Wrightington, Wigan and Leigh Teaching Hospitals

NHS Foundation Trust

Annual Report and **Accounts 2021/22**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Annual report and accounts 2021/22

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

Contents

Opening remarks from the Chair

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

Although I took up post formally in November, I spent six months before this working with my predecessor, Robert Armstrong, to ensure a smooth handover. I will forever value this time because it meant that I could get out and about, meeting our patients and our people, visiting our sites, our NHS neighbours, and our partner organisations. That six months helped me to really appreciate what working for and receiving care from WWL is like. I am grateful to Robert for his support and wise counsel during our handover period and I wish to pay tribute to both his leadership and his many years of service to WWL.

I believe that WWL is a unique and special place. We have extremely close links with the local communities that we serve and our orthopaedic centre in Wrightington is nationally recognised as a centre of excellence. WWL is the largest employer in Wigan and, through our apprentice programmes and close link with Edge Hill University, we are helping to create career opportunities for local people. I regard it as a privilege to hold a leadership position in such an important organisation for the Wigan Borough.

At the start of this year, we agreed our vision for the 20s in the form of *Our Strategy 2030*. This sets out our vision for WWL to be a provider of excellent health and care services for our patients and the local community. Key in improving patient health will be to continue to prioritise the wellbeing of our colleagues through our *Our Family, Our Future, Our Focus* programme which builds on evidence that teams which deliver the best care and outcomes for patients are those in which colleagues feel supported, respected and valued. In this, we are committed to reducing inequality on the grounds of ethnicity, socio-economic background, sexual orientation and other aspects of diversity.

We are committed to improving, integrating and innovating so that, with ‘good’ as our baseline, we will ensure a continuous drive from good to great to outstanding as an organisation over the coming years.

At the time of writing, the Health and Care Act 2022 has just received Royal Assent. This legislation has been described as the most significant health legislation in a decade and aims to tackle backlogs caused by the COVID-19 pandemic, harness the best ways of working and ensure that people benefit from more joined-up care. One of the most fundamental changes is the fact that every part of England will now be covered by an integrated care system (ICS) which brings together NHS, local government and wider system partners to put collaboration and partnership at the heart of healthcare planning. For WWL, this means that we will continue to work as part of a Greater Manchester collaborative, but this will now have a more formal, statutory function. A key component of the new legislation is place-based leadership, which is based on collaboration between organisations which are responsible for arranging and delivering health and care services locally and, in Wigan, our place-based arrangements will be chaired by the Chief Executive of Wigan Council.

In Wigan, we are used to working together and there is a track history of local authority, health and social care, community and voluntary organisations working in partnership and we welcome this new approach. As a member of Wigan’s place-based leadership, we will continue to play our part in making the vision of improved health and wellbeing and smoother patient journeys for our communities a reality for our patients and population.

Working together is a key element of the new vision for the NHS. I am privileged to lead a board which is made up of high calibre executive and non-executive directors, who work together as a unitary board to lead this organisation and who collaborate with colleagues from other organisations to share best practice and to learn from others. I thank them for all that they do each day for WWL.

We are supported in this by our Council of Governors, which represents the interests of our members and the public. Comprised of elected representatives from across our footprint and appointed representatives from our partners, our governors help to ensure accountability at a local level.

My final and most important note of thanks, however, goes to our people who are at the beating heart of our organisation. Wherever you work and whatever you do, WWL would not be what it is without you and I offer you my personal thanks for all that you do to provide the best possible care to our patients. You are seen and it is appreciated.

Mark Jones
Chair

20 June 2022

PERFORMANCE REPORT.

PERFORMANCE REPORT

Performance overview

The purpose of this overview of performance is to provide information on our organisation, its history and purpose. The Chief Executive also presents his perspective on our performance during the financial year 2021/22 and describe the key issues, opportunities and risks as determined by the board.

Who we are

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust is a medium-sized acute and community foundation trust in the North West of England, within the Greater Manchester footprint. On 1 April 2020 we changed our name to Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust to reflect our commitment to education and training, as the first step towards our overarching aim of achieving university teaching hospital status in the future. We are registered with the Care Quality Commission without conditions and they rated us as “Good” at our last inspection. NHS Improvement has also judged our use of resources to be “Good”.

We serve a local population of 326,000 and we provide specialist services to a much wider regional, national and international catchment area. We provide our acute clinical services from our five main sites: Royal Albert Edward Infirmary, Wrightington Hospital, Leigh Infirmary, Thomas Linacre Centre and Boston House. Our community services are provided from a range of locations across the borough.

Royal Albert Edward Infirmary is our main district general hospital site and is located in central Wigan. Here you will find our Accident and Emergency department as well as the majority of our in-patient services. There has been a hospital on this site since 1873 and it was named after the then-Prince of Wales who officially opened it in 1875.

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

Leigh Infirmary is an outpatient, diagnostic and treatment centre in the south of the borough. Thomas Linacre Centre is a dedicated outpatient centre in central Wigan and Boston House is a specialist ophthalmology unit, again in central Wigan.

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

Review of the year

As always there is much to be proud of at WWL this year. During the year we have come together – in WWL, in Greater Manchester and across the nation as a whole – to deal with the challenges faced

by the global COVID-19 pandemic and in the recovery period which follows. Our people responded in ways we could never have foreseen, and we are unbelievably proud of each and every one of them.

The usual metrics around access to services and quality are not directly comparable with previous years because of the unprecedented circumstances over the last two years and we ask that you bear this in mind when considering our performance.

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

Access headlines	▪ **76.53%** performance against the Accident and Emergency four-hour wait target (target 95%; 2020/21: 87.48%) ▪ **75.29%** performance against two-week wait from referral to date first seen for all urgent cancer referrals (target 93%; 2020/21: 74.58) ▪ **61.01%** performance against the 18-week referral-to-treatment pathway (target 92%; 2020/21 59.33%) ▪ **78.62%** performance against 6-week diagnostic standard (target 99%; 2020/21: 67.74%)
Quality headlines	▪ **1** MRSA bacteraemia during the year (target 0; 2020/21: 2) ▪ **53** *C. difficile* infections against a target of 46, with **15** attributable to lapses in care (2020/21: 43 with 13 attributable to lapses in care) ▪ **2** never events against a target of 0 (2020/21: 1) ▪ Hospital Standardised Mortality Rate (HSMR) of **89.28** for the period January 2021 to December 2021 (average is 100) (Jan to Dec 2020: 102.47)

As you will see from the staff report which begins on page 63, we place great importance on supporting our colleagues and we want to be an employer of choice in the local area. We take feedback from our workforce seriously and we undertake quarterly surveys to seek feedback. We have provided an analysis of the results of this year's national staff survey later in this report.

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

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

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

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

Principal risks faced and impact

Throughout the year, the main risk to the organisation was the impact of COVID-19 on day-to-day operations and on our elective recovery programme. Social distancing requirements continued to impact on us, and we had to take a difficult decision to suspend inpatient visiting. We continued working by videoconference wherever possible to reduce the need for face-to-face contact, conducting virtual clinics for our patients and transacting business online.

For more information on how we manage risk within the foundation trust, including the detail of the key risks that the organisation was exposed to during 2021/22 and those identified for 2022/23, please see the Annual Governance Statement which begins on page 88.

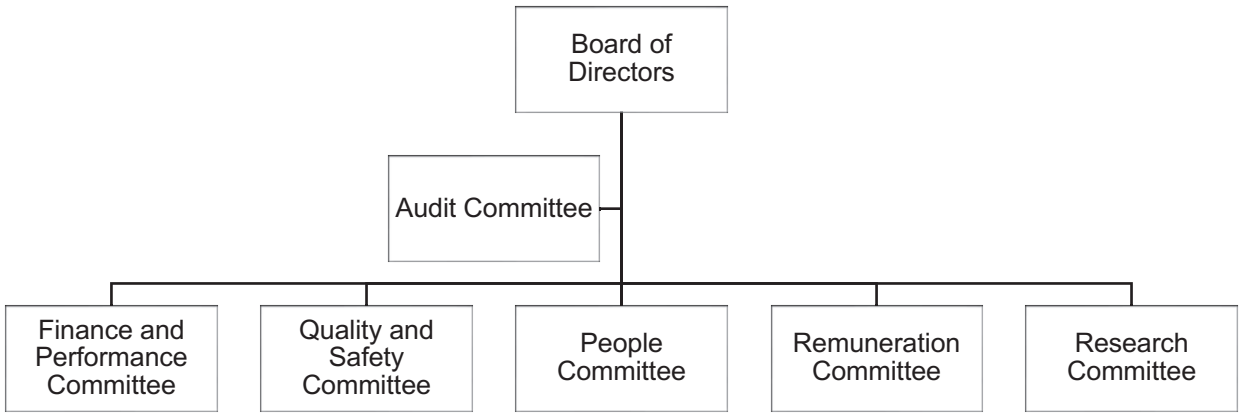
Silas Nicholls
Chief Executive and Accounting Officer

20 June 2022

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 40 to 43.

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



Audit Committee

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

Finance and Performance Committee

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

Quality and Safety Committee

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

People Committee

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

Remuneration Committee

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

Research Committee

Responsible for oversight of our research activities and seeking assurance around delivery of the Research Strategic Plan. A new committee this year, established as part of our wider ambition to become a university teaching hospital.

The Council of Governors, made up of elected governors from our public and staff membership and appointed governors from our key stakeholders, has a number of statutory functions and two general duties – to represent the interests of members and the general public and to hold the non-executive directors to account for the performance of the board. More information on the Council of Governors is available on page 79.

Our Company Secretary provides corporate governance leadership, advice and support to both the board and the council. The Company Secretary 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.

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 clinical care across four divisions, each headed by a divisional triumvirate comprising a Divisional Medical Director, a Director of Nursing and a Director of Operations. Other services are provided through our corporate and estates and facilities teams.

We employ 6,427 members of staff, all of whom play their part in delivering high quality, safe and effective patient care. Our quality report will be published separately this year 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 Company Secretary; please use the contact details on page 155.

Summary of our operational activity

The table below summarises our activity during 2021/22, and the figures for 2020/21 are provided for comparison:

		2021/22	2020/21
Referrals	GP	77,942	58,293
	Other	93,762	69,578
	Total	**171,704**	**127,871**
In-patient activity	Elective/planned	6,075	2,903
	Day cases	30,526	20,717
	Non-elective	39,017	37,719
	Total	**75,618**	**61,339**
Outpatient activity	New appointments (attendances)	131,963	104,616
	Follow-up appointments (attendances)	335,246	276,315
	Total	**467,209**	**380,931**
Accident and emergency	**Total**	**110,653**	**86,118**
Walk-in centre	**Total attendances**	**46,317**	**25,513**

Please note that direct comparison with the prior year is not possible due to the varying impact of COVID-19.

Social, community and human rights issues

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

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

We have anti-fraud policies in place and further information is available within the staff report which begins on page 63 and within the annual governance statement which commences on page 88.

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

Equality of service delivery to different groups

As an NHS organisation, we aim to provide our services to all groups equally. We are subject to the public sector equality duty, which was introduced as part of the Equality Act 2010 and requires NHS organisations to eliminate unlawful discrimination, advance equality of opportunity and to foster good relations. We do this in different ways:

- Our patient information leaflets are available online, in hard copy and can be provided in different formats such as large print, braille and in various languages
- We provide access to face-to-face British Sign Language interpreters which is available in our Emergency Department on a video remote access basis
- Our online appointment booking webpage and telephone operators seek information about communication or other information needs

We have also implemented the Equality Delivery System (EDS2) set out by the Department of Health and Social Care. Every year we are required to assess our performance against EDS2 and we review a number of outcomes each year to ensure that we look at all outcomes over a period of time. The EDS2 toolkit is structured around four goals, two of which relate to patients and two which relate to workforce. There are a total of 18 specific outcomes across these four areas and for each outcome there are four possible grades:

- *Underdeveloped* – people from all protected groups fare poorly compared with people overall
- *Developing* – people from only some protected groups fare as well as people overall
- *Achieving* – people from most protected groups fare as well as people overall
- *Excelling* – people from all protected groups fare as well as people overall

Two service delivery outcomes were last reviewed in March 2020 and the review was informed by the following:

- A report of engagement conducted with Leigh Deaf Club;
- A patient experience survey conducted with the Wigan Pride team;
- A review of the Urgent and Emergency Care Survey undertaken by the Picker Institute;
- A report entitled “A week in A&E” undertaken by Healthwatch Wigan and Leigh;

- A review of equality impact assessments; and
- A review of the results of a black, Asian and minority ethnic group patient experience survey relating to cancer services

The review found that we were achieving the requirements in relation to services being designed and delivered to meet the health needs of local communities and that we were developing in relation to handling complaints respectfully and efficiently.

The review highlighted areas of good practice, such as the availability of a mental health urgent response team and direct access to the learning disability liaison team as well as a dedicated Independent Domestic Violence Advisor role. In response to the feedback we received, we have introduced long-range pagers in the Emergency Department for hearing impaired patients who cannot always hear their name being called. We have also designed a dedicated form in collaboration with the local deaf community, which means that the local deaf community know what questions the receptionist is going to ask and can provide these on the form when they attend.

Our Emergency Department also offer regular tours of the department for people with learning difficulties and their families so that they are familiar with the department in case they have to attend. A learning disability link nurse also participates in these visits and will work with patients with learning disabilities and autism if they need to attend for elective procedures or outpatient appointments. They can also produce bespoke paperwork for these patients to help them actively participate in their care and for patients with more complex needs, multidisciplinary planning meetings take place to reduce the likely distress of visiting the hospital.

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

Financial performance

A number of the changes introduced to the NHS financial regime at the beginning of the COVID-19 pandemic continued in to and through the 2021/22 financial year, namely:

- NHS organisations function within wider care systems, for the Trust this is the Greater Manchester care system.
- The payment by results (PBR) funding mechanism for Providers remained suspended, replaced by a predominantly fixed funding allocation.
- Restraints on the value of capital trusts can spend are limited by a threshold called Capital Departmental Expenditure Limit (CDEL).

There was a recognition that expenditure would continue to be incurred aligned to Covid however unlike in the previous year there was set funding as opposed to full recovery and there was an expectation that Covid expenditure would reduce in real terms versus 2020/21. The Trust incurred £11.0m of Covid expenditure in 2021/22 compared with £32.8m the year before.

The Trust is reporting £477.2m of income in 2021/22 and total expenditure of £479.3m therefore a deficit of £2.1m.

£26.3m was spent on capital projects during the year, £17.8m funded via the CDEL threshold, a further £7.5m of funded via central allocations and the balanced donated and disposals.

Income

The Trust generated £477.2m of income in 2021/22 compared with £454.8m in 2020/21; an increase of £22.4m or 5%.

The usual payment by results (PBR) system for clinical income remains suspended and has been replaced by block funding and system top up similar to the funding arrangements during the second half of 2020/21. In 2021/22 the Trust was allocated a fixed funding envelope from the Greater Manchester ICS and there was also additional funding made available from the Elective Recovery Fund (ERF) subject to meeting activity targets. The ERF was set up to incentivise Trusts to restore activity and reduce the waiting list backlog of patients that has been caused by the COVID-19 pandemic.

