ensure that any new or existing policies and practices do not disadvantage any group or individual.

Risk management is also embedded into the activity of our organisation through incident reporting. This is openly encouraged throughout the organisation and a 'just culture' is promoted.

Our approach to incident management is set out in our incident reporting policy. Identification and investigation of serious incidents and never events is undertaken by the Executive Scrutiny Group which is chaired by our Medical Director.

During the year our internal auditors have undertaken an audit of our risk management core controls arrangements and we are grateful to them for the rigour with which they have done so. High assurance was received and the following key findings were identified:

- Governance processes were clearly defined, and the Trust had a Risk Appetite statement in place. Roles and responsibilities relating to risk management were clearly outlined and standardised risk recording processes were in place

- Risk management training was delivered to all staff through mandatory training modules, supported by compliance monitoring dashboards

- Risk reporting, monitoring and escalation processes were clearly outlined and supported by regular risk reporting mechanisms

Key stakeholders, including patients, our public and staff membership and local partner organisations are engaged on service developments and changes. We are also working across the local health economy including engagement with ICS colleagues on the delivery of integrated care pathways.

We facilitate lay representation on a number of our key committees, including having governors on our Quality and Safety, Finance and Performance, Research and People Committees. Governors also participate in PLACE (patient-led assessments of the care environment) visits, which is a nationally recognised system for assessing the quality of the patient environment, and they usually join with an executive and non-executive director in undertaking leadership and safety walks on a regular basis.

We recognise that risk management is a two-way process between healthcare providers across the health economy. Issues raised through our internal risk management processes that impact on partner organisations are discussed in the appropriate forum so that the required action can be agreed.

The board has oversight of our workforce strategies via the People Committee, which meets on a bimonthly basis. The committee seeks assurance on our strategic workforce priorities and any key

themes, including safe staffing reports where modelling exercises have been undertaken to assess workforce staffing levels against patient acuity and requirement in comparison with national guidance such as that issued by the Royal College of Physicians. The People Committee also approves overarching strategies that fundamentally lead to safe, sustainable and effective staffing, such as our Recruitment and Retention Strategy and Apprenticeship Strategy and over the course of 2024/25 will approve and oversee the delivery of our newly developed WWL People & Culture Strategy. Through the latter, the board will continue to assess and monitor culture, where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the Trust's vision, values and strategy, it will seek assurance through the People Committee that management has taken corrective action.

WWL People & Culture Strategy, will outline how we will meet objectives around:-

- Living our shared values
- Having brilliant, compassionate and inclusive leaders
- Being intentional in our approach to inclusion
- Growing and developing our workforce
- Looking after our people

Progress in these areas will be managed via the People Committee.

The Trust continues to offer a comprehensive package of wellbeing support to its staff. This ranges from relevant self-help tools or signposting to helpful websites, right through to individualised psychological support if required. We recognise that a "one-size fits all approach" can be unhelpful for our staff and seek to ensure a diversity of offers exists, which also includes support around financial wellbeing or topic specific subjects such as the menopause. This year the Trust has been specifically exploring how it can strengthen its support to those with attention deficit disorder (ADHD) or other neuro-divergent conditions.

The board is sighted on the NHS Long Term Plan, specifically in relation to digital development and has implemented eJob Planning for medical staff. We will also consider expansions to eRostering and eJob Planning for wider workforce groups should capital resource funding be available via any bidding process. This will enable broader reporting on all staffing groups, thus providing additional assurance to the board.

To ensure adherence to the principles of safe staffing, as defined in the national guidance *Developing Workforce Safeguards*, we use evidence-based tools and data such as the Safer Nursing Care tool, Birthrate Plus, eRostering and Model Hospital. Alongside this we use professional judgment and patient outcome information such as real-time patient surveys or mortality data to ensure workforce planning is responsive to need and proactive in relation to forward planning. The implementation of the Allocate Safe Care module as part of our electronic roster system has also enhanced and transformed our ability to respond to the requirements of our patients and their daily needs, as they change.

The People Committee also oversees our wider talent management, leadership development and training initiatives designed to create resilience and capacity within the workforce.

Nurse staffing is reported to the board regularly. On a quarterly basis, the People Committee considers staffing from workforce activity reports and any associated long-term risks. The Risk Management Group reviews and oversees all corporate risks including those related to staffing.

We are fully compliant with the registration requirements of the Care Quality Commission.

Our website includes an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

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

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

We have undertaken risk assessments on the effects of climate change and severe weather and have developed a Green Plan following the guidance of the Greener NHS programme. We ensure that our obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

We have robust arrangements in place for setting financial objectives and targets. Our arrangements include ensuring the financial plan is achievable, ensuring the delivery of efficiency requirements, compliance with our provider licence and the co-ordination of financial objectives with corporate objectives as approved by the board:

- Objectives are approved and monitored through a number of channels, including regular review of the foundation trust's financial position by a dedicated Finance and Performance Committee
- Approval of annual budgets by the board
- Formal acceptance of annual budgets by delegated budget holders
- Bi-monthly reporting to the board, via its committees, on key performance indicators covering quality and safety, finance, and workforce targets
- Scrutiny of divisional performance against objectives at committees
- Regular divisional performance and assurance reviews
- Reporting to NHS England and compliance with our provider licence
- Service transformation managed by a dedicated transformation team
- In-year cost pressures are rigorously reviewed and challenged, and alternatives for avoiding cost pressures are always considered and
- A robust assessment process for business cases

We also participate in initiatives to ensure value for money, for example:

- Value for money is an important component of the internal and external audit plans that provides assurance to the board regarding processes that are in place to ensure effective use of resources
- On-going benchmarking and tenders of operations occur throughout the year to ensure the competitiveness of service

- We use numerous data sources in order to undertake comparative analysis. This analytic either provides assurances or helps identify opportunities for improvement in care provision

- Service line reporting is used by divisional managers to seek to improve financial performance

- Commissioning for Quality and Innovation schemes are negotiated and signed off by clinical, operational and finance directors and operational leads are assigned for each scheme and

- An on-line intelligence tool allowing individual budget holders to see their in-month and cumulative budget performance.

- Benefits realisation reviews are carried out for business cases at an appropriate time, post investment

We have outsourced our transactional financial processing activities to NHS Shared Business Services, for which there is a contract in place which clearly outlines the roles and responsibilities of both organisations. We regularly review key performance indicators and we meet regularly to discuss any issues or concerns.

NHS Shared Business Services has processes and procedures in place which are compliant with central government standards as outlined in the information assurance maturity model and the NHS information governance assurance framework and it provides annual updates on the testing of controls and operations within its shared business facilities in the form of an International Standard on Assurance Engagements 3402 (ISAE3402) report.

WWL are part of the Trust Provider Collaborative, which has governance processes in place as part of the operating model for the Greater Manchester ICS and we are working with this organisation, the Healthier Wigan Partnership System Board and the Integrated Delivery Board to develop a shared set of corporate objectives. Once these are finalised, delivery will be monitored in line with the governance processes set out above. As a precursor to the objectives we have agreed priorities in place which are: diabetes, discharge and flow; and children and young people.
A biannual report from our data assurance and analytics team, based on disaggregated health data according to ethnicity and deprivation, along with health inequalities focussed changes to our key performance indicators will assist us to monitor our role in reducing health inequalities, access, experience and outcomes through tackling these shared challenges with our partner organisations.

Information governance

Information governance provides the framework for handling personal and sensitive date in a secure and confidential manner. Covering the collection, storage and sharing of information, it provides assurance that personal and sensitive data is managed legally, securely, efficiently and effectively in order to deliver the best possible care and service.

Our control and assurance processes for Information Governance include:

- A network of information asset owners, covering patient and staff personal data systems

- A trained Caldicott Guardian, a trained Senior Information Risk Owner and a trained Data Protection Officer

- A risk management and incident reporting process and related risk register
- Mandatory training for all staff
- An annual confidentiality code of conduct signing
- Data protection, information security, records management and confidentiality policies
- A quarterly report to the board summarising key information governance activities and compliance with requirements (including the Data Security and Protection Toolkit, General Data Protection Regulation arrangements and incidents)

Our information governance team have reviewed 1,428 incidents between 1 April 2023 and 31 March 2024. After reviewing, we escalated 26 incidents to the Information Commissioner's Office (ICO). Of these 26 incidents, 2 remain open with the ICO, while all others have been closed.

