NHS

Wrightington, Wigan and Leigh Teaching Hospitals

NHS Foundation Trust

Annual Report and **Accounts 2022/23**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

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

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Opening remarks from the Chair

I am delighted to be able to present my second annual report as the Chair of Wrightington, Wigan and Leigh Teaching Hospitals NHS FT (WWL).

WWL is a remarkable trust, with staff who are truly committed to providing outstanding patient care. Despite our relatively small size, we serve a borough with the second highest population in Greater Manchester, with a unique demographic of patients amongst which health deprivation is heavily concentrated when compared with those of other trusts across Greater Manchester. As a result, we face our own set of challenges, which we work with partners across the borough to tackle.

The Health and Care Act 2022 which came into force on 1 July 2022 led to the establishment of integrated care systems (ICSs) across England. In our own locality WWL, Wigan Council and wider system partners across Greater Manchester have been formally brought together to operate as part of an integrated care partnership (ICP). A key component of the new legislation is place-based leadership, which is based on collaboration between organisations which are responsible for arranging and delivering health and care services locally. In Wigan, our place-based arrangements are chaired by the Chief Executive of Wigan Council, now known as our Place Based Lead for Health and Care Integration.

This year the NHS has seen a national focus on reducing the backlog in the provision of elective care and reducing the number of patients waiting over 104 weeks from referral until treatment. I am pleased to report that we were able to treat all patients waiting 104 and 78 weeks by 31st March 2023, in line with national targets and we saw a decrease in the total number of patients waiting over 52 weeks. In terms of cancer performance, March 2023 saw our highest level of performance all year and we were able to treat 79.4% of diagnosed patients within 62 days, against the 85% target. In addition, we remained the top performing trust across the Greater Manchester Integrated Care Partnership for performance against the Accident and Emergency Department's 4-hour standard.

However, it is the national increase in the number of patients residing in hospital beds which has, and continues to be, the greatest hurdle for WWL to overcome. Many of these patients no longer require hospital care but do need additional support to be able to leave the hospital. We are working closely with our Place Based Lead on the 'System Discharge and Flow' programme, which with primary care, social care, the voluntary sector, mental health and therapy services teams, can support patient care outside of the hospital. In the longer term, this will, alongside other measures, facilitate broader health improvement, admission avoidance and address health inequalities.

Internal innovation will also be key to improving discharge and flow. WWL is one of the country's pioneering trusts, in making a Virtual Ward available to our out of hospital patients. This is a direct access pathway, delivering hospital level healthcare closer to home (or at home), monitored through digital technology and supported by our clinicians. It helps patients to avoid admission and creates additional beds space for patients who do need hospital care.

I am passionate about research and am always pleased to see how keen our board is to support research and innovation. We continue to progress towards our ambition of becoming a university hospital in partnership with Edge Hill University. WWL has made significant progress this year with raising the profile of research across the organisation and encouraging our colleagues to get involved in research projects. March 2023 saw the official opening of our Clinical Research Hub, which will be home to our research management team and provide space for clinical colleagues, working both within WWL and within partner organisations across the community, to carry out consultations, sample processing and trial associated medicine dispensation.

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. Acting on the recommendations of last year's external review, this year we have worked to successfully improve our board's model of assurance. Our committee chairs now provide written summaries to our board which highlight areas of assurance and risk and alert it to any potential concerns. Agendas and attendance at our meetings have been streamlined, to ensure issues are considered through a strategic lens and that the challenge brought is robust. We have also provided training for those who write assurance reports for the board and its committees to refine their ability in being able to maintain an assurance focus. I am privileged to lead a group of such talented individuals and a board which is continually evolving and improving. Thank you for all that you do as leaders of our organisation.

The WWL Board is also supported and held to account by our Council of Governors and we are fortunate to have a highly engaged, informed and committed Council. In addition to their work inside the Trust, we are introducing an externally focussed programme, bringing groups such as the Wigan Borough Engagement Group and voluntary organisations, via Wigan Council, to some of our meetings.

My final words of thanks must be offered to our staff. This has been one of the most difficult years that the NHS has ever had to face and I know that no matter whether you are a colleague working on the front line or in one of the many internal services that keep this Trust in operation, at some point this year everyone has felt that strain. And so I want to thank each one of you individually for your hard work, your dedication and for continuing to be a member of our WWL family.

Mark Jones
Chair

19 June 2023

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 his perspective on our performance during the financial year 2022/23 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 medium-sized 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. NHS England has also judged our use of resources to be “Good”.

We serve a local population of 329,800 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. We are celebrating out 150th birthday this summer, with MP Lisa Nandy joining us on site for the unveiling of a commemorative mural, feature 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. This year our Wrightington site is celebrating its 90th birthday.

Leigh Infirmary is an outpatient, diagnostic and treatment centre in the south of the borough. 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

As always there is much to be proud of at WWL this year. During the year we have come together – in WWL, in Greater Manchester and across the nation as a whole to deal with the challenges faced in recovering from the effects of the global COVID-19 pandemic. Key challenges have included the need to reduce the backlog in the provision of elective care as well as the number of people on our waiting lists.

Whilst access time 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 78 (rather than 18) week referral-to-treatment pathway, which WWL did achieve. We also maintained achievement of the two-week wait target for cancer referrals, despite these referrals increasing by circa 135%, compared to pre COVID-19 levels.

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 numbers 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 resulting 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 are now taking steps to tackle this issue and have begun working collaboratively with local partners on projects which aim to reduce 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.

We have seen several periods of industrial action this year, which have 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.

Last year's metrics around access to services and quality are not directly comparable with this year's because of the unprecedented circumstances created by the global COVID-19 pandemic 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**	▪ **68.62%** performance against the Accident and Emergency four-hour wait target (target 95%; 2021/22: 76.53%) ▪ **93.71%** performance against two-week wait from referral to date first seen for all urgent cancer referrals (target 93%; 2021/22: 94.27) ▪ **57.96%** performance against the 18-week referral-to-treatment pathway (target 92%; 2021/22 61.01%) ▪ **78.01%** performance against 6-week diagnostic standard (target 99%; 2021/22: 78.62%)

Quality headlines	▪ **0** MRSA bacteraemia during the year (target 0; 2021/22: 1) ▪ **70** *C. difficile* infections against a target of 53, with **16** attributable to lapses in care (2021/22: 53 with 15 attributable to lapses in care) ▪ **4** never events against a target of 0 (2021/22: 2) ▪ Summary Hospital-level Mortality Indicator (SHMI) is **114.09** for rolling 12 months to January 2023 (average is 100) (Rolling 12 months to January 2022: 110.2)

As you will see from the staff report which begins on page 67, 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.

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 2022/23 and those identified for 2023/24, please see the Annual Governance Statement which begins on page 91.

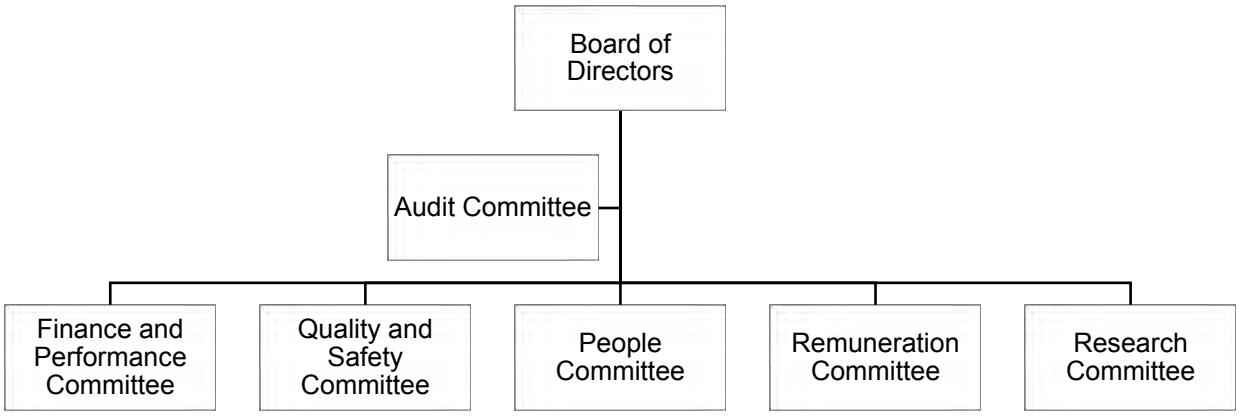
Silas Nicholls
Chief Executive and Accounting Officer

19 June 2023

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 43 to 46.

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. A new committee this year, 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 82.

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 6,882 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 163.

Summary of our operational activity

The table below summarises our activity during 2022/23, and the figures for 2021/22 are provided for comparison:

		2022/23	2021/22
Referrals	GP	84,593	77,341
	Other	94,924	94,094
	Total	**179,517**	**171,455**
In-patient activity	Elective/planned	6,808	6,121
	Day cases	34,142	30,541
	Non-elective	37,523	39,094
	Total	**78,473**	**75,756**
Outpatient activity	New appointments (attendances)	134,774	131,089
	Follow-up appointments (attendances)	320,127	333,011
	Total	454,901	464,100
Accident and emergency	**Total**	**101,431**	**110,649**
Walk-in centre	**Total attendances**	**51,313**	**46,317**

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 67 and within the annual governance statement which commences on page 91.

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

Equality of service delivery to different groups

The core commitment of the NHS is to provide fair, accessible services for all. Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust is committed to actively recognising and promoting equality, diversity and inclusion (EDI) within our community. We believe that people who use our services, their carers and our staff should be treated with respect and dignity. 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 to foster good relations.

We recognise that people access services in a range of different ways and may encounter different barriers in doing so. Our aim is to effectively engage with our local communities and organisations representing protected groups to understand their diverse needs and then to provide services which meet these local needs.

We have continued to enhance patient experience by engaging and involving patients and their families. During 2022/23, WWL sourced and implemented transparent face masks to help improve communication and a focus group was established to involve patients living with disabilities in the design and implementation of our new website. The EDI patient services team continued to support the patient-led assessment of the care environment (PLACE) National Estate and Facilities Programme and have successfully obtained funding to extend our AccessAble contract for a further 5 years, sustaining provision of our on-line hospital accessibility checker. We continue 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. EIAs are now included as a requirement to achievement of our ASPIRE Ward Accreditation Scheme, at all levels.

During 2022, WWL was instrumental in the implementation of a Greater Manchester wide interpretation and translation service across all 10 boroughs, which will provide consistency of service, care and treatment for our patients. Patients have access to telephone and face-to-face interpreters and written information can be translated into other languages and formats on request. In March 2023, an on-demand British Sign Language (BSL) video remote service was 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.

An updated version of the Equality Delivery System (EDS) was commissioned by NHS England in February 2020 (now called EDS2022) to incorporate feedback and take into consideration the new NHS infrastructure and the effects of COVID-19. NHS organisations were asked to test out the EDS2022 from April 2022 until the test period ended in February 2023 and all NHS organisations are expected to implement this revised tool from April 2023.

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, 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. During 2022/23, WWL implemented as many aspects of EDS2022 as possible, to prepare for full implementation in 2023/24. Overall, this will help us to become a more inclusive and diverse organisation, from both a patient and staff perspective.

On 13 August 2022, Wigan Pride returned for a seventh year to Wigan Town Centre, celebrating equality and the 50th anniversary of Pride events in the UK. We were proud to be the headline sponsor of Wigan Pride 2022 and we were actively involved and worked in partnership with the BYOU community group, Wigan Council and other local providers. Our staff and supporters were joined in the parade by our Chair, Deputy Chief Executive and Director of Strategy and Planning, and our Director of Corporate Affairs and our LGBTQIA+ Network Chair gave a keynote speech to the crowd on the Unity Stage. Advice and free sexual health testing were 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 Engagement and Experience Team actively engaged with the local community to ascertain their feedback about hospital services, providing assurance that WWL are part of the community and continually working hard to ensure services are accessible.

During 2022, we were also offered a place on Phase 2 of the NHS Rainbow Badge Assessment Programme and received bronze accreditation. A number of service, patient and staff surveys were also undertaken across the organisation to ascertain how well our services are currently performing at being inclusive of LGBT+ people.

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

Financial performance

The Trust has ended the 2022/23 financial year with a deficit of £6.5m. The adjusted financial performance, was a deficit of £2.9m, which was £5.5m favourable to the planned deficit of £8.4m. The adjusted financial performance is the key performance measure used to assess achievement of the financial plan for both the Trust and the Greater Manchester ICS; the surplus/deficit is adjusted for specific technical items including certain impairments and the impact of donated assets.

When ICSs were established across England on a statutory basis on 1 July 2022, the establishment of ICBs replaced Clinical Commissioning Groups (CCGs). The Trust now operates within the Greater Manchester ICS. Revenue allocations are made at the system level and include both recurrent funding and funds for non-recurrent areas such as COVID-19 or elective activity recovery. Capital allocations are also made at a system level.

We delivered our agreed financial position with the Greater Manchester ICS which contributed to the system achieving its requirement to break even. This was done by working collaboratively with both locality and system partners.

Capital investment of £25.1m was made in 2022/23, including £13.2m of schemes funded through national public dividend capital which included commencing building work at our Leigh site for the Community Diagnostic Centre (CDC) and a new laminar flow theatre.

Income

We generated £522.6m of income in 2022/23 compared with £477.2m of income in 2021/22; an increase of £45.4m or 10%.

The usual payment by results (PBR) system for clinical income remained suspended in 2022/23 and was replaced by block and system funding as per 2021/22. Elective Recovery funding (ERF) has also continued in 2022/23 to support us in restoring activity levels and reducing the waiting list backlog of patients that has been caused by the COVID-19 pandemic.

The increased income of £45.4m compared to 2021/22 can predominantly be explained by several items. £11.8m of the increase relates to additional funding from NHS England predominantly relating to the pay award and £21.9m relates to an increase in ICB block and system funding. Local Authorities income increased by £6.9m and there was also an increase of £6.1m of education funding mainly relating to our Global Training and Education Centre and professional practice team funding which is offset by a reduction in employee salary recharges of £2.1m.

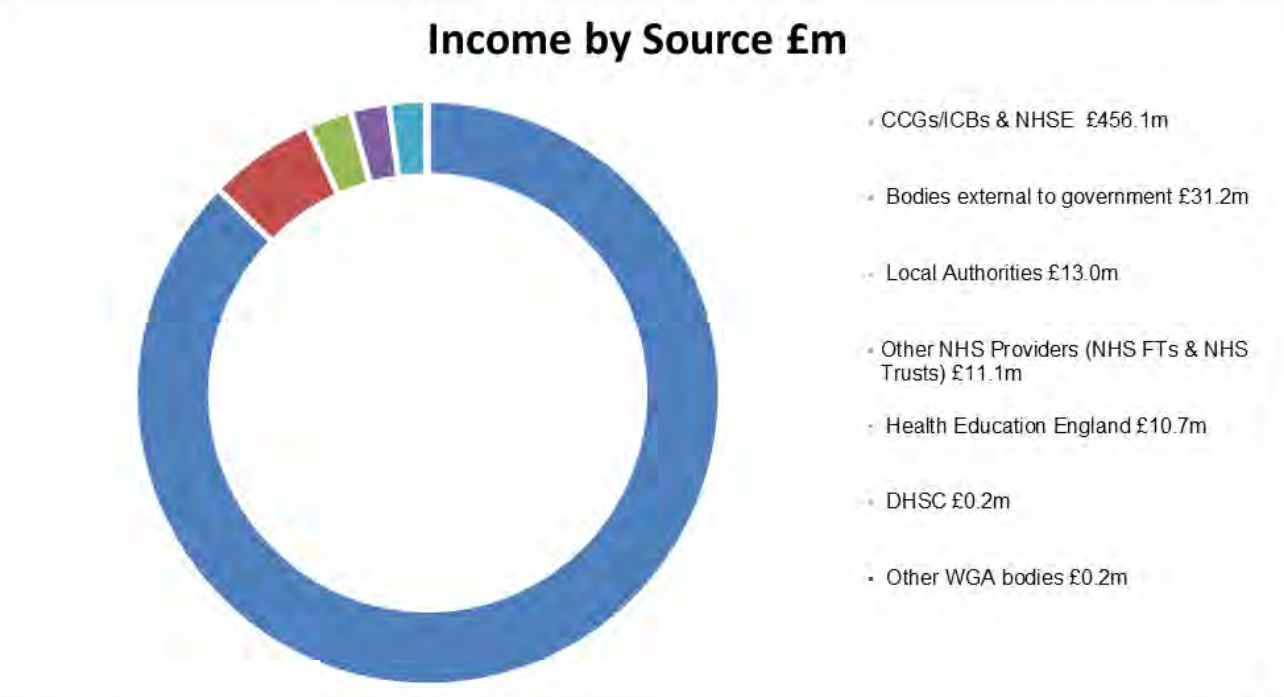
Principal and non-principal income

As a Foundation Trust, the income we receive from the provision of goods and services for the purposes of the health service in England (often referred to as our “principal purpose”) must be greater than the income we receive from the provision of goods and services for any other purposes (which we have termed “non-principal income”). The table below demonstrates our compliance with this requirement.

	2022/23 £m	2021/22 £m
Non-Principal Income	15.3	12.8
Total Income	522.6	477.2
Non-Principal Income as a % of all Income	**2.9%**	**2.7%**

Income by source

The chart below shows the split of our income by source during the year. Most of the income is received from government bodies, with only 6% of income received from bodies outside of the government.



