NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

2025/26

Annual Report & Accounts

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

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Our Values | People at the Heart | Listen and Involve | Kind and Respectful | One Team

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Annual report and accounts 2025/26

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

It is a privilege to present my first Annual Report as Chair of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, having taken up the role in December 2025.

This year has again been a challenging one for the NHS, with sustained pressure across urgent and emergency care, workforce challenges and increasing demand for services. Against that backdrop, I want first to recognise the extraordinary commitment, professionalism and compassion of colleagues across the Trust. Time and again, colleagues have continued to deliver high quality care in difficult circumstances, always keeping patients at the centre of what they do. Our people are our greatest strength, and I want to place on record my sincere thanks for their continued dedication.

Since joining, what has stood out most is the strength of the Trust's connection to the communities we serve, and the pride colleagues take in their work. There is a clear sense of shared purpose across colleagues, partners and the voluntary sector, alongside a growing focus on neighbourhood working and more joined-up models of care.

At WWL, our values are clear. We put people at the heart, we listen and involve, we are kind and respectful, and we work as one team. These values are lived every day across our services.

I reflect on the year through our values and the priorities that have shaped our work: our people, our patients and our performance, underpinned by inclusion, integrity and improvement.

Our people are at the heart of everything we do. The priority has been wellbeing, engagement and creating the right culture. Advocacy matters. Listening matters. Acting on what we hear matters. We have continued to strengthen how we support colleagues, recognising the direct impact this has on the quality of care we provide. Inclusion remains central to this, creating a culture where colleagues feel safe, valued and heard. The staff survey tells us we are making progress, but also that there is more to do, particularly in strengthening advocacy and ensuring colleagues feel consistently supported and able to speak up. Our bronze anti-racist accreditation from the North-West Black, Asian and Minority Ethnic Assembly is an important milestone, but it must be matched by sustained action and accountability.

This year has also seen significant national recognition for our workforce. Our nursing staff, in particular, have been recognised at the highest level, including the Trust's first Chief Nursing Officer Gold Award, alongside a national 'Nurse of the Year' accolade from the Caribbean & African Health Network (CAHN). Colleagues have also been recognised through the Health Service Journal Awards, including 'Leader of the Year' recognition, and the Trust was named 'Equality, Diversity and Inclusion Champion' at the CAHN awards. We have also seen success across a range of national award programmes and shortlistings, reflecting innovation, inclusion and excellence in patient care. This recognition is complemented by national honours within our medical leadership, including an OBE awarded to our Chief Medical Officer, demonstrating the growing impact of our people on the national stage. It is important that we take the opportunity to recognise and celebrate these achievements, as they not only reflect the dedication and expertise of our people, but also reinforce a culture of pride, inspiration and continuous improvement across the organisation.

For our patients, we have continued to invest in improving access, dignity and outcomes. Developments in diagnostics, elective care and patient flow, alongside new facilities, are helping to improve both experience and outcomes. Being recognised as the cleanest acute Trust in the country for the third consecutive year also reflects the pride colleagues take in the environments in which care is delivered.

Improvement is also reflected in how we work with partners. We continue to work closely across Greater Manchester to support a shift towards prevention, earlier intervention and care closer to home,

recognising our role as an anchor institution in addressing health inequalities and the wider determinants of health.

For our performance, integrity is key. We know that we have not consistently met all constitutional standards and key elective care targets, and it is important to acknowledge that openly. At the same time, there are encouraging signs of improvement, particularly in urgent and emergency care, where we met the 4-hour constitutional standard, reflecting the sustained effort to improve flow and reduce waiting times.

We have continued to balance operational delivery with financial discipline in a very challenging environment, while maintaining focus on safety, quality and productivity and responding to ongoing system pressures, including periods of industrial action.

As a teaching hospital, we are continuing to strengthen our role in education, training and research. This includes our developing partnership with Edge Hill University Medical School, our work with the University of Greater Manchester, and our support for the wider healthcare workforce, including nursing, allied health professionals and non-clinical staff. We are also working towards our ambition to achieve university hospital accreditation, as part of our wider commitment to education, research and clinical excellence.

Strong governance remains fundamental. I want to recognise the contribution of the board, including the Chief Executive, executive team and non-executive directors, for their leadership, support and constructive challenge during a demanding year. Our Council of Governors also continues to bring valuable insight and connection to the communities we serve, and I want to recognise their important contribution, alongside the wider volunteer community across the Trust.

Finally, I would like to thank my predecessor, Mark Jones, for his leadership, Francine Thorpe for her contribution as Acting Chair between June 2025 and November 2025, and Claire Austin, retiring Non-Executive Director, for her continued contribution and support.

While this year has tested the resilience of the organisation, it has also demonstrated the strength of our people, the value of our partnerships and the clarity of our purpose. I remain confident in our ability to build on this progress and continue delivering high quality, compassionate and sustainable care for the communities we serve.

Professor Dame Robina Shah
DBE CPsychol FRCGP(Hon) FRSM(Hon)
Chair
23 June 2026

Performance Report

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PERFORMANCE REPORT

Performance overview

The purpose of this overview of performance is to provide information on our organisation, its history and purpose. The Chief Executive also presents her perspective on our performance during the financial year 2025/26 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 large acute and community foundation trust serving the North-West of England within the Greater Manchester Integrated Care System. As a teaching hospital, our commitment to education and training remains a defining part of our identity, and we continue work towards university teaching hospital status in partnership with Edge Hill University. This matters because growing and retaining talent locally is not only a workforce priority - it is part of improving life chances and addressing health inequalities. Progress towards this objective - one of the Trust's enduring corporate priorities - is overseen by the Research Committee and assessed against the University Hospital Association's recognition criteria. Significant progress has been made to date.

We are registered with the Care Quality Commission without conditions and they rated us as 'Good' at our last inspection in November 2019. Every WWL service and location inspected since then has been rated as either 'Good' or 'Outstanding'.

The Trust serves a local resident population of approximately 345,000 people, while also providing specialist services to a much broader regional, national and international population. Acute services are delivered across five principal sites: Royal Albert Edward Infirmary, Wrightington Hospital, Leigh Infirmary, the Thomas Linacre Centre and Boston House. Community services are provided from a range of locations across the borough, supporting care closer to home.

Royal Albert Edward Infirmary, located in central Wigan, is the Trust's main district general hospital and houses the emergency department along with the majority of inpatient services. Healthcare has been provided on this site since 1873, when the hospital was opened by the then Prince of Wales in 1875, giving it a history spanning more than 150 years.

Wrightington Hospital is internationally recognised as a centre of excellence for orthopaedic care. Located just over the border in West Lancashire, it is renowned as the birthplace of modern hip replacement surgery, pioneered by Professor Sir John Charnley in 1962. In late 2024, a commemorative heritage plaque was unveiled at the hospital in his honour. Today's surgical teams continue to uphold this legacy from a site that is over 90 years old.

Leigh Infirmary serves as a key outpatient, diagnostic and treatment centre for the south of the borough and is now home to the Jean Hayes Reablement Unit, providing intermediate care to support recovery and independence, as well as the Community Diagnostics Centre. The Thomas Linacre Centre is a dedicated outpatient facility in central Wigan, while Boston House delivers specialist services for ophthalmology, musculoskeletal and other long term conditions.

Our *Strategy 2030* sets out a clear ambition to be a provider of excellent health and care services for our patients and local communities. Achieving this vision depends on supporting and empowering our people to deliver consistently high-quality, patient-centred care. Each year, the Trust strengthens its approach to continuous improvement by embedding evidence-based methodologies and fostering a culture that encourages learning, innovation and improvement in everything we do.

Review of the year

There is again much to recognise and celebrate at WWL this year. While the NHS continues to operate in a challenging environment, following a sustained period of pandemic recovery, we have now moved into a phase of consolidation, improvement and transformation.

National pressures have remained, including sustained service demand, workforce constraints and episodes of industrial action. Progress in managing elective waiting lists has therefore been incremental rather than rapid. Nevertheless, the organisation has continued to deliver safe, effective care while adapting to evolving expectations around access, productivity and financial sustainability.

Central to this progress has been the commitment, adaptability and professionalism of our staff. As passionate as ever about patient care, colleagues have responded to pressure with innovation and flexibility, redesigning services, leading change and accelerating the use of digital tools and new ways of working. This has taken place within a more mature and collaborative integrated care system, with stronger partnerships and shared approaches to improvement.

Taken together, this year reflects an organisation that has learned from recent years, is no longer defined by the pandemic, and is steadily building resilience, capability and confidence for the future.

Our 'Better Lives Programme' is now well underway and is supporting our Wigan residents to remain or return to their own homes or the place that they call home. This has further enhanced by work around inpatient flow supported by the Getting It Right First Time (GIRFT) team, both of which are supporting us to provide better patient care.

In addition to this ongoing work, following the publishing of the government's *10 Year Health Plan for England: fit for the future* (the 10 Year Plan), this year we began to review service models to identify how we can ensure that care aligns the three radical shifts which the plan identifies: analogue to digital; hospital to community and treatment to prevention. With the support of leaders and colleagues across the trust, we began work on a transformational organisational redesign programme. Work will have concluded by the time this report is published and we will move forwards operating through two (as opposed to our previous four) clinical divisions: Live Well and Urgent Care and Start Well and Planned Care. This work has been supported by consistent engagement and communication across the Trust, helping to build shared understanding and ownership of the future operating model.

WWL has worked hard this year to reduce the number of patients waiting over 52 weeks to receive their treatment against the national care standards in the Wigan locality and further, reduced the number of overall patients waiting for elective care. WWL continued to focus on waiting times particularly for patients waiting for gynaecology, breast, gastroenterology and vascular services.

WWL have once again cared for a consistently high number of patients this year, in the backdrop of having the smallest general and acute bed base in Greater Manchester, seeing an 8% increase in the number of patients attending to use urgent and emergency care services (UEC). This has had a resultant effect on our ability to ensure a consistent flow of patients through our accident and emergency department and impacted our ability to meet the 4-hour care standard and the number of patients who stay in our A&E department for longer than 12 hours, particularly during peak attendance times and periods of sustained pressure. This year, we have seen a more frequent use of escalation spaces (i.e. temporary additional beds), however in March 2026 we did achieve the 4-hour national standard for UEC, with 78.1% of patients treated within this timeframe, a direct result of the extraordinary commitment and hard work of our staff. Our 'Better Lives Programme' combined with step-down care initiatives such as our Virtual Ward and Home First service continue to help us to tackle this issue and reduce admissions and the number of patients residing in hospital, where they could be better cared for outside of hospital, which will make more beds available for those who have a greater need for hospital care.

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

Access headlines	71.88% performance against the Accident and Emergency four-hour wait target (target 78%; 2024/25: 70.61%). (Performance during March 2026: 78.10%) 81.70% performance against two-week wait from referral to date first seen for all urgent cancer referrals (target 93%; 2024/25: 85.56%) 61.2% performance against the 18-week referral-to-treatment pathway as at March 2026 (target 60%; 2024/25: 56.02%) 69.98% performance against 6-week diagnostic (target 95%; 2024/25: 81.21%)
Quality headlines	1 MRSA bacteraemia during the year (threshold 0; 2024/25: 1) 77 C. difficile infections against a threshold of 62 with 23 attributable to lapses in care (2024/25: 76 with 26 attributable to lapses in care) 2 never events against a threshold of 0 (2024/25: 5) Summary Hospital-level Mortality Indicator (SHMI) is 102.34 for the rolling 12 months to December 2025 (national baseline is 100) (rolling 12 months to December 2024: 104.49)

As you will see from the staff report, we place great importance on supporting our colleagues and living our values by putting people at the heart; listening to and involving staff in key decisions; being kind and respectful; and working as one team. We take feedback from our workforce seriously and we undertake regular surveys to seek feedback. This year we have seen how colleagues responding to the NHS Staff Survey recognised the Trust's people-centred approach. The results demonstrated strong indicators of psychological safety and the highest scores across Greater Manchester for both staff morale and the 'we are safe and healthy' theme. The Trust also received an unprecedented uplift in engagement, with over 1,000 additional staff voices contributing to the survey. We have provided an analysis of the results of this year's national staff survey later in this report.

In addition to recognising the contribution of our own workforce, we wish to acknowledge the essential role played by colleagues across our partner organisations in Wigan. Delivering high-quality, sustainable care for our population depends on effective partnership working and genuinely joined-up approaches across organisational boundaries. We are proud to be an active partner in the Healthier Wigan Partnership, which brings together the local authority, NHS organisations, and voluntary and community sector partners. Through this collaboration, partners are working collectively to reduce health inequalities and reshape services closer to communities, supporting improved outcomes and long-term population health.

Following the official launch of Wigan Borough's plan; 'Progress with Unity', which is designed to create a fairer and more prosperous borough, organisations will continue to work together to deliver three key priorities in communities, focussing on:

Addressing health inequalities	Transforming local services in communities	Developing a sustainable workforce
		

Following the establishment of the Integrated Care System and the creation of NHS Greater Manchester Integrated Care Board, the Trust is pleased to be a committed member of the Greater Manchester Integrated Care Partnership. The partnership brings together NHS trusts from across all ten boroughs to work collectively to deliver more connected and coordinated services for local populations.

We now deliver a number of both clinical and corporate services collaboratively with partner trusts and will continue to pursue opportunities for partnership working where this supports improved efficiency, resilience and quality of patient care.

The Trust is well represented at system level. Board members are actively engaged in Integrated Care Board activity and regularly participate in system-wide meetings alongside colleagues from partner organisations. As Chief Executive I hold key system leadership roles, including Joint Chair of the Wigan Borough Integrated Delivery Board and Acute Chief Executive representative on the NHS Alliance Acute Advisory Board. I have also previously acted as Chief Executive Representative for the Greater Manchester Trust Provider Collaborative within the Urgent and Emergency Care System Group.

At WWL, the board places continuous improvement at the heart of its governance approach. Through integrated performance reporting and a clear performance dashboard, the board maintains strong assurance, supports early identification of challenges and ensures focused action to drive improvement and quality.

Principal risks faced and impact

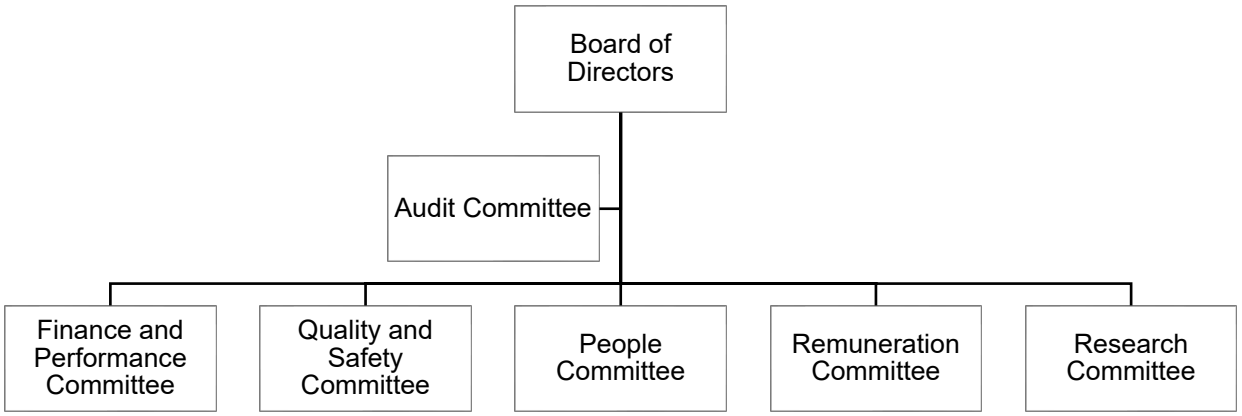
For more information on how we manage risk within the Trust, including the detail of the key risks that the organisation was exposed to during 2025/26 and those identified for 2006/27, please see the Annual Governance Statement.

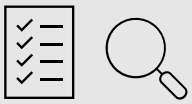
Mary Fleming
Chief Executive and Accounting Officer
23 June 2026

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 60 to 66.

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





Audit Committee

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

Finance and Performance Committee

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

Quality and Safety Committee

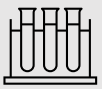
Responsible for seeking assurance on and having oversight of the quality and safety elements of the business and reviewing high level risks allocated to the strategic objective of patients

People Committee

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

Remuneration Committee

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



Research Committee

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

The Council of Governors, made up of elected governors from our public and staff membership and appointed governors from our key stakeholders, has a number of statutory functions and two general duties – to represent the interests of members and the general public and to hold the non-executive directors to account for the performance of the board. More information on the Council of Governors is available on page 103.

Our Director of Corporate Governance provides corporate governance leadership, advice and support to both the board and the council. The Director of Corporate Governance 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 our clinical divisions, each headed by a divisional triumvirate comprising a Divisional Medical Director, a Director of Nursing and a Director of Operations. Other services are provided through our corporate and estates and facilities teams.

We employ 7,363 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 190.

Summary of our operational activity

The table below summarises our activity during 2025/26, and the figures for 2024/25 are provided for comparison:

		2025/26	**2024/25**
Referrals	GP	103,763	101,305
	Other	103,079	105,726
	Total	**206,842**	**207,031**
In-patient activity	Elective/planned	9,009	8,484
	Day cases	44,421	40,983
	Non-elective	38,922	41,273
	Total	**92,352**	**90,740**
Outpatient activity	New appointments (attendances)	159,888	161,866
	Follow-up appointments (attendances)	367,373	351,136
	Total	**527,261**	**513,002**
Accident and emergency	**Total**	103,497(All) **88,107**(Type 1)	99,056(All) 85,437(Type 1)
Walk-in centre	**Total attendances**	**47,485**	**49,152**

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

Social, community and human rights issues

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

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

We have anti-fraud policies in place and further information is available within the staff report and within the annual governance statement.

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

Equality of service delivery to different groups

WWL is committed to promoting equality, diversity and inclusion (EDI) - as an employer, in the services we provide, in partnerships, and in the decisions we make. We are continuing with our ambition to embed equality, diversity, and inclusion as a golden thread throughout everything that we do. We understand that everybody's journey through life is unique and individual to them, and value the importance of diversity and inclusion across our services, our workforce, and the wider WWL community.

People and communities are at the heart of everything we do and we are dedicated to developing an organisational culture that embraces difference, valuing everyone's contribution, treating people with dignity and respect and increasing our understanding of what matters most for our patients by hearing about their lived experiences. That is why this year, we introduced sveral voluntary roles for lived experience partners. They meet regularly with our teams and offer an invaluable insight on what it is like to access and receive care with us.

As an NHS organisation we aim to provide our services to all groups equitably and fully embrace the requirements of the public sector equality duty to eliminate discrimination, advance equality of opportunity and foster good relations. This year we continued to embed and integrate the Equality Delivery System (EDS2022) for both service provision for patients and employment practice for staff. For domain 1 (patient services), equality evidence was collated against 4 patient outcomes for the COPD Service, community chronic fatigue service and the mortuary service at the Royal Albert Edward infirmary. Engagement with patients and the public was undertaken from November until January to obtain feedback and scores. Engagement included encouraging service users, the local community, staff, volunteers, governors and our lived experience partners to complete our feedback survey; undertaking 'real time' engagement; and attending key stakeholder meetings. Feedback and scores enabled each service to implement their own specific improvement recommendation proposals.

Our lived experience partners (LEPs) continue to work with staff across the organisation to listen to patient/service user voice with a purpose of ensuring that healthcare professionals, can provide the best quality care and support, ensuring that the people receiving the service are at the heart of everything that is done. LEPs help bridge the gap, contributing to the design, improvement, and delivery of our healthcare services.

We have recruited 12 LEP's from various healthcare backgrounds who live in the Wigan borough. Their wealth of lived experience of using our services has enabled the organisation to ground our work and fulfil our commitment to ensuring that our patients and communities are at the heart of everything we do. Our WWL LEPs meet monthly and agendas have been set around topics of engagement with internal and external stakeholders coming to the group for support and advice.

During the last 12 months, there have been two stakeholder workshops held which have been well attended, along with a workshop facilitated by the staff experience team with the LEP membership to pull together a LEP charter, values and purpose statement. A draft LEP strategy has been produced,

which will encompass, all patients, service users across all 9 protected characteristics, including seldom heard groups and incorporating the requirements of EDS domain 1.

On 16 August 2025, Wigan Pride returned to Wigan Town Centre, celebrating a special milestone, its 10 Year Anniversary. As a dedicated supporter, WWL was once again proud to be part of this event. And what a fabulous day it was, enjoyed by all. The event begun with a vibrant parade through the town centre. Over 30 members of WWL staff, including board members and governors, proudly marched in the parade along with our Three Wishes charity mascot, Albert the Bear, all carrying NHS banners, flags and rainbows, dressed in pink. Our patient experience team hosted a stall throughout the day, promoting WWL services. 150 local residents participated in our patient experience survey, sharing their experience of using WWL services. Our Breast Screening Navigator was also present on the day promoting breast screening services.

During 2025/26, WWL continued to work in partnership with AccessAble, creating, developing and updating detailed on-line access guides for patients to all the Trust's sites. During October 2025, AccessAble revisited the Leigh Infirmary site to resurvey and update access guides.

EDI leads continue to be included within the stakeholder engagement process for business case development and equality impact assessments continue to be undertaken to assess impacts across all 9 protected characteristics when developing or reviewing existing policies, guidelines and services.

We have continued to review the effectiveness of our interpretation and translation services to ensure that service users can be communicated with appropriately and effectively, in as timely a manner as possible. The fundamental and unprecedented combined effects of the pandemic and the cost of living crisis has continued to have an impact across the entire interpretation industry and hampered the national availability of linguists, especially those who traditionally provided face to face services.

During 2025/26 we trialled video remote interpreting in Cardiology at RAEI and across all maternity services. Due to its success, we are looking to roll out to other areas within the Trust.

We have implemented an improvement plan to increase fulfilment rates and efficiencies and continue to meet monthly with our current Provider DA Languages to monitor progress.

During 2025/26 a Reasonable Adjustment Working Group was established to review WWL's approach to providing reasonable adjustments for service users, incorporating the requirements of the NHS England's *reasonable adjustments digital flag information standard* (and *accessible information standard*). Membership includes LEPs and Royal National Institute of the Blind representation.

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

Financial performance

During the financial year ending 31 March 2026, we delivered an adjusted financial performance surplus of £3.3m. WWL agreed a breakeven control total for 2025/26. The Trust over delivered against this by £3.3m, reflecting additional Deficit Support Funding awarded to trusts that achieved their 2025/26 control total and submitted a compliant plan for 2026/27. The 2026/27 plan includes a Cost Improvement target (CIP) of £31.8m, 5.2% of operating expenditure and the plan does not include any Deficit Support Funding.

When we consider the statutory financial accounts, the financial outturn for the 2025/26 financial year, including those items that are excluded from our control total due to national guidance, was a deficit of £6.3m (2024/25: £28.4m deficit). This includes impairments of £9.5m arising from re-valuation of land and buildings and impairment of assets, which are excluded from the adjusted financial position of £3.3m deficit.

The Financial Sustainability Plan continued through 2025/26 supported by key transformational programmes such as the Better Lives Programme and elective recovery centred on improving both operational and financial performance.

The total cost improvement programme (CIP) target for 2025/26 was £38.4m, with a recurrent target of £23.0m expected to be delivered within this. Whilst the in-year value of the recurrent schemes delivered was £2.8m behind this plan, the full year effect was an over delivery of £2.5m; £25.5m of recurrent efficiencies have been delivered. In total WWL delivered £39.1m of efficiency savings in 25/26, £0.7m better than target.

We had a year-end cash balance of £16.6m, a decrease of £1.5m from the previous year. Within the cash position for the year, we received £17.5m of national funding for capital projects. Our Better Payment Practice Code was maintained in year, achieving 96.4% by value which is above the target of 95.0% (2024/25: 96.5%).

We invested £32m into our capital programme during 2025/26. This investment, which included the continuation of expansion of our endoscopy departments, the continued investment in the theatres at Wrightington, and investment in the Wigan site for A&E diagnostics, surgical admissions and discharge lounge will support productivity, reduction in waiting times and improve our hospital environment and services for patients visitors and staff.

The annual accounts included within this report provide detailed information for our financial performance in 2025/26.

Income

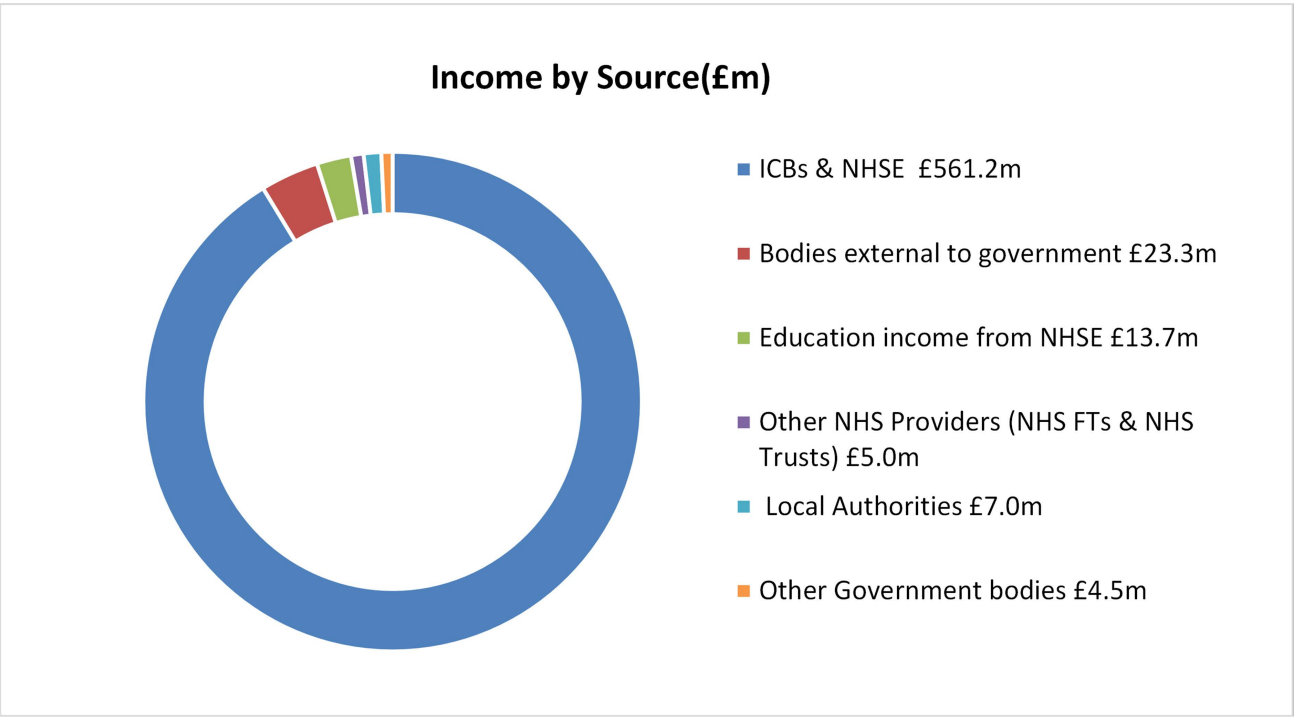
We generated £614.7m of income in 2025/26, compared with £581.2m in 2024/25; an increase of £33.5m (5.8%). This increase was driven primarily by a £32.9m uplift in funding from ICBs and NHS England, as set out below.

In 2025/26, the Aligned Payment and Incentive (API) system continued. For all commissioner contracts over £0.5m, payments are determined in line with the API approach and include fixed and variable elements. Under the variable element, income is linked to actual activity delivered against elective recovery and unbundled targets.

Each year, the income we receive from providing goods and services for the purposes of the health service in England must exceed the income we receive from other activities. We complied with this requirement in 2025/26.

Income by source

The chart below shows the split of income by source for the year. Most of our income was received from government bodies, with £23.3m (3.8%) of the total £614.7m generated from non-government sources.



Income from patient care activities

Income generated from the provision of patient care totalled £585.4m in 2025/26, compared with £552.0m in 2024/25; an increase of £33.4m (6.1%). ICB and NHSE income accounted for £32.8m of this increase. Key drivers included the cost uplift factor (CUF) of £13.1m (net of efficiency), a £1.4m increase in central pensions funding and £4.6m relating to drugs and devices, including funding for bespoke limb salvage prostheses (£3.2m) and drugs gainshare (£1.0m). The Trust also delivered £10.0m of additional Elective Recovery Fund (ERF) activity in year (net of the £3.6m CUF uplift). This was partially offset by a £4.4m reduction in deficit support funding.

Greater Manchester ICB is the Trust's largest commissioner of services, contributing 78.4% (£458.7m) of patient care income, compared with 77.0% (£433.5m) in 2024/25.

Income from patient care (by nature)

Income from patient care (by nature)	2025/26 £m	2024/25 £m
Acute services		
Income from commissioners under API contracts - variable element*	137.2	123.7
Income from commissioners under API contracts - fixed element	305.2	299.7
High cost drugs income from commissioners (excluding pass through costs)^	31.1	26.5
Other NHS clinical income*	7.5	5.5
Community Services		
Income from commissioners under API contracts	63.1	55.9
Income from Other Sources (e.g. local authorities)	7.0	6.7
Additional income		
Private patient income	7.4	7.8
National pay award central funding	0.0	1.0
Additional pension contribution central funding	22.6	21.1
Other clinical income**	4.3	4.0
Total income from activities	**585.4**	**552.0**

* 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 and First Contact Practitioner income.

Other operating income

Other operating income received in year was £29.4m in 2025/26 compared to £29.3m in 2024/25, which is an increase of £0.1m (0.4%). There has been an increase in research and development income £0.4m and education income £1.0m offset by a reduction in other income.

Expenditure

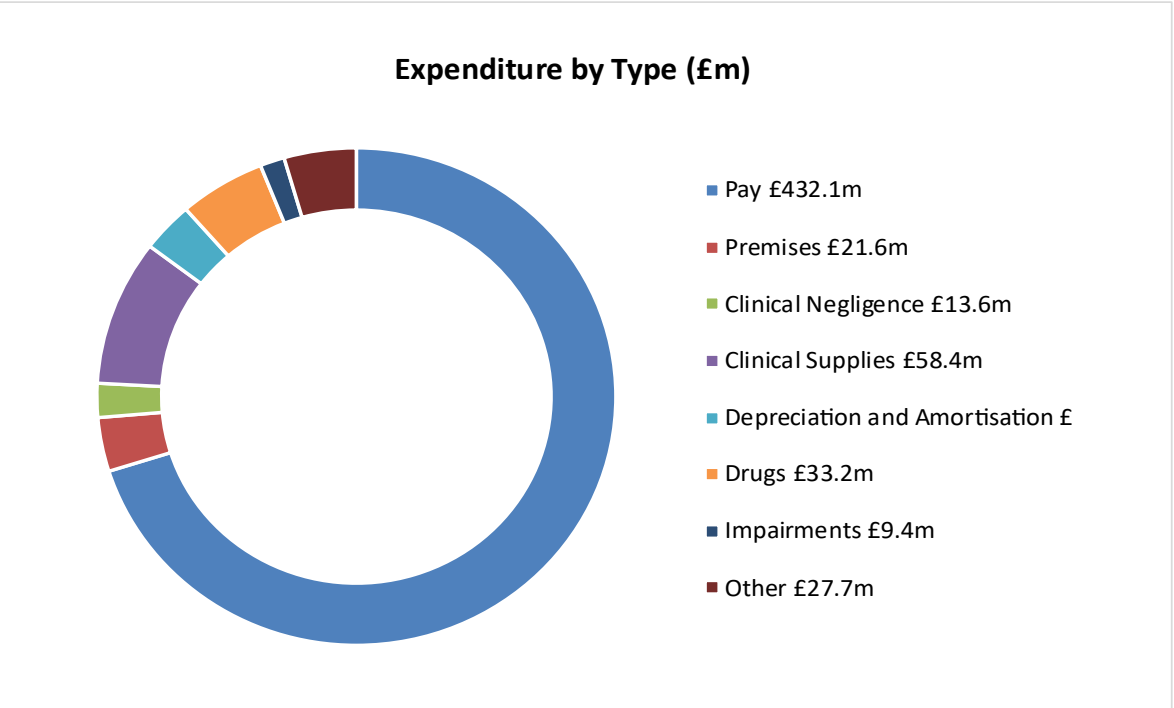
Operating expenditure for the 2025/26 financial year was £616.0m, compared to £604.3m for 2024/25, which was an increase of £11.7m (1.94%).