The increased income of £22.4m compared to 2020/21 can predominantly be explained by a number of items. £25.1m of the increase relates to additional funding from NHS England and Clinical Commissioning Groups (CCG's) to fund inflation, pay awards and also to restore clinical services and reduce waiting lists following the pandemic. Private patient income increased by £2.1m and there was a reduction of £5.1m relating to PPE push stock funding.

Principal and non-principal income

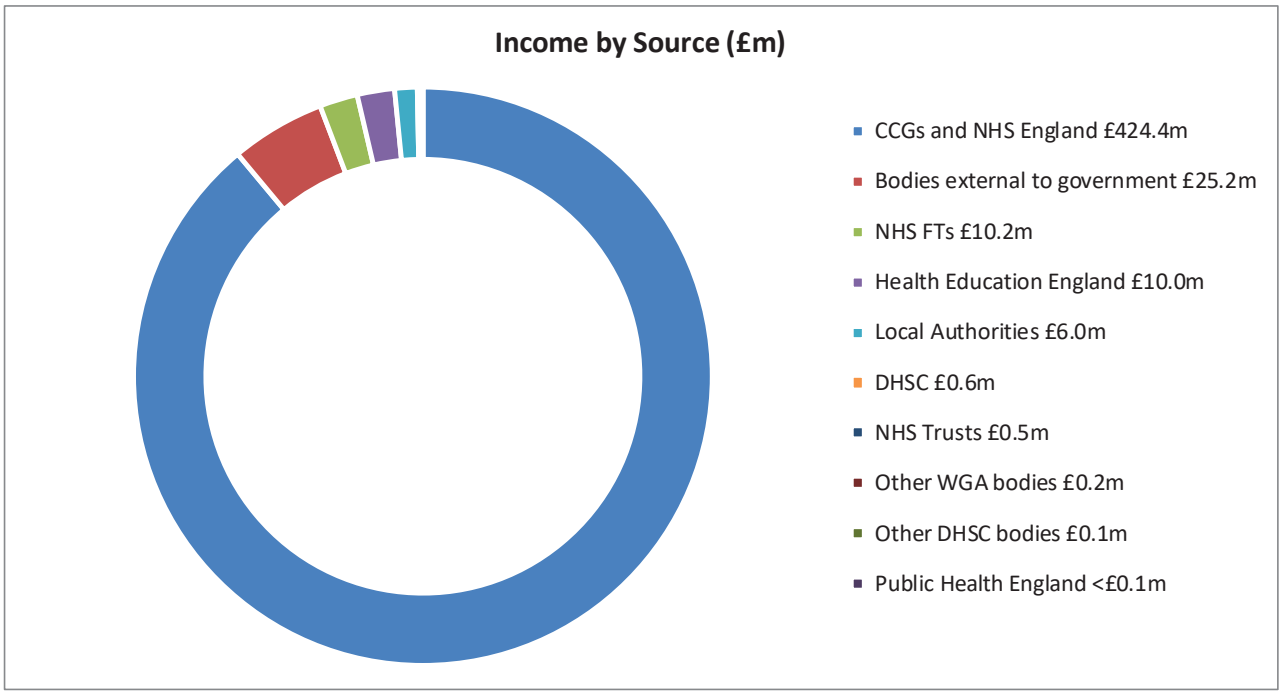
As a Foundation Trust, the income we receive from the provision of goods and services for the purposes of the health service in England (often referred to as our "principal purpose") must be greater than the income we receive from the provision of goods and services for any other purposes (which we have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

	2021/22 £m	2020/21 £m
Non-principal Income	12.8	14.2
Total income	477.2	454.8
Non-principal income as a % of all income	2.7	**3.1**

The directors consider that the income received otherwise than from the provision of goods and services for the purposes of the health service in England has not had an impact on the provision of goods and services for those purposes.

Income by source

The chart below shows the split of our income by source during the year. The majority of income is received from government bodies with only 5.3% of income received from bodies outside of the government.



Income from patient care activities

Income generated from the provision of patient care totaled £451.2m in 2021/22, compared with £383.6 in 2020/21; an increase of £67.6m (17%). £60m of the increase relates to CCG block contract / system funding income. In the first half of the prior year NHSEI provided the Trust with top up funding to break even, and this was coded to other operating income. This top up funding has now ceased and been replaced with block / system allocations from Greater Manchester ICS to fund COVID-19 related pressures, inflation and pay awards which is coded to income from patient care activities. The Trust also received £4.1m of ERF funding for achieving activity restoration targets in H1 but did not meet the increased targets in H2. Wigan Borough Clinical Commissioning Group remains the largest commissioner of services, contributing 56% (£251.5m) of our patient care income compared to 64% (£246.4m) in 2020/21.

Income from patient care (by nature)

	2021/22 £m	2020/21 £m
Acute services		
Block contract/system envelope income	370.0	310.0
High-cost drugs income from commissioners	1.7	0.5
Other NHS clinical income*	11.0	10.1
Community services		
Block contract/system envelope income	40.3	37.6
Income from other sources (e.g. local authorities)	5.8	6.2
Additional income		
Private patient income	4.5	2.4
Additional pension contribution central funding	11.1	10.3
Other clinical income†	6.7	6.5
Total income from patient care activities	451.2	**383.6**

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

† Other clinical income includes income relating to the elective recovery fund, NHS injury recovery scheme, occupational health and cross-border income

Other operating income

Other operating income received for the year was £26m compared to £71.2m in 2020/21, which is a reduction of £45.2m. £40.8m of this reduction relates to system top up and COVID-19 funding that ceased in H1 of the prior year and has been replaced by block contract / system funding and is now coded to income from patient care activities. There was a further reduction of £5.1m relating to PPE push stock funding.

Expenditure

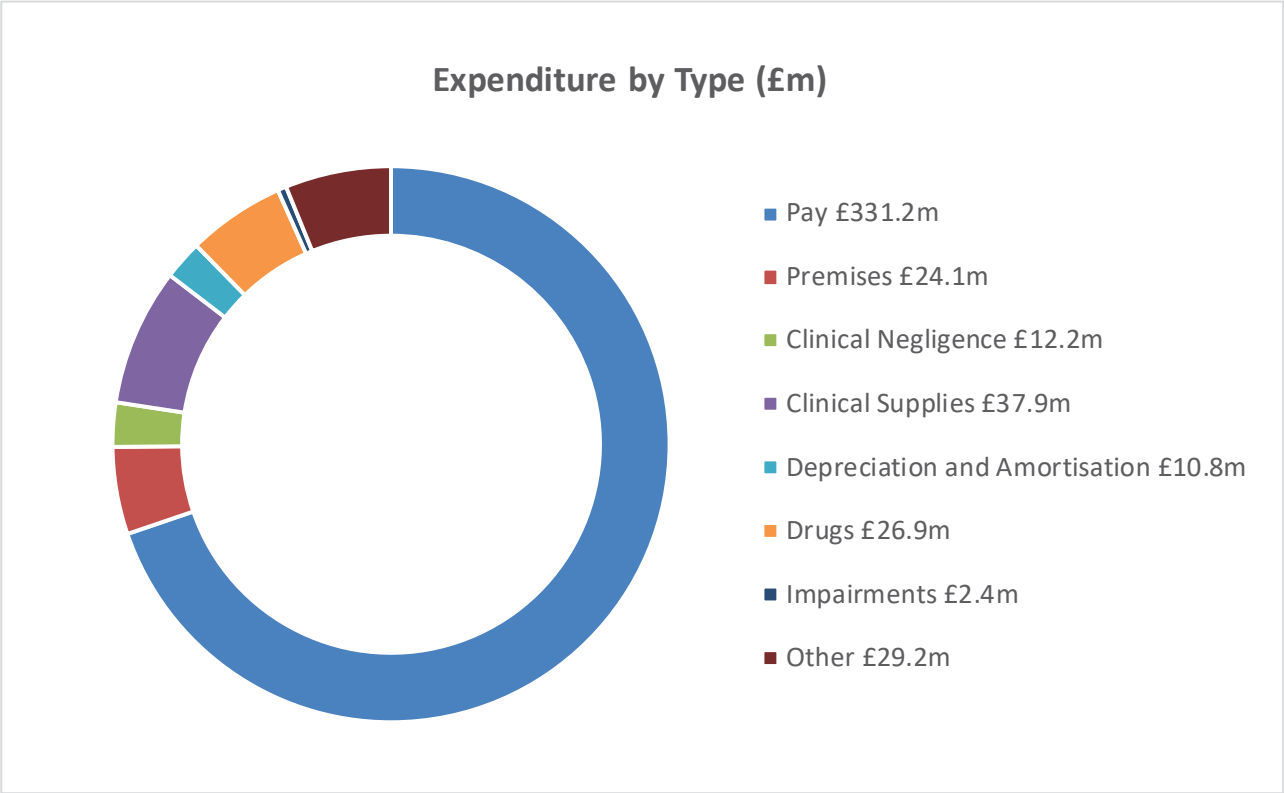
Total expenditure for the year was £479.3m compared to £467.4m in 2020/21, which is an increase of £11.9m (2.5%). There is an increase in pay expenditure of £14.3m which includes pay award and incremental drift of £7.6m. The net increase in temporary staffing expenditure is £5.4m, which includes a reduction in agency expenditure of £2.7m offset by an increase in bank expenditure of £8.2m.

Expenditure attributed to the COVID-19 pandemic was £11m in 2021/22, a reduction of £21.8m from 2020/21. This is offset by an increase in direct expenditure associated with elective activity as activity levels increased during the year.

Pay was the largest expenditure item at £331.2m (2020/21: £316.9m) which is 70% of total expenditure. Within this figure, the amount spent on registered nursing, midwifery and health visiting staff remains the most significant at £94m (2020/21: £90m). Expenditure on medical staff was £79.3m (202021: £80m).

The largest items of non-pay expenditure included £26.9m spent on drugs (2020/21: £22.6m), £37.9m on clinical supplies (2020/21: 37.4m), £12.2m on clinical negligence premiums (2020/21: £11.2m) and £24.1m in premises costs (2020/21: £24.3m). Depreciation and amortisation of £10.8m and net impairments of £2.4m are included in the overall expenditure figure.

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



Cost improvement plans

The financial benefit derived from our cost improvement programme, internally known as service and value improvements, was £2.4m. This was delivered though divisionally led transactional efficiency schemes. The programme was suspended in 2020/21 to allow operational managers to focus on the planning and delivery of our response to COVID-19.

Capital investment programme

During the year we completed £26.3m (2020/21: £35.7m) of capital investments including £0.25m of donated assets (2020/21: £0.7m), which have significantly improved services for both patients and staff. A summary of the capital investments undertaken in the year is provided below:

Capital investment scheme	Investment benefits	£000k
Elective Care Recovery programme	Improvements to the Trust buildings including Theatres at Wrightington, and new medical equipment to assist with the recovery of elective care across the Trust.	4,174
CHIP	A joint initiative with Wigan Borough Council, CHIP is an investment in assets outside of the hospital. This scheme will help stem demand into the hospital and improve the overall health and wellbeing of the locality.	4,084

Capital investment scheme	Investment benefits	£000k
IM&T	The continued development of the Health Information System (HIS) platform providing rapid and seamless access to patient information (software and hardware) and the continued investment in IT systems as part of the Digital Aspirant Programme to raise digital maturity across the Trust sites	6,476
Medical Equipment	The continued investment in medical equipment, including an Orthopaedic Robot for use on the Wrightington Site, and two new Xray rooms at the Thomas Linacre Centre.	4,715
Energy Efficiency Schemes	Purchase and installation of energy efficient heating and lighting systems.	1,354
Site improvements, upgrades and maintenance	Improvements and upgrades to our sites.	5,133
Lakeside Step down facility	Investment in a new ward on the Leigh site which will become a step- down facility for patients discharged from acute wards.	391
	TOTAL (including donated assets):	**26,327**

Going concern

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

Silas Nicholls
Chief Executive and Accounting Officer

20 June 2022

Performance analysis

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

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

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

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

Operational and clinical performance: Division of Medicine

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

- General medicine;
- Unscheduled care, which is further divided into emergency and acute medicine;
- Elderly care and specialist rehabilitation; and
- Therapy services.

The division also incorporates pharmacy services on all sites.

Unscheduled care

Throughout 2021/22, we continued to see an increase in both the number and the acuity of patients admitted through A&E, which contributed to us being unable to maintain the delivery of the 95% 4-hour A&E standard. In 2021/22, average daily attendances equated to 300 patients per day, compared to 216 average attendances per day in 2020/21. Despite the increased demand on A&E throughout the year, we did see an overall reduction in the percentage of patients waiting over 4 hours at the end of the year.

During the year we have taken the opportunity to reset our focus within the Accident and Emergency department and in relation to wider patient flow. We have focused on the following:

- Within the Accident and Emergency department, we have focused on ensuring early ambulance handovers to ensure that we rapidly respond to patients with high clinical need as well as freeing ambulance crews up to attend other calls. As a result, we have seen a continued reduction in the number patients waiting 12 hours or more within the department;

- Across our wards, we have relaunched the SAFER initiative on wards, resulting in a greater number of patients being safely discharged earlier in the day;

- We have continued to focus on delayed transfers of care; and

- We have worked with system partners to emphasise the need to continue to use services appropriately, signposting to other service such as NHS 111, and we have continued to work with local partners to provide community-based services and early intervention to enable patents to be treated outside of the hospital setting when possible.

During 2022/2023 we will work towards further improvements in our 4-hour Accident & Emergency performance, together with an improvement in the reduction of patients waiting 12 hours or more in the department and an improvement in ambulance handover and turnaround times. This will be complemented by the ongoing working with system partners to support safe and timely discharge.

Scheduled Care

Continuing the trend of the last few years, in 2021/2022 we again saw an increase in referrals to many of our scheduled care services.

As a division, we continued our focus on ensuring that new patients who were referred into our services were seen at the earliest opportunity as determined by their clinical need, whilst ensuring existing patients were scheduled appropriately.

For the coming year, the scheduled care teams will continue to focus on ensuring we see patients based on their clinical need, whilst at the same time reducing the waiting lists for our services. We will work with community partners and General Practitioners to support a reduction in the number of referrals to hospital by supporting community-based models of care and further expanding advice and guidance services.

Clinical Governance

Despite the challenges seen throughout 2021/22, positive changes have been made to the division's clinical governance structure to improve the reporting and review of incidents, complaints and mortality to improve patient outcomes. The clinical governance agenda within the division encompasses operational, medical and nursing colleagues as a triumvirate to deliver safe and effective care.

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

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

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

Operational and clinical performance: Division of Surgery

The Division of Surgery is large and diverse, covering areas from community paediatric clinics through to adult and neonatal intensive care.

Although the pandemic undoubtedly caused disruption, 2021/22 remained a successful year for the division. Like others, staffing levels were reduced due to sickness and isolation and further impacted by infection prevention and control requirements.