Income from patient care activities

Income generated from the provision of patient care totalled £492.5m in 2022/23, compared with £451.2m in 2021/22; an increase of £41.3m (9%). £12.1m of the increase relates to additional funding from NHS England to fund the non-consolidated retrospective pay award proposal for 2022/23. £21.9m of the increase relates to ICB block contract and system income to fund inflation, pay award, service developments. The ICB funding also includes an additional £6.1m of ERF funding to restore clinical services and reduce waiting lists following the COVID pandemic. Local Authorities income increased by £7.0m due to non-recurrent funding to support delayed discharges and additional community funding. Private patient income increased by £0.6m in year predominantly due to additional activity within the Trauma and Orthopaedics specialty.

Greater Manchester ICB is the largest commissioner of services, contributing 75% (£368.7m) of our patient care income compared to 78% (£352.1m) in 2021/22.

Income from patient care (by nature)

	2022/23 £m	2021/22 £m
Acute services		
Aligned payment & incentive (API) contract income / system block income	374.7	370.0
High cost drugs income from commissioners	1.7	1.7
Other NHS clinical income*	16.7	11.0
Community services		
Block contract / system envelope income	44.5	40.3
Income from other sources (e.g. local authorities)	6.5	5.8
All trusts		
Private patient income	5.1	4.5
Elective recovery fund	10.2	4.1
Agenda for change pay offer central funding	12.1	0.0
Additional pension contribution central funding	12.0	11.1
Other clinical income**	9.0	2.6
Total income from patient care activities	**492.5**	**451.2**

* 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 £30.1m compared to £26.0m in 2021/22, which is an increase of £4.1m (16%). This largely relates to an increase of £6.1m of education funding offset by a reduction of £2.2m relating to employee salary recharges due to a reclassification between income type. Car parking income has also increased by £0.3m in year due to recommencing staff charges. Catering income also increased by £0.7m. We have seen a reduction in COVID top up funding of £0.6m in year as the reimbursement process has now ceased.

Expenditure

Operating expenditure for the 2022/23 financial year was £524.7m, compared to £474.7m for 2021/22, which was an increase of £50.0m (11%).

Employee expenses was the largest item at £366.3m (2021/22: £332.1m) which is 70% of operating expenditure. Within this figure, the amount spent on registered nursing, midwifery and health visiting staff was £107.7m (20221/22: £94.0m). Expenditure on medical staff was £81.0m (2021/22: £79.3m).

There is an increase in employee expenses of £34.2m. This includes an increase of £11.9m associated with temporary staff which comprises bank and agency expenditure. Pay expenditure has

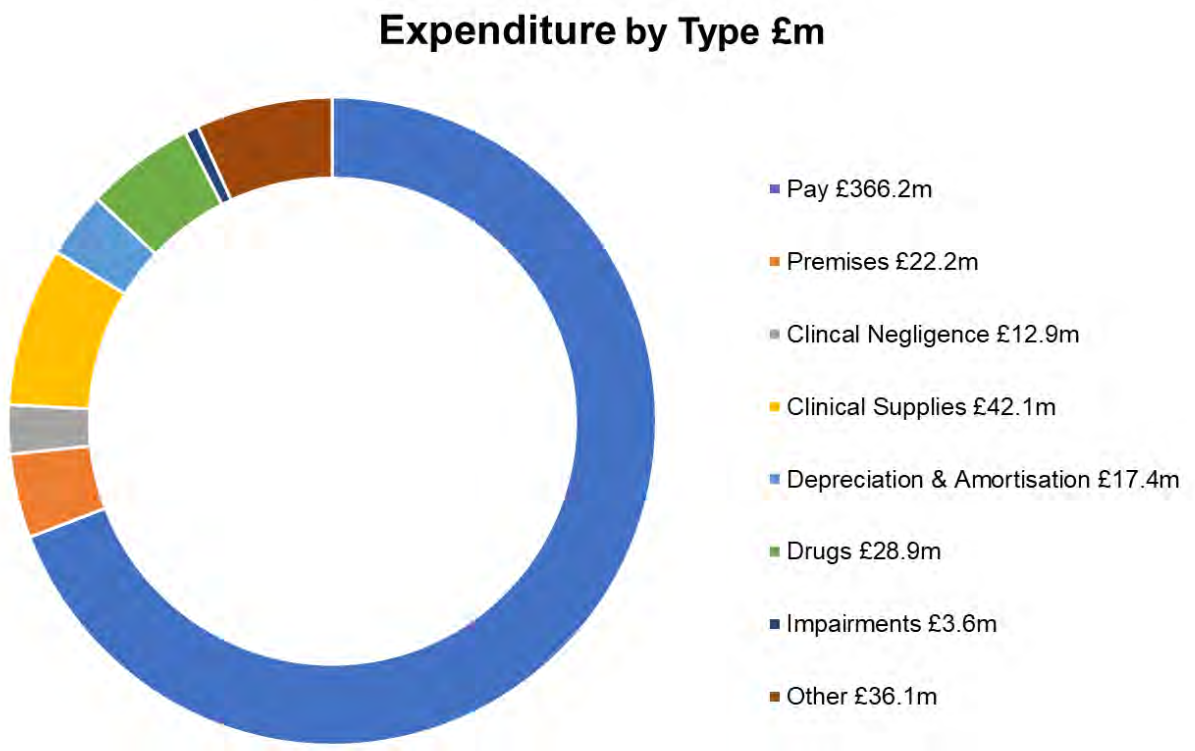
increased due the 2022/23 pay award (£12.8m) and the inclusion of the proposed non-consolidated additional pay award bonus (£12.5m), both of which were funded nationally.

Pay expenditure has also increased by an estimated £13.0m due to increasing escalation of bed capacity, driven in part by significant numbers of patients who reside in hospital but are medically fit to be discharged. Temporary staff have been utilised to support this escalation and deliver dedicated 1:1 care to support enhanced levels of care.

The largest items of non-pay expenditure included £28.9m spent on drugs (2021/22: £26.9m), £42.1m on clinical supplies (2021/22: £37.9m), £12.9m on clinical negligence premiums (2021/22: £12.2m) and £22.9m in premises costs (2021/22: £24.1m). Depreciation and amortisation of £17.4m and net impairments of £3.6m are included in the overall expenditure figure.

Expenditure associated with COVID-19 was £3.9m in 2022/23 (2021/22: £11.0m), a reduction of £7.1m primarily associated with employee costs.

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



Cost improvement plans

As the command and control financial regime came to an end in 2021/22, 2022/23 was the first year that our cost improvement plans (CIP) were reinstated to the pre-pandemic values. Despite an exceptionally challenging start to the year, we delivered £25.8m against the target of £23.9m. Although this was predominantly delivered through divisionally led transactional 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 2022/23 CIP were the clinical services collaboration programme and the value for money assessments on contracts we hold. Further to this, we have developed a clear and robust governance structure and communications strategy around the importance of cost controls throughout the organisation.

Capital investment programme

During the year we completed £25.1m (2021/22: £26.3m) of capital investments including £0.2m of donated assets (2021/22: £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
Community Diagnostic Centre	Commencement of a £10.2m scheme to refurbish and extend existing estate and provide additional diagnostic capacity on the Leigh site. Completion of the scheme is expected in Autumn 2023.	5,266
Information technology	Continued development of the Health Information System (HIS) platform providing rapid and seamless access to patient information (software and hardware) and the continued investment in IT systems to raise digital maturity across the Trust sites.	6,327
Medical equipment	The continued investment in medical equipment, including upgrades to MRI scanners, x-ray equipment, breast screening and endoscopy equipment.	4,561
Leigh laminar flow theatre	Commencement of a £7.9m scheme to create an ultra-clean theatre on the Leigh site increasing available theatres from 3 to 4.	4,216
Site improvements, upgrades and maintenance	Development of an urgent assessment facility within the existing emergency department; conversion of accommodation into a single point of access palliative care hub, and improvements and upgrades to all our sites including electrical infrastructure work, and general maintenance to improve our hospital environment.	4,723
Total (including donated assets)		**25,093**

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.

Silas Nicholls
Chief Executive and Accounting Officer

19 June 2023

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: **www.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 2022/23, 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. Although in 2022/23, average daily attendances equated to 277 patients per day, compared to 300 average attendances per day in 2021/22, the higher complexity of patients combined with increased length of stay and a number of industrial actions during the final quarter of 2022/23 contributed to the pressures within the department and the number of patients waiting over 4 hours increased over the winter months in 2022/23. 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 have maintained our position as the best performing 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 renew our focus within the accident and emergency department and in relation to wider patient flow. We have focused on the following:

- Ensuring early ambulance handovers to our accident and emergency department, to make sure that we rapidly respond to patients with high clinical need as well as freeing ambulance crews up to attend other calls.
- We have relaunched our SAFER initiative on across our wards, we, resulting in a greater number of patients being safely discharged earlier in the day. This stands for: Senior clinical review - All patients – Flow - Early discharge - Review by senior staff of performance.
- We have continued to focus on delayed transfers of care in collaboration with our system partners.
- We have worked with system partners to emphasise the need to continue to use services appropriately, signposting to other service such as NHS 111 and 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.
- We have enhanced our urgent and emergency care offering by extending the availability of our same day emergency care service, within the week and on weekends.

Looking forwards to 2023/24, we will work towards improvements in our 4-hour accident & 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 commence a same day emergency review and management service for the frail and elderly patients who visit our accident and emergency department. This initiative in conjunction with the virtual ward provided by our Community Division will support our patients to live well in their homes, reduce hospital admission related complications by avoiding admissions and support better patient care for those patients who do need hospital admission. We will work with our healthcare focussed data scientists to better understand the patient journey and length of stay within the hospital and focus on improving the road to recovery.

Scheduled care

Continuing the trend of the last few years, in 2022/23 we again saw an increase in referrals to many of our scheduled care services.

As a division, we maintained our 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 78 weeks and therefore met the national waiting list target for 2022/23.

For the coming year, the 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 exceed the national target to see and treat patients within 65 weeks of referral. We will work with community partners and General Practitioners to support a reduction in the number of referrals to hospital by supporting community-based models of care and further expanding advice and guidance services.

Clinical governance

Despite the challenges seen throughout 2022/23, 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.

During the year, we undertook a quality improvement project to review our complaints. Following the successful completion of the project we have identified themes for improvement of care and communication for our patients & their carers, thus enhancing their experience when using our services.

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 focus for the year was centred around reducing waiting times; we have been extremely successful in reducing 2 year waiting times, which had increased as result of the pandemic, down to 78 weeks in all areas. This has been a coordinated effort, involving a number of our NHS and independent sector partners.

The reduction of waiting times remains our focus and to help facilitate this, work has now started to build an additional laminar air flow theatre as well as to run additional funded theatre sessions at Leigh. In readiness for the new theatre and increased capacity at Leigh, the listing and anaesthetic

criteria has been reviewed and will allow additional activity to be undertaken. Together these changes will help facilitate the transfer of cases from the acute Royal Albert site, allowing more capacity there for the more complex cases.

We have appointed a GP into a mastalgia pain post who will start in June 2023. This dedicated service will stream referrals away from limited one stop capacity and help increase overall capacity. This is a Greater Manchester initiative, centrally funded for 12 months, that we will look to establish as a permanent additional resource to meet the continuity capacity demands within this pressured area.

In colorectal services, following prolonged discussion across Greater Manchester, agreement was finally reached in January confirming that the responsibility for the organisation of the Faecal Immunochemical Test (FIT test) would sit within primary care. This is a revolutionary means of detecting early stages of cancer by confirming if there is a bleed anywhere along the gastrointestinal tract. Arranging the tests did only put significant pressure on the department it also had an adverse impact on the total time a patient sat on the cancer pathway. With the results known at referral, the patient is now streamed to the most suitable pathway releasing capacity in pressured areas.

Endoscopic capacity for therapeutic specialist lists has also been increased which, along with the change in pathway will result in improved 62 day position.

The division has increased its number of junior doctors to 12, which now means that each surgical subspecialty has the same access to a better training experience in that they are able to spend more time within their own area whereas previously there was a considerable amount of cross cover. We expect this to reflect extremely positive in the next set of General Medical Council survey results.

Further to this, rotas have changed to facilitate additional support for the junior workforce when WWL are covering the urology ‘hot’ week, which is shared with Bolton NHS Foundation Trust. Earlier in year we successfully recruited a sixth urology consultant. This in tandem with the establishment of bi-weekly on-call service provision with Bolton NHS Foundation Trust takes us to the next stage of our strategic vision to establish a ‘single service’ with 10 consultants working a 1 in 10 joint on-call service.

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

As was the case for the surgical specialities, the head and neck specialities’ main focus was also to reduce waiting times. Our oral surgery and earn nose and throat (ENT) services played, and will continue to play, and important role in reducing the waiting times across Greater Manchester. Through mutual aid we have received and treated long waiting patients from across different geographies across the wider Manchester locality. Earlier in the year our new orthodontic consultant started following a significant period without anyone in this post. In addition to our new starter, we are now in the position to recruit into a second consultant post. Furthermore, our orthodontic therapist support should increase shortly as one of our oral surgery nurses completes her training. Together with a potential trainee, this will not only full stabilise what has been a fragile service but will also allow us to clear our backlogs and play an important role within the area as other departments have collapsed.

We are in our fourth year of a very rewarding partnership with the University of Central Lancashire, training students for an MSc in oral surgery. The success of this could result in expanding this course further with other institutions.

The paediatric sedation service has been extremely effective in enabling us to convert/remove previous general anaesthetic theatre cases from the waiting list reducing our overall waiting times. We are in discussions now with other providers in regard to transferring some of their long waiting patients.

Although there is a national shortage in this area with lots of competition for new consultants we have been successful in appointing a fourth consultant who will be beginning work with us in June 2023. He will work alongside his colleagues in helping take some of the pressure away from head and neck cancer demand.

In addition to the increase in theatre capacity planned at our Leigh site, we have now established an injection service based on Ward 3; transferring a lot of work out of Boston House as well supporting the population to the east of the Borough.

We are still working with other providers to try and fill consultant vacancies, which is a national challenge. We have been able to mitigate some of the associated risk by continuing to recruit our international fellows as well as transferring cases to other providers. A job plan has been agreed with Manchester Foundation Trust for a shared post, however we still await confirmation of any appointment.

Discussions are on-going with the local optometrists that will see a reduction of lower level glaucoma patients being referred into the department as they become more capable of treating this in primary care; likewise we will be able to discharge some of our longstanding patients as they are suitable to be managed locally.

With the exception of optometry, we have been successful in appointing into all orthoptic vacancies this year, enabling us to bring our backlogs back under control.

Theatres and anaesthetics

We have been successful in acquiring investment to build a fourth theatre at our elective day case unit at Leigh Infirmary. This will enable us to facilitate breast surgery, including cancer, on our Leigh site. This will support more day case activity on the Leigh site, allowing us to prioritise Wigan for more complex surgery. The building work is underway and we hope to open in the autumn. In the meantime the site will continue to operate as normal. As part of the investment in theatres we have held a theatre staff recruitment event which was at full capacity on the day with registered and unregistered staff attending, keen to work across our theatre sites. In addition we have recruited a number of anaesthetists to support our surgical activity and support our out of hours services.

In the forthcoming year we are focused on a project to support our pre-operative service, to facilitate maximizing 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 number of initiatives currently in the scoping and implementation phase to recognise the benefits of how sustainability can be cost effective.

Maternity and child health

Maternity

In March 2022 the Ockenden 2 report was published which highlighted a further 15 essential actions for maternity units to implement, containing 92 sub actions. Following its publication, our maternity

services are actively working to complete the essential actions and currently hold a 75% compliance rate against the 92 actions. However, it should be noted that national support for implementation of some of the actions is required.

The recently published East Kent report (October 2022) provides further recommendations for maternity services and focused on four areas for action:

- Monitoring safe performance
- Standards of clinical behaviour
- Team working and culture
- Organisational behaviour

The 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. We achieved 7 out of 10 for our year 4 performance and are committed to achieving 100% in year 5.

We are committed to delivering the 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 be concentrating 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.

Child health

The neonatal unit has achieved several quality improvement initiatives which include achieving reaccreditation for the baby friendly initiative, we are due for reaccreditation in August 2023 to achieve gold standard. We also achieved the bronze award for the 'Bliss Baby charter'.

The unit's education team has been the first in the Northwest Neonatal Operational Delivery Network (NWNODN) to develop a difficult airway study day for all medical and nursing staff. Our unit has inspired units in the NWNODN to develop their own difficult airway training. It was also was successfully nominated for the Neonatal Nursing Associations practice improvement awards and came second in the finals for this national award, for developing difficult airway training.

The unit has made several improvements in respiratory care including purchasing new equipment to provide non-invasive ventilation support from birth optimising respiratory care.

From a research perspective the unit is currently taking part in the 'Feed1' trial. We are also an active participant in the NHS England quality improvement 'MatNeo' service improvement project. In March 2023 we gained an award for the most improved neonatal/maternity unit in optimal cord management. Out Band 7 'MatNEO' Nurse lead also gained an individual award for outstanding contribution throughout the programme.

Nationally there is a critical care review ongoing, reviewing the number of cots each neonatal unit provides – this has a potential impact on our services going forward.

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 – this has a potential impact on our services going forward.

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

The ward is commissioned to care for children and young people with an eating disorder for both Wigan and Bolton boroughs. In September 2022, Greater Manchester Mental Health NHS Foundation Trust funded a Registered Mental Health Nurse to work alongside both our eating disorder and our general children and adolescent mental health admissions to the ward. The role has greatly improved the quality of service and delivery of care to both groups of children and young people on the ward.

Our paediatric outpatient activity was largely maintained throughout the pandemic, primarily through the use of virtual appointments. We have now increased the number of face-to-face appointments and we are reintroducing registrars into clinics to minimise multiple visits for children and young people and to maximise capacity and throughput. Clinical activity has increased due to increased referrals into the community service. The introduction of the text and remind service has been introduced aiming to reduce the number of patients who do not attend appointments.

Transition of young people seamlessly into adult services is an ongoing project in the department aiming at bridging the gap between the services.