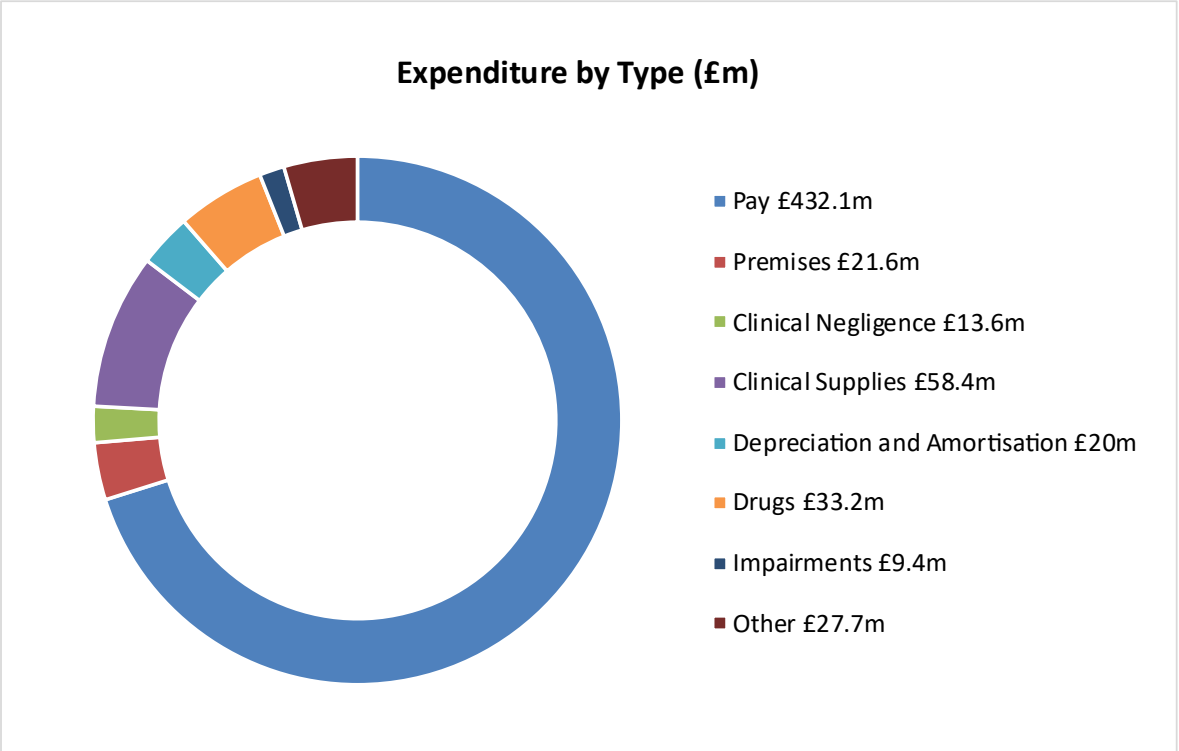
Employee expenses (pay) was the largest item at £434.5m (2024/25: £411.4m) which is 70.5% of operational expenditure. Within this figure, the amount spent on registered nursing, midwifery and health visiting staff was £121.0m (2024/25: £115.4m). Expenditure on medical staff was £105.2m (2024/25: £99.0m).

There was an increase in established staff costs of £27.4m of which £24.1m relates to pay award, including social security costs and employer pension contributions. Additional pay costs have been incurred to deliver additional activity and income. There was also an increase in central pension contribution rate (£1.4m), for which there is a corresponding increase in income. There was a decrease of £6.6m associated with temporary staff which comprises bank and agency expenditure.

The largest items of non-pay expenditure included £33.3m spent on drugs (2024/25: £32.2m), £58.4m on clinical supplies (2024/25: £51.8m), £13.5m on the clinical negligence premium (2024/25: £13.1m) and £21.8m in premises costs (2024/25: £21.8m). Depreciation and amortisation of £20.0m and net impairments of £9.4m (2024/25, £27.5m) are included in the overall expenditure figure.

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





Cost improvement plans

In 2025/26, we achieved our cost improvement plan (CIP), delivering savings of £39.1m against the target of £38.4m (2024/25 delivery: £27.4m), which further supported our steps to reduce the underlying deficit and move towards financial recovery and future sustainability.

Despite another exceptionally challenging year, recurrent delivery remained the focus for the Trust in line with our ambitious Financial Sustainability Plan and drive to reduce the underlying deficit. £25.5m of recurrent savings have been delivered (£20.2m in year) – our highest level of delivery.

This was facilitated through delivery of key Transformation Programmes and Divisionally owned and led schemes supporting operational and financial improvements. Areas of success that should be recognised are:

Corporate Transformation Programme: £4.7m

This is the second year of the programme which aims to improve the Trust position through reduction of corporate services in line with the corporate benchmarking outcome.

All areas of corporate services have been expected to deliver recurrent savings across 2024/25 and 2025/26; services included are digital services, finance, GTEC, HR and people services, corporate nursing, and budgets for the Chief Medical Officer, Chief Operating Officer and executive office. This programme has focussed on reducing the pay bill across these services in line with NHSE expectations and ensuring non-pay spend is contracted and provides value for money.

Better Lives Programme: £4.1m

Again, this is a continued programme of work from 2024/25 centred on providing patients with a better experience through our urgent care pathways and removing premium spend in areas of escalation. Whilst 2025/26 delivered financial savings through providing improved patient flow throughout the hospital, 2026/27 will build on this success by developing a sustainable bed and supporting workforce model, redesigning our acute medical offer and focusing on admission avoidance.

There have also been numerous invest to save schemes such as; the new car park, LED lighting, medicines gainshare with GM ICB, catering services review, electronic prescribing and supporting divisions to provide patient services within their core time, all successfully reducing our costs whilst supporting our wider ambitions in providing the services our patients need and supporting the green agenda.

Capital investment

During the year we invested £32.0m (2024/25: £24.0m) in our capital programme which has 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	£m
Endoscopy expansion	Completion of the expansion of the endoscopy department on the Leigh site, and continuation of the work to expand endoscopy on the Wigan site. These developments will improve diagnosis, reduce waiting times and increase care capacity across the Wigan Borough.	3.8
RAEI	Investment in A&E diagnostics environment and equipment, surgical admissions lounge and the refurbishment of the discharge lounge on our Wigan site.	5.9
New theatres at Wrightington	Continued investment in two theatres on the Wrightington site to improve productivity. Delivering high volume low complexity procedures to support a reduction in long waiting lists these new theatres also support the plans to de-commission out of date unproductive theatres.	1.4
Digital	Continued investment in IT systems to raise digital maturity across our sites.	3.3

Medical equipment	The continued investment in medical equipment, including upgrades to scanners, x-ray machines, ultrasound, audiology, ophthalmology and endoscopy equipment and MRI scanner.	4.9
Site improvements, upgrades and maintenance	Improvements, upgrades, and general maintenance to improve our hospital environment and make our hospitals safer, including the renewals of two significant leased buildings.	7.9
Sustainability schemes	Continued investment in LED lighting installation and solar energy in our community buildings to make our buildings more energy efficient.	4.8
Total		**32.0m**

Whilst the Trust has delivered a capital programme of £32.0m in 2025/26, this has been achieved within a highly constrained capital environment, with prioritisation required to ensure that available resources are directed towards schemes that support patient safety, operational resilience and delivery of strategic objectives.

The Trust continues to face significant demand for capital investment, including estate maintenance, backlog infrastructure requirements and service developments, which cannot be fully met within current funding allocations. As a result, a number of schemes have been deferred or re-phased, presenting an ongoing risk to estate condition, service capacity and long-term sustainability. This position is reflected within the board assurance framework as a principal risk relating to the affordability and prioritisation of capital investment.

The Trust maintains a robust prioritisation process through the Capital Strategy Group and continues to actively engage in system planning discussions to ensure that organisational risks are appropriately represented.

The board recognises that the underlying pressures on capital will continue into 2026/27 and will require ongoing management, with a continued focus on aligning available investment to areas of greatest risk and strategic importance

Cash position

Whilst the Trust ended the financial year with a cash balance of £16.6m, cash balances continue to require careful and active management and maintaining a sustainable cash position in 2026/27 represents a key financial risk for the Trust.

Cash balances have declined over recent years, reflecting the Trust's underlying deficit position and therefore cash levels have remained under close scrutiny throughout the year, with the board recognising that, whilst compliant with operational requirements, the level of headroom remains limited when considered against the scale and timing of the Trust's financial commitments.

The Trust's cash position is highly dependent on delivery of its financial plan, including achievement of the 5.5% cost improvement programme, delivery of the elective recovery programme and the phasing and affordability of the capital programme. Variances against any of these assumptions present a direct risk to liquidity.

Cash flow projections indicate that, if the current run rate were to continue, cash balances could reduce to minimum levels during 2026/27, requiring mitigating action. In addition, access to external cash support is expected to become more constrained, with NHS England strengthening its approach to the review and approval of support requests.

The Trust is therefore reliant on robust cashflow forecasting, active working capital management and the timely receipt of system funding to maintain liquidity.

The board, supported by the Finance and Performance Committee, receives regular updates on cashflow projections and mitigations, including scenario planning to ensure that emerging risks to liquidity are identified early and managed proactively.

Going concern

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

Mary Fleming
Chief Executive and Accounting Officer
23 June 2026

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 integrated performance report and presented to the board at each meeting for scrutiny. Copies of our board papers are available to download from our website, and we produce a dedicated Quality Account each year. This is published separately and available on our website.

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

There is a clear link between our key performance indicators and the risks facing the organisation. For example, non-achievement of the 4-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 three directorates. The three directorates are:

- General medicine including cardiology, respiratory medicine, diabetes and endocrinology;
- Gastroenterology, elderly care and specialist rehabilitation;
- Unscheduled care, which is further divided into acute and emergency medicine;

The division also incorporates pharmacy services on all sites.

Unscheduled care

Throughout the year, we continued to see an increase the acuity of patients admitted through our accident and emergency department, and a large increase in the number of walk-in presentations. Despite this, in March 2026, the organisation delivered the 78% 4-hour performance standard. In 2025/26, average daily attendances equated to 284 patients per day, compared to 272 average attendances per day in 2024/25. The organisation has experienced an increase in the number of patients attending the department with frailty, in line with our local demographic. These patients often have higher care needs and complexity which has resulted in increased length of stay. This has contributed to the pressures within the emergency department, particularly during the winter months.

During the year we have continued to focus on delivery of transformational and operational initiatives to improve flow through the hospital and support delivery of urgent and emergency care performance standards. These improvements have included:

- The admission avoidance and reduction in time to discharge, following completion of medical treatment, directly resulting from our system-wide 'Better Lives Programme' (as detailed by our Chair's introduction and Chief Executive's review of the year, earlier in the report).

- Expansion of our frailty same day emergency care model which has doubled the daily capacity. Frail patients attending the department are now able to access the care of the elderly team directly without an extended and avoidable stay in the emergency department.

- Introduction of our *Call Before Convey* model which has supported in reducing avoidable conveyances to the emergency department

- We have continued to work with local partners to provide community-based services and early interventions to enable patients to be treated outside of the hospital setting when possible.

- Support provided by NHS England specialist teams – including the (Emergency Care Improvement Support Team) ECIST - to improve the flow of patients across the emergency department and the rest of the hospital.

These initiatives have contributed to bed reductions which have enabled the closure of Bryn Ward North, a 27 bedded ward previously used for medically optimised patients.

Looking forward to 2026/27, we will continue to embed and implement improvement to consistently delivery 4-hour performance, together with a reduction in the number of patients waiting 12-hours for admission. This will be done through an expansion of the *Call Before Convey* model, redesign of the Virtual Ward model and development of a new approach to managing patients attending the emergency department who require acute medical intervention. We will continue to support delivery of the Better Lives Programme and engage with system partners to support safe and timely discharge.

Scheduled care

The medicine division maintained 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. Most medicine specialties managed to reduce waiting times under 52-week by December 2025, however there remain challenges in delivery of the referral to treatment standards in gastroenterology and endocrinology.

In gastroenterology, a revised capacity and demand model has been undertaken with a business case approved to increase capacity on the Leigh site through an increase in substantive workforce. Whilst recruitment takes place, an insourcing provider has been engaged which, along with productivity opportunities, has delivered a significant reduction in Referral to Treatment, Diagnostic and Cancer waiting times. These improvements have supported accreditation from the Joint Advisory Group for Gastrointestinal Endoscopy (JAG) being achieved on the Leigh site. Focus for 2026/27 includes recruitment and mobilisation of a sustainable endoscopy workforce, as well as commencement of the JAG accreditation process for the new endoscopy unit on the RAEI site.

Waiting times in endocrinology have improved through the use of additional sessions and short-term insourcing. The service has managed to eliminate 65-week waits with most patients waiting less than 52-weeks for treatment.

For the coming year, our scheduled care teams will continue to focus on ensuring that we see patients based on their clinical need, whilst at the same time reducing the waiting lists for our services. We aim to meet the national target to reduce waiting lists so that 65% of patients are provided with treatment within 18-weeks of referral and that no patients exceed 52-weeks from referral to treatment. We will work with community partners and GPs to support a reduction in the number of referrals to hospital through single point of access 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 the intensive care units (ICU)
- Healthcare operations
- Maternity and child health

General Surgery including breast, colorectal, general and urology

The continued focus for our division this year remained the reduction in waiting times; this has been possible by maximising the use of the Leigh Surgical Hub and introducing a SPOA (single point of access referral process, across GM, for 'hub suitable' patients), Leigh Hub has continued offers of mutual aid to GM for general surgery.

Capacity at the Leigh site is integral in continuing to reduce overall waiting times as we continue to review cases and procedures undertaken on the acute site that could transfer to the hub. Further, by reducing how long patients wait to go straight for diagnostic tests, such as endoscopy, the main delay in the pathway has been removed. As a result, patients are being diagnosed more quickly and waiting-time standards are being met more consistently.

The breast services has faced continual challenges with achieving its 62-day target, as pressures have been exacerbated by an increased demand for the service but also by difficulty in recruiting to one of the department's posts. The focus for the year ahead will be recovering the 62-day target with a plan and monitoring in place, guaranteeing that all patients with breast cancer symptoms (symptomatic patients) attend a 'one stop' clinic and ensuring there is theatre capacity at the correct site to ensure that patients are seen within the required 62-day period.

Urology, has seen the waiting times reduce for access to treatment. There is a successful joint on-call service between WWL and Bolton NHS Foundation Trust and the focus in 2026/27 will be the pathway for ureteric stones.

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

The waiting times within our head and neck directorate continue to reduce however ENT (ear, nose and throat) services and paediatric dental services remains pressured.

The continued use of out-of-theatre treatment pathways within ENT has enabled suitable patients to be treated more efficiently while maximising capacity across services. This approach has supported waiting-time reduction and improved use of clinical resources, and the innovation was recognised during a visit from the Cabinet Office.

There remain significant pressures across the region for these specialities in particular for CYP (children and young people). The introduction of paediatric surgery at Leigh has provided an outlet

for non-complex cases within theatres. ICB funding to provide additional activity and a Tier 2 (primary care) service has supported both a reduction in wait times and the mitigation of referrals to the ENT service. We continue to develop utilisation of direct audiology pathways from triage to reduce demand for consultant led clinics. Ophthalmology capacity has been expanded and a single point of access introduced to streamline non-complex referrals from opticians for cataracts, with waiting times now reduced to be competitive with the independent sector. Several engagement events have been held to support promoting the pathway.

Theatres and anaesthetics

There has been a joined-up approach across all theatres to maximise the resource for anaesthetics and theatre staff to maintain activity and session utilisation. The Leigh Surgical Hub has reintroduced paediatric services for theatres for the first time in 30 years and expansion across ophthalmology has supported reducing wait times for cataract patients.

Joint appointments for consultant posts in critical care with acute medicine has provided an alternative workforce model to reduce reliance on anaesthetics to cover these services.

Maternity and child health

Maternity

Our maternity services are nearing completion of the NHS England three-year delivery plan for maternity and neonatal services, which aims to make care safer, more personalised, and more equitable for women, babies, and families. Over the past three years, we have focused on four high-level themes, demonstrating strong progress at each checkpoint:

- **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:** Embedding the standards and structures required for safer, more personalised, and more equitable care

Final oversight panel approval is expected before summer 2026, where we will evidence that all actions have led to significant improvements and are either compliant or on track for completion in the coming months.

To deliver on these ambitions, we have expanded our enhanced maternity care teams in line with national and local priorities. Particular emphasis has been placed on improving outcomes for women and families with complex needs and those affected by longstanding health inequalities. By addressing wider determinants of health, we are supporting greater health equity and improving overall maternal and neonatal outcomes.

We have successfully completed Year 7 of the Maternity (and Perinatal) Incentive Scheme, achieving compliance against all ten safety actions. Work is now underway in preparation for the Year 8 standards.

Child health

The Neonatal Unit (NNU) continues to work closely with maternity services as part of the NHS England *MatNeoSIP* quality improvement programme. Significant improvements have been demonstrated across the eight optimisation measures, with actions now embedded and sustained.

The NNU has achieved the highest level of accreditation for Family Integrated Care (FICare), a model that fosters partnership between families and staff and empowers parents to become confident, independent primary caregivers. The service is also progressing towards Baby Friendly

accreditation (in line with the programme set out by UNICEF and the World Health Organisation), supporting optimal parent–infant bonding, feeding, and early development.

Paediatric surgical activity continues to grow, with elective services now provided in ENT, urology, maxillofacial, ophthalmology, and orthopaedics, alongside emergency orthopaedic trauma and general emergency surgery. Paediatric theatre lists have also been successfully introduced within the surgical hub at Leigh Infirmary.

However, the provision of community paediatric outpatient services remains a significant challenge. Although referral-to-treatment targets have been removed, children and young people are still experiencing long waits for assessment and treatment. This has been recognised as a regional priority, with a neurodevelopmental pathway redesign underway aligned with the THRIVE framework, a structured approach, used in mental health, which supports integrated, person-centred, needs-led care and aims to reduce reliance on diagnostic labels. WWL is actively contributing to this work.

Internally, the team continues to develop pathway improvements, including the implementation of one-stop clinics. The introduction of electronic prescribing in community paediatrics has already delivered notable benefits, reducing delays in repeat medication and easing clinical workload.

Healthcare operations

It has been an extremely challenging year for members of the healthcare operations team. They have continued to support the scheduling of outpatient and elective admission activity to facilitate the elective recovery programme. They have supported the transfer of patients from other providers through the mutual aid process and have also facilitated the transfer of WWL patients to independent sector partners, which has both increased WWL activity and helped to maintain the 65-week target.

Our outpatient teams have been working hard to reduce waiting times, with extra clinics added across a range of specialities. This has been particularly challenging due to the high volume of additional sessions that were needed.

The endoscopy team has also faced pressures, with new staff having now joined the team and currently completing their training to support extra clinic sessions, whilst existing staff are working hard to improve appointment availability and reduce waits for patients.

A new digital preoperative assessment form for paediatrics has been implemented, this has been pivotal in the setting up of the paediatrics dental services at our Leigh site, as well as supporting ENT theatre lists.

We continue to work closely with the digital team in the development of a digital outcome form. The secretarial teams have been involved in the successful pilot of the Heidi system, an AI solution which generates clinic letters from transcriptions of patient consultations. We now await the full rollout and implementation of Heidi which the team are looking forward to.

Operational and clinical performance: Specialist Services Division

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

- Trauma and orthopaedics
- Rheumatology
- Radiology
- Outpatients

- Oncology (cancer services)
- Dermatology
- Medical illustration; and
- Private patients and overseas visitors

The division's governance groups have a comprehensive work programme which allows scrutiny and monitoring of key areas, including incidents, compliments, patient stories, concerns and complaints, risks, lessons learned, and areas of good practice. The division continues to monitor its reporting structures to ensure they are effective and include emerging topics.

The division has implemented the NHS Patient Safety Incident Response Framework (PSIRF). This change means different ways of working and investigating incidents, which is improving patient outcomes through identifying learning. As part of this work the division has completed some thematic reviews to identify systems learning and actions.

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 division uses complaints to identify themes 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 symptomatic breast imaging
- Vascular and non-vascular interventional radiology
- Bone densitometry (DEXA)
- Medical illustration

Medical Imaging remains an essential element of the patient pathway across the healthcare economy and is a key dependency in delivering care in compliance with constitutional standards. Throughout the 2025/26 planning period, diagnostic services received less focus in the delivery guidance which has resulted in a general deterioration in performance. In counterbalance, WWL has continued to invest in diagnostic imaging services in response to changing care pathways and an overall increase in demand and complexity. Demand for diagnostic imaging shows no sign of decreasing and is expected to significantly increase in the next four years as a requirement to deliver elective recovery and compliance with the national 6-week and 18-week RTT standards. The service at WWL continues to deliver more than 333,000 procedures across all imaging modalities.

Turning to community care, our Community Diagnostic Centre (CDC) at Leigh Infirmary has been operational for over two years, providing additional diagnostic capacity away from the acute site and enabling one-stop and straight-to-test pathways to support cancer performance across key specialties. Delivered in line with the national service specification, the CDC offers extended evening and weekend access to improve accessibility and waiting times, alongside a purpose-built

environment designed for patient and staff comfort, including accessible facilities for disabled patients, modern imaging equipment, and improved flow for urgent care services.

Demand for diagnostic imaging continues to grow at a significant rate within the unscheduled care sector with more than half of the demand for CT and MRI coming from this source. The service has responded pro-actively to meet the needs of time critical demand and a requirement to support hospital flow. A new CT scanner was installed within the emergency department which became operational in January 2026. The scanner has been specified to manage a high volume case load including complex trauma scanning with potential to undertake specialised cardiovascular scans if these are adopted as part of the acute pathway.

MRI services have managed significant growth in unscheduled demand through the implementation of AI-driven advanced acceleration technology across all sites, improving scan efficiency and productivity, with WWL recognised as an exemplar site and sharing optimisation learning at national forums including UKIO (June 2025) and the Society and College of Radiographers (April 2026). Investment in service development includes the opening of a 3T MRI facility at Wrightington Hospital in July 2025 - one of only two in the North-West - enabling advanced musculoskeletal and oncology imaging, alongside expansion of specialised examinations such as MRI-guided breast biopsy and scanning for patients with complex pacemakers, which has also supported mutual aid across Greater Manchester providers.

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 live deliveries per annum. Outpatient ultrasound scans are performed across sites over 14 hospital-based scan rooms and within community venues, typically within several GP surgeries across the borough. Inpatient examinations are carried out at RAEI, Leigh Infirmary and Wrightington Hospital. A range of interventional procedures including biopsies and therapeutic injections are undertaken both the Wigan and Wrightington sites.

Ultrasound services have presented the organisation with a significant clinical and performance risks throughout the reporting period. Recovery actions to provide additional capacity have permitted the service to gradually reduce a significant backlog with the ambition to achieve compliance with national diagnostics waiting times targets by April 2026. In the longer-term, the service faces a challenging operating environment which is affected by national workforce and skills shortages exacerbated by a competitive independent sector, rising demand and uncertainly of commissioning arrangements for direct access diagnostics.

Performance of the service against the national diagnostic waiting time 6-week referral to exam target has been challenging, although recovery actions have started to deliver gradual improvements. DEXA - a type of X-ray that measures bone mineral density - has transformed the service delivery model to recover a significant backlog and to meet the increasing demand, complimented by training additional staff and expanding the operating hours. All measured tests within radiology have delivered activity above the operational plan since the penultimate quarter of this year to recover backlog and activity shortfalls.

The department supports a wide range of trainees, including international fellows, and has strengthened future workforce resilience through targeted training posts in key specialities, alongside leadership and management development delivered in partnership with the North-West Imaging Academy to address anticipated skills gaps. This is complemented by regional collaboration and sustained workforce investment, including leadership of a reporting radiographer community of practice, cross-site training rotations, full recruitment to vacancies, increased student intake to 32

trainees by 2026, and enhanced clinical education and upskilling opportunities across the wider workforce.

The service maintains a strong focus on clinical governance and proactive risk management, enabling safe operation and full compliance with regulatory requirements, as confirmed by a Care Quality Commission inspection in November 2025 which found no breaches of IR(ME)R 2017 regulations. Further inspection at the Thomas Linacre Centre in January 2026 reinforced the quality of outpatient and diagnostic services, with additional improvements supported through dedicated radiology leadership for reporting discrepancies and duty of candour processes.

Trauma and orthopaedics

Trauma and orthopaedics has delivered a series of significant operational and quality improvements during 2025/26. Outpatient performance has strengthened considerably, with average waiting times for first appointments reduced to seven weeks and variation between clinicians markedly narrowed. The service has consistently delivered 87% of first outpatient appointments within 18 weeks, exceeding the NHSE standard. This has been achieved through a combination of initiatives including reducing the DNA (“did not attend”) rate to 6%, expanding the use of patient initiated follow-up - a healthcare model that allows patients to take control of their follow-up appointments - increasing clinic utilisation from 72% to 84% through tighter operational grip, and updating the directory of services to ensure accurate subspecialty referral pathways eradicating unnecessary redirection of referrals/cancellations for patients. GIRFT (getting it right first time) is a national NHS programme aimed at improving patient care and efficiency by reducing unwarranted variations in medical services. Our services are often reviewed in line with GIRFT requirements and collaborative work with clinical teams to align clinic templates with GIRFT recommendations has further enhanced efficiency. As a result, the service is on track to deliver its revised plan of over 22,000 new patients, including 1,000 additional new appointments compared to last year created through reduced follow-up demand on the back of reviewing pathways with clinicians.

Improved access to first outpatient appointments has translated into better treatment timeliness. Average treatment times for high-volume, low-complexity (HVLC) procedures are now approximately 24 weeks, with 60% of patients treated within 18 weeks in line with national expectations. Overall, 65-week waits have been eliminated, and focused work continues to reduce and tightly manage 52-week breaches.

Building on the successful introduction of theatre 11, the service has maximised the utilisation of the additional theatre 12, improving productivity and patient flow by co-locating low complexity soft tissue knee and foot and ankle procedures. Upper limb services have expanded their use of the Elective Ambulatory Unit, increasing throughput through high-flow theatre lists. The service is forecast to deliver 11,800 elective procedures, representing a 7% increase on the previous year with no real growth in expenditure. Despite these gains, the service is expected to fall marginally short of its ambitious elective plan by approximately 150 cases (97%) due in part to significant disruption caused by an international shortage of bone cement supply in February 2026. The division has responded proactively, achieving the GIRFT benchmark of 92% theatre session allocation following the recruitment of three new Consultant Orthopaedic Surgeons all whilst accommodating additional sessions for surgery, ENT and dental to support their recovery trajectories.

Quality improvement has been a central focus, with redesigned pathways for Dupuytren's contracture and carpal tunnel syndrome access, and the redirection of community referrals for x-ray-guided injections from radiology to the arthroplasty practitioner service. A major development

has been the introduction of the second robotic system, VELYS Robotic-Assisted Solution - an advanced orthopedic robotic system used for total and partial knee replacements. This has both increased patient choice and expanded access to both manual and robotic surgical options, meeting objectives set by the Trust and also the wider Greater Manchester Integrated Care Board (ICB).

We have continued to support the Greater Manchester population by once again taking a selection of mutual aid patients from local trusts struggling with capacity, we have worked closely with ICB and various hospitals including Manchester and Bury, as well as continuing to work alongside Bolton, Alder Hey, Preston, Salford, Guernsey, the Isle of Man and the Falklands hospitals, offering our expertise and exceptional access times.

A comprehensive redesign of trauma services was implemented this year. Ensuring daily consultant-led reviews of patients has strengthened consultant presence at our Royal Albert Edward Infirmary (RAEI) site, improving early decision-making, enhancing junior doctor training, and reducing the length of time it takes us to get trauma patients to theatre. Feedback from clinicians and operational teams has been overwhelmingly positive.

The most significant achievement has been the transformation of the primary hip and knee arthroplasty pathway from a default inpatient model to an ambulatory pathway, targeting same-day or day-one discharge. This change, delivered through exceptional multidisciplinary collaboration and supported by the GIRFT national team, has reduced average length of stay from 3.67 days to 1.99 days. Rapid training and upskilling of nursing teams by physiotherapists enabled continuous mobilisation and improved patient experience. This shift has allowed Wrightington to reduce its bed base and associated costs while continuing to grow elective activity.

Rheumatology

The rheumatology service is experiencing sustained and exceptional growth in demand, which continues to exceed the capacity of the existing workforce and supporting infrastructure. The introduction of a fourth locum consultant to the team has demonstrated clear benefits, most notably reducing the time it takes for patients referred to be treated, reducing waiting times, and strengthening clinical responsiveness. It is pleasing to see that the locum investment has had a positive impact and has subsequently been made substantive. As a consequence of this consideration is being given as to how to grow the multidisciplinary team moving forward.

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 and supporting both our Leigh and Wrightington Surgical Hubs.

We have adopted projects in collaboration with the healthcare operations team, such as:

- Digitisation of our digital health information system, across outpatient settings
- Continued support and expansion of digital letters
- Support for specialties with the patient initiated follow-up programme of work

We continue to undertake service improvements which will be seen into next year.

Dermatology and plastics

Dermatology services are under significant pressure nationally, with rising demand and a limited specialist workforce. Like many NHS organisations, we are working collaboratively to maintain safe access to care while strengthening the long-term sustainability of these services. We now have two substantive consultants in post, with plans to appoint a third by autumn 2026. In addition, we have appointed a consultant nurse, who has strengthened leadership and support within the nursing team, along side another four additional members of staff.

WWL have been actively engaged in the development and mobilisation of the Greater Manchester tier 3 community dermatology service, which will improve access to specialist skin care closer to home. This new model supports quicker assessment, reduces pressure on hospital services and helps ensure patients receive the right care in the right setting. We hope to complete our substantively staffed team with the addition of two more consultants, in line with the launch of this service.

We have been excited to pilot an artificial intelligence (AI) pathway, which to concluded at the end of the financial year, with us now to consider the benefits delivered and improvements to the service which we may take forwards.

In 2025/26, we will be working collaboratively with Mersey and West Lancashire Trust to develop and implement new pathways for Wigan borough patients requiring plastics surgery input, following the closure of our service at the end of 2025/26.

Both dermatology and plastics services have faced a particularly challenging year, experiencing unprecedented growth in referrals for general dermatology and suspected skin cancer. However, despite the operational pressures, we are proud to see that the services overachieved on both activity and income plans and eliminated 65 week waits.

Private patients and overseas visitors

In 2025/26, private patient activity has remained consistent. Although activity is slightly behind on the previous year, we continue to build on the strong growth seen in the previous year with new consultants onboarded to work privately within our facilities. The ongoing pressures across the wider healthcare system, together with sustained high NHS waiting times across multiple specialties, means that more patients are actively seeking faster access to treatment. As a result, demand for private healthcare has remained high.

Growth has again been driven by both self-pay and insurance-backed pathways, with a higher take up of self-pay patient's vs insured, specifically in orthopaedics. Patients are increasingly prioritising not only timely treatment but also the ability to choose when and where they receive care. This reinforces the continuing trend of private healthcare becoming a mainstream option, signifying a further shift in how patients are choosing to navigate their care. Looking ahead, plans are progressing to re-invest in the private patient unit at the Wrightington site, expanding our private offering and strengthening the service for future demand.

Throughout the year, referrals to the overseas visitor's team have remained stable. Work continues to strengthen processes for the management of overseas visitors, supporting both compliance and operational efficiency.

Therapies

The musculoskeletal clinical assessment and triage service has recently been through a service review with the NHS Greater Manchester Integrated Care Board who were extremely pleased with the service provided to patients of the Wigan borough. As per the commissioned pathway, the team continue to work hard to ensure there is no waiting list for patients to access the service. The referral numbers have been increasing, slowly, and this is being regularly monitored. The patient pathway is under constant review and has been streamlined by improved links to primary care via the first contact practitioner service and increasing opportunities for primary care colleagues to work alongside WWL and alternative secondary care providers.

The first contact practitioner service has continued to develop with many of the clinicians being involved in and leading health prevention initiatives throughout the Wigan borough. The team continues to collect and analyse a significant amount of data about the service and has presented this at regional networking events. Pathway development for the practitioners continues, with the aim of streamlining the patient journey for those that require secondary care whilst effectively managing care at the point of initial contact in the primary care setting, for an increasing number of patients.