Our surgical wards have now returned to primarily nursing surgical patients rather than a mixed speciality which was the case during the pandemic. Langtree and Orrell wards are now designated as 'green wards' to accommodate elective surgery and Swinley ward remains an 'amber ward' to accommodate surgical patients from the surgical ambulatory emergency care unit, the emergency gynaecology clinic and A&E that do not yet have a negative swab result. This has allowed the division to commence its elective recovery programme.

Going forwards, the division is looking at how the latest infection prevention and control directives can be used for a better flow of patients to enable the recovery programme further. In the last 12 months it has been agreed that all ward leaders will have supernumerary status to allow them to focus on quality improvement. Each of the surgical wards had their accreditation visit in March 2022.

Although physical capacity was reduced on the Royal Albert Edward Infirmary site, we were still able to focus on our most clinically urgent patients, including cancer pathway patients. Day case capacity was also made available through being able to use both the Leigh Infirmary and Wrightington Hospital sites. The division has also worked closely with the independent sector to secure additional capacity that allowed the transfer and treatment of numerous patients. We have also worked closely with Bolton NHS FT and this has seen a reciprocal arrangement with some oral surgery paediatric cases being undertaken in Bolton, and some of their adult cases being undertaken by WWL.

Although the overall elective waiting list has grown over the year as a result of reduced capacity, our longest waiting patients have reduced significantly such that there were only a few waiting over 104 weeks by the end of the year. We are forecasting that there will be no patients waiting over this time by the end of June 2022.

There have been a number of developments and quality improvements highlighted below.

General, Colorectal and Urology surgery

There have been a number of significant capital investments over the past 12 months, including:

- Same Day Emergency Care Unit. This has actively supported admission avoidance and patient flow by ensuring early clinical review and uses the successful 'hot clinic' approach, as well as dedicated clinical pathways;
- Intensive Care Unit/High Dependency Unit – capital work allowing us to redevelop part of the unit to allow greater flexibility especially when it comes to infection status of patients. Business case approval allowed us to admit up to 11 ICU patients rather than the previous 9, thus making it easier to respond to the increased demands that we have seen;

- Refurbishment of theatres 1 and 2, along with reception areas to increase the waiting area which will allow for greater throughput; and
- Procurement of an electrical anaesthetic system that allow us to easily link data from the pre-operative part of a patient journey to data that is generated in the intra-operative part of their journey to data extracted from events/observations that subsequently happen on the ward.

Other developments include:

- Introduction of consultant 'hot' weeks in general surgery, that allows continuity of care throughout the week;
- Appointment of additional colorectal consultants and a review of the entire pathway, resulting in a reduced waiting list as well as overall reduced waiting times and quicker access to theatre; and
- Appointment of a fifth urology consultant and successful business case for a sixth which will help facilitate the expansion of the current on-call arrangements with Bolton FT from the current alternative weekends 'on-call' to a full week.

Head and neck surgery

Throughout the pandemic, patients requiring breast surgery have been able to receive their care at Wrightington Hospital. During the last wave we were also designated as a Breast Hub, with the ability to create capacity for our fellow Greater Manchester organisations should it be required.

We have now recruited into our current orthodontic vacancy as well as increasing the clinical capacity available in oral surgery and orthodontics which will help us to address the backlog. Within paediatric oral surgery, we have introduced a sedation service that has helped to reduce the waiting list and reduced the pressure on theatres whilst also giving patients more choice for treatment.

In the ear, nose and throat surgery team, the backlog in outpatients grew throughout the pandemic as a result of the reduction in the numbers of patients that could be seen. The team has now been able to recruit a speciality doctor from overseas to help reduce waiting times.

All emergency ophthalmology clinics and sight treating services have been fully supported. We have recently recruited into one of the consultant vacancies and we have collaborated with Alder Hey Hospital to ensure that they remain able to operate on any children requiring surgery.

Maternity services

We were successful in achieving compliance against the CNST Maternity Incentive Scheme year 3, having successfully complied with all 10 safety actions resulting in the recovery of the additional 10% contribution and a share of unallocated funds.

We have also been working towards compliance with all of 7 Ockenden immediate and essential actions in place. Following on from Ockenden Part 1, the service received funding to increase recruitment and retention within maternity. We have successfully recruited against these funds however there still remains a staffing shortfall due to staff attrition and active recruitment remains ongoing.

A digital midwife has been appointed to lead on the digital maternity agenda and we also received significant funding from the Digital Maternity Fund which has been utilised to enhance and upgrade our existing Maternity Information System. A perinatal mental health midwife is now in place to support and improve the quality of maternity services and to support the development and

implementation of integrated pathways of care for women with perinatal mental illness. We have also maintained gold standard Baby-Friendly Accreditation this year.

Child health

Our neonatal services have been successful in receiving funding from the Neonatal Critical Care fund to recruit five more nurses, which will allow for a Supernumerary Shift Coordinator on each shift and an enhanced structure for career progression within the unit.

The Assisted Conception Unit, based at Wrightington Hospital, continues to develop and widen the availability of services to the local population and surrounding areas. A number of new choose and book clinics are planned or have been established in the Lancashire and Fylde areas to increase our market share regionally.

We have successfully appointed a substantive consultant community paediatrician. This will increase capacity to address new and follow up patient backlogs. We have also successfully secured significant non-recurrent funding to support additional capacity to address increased demand and improve waiting times around autism.

Our paediatric outpatient activity was largely maintained throughout the pandemic, primarily through the use of virtual appointments. We have now increased the number of face-to-face appointments and we are reintroducing registrars into clinics to minimise multiple visits for patients and to maximise capacity and throughput.

Healthcare operations

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

- Digitisation of the Health Information System across outpatient settings;
- Implementation of digital letters and the reintroduction of SMS appointment reminders in partnership with Dr Doctor;
- Procurement and implementation of new call centre technology in the Leigh Appointment Centre;
- Assistance with procurement for a new telephony system for switchboard;
- Support for specialties with the Patient Initiated Follow-up programme of work; and
- Coordination of a large number of patients transferring to the independent sector for treatment.

Operational and clinical performance: Specialist Services Division

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

- Trauma and orthopaedics;
- Rheumatology;
- Radiology;

- Outpatients;
- Oncology (Cancer Services);
- Dermatology;
- Medical Illustrations; and
- Private Patients and Overseas Visitors

The provision of safe, effective care remains a top priority within the division. It continues to embed clinical governance processes throughout all its services and the Specialty Governance Groups and the Divisional Quality Executive Group work hard to ensure the success of this. These groups have a comprehensive work programme which allows scrutiny and monitoring of key areas, including: incidents; compliments, concerns and complaints; risks and potential risks; lessons learnt and areas of good practice and improvement.

2021/22 has been a busy year for clinical governance in the division, with a review of all divisional processes being undertaken and the realignment of divisional meetings to enable a more streamlined approach and reduce repetition. The division has developed a comprehensive monthly governance report which allows the review of all information supporting safe, effective care in a more efficient and robust manner.

All inpatient and outpatient areas in the division were successful at attaining bronze level in the Aspire ward accreditation programme before COVID-19. This provided assurance that each area had met the standards set out in our organisational assessment framework and was a great achievement. Work continues in order to maintain these standards, with planned reassessments to maintain bronze status and progress towards silver accreditation in the months ahead.

SafeCare rostering allows the division to review safe staffing across its ward areas, to ensure the needs of patients are met by reassessment of staffing and acuity of patients throughout the day and night. During the pandemic, a large number of the division's nursing and therapy staff were redeployed to support the pandemic response which displaced staff from their usual role and environment. As we recover, our focus on staff wellbeing is more important than ever and although acknowledging the improved staff survey results in the last quarter of the year, the division will continue to explore and work with staff to enable a positive work environment and to respond to the themes within the survey.

The division recognises the importance of patient feedback and this is actively encouraged. It continues to work closely with the patient relations team to support training, improve communications and learn lessons. As a result, we now actively make contact on first receiving a complaint to understand the concerns and to de-escalate where possible.

Radiology

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

- General x-ray
- Computerised Tomography (CT)
- Ultrasound
- Nuclear medicine
- Magnetic Resonance Imaging (MRI)

- Breast screening and diagnostic
- Vascular and non-vascular interventional radiology

Demand for diagnostic imaging continues to grow and we currently undertake over 320,000 examinations of increasing complexity per year. Performance against the 6-week referral to examination target of 99% was achieved in the initial COVID-19 recovery phase, although this has subsequently deteriorated due to increasing demand for diagnostics as speciality services enact recovery plans.

The department supports clinical training for medical, obstetrics, gynaecology and radiology trainees, including an increasing portfolio of international trainees. There is also an ongoing sonographer training programme to allow for succession planning against a national background shortage of sonographers. Excellent feedback is received from trainees and the department has been nominated first across the Manchester deanery for radiologist ultrasound training. A dedicated ultrasound training hub has also been opened at Leigh Infirmary in collaboration with the University of Cumbria.

Radiographers who undertake general radiography training now rotate across three, and in some cases, all four sites to ensure that there is a seamless service provision to match patient demand. Recruitment of radiographers has been a difficulty in a background of national high demand. This position has been challenged by targeting a wide range of recruitment initiatives including international recruitment, apprentice radiographers and development of the undergraduate training programme.

The radiology team is now working more closely with the multi-disciplinary teams at Wrightington Hospital to improve patient flow, promote excellent patient experiences and to continue to improve the service we provide to all areas of the site.

The service has a strong focus on clinical governance. A proactive approach to risk management has allowed the service to operate safely with compliance to regulatory requirements. A positive incident reporting stance permits the team to learn from mistakes and, with the support of the wider governance team, seeks to drive forward improvements and seek opportunities to change systems of work. The directorate governance team meets monthly and has developed a robust system of managing and updating risk assessments, policy documents and patient information leaflets to feed into the wider organisational governance cycle.

Several general X-ray equipment devices across all of our sites were installed more than 10 years ago and we are beginning to experience an increasing number of repairs and maintenance costs to prevent breakdowns. Good progress has been made to replace some of the oldest devices at the Thomas Linacre Centre and Royal Albert Edward Infirmary, although the equipment at Wrightington Hospital needs replacement to meet the demands of an ambitious orthopaedic recovery plan. The replacement of the equipment at Leigh Infirmary has been included in a bid to develop a Community Diagnostic Centre which aims to expand diagnostic capacity. Whilst a steady and planned replacement programme is being undertaken, regrettably high costs will be inevitable over the coming years.

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

to undertake complex procedures and to support the increasing volumes of patients admitted on unscheduled pathways who require CT imaging. To meet the increasing demand for acute CT the service was reconfigured to deliver a 24-hour on-site service which is responsive to the needs of clinicians and patients.

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

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

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

Diagnostic and screening Ultrasound services are provided within Radiology for non-obstetric ultrasound services and Obstetrics including the Foetal Anomaly Screening Service (FAS) for approximately 3,600 deliveries.

Outpatient ultrasound scans are performed cross site over 12 hospital-based scan rooms and within community venues, typically within several GP surgeries across the Wigan Borough. Inpatient examinations are carried out at Royal Albert Edward Infirmary, Leigh and Wrightington Hospital. A range of interventional procedures including biopsies and therapeutic injections are undertaken at the Wigan site and at Wrightington.

Trauma and orthopaedics

The 2021/22 financial year was again challenging for the trauma and orthopaedic directorate.

An increasingly complex case mix, with a higher number of patients requiring more intensive support post operatively was exacerbated by regular downtime due to COVID pressures; overall the current inpatient waiting list is approximately double pre-COVID levels. The current focus is on our longest waiters (104 weeks+) and most urgent P2 patients.

Wrightington was named as a GM Trauma & Orthopaedics Elective Hub in July 2021 which enabled access to an allocation of recovery funding to support increasing activity levels for the remainder of the year. Having been paired up with Bolton NHS Foundation Trust; Wrightington has supported Bolton Consultants to undertake one list per week within our theatres to enhance their capacity. We are also working closely with Tameside to provide mutual aid for some of their longest (104 weeks+) waiters.

In addition, in September 2021; NHS Northwest England Specialised Commissioning Team confirmed that the Trust had been identified as a Major Revision Centre for Knee Surgery. It is a clinically driven programme which has benefited from close collaboration between the British Association for Surgery of the Knee (BASK), the British Orthopaedic Association (BOA) and the Get it Right First Time (GIRFT) team.

There have been some issues with availability of the theatre stock on the Wrightington site, as in addition to the downtime resulting from COVID; we have continued to see operational challenges primarily in our old mains theatres which have continued to cause disruption to the running of planned lists. Staff have worked really hard to mitigate the resulting impact on patients and loss of activity, by flexibly moving between any functional theatres on site which requires significant moving of equipment and deep cleaning often on the day it is due to be used.

Outcomes from the Trauma service continue to be excellent despite ongoing challenges, with the fractured neck of femur (#NOF) mortality rate continuing to be much better than previously. Whilst this is positive, performance against other #NOF metrics has not been as good, particularly in relation to the number of patients arriving on Aspull Ward within 4 hours of presenting at A&E and some significantly busy weeks putting pressure on the time to theatre metric. With a focus on regaining our ringfenced #NOF beds in 22/23; the team continue to work collaboratively across both divisions and sites to manage the flow of patients; with a higher number of ambulatory Trauma patients now receiving their surgery at Wrightington instead of RAEI.

Over the coming year, the division are focused on reducing the number of long waiters; commissioning additional facilities and supporting patients whilst they wait. A number of capital programmes have been identified for the upcoming financial year and beyond which will form part of the wider site redevelopment plans and strategy.

Rheumatology

The Rheumatology team have had a positive year, an additional Nurse Specialist Prescriber has been recruited and is commencing in post late May 2022. We have also benefited from placement of a band 5 International Nurse who has settled in well and continues to learn the specialty. Due to the pandemic and sickness within this small team, severe backlogs related to blood monitoring and the telephone advice line are now within acceptable limits. Repeat prescriptions remain a huge burden on the nursing team but this will improve this year as a result of the additional RNS prescriber coming into post and the recent NMP qualification of an existing member of the team. The team will have more resilience going forward.

The service currently remains closed to out of area referrals due to existing ASI pressures. One substantive Consultant has left the Trust and a locum Consultant is currently in post. The follow up appointment backlog is reducing month on month. Ward 7 has undergone refurbishment to allow privacy and dignity to be maintained as well as slightly increasing ward capacity.

Outpatient services

Outpatient services are provided at four sites and we also support clinics managed by other organisations. All of our outpatient departments have been able to play an active part in the overall recovery programme by facilitating the provision of additional clinics. This has also been aided by the introduction of more virtual clinics during the pandemic, resulting in overall increased performance. The outpatient teams have been challenged by social distancing requirements which have limited the number of patients that are able to be seen face-to-face.

Dermatology and plastics

The development of the new dermatology service model has not gathered pace due to COVID although the communications with Bolton and Salford and relevant CCGs are still ongoing. We are working with the local CCG to improve GP training to try to reduce inappropriate referrals.

We lost two substantive dermatology consultants in 2021 and are struggling to recruit, although the service has employed excellent agency locums as well as an NHS locum Consultant.