The incidents that were reported to the ICO were related to serious breaches of confidentiality and security, whereby personal data had been shared inappropriately or there had been a contravention of data protection legislation. Examples include phishing attempts on Trust accounts, letters containing sensitive information being sent to an incorrect address and an error regarding a Trust systems retention. In the first quarter of 2023/24 the Trust saw an increase in the number of targeted phishing campaigns, with the information governance team working alongside colleagues in information management and technology and the Senior Information Risk Owner to reduce any potential impact.

In 2023/24 The Trust was awarded "Standards Met" as part of the Data Security and Protection Toolkit submission in June 2023. This submission was also audited by our internal auditors, with "Substantial Assurance" being awarded as a result.

The information governance team continue to work alongside colleagues and departments within the organisation, offering guidance and support. The team act to ensure that implementation of remedial actions address any shortfalls in controls where identified, to mitigate risk. All information incidents are reported via Datix, which aligns with regulatory requirements.

Data quality and governance

As a data-driven organisation, we recognize the critical importance of maintaining high-quality data for effective decision-making. To achieve this, we have established robust controls and procedures.

Our data analytics and assurance team create applications that identify errors and inconsistencies in our data. By doing so, they enhance transparency within the organisation, empowering service managers to implement necessary changes. These procedural adjustments address issues at their source and contribute to overall process improvement.

Timely and accurate data capture is imperative, and it is the responsibility of all staff members to ensure its integrity. We have an integrated data quality team that provides guidance on improving data quality. Regular data analysis allows the team to uncover insights that might otherwise go unnoticed by data users. The tight integration with divisional teams and analysts ensures the focus and priority is appropriate.

The Trust's Data Recording Quality Committee oversees data quality matters, ensuring resolution and reporting directly to Caldicott Committee. Representation from across the organisation ensures transparency and input from all stakeholders.

In the 2023/24 period, our Data Analytics and Assurance team introduced updated versions of the performance scorecard and specific Data Quality dashboards. For instance, these dashboards included indicators supporting hospital flow and a new dashboard for acute outpatients.

Review of effectiveness

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

Maintaining and reviewing the effectiveness of the system of internal control has been undertaken with consideration of the following:

- The board assurance framework provides evidence of the process of the effectiveness of controls that manages the principal risks to the organisation

- The Board of Directors, Audit Committee, Risk Management Group and the Executive Scrutiny Group advise me on the implications of the results of my review of the effectiveness of the system of internal control. These committees also advise outside agencies in relation to serious events

- All the relevant committees within the corporate governance structure have a timetable of meetings and a reporting structure to enable issues to be escalated

- The board monitors and reviews the board assurance framework at each meeting. Risks noted on the board assurance framework are reviewed by the Finance and Performance Committee, People Committee, Quality and Safety Committee and Research Committee as appropriate to their areas of focus and overall responsibility is retained by the Board of Directors

- The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities - both clinical and non-clinical - that supports the achievement of the organisation's objectives

- The Audit Committee has reviewed performance against the Code of Governance for NHS provider trusts, including a gap analysis against the previous NHS Foundation Trust Code of Governance, to ensure compliance in all new areas of focus

- Internal auditors review the board assurance framework and the effectiveness of the system of internal control as part of the internal audit work to assist in the review of effectiveness. The internal auditors reviewed the assurance framework and concluded that

our assurance framework meets the requirements set out in NHS guidance, is visibly used by the organisation and clearly reflects the risks discussed by the board

- Through our internal audit plan, we aim to ensure that each area of service is reviewed on a two-to-four-year basis. The plan is set annually with input from our executive team. It is in part informed by an annual risk assessment, conducted by our auditors and in part based on mandated audits which are due, as illustrated by our continuous audit cycle. Our internal auditors carried out 16 audits this year, the findings of each being reported to our Audit Committee

- 6 audits from our 2023/24 audit plan were given limited assurance, relating to the Global Training and Education Centre; escalation of deteriorating patients and sepsis; discharge planning; data quality in community services; safe medical staffing and job planning for specialty, specialist and locally employed doctors and management actions have been put in place to address the issues raised

- Of the 63 recommendations issued by the internal auditors during the year, all of which were accepted by management. 17 of the recommendations were described as high-risk recommendations and whilst the majority of these were addressed immediately, 8 were outstanding as a year end but are being followed up with revised deadlines.

The overall opinion for the period 1st April 2023 to 31st March 2024 provides substantial assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The programme delivered reflects effective use of internal audit as part of the Trust's system of internal control. The overall level of assurance is provided in the context that the organisation is risk aware and has directed internal audit into a number of risk areas. In addition, the Trust's progress in respect of addressing the control weaknesses has also been considered.

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

In providing this opinion our internal auditors confirm continued compliance with the definition of internal audit (as set out in our internal audit charter), code of ethics and professional standards. The auditors also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

The purpose of our Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. As such, it is one component that the Board takes into account in making its annual governance statement.

The opinion does not imply that the auditor has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework.

The 2023/24 internal audit plan has been delivered with the focus on the provision of our Head of Internal Audit Opinion. This position has been reported within the progress reports across the financial year. Review coverage has been focused on:

- The organisation's Assurance Framework
- Core and mandated reviews, including follow-up
- A range of individual risk-based assurance reviews

Conclusion

My review confirms that Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust has sound systems of internal control, with no significant control issues having been identified.

Mary Fleming
Chief Executive and Accounting Officer
26 June 2024

This accountability report is signed by me in my capacity as Accounting Officer.

Mary Fleming
Chief Executive and Accounting Officer
26 June 2024

INDEPENDENT AUDITOR'S REPORT.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2024 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2024 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2024 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

- Enquiring of management, the Audit Committee and internal audit as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.

- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve system control totals delegated to the Trust by NHS England.

- Reading Board and Audit Committee minutes.

- Using analytical procedures to identify any unusual or unexpected relationships.

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

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also identified a fraud risk related to expenditure recognition, particularly in relation to the completeness of year end manual accruals, in response to the setting of a system control total by NHS England that can create an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred through the omission of year end manual accruals.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries posted to unrelated accounts linked to the recognition of expenditure, revenue or cash.

- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.

- Assessing the completeness of recorded expenditure through inspecting a sample of expenditure invoices around the year end and carrying out a search for unrecorded liabilities to determine whether expenditure has been recognised in the correct accounting period.

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

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

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

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

The Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

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

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

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

Other information in the Annual Report

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

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

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

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the

Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2023/24. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2023/24.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 98, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

We have nothing to report in this respect.

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

As explained more fully in the statement set out on page 98, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2024 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Timothy Cutler

for and on behalf of KPMG LLP

Chartered Accountants

1 St Peter's Square Manchester

M2 3AE

27 June 2024

FINANCIAL REPORT.

Foreword to the accounts

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2024, have been prepared by Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed  .....

Chief Executive

Date **26 June 2024**

Statement of Comprehensive Income for the year ended 31 March 2024

	Note	2023/24 £000	2022/23 £000
Operating income from patient care activities	2	494,610	492,501
Other operating income	3	28,480	30,076
Total operating income from continuing operations		**523,089**	**522,577**
Operating expenses	4	(534,355)	(524,673)
Operating surplus/(deficit) from continuing operations		**(11,265)**	**(2,096)**
Finance costs			
Finance income	7	2,088	940
Finance expenses	8	(1,425)	(620)
PDC dividends payable		(4,855)	(4,656)
Net finance costs		**(4,192)**	**(4,336)**
Gain or (Loss) on disposal of fixed assets	9	(323)	(115)
Gains from transfers by absorption	28	0	63
(Deficit) for the year		**(15,780)**	**(6,484)**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments	11	(2,374)	(2,820)
Revaluations	12	1,987	3,035
Other reserve movements		3	0
Total comprehensive expense for the year		**(16,164)**	**(6,269)**

Statement of Financial Position as at 31 March 2024

	Note	31 March 2024 £000	31 March 2023 £000
Non-current assets			
Intangible assets	10	5,620	5,284
Property, plant and equipment	11	224,027	212,985
Right of use assets	13	33,452	32,879
Receivables	16	868	1,079
Total non-current assets		**263,967**	**252,227**
Current assets			
Inventories	15	3,332	3,693
Receivables	16	19,169	31,819
Cash and cash equivalents	18	24,945	43,098
Total current assets		**47,446**	**78,610**
Current liabilities			
Trade and other payables	19	(66,126)	(89,244)
Other liabilities	20	(8,678)	(5,723)
Borrowings	21	(7,565)	(7,441)
Provisions	22	(1,160)	(1,432)
Total current liabilities		**(83,529)**	**(103,840)**
Total assets less current liabilities		**227,884**	**226,997**
Non-current liabilities			
Other liabilities	20	(63)	(124)
Borrowings	21	(39,923)	(40,252)
Provisions	22	(2,141)	(2,656)
Total non-current liabilities		**(42,127)**	**(43,032)**
Total assets employed		**185,757**	**183,965**
Financed by			
Public dividend capital		148,576	130,620
Revaluation reserve		20,973	21,958
Income and expenditure reserve		16,208	31,387
Total taxpayers' equity		**185,757**	**183,965**

The primary financial statements on pages 125 to 128 and the notes on pages 129 to 174 were approved by the Board of Directors and authorised for issue on 26 June 2024 and signed on its behalf by Mary Fleming, Chief Executive.