Our outpatient therapy team have worked extremely hard on improving the patient journey by taking on some of the work previously undertaken by surgical appliances. They have successfully reduced the waiting list for a knee brace from seven months to three to four weeks. They have also used some of our Three Wishes charitable funds to obtain a Biodex machine which aids monitoring of patient recovery and allows them to return to work and play sports more safely. It will also improve research possibilities for the therapy and orthopaedic teams. Therapies have over-achieved on their outpatient activity figures for the year, which has been a joint effort with the teams at Wrightington and the community bases.

The elective inpatient therapy team have been flexing the workforce to support our “reducing length of stay project”. They have also been involved in upskilling the nursing workforce to get patients out of bed following orthopaedic surgery.

Cancer services and oncology

Improving cancer performance remains a core priority for the Trust, with a continued focus on delivering earlier diagnosis in line with national expectations. To support this ambition, the Trust has made targeted investment in diagnostic services, including the expansion of facilities such as the extended endoscopy department at the Wigan site.

Whilst recovery to pre-pandemic performance levels has proved challenging, there is emerging evidence that sustained improvement initiatives and investment are beginning to deliver tangible and more consistent gains. Over the past 12 months, the service has focused on strengthening pathways and improving diagnostic timeliness, with increasing confidence in the trajectory of performance.

The Faster Diagnosis Standard (FDS), introduced in 2021, remains a central performance metric. This standard measures the proportion of patients referred with suspected cancer who receive either a cancer or non-cancer diagnosis within 28 days. The Trust has not achieved the FDS target since April 2025, and this has contributed to a deterioration in performance across downstream standards, including the 31-day and 62-day pathways. Notwithstanding this position, there is growing assurance that current improvement plans, aligned to best practice timed pathways, will support delivery against the required standards.

A key enabler of improvement has been the recruitment of a Cancer Transformation Manager, funded to support delivery of recovery and transformation priorities. This role has already contributed to demonstrable improvements in performance within the most challenged pathways, notably breast and colorectal services. The role is now embedded within a formal cancer transformation programme, which provides a structured framework to deliver sustainable improvements in cancer performance across the organisation.

Performance against the 62-day standard continues to be a key area of focus. The service is prioritising reductions in the number of patients waiting more than 62 days on an open pathway without a definitive diagnosis or treatment decision. Whilst progress has been made in reducing long waits within breast and colorectal pathways, performance overall has declined during the year. This has been primarily driven by ongoing constraints in treatment capacity, particularly in these specialties, limiting the Trust's ability to initiate treatment within the required timeframe.

The Trust did not achieve its year-end objective of returning performance to pre-pandemic levels. However, significant treatment backlogs have been identified and are now subject to targeted recovery actions. These backlogs are being actively prioritised to support improvement in compliance against the 62-day standard.

Diagnostic capacity has remained a key constraint, particularly within endoscopy services. Mitigating actions have included the use of insourced capacity, which has supported restoration of a seven-day referral-to-test interval in line with best practice timed pathway requirements. In parallel, the service has continued to enhance the diagnostic model through implementation of straight-to-test pathways and strengthened clinically led triage processes, improving flow and reducing unnecessary delays.

Encouragingly, there has been strong engagement across all cancer specialties, with clinical teams demonstrating a clear willingness to adapt and improve ways of working. This includes refinement of referral pathways, increased use of clinically led triage, and strengthened multidisciplinary team collaboration. Clinical leadership has been a key factor in driving pathway redesign and supporting delivery of more efficient and patient-focused services.

Looking ahead, the cancer performance environment is expected to remain challenging, with sustained pressures on workforce, diagnostic and treatment capacity, alongside competing clinical demands. However, delivery against cancer standards remains a fundamental organisational priority. The cancer transformation programme will continue to provide oversight and coordination of improvement activity, ensuring sustained focus on pathway optimisation, capacity alignment and compliance with national standards.

The Trust continues to work collaboratively with primary care colleagues across the Greater Manchester system to deliver comprehensive cancer prevention and screening programmes. This includes established population screening services such as breast and cervical cancer screening, which remain a key component of early detection strategy.

Within the Wigan locality, participation in the Targeted Lung Health Check (TLHC) Programme has now become embedded as a routine element of pre-symptomatic detection. This programme has demonstrated measurable benefit in identifying lung cancer at an earlier stage, enabling a greater proportion of patients to access potentially curative treatment options. The continued maturity of this programme is expected to contribute positively to long-term outcomes and overall cancer performance.

The Trust has also made further progress in the development and implementation of personalised stratified follow-up pathways. This approach enables patients, following completion of treatment, to take a more active role in managing their condition, supported by rapid access back into hospital services when clinically required. This model reduces reliance on routine outpatient follow-up appointments, thereby improving patient experience while simultaneously releasing clinical capacity to support new patients entering cancer pathways.

This work has been supported by the implementation of a stratified follow-up system within the Integrated Data Platform, which went live in early 2026. The system allows NHS organisations to safely link information they already hold, with each organisation remaining in control of its own data, for cancer services, this means improved visibility and management of follow-up cohorts and an expectation of expansion of functionality and utilisation as it continues to mature. This represents a key enabler in supporting sustainable demand management and pathway efficiency across cancer services.

In addition, all cancer teams participated in a cancer peer review process during 2025–2026. The primary focus of this review cycle was to assess progress against previously agreed actions and improvement plans. Early indications suggest positive progress across several areas, reflecting the continued engagement of clinical teams in quality improvement activity.

Looking ahead, it is anticipated that the 2026/27 peer review cycle will adopt a broader, more holistic approach. This will include a comprehensive review of cancer pathways to identify ongoing challenges, areas of variation, and opportunities to further embed best practice, as well as recognising areas of demonstrable success.

Cancer treatment services are delivered through the dedicated Cancer Care Unit based at the Wigan Infirmary site. The Trust continues to provide treatment locally wherever possible, ensuring patients can access high-quality care closer to home.

The established partnership with The Christie NHS Foundation Trust marked its 10-year anniversary in the last year, recognising a decade of collaborative working to deliver systemic anti-cancer therapies and specialist cancer care. This partnership remains a key enabler in ensuring patients receive treatment aligned to best practice and achieve optimal clinical outcomes.

The service continues to work closely with The Christie to deliver effective systemic anti-cancer treatments, with a shared focus on quality, safety and patient outcomes. This collaborative model has supported the development of a robust local treatment offer, reducing the need for patients to travel outside the locality for care.

Demand for cancer treatment services has continued to increase, alongside growing complexity in treatment regimens. This has placed sustained pressure on the service; however, the Trust has responded effectively by prioritising in-house delivery of treatment wherever clinically appropriate. This approach has minimised the need for patient transfers to alternative treatment centres and has supported continuity of care.

Despite these pressures, the service has maintained a strong focus on ensuring timely access to treatment and delivering care in line with clinical priorities. Ongoing operational resilience has been supported through close working with clinical teams and system partners.

Looking ahead, there are ongoing discussions with The Christie to develop long-term strategic plans for the delivery and expansion of systemic anti-cancer treatment within the Wigan locality. These

discussions are focused on ensuring that future service models are sustainable, responsive to growing demand, and aligned with national treatment standards and best practice.

Operational and clinical performance: Division of Community

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

Our model has a strong emphasis on population health promotion, prevention, early intervention, self-care, and self-management. The model reduces demand for services and allows care and support to be increasingly delivered out of hospital, at the appropriate care level, contributing to safe and effective admission avoidance across the healthcare system. By working together across organisational boundaries as one team, we make better use of the combined skills and knowledge of all professionals co-located across a broad regional area. This has had a positive impact, enabling us to provide care for individuals more effectively at the first point of contact, ensuring that the most appropriate professional, or combined professionals, are able to deliver care and support at the right place and time. The Healthier Wigan Partnership focuses on staff taking the time to understand people's goals, supporting them to connect to their community and be well. Keeping people well for longer is key to the success of our locality transformation programme; by addressing the wider determinants of health, such as social isolation, loneliness, housing issues and school readiness we hope to see a reduction in the need for reactive and expensive hospital admissions and/or long-term social care.

Children and families

Following co-production across the Healthier Wigan Partnership since 2024, the 0-19 Universal Services at WWL have successfully secured additional investment from April 2026 which will enable the transformation of the school nursing service in line with the 10 Year Plan and the Public Health Outcomes Framework - a strategic tool designed to improve public health by measuring health outcomes and reducing health inequalities across communities.

In conjunction with this, transformational work has begun in our services to introduce new digital health needs assessments for children in Wigan and to develop public health pathways and programmes of care in co-production with our highly skilled specialist community public health nurse workforce. This transformation will enable earlier intervention to support health needs and targeting of specialist public health resources in the most efficient way to improve health outcomes for families.

WWL's 0-19 universal services health visiting team were highly commended in 2025 in a UNICEF Baby Friendly report after successfully retaining their gold accreditation for UNICEFs Baby Friendly Initiative for the past four years. The service have built upon this success and utilised intelligence from families and clinical experience to promote and support breastfeeding in the Borough, alongside WWL Maternity Services the health visiting team lead collaboration with community family hubs and early intervention support which has enabled WWL to report breastfeeding rates at 6-8 weeks average of 42% in 2025/26 (increase from average of 39% in 24/25).

Admission Avoidance

During 2025/26 our community teams have been involved in several transformational workstreams to reduce hospital admissions. Our community urgent care response (UCR) team, working with the North-West Ambulance Service and the ICB, implemented an enhanced single point of access (SPOA) which provides a single point of contact for ambulance crews to call before patients are conveyed to hospital from care homes or the community. A number of pathways have been developed as alternatives to the emergency department, including our frailty community assessment unit, virtual ward and our urgent treatment centre. The number of calls received from ambulance crews increased from around 90 to approximately 300 per month as a result of the changes, providing more opportunities to treat patients at home.

As part of our Better Lives Programme, we put in place our Community Admission Avoidance Team (CAAT) – this would see us identify a cohort of patients that could be supported at home with community teams, rather than being admitted to hospital. The appointment of advanced clinical practitioners into this team has been successful with an average of three patients per day avoiding a hospital admission since January 2026. Alongside this, we have developed our same day frailty community assessment unit (FSDEC) to increase the number of patients we are able to see and treat on the same day, resulting an average of three patients discharged home daily. During March 2026 we increased the capacity of our FSDEC service to support enabling more patients to be stepped up from community. The management of our over 65-year-old patient population will be one of our key areas of focus for 2026/27 and the development of these workstreams.

Therapy Provision

Therapy services across acute and community settings are working in line with the NHS Long Term Plan to shift care away from hospitals and bedded settings, and into community and home-based provision.

To support this shift, the acute-based therapy teams (physiotherapists, occupational therapists, dietitians and speech and language therapists) were moved into the community division in October 2024. Since then, teams, including intermediate care (IMC) at home, bedded IMC, acute therapies and the *home first* team, have been working with local authority reablement services to improve patient experience and reduce length of stay. This has been achieved through joint decision-making, piloting joint clinical triage, and creating a more efficient referral process. As a result, more patients are receiving care in their own homes and capacity has increased within the Jean Hayes Reablement Unit.

Further initiatives within the community react, access to community services (ACSTs) and medical assessment therapies teams have developed pathways and ACSTs supporting the expanded frailty same day emergency care service within our Community Assessment Unit is ensuring that patients are getting a timely assessment and importantly, getting home.

This is an ongoing programme of work. The ambition is to move to greater integrated working, reduce duplication, and establish professional development and training pathways that enhance competencies across therapy services. This will create an adaptable and flexible therapy workforce and shift assessment and intervention away from hospital settings and into patients' homes.

District Nursing and Treatment Room services

District nursing (DN) and treatment room services within WWL are currently two years into a three year transformational plan which aims to improve the efficiency and quality of service provision and to review the staffing model in line with capacity and current demand.

This year has seen the introduction of bespoke digital care plans for wound care management, insulin administration and administration of medicines. These care plans are streamlined to the needs of our patients and our clinical staff, saving clinical admin time and thereby increasing capacity to see patients. The introduction of improved digital systems has also enabled greater efficiency in undertaking local and national audits for wound care and safer staffing, which historically had been time consuming as they were predominantly prepared manually.

DN and treatment room services were delighted to successfully gain funding to recruit permanent clinical staff, thus decreasing dependency on temporary staffing and creating increased stability in their workforce.

The treatment room service took part in a sustainable healthcare quality improvement project which aimed to improve quality, provide wound dressings free at the point of care to our community patients, reduce costs to the healthcare system and improve adherence to the wound care formulary. The project has been successfully implemented and achieved its stated aims. The service was awarded 1st prize from the Green Team Competition, by the Centre for Sustainable Healthcare and was 1st Runner Up in the 2026 Tissue Viability Society Awards.

Operational and clinical performance: Estates and facilities

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

- Capital projects
- Car parking and security
- Catering
- Community equipment
- Community services administration support
- Domestic services
- Energy management
- Environmental and sustainability
- Fire safety
- General office services
- Estates and Facilities Governance and Risk
- Linen services
- Medical electronics and equipment loan store
- Community medical equipment department
- Operational Estates
- Portering services
- Residential accommodation
- Sterile services and decontamination unit
- Stores
- Switchboard
- Waste

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

Our operational estates team provides an emergency breakdown repair and planned preventative maintenance (PPM) service which involves undertaking 14,171 PPM tasks and in the region of 16,000 reactive repair responses each year.

Our operational estates team supports wider estates and facilities activity across all of our sites. Our team also provides a technical out of hours emergency on-call response service for the WWL built environment and associated engineering services. Team members continually assess the most effective way to utilise resources in this area.

The division provides an acute medical equipment management service (including an equipment loan store provision) which includes more than 38,000 acute medical device items upon a proprietary asset management database. It also provides a community equipment management service which includes 5,740 community equipment items upon a proprietary asset management database. These databases are a keystone to managing the servicing, maintenance and breakdown repair services that are delivered across all of our clinical & community departments.

In earning the title of ‘cleanest acute hospital’ in the country for the third year running, assessed in line with NHS PLACE (patient-led assessments of the care environment 2023/24), 2024/25 and 2025/26, the domestic services team completed around 5,000 terminal infected cleans in infected clinical areas - information gathered through the patient flow system.

The waste team manage around 650 tonnes of clinical waste and using at ‘point of use’ separation are able to effectively dispose of through the correct waste streams.

Our catering department make around 250,000 sandwiches each year and provide patient meals to every in-patient during each day of their stay. To accommodate an in-patient stay, the linen services team handle around 250,000 items of linen during a year.

To effectively manage theatre and other clinical activities the sterile services and decontamination unit (SSDU) sterilise around 226,000 trays of surgical instruments per annum, supplying to over 32 theatres. The two endoscope reprocessing units (ERU) combined reprocess circa 27,000 flexible endoscopes per annum. SSDU maintains internationally recognised quality management standard ISO 13485 and both ERU are audited to Joint Advisory Group on Gastrointestinal Endoscopy accreditation standards. 2025/26 external audits resulted in reporting zero non-conformances at any of the three sites. The plant rooms at SSDU and ERU departments have had failures within the year resulting in all three business continuity plans being successfully activated.

Our switchboard continues to receive escalated calls to the Trust. During these unprecedented times reflected in our increased number of patients activity regarding the increase of WWL services the Trust’s telecoms department answer around 455,751 calls per year – a monthly average of 37,979 calls.

Linen services has seen an increase in the usage of patient linen due to the higher patient attendances resulting in turnover of 2,200,465 pieces of linen for the year, manged through an in-house managed system, focusing on ensuring our patients receive the appropriate allocated linen for their detailed care package.

Stores have delivered around 30,000 items of stock and packages to wards & departments during 2025-2026 providing an efficient stock managed process.

General offices continue to process items of mail and handle cash handling for catering takings, car parking income and petty cash enquires. This year we sent 619,476 pieces of post, both through mail providers and Royal Mail.

The community administration support team provide frontline support to the thousands of patients accessing our community clinics and health centres each year. They ensure the effective management of the facilities including the booking of clinical and meeting rooms to support the clinical services. They also provide comprehensive clerical support to the age 5-19 school nursing service.

To help provide a safe environment for patients, visitors and staff, the fire safety team provided around 2,580 staff with fire training which is rolled out each year to capture all staff within the Trust over a period of time.

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

Contractual requirement	Our performance 2025/26
18.1 In performing its obligations under this Contract the Provider must take all reasonable steps to minimise its adverse impact on the environment and to deliver the commitments set out in delivering a 'Net Zero' National Health Service.	This is achieved through our Green Plan, Net Zero Strategy, Heat Decarbonisation Plan and moving forwards, will also be addressed by our Climate Change Adaptation Plan. We have carried out risk assessments in order to help mitigate the impacts of climate change and adapt to its effects. These are currently in the process of being compiled into a climate change action plan that will be integrated into decision making for any current or future developments.
18.2 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must:	
18.2.1 nominate a Net Zero Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position;	WWL's Net Zero Lead is the Deputy Chief Executive. The Operational Lead is the Sustainability Manager.
18.2.2 maintain and deliver a Green Plan, approved by its Governing Body, in accordance with Green Plan Guidance; and	Our 2025-2030 Green Plan was approved by the board and published on 12 November 2025. This document acts as the annual summary on delivery of the plan and is updated at the start of the financial year.
18.2.3 provide an annual summary of progress on delivery of that plan, covering actions taken and planned, with quantitative progress data, to the Co-ordinating Commissioner and publish that summary in its annual report.	The Trust annual sustainability report complies with SC 18.2.3 and our contracting approach for 2025/26 has been confirmed as compliant by the ICB. It should be noted that due to the delays in release of data required to complete our carbon footprint and the time needed to convert the data into a footprint,

Contractual requirement	Our performance 2025/26
	the most up to date carbon footprint we have is for 2024/25 financial year. Typically, carbon footprints data requests commence in May and are completed for the previous financial year in June/July then sent to the board for approval.
18.3 The Provider must have in place clear, detailed plans as to how it will contribute towards a 'Green NHS' with regard to delivering 'Net Zero' National Health Service commitments in relation to:	
18.3.1 air pollution, and specifically how it will take action:	
18.3.1.1 to reduce air pollution from fleet vehicles, to offer and promote more sustainable travel options for service users, staff and visitors and to increase use of such options, in accordance with the NHS Net Zero Travel and Transport Strategy; and	We are engaged with our vehicle lease provider to review electric vehicle (EV) options. However, we have some difficulty with available electrical capacity across our sites. The Trust is re-siting the transport department and transitioning to electric vehicles. A handful of vehicles do not have a suitable EV alternative that can complete the mileage required, therefore these will remain as internal combustion engine vehicles until a suitable EV alternative is sourced. The Trust operates an expenses policy that includes recompense for shared occupancy, bus, rail, electric vehicle, and bicycle travel.
18.3.1.2 to phase out fossil fuels for primary heating and replace them with less polluting alternatives.	The Trust has completed heat decarbonisation plans and submitted costs as part of critical infrastructure risk pipelines. There is currently no feasible way of the organisation funding these works either from internal funding within our capital departmental expenditure limit, or national funding.
18.3.2 climate change, and specifically how it will take action:	
18.3.2.1 to reduce greenhouse gas emissions from the Provider's Premises in line with targets in Delivering a 'Net Zero' National Health Service;	The Trust has a Green Plan, Net Zero Strategy and Net Zero Steering Group that all look to address, monitor and mitigate the targets set out in delivering a net zero health service
18.3.2.2 in accordance with Good Practice, to reduce the carbon impacts of environmentally damaging gases used as anaesthetic and analgesic agents and as propellants in inhalers; 18.3.2.3 to reduce piped nitrous oxide and nitrous oxide and oxygen mixture waste; 18.3.2.4 to eliminate the use of desflurane in line with Desflurane Decommissioning and Clinical Use Guidance;	We have completed nitrous oxide audits and have ceased delivery of nitrous oxide via manifolds. We are addressing use of metered dose inhalers, and we are switching to dry powder inhalers where clinically appropriate. We have removed desflurane from use.

Contractual requirement	Our performance 2025/26
18.3.2.5 to prescribe inhalers with the lowest environmental impact among suitable devices in line with NICE Guidance 245; 18.3.2.6 to encourage Service Users to return their inhalers to pharmacies for appropriate disposal; and	
18.3.2.3 to adapt the provider's premises and the manner in which services are delivered to reduce risks associated with climate change and severe weather.	We are in the process of completing a climate change adaptation plan tool developed by Greener NHS. Alongside collation of exiting emergency preparedness, resilience, and response (EPRR) documentation, the output will be used to produce a climate change adaptation plan.
18.4 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must ensure that, as far as reasonably feasible, all electricity it purchases is from renewable sources.	The Trust endeavours to procure energy from a renewable source, where feasible. Currently this is not financially feasible.

Taskforce on climate related financial disclosures (TCFD)

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

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

Governance pillar

The Board of Directors has oversight of climate-related issues through the Finance and Performance Committee. Our Green Plan, its annual refresh and annual sustainability reports are all submitted to the board for approval. The annual sustainability report is the document via which the Board monitors progress against goals and targets for addressing climate-related issues.

Climate related risks, opportunities and responsibilities will be addressed within our climate change adaptation plan which is currently in development. Opportunities and risks will also be addressed through our Green Plan which covers the period 2025-30. The resilience of the organisation's strategy against different climate related scenarios is still being reviewed and is therefore not fully understood.

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

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

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

Strategy pillar

Climate related risks and opportunities will be addressed within our climate change adaptation plan which is currently in development. Opportunities and risks will also be addressed through our Green Plan which covers the period 2025-2030.

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

Risk management pillar

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

Climate-related risks have not yet been collated into a dedicated plan outlining the associated opportunities presented by climate change. We intend to have a climate change adaptation plan place in 2026. However, using the national risk register as a base, the Trust has assessed how each risk will be affected by climate change and applied this assessment to internal emergency and business continuity plans that aim to ensure the continued achievement of organisational objectives and delivery of health services to provide the mitigation needed.

We make decisions around how to mitigate, transfer, accept or control climate related risks in the same way as other risks, in line with our risk management framework, detailed further in the Annual Governance Statement. This year, we held a corporate risk that the Trust would not meet its net zero commitments and that climate change would have an impact on the Trust delivering services, that could not be mitigated. We considered this to be a principal risk to the organisation.

Metrics and targets pillar

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

Historical trends for NHS Carbon Footprint and NHS Carbon Footprint Plus are provided within the Green Plan and annual sustainability report, back to 2019, the baseline year. The baseline year was set at 2019 as this was the year where datasets were comprehensive enough to calculate a carbon footprint to Greenhouse Gas Protocol Standards (GHGPS). We utilise GHPS as a methodology for our NHS Carbon Footprint. NHS eClass codes classify what the Trust buys, whilst CenSA categories

provide standard carbon emission factors that allow us to estimate the environmental impact of that spend - together, they enable consistent, audit-ready measurement of procurement-related carbon emissions and prioritisation of sustainability action For our NHS Carbon Footprint Plus, we utilise a bespoke methodology, mapping purchase order and accounts payable spend against eClass codes and CenSA categories, which allows CenSA carbon footprinting to be applied to a product. There is a significant error margin in utilising this methodology, but we feel it is the most accurate methodology available to us and becomes more accurate as we incorporate individual supplier carbon footprints into the model.

Trends are analysed year on year and are mapped against 3 trajectories to achieving net zero. Trajectory 1 is ‘business as usual’, trajectory 2 is ‘net zero by 2045’ and trajectory 3 is ‘net zero ahead of 2045 through increased investment’. We track progress against trajectory 2 as our preferred trajectory and report progress against this trajectory, positive or negative, to our Board of Directors annually.

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

Joint forward plans and capital resource plans

During 2025/26, the Trust maintained robust oversight of capital planning through established governance arrangements, including a monthly Capital Strategy Group. This enabled regular monitoring of delivery against the capital programme and ensured effective utilisation of available resources within a highly constrained capital environment.

Progress reports from major programmes were routinely reviewed, allowing emerging risks to be identified early and appropriate mitigations implemented. The Capital Strategy Group also oversaw development of the five-year capital plan, ensuring alignment with the Trust’s strategic priorities.

The annual capital programme was aligned to the annual operational plan, supporting delivery priorities while identifying and managing key risks. Capital expenditure limits and bids for national funding were coordinated at Integrated Care System level, ensuring a consistent and system-wide approach. The Trust actively contributed to Greater Manchester capital planning discussions to ensure that local priorities and risks were reflected in wider system plans.

The Finance and Performance Committee received regular updates on capital expenditure and delivery, providing assurance regarding governance, affordability, and programme performance.

Operational compliance: emergency preparedness, resilience and response

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

Overall EPRR assurance rating	Criteria
Fully compliant	The organisation is 100% compliant with all core standards it is expected to achieve. The organisation's board has agreed with the position statement.
Substantial compliance	The organisation is 89%-99% compliant with the core standards it is expected to achieve. For each non-compliant core standard, the organisation's board has agreed an action plan to meet the compliance within the next 12 months.
Partial compliance	The organisation is 77%-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's board has agreed an action plan to meet the compliance within the next 12 months.
Non-compliant	The organisation is compliant with 76% or less of the core standards it is expected to achieve. For each non-compliant core standard, the organisation's board has agreed an action plan to meet the compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

EPRR activity across the Trust operates using established emergency planning life-cycle principles which embed continual review and learning principles into planning and response. This ensures that the Trust has a process of continuous improvement for EPRR. In areas that we assess ourselves as being non-compliant to the NHS core standards for EPRR, we engage with all internal departments and with external partners to review performance and develop improvement plans to improve compliance. These improvement plans are regularly monitored until compliance is achieved. For 2025/26, 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 1 October 2025.

Health inequalities

During 2025/26, we strengthened how health inequalities are addressed by embedding consideration of inequality impacts more systematically into planning, governance and decision making, including through the routine use of quality and equality impact assessments and closer alignment with refreshed borough and system priorities. This year, we have included a new section in our annual report, to provide you with information on our work to tackle health inequalities, including the extent to which the trust has exercised its functions consistent with NHS England's statement under section 13SA(1) of the NHS Act 2006 on how NHS bodies should exercise their powers to collect, analyse and publish information related to health inequalities.

Our partnership working continues to provide opportunities to focus not only on the provision of health services, but also on addressing the wider determinants of health and reducing health inequalities. As an anchor institution within the borough, we remain an active participant in the Wigan Community Wealth Building partnership.

During 2025/26, we have continued to support improvements in the socio-economic conditions of the borough by leveraging our position as a major employer and our significant spending power. This includes sustained partnership working to support local employment, skills development and access to education and training opportunities, alongside continued growth in apprenticeships and work-based learning placements across the Trust.

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

HEALTH INEQUALITIES STATEMENT

Health inequalities are unfair, unjust and avoidable differences in health between groups. They arise from unequal access to healthy living conditions, healthcare and the support people receive. In December 2025, the Trust launched its Health Inequalities and Prevention Plan, which aims to create lasting change where preventing illness and health inequalities becomes part of our everyday practice, to improve the health of our population. A key part of this approach is using high-quality data and insight to inform action on health inequalities through both operational and strategic decision-making.

This report sets out our organisational response to NHS England's updated *Statement on Information on Health Inequalities*. The national guidance outlines the statutory requirements for NHS bodies to collect, analyse and publish robust, disaggregated data to understand and address inequalities in access, experience and outcomes. In line with the Core20PLUS5 approach and the wider ambitions of the 10-Year Health Plan, this report describes how we will embed these requirements into our local systems, strengthen data quality, and ensure that insights on health inequalities meaningfully shape our planning, commissioning and service delivery.

The report includes:

- An overview of Wigan borough's health needs
- Understanding healthcare access, experience and outcomes
- Improving data quality, collection and analysis
- Using information on health inequalities — areas of progress and next steps

Understanding Wigan's health needs

Approximately 77% of the Trust's catchment population live in the Wigan Borough[1], which is home to 330,000 people. The population is growing and ageing: between 2011 and 2021 the number of residents increased by 11,472, and the 70–79 age groups grew by over 40%, making this the fastest-growing older population in Greater Manchester. The borough remains predominantly White British (95%), though ethnic diversity is increasing, with notable growth in Asian, Black and mixed ethnic groups over the past decade.

Health inequalities remain one of the most significant challenges. Wigan is the 78th most deprived local authority in England, and 28.5% of residents live in neighbourhoods among the 20% most deprived nationally. These inequalities translate into stark differences in health outcomes: life expectancy varies by 8.1 years for men and 9.1 years for women between the most and least deprived areas, driven largely by higher rates of circulatory disease, cancers and respiratory conditions in more deprived communities.

Overall health outcomes in the borough are worse than the England average. Residents live shorter lives and spend more years in poor health, with healthy life expectancy around 58 years for both men and women. The leading causes of death mirror national trends - dementia, lung cancer, pneumonia and heart disease - but premature mortality is strongly patterned by deprivation. Key preventable risks such as smoking, alcohol-related harm, physical inactivity and obesity continue to

[1] *Microsoft Power BI*

contribute significantly to poor health, with 74.6% of adults living with overweight or obesity and high rates of falls among older adults.

Children and young people also experience poorer outcomes than national averages, including higher levels of dental decay and elevated rates of overweight and obesity in early years, alongside persistent inequalities in child poverty and early development[2].

Understanding healthcare access, experience and outcomes

To help us identify unwarranted variation in access, experience and outcomes across different population groups, this section focuses on inequalities within core performance measures that align with our operational priorities. The analysis concentrates on:

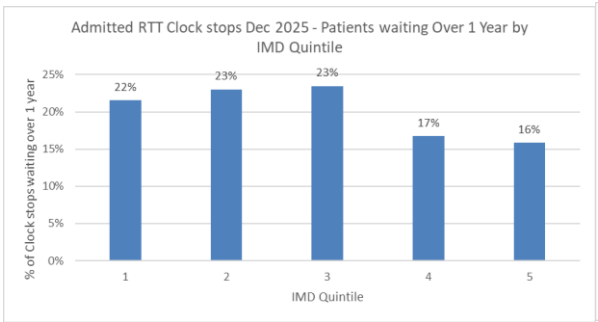
- **Elective care:** waiting lists and outpatient DNAs
- **Urgent and emergency care:** A&E frequent attenders, average length of stay and readmissions
- **In hospital mortality**
- **Index of Disparity**

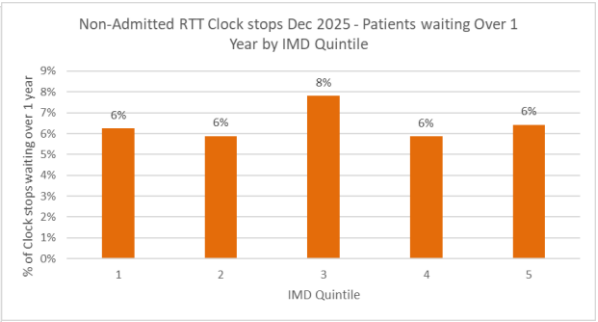
In 2023, three health inequalities insight reports were produced for the Trust, highlighting variation in waiting lists, occurrences of patients failing to attend appointments (DNAs), A&E attendances and emergency admissions. By using the same metrics, we have been able track trends annually. This paper therefore compares performance for April - December 2025 with 2024/25, 2023/24 and 2022/23.

All data has been disaggregated by age, sex, and Index of Multiple Deprivation (IMD), and where possible ethnicity, to identify unwarranted variation linked to protected characteristics and deprivation. These characteristics are now embedded within on-demand reporting, enabling more consistent and systematic monitoring of inequalities.

Waiting Lists

- As of December 2025, the proportion of patients in the more deprived, and median deprived areas who wait over 1 year for admitted care remains higher than the percentage in the least deprived areas.
- Patients waiting over 1 year for outpatient treatment across all of the quintiles ranges from 5.9%-6.4%, except for quintile 3, with 7.8% of patients.