Dermatology is currently closed to out-of-area referrals and routine referrals until the waiting list for new patients reduces, and this is now showing positive signs of a month-on-month reduction. Plastics is struggling with the admitted waiting list and St Helen's and Knowsley NHS FT is supporting our cancer surgery patient list whilst we continue to work through our priority 2 and 3 patients. The skin cancer pathway continues to perform well, the majority of patients being seen within 2 weeks and meeting the 31- and 62-day targets.

Private patients and overseas visitors

In line with the remaining elective activity, private patient activity was reduced, and at times ceased, during the year. This led to a reduction in the number of patients seen and treated however, given the greater complexity of cases, the income received exceeded previous years. In general, increasing NHS waiting lists are a driver for patients seeking private care and given the growth in NHS waiting times, a greater number of enquiries were received. Additionally, discussions are ongoing regarding the provision of services to a number of non-NHS commissioners.

The national lockdowns led to a temporary reduction in the number of patients referred to the overseas visitors' office. This, coupled with some short-term increase in staffing, allowed significant progress to be made in addressing a backlog of referrals. The key challenge is to implement a more proactive approach to the management of overseas visitors and, whilst this is a priority, our performance in terms of income collection has seen a significant improvement when compared with others and is ahead of targets set by NHS England and NHS Improvement.

Therapies

The therapies team has continued to grow within the specialist services division. Following the transfer of both the MSK community therapy teams and the MSK CATS service into WWL, the First Contact Practitioner Service was developed and implemented in January 2021 and has further evolved over the year. Musculoskeletal First Contact Practitioner Services position highly skilled and regulated practitioners as the first point of contact in primary care. The implementation and management of a successful service across the Wigan borough requires key stakeholders to work together to address local patient needs, workforce challenges, and opportunities to maximise health and well-being.

Outpatient therapists rose to the challenge during the pandemic, finding new ways to work to ensure continuity of care for patients. This included the use of virtual appointments and the recommissioning of additional areas to ensure therapy work was able to continue without interruption. With the re-introduction of face-to-face appointments, new ways of working have been developed to take account of infection prevention and control guidelines.

Inpatient therapy services adapted to different cohorts of patients with the brief introduction of medical patients to the Wrightington Hospital site and with the complexities of those who had been waiting extended periods for orthopaedic surgery. Pre-operative education was modified to be delivered virtually and has been re-designed now face-to-face sessions are resumed, to account for the change in adherence to post-operative hip precautions.

The hand therapy team has supported the set up and continuation of the ambulatory unit by taking over follow-up of post operative patients. The patient journey has now been simplified with a one

stop shop for surgical follow up and therapy. Pathways and protocols have been developed for many surgical procedures.

Cancer services and oncology

Delivery of cancer services was adversely affected by the COVID-19 pandemic with deferral of diagnostics and treatments in the initial wave of infection. The service supported speciality teams throughout the recovery period to expand and maintain cancer related services although the built-up demand has created unprecedented volumes of new referrals requiring assessment. Performance against the national targets has not been consistently achieved with recovery planning disrupted by new waves of infections which resulted in capacity loss due to patient cancellations and the absence of key staff unwell or self-isolating with infection.

A new national cancer performance target was introduced in 2021 which measures the number of patients referred from their GP as a suspected cancer to be given either a cancer or cancer ruled out diagnosis within 28 days of referral. This target has proved challenging to performance manage as capacity constraints in the early stages of the cancer pathway are challenged by reduced workforce numbers and lack of diagnostic capacity. Speciality teams are working with cancer services to monitor priority target lists to ensure delays are mitigated and actioned at the earliest opportunity. The introduction of the 28-day faster diagnosis standard has exposed some of the key challenges within service provision and has allowed teams to develop new business models and clinical pathways to mitigate the effect of this. Business planning to expand one-stop imaging capacity for the symptomatic breast pathway is a key priority of the organisation to enable patients to access essential diagnostics at an early opportunity. The colorectal pathway is expected to improve once FIT testing pathways are established and consistent across the locality and the transformation team have developed a focus group to work with local primary care networks to support this work.

Several other tumour specific pathways including prostate, lung and upper gastrointestinal tract have been involved in implementing best-timed pathways to ensure a faster diagnosis. Additionally, a new pathway for patients with non-specific symptoms that can indicate cancer and a rapid diagnostic service to support these patients has been implemented and went live on 31 March 2022.

The cancer services team has also been supporting the NHS *Galleri* trial. This trial is a national one, investigating a new blood test to see if it can help detect cancer earlier than standard pathways. The test can detect more than 50 types of cancer, often before symptoms occur. The trial has been rolled out across various localities across Greater Manchester and ran in Wigan during March 2022. The team has also been working with tumour-specific teams to implement personalised stratified follow-up pathways which will enable patients to manage their condition more effectively following treatment, having direct access back into the hospital system if required but reducing the reliance on attending routine follow up appointments which creates additional capacity for new patients.

The cancer peer review and quality surveillance team process for the majority of tumour specific teams was completed in September and October 2021. The reviews allow teams to provide an overview of their services, describe the key achievements and challenges they had experienced over the previous 18 months and to identify key service developments they would like to focus on over the coming year.

Cancer treatments are delivered within the dedicated Cancer Care Unit, supported by regular meetings with The Christie on a bi-monthly basis to discuss operational issues and key performance indicators. Activity has been steadily growing and increased as more patients required treatment in

the early recovery phase. We have confidence in our ability to gradually increase the numbers of patients we can accept for treatment and to repatriate those patients that were transferred due to reduced capacity.

Our forward planning includes working with The Christie on ideas to extend our existing premises and we are currently meeting monthly with them to look at the increasing patient activity and how we can continue to provide a great quality service. Expanding treatment capacity requires extension of the current estate, although the team working within the Cancer Care Unit are developing plans to increase treatments delivered within chairs which has the potential to create increased capacity within the current footprint.

As a new development, patients can have a holistic needs assessment at their pre-chemotherapy visit and this enables them to discuss any worries and fears before they start their treatment. The Christie team are very supportive of the service that is delivered at WWL and are keen to work with us on future service developments. During the pandemic, pre-chemotherapy visits were performed virtually which presented an unexpected opportunity for service improvement which the treatment team intent to continue beyond the pandemic.

Other developments include:

- Patients attending the cancer care centre on bank holidays for their blood test to enable smoother running of the service on the following week;
- Extending our complementary therapies hours;
- Implementing the recovery package and holistic needs assessment for pre-chemotherapy patients;
- Improved access to benefits advice for patients and their families;
- An outreach service from Macmillan Information Centre staff;
- Support groups for all tumour sites; and
- Working with Primary care to recruit cancer community support workers.

Operational and clinical performance: Division of Community

Wigan's Locality Plan, *The Deal for Health and Wellness* set out a vision to radically transform local community-based health and care services. Across the borough, community based integrated health and social care services have been successfully built around seven service delivery footprint areas. These areas have been based on naturally formed communities, each with a 30-50,000 registered population, and through these we plan delivery our services to meet local needs. The footprints include health and care partners working closer together, including community nursing, therapies and adult social care (Integrated Community Services) alongside schools, children's services, mental health, police, housing and other public and voluntary and community sector partners which are also aligned.

Our model has a strong emphasis on population health promotion, prevention, early intervention and self-care and self-management. The model reduces demand for services and allows care and support to be increasingly delivered out of hospital, at the appropriate care level, and is contributing to safe and effective admission avoidance across the system. By working together across organisational boundaries as one team, we have been able to better use the combined skills and

knowledge of all professionals co-located in a place. This has had a positive impact on how we are able to triage individuals more effectively at the first point of contact, ensuring that the most appropriate professional, or combined professionals, are able to deliver care and support at the right place and time. This improved triage process and care coordination has significantly reduced the number of hand-offs individuals experience across the system, with services feeling more connected and less fragmented for patients and residents.

Our Deal for a Healthier Wigan focuses on staff taking the time to understand people's strengths and assets and supporting them to connect to their community and be well. The application of asset-based approaches to care have been key to the transformation model; keeping people well for longer by addressing the wider determinants of health, such as social isolation, loneliness, housing issues and school readiness has led to a reduction in need for reactive and expensive hospital admissions and/or long-term social care.

Highlights for the Community Services Division in 2021/22 include:

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

- The consolidation of the Community Assessment Unit, a 21-bedded community ward which opened in February 2021 on the RAEI site. These beds have helped to reduce pressure on acute services by providing alternatives within the community and avoiding people being admitted to an acute setting unnecessarily. The unit aims to improve the experience for people accessing care, in-reaching into the Emergency Department to prevent often lengthy admissions into hospital and improving hospital discharge and flow.

- The development of an all-age community service line with a focus on smooth and seamless transition from Children and Young People's services to adult services.

- The redesign of our leadership structure to ensure community services are clinically led, provide compassionate leadership and are fully embedded in the culture of WWL.

- The implementation of the Community Clinical Variation Project which will demonstrate a reduction in unwarranted clinical variation across our services.

Operational and clinical performance: Estates and facilities

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

- Catering
- Security
- Hotel Services
- Capital design
- Medical electronics

- Operational estates maintenance
- Safety management
- Energy and waste management
- Fire safety
- Grounds maintenance
- Sterile services and endoscope reprocessing

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

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

The division also provides medical equipment management services, using an equipment database which includes more than 20,000 items. The database is a keystone to managing the servicing, maintenance and breakdown repair service that is delivered to all clinical departments and has been further enhanced in the last year by the addition of a new equipment database which will enable improvements in our record going forward.

During the year, we developed and approved our first Green Plan. As part of the NHS standard contract, all NHS organisations are required to monitor and report on compliance with the various requirements of the 'Green NHS and sustainability' clause. Our performance is provided in the table below:

Contractual requirement	Our performance
In performing its obligations under this Contract the Provider must take all reasonable steps to minimise its adverse impact on the environment.	This is achieved through the Green Plan, Net Zero Strategy and Climate Change Adaptation Plan. The Net Zero Strategy and Climate Change Adaptation Plan are currently in development and are due to be published in Q3 2022/23.
The Provider must maintain and deliver a Green Plan, approved by its Governing Body, in accordance with Green Plan Guidance and must: ▪ provide an annual summary of progress on delivery of that plan to the Co-ordinating Commissioner; and ▪ nominate a Net Zero Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position.	Our Green Plan was approved by the Board and published on 30 March 2022. This document acts as the annual summary on delivery of the plan. The Net Zero Lead is the Director of Workforce. The Operational Lead is the Environmental and Sustainability Manager.

Contractual requirement	Our performance
Within its Green Plan the Provider must quantify its environmental impacts and publish in its annual report quantitative progress data, covering as a minimum greenhouse gas emission in tonnes, emissions reduction projections and an overview of the Provider's strategy to deliver those reductions.	We are currently in the process of calculating our NHS Carbon Footprint Plus, and we are one of the first in the country to calculate our carbon footprint to this level. The sustainability team has commissioned an assessment of all of our scope 3 emissions using procurement data. This is a high-level analysis that matches spend against carbon emissions for individual spend categories. It is not a suitable methodology for calculating an accurate carbon footprint, in line with GHG protocols which is why it has not been included within our Green Plan. It does allow for identification of carbon hotspots which gives us the opportunity to identify where we can reduce our carbon footprint by changing how we spend our budgets. We are pioneering in our use of this methodology, and this has now been picked up by several other trusts and Shared Business Services. It is intended that this methodology will now be used centrally taking the onus off the Trust to calculate. The sustainability team has also commissioned a consultant to help us calculate our NHS Carbon Footprint Plus to GHG Protocol standards. This will allow us to publish our data once quantified. We will incorporate the results from the scope 3 analysis discussed above to give a more comprehensive view of our carbon footprint and will allow us to produce reduction strategies beyond those which other trusts have already developed. Previous attempts to calculate Scope 3 emissions by other Trusts have not included purchasing data as it has been deemed too complex to calculate. We estimate that 70% of our carbon footprint actually lies in purchasing and therefore not including it within reduction strategies means we will not achieve Net Zero. The consultant will also develop a Net Zero Strategy. This will provide an emissions baseline and reduction projection for each Trust owned site. The consultant will also develop an emissions baseline for the whole Trust and a high-level reduction projection that will also include data from Trust leased sites. In addition, we will also receive a strategy to achieve Net Zero by 2045. This will include projections for business as usual, increased investment and decreased investment.

Contractual requirement	Our performance
As part of its Green Plan the Provider must have in place clear, detailed plans as to how it will contribute towards a 'Green NHS' with regard to Delivering a 'Net Zero' National Health Service commitments in relation to: ▪ air pollution, and specifically how it will, by no later than 31 March 2022: – take action to reduce air pollution from fleet vehicles, transitioning as quickly as reasonably practicable to the exclusive use of low and ultra-low emission vehicles; – take action to phase out oil and coal for primary heating and replace them with less polluting alternatives; – develop and operate expenses policies for Staff which promote sustainable travel choices; and – ensure that any car leasing schemes restrict high-emission vehicles and promote ultra-low emission vehicles; ▪ climate change, and specifically how it will, by no later than 31 March 2022, take action: – 18to reduce greenhouse gas emissions from the Provider's Premises in line with targets in Delivering a 'Net Zero' National Health Service – in accordance with Good Practice, to reduce the carbon impacts from the use, or atmospheric release, of environmentally damaging gases such as nitrous oxide and fluorinated gases used as anaesthetic agents and as propellants in inhalers, including by appropriately reducing the proportion of desflurane to sevoflurane used in surgery to less than 10% by volume, through clinically appropriate prescribing of lower greenhouse gas emitting inhalers, by encouraging Service Users to return their inhalers to pharmacies for appropriate disposal; and	The sustainability team commissioned the Energy Savings Trust to complete a review of its fleet with a view to enabling the switch to electric vehicles. This has been completed and the sustainability and transport teams are now reviewing the feasibility of switching to electric vehicles for its owned and leased fleet. This is impacted by fact that Martland Point is leased and therefore amendments to the electricity infrastructure must be approved by the landlord. There is also a shortage of electric vehicles and suitable options are not currently available. As such, the decision has been made to extend the lease of transport vehicles for 6 months to allow the electric vehicle market to recover from the pandemic and in the meantime attempt to obtain an electric vehicle to trial. In relation to grey fleet, the Trust has engaged with a TfGM linked third party supplier in order to provide, manage and maintain electric vehicle charging infrastructure across all of the Trust owned sites. This is currently with our legal advisors to determine the suitability of the contract in its current form. We no longer uses coal or oil for primary heating. Staff currently receive expenses for travel via electric vehicles and bicycle and we offer free charging for electric vehicles. This is under review due to the dramatic increase in electric vehicle use. Our car leasing scheme provider NHS Fleet Solutions restricts high emission vehicles and promotes use of electric vehicles through various government backed tax reductions such as zero VED and lower rate BIK tax for electric vehicles. We have already begun the process of removing Desflurane from backboards and anaesthetic machines. The removal of Nitrous manifolds is also being discussed in the Medical Gases working group and is no longer being provided in any new capital schemes unless expressly required. Prescribing guidelines for lower carbon inhalers have been circulated to the Director of Pharmacy for review within the Medicines subgroup. We are not currently signed up to the Plastic Pledge. This requires further discussion within the net zero steering group and procurement subgroup.