Signed  ……..…… **26 June 2024**

Mary Fleming, Chief Executive

Statement of Changes in Equity for the year ended 31 March 2024

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2023	**130,620**	**21,958**	**31,387**	**183,965**
Surplus/(Deficit) for the year	0	0	(15,780)	(15,780)
Transfers between reserves	0	(601)	601	0
Impairments	0	(2,374)	0	(2,374)
Revaluations	0	1,987	0	1,987
Public dividend capital received	17,956	0	0	17,956
Other reserve movements	0	3	0	3
Taxpayers' equity at 31 March 2024	**148,576**	**20,973**	**16,208**	**185,757**

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2022	**117,458**	**22,624**	**36,990**	**177,072**
Surplus/(Deficit) for the year	0	0	(6,484)	(6,484)
Other transfers between reserves	0	(616)	616	0
Impairments	0	(2,820)	0	(2,820)
Revaluations	0	3,035	0	3,035
Transfer to retained earnings on disposal of asset	0	(265)	265	0
Public dividend capital received	13,162	0	0	13,162
Taxpayers' equity at 31 March 2023	**130,620**	**21,958**	**31,387**	**183,965**

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Foundation Trust, is payable to the Department of Health and Social Care as the public capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Foundation Trust.

Statement of Cash Flows

	Note	2023/24 £000	2022/23 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(11,265)	(2,096)
Non-cash income and expense			
Depreciation and amortisation	4	17,222	17,416
Net impairments and (reversals) of impairments	4	5,323	3,565
Income recognised in respect of capital donations (non-cash)	3	(141)	(149)
(Increase) / decrease in receivables and other assets		12,908	(18,456)
(Increase) / decrease in inventories		361	(692)
Increase / (decrease) in payables and other liabilities		(16,812)	14,842
Decrease in provisions		(834)	(2,111)
Other movement in operating cashflows		2	1
Net cash generated from operating activities		**6,763**	**12,320**
Cash flows used in investing activities			
Interest received		2,041	794
Purchase of intangible assets		(1,194)	(488)
Purchase of property, plant, equipment and investment property		(30,918)	(26,391)
Receipt of cash donation to purchase capital assets		0	58
Sales of property, plant, equipment and investment property		2	445
Net cash used in investing activities		**(30,069)**	**(25,582)**
Cash flows used in financing activities			
Public dividend capital received		17,956	13,162
Loans paid		(1,446)	(1,221)
Capital element of lease liability repayments		(4,689)	(4,535)
Interest element of lease liability repayments		(1,128)	(320)
Other interest paid		(253)	(270)
PDC dividend paid		(5,287)	(4,541)
Net cash used in financing activities		**5,153**	**2,275**
Increase in cash and cash equivalents		**(18,153)**	**(10,987)**
Cash and cash equivalents at 1 April		43,098	54,085
Cash and cash equivalents at 31 March	18	**24,945**	**43,098**

1. Accounting policies

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property.

1.2 Going concern

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

1.3 Joint arrangements

Arrangements over which the Foundation Trust has joint control with one or more parties are classified as joint arrangements. A joint arrangement is either a joint operation or a joint venture. The Foundation Trust does not have any joint ventures but does have a number of joint operations.

Joint operations are arrangements in which the Foundation Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

1.4 Critical accounting judgements and key sources of estimation uncertainty

1.4.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Foundation Trusts accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Operating segments

In line with IFRS 8 Operating Segments, the Board of Directors, as chief decision maker, has assessed that the Foundation Trust continues to report its annual accounts on the basis that it operates in the healthcare segment only. The accompanying financial statements have consequently been prepared under one single operating segment.

Interests in other entities and joint arrangements

Reporting bodies are required to assess whether they have interests in subsidiaries, associates, joint ventures or joint operations, prior to accounting for and disclosing these arrangements according to the relevant accounting standards. This assessment involves making judgements and assumptions about the nature of collaborative working arrangements, including whether or not the Foundation Trust has control over those arrangements per IFRS 10 Consolidated Financial Statements.

The Foundation Trust has assessed its existing contracts and collaborative arrangements for 2023/24, and has determined that the arrangements which would fall within the scope of IFRS 10, IFRS 11 Joint Arrangements or IFRS 12 Disclosure of Interests in Other Entities, are the NHS Foundation Trust's subsidiary charity, the NHS Foundation Trust's investment into the Community Health Investment Plan (CHIP) and three joint operations (Note 14).

Consolidation

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust is the corporate trustee to Wrightington, Wigan and Leigh Health Services Charity (also known as Three Wishes). The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

Where the fund balances held by the Charity are deemed to be of a significant value to require consolidation, then those balances will be consolidated into the Foundation Trust Accounts. There is no consolidation for 2023/24.

1.4.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Asset valuation and lives

The value and remaining useful lives of land and building assets are estimated by Cushman and Wakefield. Valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

The Foundation Trust has valued its estate using the modern equivalent asset - alternative site methodology.

A desktop valuation was undertaken during 2023/24 with a revaluation date of 31 March 2024.

Software licences are depreciated over the shorter of the term of the licence and the useful economic life.

The total net book value of intangible and tangible fixed assets as at 31 March 2024 is £227m (£218m, 2022/23).

1.5 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners under the NHS payment Scheme (NHSOS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

In 2023/24 fixed payments were set at a level assuming the achievement of elective activity targets within 'aligned payment and incentive' contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differs from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of full tariff price.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS15. Payment for CQUIN and BTP on non-elective services is included in the fixed criteria element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

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

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

NHS Injury Cost Recovery Scheme

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

1.6 Other forms of income

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Income from sale of non-current assets

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same ways as government grants.

1.7 Expenditure on employee benefits

Short-term employee benefits

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

Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

National Employment Savings Trust (NEST)

NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body (NDPB) operating at arm's length from government, and it reports to Parliament through the Secretary of State for Work and Pensions.

This alternative scheme is a defined contribution scheme, provided under the Foundation Trust's 'automatic enrolment' duties for a small number of employees who are excluded from actively contributing to the NHS pension scheme. Under a defined contribution plan, an entity pays fixed contributions to a separate entity (a fund) and has no obligation to pay further contributions if the fund does not hold sufficient assets to pay employee benefits.

The Foundation Trust is legally required to make a minimum contribution for opted-in employees who earn more than the qualifying earnings threshold, and the cost to the Foundation Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. That is, employer's pension costs of contributions are charged to operating expenditure as and when they become due.

1.8 Other expenses

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

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential be provided to the Foundation Trust;
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and
● the item has a cost of at least £5,000; or
● collectively a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

The carrying value of other existing assets will be written off over their remaining useful lives, and are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS13 Fair Value Measurement, if it does not meet the requirements of IAS40 Investment Property or IFRS5 Non-current assets held for sale.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated at the point it becomes classified as Held for Sale. Assets in the course of construction are not depreciated until the assets are brought into use. Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by a qualified valuer recognised in accordance with RICS.

Property, plant and equipment is depreciated over the following useful lives:

Buildings excluding dwellings	10 to 70 years
Dwellings	14 to 48 years
Plant and Machinery	10 to 20 years
Vehicles	10 to 13 years
Furniture and fittings	15 years
Medical and other equipment	15 years
Information Technology	8 years

Revaluation gains and losses

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenditure.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

- the impairment charged to operating expenses; and
- the balance in the revaluation reserve attributable to that asset before impairment.

An impairment arising from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that give rise to the loss are reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Assets under construction

Assets under construction are measured at cost of construction less any impairment loss, as at 31 March. Assets are reclassified to the appropriate category when they are brought into use.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as Held for Sale and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust and where the cost of the asset can be measured reliably.

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated historical cost and the value in use where the asset is income generating.

Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets re-classified as held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS13 Fair Value Measurement, if it does not meet the requirements of IAS40 Investment Property or IFRS5 Non-current assets held for sale.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Foundation Trust intends to complete the asset and sell or use it;
- the Foundation Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset; and
- the Foundation Trust can measure reliably the expenses attributable to the asset during development.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Intangible assets are amortised over the following useful lives:

Websites	8 years
Development expenditure	8 years
Software	8 years

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. All inventories are measured using the First In, First Out (FIFO) method other than drugs which are measured using the weighted average cost method.

1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Foundation Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by Office of National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and liabilities are subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable. After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Foundation Trust recognises an allowance for expected credit losses.

The Foundation Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are the probability weighted losses expected from credit loss events occurring within a defined period. Probabilities are determined based on experience and knowledge obtained through the debt collection process.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Foundation Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust is an intermediate lessor, classification of all continuing sublease arrangements has been reassessed with reference to the right of use asset.

1.15 Provisions

The Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2024:

Short term rate:	4.26% (3.27%, 2022/23)
Medium term rate:	4.03% (3.20%, 2022/23)
Long term rate:	4.72% (3.51%, 2022/23)

For post-employment benefits including early retirement provisions and injury benefit provisions the HM Treasury's pension discount rate of 2.45% in real terms (1.70%, 2022/23) is used.

1.16 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Foundation Trust pays an annual contribution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the NHS Foundation Trust is disclosed in Note 23.1 but is not recognised in the NHS Foundation Trust's accounts.

1.17 Non-clinical risk pooling

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 Contingent assets and contingent liabilities

A contingent assets is a possible asset that arises from past events and whose existence will only be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Foundation Trust. A contingent asset is disclosed in Note 24 where an inflow of economic benefits is probable.

A contingent liability is:

● a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of Foundation Trust, or

● a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed in Note 24 unless the possibility of payment is remote.

Where the time value of money is material, contingent assets and contingent liabilities are disclosed at their present value.

1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32 Financial Instruments.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at:

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.20 Value added tax

Most of the activities of the Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Corporation tax

As an NHS Foundation Trust, Wrightington, Wigan and Leigh Teaching NHS Foundation Trust is specifically exempted from corporation tax through the Corporation Tax Act 2010. The Act provides that HM Treasury may dis-apply this exemption only through an order via a statutory instrument (secondary legislation). Such an order could only apply to activities which are deemed commercial, and arguably much of the Foundation Trust's other operating income is ancillary to the provision of healthcare, rather than being commercial in nature. No such order has been approved by a resolution of the House of Commons. There is therefore no corporation tax liability in respect of the current financial year.

1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Foundation Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.24 Transfers by Absorption

Where a DHSC group body is the recipient in the transfer of a function, it recognises the assets and liabilities received as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition (i.e. the recipient and exporter of the assets and liabilities recognise the same values). The corresponding net credit / debit reflecting the gain / loss is recognised within income / expenses, but outside of operating activities.

1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 14 Regulatory Deferral Accounts: Not UK endorsed. Applies to first time adopters of IFRS after 1 April January 2016. Therefore, not applicable to DHSC group bodies.

IFRS 17 Insurance contracts: [new standard] (2024/25) – work has not yet started on understanding the full impact of this new standard in the NHS, however on the basis that the Foundation Trust does not issue insurance contracts it is unlikely that this standard will impact the Foundation Trust accounts.

IFRS 18 Presentation and Disclosure in FinancialStatements: issued in April 2024 and applies to periods beginning on or after 1 January 2027. The standard has not yet been adopted by FRAB for inclusion within the FREM and therefore it is not yet possible to confirm how this will impact on our accounts in the future.

IFRS - International Financial Reporting Standards
IFRIC – International Financial Reporting Interpretation Committee

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by source)

Income from patient care activities received from:

	2023/24 £000	2022/23 £000
NHS England*	35,454	48,482
Clinical Commissioning Groups**	0	97,954
Integrated Care Boards*	437,621	320,907
NHS Foundation Trusts	4,831	4,882
NHS Trusts	0	7
Local Authorities	6,615	12,785
NHS other (including Public Health England)	1	0
Non NHS: private patients	6,781	5,118
Non NHS: overseas patients (chargeable to patient)	98	88
NHS injury scheme (ICR)***	907	812
Non NHS: other	2,302	1,466
Total income from activities	**494,610**	**492,501**

* NHS England income includes cenral funding for national pay awards of £0.2m (£12.1m, 2022/23).

**Income from Clinical Commissioning Groups (CCGs) relates to the period April to June 2022, from 1st July 2022 CCGs were integrated into regional Integrated Care Boards.

**NHS injury scheme income is subject to a provision for doubtful debts of 23.07% (23.76%, 2022/23) to reflect expected rates of collection.

Note 2.2 Income from patient care activities (by nature)

	2023/24 £000	2022/23 £000
Acute services		
Income from commissioners under API contracts - variable element*	102,695	0
Income from commissioners under API contracts - fixed element*	305,506	374,695
High cost drugs income from commissioners (excluding pass through costs)	955	1,676
Other NHS clinical income**	6,971	16,708
Community Services		
Income from commissioners under API contracts*	48,441	44,488
Income from Other Sources (e.g. local authorities)	6,331	6,484
Additional income		
Private patient income	6,781	5,118
Elective recovery fund	0	10,234
National pay award central funding***	189	12,139
Additional pension contribution central funding ****	13,115	11,987
Other clinical income*****	3,626	8,972
Total income from activities	**494,610**	**492,501**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Other NHS clinical income includes NHS income outside the API contract for a range of services including funding to support recovery following the pandemic.

***Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year.

2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024.

2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

****The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

***** Other clinical income relates largely to income from the NHS Injury Cost Recovery Scheme (ICR) for third party injury claims.

Note 2.3 Overseas visitors

	2023/24 £000	2022/23 £000
Income recognised this year	98	88
Cash payments received in-year	40	18
Amounts added to allowance for impaired contract receivables	6	80
Amounts written off in-year	72	27

Note 3 Other operating income

	2023/24 £000	2022/23 £000
Other operating income from contracts with customers:		
Research and development (contract)	2,483	1,466
Education and training (excluding notional apprenticeship levy income)	16,273	17,369
Non-patient care services to other bodies	1,548	1,935
Reimbursement and top up funding *	0	38
Income in respect of employee benefits accounted on a gross basis**	2,141	1,529
Other contract income***	4,741	5,751
Other non-contract operating income		
Education and training - notional apprenticeship levy income	666	629
Receipt of capital grants and donations^	141	149
Charitable and other contributions to expenditure^	206	92
Contribution to expenditure - consumables donated from DHSC****	194	1,016
Rental revenue from operating leases	87	102
Total other operating income	**28,480**	**30,076**

*During 2022/23 the Foundation Trust received national Funding from NHSE and the Department of Health and Social Care to support the impact on income and expenditure of COVID. For the current year this funding was minimal and has been included within the incomce from commissioners as detailed in Note 2.2.

**Income in respect of employee benefits accounted for on a gross basis relates to recharges of staff costs for which there is a corresponding employee expense in operating expenses.

***Other contract income of £4.7m (£5.8m, 2022/23) includes car parking income, catering income, pharmacy income, staff accommodation rental and other miscellaneous income recharged to other NHS bodies.

**** During the year, the Foundation Trust received personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Foundation Trust has accounted for the receipt of these at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. A corresponding expenditure entry has been recorded in Note 4.

Note 3.1 Additional information on contract revenue recognised in the period

	2023/24 £000	2022/23 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	0	0

Note 3.2 Income from activities arising from commissioner requested services

Under the terms of its provider license, the Foundation Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2023/24 £000	2022/23 £000
Income from services designated as commissioner requested services	481,759	480,627
Income from services not designated as commissioner requested services	12,851	11,874
Total	**494,610**	**492,501**

Note 4 Operating expenses

	2023/24 £000	2022/23 £000
Purchase of healthcare from NHS and DHSC bodies	2,173	1,763
Purchase of healthcare from non-NHS and non-DHSC bodies	5,237	5,513
Employee expenses - non-executive directors	159	158
Employee expenses - staff*****	333,913	319,207
Employee expenses - temporary staff	38,744	46,955
Supplies and services - clinical*	44,605	42,085
Supplies and services - general	5,298	4,703
Drug costs (inventory consumed & non-inventory purchases)	31,659	28,851
Inventories written down	27	44
Establishment	3,617	5,270
Transport	2,909	4,499
Premises	24,915	22,951
Movement in credit loss allowance: contract receivables/contract assets	21	(111)
Change in provisions discount rate	(293)	(61)
Depreciation on property, plant and equipment, and RoU assets	16,326	16,420
Amortisation on intangible assets	896	996
Net Impairments***	5,323	3,565
Audit fees payable to the external auditor audit services - statutory audit	155	133
Internal audit and local counter fraud services ******	174	246
Clinical negligence	12,280	12,933
Legal fees	519	1,707
Insurance	483	466
Education and Training	3,428	3,655
Redundancy and other mutually agreed resignation schemes	72	18
Losses, ex gratia & special payments	118	440
Other***	1,597	2,267
Total	**534,355**	**524,673**

* During the year, the Foundation Trust received personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Foundation Trust has accounted for the receipt of these at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. The total value transacted within supplies and services - clinical is £0.2m (£1.0m. 2022/23). A corresponding Income entry has been recorded in Note 2.2.