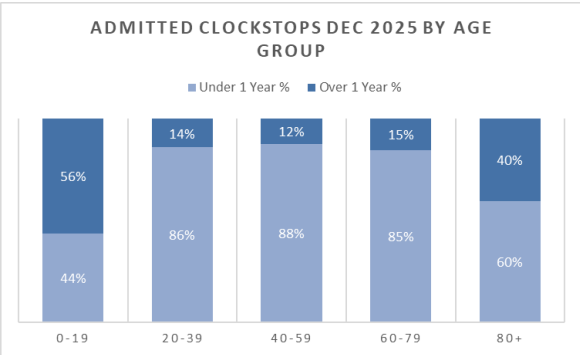


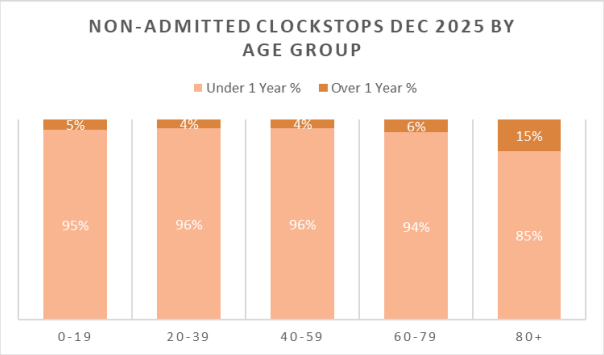


- Children remain more likely to wait over 1 year for admitted treatment, 56%, with 40% of patients aged over 80 years waiting over 1 year, compared with 12-15% for remaining

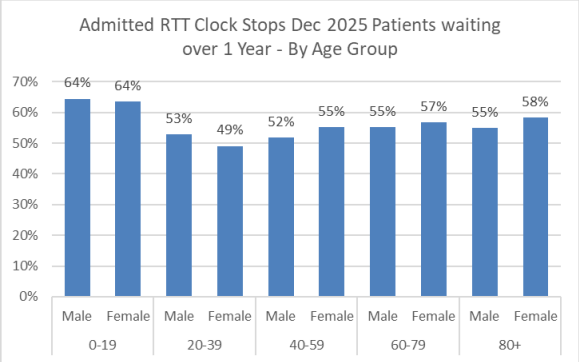
[2] Wigan Borough Joint Strategic Needs Assessment Population Health Summary

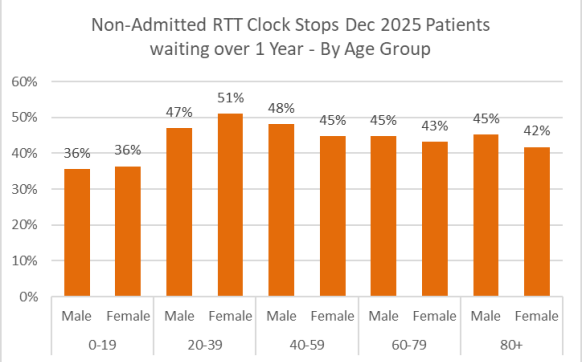
patients. 15% of patients aged over 80 wait over 1 year for outpatient treatment compared to 4-6% for other patients.





- The latest waiting list position, as at December 2025, shows a higher proportion of patients aged 0-19 who waited over 1 year for admitted care.

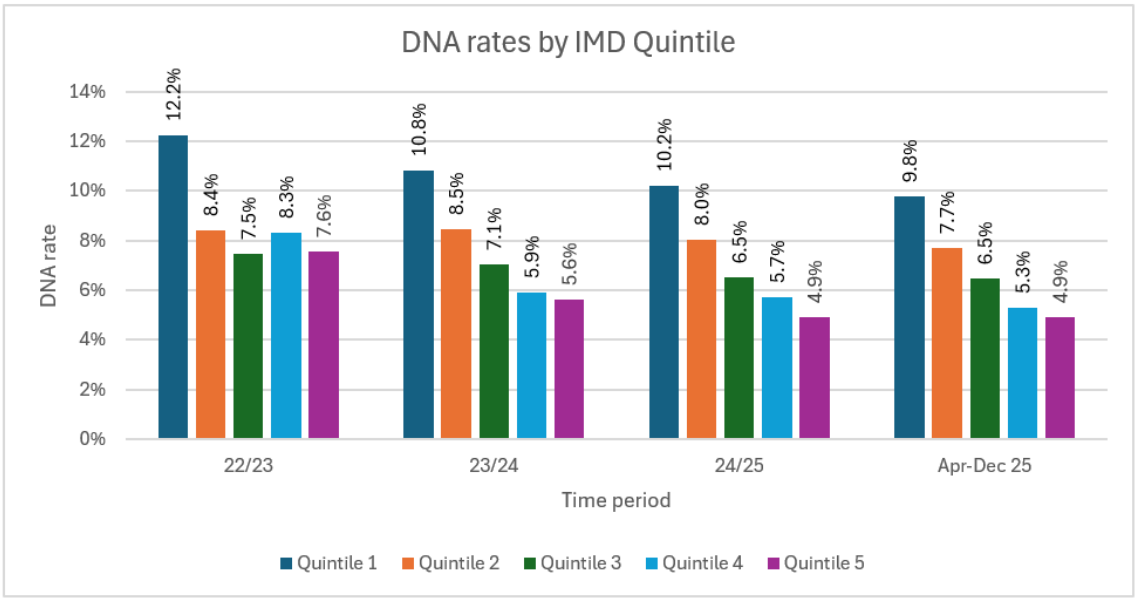




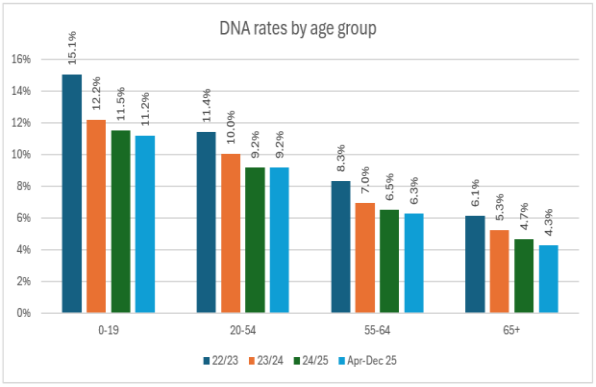
- Disaggregation of patients waiting over 1 year by ethnic group was conducted, but due to small numbers it was not possible to draw any conclusions.

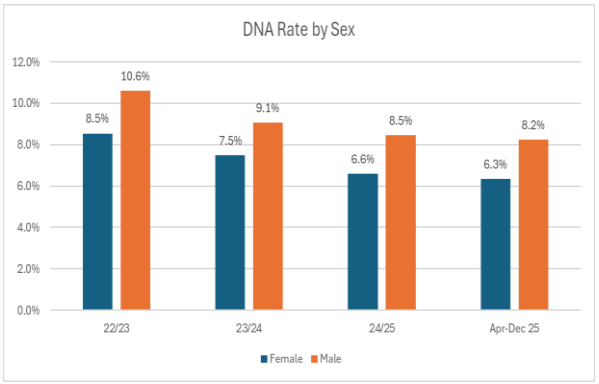
Outpatient DNAs

- The overall DNA rate for the Wigan residents at WWL was 7.4% in April - December 2025, this is showing a downward trend (9.4% in 2022/23 to 8.2% in 2023/24, 7.6% in 2024/25).
- Outpatient DNA rates continue to be highest for those living in the most deprived areas, as deprivation reduces so does the DNA rate.
- Between April - December 2025, the DNA rate for patient's resident in quintile 1 (20% most deprived areas) was twice as high as for those residents in quintile 5 (20% least deprived areas).
- This is consistent with previous years showing a persistent inequality.

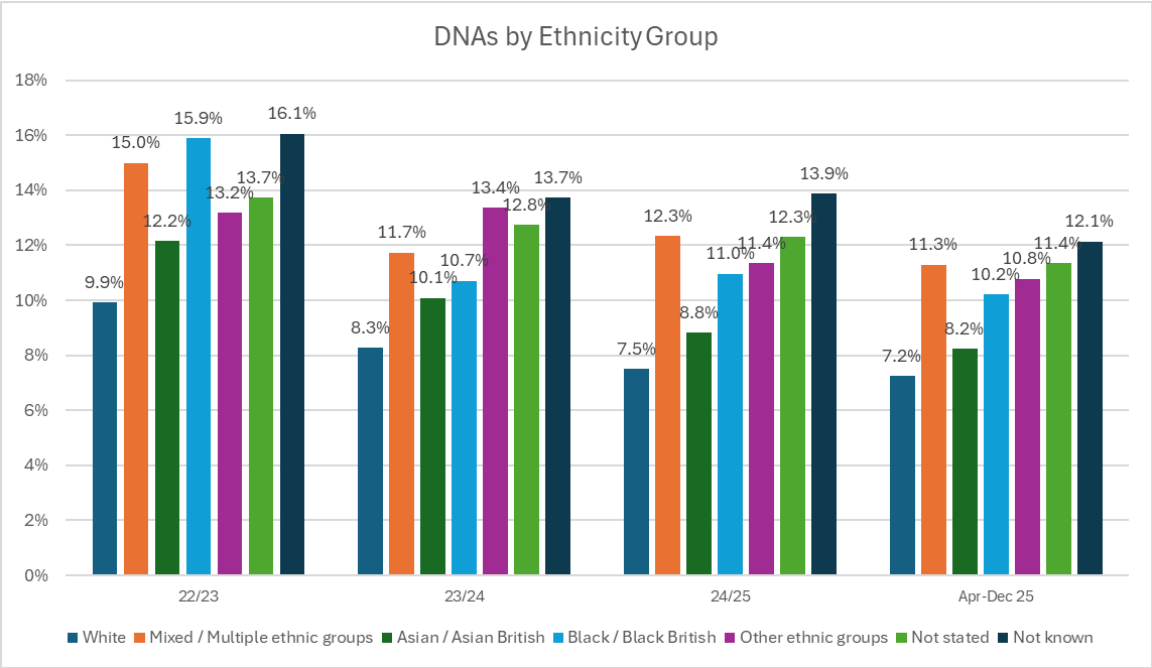


- There has been a year-on-year reduction in DNA rates across all age groups, and by sex. The highest levels remaining amongst the younger age groups, specifically those aged 0 to 19 and males aged 20 to 54 years. As age increases, the rate of DNA continues to reduce across all time periods analysed.
- DNA rates remain consistently higher in males, particularly those aged 20-54 years, with the latest DNA rate being 15.28%.



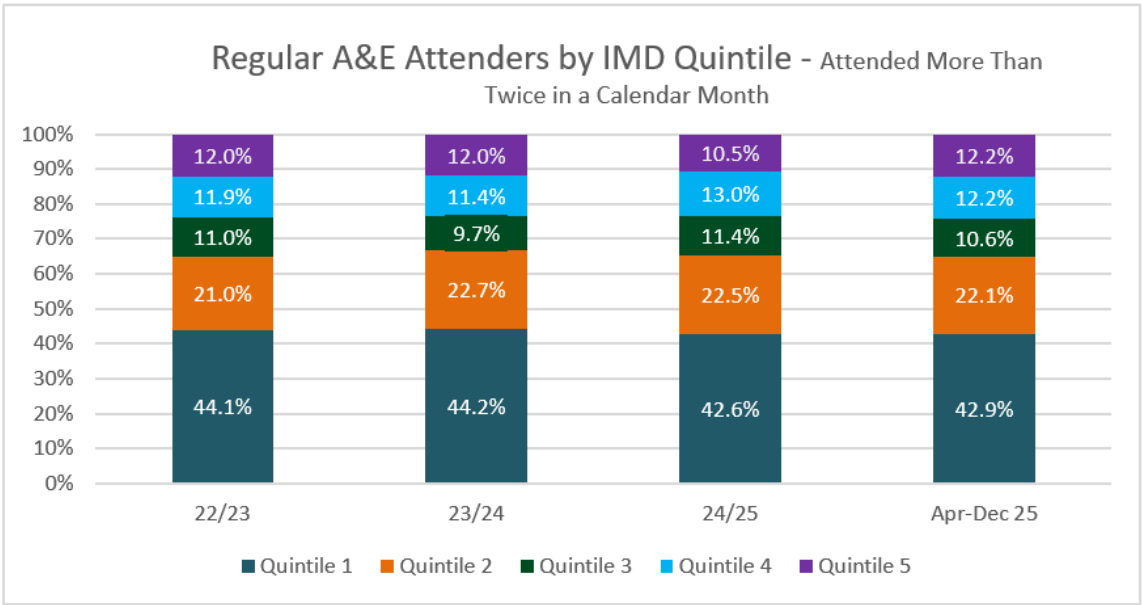


- DNA rates have reduced over time across all ethnicity groups; however, the chart demonstrates a persistent inequality gradient, with some groups consistently experiencing higher non-attendance than others. In every year shown, patients recorded as “Not known” and those in “Mixed / Multiple ethnic groups” have the highest DNA rates, while the “White” group has the lowest. Although the gap between groups has narrowed by April - December 2025, these differences remain, indicating that improvements have been unevenly realised. The continued prominence of the “not known” category also highlights a data quality inequality, where incomplete ethnicity recording may both mask true disparities and reflect lower engagement with services.

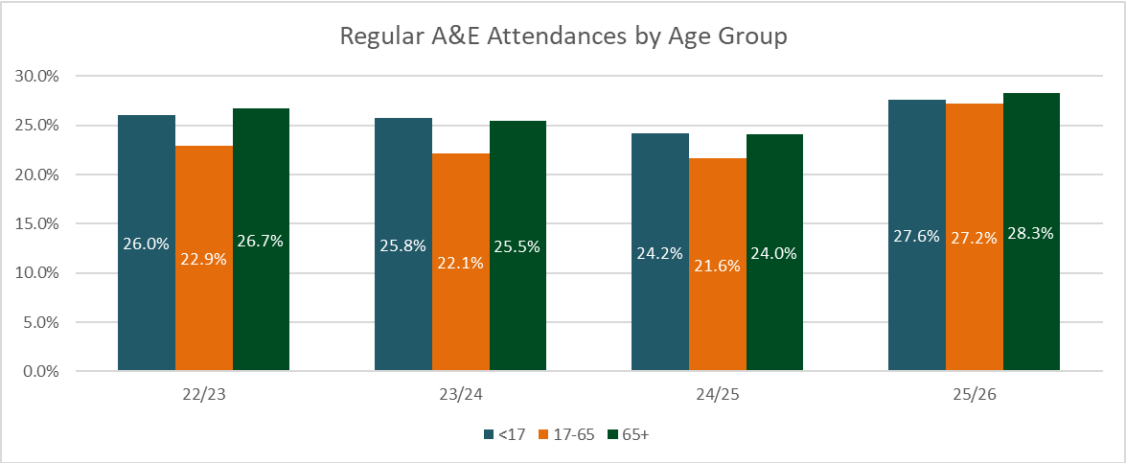


A&E Frequent attenders

- Patients living in the most deprived areas were found more likely to be an A&E regular attender. Reviewing the data for patients who attend more than twice in a calendar month, the most deprived quintile equated to between 42.6% and 44.2% for the time periods analysed, compared to the least deprived quintile ranging from 10.5% - 12.2%.
- This is consistent with the findings from previous years.



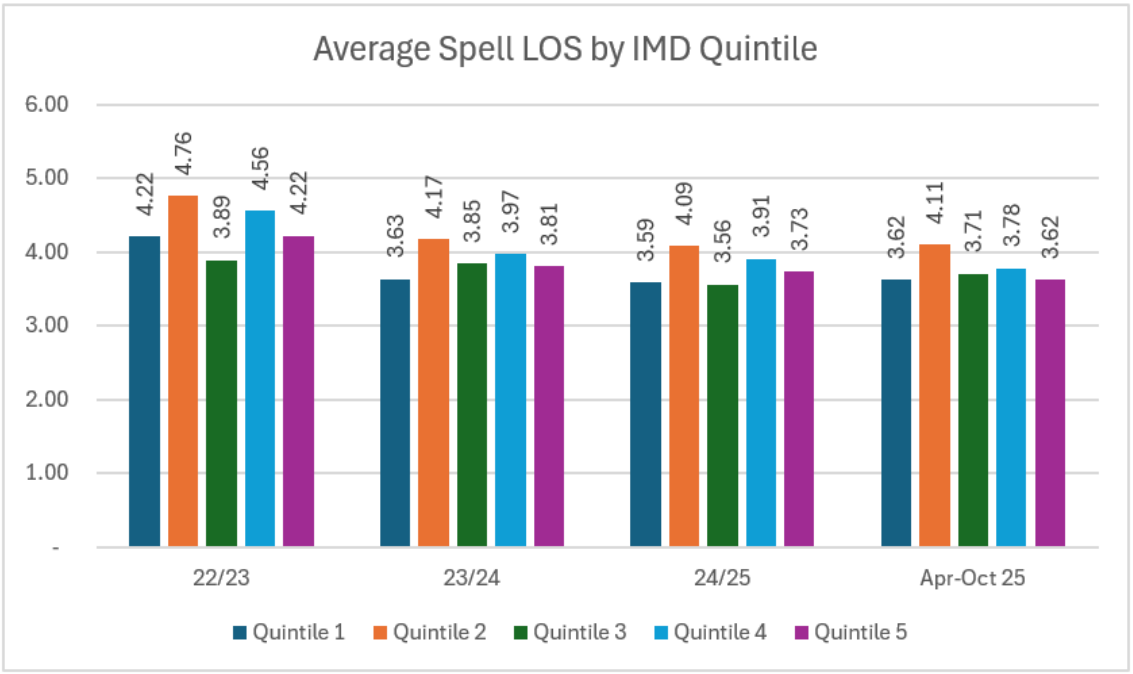
- A&E reattendance rates over the 4 years are highest amongst older age groups, closely followed by those in the <17 category.
- In terms of regular A&E attendance rate, there is a dip across all age groups in 2024/25 followed by a marked increase in 2025/26 across all age groups, indicating a broad rise rather than pressure within a particular age cohort.



- Across all time periods, the White ethnic group makes up the clear majority of regular A&E attenders, accounting for around 86–89% of attendances. All other ethnic groups individually represent small proportions, generally 1–3% each, including Asian / Asian British, Black / Black British, Mixed / Multiple ethnic groups, and Other ethnic groups. This reflects the ethnic make-up of the local population, and it is difficult to draw further conclusions due to small numbers.

Average length of stay

- The average length of stay shows a general downward trend across all quintiles over time.
- Average length of stay is a similar when comparing quintile 1 (most deprived) to quintile 5 (least deprived), whilst quintile 2 consistently shows the highest length of stay. It is unclear why we observe this trend, and it may warrant further investigation.

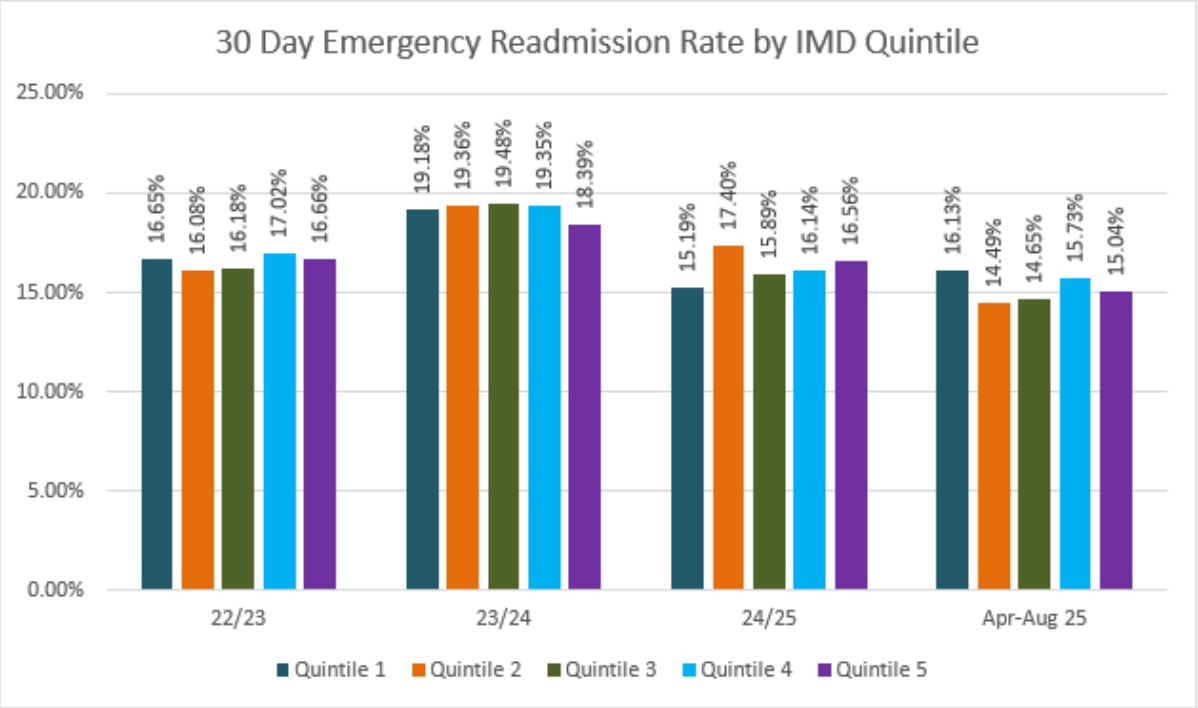


Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

Readmissions

- There is no consistent pattern to show that more or less deprived patients are more likely to be readmitted within 30 days.
- During April - August 2025, the lowest rate was in quintile 2, 14.49% and the highest rate in quintile 1, with 16.13%. However, this is inconsistent with previous years, meaning that the

significance is unclear - during 2022/23 and 2023/24 there was little variation in 30-day readmission rate between the quintiles. During 2024/25 quintile 1 had the lowest level of 30-day readmission rate at 15.19% and quintile 2 saw the highest rate at 17.4%.

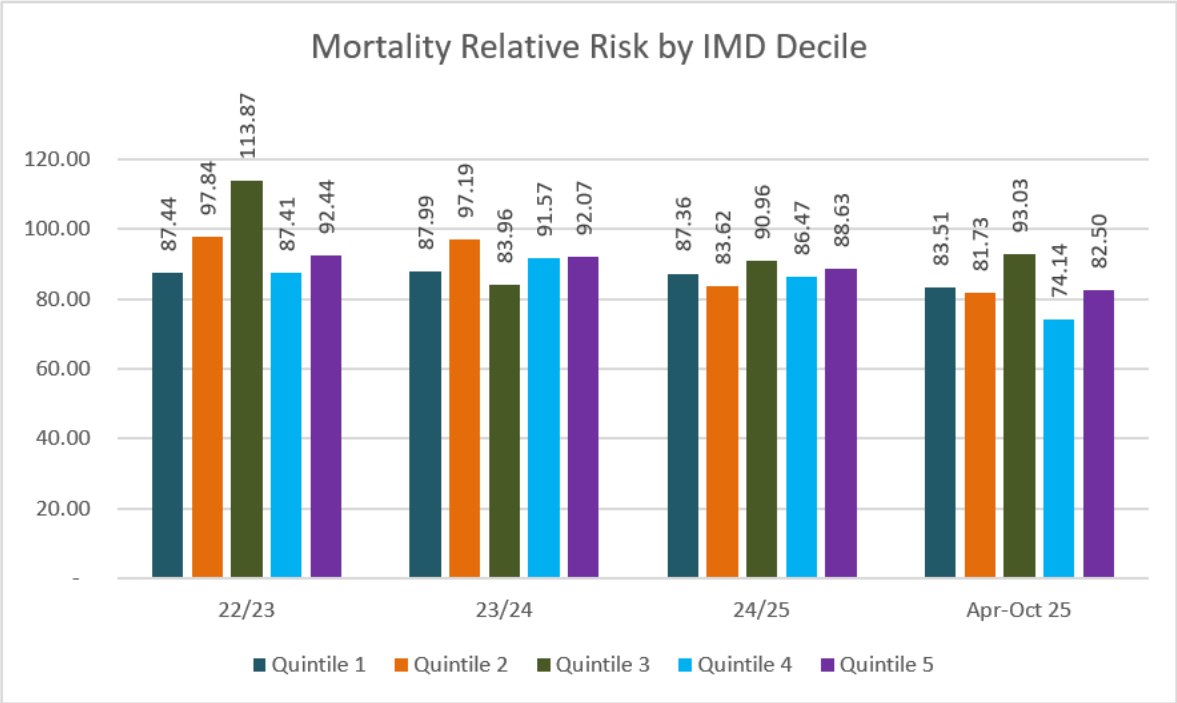


Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

- As age increases, the rate of readmission also increases. During 2022/23 19.65% of patients aged 75 years and above were readmitted into hospital within 30 days of discharge; the figure for 2023/24 was 21.24%, for 2024/25 was 20.73% and for April - August 2025 was 21.11%.

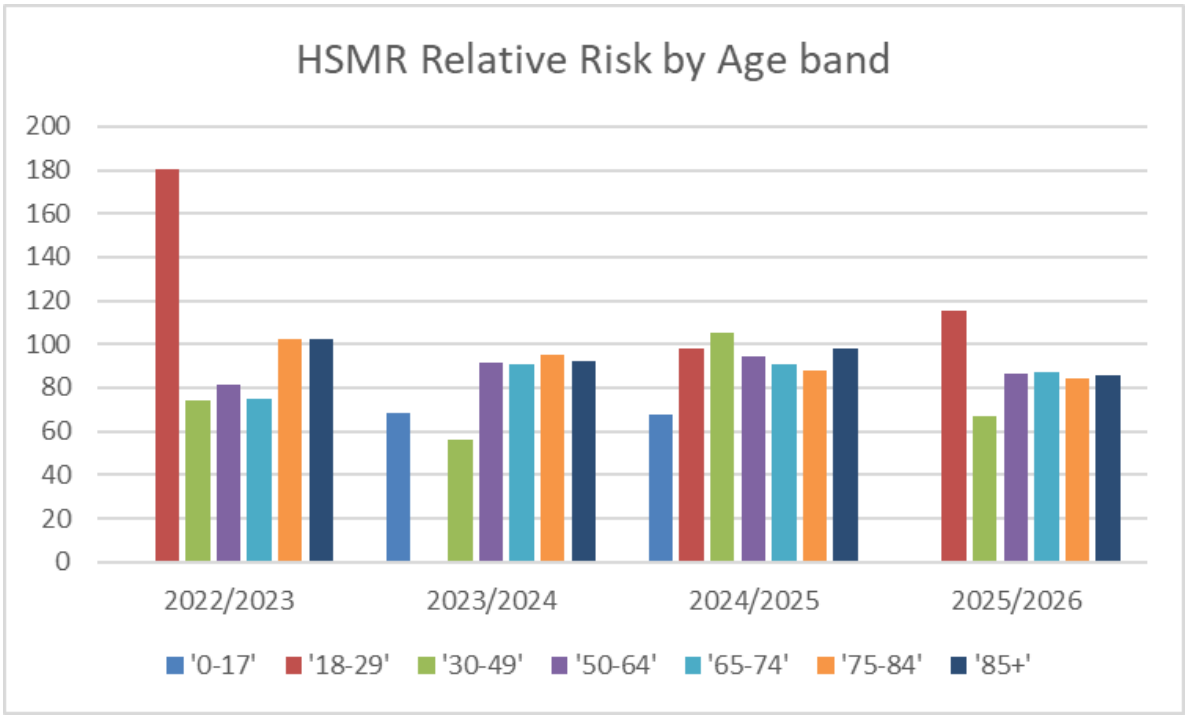
In hospital mortality

- In hospital mortality relative risk has been calculated using 'Dr Foster Limited' methodology. Dr Foster's Hospital Standardised Mortality Ratio (HSMR) Relative Risk is a statistical measure used to compare the number of observed in-hospital deaths within a trust or specialty to the number of deaths that would be *expected* based on national benchmarks. The national benchmark position compares relative risk to 100; below this number is a more favourable comparison.
- In 2022/23, quintile 3 is above the threshold, at 113.87. Whilst for 3 of the 4 time periods, quintile 3 is the highest reported relative risk, this has been below 100 since 2023/24, suggesting that deaths are within what is expected.
- There are no notable inequalities by deprivation.



Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

- HSMR Mortality Relative Risk is calculated for individual patients and rates are reported within or outside of expected ranges. Although some levels are above the national 100 benchmark, all levels are within expected ranges, with the 18-29 age banding having 1-2 deaths per year. The majority of relative risk relating to in hospital standardised mortality ratios have reduced across all age bands.



HSMR Relative Risk by age group	2022/2023	2023/2024	2024/2025	Apr-Nov 25
'0-17'	0.00	68.18	67.44	0.00
'18-29'	180.34	0.00	98.28	115.17
'30-49'	74.14	56.25	105.20	66.78
'50-64'	81.75	91.24	94.18	86.79
'65-74'	75.10	90.65	90.92	86.83
'75-84'	102.45	95.28	87.96	84.55
'85+'	102.61	92.47	97.79	85.93

Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

- The relative risk for both sexes converge over time, latest figures females 83.5, males 86.5, both significantly under the 100 national benchmark.

Index of Disparity

The Index of Disparity (IoD) is a summary measure used to quantify relative inequality across multiple groups for a given indicator. The table below gives a breakdown of the inequality measures for the metrics included in this paper. It is calculated by measuring the disparity between different groups from the average. The groups used in calculating the IoD are: Age, Gender, Deprivation Quintile and Ethnicity.

To illustrate how the index of disparity works take the following example:

If 5 people have an average of 10 sweets in a bag the disparity would be how far away from 10 sweets each person actually had. If all 5 people had 10 sweets each, then disparity would be 0. If some people had much higher or lower than 10 sweets the bigger the disparity would be.

Metric Name	Age	Gender	IMD Quintile	Ethnicity	Total IoD
DNA Rate	0.34	0.14	0.22	0.12	0.21
Average Length of Stay	0.38	0.03	0.04	0.2	0.16
RTT - 52+ Week Waiters (Rate)	0.48	0.05	0.08	0.42	0.26
Hospital Standardised Mortality Ratio (HSMR)	0.1	0.18	0.04	0.24	0.12
30 Day Readmissions	0.31	0.08	0.04	0.23	0.16
A&E Frequent Attenders	0.01	0.01	0.03	0.42	0.12

In summary:

- This approach is new to the Trust and represents an innovative way of working that is not yet routinely used within the NHS. It is being trialled as part of the NHS commitment to addressing health inequalities. As this work is still at an early stage, the results should be interpreted with caution while we continue to develop our understanding of its usability and limitations.
- The analysis suggests higher levels of overall inequality in DNA rates and waits of over 52 weeks.

- There is variation by age across DNA rates, average length of stay, waiting times and readmissions.
- Deprivation (IMD quintile) appears to be a less consistent driver of inequality across the selected metrics, except for DNA rates, where the gradient remains strong.
- Ethnicity appears to influence waiting times, HSMR, readmissions and A&E frequent attenders suggesting potential inequalities. However, these findings should be interpreted with caution due to small sample sizes and incomplete ethnicity recording.

To strengthen our ability to identify and act on inequalities, the Index of Disparity will be introduced into key metrics within the Trust's integrated performance report, with opportunities to extend its use across other strategic and operational reporting. Using a single, comparable measure will support prioritisation, enable monitoring of progress over time, and raise the visibility of inequalities within routine reporting to drive discussion and action.

Improving data quality, collection and analysis

Accurate, comprehensive and consistently recorded data is essential for identifying health inequalities and taking effective action. Incomplete or inconsistent data limits our ability to understand whether services are meeting the needs of all population groups.

Ethnicity

For this report, it has not been possible to present all metrics disaggregated by ethnicity due to small sample sizes, which would risk presenting misleading conclusions. This reflects both the demographic profile of Wigan Borough, where 95% of residents identify as White British, and incomplete ethnicity recording across Trust services. A high proportion of patients continue to have 'unknown' or 'not recorded' ethnicity, highlighting the need for improvement.

Ethnicity recording rates for April - December 2025 are shown in the table below. The proportion of patient records with valid ethnic group codes exceeds the national averages reported in NHSE's Ethnicity Recording Improvement Plan. It is positive that no records contain a blank or null ethnicity field. However, there remains room for improvement in the use of 'not stated' and 'not known' codes, which appear to be used more frequently in outpatient data.

Core measures for A&E attendances / DNAs / inpatient admissions April - December 2025			
Core measures	A&E attendances	DNA (Outpatient)	Inpatient admissions
Percentage of records with blank or null codes for ethnicity	0.0%	0.0%	0.0%
Percentage of records with residual ethnic codes including – not stated, not known	1.6%	9.1%	2.9%
Percentage of patient records with a valid, non-residual ethnicity code in data sets	98.4%	90.9%	97.1%

In 2024, our data, analytics and assurance (DAA) team reviewed ethnicity recording across inpatient, outpatient and emergency care contacts. The review identified inconsistent recording practices, variation in data completeness between services, and the absence of a standard operating procedure. Since then, system change recommendation to mandate ethnicity recording on the Leigh Urgent Treatment Centre has been implemented and has resulted in improving completion from 78% to 86%. In addition, protected characteristic fields are now embedded within core Qlik applications, and the DAA team continues to apply a health inequalities lens where data allows. Continued work to further standardise ethnicity recording across our services will help strengthen data quality and consistency.