We have successfully appointed a substantive consultant community paediatrician. This will increase capacity to address new and follow up backlogs in children and young peoples' services, although demand continues to outstrip capacity. An additional neurodevelopmental specialist nurse was appointed in March 2022 to support management of this waiting list.

Healthcare operations

It has continued to be an extremely challenging year for the healthcare operations team, which has continued to support the scheduling of outpatient and elective admission activity to facilitate the elective recovery programme. The team has adapted and been flexible to all different types of working and facilitating outpatient appointments via alternative media such as telephone and video consultations. On a wider scale across the organisation, the team has continued to support a number of organisation-wide projects including:

- Digitisation of the Health Information System across outpatient settings;
- Continued support and expansion of digital letters and the reintroduction of SMS appointment reminders (with the options for patients to reschedule or cancel their appointment via this SMS message) in partnership with DrDoctor across the Trust including assisting areas outside of health care operations;

- Working alongside other departments to ensure the Accessible Information Standard is met and enforced;
- Ongoing implementation of new call centre technology in the Leigh Appointment Centre with new Omni channels due to be rolled out to the Trust allowing our patients to communicate with us via different routes which will be a great asset for communication with our deaf and hard of hearing community;
- Support for specialties with the Patient Initiated Follow-up programme of work; and
- Coordination of a large number of patients transferring to the independent sector for timely treatment
- Procurement of digital solutions such as DrDoctor Quick Question and Broadcast Messaging to support patient communication and waiting list management.

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 specialty governance groups and its Divisional Quality Executive Group work hard to ensure the success of its clinical governance processes, to ensure the provision of safe and effective care. These groups have a comprehensive work programme which allows scrutiny and monitoring of key areas, including: incidents; compliments, concerns and complaints; risks and potential risks; lessons learned and areas of good practice and improvements to our monthly governance report and development of divisional dashboard reports further support performance discussions and the review of themes.

The division has developed a monthly lessons learned bulletin, used to share learning from complaints and incidents widely across the division has been received positively by staff.

All inpatient and outpatient areas in this division have attained bronze through our ASPIRE ward accreditation program, providing assurance that each area meets the standards set out in our organisational assessment framework. Work continues in order to maintain these standards, and progress towards silver and, in some areas, platinum accreditation. accreditation.

Our HealthRoster SafeCare software system allows the division to review safe staffing across its ward areas, to ensure the needs of patients are met by reassessment of staffing and the acuity of patients throughout the day and night. 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 (MRI)
- 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. We achieved 99% performance against the 6 week referral to examination target across all imaging modalities in the initial COVID-19 recovery phase. However, this has deteriorated due to increasing demand for diagnostics, specifically in the unscheduled care sector which has increased by 28% compared to pre-pandemic levels. The service has improved performance and has now achieved service levels within the re-defined NHSE target of having no more than 5% of patients waiting more than 6-weeks for diagnostic imaging.

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 post 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 run. Post-placement feedback from trainees within the Manchester Deanery, the Trust has been identified as the best provider in Greater Manchester of radiologist ultrasound training. Further, a dedicated ultrasound training hub is now established at Leigh Infirmary in collaboration with the University of Cumbria.

Radiographers who undertake general radiography training now rotate across three, and in some cases, all four 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 and development of an undergraduate training programme. 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. 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. This is supported by investment from Health Education England which allowed the existing student training room to be expanded, refurbished and re-equipped. Additional funding will support 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 in Imaging program.

Several general X-ray equipment devices across our sites were installed more than 20 years ago and we are beginning to experience an increasing number of repairs and maintenance costs to prevent breakdowns. Good progress has been made to replace some of the oldest devices at the Thomas Linacre Centre and Royal Albert Edward Infirmary, with further replacements at Wrightington Hospital and Leigh Infirmary planned to take place in 2023. . After being awarded funding following a bid to develop a Community Diagnostic Centre we will be able to further expand diagnostic capacity at our Leigh Infirmary site.

The CT and MRI departments are located at Royal Albert Edward Infirmary and Wrightington Hospital and perform around 54,000 CT and 23,000 MRI examinations per year. The department comprises 3 CT and 3 MRI scanners which operate over 7 days a week. A new CT scanner was delivered to Wrightington Hospital in April 2022 to replace an obsolete mobile scanner. This equipment will primarily deliver the elective element of the service allowing the scanners at Wigan to undertake complex procedures and to support the increasing volumes of patients admitted on unscheduled pathways who require CT imaging. 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.

The CT department successfully developed a cardiac CT service which will negates the need for Wigan Borough patients to travel to Wythenshawe for the investigation. This examination is in high demand due to its safety profile and convenience. The expansion of diagnostic capacity within a Community Diagnostic Centre at Leigh Infirmary aims to increase the availably of this procedure for a wider cohort of the eligible population.

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

The installation of a SPECT/CT scanner has increased both the sensitivity and specificity of imaging, which in particular 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 12 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 at the Wigan site and at Wrightington.

Trauma and orthopaedics

The 2022/23 financial year was a further challenging period for the trauma and orthopaedics directorate.

An increasingly complex case mix, with a higher number of patients requiring more intensive support post operatively was exacerbated by regular downtime due to COVID pressures; overall the current inpatient waiting list is approximately double pre-COVID levels. During the year we met the NHS England target for ensuring that no patient had been waiting for more that 78 weeks for surgery by 31 March 2023.

Wrightington was named as a Greater Manchester Trauma & Orthopaedics Elective Hub in July 2021 and having been paired up with Bolton NHS Foundation Trust; Wrightington has supported Bolton Consultants to undertake one list per week within our theatres to enhance their capacity. Throughout the year, under the Greater Manchester Mutual Aid programme, assistance has been provided to patients from Tameside and Stockport 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 confirmed in September 2021, our efforts have been focused on helping to improve knee revision surgery across Greater Manchester, Lancashire and South Cumbria. The end of March 2023 represents the completion of the first year of this pilot project which is a clinically driven programme which has benefited from close collaboration with the British Association for Surgery of the Knee (BASK), the British Orthopaedic Association (BOA) and the Get it Right First Time (GIRFT) team.

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 have redeveloped an old facility to develop an Elective Ambulatory Unit, increasing our ability to offer surgery on a walk in, a walk out basis. In addition, we have created a new Discharge Lounge to improve patient flow and we are currently in the planning phase of adding a further operating theatre to our RAEI site which will improve capacity and resilience.

During 2022/23, bed pressures within the system have compromised 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 RAEI site has led to patients in some cases residing on the wrong wards. To assist, where possible, trauma patients have been transferred for surgery at the Wrightington site which although impacting 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 plans and strategy.

Rheumatology

Our rheumatology team have had a positive year, with an additional Nurse Specialist Prescriber commencing in post in late May 2022. Despite previous challenges to recruit substantive consultants

in this field, posts were successfully recruited to this year with our new colleagues to begin in post in Spring 2023.

The service is open to out of area referrals and continues to work on reducing backlogs.

Outpatient services

Outpatient services are provided at four sites and also support clinics managed by other organisations. All of our outpatient departments have been able to play an active part in the overall recovery programme by facilitating the provision of additional clinics. This has also been aided by the use of virtual clinics. The ongoing national infection control restrictions impacted on the number of face-to-face appointments which we were able to offer in the early part of the year.

Dermatology and plastics

This year has seen a positive recruitment round for consultant and speciality doctors across the service. We have been working across the system to support the backlog of referrals and re-opened to out of are referrals this year. Despite challenging circumstances the service has stabilised and increased productivity and efficiency.

Private patients and overseas visitors

In line with the remaining elective activity, private patient activity was reduced and at times ceased this year. This led to a reduction in the number of patients seen and treated however, given the greater complexity of cases, the income received by the service exceeded 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.

As we have moved back towards business as usual, there has been a significant increase in the number of patients referred to the overseas visitors team. Historically the growth in referrals to the overseas visitors team has not been met with a growth in resources. This has led to a backlog in cases and difficulty in maintaining patient flow. Following internal discussions, a plan to improve this has been agreed, including the appointment of an additional overseas visitors officer, a review of the process for managing overseas visitors and the potential for the implementation of robotic assisted processes.

Therapies

The musculoskeletal clinical assessment and triage service service has continued to adapt to meet referral demands with an ever-changing workforce this year. Recruitment has been very successful, and the team is fully staffed with no vacancies. As per the agreed and 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 to work alongside colleagues within WWL and alternative secondary care providers.

The First Contact Practitioner service has continued to develop, with staffing numbers expanding by 50%. 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 these practitioners continues, with the aim of streamlining the patient journey for those that require secondary care whilst increasing the number that are effectively managed at point of initial contact in the primary care setting.

Outpatient therapy has progressively returned to pre-COVID-19 levels of activity as infection prevention and control limitations have reduced. Recruitment has remained a challenge over the past 12 months with all therapy services holding some vacancies due to a shortage of candidates. Therapy teams across Specialist Services have worked together cross-site to ensure an equitable service for patients and minimise waiting times.

Inpatient therapy services continue to adapt to different cohorts of patients with the brief introduction of medical patients to the Wrightington Hospital site and with the complexities of those who had been waiting extended periods for orthopaedic surgery. Pre-operative education was modified to be delivered virtually including the use of the myrecovery app and continues to be updated with best practice guidelines. With the increase in patient complexity the pre-operative service can now include assessing patients in their own home. Re-deployment throughout the year has occurred during critical incidents, to support acute medical and orthopaedic services across the trust.

The hand therapy team continue to manage post-operative patients from the ambulatory unit. The patient journey has now been simplified with a one stop shop for surgical follow-up and therapy.

Cancer services and oncology

The longer-term effects of the COVID-19 pandemic continue to be experienced across multiple clinical specialities which has negatively impacted on cancer performance. Recovery to pre-pandemic performance levels remains challenged, 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 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 this has proved challenging to sustain consistent performance during periods when we have been operating under significant pressure.

The faster diagnosis standard 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. The service will now focus attention on improving performance in the early stages of the pathway which will require a strong emphasis on diagnostic performance in pathology, endoscopy, and imaging. A target to achieve a 75% performance target has been set for the 2023/24 planning period.

The service has been involved in business planning to expand one-stop imaging capacity for the symptomatic breast pathway. This key priority of the organisation to enable patients to access essential diagnostics at an early stage has delivered a significant improvement in breast cancer performance in addition to reconfiguring the estate to provide a more suitable environment to deliver care across the surgical and imaging specialities. The colorectal pathway is expected to improve once faecal immunochemical (FIT) testing pathways are established that are compliant with new guidance which was issued in late 2022. This requires a consistent application of FIT testing across the locality which is being supported by the cancer transformation team who have developed a focus group to work with local primary care networks.

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. Additionally, a new pathway for patients with non-specific symptoms that can indicate cancer and a rapid diagnostic service (RDS) to support these patients has been implemented and went live Spring 2022 and 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 team and RDS has continued to support the NHS Galleri trial which is using a novel blood test to detect positive cancer signals which aim to diagnose cancer before symptoms are evident. The data from the first year of the trial identified 7 patients with a positive cancer signal which were investigated through the RDS and referred for onward treatment. Several patients were successfully treated for early malignancy including oesophageal and haematological cancer which could be treated in the early stage of the disease. The trail has now progressed into the second year of recruitment with patients invited for screening in March and April 2023. The trail has the exciting potential to realise the national ambition to diagnose more patients in the early stage of disease when treatment options have a curative intent.

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 2022. 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. It has been proposed to extend the reach of cancer peer review to include diagnostic services which are essential to achieving strong performance on the FDS target.

Cancer treatments are delivered within the dedicated Cancer Care Unit, supported by regular meetings with The Christie NHS Foundation Trust (the Christie) on a bi-monthly basis 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 on a monthly basis 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 within 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.

The recently established service transformation allows patients to undergo a holistic needs assessment at their pre-chemotherapy visit, enabling them to discuss any worries and concerns before they start their treatment. The Christie team are very supportive of the service that is delivered at WWL and are keen to work with us on future service developments. 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

Wigan's Locality Plan, The Deal for Health and Wellness 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 service delivery footprint areas. These areas have been based on naturally formed communities, each with a 30-50,000 registered population, and through these we plan delivery our services to meet local needs. The footprints include health and care partners working closer together, including community nursing, therapies and adult social care (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 and 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, and is contributing to safe and effective admission avoidance across the system. By working together across organisational boundaries as one team, we have been able to better use the combined skills and knowledge of all professionals co-located in a place. This has had a positive impact on how we are able to triage 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 triage process and 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.

Our Deal for a Healthier Wigan focuses on staff taking the time to understand people's strengths and assets and supporting them to connect to their community and be well. The application of asset-based approaches to care have been key to the transformation model; keeping people well for longer 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.

Highlights for our Community Services in 2022/23 include:

- The consolidation of the Jean Heyes Reablement Unit (JHRU) a 24 bedded community ward at our Leigh Infirmary site, which opened in January 2022. JHRU supports individuals who are medically well enough to continue their care out in the community but require a period of bed-based rehabilitation that is nurse/therapy led, supporting them to achieve specific goals which enable safe discharge back into the community or their own home. The aim is to increase the number of patients able to return to their usual place of residence/home following discharge from hospital and reduce the need for formal care on discharge.

- The creation and expansion of a Virtual Ward which currently has 40 virtual beds and accepted its first patient in January 2022. 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.

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:

- Catering
- Security
- Hotel Services
- Capital design
- Medical electronics
- Operational estates maintenance
- Safety management
- Energy and waste management
- Fire safety
- Grounds maintenance
- Sterile services and endoscope reprocessing

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 service and 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 20,000 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.

During the year, we developed and approved our first Green Plan. 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 is provided in the table below:

Contractual requirement	Our performance 22/23
In performing its obligations under this Contract the Provider must take all reasonable steps to minimise its adverse impact on the environment.	This is achieved through the Green Plan and Net Zero Strategy and moving forwards, will also be addressed by our Climate Change Adaptation Plan. The Net Zero Strategy has been developed and is due to be published in Q1 23/24. 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.

Contractual requirement	Our performance 22/23
The Provider must maintain and deliver a Green Plan, approved by its Governing Body, in accordance with Green Plan Guidance and must: ▪ provide an annual summary of progress on delivery of that plan to the Co-ordinating Commissioner; and ▪ nominate a Net Zero Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position.	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. WWL's Net Zero Lead is the Director of Strategy and Planning. The Operational Lead is the Environmental and Sustainability Manager.
Within its Green Plan the Provider must quantify its environmental impacts and 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.	Going forward we will quantify our environmental impacts via the Greener NHS emissions dataset. The datasets are currently provided up to financial year 2019/20. We are now involved in a pilot program to report on our air quality impact. This will be reported on in the financial year 2022/23. The Trust Net Zero Strategy has now been developed. It details a routemap to net zero for our built estate and will be released in Q1 2023/24.
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, by no later than 31 March 2022: – take action to reduce air pollution from fleet vehicles, transitioning as quickly as reasonably practicable to the exclusive use of low and ultra-low emission vehicles; – take action to phase out oil and coal for primary heating and replace them with less polluting alternatives; – develop and operate expenses policies for Staff which promote sustainable travel choices; and – ensure that any car leasing schemes restrict high-emission vehicles and promote ultra-low emission vehicles; ▪ climate change, and specifically how it will, by no later than 31 March 2022, take action: – to reduce greenhouse gas emissions from the Provider's Premises in line with targets	**Air pollution** 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 Heinz regarding them providing a charging hub for local businesses in the area. We offer lease options on several EV vehicles and over 50% of all new leases are now EV. We do not use oil or coal for primary heating on any site. **Climate change** 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 We are in the process of removing desflurane from use, to meet the 2024/25 deadline. We have completed nitrous oxide audits and are in the process of stopping use via manifolds. At present we need to upgrade anaesthetic machinery before this can go ahead. Once yokes have been received and regulators fitted, the manifolds will be decommissioned. We are in the process of completing a climate change adaptation plan tool developed by Greener

Contractual requirement	Our performance 22/23
in Delivering a 'Net Zero' National 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, including by appropriately reducing the proportion of desflurane to sevoflurane used in surgery to less than 10% by volume, through clinically appropriate prescribing of lower greenhouse gas emitting inhalers, by encouraging Service Users to return their inhalers to pharmacies for appropriate disposal; and – to adapt the Provider's Premises and the manner in which Services are delivered to mitigate risks associated with climate change and severe weather; ▪ single use plastic products and waste, and specifically how it will, no later than 31 March 2022 take action: – to reduce waste and water usage through best practice efficiency standards and adoption of new innovations; – to reduce avoidable use of single use plastic products, including by signing up to and observing the Plastics Pledge; – so far as clinically appropriate, to cease use at the Provider's Premises of single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics; – to reduce the use at the Provider's Premises of single-use plastic food and beverage containers, cups, covers and lids; 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.	NHS. Alongside collation of exiting emergency preparedness, resilience and response (EPRR) documentation, the output will be used to produce a Climate Change Adaptation Plan. **Single Use Plastics** 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. We are signed up to the Local Authority walking aid refurbishment scheme.

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

Joint forward plans and capital resource plans

During 22/23, WWL continued to exercise its responsibilities on capital planning through robust governance, including a capital strategy group, which met monthly. This allowed us to both monitor capital spend on key programmes and to ensure that future years' plans were appropriately aligned to the organisation's strategy. We developed a system of categorisation of capital projects to enable prioritisation and greater transparency. Our capital plans are aligned to our estates and digital strategy as well as ensuring that routine maintenance and equipment replacement costs are met. As capital, both capital departmental expenditure and public dividend capital, are to a large extent managed on a system basis. There are regular Greater Manchester wide capital planning discussions, which are reflected in our organisational plans and overseen by the capital strategy group. The Finance and Performance Committee seeks and receives assurance on those capital plans.