Contractual requirement	Our performance
– to adapt the Provider's Premises and the manner in which Services are delivered to mitigate risks associated with climate change and severe weather; ▪ single use plastic products and waste, and specifically how it will, no later than 31 March 2022 take action: – to reduce waste and water usage through best practice efficiency standards and adoption of new innovations; – to reduce avoidable use of single use plastic products, including by signing up to and observing the Plastics Pledge; – so far as clinically appropriate, to cease use at the Provider's Premises of single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics; – to reduce the use at the Provider's Premises of single-use plastic food and beverage containers, cups, covers and lids; and – to make provision with a view to maximising the rate of return of walking aids for re-use or recycling, and must implement those plans diligently.	We are currently reviewing the purchase and use of single use plastics which has been enabled through the Scope 3 carbon footprint work discussed above. This work has allowed us to identify where items of spend on single use plastic products such as aprons, cutlery etc. can be reduced. The catering department only provide biodegradable compostable single use cutlery, plates and cups. We are currently submitting a business case to further utilise Wigan Council walking aid refurbishment scheme. Whilst this was previously in use, Wigan Council have requested that payment be made to help subsidise its operation.
The Provider must ensure that with effect from the earliest practicable date (having regard to the terms and duration of and any rights to terminate existing supply agreements) all electricity it purchases is from Renewable Sources.	As of April 2021, we purchase our electricity from renewable sources and certify this with Renewable Energy Guarantee of Origin certificates (REGO backed).
The Provider must, in performing its obligations under this Contract, give due regard to the potential to secure wider social, economic and environmental benefits for the local community and population in its purchase and specification of products and services, and must discuss and seek to agree with the Co-ordinating Commissioner, and review on an annual basis, which impacts it will prioritise for action.	We give due regard to this through our anchor institution involvement which has been formed to address the impact the Trust has upon the local community and its population.

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

Operational compliance: Emergency preparedness, resilience and response

We have undertaken a self-assessment against required areas of the emergency preparedness, resilience and response (EPRR) core standards self- assessment tool during the year.

Where areas require further action, we will meet with the Local Health Resilience Partnership to review the core standards and associated improvement plan and to agree a process for ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Compliance with EPRR core standards is rated by way of self-assessment, using the definitions below:

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

For 2021/22, we have been assigned an EPRR assurance rating of 'substantial compliance' against the core standards. This was agreed by the Board of Directors at its meeting on 24 November 2021.

ACCOUNTABILITY REPORT.

ACCOUNTABILITY REPORT

Directors' report

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

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

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

Silas Nicholls, Chief Executive | Permanent post

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

Prof Sanjay Arya, Medical Director | Permanent post

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

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

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

Lady Rhona Bradley, Non-Executive Director (Independent) | Appointment 1 Dec 2019 to 31 Nov 2022

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

substance misuse services for almost 50 years. Rhona continues her involvement with the charity as a trustee of the board.

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

Alison Balson, Director of Workforce | Permanent post

Alison has extensive experience in managing human resources services and has worked in the NHS for over 15 years. She is committed to demonstrating the link between staff engagement, organisational performance and patient satisfaction. Alison genuinely believes in partnership working and the need to work collaboratively with trade union partners.

Ian Boyle, Chief Finance Officer | Permanent post

Ian is a qualified accountant and has more than 26 years' experience in NHS finance. He is a Fellow of the Chartered Institute of Public Finance and Accountancy and has worked in trusts, CCGs and NHS regulatory bodies, with the last nine years at board level. Ian is passionate about finance staff development and is the Chair of the Healthcare Financial Management (HFMA) North West branch committee. He also has a keen interest in strategic financial planning in support of quality and transformation.

Dr Steven Elliot, Non-Executive Director (Independent) | Appointment 1 Apr 2018 to 31 Mar 2024

Steven has worked as a GP since 1983 and has previously been a partner, both single handed and salaried. He was a GP with special interest in headaches at Salford Royal NHS Foundation Trust from 2004 to 2014 and spent 4 years as Associate Medical Director at NHS Salford PCT. Steven was previously the Regional Director for commercial company Primecare UK and Chair of the Community Based Strategy Group at NHS Salford CCG.

Mary Fleming, Deputy Chief Executive | Permanent post

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

Ian Haythornthwaite, Non-Executive Director (Independent) | Appointment: 9 Apr 2018 to 8 Apr 2024

Ian was previously the Chief Finance and Operating Officer for BBC Nations and Regions with overall responsibility for the effective delivery of all BBC operations outside of London, and before this he was the BBC's Director of Finance. Ian is a Fellow of the Chartered Institute of Management Accountants, with extensive public sector management experience and chairs our Audit Committee. He is also chair of the Countess of Chester Hospital NHS FT.

Paul Howard, Director of Corporate Affairs | Permanent post

Paul began his NHS career in 2001 with the then Greater Manchester Ambulance Service, qualifying as a paramedic and undertaking a range of clinical roles before taking up the role of Corporate Governance Manager with North West Ambulance Service. Paul went on to work in Company Secretary roles within the acute health sector and in the education sector and in 2014 he was named not-for-profit Company Secretary of the Year by the Institute of Chartered Secretaries and Administrators. In the same year, Paul coordinated the development of new national rules on behalf of NHS Providers which allowed votes in elections to FT councils of governors to be cast online or by text message to increase participation and engagement.

Lynne Lobley, Senior Independent Director (Independent) | Appointment 26 Mar 2018 to 25 Mar 2024

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

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

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

Richard Mundon, Director of Strategy and Planning | Permanent post

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

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

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

Rabina Tindale, Chief Nurse | Permanent post

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

Alison Tumilty, Non-Executive Director | Appointment 1 September 2021 to 31 August 2024

Alison qualified as a Chartered Accountant with Ernst and Young Manchester before pursuing a career as a Finance Director in property and development. During this time, she held key roles with UNITE plc and with Manchester Airport Group. Alison then went on to spend 6 years in the role of Deputy Chief Executive with Rathbone, a UK wide charity supporting disadvantaged young people to develop their employment and life skills through education. She is currently Chair of Rochdale Boroughwide Housing and has held non-executive roles in education and housing.

The following individuals were also directors of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust during 2021/22:

- Robert Armstrong (Chair to 31 October 2021)
- Mick Guymer (Non-Executive Director to 31 Jul 2021)
- Tony Warne (Non-Executive Director and Vice-Chair to 14 May 2021)

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 Company Secretary.

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 to the Company Secretary, reported formally to the board, and entered into a register which is available to the public. A copy of the register is available on our website or on request from the Company Secretary.

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

Independence of directors

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

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

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

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

Attendance summary

The table below shows the attendance at board meetings for all directors in post during 2021/22:

Name of director	A	B	Percentage attendance
Robert Armstrong, Chair (to 31 Oct 2021)	4	5	80%
Mark Jones, Chair (from 1 Nov 2021)	5	5	100%
Sanjay Arya, Medical Director	7	10	70%
Claire Austin, Non-Executive Director	10	10	100%
Alison Balson, Director of Workforce	9	10	90%
Ian Boyle, Chief Finance Officer	10	10	100%
Rhona Bradley, Non-Executive Director	9	10	90%

Name of director	A	B	Percentage attendance
Steven Elliot, Non-Executive Director*	6	10	60%
Mary Fleming, Deputy Chief Executive	9	10	90%
Mick Guymer, Non-Executive Director (to 31 Jul 2021)	2	3	67%
Ian Haythornthwaite, Non-Executive Director	9	10	90%
Paul Howard, Director of Corporate Affairs†	10	10	100%
Lynne Lobley, Non-Executive Director	10	10	100%
Anne-Marie Miller, Director of Communications and Stakeholder Engagement†	10	10	100%
Richard Mundon, Director of Strategy and Planning	8	10	80%
Silas Nicholls, Chief Executive	9	10	90%
Francine Thorpe, Non-Executive Director (from 1 May 2021)	9	10	90%
Rabina Tindale, Chief Nurse	10	10	100%
Alison Tumilty, Non-Executive Director (from 1 Sep 2021)	7	7	100%

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

* During the year, Steven Elliot had an agreed period of recovery and recuperation following surgery. His attendance should therefore be viewed in this context.

† Indicates non-voting director

Evaluating performance and effectiveness

During the year, we commissioned an external review of its leadership and governance using the NHS well-led framework, in line with best practice. No major concerns were identified and we have developed an action plan as a result, which we will monitor through our public board meetings until all actions have been closed.

The review was comprised of a desktop review of relevant documentation, an online survey completed by all board members, 1:1 interviews with each member of the board, 1:1 interviews with a sample of senior staff and joint interviews with each of the divisional leadership teams. In addition, the review team undertook observations of our key meetings, undertook focus groups with our staff and our Council of Governors and sought the views of our key external stakeholders by way of telephone interviews. The themes from the review were then explored in detail with the board at a dedicated workshop.

The review team acknowledged the recent period of transition given the recent changes to non-executive board membership and in particular the in-year change of Chair, but recognised that the foundations are in place for us to evolve into a high performing board. The team commented that we follow good practice in several areas, including the development of our strategy, the launch of initiatives aimed at positively influencing culture and the refreshing of our risk management arrangements described earlier in this statement. Our committee structure was acknowledged to be in line with good practice, although some suggestions to improve effectiveness were shared, including an additional focus on the digital agenda.

In terms of areas of focus, the review team suggested that improvements in accountability from senior leaders should be a key priority for us, and a number of helpful suggestions as to how this could be achieved were provided. The team also observed a requirement for us to reset the

relationship between the board and governors and to increase NED visibility across the organisation and we are looking to take these forward during FY2022/23.

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

The Chair undertakes the performance review of non-executive directors using our non-executive director competency framework and the outcomes of these appraisals are reported to the Council of Governors. During 2021/22, 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 Company Secretary.

Mandatory declarations required within the directors' report

- We have complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.
- A statement describing adoption of the Better Payment Practice Code is included within the accounts.
- No interest or compensation was paid under the Late Payment of Commercial Debts (Interest) Act 1998 during 2021/22 or 2020/21.
- More information on the arrangements that are in place to ensure that services are well-led can be found in our annual governance statement.
- Income disclosures as required by section 43(2A) of the National Health Service Act 2006 are included within the performance report.
- Fees and charges levied by the foundation trust did not exceed £1m and were not otherwise material to the accounts
- Each director has taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

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

REMUNERATION REPORT

I am pleased to present the remuneration report for the financial year 2021/22 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 Improvement 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 Improvement, 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 Improvement has published guidance on the remuneration of chairs and non-executive directors of NHS foundation trusts and NHS trusts. This guidance acknowledges that whilst there are 150 foundation trusts in existence, they are not necessarily the largest or most complex NHS organisations. The guidance argues that there is essentially no distinction between the services provided by NHS trusts and NHS foundation trusts, nor in their respective responsibilities, yet there was significant variation in the level of remuneration paid to non-executive directors. The guidance

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

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

The Council of Governors has previously agreed that all new chair and non-executive director appointments would be made in accordance with the recommendations contained in the national guidance. In October 2021, prior to the new Chair taking up post, the Council of Governors reviewed the proposed level of remuneration against the most recent benchmarking data published by NHS Providers and agreed to set the remuneration at the median level for medium acute trusts, as set out in national guidance. In reaching this decision, the Council of Governors took account of the levels of remuneration of other local chairs and was mindful of the fact that the benchmarking data within the guidance was some two years old.

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

Executive directors

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

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

As a Consultant Cardiologist, the Medical Director is employed in accordance with the 2003 Consultant terms and conditions. He receives a management allowance for his non-clinical responsibilities which include acting as Medical Director, and this was uplifted by £744 (3%) to £25,538 per annum from 1 April 2021.

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

The four executive director pay scales, all of which are based on benchmarking data provided by NHS England and NHS Improvement, 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 2021/22, an uplift of 3% was applied which mirrored the approach to those on Agenda for Change terms and conditions. This approach was also adopted by the majority of NHS provider organisations in Greater Manchester.

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

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

Mark Jones
Chair

20 June 2022

Senior managers' remuneration policy

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

Element of pay	Purpose and link to strategy	How operated	Maximum opportunity	Description of performance metrics	Changes from previous year
Executive directors' base salary	To help promote the long-term success of WWL and retain high calibre executive directors	Salary scales set out in the Executive Remuneration Framework Progression to next pay point based on performance in post and other criteria Annual increases in line with national VSM pay recommendations or, if appropriate, in line with other local NHS organisations	Pay scales are based on established pay ranges published by NHS England and NHS Improvement, 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.	The Remuneration Committee departed from national VSM guidance this year in relation to the level of salary uplift. Instead, a consistent approach was agreed amongst the majority of local NHS organisations.
Executive directors' taxable benefits	To help promote the long-term success of WWL and retain high calibre executive directors	Benefits for executive directors include: Personal car allowance for those on historic pay arrangements Pension-related benefits (annual increase in NHS pension entitlement).	There is no formal maximum	N/A	No change
Executive directors' pension	To help promote the long-term success of WWL and retain high calibre executive directors	We operate the standard NHS pension scheme without any exceptions	As per standard NHS pension scheme	N/A	No change

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

During the year, two senior managers were paid more than £150,000. Benchmark salary information for comparative jobs within the NHS was considered at the time of appointment and it was concluded that the remuneration agreed was appropriate and reasonable for the current post holder.

There are currently no provisions within directors' terms and conditions of employment to allow for the recovery of any sums paid to directors or for withholding the payments of sums to senior managers. The Remuneration Committee will be reviewing this during 2022/23.

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 2021/22 we have appointed a new chair and two non-executive directors and two of the three candidates were female. As a result, the board is now made up of 53% female directors and 47% male directors (2020/21: 41% female and 59% male). 2 of our directors (12%) are from a black, Asian or minority ethnic background.

Service contract obligations

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

Policy on payment for loss of office

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

Statement of consideration of employment conditions elsewhere in the foundation trust

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

Annual report on remuneration

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

Executive directors

Name	Role	Start date	Unexpired term	Notice period
Silas Nicholls	Chief Executive	28 Oct 2019	Permanent contract	6 months
Sanjay Arya	Medical Director	1 Apr 2017	Permanent contract	3 months
Alison Balson	Director of Workforce	14 Sep 2015	Permanent contract	3 months
Ian Boyle	Chief Finance Officer	1 Oct 2020	Permanent contract	3 months
Mary Fleming	Deputy Chief Executive	1 Apr 2021*	Permanent contract	3 months
Paul Howard‡	Director of Corporate Affairs	1 Apr 2020†	Permanent contract	3 months
Anne-Marie Miller‡	Director of Communications and Stakeholder Engagement	1 Mar 2021	Permanent contract	3 months
Richard Mundon	Director of Strategy & Planning	28 Sep 2015	Permanent contract	3 months
Rabina Tindale	Chief Nurse	15 Feb 2021	Permanent contract	3 months

* Mary Fleming's employment as Deputy Chief Executive commenced on 1 April 2021, however she was first appointed to the Board of Directors as Chief Operating Officer on 1 April 2016.