Although local analysis is challenging, national evidence and local deep dives, such as the review of inequalities in endoscopy care in 2024, confirm that racial inequalities do exist. Work is underway to address this, including the development of the Trust's Anti-Racism Strategy, improvements to equality impact assessments, and actions to strengthen data quality as set out in the Health Inequalities and Prevention Plan and ethnicity data review.

Community Paediatrics

Long waiting times in community paediatrics were evident during April - September 2023 and April - September 2024, with around two-thirds of patients waiting over one year. During April - September 2024, 62% of patients waiting more than one year for an ENT admission were children. Due to data quality issues, it has not been possible to review this information for 2025. This has been identified as a risk, and work is planned to address the data quality concerns while improvements continue through the clinical cervices redesign transformation programme in community paediatrics.

Areas of Progress

During 2025/26, the Trust has strengthened its approach to health inequalities by embedding an equity lens more systematically into planning, governance and operational delivery. The Health Inequalities and Prevention Plan was finalised and implementation has begun, setting a clear strategic direction and establishing six priority areas: strengthening governance, improving data quality, developing an empowered workforce, addressing inequalities in access, experience and outcomes, advancing neighbourhood and population health, and embedding prevention in practice. A new Health Inequalities and Prevention Steering Group will oversee delivery, and the integration of health inequalities considerations across board subgroups will support action and provide challenge across all areas of activity.

Health inequalities reporting

Where possible, data within on-demand reporting is disaggregated by age, sex, ethnicity and IMD, to enable more consistent and systematic monitoring of inequalities. Work is underway to incorporate the Index of Disparity into the integrated performance report, enabling the board to routinely identify and act on inequalities. Further analytical work has strengthened understanding of variation within specific pathways. An alcohol and inequalities report (March 2025) identified a strong correlation between deprivation and alcohol-related harm, with the most deprived deciles accounting for the majority of alcohol-related A&E attendances and admissions. A specific piece of work is underway to understand inequalities in access to cardiology investigations.

Developing an empowered workforce

This year, progress includes staff education and awareness sessions, expansion of training opportunities, and the appointment of a joint Consultant in Public Health, with Wigan Council, and a

WWL-based youth worker. This approach supports the development of a confident workforce equipped to recognise and act on health inequalities.

Addressing inequalities in access, experience and outcomes
Targeted work has begun to improve health literacy, including redesigning outpatient communications, alongside specific service-level projects such as those within speech and language therapy. In relation to DNAs, the text reminder service, which was implemented following the development of a DNA predictor, was extended to two reminders for all appointments, leading to a further reduction in DNA rates. However, inequalities persist, and the Trust is exploring additional targeted action.

Working in partnership to advance neighbourhood and population health
A neighbourhood-focused approach has been initiated, beginning with Scholes in Central Wigan, to understand and address inequitable access at community level. The Integrated Delivery Board, co-chaired by the Trust's Chief Executive and Wigan Council's Director of Public Health, continues to drive system-wide action. Joint analyses with Wigan Council have informed targeted respiratory support in high-need areas, and wider neighbourhood health models are being developed through the Healthy Wigan Partnership. WWL services, are scoping and trialling new ways of working, such as 'Work Well' models, supporting people into employment, and community appointment days within musculoskeletal services.

Embedding prevention in practice
Preventative approaches continue to expand, including the trial of opportunistic inpatient flu vaccination to improve uptake among underserved groups. Joint work with Wigan Council seeks to further embed prevention into clinical pathways, with an initial focus on smoking cessation and wider determinants.

Summary and Next Steps

Analysis of elective and urgent and emergency care data shows clear and persistent inequalities across age and deprivation. DNA rates remain twice as high for patients living in the most deprived areas compared with the least deprived, despite an overall downward trend. Younger age groups (0–19) and males aged 20–54 continue to have the highest DNA rates. Inequalities are also evident in urgent and emergency care, with 43% of all A&E frequent attenders coming from the most deprived quintile. And readmission rates increase steadily with age, highlighting the need for targeted support for older adults.

Alongside this, the Trust has made year-on-year progress in strengthening its approach to health inequalities. The Health Inequalities and Prevention Plan provides a clear strategic framework, and through this, work is underway to improve data quality, deepen insight, empower the workforce and embed prevention and neighbourhood-based approaches. The evidence presented reinforces the need to accelerate this work and ensure that health inequalities are consistently addressed across transformation programmes, service design and operational decision-making.

Next Steps
Building on progress to date, the Trust will continue to strengthen its approach to health inequalities in 2026/27 by:

- **Launching the Health Inequalities and Prevention Steering Group** to oversee delivery of the health inequalities and prevention plan, and ensure a coordinated, system-wide approach.
- **Strengthening the use of the NHS England Statement on Information on Health Inequalities**, identifying a core set of metrics aligned to Trust priorities and reviewing these throughout the year to maintain a consistent narrative, and ensure timely action.
- **Introducing the Index of Disparity** within our integrated performance report and other strategic and operational reporting to support routine identification and action on inequalities.
- **Embedding health inequalities and prevention within strategic planning, transformation programmes and core business functions**, ensuring that reducing inequalities is a central priority across all Trust activity.

Accountability Report

www.wwl.nhs.uk

Our Values | People at the Heart | Listen and Involve | Kind and Respectful | One Team

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 a breadth of experience, including backgrounds in finance, primary care and education. The board considers that it is balanced and complete in its composition, appropriate to the requirements of the organisation and that each of its non-executive members is independent. The directors are responsible for preparing the annual report and accounts each year.

Professor Dame Rabina Shah, Chair | Appointment 1 Dec 2026 to 30 Nov 2029

Robina joined WWL as an experienced NHS leader, having been the previous Chair of Stockport NHS Acute Trust, Chair of Stockport NHS Foundation Trust and Deputy Chair at Northern Care Alliance NHS Foundation Trust, following a period as Acting Chair of that organisation. She has a background in Psychology, as a Chartered Consultant Psychologist; she is the Professor of Medical Education and Psychosocial Medicine at the Manchester University Medical School, Director of the Doubleday Centre and a past President of the Medicine and Society Council of the Royal Society of Medicine. She has published widely on psychosocial medicine, patient partnership and the lived experience of long term conditions. She continues to serve as a Deputy Lord-Lieutenant for the County of Greater Manchester, having previously been the High Sheriff for the County. She is a Director of Oldham Athletic AFC, and previously served on the Football Association Council and their Women's Football Board.

Mary Fleming, Chief Executive | Permanent post

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

Professor Sanjay Arya, Chief Medical Officer | 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. Dr Arya is a keen teacher, dedicated to the teaching and training of doctors and other healthcare professionals and was the Foundation Programme Director for seven years during which he raised the profile of doctor teaching and training at WWL. Dr Arya holds the position of Examiner for the Royal College of Physicians; is an Honorary Senior Lecturer and Undergraduate Clinical Lead for Edge Hill University's Medical School; a member of the Advisory Board and Honorary Professor in Health and Wellbeing for the Medical School for the University of Greater Manchester and also serves as a governor for Wigan and Leigh College. Dr Arya is an active member of various cardiovascular organisations which aim to reduce the incidence and improve the management of cardiovascular disease and has published several publications, delivered talks throughout the country. In 2025, he received an OBE (Officers of the Order of the British Empire) for his contributions to black and minority ethnic doctors and healthcare in Greater Manchester.

Professor Clare Austin, Non-Executive Director (Independent) | Appointment 1 May 2019 to 30 Apr 2026

Clare retired this year from her role as Pro Vice-Chancellor and Dean of the Faculty of Health, Social Care and Medicine at Edge Hill University, the trust's university medical school, also coming to the end of her tenure at WWL. Prior to this, she was Associate Dean for Research and Innovation and Director of the Edge Hill University Medical School. Clare holds a BSc and PhD in Pharmacology and has worked in a number of different North-West Universities.

Lady Rhona Bradley, Senior Independent Director (Independent) | Appointment 1 Dec 2019 to 30 Nov 2026

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 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, also now serving as Governor on the board of LTE Group, an integrated education and skills group, dedicated to learning, training, and employment. In her earlier career, 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.

Sarah Brennan | Chief Operating Officer | Permanent post

Sarah was previously the Chief Operating Officer at Bridgewater Community Healthcare NHS Foundation Trust. Prior to this, she held roles in Strategic Delivery, Operations and Medicines Management with Bridgewater. A Pharmacist by background, Sarah has worked in several settings including community, hospital, industry and the military, spending periods of her career working in both Germany and Guernsey. She is passionate about improving patient care and growing and developing teams to facilitate this. She has a particular interest in children's services and the links with public health and addressing health inequalities.

Tabitha Gardner, Chief Finance Officer | Permanent post

Tabitha brings extensive NHS financial leadership experience across provider and commissioning organisations in the Northwest. Since joining WWL, Tabitha has led the financial strategy and performance of the Trust, working with executive and divisional leaders to strengthen financial grip, improve risk profiling, and drive delivery. She has provided executive leadership across a range of transformation and productivity programmes, including theatre productivity work at both Trust and Greater Manchester (GM) system level. As a senior executive leader, Tabitha is also responsible for driving a culture of continuous improvement across the finance function and wider organisation, in particular championing collaboration. Tabitha is the Chair of the GM General Ledger Programme to standardise systems, and in 2025/26 the WWL finance team jointly won the NW Health and Finance Managers Association Collaboration award with Bolton NHS FT. Prior to joining WWL, Tabitha was Director of Finance at Rochdale Care Organisation, part of Northern Care Alliance NHS Foundation Trust, where she worked closely with local authority, and primary care colleagues to develop the locality and neighbourhood strategy. She previously spent eight years at NHS England in specialised services commissioning.

Julie Gill, Non-Executive Director (Independent) | Appointment 1 Apr 2023 to 31 Mar 2029

Julie has worked in senior roles across the public sector, including local government, housing, regeneration, policing and education and recently retired from her role as the Chief Officer at Cheshire Constabulary, where she took 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.

Simon Holden | Non-Executive Director (Independent) | Appointment 1 Jun 2025 to 31 May 2028

Simon has held many senior posts within the NHS, including being the first Chief Executive of NHS Property Services, a national organisation, based in London and part of the Department of Health, responsible for over 4,000 NHS buildings, and employing 3,000 people. Latterly, Simon was also the Finance Director of the Countess of Chester NHS Foundation Trust. Simon joined the NHS as an Apprentice at Blackpool Victoria Hospital, aged 18, and has over 40 years NHS finance experience. Throughout his career, he has undertaken a number of Finance Director roles, both in Commissioning and Provider organisations. In addition, Simon has also previously undertaken a number of Non-Executive roles including Treasurer of Disability Positive, Chairman of Pear Tree Primary Academy School and Non-Executive Director for LocatED Property Ltd (a wholly owned subsidiary of the Department for Education). Simon is a Fellow of the Chartered Association of Certified Accountants (FCCA), and also a Fellow of the Royal Institute of Chartered Surveyors (FRICS).

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

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

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

Mary is a retired Executive Chief Nurse having spent 44 years on an NHS career trajectory from Bedside to Board. Mary's experience was primarily in acute settings until commencing national improvement roles with the Department of Health and Social Care from 2000 – 2010. Returning to NHS acute and commissioning organisations in her executive roles in recent years. Mary has chosen to enthusiastically continue with leadership roles post-retirement in Non-Executive and Interim Executive roles and is delighted to join the WWL family. She is currently in her second term as a Clinical Non-Executive Director and Maternity Champion at NHS Stockport FT, a role that will

compliment her appointment to WWL being part of the wider Greater Manchester health and care system.

Richard Mundon, Deputy Chief Executive | Permanent post

Richard is a very experienced public servant spending the majority of his career in the health sector. He has a degree in biological sciences and is a qualified accountant. He spent 25 years in the Department of Health joining in 1986 and working in a wide variety of roles in Birmingham, London and Leeds across a range of policy, management and corporate disciplines. Richard has worked with Ministers, had multi billion pound budget responsibilities, led large change programmes, developed performance management and planning regimes and was head of profession for programme and project management. Amongst his many roles, he can list Project Manager on the 2000 NHS Plan and Director of Operations. Richard joined the Trust in 2012 where he led projects on private patients, temporary staffing, back office functions and occupational health commercialisation. He became Acting Director of Strategy and Planning in December 2014 before being appointed as Director of Strategy and Planning in August 2015.

Kevin Parker Evans | Chief Nursing Officer | Permanent post

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

Emma Newton, Interim Chief People Officer | Interim post 6 Jan 2026 to 31 Mar 2026

Emma is a specialist director in healthcare workforce transformation, with a focus on improving operational efficiency and aligning people strategy with service delivery. Prior to joining WWL, she held roles including Director of People at the Royal Liverpool Hospital (part of the Royal Liverpool University Hospital Group) and Director of Workforce Equality, Diversity and Inclusion at East Cheshire NHS Trust, with expertise in organisational redesign, performance improvement and workforce cost transformation.

Francine Thorpe, Deputy Chair (Independent) | Appointment 1 May 2021 to 30 Apr 2027

Francine has had a long career in the NHS; her most recent post was Director of Quality and Innovation at NHS Salford Clinical Commissioning Group. As well as working as a commissioner, she has held senior leadership roles within acute hospitals, primary care and community services. Francine has a clinical background as a physiotherapist and during her career worked as a Physiotherapy Advisor to the Lead Allied Health Professional at the Department of Health. Over the last few years she has been involved in the development of integrated health and social care across the Salford locality and led a large quality improvement programme focused on medication safety, safer care homes and safer handover across care settings.

Mark Wilkinson | Non-Executive Director (Independent) | Appointment 1 Nov 2025 to 31 Oct 2028

Mark is an accomplished leader with extensive experience in healthcare, housing, and education sectors. As the previous Cheshire East Place Director, Mark oversaw health integration to enhance care across the Cheshire and Merseyside region. His governance roles include Non-Executive Director positions with Mastercall Healthcare and Bolton at Home, and Edge Hill University, where he drives strategic and patient/student centred improvements. Previously Mark has held senior NHS roles, such as Executive Director of Planning and Performance at Betsi Cadwaladr Health Board as well as commissioning Chief Executive roles, managing major budgets, performance, and strategic transformations and his career is marked by a commitment to innovation, community impact, and operational excellence. Born and raised in Stockport, Mark now lives near Ormskirk and is delighted to be working at his local NHS organisation, helping to shape the services he and his family depend on.

The following individuals were also directors of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust during 2024/25:

- Mark Jones (Chair to 20 Jun 2025)
- Emma Newton (Interim Chief People Officer 6 Jan 2026 to 31 Mar 2026)
- Juliette Tait (Chief People Officer to 9 Jan 2026)

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, reported formally to the board at each meeting, and available on our electronic register which is available to the public. A copy of the register is available on our website or on request from the corporate affairs team.

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

Independence of directors

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

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

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

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

Attendance summary

The tables below show the attendance at meetings for all directors in post during 2025/26.

Board of Directors

Name of director	A	B	Percentage attendance
Robina Shah, Chair (from 1 Dec 2025)	4	4	100%
Sanjay Arya, Chief Medical Officer	9	10	90%
Sarah Brennan, Chief Operating Officer	10	10	100%
Clare Austin, Non-Executive Director	10	10	100%
Rhona Bradley, Non-Executive Director	10	10	100%
Mary Fleming, Chief Executive	10	10	100%

Name of director	A	B	Percentage attendance
Tabitha Gardner, Chief Finance Officer	10	10	100%
Julie Gill, Non-Executive Director	9	10	90%
Simon Holden, Non-Executive Director	10	10	100%
Mark Jones, Chair (to 20 Jun 2025)	3	3	100%
Anne-Marie Miller, Director of Communications and Stakeholder Engagement†	9	10	90%
Mary Moore, Non-Executive Director	7	10	70%
Richard Mundon, Director of Strategy and Planning and Deputy CEO	7	10	70%
Emma Newton, Interim Chief People Officer (from 6 Jan 2026 to 31 Mar 2026)	1	1	100%
Kevin Parker-Evans, Chief Nursing Officer	10	10	100%
Juliette Tait, Chief People Officer (to 9 Jan 2026)	9	10	90%
Francine Thorpe, Deputy Chair (Interim Chair from 23 Jun 2025 – 30 Nov 2025)	9	10	90%
Mark Wilkinson, Non-Executive Director	9	10	90%

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

† Indicates non-voting director

Evaluating performance and effectiveness

During 2026/27, as part of our ongoing commitment to ensure that we continue to operate in line with best practice and the NHS well-led framework, we intend to commission our next external leadership review. It is good practice to undertake this type of review every few years and we will be pleased to see our Chair take this forwards.

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 the NHS leadership competency framework for board members and the outcomes of these appraisals are reported to the Council of Governors. During 2025/26, 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 2024/25 or 2025/26.
- 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 2025/26 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. Whilst recognising that as an autonomous foundation trust there is no requirement for us 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 this year.

For non-executive directors appointed before the guidance was published, the recommendation was that their remuneration should be aligned to the national approach at the time of reappointment. The Council of Governors 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.

Moving forwards, all non-executive director salaries have been brought in line with the guidance and following consideration by the Council of Governors, non-executive directors will now be paid at £13,000 with supplementary payments of £2,000 awarded in recognition of designated additional responsibilities carried out by:

- The Deputy Chair
- The Senior Independent Director
- The Audit Committee Chair

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. This framework aligns with the national NHS England Very Senior Managers (VSM) Framework which was launched in 2025. All directors remuneration is within the national bandings for VSM with the exception of one director who sits slightly above the top end of the scale and therefore a paycase was submitted and subsequently approved by NHS England.

Our Chief Executive was appointed on a spot salary which was set in line with our executive remuneration framework and NHSE guidelines, following review and scrutiny of the job description for this post by the Remuneration Committee, guidance and acceptable pay ranges. We 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 £943 (3.25%) to £29,946 per annum from 1 April 2025.

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 Trust's 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 2025/26 an uplift of 3.25% was applied in line with national guidance to all pay scales.

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

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 is entitled to this benefit, who is not currently claiming it.

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

Robina Shah
Chair
23 June 2026

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. We have not consulted with employees this year on the senior managers' remuneration policy and no remuneration comparisons were used, however, the enhancements to non-executive directors' remuneration have been reduced in line with national guidance. A revised pay framework for very senior managers (VSM) was issued in May 2025 and the Trust is compliant with this framework.

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
Non-executive directors' fees	To attract and retain high quality and	The remuneration of the non-executive	As determined by the Council of Governors,	N/A	No change

Element of pay	Purpose and link to strategy	How operated	Maximum opportunity	Description of performance metrics	Changes from previous year
(including the Chair)	experienced non-executive directors	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	based on national guidance.		
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	Enhancements are applied on appointment to the additional role.	Deputy Chair: £2,000 Senior Independent Director: £2,000 Audit Committee Chair: £2,000	Appointments are be made in line with national NHS guidance on the remuneration of chairs and non-executive directors.	No

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

There are currently no provisions within directors' terms and conditions of employment to allow for the recovery of any sums paid to directors or for withholding the payments of sums to senior managers. Earn back arrangements are in place for all VSM contracts entered in to from 1 November 2020.

Policy on diversity and inclusion

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

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

During 2025/26 we appointed a female Chair (non-executive director) and one interim female executive director post, which was also filled substantively by a female post holder. As a result, at the date of signing, the board is made up of 10 (66.6%) female directors and 5 (33.3%) male directors (2024/25 (62.5%) female and 6 (37.5%) male). Two of our directors (13.33%) are from a black, Asian or minority ethnic background (2024/25: 6.25%).

Service contract obligations

The contracts of employment for executive directors are permanent, continuation of which is subject to regular and rigorous reviews of performance. There are no obligations on the foundation trust which could give rise to, or impact on, remuneration payments; payments for loss of office, or payments to past senior managers, not disclosed elsewhere in this report. No such payments were made during the year. One temporary, interim contract was awarded for an executive director post during the year but has now concluded.

Policy on payment for loss of office

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

Statement of consideration of employment conditions elsewhere in the foundation trust

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

Annual report on remuneration

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

Executive directors

Name	Role	Start date	Unexpired term	Notice period
Mary Fleming	Chief Executive	8 Jan 2024	Permanent contract	6 months
Sanjay Arya	Chief Medical Officer	1 Apr 2017	Permanent contract	3 months
Sarah Brennan	Chief Operating Officer	9 Sep 2024	Permanent contract	3 months
Tabitha Gardner	Chief Finance Officer	2 Mar 2023	Permanent contract	3 months
Anne-Marie Miller‡	Director of Communications and Stakeholder	1 Mar 2021	Permanent contract	3 months
Richard Mundon	Deputy Chief Executive	4 Dec 2024	Permanent contract	3 months
Tracy Narot	Chief People Officer	1 May 2026	Permanent contract	3 months
Emma Newton	Interim Chief People Officer	6 Jan 2026	No longer in post	3 months
Kevin Parker-Evans	Chief Nursing Officer	12 Jun 2024	Permanent contract	3 months
Juliette Tait	Chief People Officer	14 Aug 2023	No longer in post	3 months

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

** Richard Mundon was first appointed to the Board of Directors as Director of Strategy and Planning on 28 Sept 2015.

‡ 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. Our Council of Governors usually appoints non-executive directors for a three-year term.

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.

One non-executive post is usually held by an appointed representative of the trust's university medical school, Edge Hil University. This helps ensure that the trust benefits from the academic and clinical expertise of the university at a strategic level, fostering collaboration and enhancing the quality of clinical education and research that we provide in partnership. Their role with the University

enables them to be independent of the trust's management. At the time of writing, following Professor Austin's retirement, this post remains vacant, as we work with Edge Hill's senior leadership team to identify a suitable successor.

Name	Start date in role	Start date of most recent term	Unexpired portion of current term	Notice period
Robina Shah Chair	1 Dec 2025	1 Dec 2025	2 years 6 months	3 months
Clare Austin* Non-Executive	1 May 2019	1 May 2025	No longer in post	1 month
Rhona Bradley Senior Independent Director	1 Dec 2019	1 Dec 2022**	6 months	1 month
Julie Gill Non-Executive	1 Apr 2023	1 Apr 2026	2 years 10 months	1 month
Simon Holden Non-Executive	1 Jul 2024	1 Jul 2024	1 year 1 month	1 month
Mark Jones Chair	1 Nov 2021	1 Nov 2024	No longer in post	3 months
Mary Moore Non-Executive	1 Dec 2023	1 Dec 2023	5 months	1 month
Francine Thorpe Deputy Chair	1 May 2021	1 May 2024	10 months	1 month
Mark Wilkinson Non-Executive	1 Nov 2024	1 Nov 2024	1 year 5 months	1 month

* Appointed representative of the trust's university medical school

** The Council of Governors has recently agreed to extend this contract by 12 months

The work of our nominations and remuneration committees

The Remuneration Committee, established under statute 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 Robina Shah.

Attendance during 2025/26 was as follows:

Name of director	A	B	Percentage attendance
Robina Shah	1	1	100%
Clare Austin	4	4	100%
Rhona Bradley	4	4	100%
Julie Gill	4	4	100%
Simon Holden	3	4	75%
Mark Jones	2	2	100%
Mary Moore	4	4	100%
Francine Thorpe	4	4	100%
Mark Wilkinson	4	4	100%

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

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

The Chief People Officer and the Director of Corporate Governance attend meetings to provide support and advice. They would withdraw from the meeting during consideration of their own performance, remuneration or terms and conditions of office. This year those colleagues have been Juliette Tait and Steve Parsons, then Julie Dawes, respectively.

The Nomination and Remuneration Committee meets to consider matters relating to the appraisal, appointment, remuneration and other terms and conditions of service of the non-executive directors, it is made up of public, staff and appointed governors and is also chaired by Robina Shah. The committee is established by the Council of Governors, which therefore must consider all of its recommendations and make decisions based on these. During the year, committee members met as part of the process of appointing a new Chair. The committee also held one formal meeting during the year, to consider the extension of the terms of office for two non-executive directors, which it was agreed would support retention of corporate memory and a smooth transition once their replacements had been identified. In addition, one of these post holders was the non-executive appointed representative of the trust's university medical school and recent changes at board level in that organisation presented challenges in identifying potential candidates to fill this post. The Council of Governors also agreed to re-appoint one non-executive director for a second term this year.

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

Name of committee member	A	B	Percentage attendance
Mark Jones, Chair	1	1	100%
Francine Thorpe, Interim Chair	1	1	100%
Peter Allard, Public Governor	1	2	50%
Les Chamberlain, Public Governor	1	2	50%
Andrew Haworth, Public Governor	2	2	100%
Malcolm Ryding, Public Governor	1	1	100%
Andrew Savage, Staff Governor	2	2	100%
Bryonie Shaw, Appointed Governor	1	1	100%

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

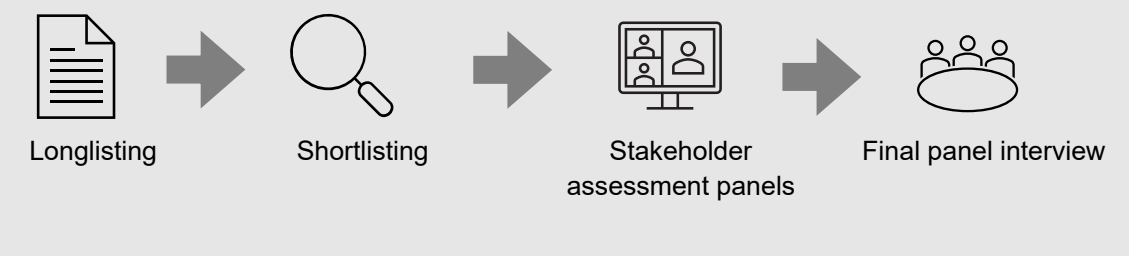
The Director of Corporate Governance or a member of their team attends each meeting to provide advice and support to the committee. The Chair withdraws from the meeting when their own reappointment, remuneration, allowances and other terms and conditions of office are under discussion.

The appointment of a new Chair was made in 2025/26, following consultation with the Nomination and Remuneration Committee and Council of Governors, a separate Chair Nomination Committee was formed to lead this process. The committee was assisted with this appointment by Seymour John, a recruitment consultancy with significant experience in recruiting non-executive directors. In determining which firm to use to support the processes, a competitive pricing exercise was undertaken to ensure value for money. The committee was satisfied that the services received were objective and independent and a total fee of £9,000 was paid. Seymour John does not have any other connection with the foundation trust or individual directors.

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

Name of committee member	A	B	Percentage attendance
Mark Wilkinson, Chair	1	1	100%
Julie Barrett, Staff Governor	1	1	100%
Axel Kaehne, Appointed Governor	1	1	100%
Andrew Savage, Staff Governor	1	1	100%
Linda Sykes, Public Governor	1	1	100%

Our appointments process which was followed is summarised below:



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

The committee also supports our succession planning work.

Remuneration for the year to 31 March 2026

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)	Performance related bonuses (bands of £5000)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
Mark Jones, Chair (to 20 Jun 2025)	10 - 15	100	0	0	10 - 15
Robina Shah, Chair (from 1 Dec 2025)	15 – 20	0	0	0	15 - 20
Mary Fleming, Chief Executive	210 - 215	0	0	77.5 - 80	290 - 295
Sanjay Arya, Medical Director*†‡	325 - 330	1,700	0	0	325 - 330
Sarah Brennan, Chief Operating Officer	145 - 150	0	0	70 – 72.5	220 - 225
Kevin Parker-Evans Chief Nursing*	135 - 140	1,700	0	72.5 - 75	210 - 215
Tabitha Gardner, Chief Finance Officer*	155 - 160	1,800	0	110 - 112.5	270 - 275
Juliette Tait, Chief People Officer (to 9 Jan 26)*	110 - 115	500	0	52.5 - 55	165 - 170
Richard Mundon, Director of Strategy and Planning and Deputy Chief Executive*	165 -170	2,300	0	147.5 - 150	315 - 320
Anne-Marie Miller, Director of Communications and Stakeholder*	110 - 115	3,600	0	127.5 - 130	245 - 250
Clare Austin, Non-Executive Director	10 - 15	0	0	0	10 - 15
Rhona Bradley, Non-Executive Director	15 - 20	0	0	0	15 - 20
Francine Thorpe, Non-Executive Director and Acting Chair from 23 Jun 25 to 30 Nov 25	25 - 30	0	0	0	25 - 30
Mary Moore, Non-Executive Director	10 - 15	0	0	0	10 - 15
Julie Gill, Non-Executive Director	10 - 15	0	0	0	10 - 15
Simon Holden, Non-Executive Director	15 - 20	0	0	0	15 - 20
Mark Wilkinson, Non-Executive Director	10 - 15	0	0	0	10 - 15
Emma Newton, Interim Chief People Officer (from 6 Jan 26 to 31 Mar 26)^	0	0	0	0	0

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

† Sanjay Arya remuneration includes clinical duties of £115-£120k and an NHS England Clinical Excellence Award of £45-£50k that are not part of the individual's management role. The remuneration for the medical director role is £175-£180k.

‡ 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 (£10-£15k) recharged to Edge Hill University.

^ Emma Newton was seconded from Liverpool University Hospitals NHS Foundation Trust from 6 January 2026 to 31 March 2026.There was no salary recharge paid by Wrightington, Wigan and Leigh Teaching NHS Foundation Trust for the period of secondment. The total salary paid by Liverpool University Hospitals NHS Foundation Trust for the period 6 January 2026 to 31 March 2026 when she was a Board Member at Wrightington, Wigan and Leigh Teaching NHS Foundation Trust was £30-£35k.

All of the above directors were in post for the 12-month period to 31 March 2026 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 and taxable business mileage.

Remuneration for the year to 31 March 2025

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

Comparative remuneration figures for the year ended 31 March 2025 have been restated to correct an error identified during the completion of the 2025/26 tables. The revised figures reflect accurate salary, benefits and pension disclosures.

	Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Performance related bonuses (bands of £5000)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
Mark Jones, Chair	45 - 50	0	0	0	45 - 50
Mary Fleming, Chief Executive	205 - 210	100	0	262.5 - 265	470 - 475
Sanjay Arya, Medical Director†‡	325 - 330	0	0	0	325 - 330
Sarah Brennan, Chief Operating Officer (from 9 Sep 2024)	80 - 85	0	0	5 - 7.5	85 - 90
Kevin Parker-Evans Chief Nursing*^	155 - 160	600	0	190 – 192.5	345 - 350
Tabitha Gardner, Chief Finance Officer*	150 - 155	1,200	0	0	150 - 155
Juliette Tait, Chief People Officer	140 - 145	0	0	47.5 - 50	190 - 195
Richard Mundon, Director of Strategy and Planning*‡	130 -135	1,600	0	27.5 - 30	160 - 165
Anne-Marie Miller, Director of Communications and Stakeholder	105 - 110	2,300	0	0	110 - 115
Paul Howard, Director of Corporate Affairs (to 31 Dec 2024)*	80 - 85	2,000	0	12.5 - 15	95 - 100
Clare Austin, Non-Executive Director	10 - 15	0	0	0	10 - 15
Rhona Bradley, Non-Executive Director	10 - 15	0	0	0	10 - 15
Francine Thorpe, Non-Executive Director	10 - 15	0	0	0	10 - 15
Mary Moore, Non-Executive Director	10 - 15	0	0	0	10 - 15
Julie Gill, Non-Executive Director	10 - 15	0	0	0	10 - 15
Simon Holden, Non-Executive Director (from 1 July 2024)	5 - 10	200	0	0	5 - 10
Mark Wilkinson, Non-Executive Director (from 1 Nov 2024)	5 - 10	0	0	0	5 - 10
Ian Haythornthwaite, Non-Executive Director (to 31 October 2024)	10 - 15	0	0	0	10 - 15

Lynne Lobley, Vice-Chair and Non-Executive Director (to 31 Dec 2024)	10 - 15	0	0	0	10 - 15
Claire Wannell, Interim Chief Operating Officer to 30 Jun 2024)*	25 - 30	1,600	0	5 - 7.5	35 - 40
Nigel Kee, Interim Chief Operating Officer (8 July 2024 to 27 Sep 2024)	90 - 95	0	0	0	90 - 95

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

† Sanjay Arya remuneration includes clinical duties of £110-£115k and an NHS England Clinical Excellence Award of £45-£50k that are not part of the individual's management role. The remuneration for the medical director role is £165-£170k.