Health inequalities

For 2022/23, we provided a report to our board giving an assessment of our waiting lists according to ethnicity, gender and social deprivation. This did not demonstrate any material difference in treatment by these characteristics. We also established an anchor institution programme, reporting to our board, which focused on wider access to employment for local communities, increasing local procurement and procuring for social value. For 2023/24, we intend to build upon this by providing more granular health inequalities data to the board twice a year, increasingly expressing our routine performance reports from an inequalities perspective, strengthening our equality impact assessment for major change programmes and participating in cross borough priority programmes with a focus on tackling health inequalities.

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 they are 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 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.
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.
Non-Compliant	The organisation is compliant with 76% or less of 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. 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 2022/23, we have assessed ourselves as having an EPRR assurance rating of ‘substantial compliance’ against the core standards. This was agreed by the Board of Directors at its meeting on 7 December 2022.

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, and appropriate to the requirements of the organisation. 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.

Silas Nicholls, Chief Executive | Permanent post

Having previously been our Director of Strategy and Deputy Chief Executive, Silas returned to WWL as our Chief Executive in October 2019. He began his NHS career as a graduate management trainee and brings with him a wealth of experience from a number of operational and strategy roles across the North West and previous experience as the Chief Executive of two large NHS organisations.

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.

Tracy Boustead, Interim Chief People Officer | Appointment 1 Jan 2023 to 30 Jun 2023

Tracy is a well-regarded public servant, with substantial and significant leadership experience operating at the highest levels across Health, Local Authority and Higher Education. Her experience is complemented by specialist experience relating to organisational design and development, cultural change, strategic human resource management from across the public, private and voluntary

sectors. Fundamentally, Tracy believes that work can and should be a force for good, since a happy and healthy workforce is a productive workforce.

Lady Rhona Bradley, Non-Executive 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.

Mary Fleming, Deputy Chief Executive | Permanent post

Mary has a strong patient-focused operational background with extensive experience in leading service improvement and innovation across a variety of clinical disciplines in both the public and private sector. Mary was appointed as Deputy Chief Executive on 1 April 2021, having been our Chief Operating Officer prior to this. Mary retains her original responsibilities for operations and IM&T and has additional responsibilities as part of her role as Deputy Chief Executive.

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.

Dr Terence Hankin, Non-Executive Director | Appointment 1 Jun 2023 to 31 May 2026

Terry has a lifetime career in the NHS, qualifying in 1989. His last appointment was as Medical Director to Southport and Ormskirk Acute NHS Trust. Prior to that role he was a full time consultant in critical care and anaesthesia at St Helens and Knowsley Acute NHS Trust for 22 years. He has a wide experience in a variety of clinical and managerial roles supporting clinicians and doctors in

training. he has a demonstrated commitment to supporting patients, families and driving the quality of care delivered by medical staff.

Ian Haythornthwaite, Non-Executive Director (Independent) | Appointment: 9 Apr 2018 to 8 Apr 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.

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, Senior Independent Director (Independent) | Appointment 26 Mar 2018 to 25 Mar 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.

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.

Francine Thorpe, Non-Executive Director (Independent) | Appointment 1 May 2021 to 30 Apr 2024

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.

Rabina Tindale, Chief Nurse | Permanent post

Rabina is dual qualified RN and RSCN with a clinical background in emergency care. Rabina firmly believes outstanding care can only be delivered through investing in our staff, providing a psychologically safe environment to work in and enabling them to reach their full potential. Rabina is an advocate for human factors in healthcare and is passionately committed to the equality, diversity and inclusion agenda.

The following individuals were also directors of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust during 2022/23:

- Alison Balson (Chief People Officer to 31 Dec 2022)
- Ian Boyle (Chief Finance Officer to 30 Nov 2022)
- Dr Steven Elliot (Non-Executive Director to 30 Apr 2023)
- Mick Guymer (Interim Non-Executive Director from 13 Dec 2022 to 31 Mar 2023)
- Kelly Knowles (Acting Chief Finance Officer from 1 Nov 2022 to 1 Mar 2023)
- Alison Tumilty (Non-Executive Director to 25 Nov 2022)

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**

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 table below shows the attendance at board meetings for all directors in post during 2022/23:

Name of director	A	B	%
Mark Jones, Chair	10	10	100%
Sanjay Arya, Medical Director	6	10	60%
Claire Austin, Non-Executive Director	8	10	80%
Alison Balson, Chief People Officer (to 31 Dec 2022)	7	7	100%
Tracy Boustead, Interim Chief People Officer (from 1 Jan 2023)	2	2	100%
Ian Boyle, Chief Finance Officer (to 30 Nov 2022)	6	6	100%
Rhona Bradley, Non-Executive Director	10	10	100%
Steven Elliot, Non-Executive Director	6	10	60%
Mary Fleming, Deputy Chief Executive	8	10	80%
Tabitha Gardner, Chief Finance Officer (from 2 Mar 2023)	1	1	100%
Mick Guymer, Interim Non-Executive Director (from 13 Dec 2022 to 31 Mar 2023)	2	2	100%
Ian Haythornthwaite, Non-Executive Director	9	10	90%
Kelly Knowles, Acting Chief Finance Officer (from 1 Nov 2022 to 1 Mar 2023)	2	2	100%
Paul Howard, Director of Corporate Affairs†	10	10	100%
Lynne Lobley, Non-Executive Director	9	10	90%
Anne-Marie Miller, Director of Communications and Stakeholder Engagement†	9	10	90%
Richard Mundon, Director of Strategy and Planning	9	10	90%
Silas Nicholls, Chief Executive	9	10	90%
Francine Thorpe, Non-Executive Director	9	10	90%
Rabina Tindale, Chief Nurse	10	10	100%
Alison Tumilty, Non-Executive Director (to 25 Nov 2022)	7	7	100%

A: number of meetings attended
B: number of meetings the director could have attended
† Indicates non-voting director

Evaluating performance and effectiveness

During 2021/22, we commissioned an external review of our leadership and governance using the NHS well-led framework, in line with best practice. No major concerns were identified 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 2022/23, 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.

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 2020/21.
- 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 2022/23 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 two non-executive directors who were reappointed in-year 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 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 have reviewed that salary in-year and uplifted it to take account of performance in post and comparative data.

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 £767 (3%) to £26,305 per annum from 1 April 2022.

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 2022/23, an uplift of 3% was applied in line with national guidance to all pay scales aside from the non-voting director pay scales. The non-voting director pay scale received an uplift of 3.5%, as provided for within national guidance, in order to ameliorate the differential between the top of the Agenda for Change band 9 pay scale and the VSM pay scale.

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.

Mark Jones
Chair

19 June 2023

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. The Remuneration Committee will be reviewing this during 2023/24.

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 2022/23 we have appointed two executive directors, one being on an interim basis, and both candidates were female. We also appointed two non-executive directors; one male appointment being on an interim basis, followed by substantive recruitment to the same post by appointment of a female candidate. As a result, the board is now made up of 62.5% female directors and 37.5% male directors (2021/22 53% female and 47% male). 2 of our directors (12.5%) are 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. The contract of employment for the interim executive director is for a fixed term of 6 months. 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
Silas Nicholls	Chief Executive	28 Oct 2019	Permanent contract	6 months
Sanjay Arya	Medical Director	1 Apr 2017	Permanent contract	3 months
Tracy Boustead	Chief People Officer	1 Jan 2023	1 month	3 months
Mary Fleming	Deputy Chief Executive	1 Apr 2021*	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 Engagement	1 Mar 2021	Permanent contract	3 months
Richard Mundon	Director of Strategy & Planning	28 Sep 2015	Permanent contract	3 months
Rabina Tindale	Chief Nurse	15 Feb 2021	Permanent contract	3 months

* Mary Fleming's employment as Deputy Chief Executive commenced on 1 April 2021, 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	1 year, 5 months	31 Oct 2030	3 months
Clare Austin Non-ExecutiveDirector	1 May 2019	1 May 2022	1 year, 11 months	30 Apr 2028	1 month
Rhona Bradley Non-Executive Director	1 Dec 2019	1 Dec 2022	2 years, 6 months	30 Nov 2028	1 month
Julie Gill Non-Executive Director	1 Apr 2023	1 Apr 2023	2 years, 10 months	31 Mar 2032	1 month
Ian Haythornthwaite Non-Executive Director	9 Apr 2018	9 Apr 2021	11 months	31 Mar 2027	1 month
Terence Hankin Non-Executive Director	1 Jun 2023	1 Jun 2023	2 years, 11 months	31 May 2032	1 month
Lynne Lobley Non-Executive Director	28 Mar 2018	28 Mar 2021	10 months	27 Mar 2027	1 month
Francine Thorpe Non-Executive Director	1 May 2021	1 May 2021	11 months	30 Apr 2030	1 month

Membership of 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 2022/23 was as follows:

Name of director	A	B	%
Mark Jones	2	2	100%
Clare Austin	2	1	50%
Rhona Bradley	2	1	50%
Ian Haythornthwaite	2	2	100%
Lynne Lobley	2	2	100%
Francine Thorpe	2	1	50%

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 his 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 two new non-executive directors. The committee also held one formal meeting during the year, to consider the reappointment of one of the non-executive directors.

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

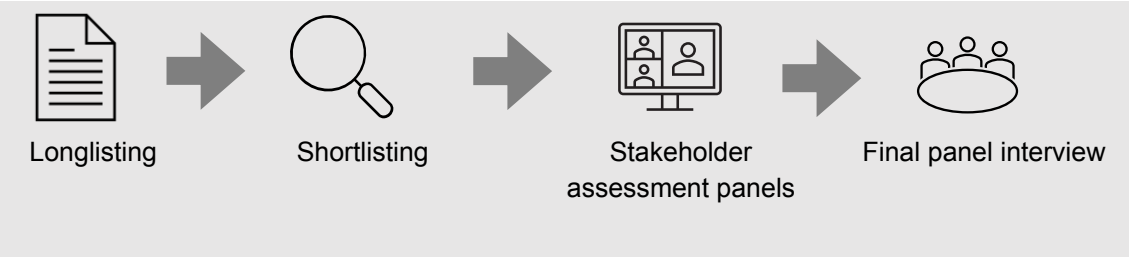
Name of committee member	A	B	%
Mark Jones, Chair	2	2	100%
Les Chamberlain	1	1	100%
Bill Anderton, Public Governor	1	1	100%
Pauline Gregory, Public Governor	1	1	100%
Andrew Haworth, Public Governor	2	2	100%
Julie Hilling, Public Governor	1	1	100%
Andrew Savage, Staff Governor	2	2	100%
Bryonie Shaw, Appointed Governor	2	1	50%
Linda Sykes, Public Governor	1	1	100%

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 2022/23. The committee was assisted with this appointment by Diane Charnock Consulting, a recruitment consultancy with significant experience in recruiting non-executive directors. In determining which firm to use to support the process, 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 £14,000 was paid.

The process which was followed for the appointment is summarised below:



The interim appointment which was made in respect of the same post saw the committee resolve to re-appoint the previous post holder until the recruitment exercise was complete**.** One additional 6-month interim appointment was also made.

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, Chief Operating Officer	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 (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

† 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.

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.

Remuneration for the year to 31 March 2022

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 (from 1 Nov 2021) *	30 – 35	0	0	30 – 35
Robert Armstrong, Chair (to 31 Oct 2021)	25 – 30	0	0	25 – 30
Silas Nicholls, Chief Executive**	195 – 200	900	0	195 – 200
Sanjay Arya, Medical Director†‡	255 – 260	0	30.0 – 32.5	285 – 290
Clare Austin, Non-Executive Director	10 – 15	0	0	10 – 15
Alison Balson, Director of Workforce	135 – 140	0	32.5 – 35	165 – 170
Ian Boyle, Chief Finance Officer**	130 – 135	0	75 – 77.5	205 – 210
Rhona Bradley, Non-Executive Director	10 – 15	0	0	10 – 15
Steven Elliot, Non-Executive Director	10 – 15	0	0	10 – 15
Mary Fleming, Deputy Chief Executive	145 – 150	0	140 – 142.5	285 – 290
Mick Guymer, Non-Executive Director (to 31 Jul 2021)	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	20 – 22.5	120 – 125
Lynne Lobley, Non-Executive Director	15 – 20	0	0	15 – 20
Anne-Marie Miller, Director of Communications	105 – 110	0	85 – 87.5	190 – 195
Richard Mundon, Director of Strategy and Planning§	110 – 115	0	35 – 37.5	145 – 150
Rabina Tindale, Chief Nurse	120 – 125	0	0	120 – 125
Francine Thorpe, Non-Executive Director	10 – 15	0	0	10 – 15
Alison Tumilty, Non-Executive Director (from 1 Sep 2021)	5 – 10	0	0	5 – 10
Tony Warne, Non-Executive Director (to 14 May 2021)	0 – 5	0	0	0 – 5

* Although Mark Jones took up post formally on 1 November 2021, he was remunerated at 50% rate from 1 May to 31 August 2021 and at full rate from 1 September 2021 to reflect the time commitment associated with the handover period.

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

† The above remuneration includes clinical duties of £114k 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.

All of the above directors were in post for the 12-month period to 31 March 2022 except where indicated. No annual performance or long-term performance-related bonuses were paid during the period. Taxable benefits relate to car lease contributions.

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 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 value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023/24 CETV figures.

Pension entitlements for year-ended 31 March 2022

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 0.5% CPI on the opening cash equivalent transfer value at 31 March 2022 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 2022 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2022 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real increase in Cash Equivalent Transfer Value £000
Silas Nicholls* Chief Executive	0	0	0	0	0	0	0
Sanjay Arya Medical Director	2.5 – 5.0	2.5 – 5.0	70 – 75	210 – 215	1,760	1,660	63
Alison Balson Director of Workforce	2.5 – 5.0	0 – 2.5	15 – 20	15 – 20	245	209	16
Ian Boyle Chief Finance Officer	2.5 – 5.0	5.0 – 7.5	50 – 55	100 – 105	888	797	68
Mary Fleming Deputy Chief Executive	5.0 – 7.5	12.5 – 15.0	45 – 50	105 – 110	1,026	854	147
Paul Howard Director of Corporate Affairs	0 – 2.5	0	10 – 15.0	30-35	221	199	8
Anne-Marie Miller Dir. of Communications	5.0 – 7.5	0	20 – 25	0	234	177	41
Richard Mundon Director of Strategy and Planning	2.5 – 5.0	0	20 – 25	0	343	295	28
Rabina Tindale Chief Nurse	0 – 2.5	0 – 2.5	50 – 55	150 – 155	1,198	1,151	24

* 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.

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 2023 was 27 (2022: 27).

The total number of directors in office as at 31 March 2023 was 17 (2022: 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 3 directors during the year was £3,441 (4 directors, £2,500 in 21/22).

The total amount of expenses reimbursed to 4 governors during the year was £471 (3 governors, £47 in 2021/22).

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.

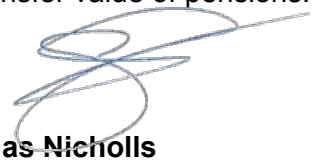
The banded remuneration of the highest paid director of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust in the financial year 2022/23 was ££265-270k (2021/22: £255-260k). This is an increase of 3.7% The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

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

2021/22	**25th percentile**	**Median**	**75th percentile**
Salary component of pay	£21,777	£34,026	£45,908
Total pay and benefits excluding pension benefits	£25,145	£36,676	£49,405
Pay and benefits excluding pension: pay ratio for highest paid director	11.4	6.9	6.1

For employees of the Trust as a whole, the range of remuneration in 2022/23 was from £13k to £320k (2021/22 £12.5k to £330k). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 8%. 1 employee received remuneration in excess of the highest-paid director in 2022/23, (2021/22,1).

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.



Silas Nicholls
Chief Executive and Accounting Officer

19 June 2023

STAFF REPORT

Throughout 2022/23 we have continued our recovery from the impact of the pandemic although the pace of this has been slow and the investment into our workforce limited given the financial, external and operational pressures faced.

In addition to this, staff dissatisfaction with pay and conditions in the NHS has led to large scale industrial action, causing service and patient care disruption locally. More positively, it has brought us closer together at WWL as unions, staff and leaders have worked in partnership to protect the safety of our patients and staff and minimise disruption where possible.

To respond to the challenges that our staff are facing, we have made a commitment to support staff wellbeing, prosperity, and flexibility. During 2022/23, we have:

- strengthened our Steps 4 Wellness & psychological support offering,
- built our staff diversity networks;
- implemented and expanded our exit interview and stay conversation mechanism for staff;
- reintroduced local wellbeing conversations;
- embedded supernumerary ward leaders;
- launched 'Just and Learning Culture' Leadership Training across our senior leadership teams.

We have also launched our cost of living and financial wellbeing programme in response to the economic hardship felt by our staff as a result of the worldwide economic downturn and increase in energy prices. The programme includes but is not limited to:

- financial advice sessions;
- discounted staff public transport;
- reduced cost or free food and drink from our dining facilities/on-site shops.

We continue to explore other avenues of support that we can provide to our staff as part of this programme..

Another key focus to increase staff prosperity is adoption of the Real Living Wage (RLW). The 2022/23 NHS pay award took our lowest earners in band 2 and band 3 above the RLW. Irrespective of the backdated and in-year pay deals, RLW may outstrip NHS Band 2 and Band 3 pay rates in 2023/23, therefore system wide discussions will take place in response to this.

Our work on digital HR systems has continued at pace throughout 2022/23. The implementation of the absence management system 'Empactis' has delivered reductions in sickness absence while promoting staff wellbeing in the areas of implementation. Increased use of the Health Roster system has been beneficial in providing real time workforce data which not only supports day to day operational management and planning but has been invaluable during the recent industrial action. Medical rostering has provided greater scrutiny of rotas and opportunities to reduce temporary staffing usage.