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

‡ Indicates non-voting director

Non-executive directors

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

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

Name	Start date in role	Start date of current contract	Unexpired portion of current contract	Maximum term end date	Notice period
Mark Jones Chair	1 Nov 2021	1 Nov 2021	2 years, 4 months	31 Oct 2030	3 months
Clare Austin Non-Executive Director	1 May 2019	1 May 2022	2 years, 10 months	30 Apr 2028	1 month
Rhona Bradley Non-Executive Director	1 Dec 2019	1 Dec 2019	5 months	30 Nov 2028	1 month
Steven Elliot Non-Executive Director	1 Apr 2018	1 Apr 2021	2 years, 10 months	31 Mar 2027	1 month
Ian Haythornthwaite Non-Executive Director	9 Apr 2018	9 Apr 2021	1 year, 10 months	31 Mar 2027	1 month
Lynne Lobley Non-Executive Director	28 Mar 2018	28 Mar 2021	1 year, 9 months	27 Mar 2027	1 month
Francine Thorpe Non-Executive Director	1 May 2021	1 May 2021	1 year, 10 months	30 Apr 2030	1 month
Alison Tumilty Non-Executive Director	1 Sep 2021	1 Sep 2021	2 years, 2 months	30 Aug 2030	1 month

Membership of remuneration committees

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

Attendance during 2021/22 was as follows:

Name of director	A	B	Percentage attendance
Mark Jones	3	3	100%
Robert Armstrong	1	1	100%
Clare Austin	3	3	100%
Rhona Bradley	3	3	100%
Steven Elliot*	1	3	33%
Ian Haythornthwaite	2	3	67%
Lynne Lobley	2	3	67%
Francine Thorpe	3	3	100%
Alison Tumilty	2	3	67%

A: number of meetings attended

B: number of meetings the director could have attended

* During the year, Steven Elliot had an agreed period of recovery and recuperation following surgery. His attendance should therefore be viewed in this context.

The Chief Executive attends the committee in relation to discussions around board composition, succession planning and the remuneration and performance of executive directors. The Chief

Executive is not present during discussions relating to his own performance, remuneration or terms and conditions of office.

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

The Nomination and Remuneration Committee established by the Council of Governors to consider matters relating to the appointment, remuneration and other terms and conditions of service of the non-executive directors is also chaired by Mark Jones. During the year, committee members met on several occasions as part of the process of appointing two new non-executive directors. The committee also held one formal meeting during the year, to consider the reappointment of one of the non-executive directors.

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

Name of committee member	A	B	Percentage attendance
Mark Jones, Chair	1	1	100%
Bill Anderton, Public Governor	1	1	100%
Pauline Gregory, Public Governor	1	1	100%
Andrew Haworth, Public Governor	1	1	100%
Andrew Savage, Staff Governor	1	1	100%
Bryonie Shaw, Appointed Governor	1	1	100%
Linda Sykes, Public Governor	1	1	100%

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

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

Although the new Chair took up post during the year, the recruitment process was undertaken during 2020/21 and was included in last year's report. Two non-executive directors have been appointed during 2021/22. The committee was assisted with these appointments by Diane Charnock Consulting, a recruitment consultancy with significant experience in recruiting non-executive directors. In determining which firm to use to support the process, a competitive pricing exercise was undertaken to ensure value for money. The committee was satisfied that the services received were objective and independent and a total fee of £28,000 was paid.

The process which was followed for both non-executive director appointments is summarised below:

Remuneration for the year to 31 March 2022

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

	Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
Mark Jones, Chair (from 1 Nov 2021) *	30 – 35	0	0	30 – 35
Robert Armstrong, Chair (to 31 Oct 2021)	25 – 30	0	0	25 – 30
Silas Nicholls, Chief Executive †	195 – 200	900	0	195 – 200
Sanjay Arya, Medical Director ‡,§	255 – 260	0	30.0 – 32.5	285 – 290
Clare Austin, Non-Executive Director	10 – 15	0	0	10 – 15
Alison Balson, Director of Workforce	135 – 140	0	32.5 – 35	165 – 170
Ian Boyle, Chief Finance Officer †	130 – 135	0	75 – 77.5	205 – 210
Rhona Bradley, Non-Executive Director	10 – 15	0	0	10 – 15
Steven Elliot, Non-Executive Director	10 – 15	0	0	10 – 15
Mary Fleming, Deputy Chief Executive	145 – 150	0	140 – 142.5	285 – 290
Mick Guymer, Non-Executive Director (to 31 Jul 2021)	0 – 5	0	0	0 – 5
Ian Haythornthwaite, Non-Executive Director	15 – 20	0	0	15 – 20
Paul Howard, Director of Corporate Affairs †	100 – 105	0	20 – 22.5	120 – 125
Lynne Lobley, Non-Executive Director	15 – 20	0	0	15 – 20
Anne-Marie Miller, Director of Communications	105 – 110	0	85 – 87.5	190 – 195
Richard Mundon, Director of Strategy and Planning ‖	110 – 115	0	35 – 37.5	145 – 150
Rabina Tindale, Chief Nurse	120 – 125	0	0	120 – 125
Francine Thorpe, Non-Executive Director (from 1 May 2021)	10 – 15	0	0	10 – 15
Alison Tumilty, Non-Executive Director (from 1 Sep 2021)	5 – 10	0	0	5 – 10
Tony Warne, Non-Executive Director (to 14 May 2021)	0 – 5	0	0	0 – 5

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

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

‡ The above remuneration includes clinical duties of £109k that are not part of the individual's management role.

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

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

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

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

Remuneration for the year to 31 March 2021

	Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
Robert Armstrong, Chair	50 - 55	0	0	50 - 55
Silas Nicholls, Chief Executive	185 - 190	900	32.5 – 35.0	220 - 225
Sanjay Arya, Medical Director *	245 - 250	100	57.5 – 60.0	305 - 310
Clare Austin, Non-Executive Director	10 - 15	0	0	10 - 15
Alison Balson, Director of Workforce	130 - 135	0	30.0 – 32.5	160 - 165
Ian Boyle, Chief Finance Officer (from 1 Oct 2020)	65 - 70	0	40.0 – 42.5	105 - 110
Rhona Bradley, Non-Executive Director	10 - 15	0	0	10 - 15
Steven Elliot, Non-Executive Director	10 - 15	0	0	10 - 15
Mary Fleming, Deputy Chief Executive	130 - 135	100	55.0 – 57.5	185 - 190
Mick Guymer, Non-Executive Director	10 - 15	0	0	10 - 15
Ian Haythornthwaite, Non-Executive Director	15 - 20	0	0	15 - 20
Paul Howard, Director of Corporate Affairs	100 - 105	0	25.0 – 27.5	125 - 130
Lynne Lobley, Non-Executive Director	15 - 20	0	0	15 - 20
Anne-Marie Miller, Director of Communications	5 - 10	0	0	5 - 10
Richard Mundon, Director of Strategy and Planning	130 - 135	100	32.5 – 35.0	165 - 170
Ged Murphy, Acting Chief Finance Officer (to 30 Sep 2020)	60 - 65	0	0	60 - 65
Morag Olsen, Interim Chief Nurse (9 Nov 2020-21 Feb 2021)	45 - 50	0	0	45 - 50
Helen Richardson, Chief Nurse (to 31 Oct 2020)	75 - 80	0	25.0 – 27.5	100 - 105
Rabina Tindale, Chief Nurse (from 15 Feb 2021)	25 - 30	0	27.5 – 30.0	50 - 55
Tony Warne, Non-Executive Director	15 - 20	0	0	15 - 20

* The above remuneration includes clinical duties of £109k that are not part of the individual's management role.

All of the above directors were in post for the 12-month period to 31 March 2021 except where indicated. No annual performance or long-term performance-related bonuses were paid during the period. Taxable benefits relate to car lease contributions.

Pension entitlements for year-ended 31 March 2022

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

In accordance with guidance issued by the NHS Business Services Authority, an increase of 0.5% CPI on the cash equivalent transfer value at 31 March 2021 has been applied.

	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 as at 31 March 2022 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2022 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real increase in Cash Equivalent Transfer Value £000
Silas Nicholls * Chief Executive	0	0	0	0	0	685	0
Sanjay Arya Medical Director	2.5 – 5.0	2.5 – 5.0	70 – 75	210 – 215	1,760	1,660	63
Alison Balson Director of Workforce	2.5 – 5.0	0-2.5	15 – 20	15 – 20	245	209	16
Ian Boyle Chief Finance Officer	2.5 – 5.0	5.0 – 7.5	50 – 55	100 – 105	888	797	68
Mary Fleming Deputy Chief Executive	5.0 – 7.5	12.5 – 15.0	45 – 50	105 – 110	1,026	854	147
Paul Howard Director of Corporate Affairs	0 – 2.5	0	10 – 15.0	30-35	221	199	8
Anne-Marie Miller Director of Communications	5.0 – 7.5	0	20 – 25	0	234	177	41
Richard Mundon Director of Strategy and Planning	2.5 – 5.0	0	20 – 25	0	343	295	28
Rabina Tindale Chief Nurse	0 – 2.5	0 – 2.5	50 – 55	150 – 155	1,198	1,151	24

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

Pension entitlements for the year ended 31 March 2021

In accordance with guidance issued by the NHS Business Services Authority, an increase of 1.7% CPI on the cash equivalent transfer value as at 31 March 2020 has been applied.

	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 as at 31 March 2021 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2021 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Real increase in Cash Equivalent Transfer Value £000
Silas Nicholls Chief Executive	0 – 2.5	5.0 – 7.5	40 - 45	75 - 80	685	158	510
Sanjay Arya Medical Director	2.5 – 5.0	10.0 – 12.5	65 - 70	205 - 210	1,660	1,508	100
Alison Balson Director of Workforce	0 – 2.5	0	15 - 20	15 - 20	209	178	10
Ian Boyle Chief Finance Officer (from 1 Oct 2020)	0 – 2.5	2.5 – 5.0	45 - 50	95 - 100	797	691	36
Mary Fleming Deputy Chief Executive	2.5 – 5.0	2.5 – 5.0	40 - 45	90 - 95	854	764	59
Paul Howard Director of Corporate Affairs	0 – 2.5	0	10 - 15	30 - 35	199	174	10
Anne-Marie Miller Dir. of Comms (from 1 Mar 2021)	0 – 2.5	0	15 - 20	0	177	153	1
Richard Mundon Director of Strategy and Planning	2.5 – 5.0	0	20 - 25	0	295	249	24
Helen Richardson Chief Nurse (to 31 Oct 2020)	2.5 – 5.0	0 – 2.5	45 - 50	145 - 150	0	1,038	0
Rabina Tindale Chief Nurse (From 1 Feb 2020)	0 – 2.5	2.5 – 5.0	50 - 55	150 - 155	1,151	958	33

Cash Equivalent Transfer Values

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

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

Real increase in CETV

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

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

Directors' and governors' expenses

The total number of governors in office as at 31 March 2021 was 27 (2021: 26).

The total number of directors in office as at 31 March 2022 was 17 (2021: 17)

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

The total amount of expenses reimbursed to 1 director during the year was £190 (2020/21: 3 directors, £300).

The total amount of expenses reimbursed to 3 governors during the year was £47 (2020/21: 2 governors, £100).

Fair pay multiples

We are required to disclose the relationship between the total remuneration of the highest-paid director against the 25th percentile, median and 75th percentile of remuneration of the organisation's

workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust in the financial year 2021/22 was £255-260k (2020/21: £245-250k). This is an increase of 3.9%. The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

	25th percentile £	Median £	75th percentile £	2020/21 Median £
Salary component of pay	21,777	34,026	45,908	-----
Total pay and benefits excluding pension benefits	25,145	36,676	49,405	29,434
Pay and benefits excluding pension: pay ratio for highest paid director	11.4	6.9	6.1	9.00

For employees as a whole, the range of remuneration in 2021/22 was from £12.5k to £330k (2020-21 £12.6k to £265k). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years was 1%. 1 employee received remuneration in excess of the highest-paid director in 202122 (2020/21:1).

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

Silas Nicholls
Chief Executive and Accounting Officer

20 June 2022

STAFF REPORT

2021/22 has been a year of gradual stabilisation as the NHS continues to manage and address the repercussions of the COVID-19 pandemic. Staff have been significantly affected by short term redeployment, working in unfamiliar areas, retraining in new or different skills, the absence of other colleagues and the impact of being unable to take planned annual leave. This continues to test the resolve, resourcefulness and resilience of our staff, who have been fantastic in their response to ensure that patients remain safe, well cared for and fellow colleagues are supported.

The fallout from the pandemic, in addition to the impact of other global events, has had a significant effect on the economy and is now causing financial constraints and difficulties for our staff. In response, as we head into 2022/23, we have made a commitment to support staff wellbeing, prosperity and flexibility. We are planning to explore a range of financial support measures, including recently launched schemes enabling staff to buy and sell annual leave. We have seen high demand from staff for our Steps 4 Wellness offer and continue to seek opportunities to strengthen and expand this further. A positive development in the past year has been the continuation and growth of our psychological support service. This has been a pivotal source of support for our staff over the past 12 months and its further development will ensure that more staff have access to the service it provides.

The pandemic became an accelerator for the growth in our digital workforce systems and in 2021/22 we appointed a new Electronic Staff Record (ESR) project team that has since been expanded to oversee three key workstreams - ESR, the introduction of the Empactis absence management system and the use of of medical and non-medical Allocate Healthroster. The use of ESR Manager Self Service and E-roster will result in a significant drop in paper forms, freeing up time and resource and reducing duplication. The availability of real time, or near to real time data, will also be a significant benefit to workforce reporting and discussions with the Business Intelligence team are taking place to automate this reporting further. The Empactis system will provide a much better day-to-day oversight of departmental and organisational absence, and the functionality to manage and record cases as they arise. Staff will also have easy access to their employee data, payslip and pensions statement data through the ESR app.

As has been the case across the NHS as a whole, we have seen overall levels of staff turnover and turnover for staff employed for less than 12 months start to increase. This is now the focus of our strategic retention group which includes representation from across the workforce – particularly from Ward Managers, Matrons, Community, Nursing, Allied Health Professionals (AHPs) and medical teams, and corporate leads. This will help to provide a greater understanding of the issues driving increasing staff turnover and possible solutions. One of the tasks of the group will be to assess our current retention initiatives against the new NHSEI improving staff retention guide and retention initiatives in other organisations to see what learning we can take. We're also excited to promote a local return to practice campaign based on the experiences and stories of the people we employ.

Our focus on recruitment is now starting to narrow the vacancy gap. Our Operational Planning 2022/23 workforce return has factored in a forward projection of our establishment and worked whole time equivalents (WTE), with adjustments accounted for around anticipated domestic, Global Training and Education Centre (GTEC) and student recruitment, anticipated staff turnover, projected winter funded roles plus approved business cases not already built into the existing establishment. Our plan shows that by August 2022 we will have recruited to the vacancy gap for our nursing workforce although we will continue to see turnover at up to 10% thereafter.

In 2021/22 we appointed 1,245 staff to roles. This is a significant amount of recruitment and, whilst to some extent this reflects growth in the workforce, it also reflects staff movement within the NHS and leavers from the service. On the back of this we are reviewing our recruitment and redeployment protocols to improve efficiency/effectiveness and improve our opportunities around growing our own workforce by extending the apprenticeship scheme and strengthening our talent management/succession planning pipelines.