‡ 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 (£10-£15k) 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.

Nigel Kee was appointed as an interim via an agency, the salary in the above table is the total cost of paid by Wrightington, Wigan and Leigh Teaching NHS Foundation Trust.

^ Kevin Parker-Evans was seconded from Tameside NHS Foundation Trust until his permanent appointment on 1st September 2024. The salary in the above table includes the total cost paid by Wrightington, Wigan and Leigh Teaching NHS Foundation Trust for the period of secondment of £80-£85k, this includes employer costs not directly received by the Chief Nursing Officer.

All of the above directors were in post for the 12-month period to 31 March 2025 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 and taxable business mileage.

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 2026

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 1.7% CPI on the opening cash equivalent transfer value at 31 March 2025 has been applied. The following pension entitlement tables are subject to audit.

	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in pension lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age as at 31 March 2026 (Bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2026 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Cash Equivalent Transfer Value at 31 March 2026 £000	Real increase in Cash Equivalent Transfer Value £000
Sanjay Arya Medical Director	0 - 2.5	0	10 - 15	0	173	194	0
Juliette Tait Chief People Officer	2.5 - 5	0	35 - 40	0	469	546	40
Tabitha Gardner Chief Finance Officer	5 - 7.5	7.5 - 10	50 - 55	125 - 130	1032	1184	115
Mary Fleming Chief Executive	5 - 7.5	2.5 - 5	80 - 85	200 - 205	177	253	46
Anne-Marie Miller Director of Communications	5 - 7.5	0	35 - 40	0	435	549	93
Richard Mundon Director of Strategy and Planning	7.5 - 10	0	40 - 45	0	596	770	142
Sarah Brennan Chief Operating Officer	2.5 - 5	0	30 - 35	0	380	451	46
Kevin Parker-Evans Chief Nursing Officer	2.5 - 5	2.5 - 5	40 - 45	90 - 95	684	772	59
Emma Newton Interim Chief People Officer	0	0	20 - 25	0	382	325	0

Pension entitlements for year-ended 31 March 2025

In accordance with guidance issued by the NHS Business Services Authority, an increase of 6.7% CPI on the opening cash equivalent transfer value at 31 March 2024 has been applied.

Comparative pension entitlement figures for the year ended 31 March 2025 have been restated to correct an error identified during the completion of the 2025/26 tables. The revised figures reflect accurate pension disclosures.

	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in pension lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age as at 31 March 2025 (Bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2025 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2024 £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Real increase in Cash Equivalent Transfer Value £000
Sanjay Arya Medical Director	0	0	10 - 15	0	131	173	8
Juliette Tait Chief People Officer	2.5 - 5	0	30 - 35	0	389	469	36
Tabitha Gardner Chief Finance Officer	0	0	45 - 50	115 - 120	977	1032	0
Mary Fleming Chief Executive	12.5 - 15	25 - 27.5	75 - 80	195 - 200	1471	177	0
Paul Howard Director of Corporate Affairs	0 – 2.5	0	20 - 25	40 - 45	364	414	9
Anne-Marie Miller Dir. of Communications	0	0	30 - 35	0	407	435	0
Richard Mundon Director of Strategy and Planning	0 – 2.5	0	30 – 35	0	515	596	28
Sarah Brennan Chief Operating Officer	0 – 2.5	0	25 - 30	0	334	380	3
Claire Wannell Interim Chief Operating Officer	0 – 2.5	0	5 - 10	0	62	84	1
Kevin Parker-Evans Chief Nursing Officer	7.5 – 10	17.5 - 20	35 - 40	85 - 90	479	684	163

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 in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accumulated as a consequence of their total membership of the scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2026.

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).

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 2026 was 26 (2025: 25).

The total number of directors in office as at 31 March 2026 was 16 (2025: 16).

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

The total amount of expenses reimbursed to 4 directors during the year was £1,215 (5 directors, £2,454 in 2024/25).

The total amount of expenses reimbursed to 5 governors during the year was £264 (7 governors, £380 in 2024/25).

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.

Comparative fair pay multiples figures for the year 2024/25 have been restated to correct an error identified during the completion of the 2025/26 tables. The revised figures reflect accurate salary, benefits and ratios.

The banded remuneration of the highest paid director of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust in the financial year 2025/26 was £325-£330k (2024/25: £325-330k). This is an increase of 0.0% (2024/25: 6.5%). The relationship to the remuneration of the organisation's workforce is disclosed in the below table, which is subject to audit.

2025/26	**25th percentile**	**Median**	**75th percentile**
Total pay and benefits excluding pension benefits.	£30,285	£40,823	£54,710
Salary component of pay	£27,100	£42,943	£55,926
Pay and benefits excluding pension: pay ratio for highest paid director.	10.8	7.6	5.9

Excludes the remuneration of Non-Executive Directors which was included in 2024/25.

2024/25	**25th percentile**	**Median**	**75th percentile**
Total pay and benefits excluding pension benefits.	£29,158	£41,470	£58,114
Salary component of pay	£26,158	£39,405	£56,454
Pay and benefits excluding pension: pay ratio for highest paid director.	11.2	7.9	5.6

Figures have been restated to correct for a miscalculation.

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £24k to £498k (2024/25 £13k to £499k) including highest paid director but excluding pension benefits. The change to the average employee remuneration (based on total for all employees, including bank and agency staff, and excluding non-executive directors on an annualised basis divided by full time equivalent number of employees is 0.4% (2024-25, 0.2%). 2 employees received remuneration more than the highest-paid director in 2025-26, (2024-25, 5).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include the highest-paid director, employer pension contributions and the cash equivalent transfer value of pensions. The 2025-26 figures include payments for the junior doctor pay award, an element of which is arrears for 2024-25, and the non-executive directors, therefore the ratios may not be consistent with the pay policies for the Trust when taken as a whole.

Mary Fleming
Chief Executive and Accounting Officer
23 June 2026

STAFF REPORT

In 2025/26, we continued to strengthen our commitment to staff wellbeing by reviewing and re-launching our approach to attendance management through our new wellbeing and attendance support polic**y**. The policy was co-produced with colleagues from across the people services team and wider, ensuring it reflects what matters most to them in maintaining their attendance, health and overall wellbeing at work.

The updated policy encourages proactive, wellbeing-focused conversations and supports managers and colleagues to work together to put reasonable adjustments and tailored support in place to help people stay well in work. It also embeds a more compassionate, person-centred approach to managing health-related absence, with an emphasis on early intervention, constructive dialogue and meaningful engagement with support services. To support implementation, we introduced a series of training sessions for managers and expanded our Steps4Wellness (staff wellbeing programme) resources to provide a comprehensive suite of tools that enable high-quality, wellbeing-centred conversations.

Looking after our people

- We continue to invest in the growth, wellbeing and experience of our workforce through a range of initiatives aligned to our People & Culture Strategy:
- Launching We Lead – WWL's new Leadership Development Programme, an integral part of our People & Culture Strategy. We Lead is anchored in our organisational values and supports leaders at all levels to build compassionate, inclusive and high-performing teams.
- Strengthening our commitment to inclusion and anti-racism as we begin our journey to becoming an unapologetically anti-racist organisation. We continue to embed anti-racist practice into our leadership development, culture programmes and decision-making processes, ensuring every member of our workforce feels respected, valued and able to thrive.
- Developing our staff through continued partnerships with local education providers, including our Sector-Based Work Academy Programmes (SWAPs), which have expanded accessible pathways into health and care roles for people not currently in education, employment or training. These programmes have supported participants into permanent, life-changing employment across the borough.

Supporting our people

- We have now developed a more sustainable and accessible model for mental health and emotional wellbeing support. Our aim is to empower leaders to play a more active role in fostering a positive, wellbeing-focused culture across their teams, while ensuring all colleagues have access to high-quality professional support.
- To support this shift, we have invested in an enhanced Employee Assistance Programme (EAP) delivered by PAM Wellness, offering colleagues timely, confidential access to a wide range of wellbeing services, including counselling, psychological guidance and 24/7 advice.
- This approach enables a leader-led wellbeing culture, supported by a comprehensive external offer that ensures colleagues receive the right support at the right time.
- To strengthen our approach to workplace adjustments and targeted wellbeing support, we secured temporary funding from NHSE and NHS Charities Together to recruit a Wellbeing Adjustment Advisor. This role will enable us to raise awareness and build leaders' confidence in supporting staff wellbeing, workplace adjustments and broader wellbeing conversations. It will also promote the benefits of effective adjustments, enhance links with support services,

and ensure more consistent monitoring of adjustment activity across WWL, supporting a proactive approach to helping colleagues stay well in work.
- We continue to work closely with local services and community mental health teams to ensure colleagues can access specialist support when their needs extend beyond the scope of our internal wellbeing offer.
- Our Steps 4 Mindful Living programmes remain highly valued by staff and managers, providing practical tools to support resilience, emotional wellbeing and healthier ways of working.
- We maintain a strong trauma risk management (TRiM) service, with trained practitioners offering structured support to colleagues who have experienced traumatic incidents at work.

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 support for those who deliver local healthcare for the population that we serve.

Learning and development

- Leadership development remains a key priority for WWL. In 2025, we launched We Lead, our in-house leadership programme built around three core domains; leading self, leading others and leading for improvement, and grounded in inclusive and compassionate leadership. More than 300 leaders have now completed the programme, with consistently positive feedback.
- Interest in leadership apprenticeships has continued to grow, with 38 colleagues undertaking accredited leadership qualifications. This investment strengthens our leadership pipeline and supports our commitment to developing capable, confident and compassionate leaders at all levels.
- 2026 brings the introduction of a new national management and leadership framework, providing updated competencies and a code of practice that will further support leaders to meet nationally defined standards.
- Our Talent for Care Strategy continues to provide young people, unemployed individuals and those facing disadvantage with opportunities to gain skills and experience at WWL, supporting our commitment to attracting future NHS workers and fulfilling our role as an anchor institution across the borough.
- In partnership with Wigan and Leigh College, we secured funding for a Talent for Care post in 2024, with future funding arrangements agreed until 2027. During this period, we have delivered two successful SWAP programmes, achieving a 55% conversion rate into employment, with a third cohort commencing in February 2026.
- Across WWL, we have 171 active apprenticeships, with colleagues undertaking a wide range of professional qualifications that support both individual growth and organisational development.
- This year, several staff members completed their second qualification through the apprenticeship route, demonstrating how this pathway enables ongoing progression within the Trust.
- National Apprenticeship Week saw WWL showcase the impact and success of apprenticeships across the Trust with two colleagues recognised as Apprenticeship Award winners by the University of Greater Manchester - further evidence of the strong engagement, high achievement and positive outcomes our apprenticeship programmes continue to deliver.

- This year, our Learning & Development Team welcomed over 400 new colleagues through the *Welcome to WWL* induction. The programme provides a warm introduction to the Trust, including a marketplace showcasing key services and presentations from guest speakers, ensuring all new starters have an informative and positive start to their WWL journey.

Staff experience and engagement

At WWL, we are committed to ensuring colleagues have a positive experience at work and feel supported throughout their career. We offer a wide range of ways for staff to share their views, including the National Staff Survey, Quarterly Pulse Surveys, staff networks, Trust-wide forums, Freedom to Speak Up, and regular listening events and focus groups.

A key mechanism for staff feedback includes the annual National Staff Survey and National Quarterly Pulse Surveys. All staff are invited to share their views and experiences in an anonymous survey with results being broken down by division, subdivision, staff group and protected characteristics to allow insight into where changes is most needed. The staff survey results are shared with the board to set strategic Trust-wide priorities for areas for development and cascaded to divisional leadership teams to develop divisional annual actions plans to improve staff experience within their areas driven through divisional assurance processes. Any trust-wide key areas of improvement have also been included in our People and Culture Strategy.

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

Our staff networks play a vital role in ensuring colleagues are represented in the development of strategies, policies and processes. This includes our True Colours Network, Disability and Long-Term Health Conditions Network, and FAME Network, alongside our wellbeing champions and Staff Engagement Associates. Membership across these groups has continued to grow, with over 500 colleagues now actively involved.

We remain focused on improving how we learn from staff feedback. In 2025/26, our priorities include increasing the visibility of routes for colleagues to speak up, strengthening communication on how feedback influences change, and further embedding a learning culture by holding learning events in response to concerns raised by individuals or teams.

The NHS staff survey

We achieved a 48.0% response rate (3,527 respondents) in the 2025 National Staff Survey (NSS), a 13% improvement from 2024. The overall average response rate for the category “acute and acute & community trusts” contracted to IQVIA (the survey provider) was 47%, meaning WWL were above the average response rate for the first time.

The results from the National Staff Survey revealed that most People Promises remained broadly in line with last year’s scores, with one People Promise “We are a Team” showing a significant improvement. WWL scored significantly better than the sector (acute and acute & community trusts) and highest in Greater Manchester for the People Promise and themes – “We are Safe and Healthy”

and “Morale”. However, WWL scored significantly worse than sector in “We are Always Learning”. Whilst question level responses suggest a slight improvement in scores locally, they were not statistically significant.

Staff recommending the Trust as a place to work has significantly declined and was significantly lower than the sector (WWL 55%; sector 58%). Staff feeling happy with the standard of care if a friend or relative needed treatment significantly declined since 2024 and was significantly worse than the sector (WWL 55.7%; sector 60.8%).

We were most proud of:

- “We are a Team” – where our score has significantly improved (including improvement in line management and teamworking including mutual respect, role clarity and shared objectives)
- “Leadership” scores have had significant improvements (including compassionate leadership and line management)
- “Equality”: There is a small sign of improvement in experiences of discrimination, bullying and abuse
- “Inclusion" has improved since 2024, both compared to WWL’s scores and with comparator organisations
- We were top in Greater Manchester for the theme “Morale” and above the sector (acute and community trusts) for the fifth year running.
- We continued to score highest in Greater Manchester for ‘We are Safe and Healthy’.

Areas for focus in 2025

We identified that we need to be better at:

- **“**Compassionate Culture” – this is worse than the sector average and has declined
- “Advocacy” – this refers to staff’s perception of patient care and recommendation as a place of care and as a place to work
- “Raising Concerns” – we experienced a decline in staff having confidence in the organisation to act on concerns and in response to errors, near misses or incidents
- “Health and Wellbeing” – we experienced a decline in staff having confidence that the organisation takes positive action on health and wellbeing
- “We are Always Learning” and “Appraisal” scores continue to be our lowest scoring People Promise scores and are worse than the sector average

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

	2025/26		**2024/25**		**2023/24**		**Improvement/ deterioration**
	WWL	**Sector average**	**WWL**	**Sector average**	**WWL**	**Sector average**	
Response Rate	**48%**	**47%**	**35%**	**51%**	**37%**	**45%**	**Deterioration**
13b) In the last 12 months I have personally experienced physical violence at work from managers.	0.6%	0.8%	0.4%	0.9%	0.4%	0.8%	Deterioration

(16c03) Experienced discrimination on grounds of gender reassignment *	1.2%	1.6%	NA	NA	NA	NA	*This was a new question in the 2025 survey; no data is available for previous years
(13c) In the last 12 months I have personally experienced physical violence at work from other colleagues.	1.5%	2.0%	1.0%	2.2%	1.0%	2.0%	Deterioration
(16c04) Experienced discrimination on marriage or civil partnership *	2.1%	1.3%	NA	NA	NA	NA	*This was a new question in the 2025 survey; no data is available for previous years
(16c05) Experienced discrimination on grounds of pregnancy or maternity *	2.5%	2.8%	NA	NA	NA	NA	*This was a new question in the 2025 survey; no data is available for previous years

	2025/26		2024/25		2023/24		Improvement/ deterioration
	WWL	Sector average	WWL	Sector average	WWL	Sector average	
(23b) The appraisal/ review helped me to improve how I do my job	23.3%	27.3%	23.2%	27.9%	22.6%	26.6%	No change
(23d) The appraisal/ review left me feeling that my work is valued by my organisation	29.2%	33.2%	36.9%	35.5%	35.6%	36.5%	Deterioration
(5a) I never/ rarely have unrealistic time pressures	29.6%	25.5%	30%	25.8%	29.3%	25.2%	Deterioration
(23c) The appraisal / review helped me to agree clear objectives for my work	31.1%	36.3%	31.2%	36.8%	31.9%	36.1%	No change

(4c) I am satisfied with my level of pay	33.6%	31%	36.3%	30.4%	35.8%	29.8%	Deterioration

At question level, 29 (26%) questions score significantly better than sector, 20 (18%) questions score significantly worse and 62 (56%) questions show no significant difference. Our significantly worse scores relate to areas including appraisals, advocacy, equity, and speaking up.
Compared to 2024, 12 (12%) questions have significantly improved, 8 (8%) questions have significantly declined, and 79 (80%) questions show no significant difference. Significantly worse scores include themes of quality of care
recognition, speaking up and positive action on health and wellbeing.

2025/26, 2024/25, 2023/24
Scores for each indicator together with that of the survey benchmarking group (Combined Trusts) are presented below.

		2025/26		**2024/25**		**2023/24**	
		WWL	**Combines trusts**	**WWL**	**Combined trusts**	**WWL**	**Combined trusts**
People Promise 1:	Diversity and equality	8.55	8.35	8.41	8.01	8.14	8.05
People Promise 2:	Recognition	5.91	5.88	5.89	5.9	5.99	5.91
People Promise 3:	Raising concerns	6.3	6.33	6.36	6.42	6.5	6.4
People Promise 4:	Health and safety climate	5.59	5.42	5.62	5.51	5.7	5.5
People Promise 4:	Burnout	5.11	4.95	5.06	5	5.2	5.0
People Promise 4:	Negative experiences	8.07	7.90	7.84	7.78	7.9	7.8
People Promise 5:	Appraisals	4.42	4.95	4.32	4.96	4.4	4.7
People Promise 6:	Flexible working	6.19	6.17	6.15	6.15	6.3	6.1
People Promise 7:	Team working	6.68	6.66	6.58	6.68	6.7	6.7
People Promise 7:	Line management	6.89	6.84	6.7	6.81	6.9	6.8
Theme 1:	Morale	6.03	5.88	6.04	5.93	6.2	5.9
Theme 2:	Staff engagement	6.73	6.75	6.77	6.85	6.9	6.9
Staff Engagement:	Advocacy	6.43	6.61	6.61	6.8	6.8	6.7

National Staff Survey: improvement plans

For 2026/27, we are proposing a strengthened “One Team” approach, in line with our organisational value of “One Team” and grounded in genuine partnership working across the organisation, to ensure that improvements to staff experience are shaped directly by staff voice and by the insights emerging from the NSS. A central focus of this year’s engagement activity is improving staff advocacy, measured specifically through the two NSS metrics: whether staff would recommend the organisation as a place to work, and whether they would recommend it as a place to receive care. Our approach is designed to positively influence these measures by targeting four priority drivers known to underpin staff advocacy.

To support this approach, we propose the establishment of a people experience multi-disciplinary team (MDT), bringing together expertise to coordinate delivery, triangulating organisational insight and providing targeted support to divisions, leaders and teams. The MDT will oversee four key engagement workstreams designed to ensure meaningful activity at every level of the organisation:

- Executive listening into action
- Divisional people promise plans
- Team in reach support and
- Leadership engagement

The National Staff Survey engagement activities will be coordinated and monitored by the people experience MDT to provide central oversight of the engagement strategy. Progress on all NSS engagement activity will be reviewed at the senior leadership team meetings on a bi-monthly basis, enabling the sharing of good practice and early identification of any support required by divisional leaders. In addition, biannual assurance reports will be submitted to the People Committee and the Board of Directors to provide oversight of progress, risks, and organisational learning.

Equality, diversity and inclusion

Our 2022-26 Equality, Diversity and Inclusion (EDI) Strategy is centred around increasing diversity and accessibility, eliminating inequality, and improving experience for protected groups. We strengthened our governance and leadership around EDI by further embedding and enhancing the work of our established EDI Strategy Group, chaired by the Chief Executive, with workstreams aligned to the NHS England High Impact Actions. This group is a central mechanism to drive forward our EDI priorities and oversee delivery of our improvement actions.

We will continue to ensure that our staff and service users are in a safe, inclusive and accessible environment where there is a true sense of belonging and that our services are accessible to all communities across the borough of Wigan. We also issued our Board-level statement and

commitment to becoming an anti-racist organisation, reinforcing our zero-tolerance approach to discrimination in all its forms.

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

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

- Active Bystander Training, delivered to senior nursing, midwifery and AHP colleagues, with over 700 attendees, empowering staff to challenge poor behaviours and promote a culture of civility and respect.
- Strengthening support for disabled colleagues, with activity focused on improving the implementation of reasonable adjustments and embedding a compassionate, person-centred approach to supporting staff with long-term health conditions or disabilities.
- Creating safe routes to speak up, through our Freedom to Speak Up Guardian, the Speak Up Safely campaign and ongoing work to ensure colleagues feel confident raising concerns.
- A cultural development plan improving belonging and inclusion while reducing bullying, discrimination, harassment and violence at work.
- Empowering our board members to have an EDI objective aligned with improving inclusion and reducing inequality.
- Continuing to provide EDI training for our governors, board and the executive team.

WWL staff inclusion and diversity networks

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

Our Disability and Long-Term Health Conditions Network (DaWN) has made a significant contribution to improving disability inclusion across WWL. The network's lived experience has directly shaped our new attendance and wellbeing support policy and strengthened our approach to reasonable adjustments, helping to remove barriers and improve consistency for colleagues and managers. The network has also informed the development of our wellbeing at work resources, ensuring they are practical, accessible and supportive for staff with long-term conditions and for leaders holding wellbeing conversations.

Our True Colours Network is WWL's LGBTQIA+ Network. Members and allies of the network once again this year sponsored Wigan Pride and will continue to have an important presence at this event to celebrate diversity but also to address health inequalities of the LGBTQIA+ community As part of strengthening the work of the True Colours Network, we organised a series a development sessions to help the network refine its purpose, priorities and long-term impact. The sessions support the network to clarify its goals, identify what enables or hinders progress, and outline practical activities to grow engagement and strengthen its influence across the Trust with the aim of increasing engagement, building partnerships and enhancing visibility of our LGBTQIA+ community.

Our FAME (For All Minority Ethnicities) Network continues to play a central role in celebrating cultural diversity, supporting colleagues from ethnic minority backgrounds and amplifying their voices across WWL. We also launched the FAME culture and diversity wall; a vibrant installation celebrating the 67 nationalities represented by WWL colleagues across the trust. More than a visual display, the wall acts as a powerful symbol of the diversity and richness of our workforce. Located at our Royal Albert siti, it promotes belonging, sparks learning and conversation, and reinforces our commitment to recognising and valuing the contribution of colleagues from all backgrounds.

The Global Majority Network for Nursing, Midwifery and Allied Health Professional (AHP) colleagues has provided an important space for staff from under-represented backgrounds to connect and support one another. The network is led by our Global Majority Practice Development Nurse, who was presented with a Silver Award from the Chief Nursing Officer for England for his work to support systemic change for global majority staff, improving access to career progression, funding, and leadership development across nursing, midwifery, and allied health professionals. He was also recognised by the Caribbean & African Health Network's Black Healthcare Awards for his leadership in driving this remarkable area of change.

Gender pay gap report

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

Mandatory disclosures within the staff report

Workforce gender profile as at 31 March 2026

Directors:	10 female (67%), 5 male (33%)
Senior managers:	272 female (74%), 95 male (26%)
Employees:	5601 female (80), 1,380 male (20%)
(by headcount, senior managers are band 8a and above)	

Workforce diversity profile as at 31 March 2026 (per indicator nine of the NHS Workforce Race Equality Standard)

Directors:	13 white (87%), 2 BME (13%)
Senior managers:	336 white (92%), 24 BME (7%), 7 not Stated (2%)
Employees:	5565 white (80%), 1193 BME (17%), 223 not stated (3%)
(by headcount, senior managers are band 8a and above)	

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

Sickness absence data

Sickness absence data for NHS organisations is published online by NHS Digital. The table below shows the figures for January to December 2025 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	**Adjusted FTE days lost to Cabinet Office definitions**	**Average Sick Days per FTE**	**FTE-Days available**	**FTE-Days Lost to Sickness Absence**
6,434	88,150	13.7	2,348,442	142,998

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

Consultancy

We spent £0.9m on consultancy fees during the year in support the Better Lives Programme, a joint transformation programme with Wigan Council and NHS GM ICB.

Occupational health

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

Counter-fraud and corruption

We employ our own Accredited Fraud Specialist Manager who is qualified to investigate fraud to a criminal standard, we have a fraud, corruption and bribery policy and response plan in place which has been developed in line with NHS Counter-Fraud Authority requirements and the expectations

detailed in the Government's Functional Standard (GovS 013) relating to fraud, bribery and corruption. All staff are required to successfully complete a mandatory e-learning anti-fraud module every three years and continuous fraud awareness campaigns are undertaken via the intranet, news articles and presentations.

A new 'failure to prevent fraud' offence has now been introduced, effective from 1 September 2025 as part of the Economic Crime and Corporate Transparency Act 2023 (ECCTA).

Under this legislation, an organisation will be criminally liable where:

- A fraud offence is committed by an employee, agent or other 'associated' person, with the intention of deriving a benefit for the organisation or a related body; and
- The organisation did not have 'reasonable' fraud prevention procedures in place

All NHS organisations need to consider the impact of the new legislation carefully and take appropriate action to ensure that adequate procedures are in place to prevent this offence occurring in their organisation. As a result, WWL will commit sufficient time and resources to the development and embedding of an appropriate anti-bribery and corruption programme, which will include the application of the legislation.

We will continue to work with our Counter Fraud Specialist to ensure we meets the six guiding principles in which counts as reasonable procedures for fraud prevention under ECCTA.

Health and Safety

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

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

Health and safety risk assessments and incident reporting remain important roles for the health and safety team. The team investigates incidents reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 and works with our legal team where issues with employer's liability arise.

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

Employee costs (subject to audit)

	Permanent	Other	2025/26 Total	2024/25 Total
	£000	£000	£000	£000
Salaries and wages	297,434	12,460	309,894	294,186
Social security costs	36,894		36,894	28,690
Apprenticeship levy	1,463		1,463	1,399
Employer contributions to NHS pension scheme	34,063		34,063	32,148
Employer contributions paid by NHSE	22,557		22,557	21,132
Termination benefits	1,593		1,593	741
Temporary staff - external bank / agency /contract	0	27,990	27,990	34,651
Total staff costs	394,004	40,450	434,454	412,947
Costs capitalised as part of assets	583	285	868	924

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

	Permanent	Other	**Total 2025/26**	Total 2024/25
	(Number)	(Number)	(Number)	(Number)
Medical and dental	672	65	737	714
Administration and estates	1,477	19	1,496	1,553
Healthcare assistants and other support staff	714	5	719	731
Nursing, midwifery, and health visiting staff	2,704	288	2,992	3,009
Scientific, therapeutic and technical staff	1,029	28	1,057	1,051
Healthcare science staff	4	1	5	6
Other	10	0	10	11
Total average numbers	6,610	406	7,016	7,075
Number of employees (WTE) engaged on capital projects	8	3	11	34

Reporting of compensation schemes: exit packages 2025/26 (subject to audit)

Exit package cost band	Number of compulsory redundancies	Number of other departures	Total number of exit packages	Total cost of exit packages
<£10,000	2	41	43	£172,000
£10,001 to £25,000	0	15	15	£215,000
£25,001 to £50,000	3	12	15	£543,000
£50,001 to £100,000	2	9	11	£776,000
Total :	7	77	84	£1,706,000

Reporting of compensation schemes: exit packages 2024/25

Exit package cost band	Number of compulsory redundancies	Number of other departures	Total number of exit packages	Total cost of exit packages
<£10,000	1	42	43	£149,000
£10,001 to £25,000	0	9	9	£135,000
£25,001 to £50,000	3	8	11	£396,000
£50,001 to £100,000	0	4	4	£285,000
Total:	4	63	67	£965,000

Exit packages: non-compulsory departure payments 2025/26:

Type of departure	Agreements Number	Total value of agreements £000
Mutually agreed resignations (MARS) contractual costs	44	£1,272
Contractual payments in lieu of notice	31	£132
Exit payments following Employment Tribunals or Court Orders	3	£15
Total	78	£1,419

Exit packages: non-compulsory departure payments 2024/25:

Type of departure	Agreements Number	Total value of agreements £000
Mutually agreed resignations (MARS) contractual costs	26	£685
Contractual payments in lieu of notice	41	£146
Exit payments following Employment Tribunals or Court Orders	4	£29
Total	71	£860

As a single exit package can be made up of several components, each of which will be counted separately in this note, the total number above will not necessarily match the total numbers in note the total reporting of exit packages which will be the number of individuals.

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

Highly paid off-payroll worker engagements as at 31 March 2026, earning £245 per day or greater	
Number of existing engagements as at 31 March 2026:	23

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:	4
For between two and three years at time of reporting:	5
For between three and four years at time of reporting:	1
For four or more years at time of reporting:	3

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2026:	40
Of which:	
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	40
Subject to off-payroll legislation and determined as out-of-scope of IR35*	0
Number of engagements reassessed for compliance or assurance purposes during the year:	0
Of which, number of engagements that saw a change to IR35 status following review:	0

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

Off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026	
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)	18

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

We apply rigorous controls to all aspects of discretionary expenditure, including the use of off payroll arrangements. We follow rules from His Majesty's Revenue and Customs (HMRC)

surrounding off-payroll working, commonly known as IR35. For tax purposes, an assessment is carried out on a case-by-case basis, and IR35 compliance is confirmed prior to commencement.

Mary Fleming
Chief Executive and Accounting Officer
23 June 2026

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

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

The NHS Foundation Trust Code of Governance contains guidance on good corporate governance. NHS England recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for any non-compliance with the code should be explained. This "comply or explain" approach has been in successful operation for many years in the private sector and within the NHS foundation trust sector. There are no provisions within the NHS Foundation Trust Code of Governance that we did not comply with during 2025/26.

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

Council of Governors

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

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

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

Decisions made by our Council of Governors include:

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

We now support effective mechanisms for communication between governors and members from our constituencies through our Governor Engagement Group, which was established earlier this year with the task of considering how engagement can be taken forward, in light of the aims set out in the government's 10 Year Plan. The contact details for members who wish to communicate with

governors and/or directors are made available on our website and throughout this report and our corporate affairs team are happy to support this process.

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 2025/26 of those governors who remain in post as at the date of writing:

Name	Constituency/organisation	Term of office ends (see note 1)	Attendance 2025/26 (see note 2)
Public governors			
Peter Allard	Public: Wigan	2028	100%
Anthony Ashworth-Steen	Public: Rest of England and Wales	2028	100%
Anita Baker	Public: Wigan	2027	50%
Alan Baybutt	Public: Wigan	2027	60%
Andrew Bullen	Public: Makerfield	2026	100%
Steven Eastwood	Public: Rest of England and Wales	2028	50%
Robert Ford	Public: Leigh	2028	100%
Pauline Gregory	Public: Wigan	2027	80%
Ken Griffiths**	Public: Makerfield	2026	0%
Andrew Haworth	Public: Leigh	2027	100%
Michael Mills	Public: Makerfield	2026	50%
Linda Sykes	Public: Leigh	2027	100%
Gary Twist	Public: Leigh	2028	50%
Philip Woods	Public: Makerfield	2026	60%
Staff governors			
Ali Al-Chalabi	Staff: All other staff	2026	60%
Julie Barrett	Staff: Nursing and Midwifery	2026	80%
George Ghaly	Staff: Medical and Dental	2027	40%
Michelle Hartley	Staff: Nursing and Midwifery	2027	100%

Name	Constituency/organisation	Term of office ends (see note 1)	Attendance 2025/26 (see note 2)
Andrew Savage	Staff: All other staff	2026	100%
Appointed governors			
John Cavanagh***	Foundation Trust volunteers	2027	20%
Rupal Lovell-Patel	University of Central Lancashire	2027	20%
David Humphries	Local Medical Committee and CCG	2026	20%
Axel Kaehne	Edge Hill University	2026	80%
Jonathan Kerry	Integrated Care Board	2027	0%
David Molyneux	Wigan Council	2026	33%
Neil Turner	Age UK Wigan Borough	2028	100%

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 five formal meetings of the Council of Governors during 2024/25 in addition to informal workshops and briefing sessions. The attendance figures above are calculated on the basis of formal meetings only. One of these meetings was called at short notice and this may have impacted on governors' ability to attend on that occasions.