For 2023/24, we have redeveloped our corporate objectives aligned to the people strategic priority. Key milestones and improvement trajectories for each quarter will be agreed along with performance reporting to monitor and measure progress:

- to enable better access to the right people, in the right place, in the right number, at the right time;
- to ensure we improve experience at work by actively listening to our people and turn understanding into positive action;
- to develop system leadership capability whilst striving for true placed based collaboration for the benefit of our people.

In 2023/24 we will build on our people programmes by further developing the following:

Looking after our people

- leadership development linked to the Our Family, Our Focus, Our Future strategy which will be open to leaders at a range of levels;
- a coaching programme to develop leadership capability at all levels;
- organisational development solutions for teams or leaders to support them in strengthening engagement, teamworking or culture.

Supporting our people

- a Staff Psychological Support Service which is a non-crisis service for staff with mild to moderate concerns relating to their mental wellbeing;
- employment support for staff to liaise with their managers and HR representatives to ensure their mental health is supported and to increase understanding of mental health needs;
- our Steps 4 Wellness offer to better provide holistic support, with work ongoing to develop wellbeing plans for every area across the Trust;
- our Stress Management Teams Programme which aims to identify triggers to stress amongst teams and to produce meaningful action plans;
- work with local services such as Think Wellbeing, Increasing Access to Psychological Therapies services and the Greater Manchester Resilience Hub, to provide appropriate support for staff when their needs go beyond those provided by our in-house services.

Supporting staff attendance and wellbeing

- our Steps 4 Wellness and Psychological Support Service will provide a targeted response to support staff who report sickness absence relating to their mental health and work closely with HR colleagues to establish clear and timely pathways to psychological and wellbeing support for staff;
- early interventions from our Steps 4 Wellness function, such as screening tools, mental health support and staff musculoskeletal services. We will also continue to offer proactive support such as health checks.

Working differently

In addition to the agreement of our 2023/24 corporate objectives, each service has developed their own aligned business plan to support achievement of national plans and targets which confirms the local actions required to achieved these. This includes opportunities for the expansion of community discharge services and diagnostic hub, and use of technology to analyse our workforce requirements such as the expansion of the Virtual Ward and automation of manual IT processes. This enables the opportunity for upscaling of corporate services at ICS level.

Local efficiencies to be implemented in 2023/24 include:

- a new medical locum protocol focussing on robust financial sign off, increase in locum direct engagement, and the introduction of an early bird rate incentive;
- the development of a new medical workforce plan incorporating a wider skill mix review and opportunities for new role development;
- greater control of temporary medical staffing use, leading to better continuity of medical care and a reduction in locum spend;
- a workforce efficiency programme to reduce our time to hire, the number of recruitments made, medical locum usage (as above) and to increase nurse e-rostering efficiency.

Employment Essentials

Innovations in retention

To support our staff, we are updating our exit questionnaire to inform data analysis and action planning in response to the feedback received; identifying what we need to improve as an employer to reduce turnover related to staff experience.

Innovation in recruitment

In 2022/23, we have:

- held student nurse, AHP and midwifery transition to practice events to increase the numbers of students that convert to employment;
- increased domestic recruitment opportunities through social media and marketing improvements and use of targeted recruitment for larger services such as theatres;
- developed apprenticeships, pre-employment, talent for care and traineeship programmes;
- reignited and re-energised work experience and clinical placements for medical and non-medical students;
- implemented a fixed term to permanent contract process;
- made use of mass recruitment events with more planned;
- implemented an electronic right to work check system (Trust ID);
- developed and implemented a shortened MS Teams application form which is used for domestic, catering and for all honorary appointments;
- appointed a Recruitment Digital Marketing Lead to support recruitment campaign management;
- revised and launched an internal transfer protocol for nurses.

Next steps planned for 2023/24 include:

- looking to make use of robotic process automation for recruitment processes;
- developing an internal transfer protocol for other staff groups;
- developing talent pools across multiple roles;
- guaranteeing employment for health and care traineeships / apprenticeships;
- using the vacancy authorisation process for bank and agency usage;
- using the TRAC recruitment system for the new starter form process;

Since October 2021, when our freedom to speak up services started being provided by The Guardian Service, we have seen a positive culture change across the organisation. Nevertheless, work continues to embed a culture where colleagues feel that they have freedom to speak up safely and to demonstrate prompt action when addressing patient and staff concerns.

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.

Your Voice Matters

The National Staff Survey 2022 and our Your Voice survey April 2022, achieved the highest response rates since we began doing a full census of the surveys. The National Staff Survey results indicate that our scores have remained stable since 2021/22 with WWL scoring highest for 'morale' compared to similar organisations in Greater Manchester.

In response to these themes highlighted in the survey, we will:

- continue to strengthen engagement and staff voice through the Staff Engagement Associates (SEAs) network;
- launch a Just and Learning Culture Programme during 2023 which will include a culture-focused team and leadership development offer;
- roll out a revised appraisal system with focus on strengthening goal setting and alignment with strategic objectives cascade;
- focus on urgent and emergency care, particularly discharge and flow programmes to reduce operational pressures, continue to strengthen awareness of and access to personal development solutions and career pathways at WWL for all staff.

Our Family, Our Future, Our Focus culture and engagement programme continues to be the mechanism through which we audit and drive our engagement initiatives through executive sponsorship.

Learn and Grow

A focus in the next year is on launching a new appraisal system and developing mechanisms for staff to have positive, constructive conversations with their line manager about their performance and aspirations. The new process will provide leaders with the structure and tools to set clear goals and expectations which align with strategic objectives. It will support regular check ins throughout the appraisal cycle to manage progress and agree support for staff which will improve wellbeing, engagement and performance, and ultimately overall retention.

Our Talent for Care Strategy provides 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, fulfilling associated obligations as an anchor institution across the locality. To deliver this, we work in collaboration with Wigan and Leigh College, the Department for Work and Pensions and Wigan Council.

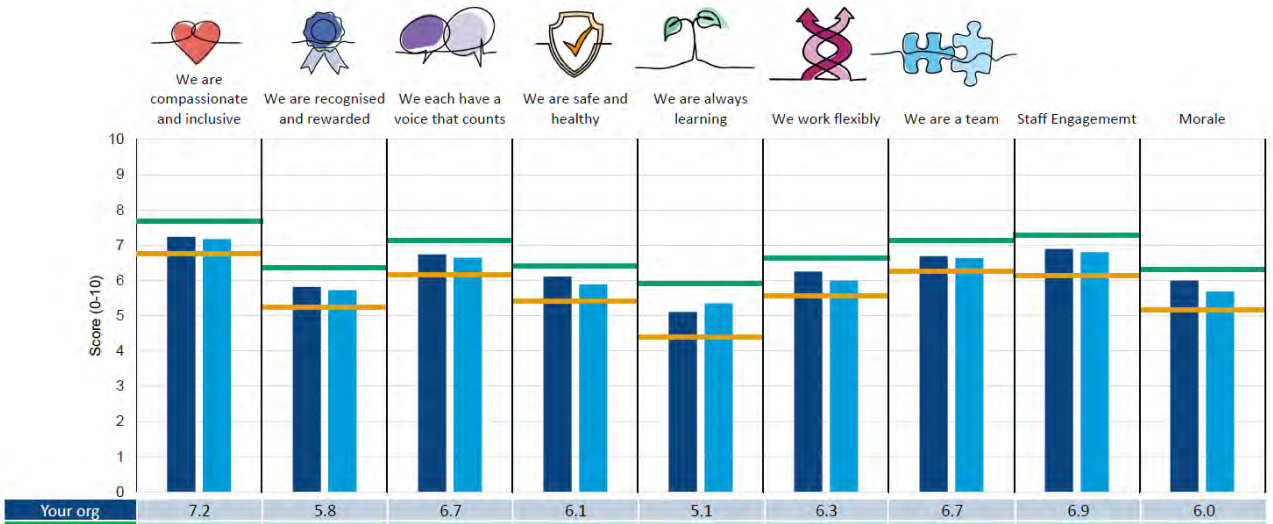
Our commitment to leadership development is as strong as ever. We will be focusing on expanding our coaching offer to strengthen leadership capabilities by developing more leaders as coaches,

offering leadership clinics to support leaders' personal development and continuing to support our senior leaders with 360 feedback and executive coaching. There will also be a new focus in 2023/24 on the design and implementation of a talent programme that will encourage, identify, develop, and deploy high potential talent into WWL leadership positions.

Staff experience and engagement: the NHS staff survey

We achieved a 35.0% response rate (2,417 respondents) in the 2022 National Staff Survey, a 5.5% increase from 2021. Whilst there is still work to do to increase the response rate in future surveys (sector average 44.7%), this is excellent progress and the highest response rate at WWL in 5 years.

The results from the National Staff Survey (NSS) revealed that all the People Promise scores and themes are similar to 2021, with no significant local changes since that time. This suggests a stable picture over the past 12 months which can be viewed positively, given the wider context we are working in.



	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 Engagememt	Morale
Your org	7.2	5.8	6.7	6.1	5.1	6.3	6.7	6.9	6.0
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2416	2410	2392	2399	2276	2397	2406	2416	2416

The results from the National Staff Survey revealed that the majority of the People Promise scores were above national average of the benchmarking group of Acute and Acute & Community trusts and broadly in line with the sector scores for similar organisations.

Staff Engagement (6.89) is also in line with scores for similar organisations, ranking 22nd out of 62 (14th in 2021), whilst staff 'Morale' (6.00) is significantly better than in other Trusts and ranks 8th out of 62 organisations (3rd in 2021).

Staff recommending WWL as a place to work is higher than the sector (WWL 61%; sector 56.96%). Despite being in line with the sector, staff feeling happy with the standard of care if a friend or relative needed treatment, has significantly declined by 5% this year (WWL 62.4%; sector 62.9%).

Based on the results, we identified different areas of focus for future improvements. Areas of strength include wellbeing support, flexible working, and equality and diversity. Areas of focus include acting on raised concerns, quality of appraisals and personal development and career pathways.

Areas of focus for Our Family Our Future Our Focus 2023/24:

- Showing how we are acting on concerns raised by staff and patients/service users using We Said We Did messages;
- The roll out of a revised Route Plan Appraisal strategy, with focus on strengthening goal setting and alignment with strategic objectives cascade;
- Continuing to strengthen awareness of and access to personal development solutions and career pathways at WWL including the Talent Programme;
- Building on the success of our culture programme, continuing to develop the work on civility, respect and just culture with teams and leaders.

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

	2022/23		2021/22		Improvement/ deterioration
	WWL	Sector average	WWL	Sector average	
Response rate	35%	43%	29.5%	45%	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%	1%	1%	Improvement
(13c) In the last 12 months I have personally experienced physical violence at work from other colleagues.	1.3%	2%	1%	2%	Deterioration
(16c03) Experienced discrimination on grounds of religion.	5.6%	4.9%	3%	5%	Deterioration
(16a) In the last 12 months I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	5.2%	8.9%	5%	8%	Deterioration
(16c04) Experienced discrimination on grounds of sexual orientation.	5.6%	4.1%	5%	4%	Deterioration

	2022/23		2021/22		Improvement/ deterioration
	WWL	Sector average	WWL	Sector average	
Bottom 5 ranking scores					
(21b) The appraisal/review helped me to improve how I do my job	19.7%	22.7%	18%	20%	Improvement
(21c) The appraisal/review helped me agree clear objectives for my work	27%	32.3%	28%	30%	Deterioration
(21d) The appraisal / review left me feeling that my work is valued by my organisation	27.4%	30.6%	29%	29%	Deterioration
(5a) I have unrealistic time pressures (never / rarely)	27.7%	22.6%	29%	23%	Deterioration
(4c) I am satisfied with my level of pay	29.9%	24.8%	38%	32%	Deterioration

At question level, most scores are in the intermediate-60% range of similar organisations. There are 29 scores that are in the top 20% and 6 scores that sit in the bottom 20% range clustered around discrimination and ‘We are always learning’. There are 43 scores that are significantly better than the sector average and only 7 that are worse.

2022/23 and 2021/22

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

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

People Promise 6:	Flexible working	6.2	5.9	6.1	5.9
People Promise 7:	Team working	6.6	6.6	6.3	6.5
People Promise 7:	Line management	6.7	6.6	6.7	6.8
Theme 1:	Morale	6.0	5.7	6.3	6.2
Theme 2:	Staff engagement	6.89	6.76	7.1	7.0
Staff engagement:	Advocacy	6.7	6.6	7.0	6.8

2020/21, 2019/20 and 2018/19

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

	2020/21		2019/20		2018/19	
	WWL	**Combined trusts**	**WWL**	**Combined trusts**	**WWL**	**Acute trusts**
Equality, diversity and inclusion	9.2	9.1	9.2	9.2	9.1	9.1
Health and Wellbeing	5.9	6.1	5.9	6.0	5.8	5.9
Immediate Managers	6.7	6.8	6.9	6.9	6.8	6.7
Morale	6.3	6.2	6.5	6.5	6.2	6.1
Quality of Appraisals	N/A	N/A	5.0	5.5	4.9	5.4
Quality of care	7.7	7.5	7.8	7.5	7.8	7.4
Safe environment – bullying and harassment	8.0	8.1	8.3	8.2	8.0	7.9
Safe environment – violence	9.6	9.5	9.6	9.5	9.6	9.4
Safety culture	6.7	6.8	6.9	6.8	6.5	6.6
Staff engagement	7.1	7.0	7.3	7.1	7.0	7.0
Team Working	6.3	6.5	---	---	---	---

Diversity and inclusion and our longer-term ambitions

WWL's 2022-26 Equality, Diversity and Inclusion (EDI) Strategy was published in January 2022 and is centred around increasing diversity and accessibility, eliminating inequality, and improving experience for protected groups.

In a true commitment to the EDI agenda, we have taken the stance that EDI will be everybody's responsibility, to help to deliver our strategy. The new Equality Delivery System 2022 (EDS3), places much more emphasis on EDI responsibility belonging to everyone than its predecessor EDS2 did. Leaders will be supported to understand what EDI is and what short, medium and long-term EDI objectives could look like in their team/division in order to achieve this.

We continue our internal activities to promote an inclusive culture including:

- acting on staff feedback and diversity data to improve Workforce Race Equality Standards, Workforce Disability Equality Standards and Gender Pay Gap scores, including positive action;
- the Disability Confident Scheme, Rainbow Badge Scheme, Race Equality Standards, with strong focus on inclusive recruitment and induction as well as confidence in using equality impact assessments;
- EDI engagement work including EDI Champion and Gold Champions to cascade EDI related learning to local areas and an EDI calendar to raise cultural awareness amongst staff.

Great progress has been made with our diversity networks - disability and long-term conditions, FAME (For All Minority Ethnicities) and True Colours (LGBTQIA+). These networks provide a safe forum for staff to connect and share experiences with others within the same community. The second function of the networks is to help to deliver the EDI Strategy objectives, and each network will have at least one live project progressing at any one time, which have included:

- FAME: increasing cultural competency of WWL staff
- LGBTQIA+ : headline sponsorship of Wigan Pride
- Disability: scoping Invisible Disability Employer status.

We remain a Disability Confident employer, which means that we guarantee interviews to anyone declaring a disability during the recruitment process that meets the essential criteria for the role. We also ensure that equal opportunities and equality and diversity training is completed by managers with recruiting responsibilities, and we work proactively with the Access to Work service to make appropriate adjustments where required to ensure that disabled employees can fulfil their roles.

As at March 2022, the Trust has a 13.3% (15.02%, 2021) median hourly rate gender pay gap. When comparing mean (average) hourly pay, women's mean hourly pay is 30.1% lower than men's. The median gender pay gap in 2022 has reduced by 2% since 2020. Whilst women are the predominant workers across all four pay quarters, male workers are not evenly distributed and a significant proportion falls in the top quarter, particularly in the medical and dental staff group.

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 2023

Directors:	9 female (52.94%), 8 male (47.06%)
Senior managers:	246 female (73.43%), 89 male (26.56%)
Employees:	5,589 female (81.21%), 1,293 male (18.79%)
(by headcount, senior managers are band 8a and 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 2021 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 2021	**Adjusted FTE days lost to Cabinet Office definitions**	**Average sick days per FTE**	**FTE days available**	**FTE days lost to sickness absence**
5,933	91,818	15.5	2,165,464	148,949

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 (LCFS1449) who is trained to investigate to a criminal standard. We have a Fraud, Corruption and Bribery Policy & 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 relating to fraud, bribery and corruption. All staff are required to successfully complete a mandatory e-learning anti-fraud module every two years and continual fraud awareness campaigns are undertaken via the intranet, news articles and presentations.

Health and Safety

This year, our health and safety team, have been focusing on a post-pandemic recovery plan to reintroduce some proactive aspects of the health and safety service that had been stood down, including health and safety support visits, face-to-face training, and work associated with the management of medical sharps. The team have also been supporting the Trust's new agile way of working by developing a health and safety management system to identify and control associated risks. Handling non-clinical incidents remains an important role along with the investigation of incidents which were reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, as does working with the our legal team where issues with employer's liability arise, The ongoing review and update of health and safety policies and procedures continued; however, the team have begun to structure these to adopt the Health and Safety Executive's 'plan, do, check, act' model as set out in HSG65: Successful Health and Safety Management. In September 2022, the Trust engaged the services of the Health and Safety Executive, and the executive team completed the NEBOSH HSE Leadership Excellence training course. The year ahead is exciting, as well as the roll-out of a bespoke system that will hold all health and safety risk assessments and other documentation, the team are planning to provide new health and safety training courses to support leadership onboarding.

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 2022/23.