*** Further details of net impairments can be found in Note 11.

****Other expenditure of £1.6m (£2.2m, 2022/23) includes car parking and security costs, and other miscellaneous expenditure charges.

***** Staff costs includes £0.2m in respect of the national pay award offer agreed during the year but which will not be paid until 2024/25

****** Audit fees payable to the external auditor inclusive of VAT was £155k during the year (£133k, 2022/23) and £128k (£111k, 2022/23) exclusive of VAT.

Note 4.1 Other auditor remuneration

There was no other auditor remuneration during the current or prior year.

Note 4.2 Limitation on auditor's liability

There is a £1.0m limitation on auditor's liability for external audit work carried for the financial years 2023/24 and 2022/23.

Note 4.3 Better payment practice code (BPPC)

The better payment practice code gives NHS organisations a target of paying 95% of invoices within agreed payment terms or in 30 days where there are no terms agreed.

Performance for the financial year against this target is contained in the table below.

	2023/24		2022/23	
	Number	£000	Number	£000
Non-NHS				
Trade invoices paid in the period	70,363	274,349	70,125	252,810
Trade invoices paid within target	66,061	253,096	63,447	237,974
Percentage of trade invoices paid within target	**93.9%**	**92.3%**	**90.5%**	**94.1%**
NHS				
Trade invoices paid in the period	1,842	38,499	1,853	39,655
Trade invoices paid within target	1,670	36,300	1,624	36,377
Percentage of trade invoices paid within target	**90.7%**	**94.3%**	**87.6%**	**91.7%**
Total				
Trade invoices paid in the period	72,205	312,848	71,978	292,465
Trade invoices paid within target	67,731	289,396	65,071	274,350
Percentage of trade invoices paid within target	**93.8%**	**92.5%**	**90.4%**	**93.8%**

Note 5 Employee benefits

	2023/24 Total £000	2022/23 Total £000
Salaries and wages	264,537	256,041
Social security costs	27,350	24,888
Apprenticeship levy*	1,343	1,153
Employer's contributions to NHS pensions	29,701	27,257
Employer's contributions to NHS pensions paid by NHSE on behalf of the Foundation Trust (6.3%)**	13,115	11,987
Temporary staff	38,744	46,955
Total staff costs	**374,790**	**368,281**
Costs capitalised as part of assets	1,994	2,032

*The Apprenticeship Levy requires all employers operating in the UK, with a pay bill over £3.0m each year, to invest in apprenticeships. The Foundation Trust is required to pay a levy of 0.5% of it's pay bill, less an allowance of £15,000.

**From 1 April 2019 the employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge). Since 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Total staff costs in 2023/24 are £374.8m (£368.3m, 2022/23) which is an increase of £6.5m. This includes the impact of the 2023/24 pay award. Pay expenditure has also increased due to NHSE funded deverlopments at our Leigh site, which include the Community Diagnostic Centre and Theatre 4. Other developments include the Virual Ward and expanded SDEC to support urgent care. Esclation costs have reduced compared to last year.

Temporary staff have been utilised to support ongoing escalation and deliver dedicated 1:1 care to support patients clinical needs as well as covering established vacant posts across the organisation. Temporary staffing costs amounted to £28.4m (2022/23: £32.8m) for bank staff and £9.5m (2022/23: £14.2m) for agency staffing.

A further analysis of staff costs can be found in the remuneration section of the Annual Report.

Note 5.1 Retirements due to ill-health

The Foundation Trust had 5 early retirements agreed on the grounds of ill-health during the year (7, 2022/23). The cost of these ill-health retirements, 635k (£601k, 2022/23) is borne by the NHS Business Services Authority - Pensions Division.

Note 5.2 Executive directors' and non-executive directors' remuneration and other benefits

	2023/24 £000	2022/23 £000
Salary	1,459	1,413
Employer's pension contributions	172	158
Taxable benefits	9	1
Total	**1,640**	**1,572**
Non-executive directors' remuneration *	159	158
Total	**1,799**	**1,730**
The total number of directors accruing benefits under the NHS Pension Scheme	11	11

* Non-executive directors are not members of the NHS Pension Scheme.

Further details of directors' remuneration can be found in the remuneration section of the Annual Report.

Note 5.3 Employee benefits

During the year, the Foundation Trust confirmed the policy for staff to take their full annual leave entitlement to enable themselves to look after their health and wellbeing. Therefore, this was no accrual in respect of annual leave entitlements carried forward at the Statement of Financial Position date (£2.8m, 2022/23). There were no other employee benefits during the year.

Note 6 Operating lease income

This note discloses income generated in operating lease agreements where the Foundation Trust is the lessor. There is no change to how this income is accounted for under the implemention of International Financial Reporting Standard 16 Leases (IFRS16).

Note 6.1 Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust as a lessor

	2023/24 £000	2022/23 £000
Operating lease income		
Minimum lease receipts	87	102
Total	**87**	**102**

	31 March 2024 £000	31 March 2023 £000
Future minimum lease receipts due:		
- not later than one year	87	96
- later than one year and not later than five years;	545	385
- later than five years.	0	115
Total	**632**	**596**

Note 7 Finance income

Finance income represents interest received on assets and investments in the period.

	2023/24 £000	2022/23 £000
Interest on bank accounts	2,088	940
Total	**2,088**	**940**

The interest received on bank accounts increased as a resut of the increase in the Bank of England base rate.

Note 8 Finance expenses

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2023/24 £000	2022/23 £000
Interest expense		
Loans from the Department of Health and Social Care	250	266
Interest on lease obligations	1,128	320
Total interest expense	**1,378**	**586**
Other finance costs - unwinding of discount	47	34
Total	**1,425**	**620**

The interest on lease obligations increased as a result of new lease arrangements arising from IFRS16 Right of Use Asset additions in 2022/23 and the remeasurment of existing leases with that includes annual rent increases in line with RPI, efer to Note 13.

Note 9 Gains and (losses) on disposal of assets

	2023/24 £000	2022/23 £000
Gains on disposal of assets	2	155
(Loss) on disposal of assets	(325)	(270)
Total	(323)	(115)

The gains on disposal of assets arose as a result of a profit on sales of equipment, the loss on disposal of assets arose from the disposal of various items of medical equipment and IT hardware becoming beyond economic repair, refer to Note 11.

Note 10 Intangible assets

Note 10.1 Intangible assets - 2023/24

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation/gross cost at 1 April 2023	**17,833**	**713**	**44**	**18,590**
Transfers by absorption	0	0	0	0
Additions	1,232	0	0	1,232
Disposals/derecognition	(613)	0	(8)	(621)
Gross cost at 31 March 2024	**18,452**	**713**	**36**	**19,201**
Amortisation at 1 April 2023	**12,564**	**713**	**29**	**13,306**
Provided during the year	896	0	0	896
Disposals/derecognition	(613)	0	(8)	(621)
Amortisation at 31 March 2024	**12,847**	**713**	**21**	**13,581**
Net book value at 31 March 2024	**5,605**	**0**	**15**	**5,620**
Net book value at 1 April 2023	**5,269**	**0**	**15**	**5,284**

Note 10.2 Intangible assets - 2022/23

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation/gross cost at 1 April 2022	**17,282**	**713**	**44**	**18,039**
Transfers by absorption	63	0	0	63
Additions	488	0	0	488
Valuation/gross cost at 31 March 2023	**17,833**	**713**	**44**	**18,590**
Amortisation at 1 April 2022	**11,573**	**713**	**24**	**12,310**
Provided during the year	991	0	5	996
Amortisation at 31 March 2023	**12,564**	**713**	**29**	**13,306**
Net book value at 31 March 2023	**5,269**	**0**	**15**	**5,284**
Net book value at 1 April 2022	**5,709**	**0**	**20**	**5,729**

Note 10.3 Intangible assets financing 2023/24

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Purchased	5,529	0	15	5,544
Donated	76	0	0	76
NBV total at 31 March 2024	**5,605**	**0**	**15**	**5,620**