* Alan Boardman resigned part way through his term and only had the opportunity to attend one meeting, for which apologies were tendered.

** Ken Griffith had a period of leave for personal reasons.

*** John Cavanagh had a period of leave for personal reasons.

The Council of Governors appoints a lead governor each year. Andrew Savage was reappointed to this role on 24 February 2026.

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 the next page.

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, an additional Chair Nomination Committee has led on the recruitment of our incoming Chair on behalf of the Council of Governors, as outlined on page 77.

Training and development for governors

During 2025/26, 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 sessions offered by NHS Providers 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:

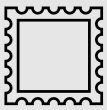
Email

governors@wwl.nhs.uk

Telephone

0300 707 2186

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 2025/26:

- Clare Austin
- Rhona Bradley
- Mary Fleming
- Julie Gill
- Simon Holden
- Mark Jones
- Mary Moore
- Kevin Parker-Evans
- Robina Shah
- Juliette Tait
- Francine Thorpe
- Mark Wilkinson

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.

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

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

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

Our membership

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

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

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

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

Last year, we carried out a data revalidation exercise, which essentially means that we wrote to all public members whose details we held in our membership database and asked them to confirm by freepost return if they wished to remain a member, otherwise, they would be removed from our database. There were several reasons for doing this:

- As a principle of good practice, in line with data retention regulations;
- To check in with members and make sure that they still wish to be involved with WWL, thereby ensuring that the group of members we have is engaged;
- Finally, it ensures that the money spent on member communications and governor elections is proportionate to match the need of the group that we serve

The membership figures have significantly reduced as a result of this exercise, however, voter turnout at our last governor election was the highest that we have ever seen, which shows that we have already made progress with our aim of cultivating a more engaged membership. The table below provides a summary of our membership as at 31 March 2026 and comparative figures for the previous year have also been provided.

Constituency	No. members as at 31 Mar 2026	No. members as at 31 Mar 2025	Change
Public: Leigh	121	110	+11
Public: Makerfield	180	185	-5
Public: Wigan	209	200	+9
Public: Rest of England and Wales	211	205	+6
Staff: Medical and Dental*	490	577	-87
Staff: Nursing and Midwifery*	2175	2177	-2

Constituency	No. members as at 31 Mar 2026	No. members as at 31 Mar 2025	Change
Staff: All other staff*	4564	4776	-212
Total members:	**7950**	**8230**	**-280**

*The previous year's figures were based on whole-time equivalent workforce hours, they have been reviewed and updated this year to reflect headcount

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

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

The Audit Committee

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

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

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

- Progress with the implementation of actions arising from internal audit reviews in previous years. 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
- A limited assurance internal audit report around medical job planning, on which the committee was briefed during the year
- High assurance levels were allocated to internal audits of emergency preparedness and response (EPRR); cash flow forecasting and management, as well as our ESR payroll system

KPMG became our external auditors during 2022 following a tender exercise which was conducted in 2020/21. This contract was extended to the maximum term of five years. The Council of Governors therefore considered the matter of appointing an auditor at its meeting in January 2025. Once again,

it agreed to appoint KPMG, based on feedback from market testing, a review of the auditor's performance and consideration of their independence. No non-audit services were provided by KPMG during 2025/26.

A key aspect of the Audit Committee's work is to consider significant issues in relation to financial statements and compliance. As part of the preparation for the audit of financial statements, KPMG undertook a risk assessment and identified a number of risks including management override of controls, valuation of land and buildings and a fraud risk from expenditure recognition. These are relatively standard audit risks prescribed by professional auditing standards and do not imply any particular control issues within the foundation trust. They also undertook a value for money risk assessment, which identified no significant risks in respect of financial sustainability, governance and improving economy, efficiency and effectiveness.

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

Audit Committee membership and attendance during 2025/26 was as follows:

Name	A	B	%
Clare Austin	5	5	100%
Rhona Bradley	5	5	100%
Simon Holden (Chair)	5	5	100%
Mary Moore	4	5	80%

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 Robina Shah. Attendance information is provided on page 78.

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

The committee also supports our succession planning work. Last year, the Remuneration Committee of the board reviewed our succession planning, as part of a submission process to NHS England. It

had positive assurance that the Trust has appropriate and robust succession planning for any short and medium-term absences in the executive team; that there was an appropriate depth of talent available supporting the executive team; and that colleagues supporting executive directors were being appropriately developed to maximise their potential, in line with their ambitions. 2024/25 was the first time we had been asked to submit a succession planning return to the ICB.

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

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

The Nomination and Remuneration Committee

The Council of Governors has established a Nomination and Remuneration Committee. Its responsibilities include consideration of matters relating to the appointment, remuneration and other terms and conditions of service of the non-executive directors and providing recommendations to the Council of Governors for consideration. Membership and attendance information is provided on page 78.

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

Assurance Committees

The Finance and Performance Committee met six times during 2025/26 and membership and attendance was as follows:

Name	A	B	%
Rhona Bradley	6	6	100%
Sarah Brennan	5	6	83%
Tabitha Gardner	5	6	83%
Julie Gill (Chair)	6	6	100%
Simon Holden	5	6	83%
Richard Mundon	6	6	100%
Francine Thorpe	5	6	83%

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

The People Committee met seven times during 2025/26 and membership and attendance was as follows:

Name	A	B	%
Clare Austin	7	7	100%

Sanjay Arya	5	7	71%
Julie Gill	5	7	71%
Mary Moore	5	7	71%
Emma Newton	2	2	100%
Kevin Parker-Evans	5	7	71%
Juliette Tait	5	5	100%
Mark Wilkinson (Chair)	7	7	100%
Charlotte Wright	1	1	100%

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

The Quality and Safety Committee met six times during 2025/26 and membership and attendance was as follows:

Name	A	B	%
Sanjay Arya	6	6	100%
Rhona Bradley	6	6	100%
Mary Moore	6	6	100%
Kevin Parker-Evans	6	6	100%
Francine Thorpe (Chair)*	3	3	100%
Mark Wilkinson	6	6	100%

A: Number of meetings attended
B: Total number of meetings the director could have attended
* During the period that Francine Thorpe acted as Interim Chair, Mary Moore chaired the committee

The Research Committee met four times during 2025/26 and membership and attendance was as follows:

Name	A	B	%
Sanjay Arya	4	4	100%
Clare Austin (Chair)	4	4	100%
Anne-Marie Miller	4	4	100%
Richard Mundon	4	4	100%
Kevin Parker-Evans	2	4	50%
Francine Thorpe	2	2	100%
Mark Wilkinson	3	4	75%

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

NHS England's system oversight framework

NHS England's *NHS Oversight Framework 2025/26* is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)

b) considering financial override which may limit a segment to be no better than 3

c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and

d) capability assessments which consider the organisation's leadership and governance.

WWL currently sits in segment 3. This segmentation information is the trust's position as at 31 March 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website. The trust is included on the acute trust dashboard.

For current segmentation, please visit **england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/**

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 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.

Mary Fleming
Chief Executive and Accounting Officer
23 June 2026

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 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, I am primarily responsible on behalf of the board for WWL's risk management arrangements. Our Chief Nursing Officer holds the portfolio for risk management, with a dedicated Head of Risk, who has day-to-day responsibility for this function in conjunction with the Associate Director of Governance and Patient Safety and also the Director of Corporate Governance.

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

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

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

objectives. During 2025/26, we continued to adapt our risk management arrangements to ensure that our board are regularly sighted on risks relating to both of these frameworks. Currently, our board receives both a partnerships report and a system partnerships report annually, facilitating oversight of how we work collaboratively with our regional and local partners. These documents, along with the 'partnerships' section of our board assurance framework, inform our board of any risks around partnership working.

Our risk management policy and risk management framework document our leadership arrangements for risk management, these documents are approved and their implementation monitored by our Audit Committee. The senior operational risk group reporting to the Audit Committee is our Risk Management Group, which is chaired by our Deputy Chief Executive and is routinely attended by other senior leaders. The chairing and attendance arrangements for the Risk Management Group reinforce the importance of ensuring that governance arrangements surrounding risk are robust, as well as the need for a clear line of sight to the executive team. Monthly reporting from this group into our Executive Team Meeting allows me and other executive colleagues proper oversight in this area. The group reviews all risks scoring 15 and above (more information on the scoring methodology used is provided below) and identifies where a risk or collection of risks may impact upon achievement of our corporate objectives, thereby escalating risks for inclusion on our board assurance framework. The Audit Committee receives a biannual deep dive in to risks scoring 15 and above, as selected by the Committee Chair.

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

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

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

We aim to learn from good practice and hold a clinical audit conference each year. The purpose of this event is to showcase best practice and the positive impact that our improvement work has had on patient care. Colleagues are invited to submit any audit work they have done for shortlisting, and four projects are chosen which are presented on the day, with an overall winner chosen by a panel of judges to receive the Dr Naqvi Award For Best Clinical Audit.

We also host a number of learning events through the year, detailing shared learning from adverse events as well as learning from excellence to a wide range of medical, nursing and allied health professionals (AHP) staff as well as colleagues from all areas of the Trust. Each event is organised around a distinct theme and staff are asked to present cases for leaning to the wider audience.

Risk management core controls are included in our internal audit plan cycle, with our 2025/26 audit result being one of high assurance.

The risk and control framework

The risk management framework supports the consistent and robust identification and management of opportunities and risks within desired levels across the trust, supporting openness, challenge, innovation and excellence in the achievement of objectives. The board is corporately accountable for ratifying, adhering to, and delivering the risk management framework. The board determine and continuously assess the nature and extent of the principal risks that the trust is exposed to and is willing to take to achieve its objectives - its risk appetite – and ensure that planning and decision-making reflects this assessment.

Identification of risk

Risk identification activities provide an integrated and holistic view of risks, organised into categories relating to the four principal objectives: patients, people, performance and partnerships. We have established risk management activities which cover all types and sources of risk. The aim is to understand the trust's 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

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

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

Control of risk

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

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

- A risk can be **treated** by taking mitigating action to reduce it to a tolerable level as identified through a target risk score;
- It may be that, in line with the foundation trust's risk appetite statement approved by the board, a risk can be **tolerated** – either in its initial form or following mitigation to reach the target risk score;

- We may take the decision to **transfer** the risk, such as by taking out an insurance policy or commissioning the services from a third-party supplier;

- Where risks are of such significance that there are no other alternatives, we may decide to **terminate** the risk by stopping the associated activities or

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

As part of the selection and development of risk treatments, 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 our principal risks and how management is responding to those risks.

Risk appetite

Risk appetite is defined as the level of risk with which we aim 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 we are is willing to operate, given current constraints. This balances the funding position with the position outlined our objectives. Above this threshold, we actively seek to manage risks and prioritises time and resources to reduce, avoid or mitigate these risks. The board agrees our risk appetite and risk tolerance levels as part of the annual strategic planning process.

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

The current risk appetite statement approved by the board on 1 April 2026 and correct as at the date of signing this report, is summarised by risk category and principal objective in the following matrix:

Risk category and link to principal objective	Threat		Opportunity	
	Optimal	Tolerable	Optimal	Tolerable
Quality and Safety How will we deliver safe services?	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
People How will organise our workforce?	**≤ 8 Open**	**≤ 12 Open**	**≤ 15 Eager**	**≤ 16 Eager**
Financial How will we use our resources?	**≤ 6 Cautious**	**8 – 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
Performance How will we be perceived by regulators?	**≤ 6 Cautious**	**8 – 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**
Reputational How will we be perceived by the public and our partners?	**≤ 6 Cautious**	**8 - 10 Cautious**	**≤ 8 Open**	**≤ 12 Open**

In line with recommended practice, a one-word description of our risk appetite levels has been devised into five categories on a scale from least risk to most risk. NHS GM use a similar scale, but have a sixth category named 'mature', which is incorporated into the 'eager' category within the WWL risk appetite scale.

Least risk				**Most risk**
Adverse	Minimal	Cautious	Open	Eager

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

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

Our last full inspection by the Care Quality Commission was in October and November 2019, with the report published in February 2020. As the CQC are no longer conducting full site inspections and, instead, carrying out service specific focused inspections, we have undergone one within our nuclear medicine services under the Ionising Radiation (Medical Equipment) Regulations IR(ME)R in December 2005. There were no enforcement or improvement notices issued and, whilst this does not influence our overall rating, is considered during our ongoing liaison with the CQC.

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

Our major risks are included on the board assurance framework and included the following for 2025/26:

Patients:	• Quality of care • Patient experience • Early detection and intervention, preventing avoidable ill-healthcare
People:	• Workforce sustainability
Performance:	• Delivery of the Financial Recovery Strategy • Performance • Delivery of our elective and non-elective services
Partnerships:	• Partnership working

These risks are likely to remain the same during 2026/27.

A Well-Led Developmental Review was undertaken by Deloitte LLP in 2021/22 and all recommendations were subsequently fully implemented. In line with current best practice guidance from NHS England, it is expected that a similar review will be commissioned during 2026/27.

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 section 4 (governance). This condition covers the effectiveness of governance structures, the responsibilities of directors and committees, the reporting lines and accountabilities between the board, its committees and the executive team.

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

At WWL, risk management is an integral part of all organisational activities to support decision-making in achieving objectives. For example, equality impact assessments are integrated into our core business. Control measures are in place to ensure compliance with our obligations under equality, diversity and human rights legislation. We continue to demonstrate compliance with the general and specific duties of the Public Sector Equality Duty on an annual basis through publishing relevant equality information as part of our annual inclusion and diversity monitoring report. We also undertake an assessment of current performance against the criteria stated in the national equality delivery system on an annual basis. We have continued to review and assess performance in collaboration with staff and local stakeholders, using this framework as well as identifying priorities going forward.

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

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

Our EDI Strategy has the following key aims:

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

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

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

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

Our approach to incident management is set out in our incident reporting policy and Patient Safety Response Framework (PSIF). The identification and investigation of serious incidents and never events is undertaken by the Learning from Patient Safety Events Group which is chaired by our Chief Medical Officer.

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

- Governance processes were clearly defined, and the Trust had a risk appetite statement in place. Roles and responsibilities relating to risk management were clearly outlined and standardised risk recording processes were in place
- Risk management training was delivered to all staff through mandatory training modules, supported by compliance monitoring dashboards
- Risk reporting, monitoring and escalation processes were clearly outlined and supported by regular risk reporting mechanisms

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

Our governors participate in PLACE (patient-led assessment 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 OWLL (observe, watch, listen and learn) walks across hospital sites on a regular basis.

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

The board has oversight of our workforce strategies via the People Committee, which meets on a bimonthly basis. The committee seeks assurance on our strategic workforce priorities and any key themes, including safe staffing reports where modelling exercises have been undertaken to assess workforce staffing levels against patient acuity and requirement in comparison with national guidance such as that issued by the Royal College of Physicians. The People Committee also approves overarching strategies that fundamentally lead to safe, sustainable and effective staffing, such as our approach to recruitment and retention, learning and development, leadership development,

talent management and apprenticeship strategy. These strategies are designed to support the development of resilience and capacity within the workforce.

Through our delivery and embedding of the WWL People & Culture Strategy, we have continued to progress in meeting objectives around:-

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

Our People Committee maintain oversight of the delivery and impact of the People and Culture Strategy.

The Trust continues to offer a comprehensive package of wellbeing support to its staff. This ranges from relevant tools or signposting to helpful websites, right through to individualised support if required via our Employee Assistance Programme provision. We recognise the importance and value of a person-centred approach, rather than a “one-size fits all" and we seek to ensure a diversity of offers exists, which also includes support around financial wellbeing, workplace adjustments, and wellbeing training and support for leaders.

Through People Committee the board is sighted on the workforce plan that support delivery of the NHS Medium Term Plan, and the alignment with the 10 Year Plan. We have continued to explore digital developments and optimisation of existing digital systems including eJob Planning for medical staff and eRostering, which support improvements in productivity and support staff to balance their home and work lives.

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

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

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

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

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

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

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

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

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

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

- Objectives are approved and monitored through a number of channels, including regular review of the foundation trust's financial position by a dedicated Finance and Performance Committee
- Approval of annual budgets by the board
- Formal acceptance of annual budgets by delegated budget holders
- Bi-monthly reporting to the board, via its committees, on key performance indicators covering quality and safety, finance, and workforce targets
- Scrutiny of divisional performance against objectives at committees
- Regular divisional performance and assurance reviews
- Reporting by exception 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 through the procurement process

- 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

- Getting It Right First Time (GIRFT), Service line reporting (SLR) and National Costs Collection data is used by divisional managers to seek to improve financial performance

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

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

WWL is part of the Greater Manchester Integrated Care Partnership (GMICP) which brings together partners across Greater Manchester to set the strategy and take actions which will make a difference to the health of the population of Greater Manchester.

We also continue to play an active role in the Healthier Wigan Partnership which brings together key partners across the Wigan Locality including Wigan Council, WWL, the locality ICB team and representatives from the voluntary, community and faith sectors (VCFS).

These partnerships have their own assurance frameworks which will work similarly to our own in monitoring achievement of and risks related to our wider regional and local objectives. During 2025/26, we have continued to adapt our risk management arrangements to ensure that our board are regularly sighted on risks relating to both of these frameworks.

Currently, our board receives a partnerships report bi-annually, facilitating oversight of how we work collaboratively with our regional and local partners. These documents, along with the 'partnerships' section of our board assurance framework, inform our board of any risks around partnership working.

A biannual report from our data assurance and analytics team, based on disaggregated health data according to ethnicity and deprivation, along with health inequalities focussed changes to our key performance indicators will assist us to monitor our role in reducing health inequalities, access, experience and outcomes through tackling these shared challenges with our partner organisations.

Information governance

Information governance provides the framework for handling personal and sensitive date in a secure and confidential manner. it covers the lawful collection, secure storage and appropriate sharing of information, providing assurance that personal and sensitive data is handled legally, securely, efficiently and effectively to support the delivery of high quality care and services.

The Trust's information governance and assurance arrangements include:

- A network of information asset owners with responsibility for systems holding patient and staff personal data.
- Appointed and trained Caldicott Guardian, Senior Information Risk Owner and Data Protection Officer.
- Defined risk management and incident reporting processes, supported by an information governance risk register.
- Mandatory information governance training for all staff

- Annual signing of the confidentiality code of conduct signing.
- Approved policies covering data protection, information security, records management and confidentiality.
- A quarterly report to the board summarising key information governance activities and compliance with requirements (Including the Data Security and Protect Toolkit, Cyber Assessment Framework, General Data Protection Regulation arrangements and incidents)

Our information governance team have reviewed 949 incidents between 1 April 2025 and 31 March 2026. After reviewing, we escalated 26 incidents to the Information Commissioner's Office (ICO). Of these 10 incidents, two remain open with the ICO, while all others have been closed.

The incidents reported to the ICO related to serious breaches of confidentiality and security, where personal data had been shared inappropriately or there had been a contravention of data protection legislation. Examples included data integrity incidents in which sensitive information relating to patient treatment was inadvertently disclosed to another data subject, resulting in the exposure of highly sensitive personal data to an unauthorised recipient. Other incidents included phishing attempts on our email accounts, correspondence containing sensitive information being sent to an incorrect address, and errors associated with the application of system retention settings.

We also identified incidents involving data breaches by third-party suppliers authorised to undertake limited data processing on its behalf. These incidents were promptly contained, with the information governance team working closely with colleagues in information management and technology and the Senior Information Risk Owner to mitigate any potential impact.

In 2024/25 we were awarded "approaching standards" as part of the Data Security and Protection Toolkit and Cyber Assurance Framework submission in June 2025.To rectify this, the Trust has submitted an improvement plan to NHS England with planned completion set for 30 June 2026. This submission was also audited by our internal auditors, with high assurance being awarded as a result and we therefore expect to receive a rating of 'standards met' for 2026.

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

Data quality and governance

As a data-driven organisation, we recognise the critical importance of maintaining high-quality data for effective decision-making. To achieve this, we have established robust controls and procedures that underpin our commitment to data integrity and accuracy throughout all levels of the Trust.

Our data analytics and assurance team are instrumental in maintaining data quality. They develop applications specifically designed to detect errors and inconsistencies within our datasets. This proactive approach not only increases transparency across the organisation but also enables service managers to implement targeted procedural changes, thereby addressing issues at their source and driving continuous improvement.

Ensuring the timely and accurate capture of data is the responsibility of all staff members. To support this, our integrated data quality team provides guidance and practical advice to promote best practices. Regular analysis of organisational data allows the team to uncover insights that may not

be immediately apparent to other data users. Close collaboration with divisional teams and analysts ensures that our focus and priorities are closely aligned with organisational needs.

The Data Recording Quality Committee plays a pivotal role in overseeing data quality matters. The committee ensures that any issues are resolved and reports directly into the Caldicott Committee. Broad representation from across the organisation guarantees transparency and encourages input from all relevant stakeholders.

During the latest period, the Trust has introduced data quality indicators into the Integrated Performance Report presented to the board. These indicators provide essential support to board members, enabling them to make informed decisions based on the quality of the data provided.

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 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 and the Quality and Risk Committee advise me on the implications of the results of my review of the effectiveness of the system of internal control. These committees also advise outside agencies in relation to serious events.

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

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

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

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

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

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

- Our internal auditors carried out ten audits this year, the findings of each being reported to our Audit Committee.

- The core and risk-based audit reviews undertaken for 2025/26 received the following assurance ratings;

One Limited Assurance Opinion	Consultant Job Planning
One high assurance opinion	Risk Management Core Controls
Six substantial assurance opinions:	Appraisals Cashflow Forecasting and Management Core Financial Systems Review Emergency Preparedness, Resilience and Response Review ESR Payroll Fit and Proper Person Test
Two moderate assurance opinions:	Waiting List Management (Draft) Infection Prevention

- Of the 39 recommendations issued by the internal auditors during the year, (34 of which relate to reports which have been finalised from 2025/26 and five of which relate to reports finalised from 2024/25 not included in the final Head of Internal Audit opinion for 2024/25. All recommendations were accepted by management. Five of the recommendations were described as high-risk recommendations in relation to the reviews of Consultant Job Planning, Infection Prevention Control (C.difficile) and Cyber Assurance Framework (CAF) aligned to the Data Protection Security Toolkit (DSPT).

- Whilst there were 33 outstanding recommendations relating to prior year reviews as at the 1 April 2025, during the course of the year, follow-up reviews were undertaken by the internal auditors resulting in the implementation of 51 actions during 2025/26.

- The total number of recommendations yet to be implemented as at 9 June 2026 is 21, which includes three high risk and six medium risk. In addition, two recommendations with no risk rating were overdue at 9 June 2026. The remaining 10 recommendations were not yet due as at the date of this report.

The overall opinion for the period 1 April 2025 to 31 March 2026 provides substantial assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. The overall assurance rating continues to be in line with previous years.

This opinion is provided in the context that the Trust like other organisations across the NHS is continuing to face a number of challenging issues and wider organisational factors particularly with regards to the changes to national and local bodies and the corresponding uncertainty this causes, ongoing elective recovery response, national industrial disputes, workforce challenges, financial challenges and increasing collaboration across organisations and systems. In providing this opinion our internal auditors confirm continued compliance with the definition of internal audit (as set out in our internal audit charter), code of ethics and professional standards. The auditors also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

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

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

The 2025/26 internal audit plan has been delivered with the focus on the provision of our Head of Internal Audit Opinion. This position has been reported within the progress reports across the financial year. Review coverage has been focused on:

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

Conclusion

My review confirms that Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust has sound systems of internal control, with no significant control issues having been identified. This accountability report is signed by me in my capacity as Accounting Officer.

Mary Fleming
Chief Executive and Accounting Officer
23 June 2026

Independent Auditor's Report

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Our Values | People at the Heart | Listen and Involve | Kind and Respectful | One Team

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 2026 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

• give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its income and expenditure for the year then ended; and

• have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and

• have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

• we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and

• we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

• Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England

• Reading Board and Audit Committee minutes.

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

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 Trust management may be in a position to make inappropriate accounting entries.

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

We identified a fraud risk related to expenditure recognition, particularly in relation to the completeness of year end manual accruals, in response to the setting of a financial performance target by NHS England that can create an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred through the omission of year end manual accruals.

We performed procedures including:

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

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

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

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

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the 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.

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

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery and employment law, recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

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

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

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

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we

do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

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

• we have not identified material misstatements in the other information; and

• in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 113, 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.

The Audit Committee is responsible for overseeing the Trust's financial reporting process.

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 113, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

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

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

• we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or

• we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or

has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

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

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

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

Timothy Cutler
for and on behalf of KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

26 June 2026

Financial Report

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Our Values | People at the Heart | Listen and Involve | Kind and Respectful | One Team

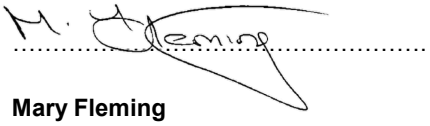
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Annual Accounts for the year ended 31 March 2026

Foreword to the accounts

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006

Signed 

Mary Fleming
Chief Executive

Date **23 June 2026**

Statement of Comprehensive Income for the year ended 31 March 2026

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	2	585,380	551,966
Other operating income	3	29,360	29,248
Total operating income from continuing operations		**614,740**	**581,214**
Operating expenses	4	(615,981)	(604,280)
Operating deficit from continuing operations		**(1,242)**	**(23,065)**
Finance costs			
Finance income	7	1,574	1,903
Finance expenses	8	(1,697)	(1,634)
PDC dividends payable		(4,830)	(4,813)
Net finance costs		**(4,953)**	**(4,544)**
Loss on disposal of fixed assets	9	(93)	(771)
Deficit for the year		**(6,287)**	**(28,380)**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments	11	(1,682)	(4,986)
Revaluations	12	2,630	7,503
Other reserve movements		0	0
Total comprehensive expense for the year		**(5,339)**	**(25,863)**

Statement of Financial Position as at 31 March 2026

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	10	5,109	4,936
Property, plant and equipment	11	212,119	208,226
Right of use assets	13	29,509	29,517
Receivables	16	800	788
Total non-current assets		**247,537**	**243,467**
Current assets			
Inventories	15	2,980	3,805
Receivables	16	24,508	20,846
Cash and cash equivalents	18	16,611	18,070
Total current assets		**44,099**	**42,721**
Current liabilities			
Trade and other payables	19	(53,943)	(58,349)
Other liabilities	20	(7,300)	(8,173)
Borrowings	21	(8,387)	(6,607)
Provisions	23	(503)	(1,046)
Total current liabilities		**(70,133)**	**(74,175)**
Total assets less current liabilities		**221,503**	**212,013**
Non-current liabilities			
Other liabilities	20	0	0
Borrowings	21	(33,058)	(36,124)
Provisions	23	(2,319)	(1,967)
Total non-current liabilities		**(35,377)**	**(38,091)**
Total assets employed		**186,126**	**173,922**
Financed by			
Public dividend capital		180,148	162,605
Revaluation reserve		23,122	22,825
Income and expenditure reserve		(17,144)	(11,508)
Total taxpayers' equity		**186,126**	**173,922**

The primary financial statements on pages 140 to 143 and the notes on pages 144 to 189 were approved by the Board of Directors and authorised for issue on 23 June 2026 and signed on its behalf by Mary Fleming, Chief Executive.

Signed ……..…… **23 June 2026**
Mary Fleming, Chief Executive

Statement of Changes in Equity for the year ended 31 March 2026

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2025	**162,605**	**22,825**	**(11,508)**	**173,922**
Surplus/(Deficit) for the year	0	0	(6,287)	**(6,287)**
Transfers between reserves	0	(651)	651	**0**
Impairments	0	(1,682)	0	**(1,682)**
Revaluations	0	2,630	0	**2,630**
Public dividend capital received	17,543	0	0	**17,543**
Taxpayers' equity at 31 March 2026	**180,148**	**23,122**	**(17,144)**	**186,126**

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2024	**148,576**	**20,973**	**16,208**	**185,757**
Surplus/(Deficit) for the year	**0**	**0**	(28,381)	**(28,381)**
Other transfers between reserves	0	(665)	665	**0**
Impairments	0	(4,986)	0	**(4,986)**
Revaluations	0	7,503	0	**7,503**
Public dividend capital received	14,029	0	0	**14,029**
Taxpayers' equity at 31 March 2025	**162,605**	**22,825**	**(11,508)**	**173,922**

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	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(1,242)	(23,066)
Non-cash income and expense			
Depreciation and amortisation	4	19,987	18,756
Net impairments and (reversals) of impairments	4	9,458	27,458
Income recognised in respect of capital donations (non-cash)	3	(115)	(115)
(Increase) / decrease in receivables and other assets		(3,897)	(1,118)
(Increase) / decrease in inventories		825	(473)
Decrease in payables and other liabilities		(6,695)	(3,962)
Decrease in provisions		(708)	(329)
Other movement in operating cashflows		(1)	0
Net cash generated from operating activities		**17,612**	**17,151**
Cash flows used in investing activities			
Interest received		1,583	1,967
Purchase of intangible assets		(2,005)	(318)
Purchase of property, plant, equipment and investment property		(22,788)	(26,110)
Sales of property, plant, equipment and investment property		0	0
Net cash used in investing activities		**(23,209)**	**(24,461)**
Cash flows used in financing activities			
Public dividend capital received		17,543	14,029
Loans paid		(1,350)	(1,351)
Capital element of lease liability repayments		(5,772)	(5,164)
Interest element of lease liability repayments		(1,449)	(1,363)
Other interest paid		(218)	(236)
PDC dividend paid		(4,616)	(5,480)
Net cash used in financing activities		**4,138**	**435**
Decrease in cash and cash equivalents		**(1,459)**	**(6,875)**
Cash and cash equivalents at 1 April		18,070	24,945
Cash and cash equivalents at 31 March	18	**16,611**	**18,070**

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 2025/26 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, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Going concern

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

1.3 Joint arrangements

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

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

1.4 Critical accounting judgements and key sources of estimation uncertainty

1.4.1 Critical judgements in applying accounting policies

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

Operating segments

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

Interests in other entities and joint arrangements

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

The Foundation Trust has assessed its existing contracts and collaborative arrangements for 2025/26, 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 three joint operations (Note 14).

Consolidation

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

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standards (FRS) 102.

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 2025/26.

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 2025/26 with a revaluation date of 31 March 2026.

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 2026 is £217.2m (£213.3m, 2024/25).

1.5 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

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

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

The Trust also receives income from commissioners under Best Practice Tariff (BPT) schemes. Delivery under this schemes is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS15. Payment for BTP on non-elective services is included in the fixed criteria element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2025/26, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

NHS Injury Cost Recovery Scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and 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

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.

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.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.7 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

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

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

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 Insurance Contracts

An insurance contract is a contract under which the Trust has accepted significant pre-existing insurance risk from the policyholder by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder.

IFRS 17 is effective from 2025/26 for the insurer accounting for such contracts. The standard is applied retrospectively with a transition date of 1 April 2024, restating prior periods.

The Trust does not hold any contracts that meet the definition of insurance contracts under IFRS17.

1.10 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 assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset basis.

A DRC model estimates current value in existing use 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. 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	5 to 20 years
Vehicles	10 to 13 years
Furniture and fittings	15 years
Medical and other equipment	5 to 15 years
Information Technology	5 to 10 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.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Foundation Trust. They are capable of being sold separately from the rest of the Foundation Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the 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 where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets 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.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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	2 to 8 years

1.12 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.

1.13 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.

1.14 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.

1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Initial recognition and measurement

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

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

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

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.321% to new leases commencing in 2026.

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.

1.16 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 2026:

Short term rate: 3.64% (4.03%, 2024/25)
Medium term rate: 4.22% (4.07%, 2024/25)
Long term rate: 5.32% (4.81%, 2024/25)

For post-employment benefits including early retirement provisions and injury benefit provisions the HM Treasury's pension discount rate of 2.95% in real terms (2.40%, 2024/25) is used.