Relevant union officials

Number of employees who were relevant union officials during the relevant period:	40
Full-time equivalent employee number:	35.61

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	14
1-50%	23
51-99%	0
100%	3

Percentage of pay bill spent on facility time

Total cost of facility time:	£131,000
Total pay bill:	£320,173,000
Percentage of total pay bill spent on facility time:	0.04%

Paid trade union activities

Total paid facility and union time hours	6,754

Employee costs

	Permanent £000	Other £000	**2022/23 Total £000**	2021/22 Total £000
Salaries and wages	235,955	20,086	**256,041**	238,543
Social security costs	24,888		**24,888**	22,836
Apprenticeship levy	1,153		**1,153**	1,074
Employer contributions to NHS pension scheme	27,257		**27,257**	25,577
Employer contributions paid by NHSE	11,987		**11,987**	11,143
Temporary staff - external bank / agency /contract		46,955	**46,955**	35,023
Total staff costs	301,240	67,041	**368,281**	334,196
Costs capitalised as part of assets			**2,032**	1,534

Average number of employees (based on whole-time equivalents)

	Permanent (Number)	Other (Number)	**Total 2022/23** (Number)	Total 2021/22 (Number)
Medical and dental	583	81	**664**	632
Administration and estates	1,456	30	**1,486**	1,450
Healthcare assistants and other support staff	704	10	**714**	680
Nursing, midwifery, and health visiting staff	2,516	542	**3,058**	2,819
Scientific, therapeutic and technical staff	922	41	**963**	918
Healthcare science staff	4	0	**4**	4
Other	11	0	**11**	12
Total average numbers	6,196	704	**6,900**	6,515
Number of employees (WTE) engaged on capital projects	28	8	**36**	26.15

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 compensation schemes: exit packages 2021/22

Exit package cost band (including any special payment element)	Total number of exit packages
<£10,000	28
£10,001 to £25,000	1
£25,001 to £50,000	0
£50,001 to £100,000	0
Total number of exit packages by type:	29
Total resource cost:	**£100,000**

During 2021/22, exit packages related to payments made in lieu of notice.

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

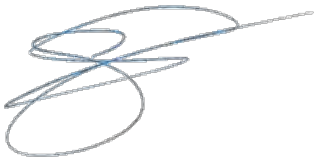
Highly paid off-payroll worker engagements as at 31 March 2023, earning £245 per day or greater	
Number of existing engagements as at 31 March 2023:	46
Of which, the number that have existed:	
For less than one year at time of reporting:	10
For between one and two years at time of reporting:	19
For between two and three years at time of reporting:	11
For between three and four years at time of reporting:	5
For four or more years at time of reporting:	1

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2023 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2023:	113
Of which:	
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	110
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 2023	
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)	21

Our use of off-payroll arrangements is limited to occasions when it is deemed unavoidable and subject to close scrutiny.



Silas Nicholls
Chief Executive and Accounting Officer

19 June 2023

Disclosures set out in the NHS Foundation Trust Code of Governance

We have applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, as revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. These principles have been applied, since they are the ones in force throughout the year 2022/23. From 1 April 2023, an updated code of governance, the Code of Governance for NHS Provider Trusts, will come in to force. The new code is modelled on the 2018 version of the UK Corporate Governance Code.

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 2022/23.

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 by canvassing the views of foundation trust members and others on our forward plan and communicating these to the Board of Directors.

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 2022/23 of those governors who remain in post as at the date of writing:

Name	Constituency/organisation	Term of office ends (see note 1)	Attendance 2022/23 (see note 2)
Public governors			
Peter Allard	Public: Wigan	2025	100%†
Alan Boardman	Public: Leigh	2025	33%†
Alan Baybutt	Public: Wigan	2024	NA**
Andrew Bullen	Public: Makerfield	2026	0%*
Les Chamberlain	Public: Makerfield	2025	100%
Ken Griffiths	Public: Makerfield	2026	75%
Andrew Haworth	Public: Leigh	2024	100%
Julie Hilling	Public: Rest of England and Wales	2024	100%
Mustapha Koriba	Public: Rest of England and Wales	2025	83%
Lisa Lymath	Public: Rest of England and Wales	2025	83%
Catherine Martindale	Public: Wigan	2024	83%
Malcolm Ryding	Public: Rest of England and Wales	2024	67%
Shelly Sephton	Public: Leigh	2023	67%
Susan Spibey	Public: Leigh	2024	50%
Linda Taberner	Public: Wigan	2025	33%†
Philip Woods	Public: Makerfield	2023	67%
Staff governors			
Emily Cooper	Staff: Medical and Dental	2024	33%††
Stephen Gorst	Staff: All other staff	2024	83%
Michelle Hartley	Staff: Nursing and Midwifery	2024	67%
Andrew Savage	Staff: All other staff	2023	100%
Appointed governors			
John Cavanagh	Foundation Trust volunteers	2024	67%
Dawne Gurbutt	University of Central Lancashire	2024	17%††
Syed Shah	Local Medical Committee and CCG	2022	50%
Bryonie Shaw	Age UK Wigan Borough	2024	100%
Fred Walker	Wigan Council	2023	67%

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 2022/23 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.

* Andrew Bullen was appointed after the last meeting of 2022/23 due to a vacancy which arose in-year. He was therefore only eligible to attend one meeting during the year, and his 0% attendance rate should be viewed in this context.

** Alan Baybutt took up his seat in June 2023, following the resignation of the highest polling candidate and was therefore not eligible to attend any meetings.

† Those governors who were elected or appointed in November 2022 were only eligible to attend three meetings during the year. Attendance figures should therefore be viewed in this context.

†† Emily Cooper and Dawn Gurbutt had periods of sickness during the year 2022/23, which affected their ability to attend meetings

The Council of Governors appoints a lead governor each year. Andrew Haworth was appointed to this role for the second 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 163.

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 one non-executive director on behalf of the Council of Governors, as outlined on page 58.

Training and development for governors

During 2022/23, 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:

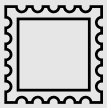
Email

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 2022/23:

- Clare Austin
- Rhona Bradley
- Mary Fleming
- Ian Haythornthwaite
- Paul Howard
- Mark Jones
- Lynne Lobley
- Anne-Marie Miller
- Richard Mundon
- Silas Nicholls
- Francine Thorpe

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.

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 2023 and comparative figures for the previous year have also been provided:

Constituency	No. members as at 31 Mar 2023	No. members as at 31 Mar 2022	Change
Public: Leigh	1,797	1,824	-27
Public: Makerfield	1,938	1,957	-19
Public: Wigan	2,404	2,450	-46
Public: Rest of England and Wales	2,548	2,564	-16
Staff: Medical and Dental	541	481	+ 60
Staff: Nursing and Midwifery	2,071	1,917	+154
Staff: All other staff	4,625	4,429	+196
Total members:	**15,924**	**15,622**	**302**

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 has 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 risk management arrangements 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 waiting list management and medical e-rostering, on which the committee was briefed during the year;

- high assurances level allocated to internal audits of risk management core controls, accounts payable and treasury management.

KPMG became our external auditors during the previous year following a tender exercise which was conducted in 2020/21. No non-audit services were provided by KPMG during 2022/23.

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 the completeness of accrued expenditure. These are relatively standard audit risks prescribed by professional auditing standards and do not imply any particular control issues within the foundation trust.

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 2022/23 was as follows:

Name	A	B	%
Clare Austin	4	5	80%
Rhona Bradley	4	5	80%
Steven Elliot	1	5	20%
Ian Haythornthwaite (Chair)	5	5	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 57.

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 his 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 58.

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

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 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 March 2023.

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.

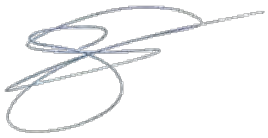
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- 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.



Silas Nicholls
Chief Executive and Accounting Officer

19 June 2023

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 2023 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, I have ultimate accountability and responsibility for leading our risk management arrangements on behalf of the board. Leadership and day-to-day responsibility for the risk management process sits with the Director of Corporate Affairs, supported by a dedicated Head of Risk.

Leadership arrangements for risk management are documented in our risk management strategy and are further supported by the board assurance framework and individual job descriptions. The risk management strategy outlines our approach to risk and the accountability arrangements, including the responsibilities of the board and its committees, executive directors and all employees. During 2021/22 we placed significant emphasis on the development and embedding of new risk management arrangements, including refreshed arrangements for recording, monitoring and scrutinising risks, and we have continued our focus on this throughout 2022/23.

Active leadership from managers at all levels to ensure effective risk management is a fundamental part of an integrated approach to quality, corporate and clinical governance, performance management and assurance. Our Risk Management Group is usually chaired by me and it reviews all risks scoring 15 and above (more information on the scoring methodology used is provided below). Chairing the Risk Management Group allows me to get a good oversight of the arrangements but 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 board and its committees receive and scrutinise the risks to achieving our corporate objectives through the board assurance framework. In 2021/22 we updated the format of our board assurance framework, taking account of the views of our internal auditor and NHS benchmarking information that was made available to us. We have further refined this during 2022/23 and our internal auditor

confirmed that our approach fully meets the expectations of an effective NHS board assurance framework.

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, including Executive Team meetings as well as board and assurance committee meetings.

As part of the on boarding process, all new members of staff are required to attend a mandatory induction and to undertake e-learning training covering key elements of risk management within two months of their appointment. This is also supplemented by local induction. The 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. Additional training is made available to all levels of staff, covering areas such as fire safety, health and safety, moving and handling, resuscitation and first aid. In September 2022, members of the Executive Team and the Chair completed the NEBOSH HSE Certificate in Health and Safety Leadership Excellence, delivered by the Health and Safety Executive, to further reinforce the importance of good risk management.

We aim to learn from good practice, and we normally hold a clinical audit conference each year. This conference last took place in May 2022, following a period where the conference was cancelled as a result of COVID-19. We also undertake regular grand rounds for doctors to discuss specific topics and to highlight best practice and we also look for examples of good practice from across the sector and beyond to inform our risk management practices.

The risk and control framework

Our 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 our objectives. The board is corporately accountable for ratifying, adhering to and delivering in line with our risk management framework. The board determines and continuously assesses our risk appetite; the nature and extent of the principal risks that we are exposed to as a trust and that we are willing to take to achieve our objectives 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 our four principal objectives: patients, people, performance and partnerships. We have established risk management activities which cover all types and sources of risk. The aim of this is to allow us to understand our overall risk profile. We use 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

We evaluate risk to determine whether the risk level is within our risk appetite range, or whether the risk requires further control measures to reduce its level, known as risk treatment. Our 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. Our willingness to accept a risk above the risk appetite will depend on which of our principal objectives is at risk and the positive or negative impact that the risk would have on achievement of our 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 our standard operating procedure for risk management, to enable us 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 of our obligations, commitments and partner/stakeholder 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, we specify 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 our 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 an organisation 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 an organisation is willing to operate, given current constraints. This balances the funding position with the position outlined in our objectives. Above this threshold, we actively seek to manage risks and prioritises time and resources to reduce, avoid or mitigate them. The board agrees our risk appetite and risk tolerance levels as part of our annual strategic planning process.

A risk lead 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.

Our risk appetite statement, for 2022/23, 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 Minimal	4 - 6 Minimal	⩽ 6 Cautious	8 - 10 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
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 Cautious	8 - 10 Cautious	⩽ 15 Eager	⩽ 15 Eager

Our key quality governance committee is the Quality and Safety Committee, chaired by a non-executive director, which reports directly to our board. This committee seeks assurance that high standards of care are provided and ensures that there are adequate and appropriate quality assurance governance systems, processes and controls in place across the organisation. Dedicated groups around patient safety, patient experience, medicines management, infection control and health and safety report into the Quality and Safety Committee. These groups provide assurances on key elements of quality and governance, allowing the Quality and Safety Committee to scrutinise these assurances on behalf of our Board of Directors.

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 inspection by the Care Quality Commission was in October and November 2019, with the report published in February 2020. The inspection comprised two elements – the first being an unannounced inspection of three core services and the second being the a well-led inspection.

We are proud that our overall provider level was found to be 'Good' with all sites being rated as either Good or Outstanding. We continue to maintain contact with the Care Quality Commission inspection 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 2022/23:

Patients:	• Clinical services - recognition, screening and treatment of the deteriorating patient • Preferred place of death • Harm free care - avoidable pressure ulcers • Ward accreditation programme • Complaint response rates
People:	• Person centred people management • Participation in preventative and restorative wellbeing activities • Fairness and compassion - workforce equality, diversity and inclusion expertise and supporting infrastructure • Personal development

Performance:	• Financial performance: failure to meet the agreed investment and expenditure position • Financial sustainability: efficiency targets & balance sheet • Estates Strategy - capital Funding • Elective services - waiting List • Urgent and emergency care • Estate strategy - net carbon zero requirements
Partnerships:	• Partnership working - CCG changes • University Teaching Hospital - University Hospital Association criteria

These risks are likely to remain the same during 2023/24.

In line with best practice guidance from NHS England, Deloitte LLP undertook an externally facilitated review of our leadership and governance using the NHS well-led framework during 2021/22, the results of which were reported to the board in February 2022. No major concerns were identified and we developed an action plan as a result, which we have continued to monitor through our public board meetings and have now closed.

The review comprised of a desktop review of relevant documentation, a board survey which was completed by all board members, interviews with each member of the board, individual interviews with a sample of senior staff and joint interviews with each of the divisional leadership teams. In addition, the review team undertook observations of our key meetings, undertook focus groups with our staff and our Council of Governors and sought the views of our key external stakeholders by way of telephone interview. The themes from the review were then explored in detail with the board at a dedicated workshop.

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, including an additional focus on the digital agenda. These have been implemented as planned this year.

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 FT4. 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.

Corporate governance statement

The board acknowledges that it is essential that the correct combination of structures and processes is in place at and below board level to enable the board to assure the quality of care that the 97rganization provides. We are committed to the continuous improvement of these structures and processes.

The review of leadership and governance undertaken last year identified no areas of concern and numerous areas of good practice. Progress against our action plan has been reported through the board. This contributes to the board's ability to assure itself of the validity of the corporate governance statement we submit to NHS England in accordance with our provider licence condition.

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 Inclusion and Diversity Steering Group on a quarterly basis and is overseen by our People Committee. An inclusion and diversity operational group, which reports to the steering group, meets on a quarterly basis and takes a lead role in supporting the delivery of the action plan.

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 have previously worked closely with Wigan Borough Clinical Commissioning Group to implement the Accessible Information Standard and look to continue this work now with our ICS colleagues.

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 internal 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:

- Overall control design for risk management at WWL was robust.
- Governance processes were clearly defined and we had a risk appetite statement in place. Roles and responsibilities relating to risk management were clearly outlined.

- Risk management training was delivered for all staff through mandatory training modules, supported by compliance monitoring dashboards. Standardised risk recording processes were in place.
- 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, these now having been reinstated following a period of suspension due to the national restrictions in place during the pandemic.

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 bimonthly. The committee seeks assurance on our strategic 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. 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.

Adhering 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. Our Nursing, Midwifery, Therapy and Care Staff Strategy reinforces this work in respect of the nursing, midwifery and therapy workforce and delivery of patient care and also defines our approach to vacancy gaps and turnover.

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.

An up-to-date register of interests is available on our website, including gifts and hospitality, for decision-making staff (as defined by the foundation trust with reference to the guidance), 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, we have control measures 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 members' pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

The foundation trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme**.** The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. We have also undertaken risk assessments and have a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). We ensure that our obligations under the Climate Change Act and the adaption reporting requirements are complied with.

For 2023/24, we have redeveloped our corporate objectives aligned to the people strategic priority. Key milestones and improvement trajectories for each quarter will be agreed along with performance reporting to monitor and measure progress:

- To enable better access to the right people, in the right place, in the right number, at the right time.
- To ensure we improve experience at work by actively listening to our people and turn understanding into positive action.
- To develop system leadership capability whilst striving for true placed based collaboration for the benefit of our people.

These objectives are also built into the board assurance framework.

In addition to the agreement of our 2023/24 corporate objectives, each service has developed their own aligned business plan to support achievement of national plans and targets which confirm the local actions required to achieved these. This includes opportunities for the expansion of community discharge services and diagnostic hub, virtual ward and upscaling of corporate services at Integrated Care System level.

Local efficiencies to be implemented in 2023/24 include:

- A new medical locum protocol focussing on robust financial sign off, increase in locum direct engagement, and the introduction of an early bird rate incentive.

- Development of a new medical workforce plan incorporating a wider skill mix review and opportunities for new role development.

- Enhanced medical resourcing expertise to support the implementation of the above; greater control of temporary medical staffing use, leading to better continuity of medical care and a reduction in locum spend.

- Our workforce efficiency programme. This aims to reduce time to hire, the number of recruitments and medical locum usage (as above) and to increase nurse e-rostering efficiency.

Our work on digital HR systems has continued at pace throughout 2022/23. We have seen a reductions in sickness absence as a result of the partial implementation of the 'Empactis' absence management system, which also promoted staff wellbeing in the areas of implementation. It is hoped that we will be able to implement 'Empactis' fully during 2023/24 so that these benefits can be expanded upon. Increased use of the Health Roster system has reduced overpayments and management costs and been beneficial in providing real time workforce data which not only supports day to day operational management and planning, but has been invaluable during the numerous periods of industrial action which took place during the year. Medical rostering has provided greater scrutiny of rotas and opportunities to reduce temporary staffing usage.

In response to the ongoing challenge in recruiting to key roles, particularly across our clinical services, in 2022/23 we have implemented:

- Student nurse, AHP and midwifery transition to practice events to increase the numbers of students that convert to employment.
- An increase in domestic recruitment opportunities through social media and marketing improvements and use of targeted recruitment for larger services such as theatres.
- Development of apprenticeships, pre-employment, talent for care and traineeship programmes, through links with local colleges, job centre plus and local community groups.
- The reignition and re-energising of work experience and clinical placements for medical and non-medical students.
- Our fixed term to permanent contract conversion process.
- Ongoing use of mass recruitment events, with more planned.
- An electronic right to work check system (Trust ID).
- A shortened Microsoft Teams application form, used for domestic, catering and mass recruitment event roles, and for all honorary appointments.