For 2022/23, we have developed the following corporate objectives aligned to the people strategic priority. Key milestones and improvement trajectories for each quarter will be agreed along with performance reporting to monitor and measure progress:

People		**To create an inclusive and people centred experience at work that enables our WWL family to flourish**			
	Purpose of the objective	**Scope and focus of objective**	**How will be know if it has been achieved**	**Lead Exec.**	**How will assurance be provided**
6	**To make working at WWL a positive experience through a just and learning culture that is compassionate and where everyone has a voice that matters**	Develop and embed a culture with compassionate leadership, civility and psychological safety.	- Engagement score within Your Voice Survey (4.00) and National Staff Survey (7.11) - Improve response rates to Your Voice and National Staff Surveys, by demonstrating actions in response to feedback - Psychological safety measure within Your Voice survey (3.75) - Reduction of concerns raised via dignity at work / grievance linked to lack of compassion or breach of Trust values - FTSU activity managed in accordance with KPIs	AB	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		We will advance and embed the implementation of our just and learning culture programme through leadership development, civility and team development / culture programmes that improve experience of work in a sustainable way and encourage our people to speak up.			
7	**Supporting the health and wellbeing of our people**	Having a comprehensive range of evidence-based well-being activities and services that are accessible to our people.	- Range of stepped care well-being services – from prevention and health promotion to support for complex needs - Well-being score within Your Voice Survey (3.25) - All divisions have a well-being plan that includes how they will ensure their employees can access services that are beneficial for their well-being - Team stress management programme rolled out to 4 cohorts in the year - Positive individual impact scores for those accessing mental health services - Sickness absence (stress and MSK) reducing by 5% - Full roll out of the Empactis absence management system	AB	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		We will support the physical health and mental wellbeing of our WWL family by ensuring we have a range of wellbeing activities and services that are accessible to our colleagues, supported by real time and accurate absence data.			

8	**ED & I – To ensure inclusion and belonging for all**	Implement our ED&I strategy, including the launch of Staff Networks for protected groups. Undertake work to pursue inclusive recruitment and selection processes, address our pay gaps, amplify diverse voices and reduce bullying, harassment, discrimination, and violence (BHDV).	- Implement and / or extend the remit of colleague diversity networks for the following protected groups: o BAME o LGBTQIA+ o Disability & long-term conditions - Positive action to increase diversity and improve experience at all levels and within all staff groups, including leadership roles - Improvements in the WRES, WDES and gender pay gap outcomes - Delivery of the in-year actions as defined by the following programmes: o Rainbow Badge Scheme o Disability confident Scheme o Race Equality Standards	AB	TBC
Draft detailed objectives for inclusion in the BAF		We will improve the equality, diversity and inclusion of our Trust by increasing diversity and accessibility, reducing inequality and improving the experience of protected groups.			
9	**To create an environment where we are always learning and everyone can flourish**	Implement our learn and grow strategy, where all colleagues have a personal development plan underpinned by a Trust wide learning needs analysis and talent management programme	- Personal development measure within Your Voice survey (3.5) - 95% of our people having a quality personal development review (Route Plan) - A Trust wide prioritised learning needs analysis and delivery plan that addresses organisational and personal development requirements - Talent management programme that includes talent identification, assessment of potential and support - 75% of employees undertaking personal development beyond mandatory training - To increase the number of Quality Improvement Champions at Bronze level to 555 by March 2023 (March 2022 – 430)	AB	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		We will prioritise personal and professional development to enable our people to flourish, making full use of all available funding sources by aligning our programmes to the learning needs analysis and strategic aspirations such as university teaching hospital status			

Freedom to Speak Up at WWL is provided by The Guardian Service, which was introduced in October 2021. Freedom to Speak Up is now more comprehensively embedded and we are seeing many more contacts with the service, which reflects the value staff place on having impartial support to help them address their concerns. The Guardian Service has also agreed to provide a 12-month exit interview pilot programme focussing on nursing, allied health professional and medical staff.

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 through the challenges of the pandemic to provide the best possible healthcare for the population that we serve.

Alongside this, the workforce team has continued to deliver services in line with our People Promise, the four core elements of which are:

Employment essentials

In 2022/23 we will build on our people programmes by further developing the following:

Looking after our People:

- Leadership development linked to Our Family, Our Focus, Our Future including a programme of leadership development open to leaders at a variety of levels and the launch of Leadership Support Circles; short, themed sessions creating a safe space to support leaders navigating through the pandemic

- A series of communications and webinars in relation to the changes to the pension system will be available to staff

- The exit interview pilot programme delivered by The Guardian Service. Initially, this will focus on nursing and medical staff with the aim of understanding the reasons why an individual has chosen to leave which will enable us to quickly respond to concerns that may be affecting staff and/or patient experience.

Supporting our people:

- Flexibility around annual leave - schemes to enable staff to buy and sell annual leave have been launched in 2021/22

- The psychological support service is due to be fully resourced by Spring 2022, with the aim of providing comprehensive, effective psychological care for our staff

- Steps 4 Wellness will continue to expand to better provide holistic support with work ongoing to develop wellbeing plans for every area across the Trust, collaboratively created between Steps 4 Wellness and departments

- A Stress Management Teams Programme has been piloted with some success and will be rolled out further in 2022. The aim of this is to identify triggers to stress amongst teams, to produce meaningful action plans to address the identified triggers, and to act accordingly to reduce stress.

- We continue to work with local services such as Think Wellbeing and the GM Resilience Hub, to provide appropriate support for staff when their needs go beyond those provided by our in-house services.

Supporting staff attendance and wellbeing:

- We have launched the Empactis Absence Management system and expect it to be operational Trust-wide by September 2022. This, along with other workforce data improvements, will provide case management and real time sickness data oversight to support absence reduction

- The improvements to our data will also improve the quality of recorded sickness reasons and allow for secondary reasons to be recorded e.g. stress related sickness that is associated with either home or work

- Early interventions from our Steps 4 Wellness functions will be key, such as screening tools, mental health support and staff MSK (musculoskeletal) services. We will also offer proactive support such as health checks.

Working differently:

- New roles will include dually registered nurse and operating department practitioners (ODPs). We are also exploring the introduction of generic support workers, with occupational therapy (OT), physiotherapy and nursing skills

- First contact practitioners are being explored in community services

- The expansion of advanced clinical practitioners will augment the medical workforce – particularly in surgery, same day emergency care, respiratory medical and community specialities

- Introduction of the generic support worker role

- Expansion of virtual ward

- Discharge to assess teams are in place, supported by the better at home service.

Innovation in recruitment:

- Recruitment events in partnership with NHS Professionals (NHSP) and Wigan and Leigh College, targeting students who either do not wish to enter into further full-time academic study or those who are unsure which healthcare path to take

- Expansion of apprenticeships across the organisation - the conversion of more band 2 roles into apprenticeships, collaborative working with Healthy Wigan Partnership (HWP) organisations to recruit into apprentice schemes, and use of degree level apprenticeships as a route into professional posts

- Continuation of our GTEC overseas recruitment programme - we will have 207 GTEC international nurses arriving in 22/23.

Your Voice Matters

Engagement has remained relatively stable in 2021/22, although we have achieved the highest response rate to Your Voice surveys since 2019. The highest-rated areas remain staff feeling trusted to do their roles, and staff feeling clear on the expectations of them in their roles. Key areas for development include staff recognition, personal development, perceived fairness and wellbeing. Some of the intended staff engagement workstreams for 2021/22 were delayed due to the ongoing pandemic, however all plans are now being implemented.

In response to these themes:

- The *Go Engage Teams* programme will recommence in 2022, delayed from 2021, offering a new virtual classroom to increase engagement.

- Staff Engagement Associates (SEAs) have been successfully launched. There are now over 70 SEAs across the Trust, fostering staff engagement in their local areas, as well as feeding key information back to the Trust and informing wider strategy.

- A review of staff recognition mechanisms is underway, including the relaunch of the Trust annual awards which aim to be more inclusive to all staff.

- A key commitment was made by the Trust to developing a just and learning culture, including the development of a civility charter, the launch of a 'culture'-focused team development programme and the expansion of our leadership development offer to support our leaders to in turn support their staff.

Building upon our experiences over the past 2 years during the pandemic, engagement activity is now focused on recovery and supporting our staff to return to normal. Our Family, Our Future, Our Focus continues to be the mechanism through which we audit our engagement activity. This continues to be led by our Deputy Chief Executive, and the five areas are each led by an executive director. We are undertaking work collaboratively between staff engagement and continuous improvement, maximising both how our staff feel about their work, and creating mechanisms for their voices to lead to improvements within their areas for patients.

Steps 4 Wellness

Last year saw the consolidation of the Steps 4 Wellness offer, with significant investment from the Trust into services which support the holistic wellbeing of our staff.

The psychological support team continues to support staff once they have experienced a level of distress, through the outreach programme supporting staff who are on sickness absence, development of the long covid offer and consolidation of existing services into a single point of access. Pressures on this team are significant, and recruitment to several new roles is ongoing, to meet demand.

Steps 4 Wellness services have resumed to support day-to-day wellbeing at a time when all staff are under pressure. This has included the availability of Salary Finance services, resumption of health checks and the rollout of departmental wellbeing plans and conversations. The Wellbeing Champions also continues to go from strength to strength.

An exciting development in the next year is the expansion of the Musculo-skeletal (MSK) support available to staff, being the second-largest reason for sickness absence at present. A joint initiative between patient physiotherapy services and the Steps 4 Wellness team has led to the creation of two new staff physiotherapy roles, with the intention being to promote positive behaviours and support staff experiencing MSK-related issues.

Learn and Grow

A focus in the next year is on rethinking the appraisal system and developing mechanisms for staff to have positive, constructive conversations with their line manager about their performance and aspirations. This will involve focused consultation to understand what staff and managers need to have good conversations.

Similarly, there will be a focus on ensuring that staff have access to appropriate opportunities to develop, through both formal and informal means. Staff have told us through their feedback that this has not always been seen as the highest priority in the past two years, so there is a commitment for

us to invest in our staff. Along this vein, we are also developing a talent management programme, to support our staff to grow within the organisation.

Talent for Care has been celebrated this year, including the highly successful Kickstart scheme for 16-24 year-olds which led to several apprentices remaining within the Trust at the end of their placements, both supporting local people and filling a number of vacancies. Our intention is to continue to build upon the success of this and other schemes with the creation of our new Talent for Care Strategy.

Our commitment is ongoing to the leadership development programme. As well as the continued development of our senior leaders through ongoing coaching and support, there is a new focus on supporting leaders who were not able to access the programme last year, particularly those at Bands 7-8b who play such a vital role in our organisation.

Staff experience and engagement: the NHS staff survey

The NHS staff survey is conducted annually. From 2021/22, the survey questions align to the seven elements of the NHS People Promise and the two previous themes of engagement and morale are retained. These retain the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions, with the indicator score being the average of those.

This year's National Staff Survey was relatively in line with that from 2020. We maintained our response rate of 29.5% (2020/21: 29%), which was below the national average; we are committed to developing this over the coming year. Our in-house Your Voice survey also measures the enablers of staff engagement and wellbeing, and we use the data from both surveys, as well as feedback from our SEAs and others, to develop our engagement strategy.

Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.3	6.0	6.8	6.2	4.9	6.2	6.7	7.0	6.1
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,964	1,950	1,948	1,952	1,854	1,935	1,954	1,965	1,966

The picture in 2021 was similar to that of 2020; overall we scored moderate-to-positive, but we continue to score below our peak in 2015 and we had one key area for development highlighted by the results. The results from the National Staff Survey revealed that the majority of the People

Promise scores are broadly in line with the sector scores for similar Acute and Acute & Community Trusts. The highest scoring People Promise is ‘We are compassionate and inclusive’ (7.30) and the lowest ‘We are always learning’ (4.93), with the latter being the only significantly worse People Promise score compared to the sector. Two People Promise/theme scores are significantly better than the sector -'We are safe and healthy' (6.17) and 'We work flexibly' (6.20). Staff Engagement (7.01) is also in line with scores for similar organisations, ranking 14th out of 68, whilst staff 'Morale' (6.12) is significantly better than in other Trusts and ranks 3rd out of 68 organisations. However, both scores have slightly declined since 2020.

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

	2021/22		2020/21	Improvement/ deterioration
	WWL	Combined trust average	WWL	
Response rate	29.5%	45%	29%	Comparable
Top 5 ranking scores				
(13b) In the last 12 months I have personally experienced physical violence at work from managers.	1%	1%	0%	Deterioration
(13c) In the last 12 months I have personally experienced physical violence at work from other colleagues.	1%	2%	1%	No change
(16c03) Experienced discrimination on grounds of religion.	3%	5%	5%	Improvement
(16a) In the last 12 months I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	5%	8%	3%	Deterioration
(16c04) Experienced discrimination on grounds of sexual orientation.	5%	4%	5%	No change

	2021/22		2020/21	Improvement/ deterioration
	WWL	Combined trust average	WWL	
Bottom 5 ranking scores				
(19b) The appraisal/review helped me to improve how I do my job	18%	20%	N/A	N/A
(12e) I often/always feel worn out at the end of my working day/shift	40%	48%	N/A	N/A
(12c) My work often/always frustrates me	37%	40%	N/A	N/A
(12a) I often/always find my work emotionally exhausting	33%	38%	N/A	N/A
(19c) The appraisal/review helped me agree clear objectives for my work	28%	30%	N/A	N/A

At a question level, a mixed picture emerges from the results. Whilst Equality, Diversity and Inclusion scored positively overall, there were some key areas of development, including in relation to reducing discrimination due to 'anything else'. In relation to 'we are always learning', scores for both quality of appraisal and opportunities for development were highlighted as areas for improvement, which has led to the commitments outlined above in Learn and Grow. There has been recent investment in improving equality, diversity and improvement at the Trust, including the new ED&I Workforce Lead role.

It has been a challenging year and maintaining some relative stability overall in these results compared with 2020 is promising. However, the results do highlight areas for improvement, and plans as outlined in the above sections will ensure we do not lose focus on improving the experiences of our staff.