1.17 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Foundation Trust pays an annual contribution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the NHS Foundation Trust is disclosed in Note 23.1 but is not recognised in the NHS Foundation Trust's accounts.

1.18 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.

1.19 Contingent assets and contingent liabilities

A contingent assets is a possible asset that arises from past events and whose existence will only be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Foundation Trust. A contingent asset is disclosed in Note 24 where an inflow of economic benefits is probable.

Contingent liabilities are defined as:

● 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.

Contingent liabilities are not recognised but are disclosed in Note 24.

Where the time value of money is material, contingent assets and contingent liabilities are disclosed at their present value.

1.20 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.

1.21 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.

1.22 Corporation tax

As an NHS Foundation Trust, Wrightington, Wigan and Leigh Teaching NHS Foundation Trust is specifically exempted from corporation tax through the Corporation Tax Act 2010. The Act provides that HM Treasury may dis-apply this exemption only through an order via a statutory instrument (secondary legislation). Such an order could only apply to activities which are deemed commercial, and arguably much of the Foundation Trust's other operating income is ancillary to the provision of healthcare, rather than being commercial in nature. No such order has been approved by a resolution of the House of Commons. There is therefore no corporation tax liability in respect of the current financial year.

1.23 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.

1.24 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Foundation Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.25 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.

1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

1.27 IFRS Standards and amendments issued but not yet adopted in the FReM

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

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 18 Presentation and Disclosure in Financial Statements: The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures: The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to non-investment asset valuation: The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £165.9m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £163.3m at 31 March 2026. The expected impact of applying the standard in future periods has not yet been assessed.

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:

	2025/26 £000	2024/25 £000
NHS England*	36,096	32,750
Integrated Care Boards	525,142	495,627
NHS Foundation Trusts	5,002	5,065
NHS Trusts	0	2
Local Authorities	7,005	6,714
NHS other (including UKHSA & MHRA)	0	0
Non NHS: private patients	7,418	7,839
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	109	25
Injury cost recovery scheme	566	1,052
Non NHS: other**	4,042	2,892
	585,380	**551,966**

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% in April 2019, and further increase to 23.7% from April 2024 (excluding administration charge). Since 2019/20, NHS providers have continued to pay over contributions at the former rate of 14.3% 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.

** Non NHS: other income relates to income from other territorial bodies and First Contact Practitioner income that are not deemed to be within the NHS England accounting boundary.

^ Prior year figures have been re-apportioned for consistency with 2025/26 income categorisation.

Note 2.2 Income from patient care activities (by nature)

	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	137,244	123,651
Income from commissioners under API contracts - fixed element*^	305,210	299,740
High cost drugs income from commissioners (excluding pass through costs)^	31,100	26,493
Other NHS clinical income**	7,494	5,489
Community Services		
Income from commissioners under API contracts*	63,118	55,928
Income from Other Sources (e.g. local authorities)	6,972	6,716
Additional income		
Private patient income	7,418	7,839
National pay award central funding	0	976
Additional pension contribution central funding ***	22,557	21,132
Other clinical income****	4,266	4,002
Total income from activities	**585,380**	**551,966**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.
NHS England » 2025/26 NHS Payment Scheme

**Other NHS clinical income includes NHS income outside the API contract for a range of services.

*** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% in April 2019, and further increase to 23.7% from April 2024 (excluding administration charge). Since 2019/20, NHS providers have continued to pay over contributions at the former rate of 14.3% 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, First Contact Practitioner income not deemed within the NHSE England acocunting boundary.

^ Prior year figures have been re-apportioned for consistency with 2024/25 income categorisation.

Note 2.3 Overseas visitors

	2025/26 £000	2024/25 £000
Income recognised this year	109	25
Cash payments received in-year	17	24
Amounts added to allowance for impaired contract receivables	16	0
Amounts written off in-year	46	8

Note 3 Other operating income

	2025/26 £000	2024/25 £000
Other operating income from contracts with customers:		
Research and development (contract)	2,306	1,880
Education and training (excluding notional apprenticeship levy income)	16,462	15,723
Non-patient care services to other bodies	1,193	1,638
Income in respect of employee benefits accounted on a gross basis*	1,991	2,286
Other**	6,241	6,790
Other non-contract operating income		
Education and training - notional apprenticeship levy income	925	692
Receipt of capital grants and donations	115	115
Charitable and other contributions to expenditure	16	17
Rental revenue from operating leases	111	108
	29,360	**29,248**

*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 £6.2m (£6.8m, 2024/25) includes car parking income, catering income, pharmacy income, staff accommodation rental and other miscellaneous income recharged to other NHS bodies.

Note 3.1 Additional information on contract revenue recognised in the period

	2025/26 £000	2024/25 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	7,300	8,678

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:

	2025/26 £000	2024/25 £000
Income from services designated as commissioner requested services	568,973	535,339
Income from services not designated as commissioner requested services	16,407	16,627
Total	**585,380**	**551,966**

Note 4 Operating expenses

	2025/26 £000	2024/25 £000
Purchase of healthcare from NHS and DHSC bodies	2,443	2,465
Purchase of healthcare from non-NHS and non-DHSC bodies	4,433	3,642
Employee expenses - non-executive directors	163	164
Employee expenses - staff	403,925	376,556
Employee expenses - temporary staff	27,990	34,651
Supplies and services - clinical	58,449	51,750
Supplies and services - general	5,577	5,250
Drug costs (inventory consumed & non-inventory purchases)	33,229	32,164
Inventories written down	33	33
Consultancy	945	733
Establishment	5,123	5,387
Transport	1,700	1,551
Premises	22,186	24,178
Movement in credit loss allowance: contract receivables/contract assets	(120)	305
Change in provisions discount rate	(61)	47
Depreciation on property, plant and equipment, and RoU assets	18,155	17,754
Amortisation on intangible assets	1,832	1,002
Net Impairments*	9,458	27,458
Audit fees payable to the external auditor**		
audit services - statutory audit	222	171
other auditor remuneration	0	2
Internal audit and local counter fraud services	148	143
Clinical negligence	13,556	13,075
Legal fees	715	843
Insurance	489	537
Education and Training	3,205	2,746
Redundancy and other mutually agreed resignation schemes	1,593	741
Losses, ex gratia & special payments	47	26
Other***	547	905
Total	**615,981**	**604,280**

* Further details of net impairments can be found in Note 11.

** Audit fees payable to the external auditor inclusive of VAT was £222k during the year (£171k, 2024/25) and £185k (£143k, 2024/25) exclusive of VAT.

***Other expenditure of £0.5m (£0.9m, 2024/25) includes changes in provisions for personal injury benefits and other claims, and other miscellaneous expenditure charges.

Note 4.1 Other auditor remuneration

Other assurance services payable to the external auditor was £0k (£2k, 2024/25) during the 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 2025/26 and 2024/25

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.

	2025/26		2024/25	
	Number	£000	Number	£000
Non-NHS				
Trade invoices paid in the period	74,724	292,583	72,017	277,555
Trade invoices paid within target	69,911	282,238	68,297	268,374
Percentage of trade invoices paid within target	**93.6%**	**96.5%**	**94.8%**	**96.7%**
NHS				
Trade invoices paid in the period	1,917	45,576	1,986	45,484
Trade invoices paid within target	1,794	43,796	1,820	42,598
Percentage of trade invoices paid within target	**93.6%**	**96.1%**	**91.6%**	**93.7%**
Total				
Trade invoices paid in the period	76,641	338,159	74,003	323,039
Trade invoices paid within target	71,705	326,034	70,117	310,972
Percentage of trade invoices paid within target	**93.6%**	**96.4%**	**94.7%**	**96.3%**

Note 5 Employee benefits

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	310,788	294,927
Social security costs	37,593	28,690
Apprenticeship levy*	1,463	1,399
Employer's contributions to NHS pensions	34,063	32,148
Employer's contributions to NHS pensions paid by NHSE on behalf of the Foundation Trust (9.4%)**	22,557	21,132
Temporary staff	27,990	34,651
Total staff costs	**434,454**	**412,947**
Costs capitalised as part of assets	868	924

*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.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% in April 2019, and further increase to 23.7% from April 2024 (excluding administration charge). Since 2019/20, NHS providers have continued to pay over contributions at the former rate of 14.3% 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 2025/26 are £434.4m (£412.9m, 2024/25) which is an increase of £21.5m. This primarily relates to the impact of the 2025/26 pay award (£15.5m) and increase in social security contribution (£8.2m).

Temporary staffing expenditure reduced compared to the previous year (£28.0m, 2025/26; £34.7m, 2024/25), which is due to bank rate standardisation and the impact of the variable pay recovery plan

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 6 early retirements agreed on the grounds of ill-health during the year (14, 2024/25). The cost of these ill-health retirements, £286k (£1,600k, 2024/25) is borne by the NHS Business Services Authority - Pensions Division.

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

	2025/26 £000	2024/25 £000
Salary	1,377	1,510
Employer's pension contributions	182	177
Taxable benefits	12	9
Total	**1,571**	**1,696**
Non-executive directors' remuneration *	146	153
Total	**1,717**	**1,849**
The total number of directors accruing benefits under the NHS Pension Scheme	8	10

* 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

The Foundation Trust's policy in relation to annual leave for staff states that full annual leave entitlement must be taken in the financial year to support health and wellbeing. However, in recognition that some statutory annual leave will not be taken in year (e.g. for staff on maternity leave) an accrual of £0.3m is included in trade and other payables.

Note 6 Operating lease income

Note 6.1 Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust as a lessor

	2025/26 £000	2024/25 £000
Operating lease income		
Minimum lease receipts	111	108
Total	**111**	**108**

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due:		
- not later than one year	0	108
- later than one year and not later than five years;	444	432
- later than five years.	28	27
Total	**472**	**567**

Note 7 Finance income

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

	2025/26 £000	2024/25 £000
Interest on bank accounts	1,574	1,903
Total	**1,574**	**1,903**

The interest received on bank accounts decreased during the year due to several changes in the Bank of England base rate.

Note 8 Finance expenses

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

	2025/26 £000	2024/25 £000
Interest expense		
Loans from the Department of Health and Social Care	214	230
Interest on lease obligations	1,449	1,363
Total interest expense	**1,663**	**1,593**
Other finance costs - unwinding of discount	34	41
Total	**1,697**	**1,634**

The interest on lease obligations increased as a result of new lease arrangements arising from Right of Use Asset additions in 2025/26 and the remeasurement of existing leases with that includes annual rent increases in line with RPI, refer to Note 13.

Note 9 Gains and (losses) on disposal of assets

	2025/26 £000	2024/25 £000
Gains on disposal of assets	0	0
(Loss) on disposal of assets	(93)	(771)
Total	(93)	(771)

The Foundation Trust disposed of a number of plant, machinery and equipment assets during the year which resulted in a loss.

Note 10 Intangible assets

Note 10.1 Intangible assets - 2025/26

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation/gross cost at 1 April 2025	**15,005**	**662**	**36**	**15,703**
Transfers by absorption	0	0	0	0
Additions	2,005	0	0	2,005
Reclassifications	0	0	0	0
Disposals/derecognition	(7,805)	(662)	(36)	(8,503)
Gross cost at 31 March 2026	**9,205**	**0**	**0**	**9,205**
Amortisation at 1 April 2025	**10,071**	**662**	**34**	**10,767**
Provided during the year	1,830	0	2	1,832
Impairments	0	0	0	0
Reclassifications	0	0	0	0
Disposals/derecognition	(7,805)	(662)	(36)	(8,503)
Amortisation at 31 March 2026	**4,096**	**0**	**0**	**4,096**
Net book value at 31 March 2026	**5,109**	**0**	**0**	**5,109**
Net book value at 1 April 2025	**4,934**	**0**	**2**	**4,936**

Note 10.2 Intangible assets - 2024/25

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation/gross cost at 1 April 2024	**18,452**	**713**	**36**	**19,201**
Transfers by absorption	0	0	0	0
Additions	318	0	0	318
Reclassifications	51	(51)	0	0
Disposals/derecognition	(3,816)	0	0	(3,816)
Valuation/gross cost at 31 March 2025	**15,005**	**662**	**36**	**15,703**
Amortisation at 1 April 2024	**12,847**	**713**	**21**	**13,581**
Provided during the year	997	0	5	1,002
Impairments	0	0	0	0
Reclassifications	43	(51)	8	0
Disposals/derecognition	(3,816)	0	0	(3,816)
Amortisation at 31 March 2025	**10,071**	**662**	**34**	**10,767**
Net book value at 31 March 2025	**4,934**	**0**	**2**	**4,936**
Net book value at 1 April 2024	**5,605**	**0**	**15**	**5,620**

Note 10.3 Intangible assets financing 2025/26

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Purchased	5,047	0	0	5,047
Donated	62	0	0	62
NBV total at 31 March 2026	**5,109**	**0**	**0**	**5,109**

Note 10.4 Intangible assets financing 2024/25

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Purchased	4,872	0	2	4,874
Donated	62	0	0	62
NBV total at 31 March 2025	**4,934**	**0**	**2**	**4,936**

Note 11 Property, plant and equipment

Note 11.1 Property, plant and equipment - 2025/26

	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 2025	**9,669**	**151,998**	**1,786**	**0**	**65,561**	**201**	**46,943**	**447**	**276,605**
Additions	0	17,945	86	450	4,795	0	1,044	0	24,320
Impairments	(166)	(16,197)	(84)	0	0	0	0	0	(16,447)
Reversals of impairments	46	1,976	0	0	0	0	0	0	2,022
Revaluations	366	654	78	0	0	0	0	0	1,098
Reclassifications	0	450	0	(450)	0	0	0	0	0
Disposals/derecognition	0	0	0	0	(18,052)	(173)	(14,728)	(41)	(32,994)
Valuation/gross cost at 31 March 2026	**9,915**	**156,826**	**1,866**	**0**	**52,304**	**28**	**33,259**	**406**	**254,604**
Accumulated depreciation at 1 April 2025	**0**	**2,297**	**1**	**0**	**34,431**	**183**	**31,172**	**295**	**68,379**
Provided during the year	0	4,849	92	0	3,559	4	3,295	25	11,824
Impairments	0	(1,986)	(6)	0	0	0	0	0	(1,992)
Reversals of impairments	0	(1,293)	0	0	0	0	0	0	(1,293)
Revaluations	0	(1,446)	(86)	0	0	0	0	0	(1,532)
Disposals/derecognition	0	0	0	0	(17,964)	(173)	(14,723)	(41)	(32,901)
Accumulated depreciation at 31 March 2026	**0**	**2,421**	**1**	**0**	**20,026**	**14**	**19,744**	**279**	**42,485**
Net book value at 31 March 2026	**9,915**	**154,405**	**1,865**	**0**	**32,278**	**14**	**13,515**	**127**	**212,119**
Net book value at 1 April 2025	**9,669**	**149,701**	**1,785**	**0**	**31,130**	**18**	**15,771**	**152**	**208,226**

Note 11.2 Property, plant and equipment - 2024/25

	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 2024	**10,772**	**155,784**	**8,928**	**3,069**	**68,049**	**222**	**48,730**	**545**	**296,099**
Additions	0	12,462	20	5,921	3,552	0	11	0	21,966
Impairments	(4,301)	(30,336)	(7,183)	0	0	0	0	0	(41,820)
Reversals of impairments	548	5,849	0	0	0	0	0	0	6,397
Revaluations	2,650	(205)	21	0	0	0	0	0	2,466
Reclassifications	0	8,444	0	(8,444)	0	0	0	0	0
Disposals/derecognition	0	0	0	(546)	(6,040)	(21)	(1,798)	(98)	(8,503)
Valuation/gross cost at 31 March 2025	**9,669**	**151,998**	**1,786**	**0**	**65,561**	**201**	**46,943**	**447**	**276,605**
Accumulated depreciation at 1 April 2024	**0**	**4,530**	**106**	**0**	**36,776**	**198**	**30,095**	**367**	**72,072**
Provided during the year	0	5,480	198	0	3,474	6	2,871	26	12,055
Impairments	0	(3,977)	(205)	0	0	0	0	0	(4,182)
Reversals of Impairments	0	1,203	0	0	0	0	0	0	1,203
Revaluations	0	(4,939)	(98)	0	0	0	0	0	(5,037)
Reclassifications	0	0	0	0	0	0	0	0	0
Disposals/derecognition	0	0	0	0	(5,819)	(21)	(1,794)	(98)	(7,732)
Accumulated depreciation at 31 March 2025	**0**	**2,297**	**1**	**0**	**34,431**	**183**	**31,172**	**295**	**68,379**
Net book value at 31 March 2025	**9,669**	**149,701**	**1,785**	**0**	**31,130**	**18**	**15,771**	**152**	**208,226**
Net book value at 1 April 2024	**10,772**	**151,254**	**8,822**	**3,069**	**31,273**	**24**	**18,635**	**178**	**224,027**

Note 11.3 Property, plant and equipment financing - 2025/26

	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	9,915	152,674	1,865	0	31,152	14	13,466	108	209,194
Donated	0	1,731	0	0	1,126	0	49	19	2,925
NBV total at 31 March 2026	**9,915**	**154,405**	**1,865**	**0**	**32,278**	**14**	**13,515**	**127**	**212,119**

Note 11.4 Property, plant and equipment financing - 2024/25

	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	9,669	147,908	1,785	0	29,974	18	15,768	131	205,253
Donated	0	1,793	0	0	1,156	0	3	21	2,973
NBV total at 31 March 2025	**9,669**	**149,701**	**1,785**	**0**	**31,130**	**18**	**15,771**	**152**	**208,226**

Note 11.5 Impairment of assets

	2025/26 £000	2024/25 £000
Net impairments charged to operating (deficit) / surplus resulting from:		
Other	0	13,747
Changes in market price	9,458	13,711
Impairments charged to operating (deficit) / surplus	9,458	27,458
Impairments charged to the revaluation reserve	1,682	4,986
Total net impairments	**11,140**	**32,444**

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 desktop valuation was undertaken revaluation date of 31 March 2026. The last full revaluation was undertaken at 31 March 2025.

As a result of this valuation some land and buildings have seen an increase in value totalling £4.1m (£7.5m, 2024/25).

In addition, some land and buildings have decreased in value totalling £14.5m (£23.9m, 2024/25). £12.8m has been charged to operating expenditure offset by the reversal of previous impairments totalling £3.3m to give a net reduction on expenditure of £9.5m and £1.7m charged to the revaluation reserve for the reversal of previous gains.

The net effect of these changes in value amounts to an overall decrease in land and buildings of £9.5m.

Assets revalued have been written down to their recoverable amount within the Statement of Financial Position, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for that asset and, thereafter, to expenditure - impairment of property plant and equipment. Increases in value have been credited to the revaluation reserve unless circumstances arose whereby a reversal of an impairment was necessary. In these circumstances this has been netted off against impairments in expenditure.

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.

Note 13 Leases - The Foundation Trust as a lessee

Note 13.1 Right of use assets - 2025/26

	Buildings excluding dwellings	Plant & machinery	Total	Of which:Leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**38,717**	**6,922**	**45,639**	**32,929**
Additions	2,396	2,611	5,007	0
Re-measurements of the lease liability	833	0	833	774
Dilapidation provisions arising	483	0	483	0
Valuation/gross cost at 31 March 2026	**42,429**	**9,533**	**51,962**	**33,703**
Accumulated depreciation brought forward	14,213	1,909	16,122	12,310
Depreciation provided during the year	4,882	1,449	6,331	4,104
Accumulated depreciation at 31 March 2026	**19,095**	**3,358**	**22,453**	**16,414**
Net book value at 31 March 2026	**23,334**	**6,175**	**29,509**	**17,289**

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.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April 2025	**31,251**	**34,651**
Lease additions	5,007	1,641
Lease liability remeasurements	833	123
Interest charge arising in year	1,449	1,363
Lease payments (cash outflows)	(7,221)	(6,527)
Carrying value at 31 March 2026	**31,319**	**31,251**

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 2026

	Total '31 March 2026 £000	Of which:Leased from DHSC group bodies £000
Undiscounted future lease payments payable in:		
- not later than one year;	6,978	4,603
- later than one year and not later than five years;	23,371	16,352
- later than five years.	4,890	395
Total gross future lease payments	**35,239**	**21,350**
Finance charges allocated to future periods	(3,920)	(2,086)
Net lease liabilities at 31 March 2026	**31,319**	**19,264**
Of which:		
- Current	6,978	4,603
- Non-Current	24,341	14,661

	Total '31 March 2025 £000	Of which:Leased from DHSC group bodies £000
Undiscounted future lease payments payable in:		
- not later than one year;	6,400	4,628
- later than one year and not later than five years;	23,445	18,481
- later than five years.	5,715	2,149
Total gross future lease payments	**35,560**	**25,258**
Finance charges allocated to future periods	(4,309)	(2,969)
Net lease liabilities at 31 March 2026	**31,251**	**22,289**
Of which:		
- Current	5,194	3,673
- Non-Current	26,057	18,616

The Foundation Trust leases various premises, to accommodate community services and administrative functions at market rates for periods up to 25 years, with a net liability of £23.3m (£26.4m, 2024/25).

Leased equipment comprises complex medical equipment used in the delivery of healthcare £6.1m (£4.8m, 2024/25).

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 Northern Care Alliance 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, Northern Care Alliance 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 (£12.6m in year and £12.1m, 2024/25).

Sterile Services Decontamination Unit (SSDU)

In this joint working arrangement with Northern Care Alliance 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 Northern Care Alliance NHS Foundation Trust, for its share of SSDU-related expenditure (£3.2m in year and £2.8m, 2024/25).

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 £0.6m (£0.6m, 2024/25).

Note 15 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	1,180	1,444
Consumables	1,515	2,041
Energy	140	144
Other	145	176
Total inventories	**2,980**	**3,805**

Inventories recognised in expenses for the year were £35.9m (£35.2m, 2024/25).

Note 16 Trade and other receivables

Note 16.1 Trade and other receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables invoiced/non-invoiced	18,671	15,006
Allowance for impaired contract receivables	(1,245)	(1,458)
Prepayments (non-PFI)	4,450	4,813
Interest receivable	148	157
VAT receivable	1,469	783
Other receivables	1,015	1,545
Total current trade and other receivables	**24,508**	**20,846**
Non-current		
Allowance for impaired contract receivables	(51)	(37)
Other receivables	851	825
Total non-current trade and other receivables	**800**	**788**
Of which receivables from NHS and DHSC group bodies:		
Current	12,004	7,272
Non-Current	608	674

Note 16.2 Allowances for credit losses - 2025/26

	Contract receivables and contract assets £000
Allowances as at 1 April 2025 - brought forward	1,495
New allowances arising	45
Reversals of allowances	(165)
Utilisation of allowances (write offs)	(79)
Allowances as at 31 March 2026	**1,296**

Note 16.3 Allowances for credit losses - 2024/25

	Contract receivables and contract assets £000
Allowances as at 1 April 2024 - brought forward	1,592
New allowances arising	478
Reversals of allowances	(173)
Utilisation of allowances (write offs)	(402)
Allowances as at 31 March 2025	**1,495**

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.

	2025/26 £000
At 31 March 2025	**18,070**
Net change in year	(1,459)
At 31 March 2026	**16,611**
Broken down into	
Cash in hand	6
Cash with the Government Banking Service	16,605
Total cash and cash equivalents	**16,611**

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 note 18. 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 2026 £000	31 March 2025 £000
Monies held on behalf of patients	0	0
Consignment inventories	14,200	10,169
Total third party assets	**14,200**	**10,169**

Note 19 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	14,623	14,010
Capital payables	5,790	4,373
Accruals	18,486	24,598
Receipts in advance	462	8
Social security costs	4,126	3,400
Other taxes payable	3,984	3,634
PDC dividend payable	0	0
Pension contributions payable	4,701	4,467
Other payables	1,771	3,858
Total current trade and other payables	**53,943**	**58,349**
Of which payables to NHS and DHSC group bodies:		
Current	4,549	4,258

Note 20 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income : contract liabilities	7,300	8,173
Total other current liabilities	**7,300**	**8,173**
Non-current		
Deferred income : contract liabilities	0	0
Total other non-current liabilities	**0**	**0**

Note 21 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Loans from the Department of Health and Social Care	827	832
Other loans*	582	581
Lease liabilities	6,978	5,194
Total current borrowings	**8,387**	**6,607**
Non-current		
Loans from the Department of Health and Social Care	8,427	9,195
Other loans*	290	872
Lease liabilities	24,341	26,057
Total non-current borrowings	**33,058**	**36,124**

*Other loans relate to public sector energy efficiency loans with Salix Finance Limited. These loans are interest-free and have financed a number of energy-saving schemes throughout the Foundation Trust. Repayments are phased to match the projected savings from the schemes. Details of the loans from the Department of Health and Social Care are detailed in Note 26.

Note 22 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Lease Liability £000	Total £000
Carrying value at 31 March 2025	**10,027**	**1,453**	**31,251**	**42,731**
Cash movements:				
Financing cash flows - payments and receipts of principal	(769)	(581)	(5,772)	**(7,122)**
Financing cash flows - payments of interest	(218)	0	(1,449)	**(1,667)**
Non-cash movements:				
Additions	0	0	5,007	**5,007**
Lease liability remeasurements	0	0	833	**833**
Change in effective interest rate	214	0	1,449	**1,663**
Carrying value at 31 March 2026	**9,254**	**872**	**31,319**	**41,445**

Note 23 Provisions

	Total £000	Other legal claims £000	Pensions: injury benefits £000	Other £000
At 1 April 2025	3,013	241	1,403	1,369
Change in the discount rate	(109)	0	(61)	(48)
Arising during the year	813	149	81	583
Utilised during the year	(386)	(93)	(114)	(179)
Reversed unused	(583)	(77)	0	(506)
Unwinding of discount	74	0	34	40
At 31 March 2026	**2,822**	**220**	**1,343**	**1,259**
Expected timing of cash flows:				
- not later than one year;	503	220	115	168
- later than one year and not later than five years;	1,138	0	530	608
- later than five years.	1,181	0	698	483
Total	**2,822**	**220**	**1,343**	**1,259**

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 2026, £155.5m was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (£153.4m, 2024/25).

Note 24 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Amounts recoverable against liabilities	(45)	(54)
Net value of contingent liabilities	(45)	(54)

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 2026	31 March 2025
	£000	£000
Property, plant and equipment	1,856	2,844
Leases	0	1,906
Total	**1,856**	**4,750**

Contractual capital commitments mainly relate to committed expenditure in respect of the Foundation Trust's development of thatres 5 and 6, surgical admisions lounge and a pharmacy robot.

Note 26 Financial Instruments

Note 26.1 Financial risk management

Liquidity risk

The Foundation Trust’s net operating costs are incurred under annual service level agreements/contracts with and Integrated Care Boards (ICBs) which are financed from resources voted annually by Parliament. The Foundation Trust received income from its commissioners via API Contracts. Monthly payments were received from the ICB and NHS England based on these funding arrangements and this reduced liquidity risk.

The Foundation Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form. Liquidity is monitored by the Board on a monthly basis 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 one energy efficiency loan with Salix Finance Limited which is interest-free and has been invested in energy-efficiency saving schemes. The savings from these schemes are matched to the loan repayment and therefore there is no risk of 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 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 £19.1m (£15.5m, 2024/25) 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 2026**	**31 March 2025**
	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	19,060	15,495
Cash and cash equivalents at bank and in hand	16,611	18,070
Carrying values of financial assets as at 31st March	**35,671**	**33,565**

Note 26.3 Carrying value of financial liabilities

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2026	
Loans from the Department of Health and Social Care	9,254
Other borrowings	872
Obligations under leases	31,319
Trade and other payables excluding non financial liabilities	40,670
IAS37 provisions which are financial liabilities	2,822
Total at 31 March 2026	**84,937**

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2025	
Loans from the Department of Health and Social Care	10,027
Other borrowings	1,453
Obligations under leases	31,251
Trade and other payables excluding non financial liabilities	46,495
IAS37 provisions which are financial liabilities	3,013
Total at 31 March 2025	**92,239**

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 2026 £000	31 March 2025 £000
In one year or less	49,704	55,510
In more than one year but not more than five years	28,510	28,586
In more than five years	11,870	13,892
Total	**90,084**	**97,988**

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.

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Overpayment of salaries	4	2	4	4
Bad debts and claims abandoned	77	77	98	391
Stores losses and damage to property	11	33	15	44
Total losses	**92**	**113**	**117**	**439**
Ex-gratia payments	59	162	48	66
Total special payments	**59**	**162**	**48**	**66**
Total losses and special payments	**151**	**275**	**165**	**505**

Note 28 Transfers by absorption

There were no transfers by absorption during the year.

Note 29 Related party transactions

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. NHS Improvement (NHSI), does not prepare group accounts; instead, NHSI prepares NHS Foundation Trust Consolidated Accounts, for further consolidation into the Whole of Government Accounts. NHSI has powers to control NHS Foundation Trusts, but its results are not incorporated within the consolidated accounts, and it cannot be considered to be the parent undertaking for Foundation Trusts. Although there are a number of consolidation steps between the Foundation Trust's accounts and Whole of Government Accounts, the Foundation Trust's ultimate parent is HM Government.

Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they fall under the common control of HM Government and Parliament. The Foundation Trust's related parties therefore include Department of Health and Social Care as the parent company, other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies, non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Foundation Trust has had a number of transactions with WGA bodies. Where the total transactions with a given counterparty are collectively significant, they are listed below. The Foundation Trust's related parties therefore include other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Foundation Trust has had a number of transactions with WGA bodies. Listed below are those entities for which the total transactions or total balances with the Foundation Trust have been collectively significant or potentially material to the other body.

In line with DHSC Group Accunting |Manual guidance, transactions with WGA odies are not disclosed by value.

NHS Greater Manchester Integrated Care Board	NHS England
HM Revenue and Customs	NHS Resolution
Wigan Metropolitan Borough Council	NHS Business Services Authority

Public dividend capital (PDC) transactions with the Department of Health and Social Care

The Foundation Trust made PDC dividend payments to the Department of Health totalling £4.6m (£5.5m, 2024/25), and is reporting a year-end PDC receivable totalling £0.3m (£0.5m PDC payable, 2024/25).

Provision for impairment of receivables - related parties

No related party debts have been written off by the Foundation Trust during the year.

Charitable related parties

Wrightington, Wigan and Leigh Health Services Charity (charitable fund with registered charity number 1048659) is a subsidiary of the Foundation Trust and therefore a related party. The Foundation Trust is the Charity's Corporate Trustee which means that the Foundation Trust's Board of Directors is charged with the governance of the Charity. The Charity's sole activity is the funding of charitable capital and revenue items for the benefit of our patients and staff.

The Charity's balance as at 31 March 2026 was £997k (£1,232k, 2024/25) with net incoming resources before transfers of £286k (£289k, 2024/25).

During the year the Charity incurred expenditure of £491k (£324k, 2024/25) in respect of goods and services for which the Foundation Trust was the beneficiary.

Other related parties

The Foundation Trust has interests in 3 joint operations with related parties as disclosed in Note 14 and has a related party relationship with NHS Shared Business Service.

Key management personnel

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.

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 the Foundation Trust.

One Non- Executive Director was Director of Place at NHS Cheshire and Merseyside ICB during the year and a Governer at Edge Hill University.

During the year the Trust recognised income of £0.4m (£0.3m, 2024/25) and incurred expenditure of £1.2m (£1.3m, 2024/25) with Edge Hill University.

All transactions were conducted in the ordinary course of business and on non commercial terms.

Note 30 Events after the reporting date

Following the governments commitment in February 2026 to deliver a fairer deal for nursing, NHS England issued a formal directive in June 2026 instructing all Trusts to undertake a comprehensive review of all band 5 nursing roles under the Agenda for Change contract.

The Trust is required to submit a job evaluation delivery plan by the 31st July 2026 and will have reviewed all affected roles by October 2028. The review may result in the re-banding of certain nursing roles from band 5 to band 6 which will result in a liability to the Trust. It is not possible at this stage to reliably estimate the financial impact, and no provision has been made within these financial statements. It should be noted that any eventual increase in costs are expected to be met by an uplift in the NHS Payment Scheme.

Further information

If you have any queries regarding this report, or wish to make contact with any of the directors or governors, please contact Katharine Dowson, Director of Corporate Governance and Company Secretary, using the contact details below:

Email

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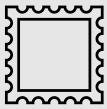

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