Note 10.4 Intangible assets financing 2022/23

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Purchased	5,220	0	15	5,235
Donated	49	0	0	49
NBV total at 31 March 2023	**5,269**	**0**	**15**	**5,284**

Note 11 Property, plant and equipment

Note 11.1 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023	**9,647**	**147,146**	**8,763**	**507**	**66,547**	**222**	**47,292**	**546**	**280,670**
Additions	0	19,745	0	2,706	3,373	0	2,217	0	28,041
Impairments	0	(13,642)	0	0	0	0	0	0	(13,642)
Reversals of impairments	0	2,516	0	0	0	0	0	0	2,516
Revaluations	1,125	(171)	166	0	0	0	0	0	1,120
Reclassifications	0	190	(1)	(144)	(12)	0	1	(1)	33
Disposals/derecognition	0	0	0	0	(1,859)	0	(780)	0	(2,639)
Valuation/gross cost at 31 March 2024	**10,772**	**155,784**	**8,928**	**3,069**	**68,049**	**222**	**48,730**	**545**	**296,099**
Accumulated depreciation at 1 April 2023	**0**	**3,886**	**7**	**0**	**35,515**	**189**	**27,745**	**343**	**67,685**
Provided during the year	0	4,818	189	0	3,028	9	2,895	26	10,965
Impairments	0	(2,712)	0	0	0	0	0	0	(2,712)
Reversals of impairments	0	(717)	0	0	0	0	0	0	(717)
Revaluations	0	(778)	(89)	0	0	0	0	0	(867)
Reclassifications	0	33	(1)	0	1	0	2	(2)	33
Disposals/derecognition	0	0	0	0	(1,768)	0	(547)	0	(2,315)
Accumulated depreciation at 31 March 2024	**0**	**4,530**	**106**	**0**	**36,776**	**198**	**30,095**	**367**	**72,072**
Net book value at 31 March 2024	**10,772**	**151,254**	**8,822**	**3,069**	**31,273**	**24**	**18,635**	**178**	**224,027**
Net book value at 1 April 2023	**9,647**	**143,260**	**8,756**	**507**	**31,032**	**33**	**19,547**	**203**	**212,985**

Note 11.2 Property, plant and equipment - 2022/23

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2022	**9,200**	**147,340**	**1,973**	**7,244**	**56,499**	**223**	**43,571**	**529**	**266,579**
Additions	0	7,836	0	189	10,473	0	6,091	17	24,606
Impairments	0	(13,346)	0	0	0	0	0	0	(13,346)
Reversals of impairments	0	4,018	0	0	0	0	0	0	4,018
Revaluations	510	1,252	115	0	0	0	0	0	1,877
Reclassifications	0	46	6,902	(6,926)	(29)	(1)	0	0	(8)
Disposals/derecognition	(63)	0	(227)	0	(396)	0	(2,370)	0	(3,056)
Valuation/gross cost at 31 March 2023	**9,647**	**147,146**	**8,763**	**507**	**66,547**	**222**	**47,292**	**546**	**280,670**
Accumulated depreciation at 1 April 2022	**0**	**3,029**	**24**	**0**	**33,498**	**180**	**25,883**	**318**	**62,932**
Provided during the year	0	4,831	88	0	2,339	10	4,065	25	11,358
Impairments	0	(2,943)	0	0	0	0	0	0	(2,943)
Revaluations	0	(1,071)	(87)	0	0	0	0	0	(1,158)
Reclassifications	0	40	(18)	0	(29)	(1)	0	0	(8)
Disposals/derecognition	0	0	0	0	(293)	0	(2,203)	0	(2,496)
Accumulated depreciation at 31 March 2023	**0**	**3,886**	**7**	**0**	**35,515**	**189**	**27,745**	**343**	**67,685**
Net book value at 31 March 2023	**9,647**	**143,260**	**8,756**	**507**	**31,032**	**33**	**19,547**	**203**	**212,985**
Net book value at 1 April 2022	**9,200**	**144,311**	**1,949**	**7,244**	**23,001**	**43**	**17,688**	**211**	**203,647**

Note 11.3 Property, plant and equipment financing - 2023/24

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned	10,772	151,254	6,973	3,069	30,078	24	18,630	155	220,955
Donated	0	0	1,849	0	1,195	0	5	23	3,072
NBV total at 31 March 2024	**10,772**	**151,254**	**8,822**	**3,069**	**31,273**	**24**	**18,635**	**178**	**224,027**

Note 11.4 Property, plant and equipment financing - 2022/23

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned	9,647	141,354	8,756	507	29,812	33	19,538	178	209,825
Donated	0	1,906	0	0	1,220	0	9	25	3,160
NBV total at 31 March 2023	**9,647**	**143,260**	**8,756**	**507**	**31,032**	**33**	**19,547**	**203**	**212,985**

Note 11.5 Impairment of assets

	2023/24 £000	2022/23 £000
Net impairments charged to operating (deficit) / surplus resulting from:		
Other	0	4,103
Changes in market price	5,323	(538)
Impairments charged to operating (deficit) / surplus	5,323	3,565
Impairments charged to the revaluation reserve	2,374	2,820
Total net impairments	**7,697**	**6,385**

Note 12 Revaluations of property, plant and equipment

The value and remaining useful lives of land and building assets are estimated by Cushman and Wakefield. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

A desk top valuation was undertaken during 2023/24 with a revaluation date of 31 March 2024.

As a result of this valuation some land and buildings have seen an increase in value totalling £3.1m.

In addition, some land and buildings have decreased in value totalling £11.3m. £9.0m has been charged to operating expenditure offset by the reversal of previous impairments totalling £1.5m to give a net reduction on expenditure of £7.5m.

The net effect of these changes in value amounts to an overall decrease in land and buildings of £8.2m.

Assets revalued have been written down to their recoverable amount within the Statement of Financial Position, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for that asset and, thereafter, to expenditure - impairment of property plant and equipment. Increases in value have been credited to the revaluation reserve unless circumstances arose whereby a reversal of an impairment was necessary. In these circumstances this has been netted off against impairments in expenditure.

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.

Note 13 Leases - The Foundation Trust as a lessee

Note 13.1 Right of use assets - 2023/24

The implementation of IFRS16 has identified right of use assets for buildings and plant and machinery. Contracts for the use of these assets are at market value. In accordance with the GAM the Trust has applied the cost model as a proxy for the measurement of the current value in existing use.

	Buildings excluding dwellings	Plant & machinery	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**36,223**	**1,718**	**37,941**
IFRS 16 implementation - adjustments for existing operating leases	0	0	0
Additions	1,640	3,599	5,239
Re-measurements of the lease liability	695	0	695
Valuation/gross cost at 31 March 2024	**38,558**	**5,317**	**43,875**
Accumulated depreciation brought forward	4,619	443	5,062
Depreciation provided during the year	4,902	459	5,361
Accumulated depreciation at 31 March 2024	**9,521**	**902**	**10,423**
Net book value at 31 March 2024	**29,037**	**4,415**	**33,452**

Note 13.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the Statement of Financial position. A breakdown of borrowings is disclosed in Note 21.

	2023/24	2022/23
	£000	£000
Carrying value at 1 April 2023	**33,406**	**-**
IFRS 16 implementation - adjustments for existing operating leases	-	33,057
Lease additions	5,239	2,056
Lease liability remeasurements	695	2,828
Interest charge arising in year	1,128	320
Lease payments (cash outflows)	(5,817)	(4,855)
Carrying value at 31 March 2024	**34,651**	**33,406**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure, disclosed in Note 4.

Cash outflows in respect of leases recognised on the Statement of Financial Position are disclosed in the reconciliation above.

Note 13.3 Maturity analysis of future lease payments at 31 March 2024

	Total 31 March 2024 £000	Total 31 March 2023 £000
Undiscounted future lease payments payable in:		
- not later than one year;	6,146	5,953
- later than one year and not later than five years;	22,564	17,304
- later than five years.	10,329	11,432
Total gross future lease payments	**39,039**	**34,689**
Finance charges allocated to future periods	(4,388)	(1,282)
Net lease liabilities at 31 March 2024	**34,651**	**33,407**
Of which:		
- Current	6,146	5,923
- Non-Current	28,505	27,484

Note 13.4 Leases - other information

The Foundation Trust leases various premises, to accommodate community services and administrative functions at market rates for periods up to 25 years.

Leased equipment comprises complex medical equipment used in the delivery of healthcare.