To respond to the challenges that our staff are facing, we have made a commitment to support staff wellbeing, prosperity and flexibility. During 2022/23 we have:

- Strengthened our Steps 4 Wellness & psychological support offering.
- Built and developed our staff diversity networks.
- Implemented an expanded exit interview and stay conversation mechanism for staff.
- Reintroduced local wellbeing conversations.

- Embedded supernumerary ward leader positions.
- Launched 'Just and Learning Culture' leadership training across our senior leadership teams.

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;
- 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 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* (CQUIN) targets 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.

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.

Information governance

Information governance provides the framework for handling information 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:

- 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 data security training for all staff.
- 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 reviewed 1,599 information incidents between 1 April 2022 and 31 March 2023. After reviewing we escalated 12 incidents to the Information Commissioner's Office (ICO). Of these 12 incidents, all have been closed with no further action being taken. Subsequently we have two open incidents with the ICO from 2020/21 and 2021/22, both relating to accuracy and availability of patient information.

The incidents that were reported to the ICO 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 no discharge letter being sent, a letter containing personal sensitive data being sent to an incorrect address, missfiling of patient records and phishing campaign attacks. In 2022/23 we have seen an increase in the number of targeted phishing campaigns and the information governance team continues to work closely with colleagues in the information management and technology team and the Senior Information Risk Owner to reduce any impact on patients as well as staff.

In 2022/23 we submitted one improvement plan as part of the Data Security and Protection Toolkit submission in June 2022. Achievement of this plan was monitored by the Senior Information Risk Owner Group, and we submitted the completed plan in December 2022, therefore meeting the standards for the 2022/23 return.

The information governance team works with colleagues, services, and departments across the organisation to offer guidance and support. The team acts to ensure that implementation of remedial actions address any shortfalls in controls where identified, to mitigate risk. All information incidents are reported on Datix, our incident management system and this aligns with regulatory requirements.

Data quality and governance

We are a data-driven organisation and recognise that to make effective use of data, we need to ensure there are controls and procedures in place to ensure that the data on which decisions are based is of a high quality.

Our data analytics and assurance team produce applications that highlight errors and inconsistences in data, providing a level of transparency to the organisation which empowers service managers to implement changes. These changes allow for the develop of procedures which aim to address any issues at source and which result in overall improvement in the way that we do things.

It is imperative that information is captured in a timely and accurate manner, it is the responsibility of all staff to ensure that this takes place. We have a dedicated data quality team, who are responsible for providing advice and guidance on how we can make improvements to our data. The team undertake regular analysis of data and feed back their findings, which may have otherwise gone unnoticed, to those using the data.

We continue to take steps towards implementing our first robotic automation process; increased use of automation will reduce errors with data and provide us with consistency between our systems.

2022/23 saw the data analytics and assurance team release the first iteration of the performance scorecard. The scorecard will centralise our top key performance indicators and enable the organisation to monitor itself against these metrics in a meaningful way. Further functionality will be released in 2023/24.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee [and risk/clinical governance/quality committee, if appropriate] 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, Quality and Safety Committee, the 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 and Quality and Safety 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 NHS Foundation Trust Code of Governance

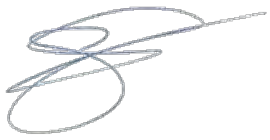
- internal auditors review the board assurance framework and the effectiveness of the system of internal control as part of the internal audit work to assist in the review of effectiveness. The internal auditors reviewed the assurance framework and concluded that our assurance framework meets the requirements set out in NHS guidance, is visibly used by the board and clearly reflects the risks discussed by the board. Feedback from the auditors on the format of the board assurance framework was instrumental in designing the new format assurance framework that is now in place.

- 2 internal audits undertaken in 2022/23 were given limited assurance, relating to Waiting List Management and Medical E-Rostering and management actions have been put in place to address the issues raised. Of the 45 recommendations issued by the internal auditors during the year, all were accepted by management. 5 of the recommendations were described as high-risk recommendations and were addressed immediately.

The Head of Internal Audit Opinion for the period 1 April 2022 to 31 March 2023 provides substantial assurance that there is a good system of internal control. The overall opinion for the period 1st April 2022 to 31st March 2023 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.

Conclusion

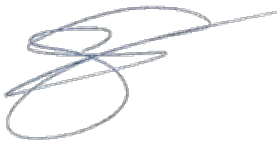
My review confirms that Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust has sound systems of internal control, with no significant control issues having been identified.



Silas Nicholls
Chief Executive and Accounting Officer

19 June 2023

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



Silas Nicholls
Chief Executive and Accounting Officer

19 June 2023

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 2023 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statements of Changes in Taxpayers' Equity, Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2023 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 March 2023 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

significant doubt on the Trust's ability to continue as a going concern for the going concern period.

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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 recognised a fraud risk related to expenditure recognition, particularly in relation to the completeness of year end accruals.

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.

We did not identify any additional fraud risks.

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 by senior finance staff and those posted to unrelated accounts linked to the recognition of expenditure or cash.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Assessing the completeness and accuracy of recorded expenditure through specific testing over accruals.

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

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

We 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 these 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 2022/23. 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 2022/23.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 89, 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 89, 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 have planned our work and undertaken 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. 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 2023 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

28 June 2023

FINANCIAL REPORT.

Foreword to the accounts

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2023, 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 ……

Silas Nicholls
Chief Executive

Date **19 June 2023**

Statement of Comprehensive Income for the year ended 31 March 2023

	Note	2022/23 £000	2021/22 £000
Operating income from patient care activities	2	492,501	451,213
Other operating income	3	30,076	25,976
Total operating income from continuing operations		**522,577**	**477,189**
Operating expenses	4	(524,673)	(474,687)
Operating surplus/(deficit) from continuing operations		**(2,096)**	**2,502**
Finance costs			
Finance income	7	940	56
Finance expenses	8	(620)	(312)
PDC dividends payable		(4,656)	(4,093)
Net finance costs		**(4,336)**	**(4,349)**
Gain or (Loss) on disposal of fixed assets	9	(115)	(311)
Gains from transfers by absorption	28	63	11
(Deficit) for the year		**(6,484)**	**(2,147)**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments	11	(2,820)	(2,861)
Revaluations	12	3,035	4,093
Other reserve movements		0	4
Total comprehensive expense for the year		**(6,269)**	**(911)**

Statement of Financial Position as at 31 March 2023

	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Intangible assets	10	5,284	5,729
Property, plant and equipment	11	212,985	203,647
Right of use assets	13	32,879	0
Receivables	16	1,079	652
Total non-current assets		**252,227**	**210,028**
Current assets			
Inventories	15	3,693	3,001
Receivables	16	31,819	13,644
Non-current assets held for sale	17	0	0
Cash and cash equivalents	18	43,098	54,085
Total current assets		**78,610**	**70,730**
Current liabilities			
Trade and other payables	19	(89,244)	(78,520)
Other liabilities	20	(5,723)	(3,304)
Borrowings	21	(7,441)	(1,588)
Provisions	22	(1,432)	(3,796)
Total current liabilities		**(103,840)**	**(87,208)**
Total assets less current liabilities		**226,997**	**193,550**
Non-current liabilities			
Other liabilities	20	(124)	(186)
Borrowings	21	(40,252)	(13,923)
Provisions	22	(2,656)	(2,369)
Total non-current liabilities		**(43,032)**	**(16,478)**
Total assets employed		**183,965**	**177,072**
Financed by			
Public dividend capital		130,620	117,458
Revaluation reserve		21,958	22,624
Income and expenditure reserve		31,387	36,990
Total taxpayers' equity		**183,965**	**177,072**

The primary financial statements on pages 2 to 5 and the notes on pages 6 to 50 were approved by the Board of Directors and authorised for issue on 19 June 2023 and signed on its behalf by Silas Nicholls, Chief Executive.

Signed …… **19 June 2023**
Silas Nicholls, Chief Executive

Statement of Changes in Equity for the year ended 31 March 2023

	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**
Implementation of IFRS 16 on 1 April 2022	0	0	0	0
Surplus/(Deficit) for the year	0	0	(6,484)	(6,484)
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 £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2021	**109,933**	**21,788**	**38,737**	**170,458**
Surplus/(Deficit) for the year	0	0	(2,147)	(2,147)
Other transfers between reserves	0	(384)	384	0
Impairments	0	(2,861)	0	(2,861)
Revaluations	0	4,093	0	4,093
Transfer to retained earnings on disposal of asset	0	(12)	12	0
Public dividend capital received	7,525	0	0	7,525
Other reserve movements	0	0	4	4
Taxpayers' equity at 31 March 2022	**117,458**	**22,624**	**36,990**	**177,072**

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	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(2,096)	2,502
Non-cash income and expense			
Depreciation and amortisation	4	17,416	10,799
Net impairments and (reversals) of impairments	4	3,565	2,432
Income recognised in respect of capital donations (non-cash)	3	(149)	(252)
Decrease in receivables and other assets		(18,456)	(1,812)
Decrease/(Increase) in inventories		(692)	280
Increase in payables and other liabilities		14,842	10,635
Decrease in provisions		(2,111)	(610)
Other movement in operating cashflows		1	(3)
Net cash generated from operating activities		**12,320**	**23,971**
Cash flows used in investing activities			
Interest received		794	28
Purchase of intangible assets		(488)	(4,306)
Purchase of property, plant, equipment and investment property		(26,391)	(15,389)
Receipt of cash donation to purchase capital assets		58	180
Sales of property, plant, equipment and investment property		445	363
Net cash used in investing activities		**(25,582)**	**(19,124)**
Cash flows used in financing activities			
Public dividend capital received		13,162	7,525
Loans received		0	1,247
Loans paid		(1,221)	(930)
Capital element of lease liability repayments		(4,535)	0
Interest element of lease liability repayments		(320)	0
Other interest paid		(270)	(289)
PDC dividend paid		(4,541)	(3,359)
Net cash used in financing activities		**2,275**	**4,194**
Increase in cash and cash equivalents		**(10,987)**	**9,041**
Cash and cash equivalents at 1 April		54,085	45,044
Cash and cash equivalents at 31 March	18	**43,098**	**54,085**

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 2022/23 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 other entities 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.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Foundation Trust is a joint operator it recognises its share of, assets, liabilities, income and expenditure in its own accounts.

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 2022/23, 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 13).

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 2022/23.

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 2022/23 with a revaluation date of 31 March 2023.

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 2023 is £218m (£209m, 2021/22).

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 in the form of fixed payments to fund an agreed level of activity.

Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration.

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. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

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 the Foundation Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

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, including payments arising from the apprenticeship levy are recognised in the period in which the service is received from employees including non-consolidated performance pay earned but not yet paid. The cost of leave 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.

NHS Pensions

Past and present employees are covered by the provisions of the two 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 are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

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

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

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 replaces *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.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line or other systematic basis.

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 2023:

Short term rate: 3.27% (0.47%, 2021/22)
Medium term rate: 3.20% (0.70%, 2021/22)
Long term rate: 3.51% (0.95%, 2021/22)

For post-employment benefits including early retirement provisions and injury benefit provisions the HM Treasury's pension discount rate of 1.70% in real terms (-1.30%, 2021/22) 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 22.1 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 23 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 23 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 disapply 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).

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 2022/23.

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] (2023/24) – 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 - 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:

	2022/23 £000	2021/22 £000
NHS England	48,482	36,755
Clinical Commissioning Groups*	97,954	396,934
Integrated Care Boards*	320,907	0
NHS Foundation Trusts	4,882	4,711
NHS Trusts	7	37
Local Authorities	12,785	5,820
Department of Health and Social Care	0	143
NHS other (including Public Health England)	0	123
Non NHS: private patients	5,118	4,459
Non NHS: overseas patients (chargeable to patient)	88	141
NHS injury scheme (ICR)**	812	823
Non NHS: other	1,466	1,267
Total income from activities	**492,501**	**451,213**

*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 23.76% (23.76%, 2021/22) to reflect expected rates of collection.

Note 2.2 Income from patient care activities (by nature)

	2022/23 £000	2021/22 £000
Acute services		
Block contract / system envelope income	374,695	370,003
High cost drugs income from commissioners (excluding pass through costs)	1,676	1,743
Other NHS clinical income*	16,708	11,023
Community Services		
Block contract / system envelope income	44,488	40,329
Income from Other Sources (e.g. local authorities)	6,484	5,777
Additional income		
Private patient income	5,118	4,459
Elective recovery fund	10,234	4,142
Agenda for change pay offer central funding****	12,139	0
Additional pension contribution central funding **	11,987	11,143
Other clinical income***	8,972	2,594
Total income from activities	**492,501**	**451,213**

*Other NHS clinical income includes NHS income outside the block contract for a range of services including funding to support recovery following the pandemic.

**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.

*** 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

	2022/23 £000	2021/22 £000
Income recognised this year	88	141
Cash payments received in-year	18	65
Amounts added to allowance for impaired contract receivables	80	114
Amounts written off in-year	27	68

Note 3 Other operating income

	2022/23 £000	2021/22 £000
Other operating income from contracts with customers:		
Research and development (contract)	1,466	1,854
Education and training (excluding notional apprenticeship levy income)	17,369	11,258
Non-patient care services to other bodies	1,935	2,484
Reimbursement and top up funding *	38	618
Income in respect of employee benefits accounted on a gross basis**	1,529	3,659
Other contract income***	5,751	3,922
Other non-contract operating income		
Education and training - notional apprenticeship levy income	629	522
Receipt of capital grants and donations^	149	252
Charitable and other contributions to expenditure^	92	16
Contribution to expenditure - consumables donated from DHSC****	1,016	1,292
Rental revenue from operating leases	102	96
Other	0	3
Total other operating income	**30,076**	**25,976**

*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 has been included within block contract/system envelope funding 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 £5.8m (£3.9m, 2021/22) 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.

^ Prior year receipts of capital grants and donations were incorrectly categorised under charitable and other contributions to expenditure. For 2022/23 these have been re- categorised and prior year comparatives re-stated.

Note 3.1 Additional information on contract revenue recognised in the period

	2022/23 £000	2021/22 £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:

	2022/23 £000	2021/22 £000
Income from services designated as commissioner requested services	480,627	439,952
Income from services not designated as commissioner requested services	11,874	11,261
Total	**492,501**	**451,213**

Note 4 Operating expenses

	2022/23 £000	2021/22 £000
Purchase of healthcare from NHS and DHSC bodies	1,763	2,299
Purchase of healthcare from non-NHS and non-DHSC bodies	5,513	3,493
Employee expenses - executive directors	1,618	1,605
Employee expenses - non-executive directors	158	181
Employee expenses - staff*****	317,589	295,321
Employee expenses - temporary staff	46,955	35,023
Supplies and services - clinical*	42,085	37,905
Supplies and services - general	4,703	3,412
Drug costs (inventory consumed & non-inventory purchases)	28,851	26,863
Inventories written down	44	88
Establishment	5,270	3,318
Transport	4,499	2,299
Premises	22,951	24,108
Movement in credit loss allowance: contract receivables/contract assets	(111)	870
Change in provisions discount rate	(61)	(45)
Lease expenditure (net)**	0	5,171
Depreciation on property, plant and equipment, and RoU assets	16,420	10,300
Amortisation on intangible assets	996	499
Net Impairments***	3,565	2,432
Audit fees payable to the external auditor		
audit services - statutory audit	133	121
Internal audit and local counter fraud services ******	246	164
Clinical negligence	12,933	12,210
Legal fees	1,707	824
Insurance	466	393
Education and Training	3,655	1,885
Redundancy and other mutually agreed resignation schemes	18	0
Losses, ex gratia & special payments	440	718
Other***	2,267	3,230
Total	**524,673**	**474,687**

* 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 £1.0m (£1.3m. 2021/22). A corresponding Income entry has been recorded in Note 2.3.

**Following the implementation of IFRS 16 continuing operating leases are included in lease liabilities. Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line or other systematic basis.

*** Further details of net impairments can be found in Note 12.

****Other expenditure of £2.2m (£3.2m, 2021/22) includes car parking and security costs, and other miscellaneous expenditure charges.

***** Staff costs includes £12.6m in respect of the agenda pay award offer agreed during the year but which will not be paid until 2023/24.

****** Audit fees payable to the external auditor inclusinve of VAT was £133k dusring the year (£122k, 2021/22) and £111k (£101k, 2021/22) 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 2021/22 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.

	2022/23		2021/22	
	Number	£000	Number	£000
Non-NHS				
Trade invoices paid in the period	70,125	252,810	65,601	217,751
Trade invoices paid within target	63,447	237,974	61,231	199,981
Percentage of trade invoices paid within target	**90.5%**	**94.1%**	**93.3%**	**91.8%**
NHS				
Trade invoices paid in the period	1,853	39,655	1,932	36,231
Trade invoices paid within target	1,624	36,377	1,648	29,939
Percentage of trade invoices paid within target	**87.6%**	**91.7%**	**85.3%**	**82.6%**
Total				
Trade invoices paid in the period	71,978	292,465	67,533	253,982
Trade invoices paid within target	65,071	274,350	62,879	229,920
Percentage of trade invoices paid within target	**90.4%**	**93.8%**	**93.1%**	**90.5%**

Note 5 Employee benefits

	2022/23 Total £000	2021/22 Total £000
Salaries and wages	256,041	238,543
Social security costs	24,888	22,836
Apprenticeship levy*	1,153	1,074
Employer's contributions to NHS pensions	27,257	25,577
Employer's contributions to NHS pensions paid by NHSE on behalf of the Foundation Trust (6.3%)**	11,987	11,143
Temporary staff	46,955	35,023
Total staff costs	**368,281**	**334,196**
Costs capitalised as part of assets	2,032	1,534

*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 2022/23 are £368.3m (£334.2m, 2021/22) which is an increase of £34.1m. This includes the impact of the 2022/23 pay award and the proposed non-consolidated bonus. Pay expenditure has also increased due to increasing escalation of bed capacity, driven in part by significant numbers of patients who reside in hospital but are medically fit to be discharged.