Note 14 Disclosure of interests in other entities

In addition to its subsidiary charity, the Foundation Trust has interests in a number of joint operations. Joint operations are arrangements in which the Foundation Trust has joint control with one or more other parties and has the rights to assets, and obligations for liabilities relating to the arrangement. The Foundation Trust therefore includes within its financial statements its share of the assets, liabilities, income and expenses relating to its joint operations.

The Foundation Trust does not attribute levels of risk significantly above 'business as usual' with these arrangements, as the operators are all partner NHS bodies and local authority organisations, working together within the same healthcare and community operating environment. In practical terms, this translates to longstanding related party relationships based in contracts and transactions, collaborative working, shared objectives and common policies.

The Foundation Trust's joint operations are detailed below.

Pathology at Wigan & Salford (PAWS)

The Foundation Trust works collaboratively with Salford Royal NHS Foundation Trust to provide pathology services to both Trusts. The intention of the arrangement is to reduce running costs through centralisation and provide resilience in each trust's pathology services. The majority of activity is carried out at a Salford site, with an essential services laboratory remaining at the Wigan site.

The Foundation Trust retains the rights to assets contributed at the start of the arrangement, and new equipment is split between both trusts when purchased. As the 'host' partner, Salford Royal NHS Foundation Trust retains the obligation to pay suppliers' invoices, recharging Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust for its share of PAWS-related expenditure (£11.7m in year and £10.6m, 2022/23).

Sterile Services Decontamination Unit (SSDU)

In this joint working arrangement with Salford Royal NHS Foundation Trust, both Foundation Trusts receive sterile services, which chiefly involves the decontamination of surgical instruments. The arrangement is similar to PAWS in that the Foundation Trusts intend to reduce running costs through centralisation, provide resilience in each organisation's sterile services, and create income through selling services to other providers in the local health economy. The majority of activity is carried out at a site in Bolton with a small service retained at the Leigh site.

The Foundation Trust retains the rights to assets contributed to the arrangement. As the 'host' partner, Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust retains the obligation to pay the majority of suppliers' invoices, recharging Salford Royal NHS Foundation Trust, for its share of SSDU-related expenditure (£2.7m in year and £2.6m, 2022/23).

Well Being Partners

This arrangement is jointly operated by Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (the 'host' operator) and Lancashire Teaching Hospitals NHS Foundation Trust. The collaboration is designed to provide resilience to each of the operators' occupational health services and to create income through selling services to other bodies. The activity is carried out at both Foundation Trusts' sites with additional outreach clinics. The Foundation Trust's share of expenditure for the year was £0.7m (£0.3m, 2022/23).

Community Health Investment Plan (CHIP)

The Foundation Trust has previously invested £20.0m into CHIP, a joint initiative with Wigan Borough Council to fund the construction of community facilities which will help to stem demand into the hospital and improve the overall health and wellbeing of the population of the Wigan borough.

Note 15 Inventories

	31 March 2024 £000	31 March 2023 £000
Drugs	1,458	1,512
Consumables	1,690	2,017
Energy	139	136
Other	45	28
Total inventories	**3,332**	**3,693**

Inventories recognised in expenses for the year were £35m (£29m, 2022/23).

Note 16 Trade and other receivables

Note 16.1 Trade and other receivables

	31 March 2024 £000	31 March 2023 £000
Current		
Contract receivables invoiced/non-invoiced*	13,345	24,280
Allowance for impaired contract receivables	(1,524)	(1,601)
Prepayments (non-PFI)	4,141	3,926
Interest receivable	221	174
VAT receivable	2,172	2,047
Other receivables	814	2,993
Total current trade and other receivables	**19,169**	**31,819**
Non-current		
Allowance for impaired contract receivables	(68)	(67)
Other receivables	936	1,146
Total non-current trade and other receivables	**868**	**1,079**
Of which receivables from NHS and DHSC group bodies:		
Current	6,718	18,404
Non-Current	661	841

*Contract receivables includes £0.2m central funding for the national pay award (£12.1m, 2022/23).

Note 16.2 Allowances for credit losses - 2023/24

	Contract receivables and contract assets £000
Allowances as at 1 April 2023 - brought forward	1,668
New allowances arising	550
Reversals of allowances	(529)
Utilisation of allowances (write offs)	(97)
Allowances as at 31 March 2024	**1,592**

Note 16.3 Allowances for credit losses - 2022/23

	Contract receivables and contract assets £000
Allowances as at 1 April 2022 - brought forward	1,823
New allowances arising	150
Reversals of allowances	(261)
Utilisation of allowances (write offs)	(44)
Allowances as at 31 March 2023	**1,668**

Note 17 Assets held for Sale

The Trust did not hold any assets for sale at the end of the financial year.

Note 18 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2023/24 £000
At 31 March 2023	**43,098**
Net change in year	(18,153)
At 31 March 2024	**24,945**
Broken down into	
Cash in hand	6
Cash with the Government Banking Service	24,939
Total cash and cash equivalents	**24,945**

Note 18.1 Third party assets held by the NHS foundation trust

During the year the Foundation Trust held cash relating to monies held on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts. The Foundation Trust also holds in the normal course of business consignment inventories which comprise orthopaedic prosthesis. These are held on Foundation Trust premises and still owned by the supplier. The Foundation Trust is only obliged to pay for these assets when they are used.

	31 March 2024 £000	31 March 2023 £000
Monies held on behalf of patients	2	7
Consignment inventories	8,619	8,436
Total third party assets	**8,621**	**8,443**

Note 19 Trade and other payables

	31 March 2024 £000	31 March 2023 £000
Current		
Trade payables	15,407	18,628
Capital payables	8,633	11,613
Accruals*	28,377	45,754
Receipts in advance	506	196
Social security costs	3,464	3,322
Other taxes payable	3,010	2,674
PDC dividend payable	124	556
Pension contributions payable	4,078	3,817
Other payables	2,527	2,684
Total current trade and other payables	**66,126**	**89,244**
Of which payables to NHS and DHSC group bodies:		
Current	4,496	3,412

* Accruals includes payments for backdated national pay awards £0.2m (£12.1m, 2022/23). 2022/23 also included £2.8m in relation to untaken annual leave entitlements.

Note 20 Other liabilities

	31 March 2024 £000	31 March 2023 £000
Current		
Deferred income : contract liabilities	8,678	5,723
Total other current liabilities	**8,678**	**5,723**
Non-current		
Deferred income : contract liabilities	63	124
Total other non-current liabilities	**63**	**124**

Note 21 Borrowings

	31 March 2024 £000	31 March 2023 £000
Current		
Loans from the Department of Health and Social Care	838	841
Other loans*	581	677
Lease liabilities	6,146	5,923
Total current borrowings	**7,565**	**7,441**
Non-current		
Loans from the Department of Health and Social Care	9,964	10,733
Other loans*	1,454	2,035
Lease liabilities	28,505	27,484
Total non-current borrowings	**39,923**	**40,252**

*Other loans relate to public sector energy efficiency loans with Salix Finance Limited. These loans are interest-free and have financed a number of energy-saving schemes throughout the Foundation Trust. Repayments are phased to match the projected savings from the schemes. Details of the loans from the Department of Health and Social Care are detailed in Note 26.

Note 22 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Lease Liability £000	Total £000
Carrying value at 31 March 2023	**11,574**	**2,712**	**33,406**	**47,692**
Cash movements:				
Financing cash flows - payments and receipts of principal	(769)	(677)	(4,689)	**(6,135)**
Financing cash flows - payments of interest	(253)	0	(1,128)	**(1,381)**
Non-cash movements:				
Impact of implementing IFRS 16 on 1 April 2022	0	0	0	**0**
Additions	0	0	5,239	**5,239**
Lease liability remeasurements	0	0	695	**695**
Application of effective interest rate	250	0	1,128	**1,378**
Carrying value at 31 March 2024	**10,802**	**2,035**	**34,651**	**47,488**

Note 23 Provisions

	Total £000	Other legal claims £000	Pensions: injury benefits £000	Other £000
At 1 April 2023	4,088	340	1,937	1,811
Change in the discount rate	(435)	0	(293)	(142)
Arising during the year	447	323	87	37
Utilised during the year	(494)	(91)	(134)	(269)
Reversed unused	(395)	(315)	0	(80)
Unwinding of discount	90	0	47	43
At 31 March 2024	**3,301**	**257**	**1,644**	**1,400**
Expected timing of cash flows:				
- not later than one year;	1,160	257	164	739
- later than one year and not later than five years;	2,141	0	1,480	661
- later than five years.	0	0	0	0
Total	**3,301**	**257**	**1,644**	**1,400**

The amounts provided for employer's/public liability claims disclosed within other legal claims, are based on actuarial assessments received from NHS Resolution (NHSR) as to their value and anticipated payment date.