Temporary staff have been utilised to support this 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 £32.8m (2021/22: £30.8m) for bank staff and £14.2m (2021/22: £9.1m) 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 7 early retirements agreed on the grounds of ill-health during the year (4, 2021/22). The cost of these ill-health retirements, £601k (£234k, 2021/22) is borne by the NHS Business Services Authority - Pensions Division.

Note 5.2 Executive directors' and non-executive directors' remuneration and other benefits

	2022/23 £000	2021/22 £000
Salary	1,413	1,359
Employer's pension contributions	158	153
Taxable benefits	1	1
Total	**1,572**	**1,513**
Non-executive directors' remuneration *	158	181
Total	**1,730**	**1,694**
The total number of directors accruing benefits under the NHS Pension Scheme	11	8

* 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

An accrual in respect of annual leave entitlements carried forward at the Statement of Financial Position date of £2.8m has been provided for within the accounts (£4.6m, 2021/22). 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

	2022/23 £000	2021/22 £000
Operating lease income		
Minimum lease receipts	102	96
Total	**102**	**96**

	31 March 2023 £000	31 March 2022 £000
Future minimum lease receipts due:		
- not later than one year	96	96
- later than one year and not later than five years;	385	385
- later than five years.	115	217
Total	**596**	**698**

Note 7 Finance income

Finance income represents interest received on assets and investments in the period.

	2022/23 £000	2021/22 £000
Interest on bank accounts	940	56
Total	**940**	**56**

Note 8 Finance expenses

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2022/23 £000	2021/22 £000
Interest expense		
Loans from the Department of Health and Social Care	266	283
Interest on lease obligations	320	0
Total interest expense	**586**	**283**
Other finance costs - unwinding of discount	34	29
Total	**620**	**312**

Note 9 Gains and (losses) on disposal of assets

	2022/23 £000	2021/22 £000
Gains on disposal of assets	155	0
(Loss) on disposal of assets	(270)	(311)
Total	(115)	(311)

The gains on disposal of assets arose as a result of a profit on sales of Marsh Green Clinic and Orrell Clinic, 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 - 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
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 10.2 Intangible assets - 2021/22

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation/gross cost at 1 April 2021	**12,956**	**713**	**44**	**13,713**
Additions	4,306	0	0	4,306
Reclassifications	20	0	0	20
Impairments charged to Operating Expenses	0	0	0	0
Valuation/gross cost at 31 March 2022	**17,282**	**713**	**44**	**18,039**
Amortisation at 1 April 2021	**11,079**	**711**	**21**	**11,811**
Provided during the year	494	2	3	499
Impairments charged to operating expenses	0	0	0	0
Amortisation at 31 March 2022	**11,573**	**713**	**24**	**12,310**
Net book value at 31 March 2022	**5,709**	**0**	**20**	**5,729**
Net book value at 1 April 2021	**1,877**	**2**	**23**	**1,902**

Note 10.3 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 10.4 Intangible assets financing 2021/22

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Purchased	5,649	0	20	5,669
Donated	60	0	0	60
NBV total at 31 March 2022	**5,709**	**0**	**20**	**5,729**

Note 11 Property, plant and equipment

Note 11.1 Property, plant and equipment - 2022/23

	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 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 11.2 Property, plant and equipment - 2021/22

	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 2021	**9,161**	**141,899**	**1,872**	**7,244**	**53,223**	**195**	**39,268**	**527**	**253,389**
Transfers by absorption	0	0	0	0	11	0	0	0	11
Additions	0	12,449	0	0	5,247	0	4,303	2	22,001
Impairments	0	(9,148)	0	0	0	0	0	0	(9,148)
Reversals of impairments	0	3,855	0	0	0	0	0	0	3,855
Reclassifications	0	0	0	0	(28)	28	0	0	0
Revaluations	39	(1,715)	101	0	0	0	0	0	(1,575)
Disposals/derecognition	0	0	0	0	(1,954)	0	0	0	(1,954)
									0
Valuation/gross cost at 31 March 2022	**9,200**	**147,340**	**1,973**	**7,244**	**56,499**	**223**	**43,571**	**529**	**266,579**
Accumulated depreciation at 1 April 2021	**0**	**4,022**	**36**	**0**	**33,025**	**169**	**22,346**	**293**	**59,891**
Provided during the year	0	4,584	79	0	2,064	11	3,537	25	10,300
Revaluations	0	(5,577)	(91)	0	0	0	0	0	(5,668)
Disposals/derecognition	0	0	0	0	(1,591)	0	0	0	(1,591)
Accumulated depreciation at 31 March 2022	**0**	**3,029**	**24**	**0**	**33,498**	**180**	**25,883**	**318**	**62,932**
Net book value at 31 March 2022	**9,200**	**144,311**	**1,949**	**7,244**	**23,001**	**43**	**17,688**	**211**	**203,647**
Net book value at 1 April 2021	**9,161**	**137,877**	**1,836**	**7,244**	**20,198**	**26**	**16,922**	**234**	**193,498**

Note 11.3 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 11.4 Property, plant and equipment financing - 2021/22

	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	9,200	142,352	1,949	7,244	21,214	43	17,674	203	199,879
Donated	0	1,959	0	0	1,787	0	14	8	3,768
NBV total at 31 March 2022	**9,200**	**144,311**	**1,949**	**7,244**	**23,001**	**43**	**17,688**	**211**	**203,647**

Note 11.5 Impairment of assets

	2022/23 £000	2021/22 £000
Net impairments charged to operating (deficit) / surplus resulting from:		
Other	4,103	0
Changes in market price	(538)	2,432
Impairments charged to operating (deficit) / surplus	3,565	2,432
Impairments charged to the revaluation reserve	2,820	2,861
Total net impairments	**6,385**	**5,293**

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 2022/23 with a revaluation date of 31 March 2023.

As a result of this valuation some land and buildings have seen an increase in value totalling £7.1m.

In addition, some land and buildings have decreased in value totalling £6.3m. £3.4m has been charged to operating expenditure offset by the reversal of previous impairments totalling £4.0m to give a net reduction on expenditure of £0.6m.

The net effect of these changes in value amounts to an overall increase in land and buildings of £0.8m.

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

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

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an International Accounting Standard 17 Operating Leases basis.

Note 13.1 Right of use assets - 2022/23

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 £000	Plant & machinery £000	Total £000
Valuation / gross cost at 1 April 2022 - brought forward	**0**	**0**	**0**
IFRS 16 implementation - adjustments for existing operating leases	31,479	1,578	33,057
Additions	1,916	140	2,056
Re-measurements of the lease liability	2,828	0	2,828
Valuation/gross cost at 31 March 2023	**36,223**	**1,718**	**37,941**
Depreciation provided during the year	4,619	443	5,062
Accumulated depreciation at 31 March 2023	**4,619**	**443**	**5,062**
Net book value at 31 March 2023	**31,604**	**1,275**	**32,879**

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.

	2022/23 £000
Carrying value at 31 March 2022	0
IFRS 16 implementation - adjustments for existing operating leases	33,057
Lease additions	2,056
Lease liability remeasurements	2,828
Interest charge arising in year	320
Lease payments (cash outflows)	(4,855)
Carrying value at 31 March 2023	**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 2023

	Total 31 March 2023 £000
Undiscounted future lease payments payable in:	
- not later than one year;	5,953
- later than one year and not later than five years;	17,304
- later than five years.	11,432
Total gross future lease payments	**34,689**
Finance charges allocated to future periods	(1,282)
Net lease liabilities at 31 March 2023	**33,407**
Of which:	
- Current	5,923
- Non-Current	27,484

Note 13.4 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	2021/22 £000
Operating lease expense	
Minimum lease payments	5,171
Total	**5,171**

	2022 £000
Future minimum lease payments due:	
- not later than one year;	4,995
- later than one year and not later than five years;	15,282
- later than five years.	13,461
Total	**33,738**

Note 13.5 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 13.6 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 15.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	**33,738**
Impact of discounting at the incremental borrowing rate	(1,472)
IAS 17 operating lease commitment discounted at incremental borrowing rate	**32,266**
Less:	
Commitments for short term leases	(1,698)
Irrecoverable VAT previously included in IAS 17 commitment	(428)
Other adjustments:	
Differences in the assessment of the lease term	2,195
Rent increases/(decreases) reflected in the lease liability, not previously reflected in the IAS 17 commitment	722
Total lease liabilities under IFRS 16 as at 1 April 2022	**33,057**

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 (£10.6m in year and £10.8m, 2021/22).

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 (£2.6m in year and £2.5m, 2021/22).

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 £0.3m (£0.4m, 2021/22).

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 2023 £000	31 March 2022 £000
Drugs	1,512	1,245
Consumables	2,017	1,641
Energy	136	102
Other	28	13
Total inventories	**3,693**	**3,001**

Inventories recognised in expenses for the year were £29m (£28m, 2021/22).

Note 16 Trade and other receivables

Note 16.1 Trade and other receivables

	31 March 2023 £000	31 March 2022 £000
Current		
Contract receivables invoiced/non-invoiced	24,280	9,011
Allowance for impaired contract receivables	(1,601)	(1,772)
Prepayments (non-PFI)	3,926	3,659
Interest receivable	174	28
VAT receivable	2,047	1,592
Other receivables	2,993	1,126
Total current trade and other receivables	**31,819**	**13,644**
Non-current		
Allowance for impaired contract receivables	(67)	(51)
Other receivables	1,146	703
Total non-current trade and other receivables	**1,079**	**652**
Of which receivables from NHS and DHSC group bodies:		
Current	18,404	3,839
Non-Current	841	489

Note 16.2 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 16.3 Allowances for credit losses - 2021/22

	Contract receivables and contract assets £000
Allowances as at 1 April 2021 - brought forward	1,033
New allowances arising	932
Reversals of allowances	(62)
Utilisation of allowances (write offs)	(80)
Allowances as at 31 March 2022	**1,823**

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.

	2022/23 £000
At 31 March 2022	**54,085**
Net change in year	(10,987)
At 31 March 2023	**43,098**
Broken down into	
Cash in hand	6
Cash with the Government Banking Service	43,092
Total cash and cash equivalents	**43,098**

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 2023 £000	31 March 2022 £000
Monies held on behalf of patients	7	6
Consignment inventories	8,436	6,596
Total third party assets	**8,443**	**6,602**

Note 19 Trade and other payables

	31 March 2023 £000	31 March 2022 £000
Current		
Trade payables	18,628	15,767
Capital payables	11,613	13,489
Accruals	45,754	37,343
Receipts in advance	196	0
Social security costs	3,322	3,540
Other taxes payable	2,674	2,815
PDC dividend payable	556	441
Pension contributions payable	3,817	3,547
Other payables	2,684	1,578
Total current trade and other payables	**89,244**	**78,520**
Of which payables to NHS and DHSC group bodies:		
Current	3,412	6,593

Note 20 Other liabilities

	31 March 2023 £000	31 March 2022 £000
Current		
Deferred income : contract liabilities	5,723	3,304
Total other current liabilities	**5,723**	**3,304**
Non-current		
Deferred income : contract liabilities	124	186
Total other non-current liabilities	**124**	**186**

Note 21 Borrowings

	31 March 2023 £000	31 March 2022 £000
Current		
Loans from the Department of Health and Social Care	841	845
Other loans*	677	743
Lease liabilities**	5,923	0
Total current borrowings	**7,441**	**1,588**
Non-current		
Loans from the Department of Health and Social Care	10,733	11,502
Other loans	2,035	2,421
Lease liabilities*	27,484	0
Total non-current borrowings	**40,252**	**13,923**

*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 25.

** The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in Note 13.

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 2022	**12,347**	**3,164**	**0**	**15,511**
Cash movements:				
Financing cash flows - payments and receipts of principal	(769)	(452)	(4,535)	**(5,756)**
Financing cash flows - payments of interest	(270)	0	(320)	**(590)**
Non-cash movements:				
Impact of implementing IFRS 16 on 1 April 2022	0	0	33,057	**33,057**
Additions	0	0	2,056	**2,056**
lease liability remeasurements	0	0	2,828	**2,828**
Application of effective interest rate	266	0	320	**586**
Carrying value at 31 March 2023	**11,574**	**2,712**	**33,406**	**47,692**

Note 23 Provisions

	Total £000	Other legal claims £000	Pensions: injury benefits £000	Other £000
At 1 April 2022	6,165	366	1,998	3,801
Change in the discount rate	(823)	0	(61)	(762)
Arising during the year	1,354	129	88	1,137
Utilised during the year	(903)	(155)	(122)	(626)
Reversed unused	(1,756)	0	0	(1,756)
Unwinding of discount	51	0	34	17
At 31 March 2023	**4,088**	**340**	**1,937**	**1,811**
Expected timing of cash flows:				
- not later than one year;	1,432	340	122	970
- later than one year and not later than five years;	565	0	514	51
- later than five years.	2,091	0	1,301	790
Total	**4,088**	**340**	**1,937**	**1,811**

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 2023, £168.0m was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (£298m, 31 March 2022).

Note 24 Contingent assets and liabilities

	31 March 2023 £000	31 March 2022 £000
Amounts recoverable against liabilities	(193)	(87)
Net value of contingent liabilities	(193)	(87)

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 2023	31 March 2022
	£000	£000
Property, plant and equipment	13,595	1,408
Leases	2,173	0
Total	**15,768**	**1,408**

Contractual capital commitments mainly relate to committed expenditure in respect of the Foundation Trust's development of Community Diagnostic Centre and Leigh Laminar Flow Theatre, medical equipment and work committed for site improvements. Leases relates to committments for leases in respect of Parr Bridge Health Centre that the Foundation Trust is contractually committed, but for which the lease arrangement has not yet commenced.

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 Clinical Commissioning Groups (CCGs) and Integrated Care Boards (ICBs) which are financed from resources voted annually by Parliament. As a result of COVID, the Foundation Trust received block funding from its commissioners and a top up payment to break even during the first half of the year. Block payments and top up funding at an Integrated Care level were allocated in the second half of the year. Monthly payments were received from the CCG 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 £25m (£8m, 2021/22) 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	25,493	8,065
Cash and cash equivalents at bank and in hand	43,098	54,085
Carrying values of financial assets as at 31st March	**68,591**	**62,150**

Note 26.3 Carrying value of financial liabilities

	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**

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2022	
Loans from the Department of Health and Social Care	12,347
Other borrowings	3,164
Trade and other payables excluding non financial liabilities	67,913
IAS37 provisions which are financial liabilities	6,165
Total at 31 March 2022	**89,589**

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 2023 £000	31 March 2022 £000
In one year or less	83,198	75,825
In more than one year but not more than five years	24,128	7,362
In more than five years	22,078	8,556
Total	**129,404**	**91,743**

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.

	2022/23		2021/22	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	0	0	0	0
Bad debts and claims abandoned	62	44	78	80
Stores losses and damage to property	12	53	10	141
Total losses	**74**	**97**	**88**	**221**
Special payments	0	0	0	0
Ex-gratia payments	86	523	84	777
Total special payments	**86**	**523**	**84**	**777**
Total losses and special payments	**160**	**620**	**172**	**998**
Compensation payments received	0	365	0	0

The Foundation Trust has a contract with Northumbria Healthcare NHS Foundation Trust for the provision of a salary sacrifice lease car scheme. The Foundation Trust was in receipt of a VAT reimbursement following a successful litigation process between Northumbria Healthcare NHS Foundation Trust and HMRC to recover restricted VAT it incurred. The Foundation Trust has made the reimbursement available to affected drivers as an ex-gratia payment.

In accordance with HM Treasury Managing Public Money, these payments totalling £0.4m have been classified as special payments for which parliamentary approval was sought on behalf of NHS organisations by NHS England.

Note 28 Transfers by absorption

During the course of the year the Foundation Trust received software and image sharing infrastructure totalling £63k from Manchester University Hospital Foundation Trust. These have been transacted in the accounts as a transfer by absorption.

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 Wigan Borough CCG	NHS England	NHS Business Services Authority
HM Revenue and Customs	NHS Resolution	Health Education England
NHS West Lancashire CCG	NHS Bolton CCG	NHS Chorley and South Ribble CCG
NHS Manchester CCG	Wigan Metropolitan Borough Council	
Greater Manchester Integrated Commissioning Board		

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 £4.5m (£3.3m, 2021/22), and is reporting a year-end PDC payable totalling £0.5m (£0.4m PDC receivable, 2021/22).

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

The Charity's balance as at 31 March 2023 was £1,204k (£1,308k, 2021/22) with net outgoing resources before transfers of £105k (£115k, 2021/22).

During the year the Charity incurred expenditure of £200k (£323k, 2021/22) 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 a cancer lead at NHS Salford CCG and a Medical Advisor at NHS England. The Foundation Trust has entered into a number of transactions with both organisations which are considered to be "at arms length".

One Non Executive Director is the Pro-Vice Chancellor and Dean, at the faculty of Health, Social Care and Medicine, Edge Hill University Hospital. The Foundation Trust has entered into a number of transactions 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

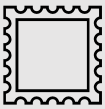
If you have any queries regarding this report, or wish to make contact with any of the directors or governors, please contact the corporate affairs team using the contact details below:

Email

company.secretary@wwl.nhs.uk

Telephone

01942 822027



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