Other provisions relate to clinicians pension tax reimbursement claims and dilapidation costs. Dilapidation costs are costs attributable to putting lease property back to its original pre-let state.

Note 23.1 Clinical negligence liabilities

At 31 March 2024, £138m was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (£168m, 31 March 2023).

Note 24 Contingent assets and liabilities

	31 March 2024 £000	31 March 2023 £000
Amounts recoverable against liabilities	(61)	(193)
Net value of contingent liabilities	(61)	(193)

Amounts recoverable against liabilities relates to amounts paid by the Foundation Trust for employers and public liability claims managed through NHS Resolution. These amounts relate to overpayments made against claims.

The Trust has no contingent assets.

Note 25 Contractual capital and lease commitments

	31 March 2024	31 March 2023
	£000	£000
Property, plant and equipment	7,902	13,595
Leases	0	2,173
Total	**7,902**	**15,768**

Contractual capital commitments mainly relate to committed expenditure in respect of the Foundation Trust's development of Theatre 11, Endoscopy Unit and work committed for site improvements.

Note 26 Financial Instruments

Note 26.1 Financial risk management

Liquidity risk

The Foundation Trust's net operating costs are incurred under annual service level agreements/contracts with and Integrated Care Boards (ICBs) which are financed from resources voted annually by Parliament. The Foundation Trust received income from its commissioners via API Contracts. Monthly payments were received from the ICB and NHS England based on these funding arrangements and this reduced liquidity risk.

The Foundation Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form. Liquidity is monitored by the Board on a monthly basis through the calculation of the Use of Resources Metric as required by NHS Improvement and by the review of cash flow forecasts for the year.

The Foundation Trust has one loan financed by the Independent Trust Financing Facility. This loan of £16.5m is repayable over 25 years at 2.24% fixed interest rate. Repayments on the loan commenced in December 2016. Repayments are built into the Foundation Trust's cash flow plans for the year and there is no risk that a number of significant borrowings could become repayable at one time and cause unplanned cash pressures.

The Foundation Trust has a number of energy efficiency loans with Salix Finance Limited. These loans are interest-free and have been invested in energy-efficiency saving schemes. The savings from these schemes are matched to loan repayments and there is therefore no risk that these borrowings will cause unplanned cash pressures.

The loan repayment schedule is contained within the maturity of financial liabilities table Note 26.4.

Interest rate risk

All of the Foundation Trust's financial assets and financial liabilities carry nil or fixed rates of interest other than the Foundation Trust's bank accounts which earn interest at a floating rate. The Foundation Trust is not exposed to significant interest rate risk.

Credit risk

The main source of income for the Foundation Trust is from CCGs and ICBs in respect of healthcare services provided under agreements. The credit risk associated with such customers is very low.

Cash required for day to day operational purposes is held within the Foundation Trust's Government Banking Services (GBS) account. This service has minimal credit risk as balances are regularly swept into and held by the Bank of England.

The Foundation Trust regularly reviews debtor balances, and has a comprehensive system in place for pursuing past due debt. Non-NHS customers represent a small proportion of income, and the Foundation Trust is not exposed to significant credit risk in this regard.

The carrying amount of financial assets represents the maximum credit exposure. Therefore, the maximum exposure to credit risk at the Statement of Financial Position date was £12m (£25m, 2022/23) being the total of the carrying amount of financial assets excluding cash.

There are no amounts held as collateral against these balances.

Currency risk

The Foundation Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Foundation Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

Note 26.2 Carrying value of financial assets	**31 March 2023**	**31 March 2022**
	Held at amortised cost	**Held at amortised cost**
	£000	**£000**
Carrying values of financial assets as at 1st April		
Trade and other receivables excluding non financial assets	11,825	25,493
Cash and cash equivalents at bank and in hand	24,945	43,098
Carrying values of financial assets as at 31st March	**36,770**	**68,591**

Note 26.3 Carrying value of financial liabilities

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2024	
Loans from the Department of Health and Social Care	10,802
Other borrowings	2,035
Obligations under leases	34,651
Trade and other payables excluding non financial liabilities	55,450
IAS37 provisions which are financial liabilities	3,301
Total at 31 March 2024	**106,239**

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2023	
Loans from the Department of Health and Social Care	11,574
Other borrowings	2,712
Obligations under leases	33,407
Trade and other payables excluding non financial liabilities	74,420
IAS37 provisions which are financial liabilities	4,088
Total at 31 March 2023	**126,201**

Note 26.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2024 £000	31 March 2023 £000
In one year or less	64,343	83,198
In more than one year but not more than five years	29,347	24,128
In more than five years	18,251	22,078
Total	**111,941**	**129,404**

Note 27 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise.

The Foundation Trust incurred the following losses and special payments during the financial year.

	2023/24		2022/23	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	102	96	62	44
Stores losses and damage to property	12	116	12	53
Total losses	**114**	**212**	**74**	**97**
Ex-gratia payments	55	103	86	523
Total special payments	**55**	**103**	**86**	**523**
Total losses and special payments	**169**	**315**	**160**	**620**
Compensation payments received	1	17	1	365

Note 28 Transfers by absorption

There were no transfers by absorption during the year.

Note 29 Related party transactions

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. NHS Improvement (NHSI), does not prepare group accounts; instead, NHSI prepares NHS Foundation Trust Consolidated Accounts, for further consolidation into the Whole of Government Accounts. NHSI has powers to control NHS Foundation Trusts, but its results are not incorporated within the consolidated accounts, and it cannot be considered to be the parent undertaking for Foundation Trusts. Although there are a number of consolidation steps between the Foundation Trust's accounts and Whole of Government Accounts, the Foundation Trust's ultimate parent is HM Government.

Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they fall under the common control of HM Government and Parliament. The Foundation Trust's related parties therefore include Department of Health and Social Care as the parent company, other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies, non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Foundation Trust has had a number of transactions with WGA bodies. Where the total transactions with a given counterparty are collectively significant, they are listed below. The Foundation Trust's related parties therefore include other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Foundation Trust has had a number of transactions with WGA bodies. Listed below are those entities for which the total transactions or total balances with the Foundation Trust have been collectively significant or potentially material to the other body.

NHS Greater Manchester Integrated Care Board	NHS England
HM Revenue and Customs	NHS Resolution
Wigan Metropolitan Borough Council	NHS Business Services Authority

Public dividend capital (PDC) transactions with the Department of Health and Social Care

The Foundation Trust made PDC dividend payments to the Department of Health totalling £5.3m (£4.5m, 2022/23), and is reporting a year-end PDC payable totalling £0.1m (£0.5m PDC payable, 2022/23).

Provision for impairment of receivables - related parties

No related party debts have been written off by the Foundation Trust during the year.

Charitable related parties

Wrightington, Wigan and Leigh Health Services Charity (charitable fund with registered charity number 1048659) is a subsidiary of the Foundation Trust and therefore a related party. The Foundation Trust is the Charity's Corporate Trustee which means that the Foundation Trust's Board of Directors is charged with the governance of the Charity. The Charity's sole activity is the funding of charitable capital and revenue items for the benefit of our patients and staff.

The Charity's balance as at 31 March 2024 was £1,216k (£1,204k, 2022/23) with net incoming resources before transfers of £27k (£105k, 2022/23).

During the year the Charity incurred expenditure of £141k (£200k, 2022/23) in respect of goods and services for which the Foundation Trust was the beneficiary.

Other related parties

The Foundation Trust has interests in 4 joint operations with related parties as disclosed in Note 14 and has a related party relationship with NHS Shared Business Service.

Key management personnel

During the financial year under review, no member of either the Board or senior management team, and no other party closely related to these individuals, has undertaken any material transactions with Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.

One Executive Director is related to a Board Member of Manchester University NHS Foundation Trust. The Foundation Trust has entered into a number of transactions with the organisation which are considered to be "at arms length".

One Non Executive Director is the Chair of the Countess of Chester Hospital NHS Foundation Trust. The Foundation Trust has entered into a number of transactions with this organisation which are considered to be at "arms length".

Key management personnel are identified as Executive Directors and Non-Executive Directors of the Foundation Trust. Details of their remuneration and other benefits can be found in Note 5.2 and the remuneration section of the Annual Report.

Further information

If you have any queries regarding this report, or wish to make contact with any of the directors or governors, please contact Paul Howard, Director of Corporate Affairs and Company Secretary, using the contact details below:

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