Our performance over the past three years is shown in the table below:

		2020/21		2019/20		2018/19	
		WWL	Combined trusts	WWL	Combined trusts	WWL	Acute trusts
Theme 1:	Equality, diversity and inclusion	9.2	9.1	9.2	9.2	9.1	9.1
Theme 2:	Health and wellbeing	5.9	6.1	5.9	6.0	5.8	5.9
Theme 3:	Immediate managers	6.7	6.8	6.9	6.9	6.8	6.7
Theme 4:	Morale	6.3	6.2	6.5	6.5	6.2	6.1
---	Quality of appraisals	---	---	5.0	5.5	4.9	5.4
Theme 5:	Quality of care	7.7	7.5	7.8	7.5	7.8	7.4
Theme 6:	Safe environment: bullying/harassment	8.0	8.1	8.3	8.2	8.0	7.9

	2020/21		2019/20		2018/19	
	WWL	Combined trusts	WWL	Combined trusts	WWL	Acute trusts
Theme 7: Safe environment: violence	9.6	9.5	9.6	9.5	9.6	9.4
Theme 8: Safety culture	6.7	6.8	6.9	6.8	6.5	6.6
Theme 9: Staff engagement	7.1	7.0	7.3	7.1	7.0	7.0
Theme 10: Team working	6.3	6.5	---	---	---	---

Diversity and inclusion and our longer-term ambitions

We are looking to develop a locality wide approach to equality, diversity and inclusion (EDI) in 2022/23, working across the Healthier Wigan Partnership. This will complement our internal activities and will help to shape our EDI strategy and objectives, improve belonging and promote an inclusive culture:

- All senior and middle managers will have an EDI objective
- Participation in the Royal College of Nursing's Cultural Ambassador scheme.
- Inclusive recruitment panels will be encouraged with a register of trained BAME interview panel members that can be used
- A talent register will be explored and will have a particular focus on identifying talented women and BAME staff
- Inclusive language training is being collaboratively developed with Wigan Council
- Our BAME network will be relaunched and LGBTQIA+ and Disability Staff networks will be set up which will offer support
- A gender pay gap action plan will tackle gender imbalances in senior positions in the Trust
- The Rainbow Badges awards scheme will produce action plans for LGBTQIA+ inclusion in the Trust.
- The Race Equality Code will produce 'must', 'should' and 'could' actions to improve race equality in the Trust.

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

As at March 2021 the Trust has a 15.02% median hourly rate gender pay gap with females earning £2.39 an hour less than males. The median gender pay gap in 2021 has not significantly changed in comparison with 2020 data when as at 31 March 2020 females earned £2.35 an hour less than males with a 15.14% median gender pay gap. Whilst women are the predominant workers across all four pay quarters, male workers are not evenly distributed and a significant proportion falls in the top quarter, particularly in the medical and dental staff group.

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

Mandatory disclosures within the staff report

Workforce gender profile as at 31 March 2022

Directors:	9 female (53%), 8 male (47%)
Senior managers:	220 female (74.57%), 75 male (25.43%)
Employees:	5,254 female (81.75%), 1,173 male (18.25%)

(by headcount, senior managers are band 8a and above)

Sickness absence data

Sickness absence data for NHS organisations is published online by NHS Digital. The table below shows the figures for January to December 2021 which is required to be disclosed in an organisation's annual report:

Figures converted by the Department of Health and Social Care to best estimates of required data items			**Statistics produced by NHS Digital from the Electronic Staff Record data warehouse**	
Average FTE 2021	**Adjusted FTE days lost to Cabinet Office definitions**	**Average sick days per FTE**	**FTE days available**	**FTE days lost to sickness absence**
5,754	77,195	13.4	2,100,224	125,227

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

Staff turnover

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

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

Consultancy

We did not incur any consultancy fees during the year.

Occupational health

Occupational health services are provided by Wellbeing Partners, a joint venture organisation between Lancashire Teaching Hospitals NHS FT, Bolton 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, bribery and corruption

We employ our own Fraud Specialist Manager and have a Fraud, Corruption and Bribery Policy 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 two years and continual fraud awareness campaigns are undertaken via the intranet, news articles and presentations.

Health and safety

This year, our health and safety team has continued to focus on supporting us to operate during the COVID-19 pandemic whilst not losing sight of routine health and safety matters. In particular, the team led on the roll-out of mask fit testing across the organisation, ensuring that we were able to continue to provide care to our patients whilst safeguarding the health and safety of our people.

The team has also had an important role to play in the oversight and investigation of incidents which were reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 as well as retaining a focus on the development and review of our policies and procedures. The team are optimistic about the year ahead and are looking forward to reintroducing proactive health and safety measures, such as audits and inspections, and re-establishing a wider face-to-face training commitment.

Time off for trade unions

The tables below outline the facilities that we have provided for trade union colleagues during the year and collectively they constitute our facility time report for 2020/21.

Relevant union officials

Number of employees who were relevant union officials during the relevant period:	39
Full-time equivalent employee number:	35.71

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	10
1-50%	26
51-99%	0
100%	3

Percentage of pay bill spent on facility time

Total cost of facility time:	£129,000
Total pay bill:	£298,099,000
Percentage of total pay bill spent on facility time:	0.04%

Paid trade union activities

Total paid facility and union time hours	6,679

Employee costs

	Permanent £000	Other £000	**2021/22 Total £000**	2020/21 Total £000
Salaries and wages	228,714	9,829	**238,543**	236,013
Social security costs	22,836	0	**22,836**	20,660
Apprenticeship levy	1,074	0	**1,074**	1,020
Employer's contributions to NHS pension scheme	25,577	0	**25,577**	23,706
Employer's contributions paid by NHSE	11,143	0	**11,143**	10,308
Temporary staff – external bank/agency/contract	0	35,023	**35,023**	26,858
Total staff costs	289,344	44,852	**334,196**	318,565
Costs capitalised as part of assets	0	0	**1,534**	1,771

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

	Permanent (Number)	Other (Number)	**2021/22 Total (Number)**	2020/21 Total (Number)
Medical and dental	565	67	**632**	590
Administration and estates	1,420	30	**1,450**	1382
Healthcare assistants and other support staff	672	8	**680**	651
Nursing, midwifery and health visiting staff	2,345	474	**2,819**	2,623
Scientific, therapeutic and technical staff	892	26	**918**	862
Healthcare science staff	4	0	**4**	5
Other	12	0	**12**	11
Total average numbers	5,910	605	**6,515**	6,124
Number of employees (WTE) engaged on capital projects	22.44	3.71	**26.15**	33

Reporting of compensation schemes: exit packages 2021/22

Exit package cost band (including any special payment element)	Total number of exit packages
<£10,000	27
£10,001 to £25,000	2
£25,001 to £50,000	0
£50,001 to £100,000	0
Total number of exit packages by type:	**29**
Total resource cost:	**£100,000**

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

Reporting of compensation schemes: exit packages 2020/21

Exit package cost band (including any special payment element)	Total number of exit packages
<£10,000	30
£10,001 to £25,000	1
£25,001 to £50,000	1
£50,001 to £100,000	0
Total number of exit packages by type:	**32**
Total resource cost:	**£137,000**

During 2020/21, the exit packages related to payments made in lieu of notice.

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

Highly paid off-payroll worker engagements as at 31 March 2022, earning £245 per day or greater	
Number of existing engagements as at 31 March 2022:	34
Of which, the number that have existed:	
For less than one year at time of reporting:	12
For between one and two years at time of reporting:	11
For between two and three years at time of reporting:	8
For between three and four years at time of reporting:	3
For four or more years at time of reporting:	0

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2022:	47
Of which:	
Not subject to off-payroll legislation*	3
Subject to off-payroll legislation and determined as in-scope of IR35*	44
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 2021 and 31 March 2022	
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)	20

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

Silas Nicholls
Chief Executive and Accounting Officer

20 June 2022

Disclosures set out in the NHS Foundation Trust Code of Governance

We have applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. Whilst the Financial Reporting Council issued a new UK Corporate Governance Code in 2018, the changes which were introduced have not yet been replicated within the NHS Foundation Trust Code of Governance.

The NHS Foundation Trust Code of Governance contains guidance on good corporate governance. NHS Improvement 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 2020/21.

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. Under normal circumstances, Governors canvas the views of foundation trust members and others on our forward plan and these views are communicated to the Board of Directors. This year, in line with the national approach, this did not take place however it will continue again in 2022/23.

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.

Our Council of Governors comprises 28 governors:

- 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 2021/22 of those governors who remain in post as at the date of writing:

Name	Constituency/organisation	Term of office ends (see note 1)	Attendance 2021/22 (see note 2)
Public governors			
Bill Anderton	Public: Wigan	2022	75%
Sean Campsall	Public: Wigan	2024	100%
Les Chamberlain	Public: Makerfield	2022	100%
Pauline Gregory	Public: Wigan	2022	100%
Ken Griffiths	Public: Makerfield	2022	50%
Andrew Haworth	Public: Leigh	2024	100%
Julie Hilling	Public: Rest of England and Wales	2024	N/A*
Mustapha Koriba	Public: Rest of England and Wales	2022	100%
Lisa Lymath	Public: Rest of England and Wales	2022	75%
Catherine Martindale	Public: Wigan	2024	100%
Malcolm Ryding	Public: Rest of England and Wales	2024	100%
Shelly Sephton	Public: Leigh	2023	100%
Susan Spibey	Public: Leigh	2024	100%
Linda Sykes	Public: Leigh	2022	75%
Philip Woods	Public: Makerfield	2023	100%
Staff governors			
Emily Cooper	Staff: Medical and Dental	2024	0%†
Lynsey Derbyshire	Staff: Nursing and Midwifery	2024	N/A*
Stephen Gorst	Staff: All other staff	2024	100%
Michelle Hartley	Staff: Nursing and Midwifery	2024	100%
Andrew Savage	Staff: All other staff	2023	100%
Appointed governors			
John Cavanagh	Foundation Trust volunteers	2024	100%
Carol Kelly	Edge Hill University	2024	100%
Dawne Gurbutt	University of Central Lancashire	2024	75%
Syed Shah	Local Medical Committee and CCG	2022	75%
Bryonie Shaw	Age UK Wigan Borough	2024	100%
Fred Walker	Wigan Council	2022	50%

Notes:

1. The term of office of all governors ends at the conclusion of the annual members' meeting in the year shown.
2. There were four formal meetings of the Council of Governors during 2021/22 in addition to informal workshops and briefing sessions. The attendance figures above are calculated on the basis of formal meetings only. In addition, due to the national restrictions in place, some business was transacted virtually throughout the year and this may have impacted on the ability to attend meetings.

* Julie Hilling and Lynsey Derbyshire were appointed after the last meeting of 2021/22 due to vacancies which arose in-year. They were not therefore eligible to attend any meetings during the year.

† Those governors who were elected or appointed in November 2021 were only eligible to attend one meeting during the year. Absence from that one meeting results in a 0% attendance rate for the year. Attendance figures should therefore be viewed in this context.

The Council of Governors appoints a lead governor each year. Andrew Haworth was appointed to this role on 11 January 2022, prior to which the role was held by Linda Sykes.

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 Company Secretary, using the details on page 155.

Nomination and Remuneration Committee

The Nomination and Remuneration Committee makes recommendations to the Council of Governors on the appointment and remuneration of the chair and the other non-executive directors. This year, the committee has led on the recruitment of two non-executive directors on behalf of the Council of Governors, as outlined on page 55.

Training and development for governors

During 2021/22, we provided our governors with access to a number of training and development opportunities to further support them in their role. These included externally provided training and development such as the GovernWell programme offered by NHS Providers and workshops provided by Mersey Internal Audit Agency and internal workshops and induction sessions

Communicating with governors

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

Email

governors@wwl.nhs.uk

Telephone

0800 073 1477

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

Post

Council of Governors
c/o Company Secretary
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 2021/22:

- Robert Armstrong
- Sanjay Arya
- Clare Austin
- Rhona Bradley
- Steven Elliot
- Mary Fleming
- Mick Guymer
- Ian Haythornthwaite
- Paul Howard
- Mark Jones
- Lynne Lobley
- Richard Mundon
- Silas Nicholls
- Francine Thorpe
- Tony Warne

The Council of Governors receives copies of the agendas of all board meetings in advance and copies of the minutes once approved. Under normal circumstances, 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.

As a result of the national restrictions in place throughout the year, this has not been possible. To ensure continued transparency and openness we invited a governor to attend our board meetings by videoconference as an observer and we have published the recordings of our board meetings on our website shortly after each meeting. Governors are also in attendance at each of our assurance committee meetings. This to help the Council of Governors to undertake its role of holding the board to account through the non-executive directors.

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

The types of decisions taken by each body are set out within our constitution and within the core governance documents of the organisation.

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

Our membership

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

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

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

- it is only possible to be a member of one constituency at any one time;

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

The table below provides a summary of our membership as at 31 March 2022 and comparative figures for the previous year have also been provided:

Constituency	No. members as at 31 Mar 2022	No. members as at 31 Mar 2021	Change
Public: Leigh	1,824	1,850	-26
Public: Makerfield	1,957	1,996	-39
Public: Wigan	2,450	2,505	-55
Public: Rest of England and Wales	2,564	2,591	-27
Staff: Medical and Dental	481	268	+213
Staff: Nursing and Midwifery	1,917	1,728	+189
Staff: All other staff	4,429	4,150	+279
Total members:	**15,622**	**15,088**	**+534**

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 review of systems of internal control undertaken by the board was informed by the work of the Audit Committee.

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

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

- progress with the implementation of actions arising from an internal audit review of risk management arrangements which received limited assurance during FY2020/21. Updates were also provided to the Board of Directors and confirmation was provided in-year by the internal auditors that all recommendations had been actioned appropriately;
- two limited assurance internal audit reports around private patients and overseas visitors, on which the committee was briefed during the year;
- regular reviews of the risk register and high-level risks, including the attendance of risk owners at meetings;
- an assurance review of the format of the assurance framework; and
- the high assurance level allocated to an internal audit of key financial systems.

Deloitte LLP served as our external auditors up to and including the audit in respect of FY2020/21 and KPMG became our external auditors during the year following a tender exercise which was conducted in 2020/21. No non-audit services were provided by KPMG during 2021/22. Whilst Deloitte were appointed to undertake our external review of leadership and governance for which a fee of £49,032 was paid, this contract was awarded to a different part of the wider Deloitte business and was not linked to the team who provided our external audit services.

A key aspect of the Audit Committee's work is to consider significant issues in relation to financial statements and compliance. As part of the preparation for the audit of financial statements, KPMG undertook a risk assessment and identified a number of risks, including management override of controls, valuation of land and buildings and the existence and accuracy of accrued expenditure. These are relatively standard audit risks prescribed by professional auditing standards and do not imply any particular control issues within the foundation trust.

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

Audit Committee membership and attendance during 2021/22 was as follows:

Name	A	B	%
Clare Austin	3	5	60%
Rhona Bradley	5	5	100%
Steven Elliot	3	5	100%
Ian Haythornthwaite (Chair)	5	5	100%

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

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

The Remuneration Committee

The Board of Directors has established a Remuneration Committee. Its responsibilities include consideration of matters relating to the remuneration and terms and conditions of office of the executive directors. The committee comprises all non-executive directors and is chaired by Mark Jones. Attendance information is provided on page 54.

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

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

The Nomination and Remuneration Committee

The Council of Governors has established a Nomination and Remuneration Committee. Its responsibilities include consideration of matters relating to the appointment, remuneration and other terms and conditions of service of the non-executive directors and providing recommendations to the Council of Governors for consideration. Membership and attendance information is provided on page 55.

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

NHS England and NHS Improvement's system oversight framework

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

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

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

Segmentation

WWL is currently placed in segment 2 of NHSI's Single Oversight Framework (providers offered targeted support; potential support needed in one or more of the five themes but not in breach of licence and/or formal action is not needed) as notified by NHS Improvement. This segmentation information represents the position as at 31 March 2022.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England and NHS Improvement website.

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

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

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

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

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

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

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

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

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

Silas Nicholls
Chief Executive and Accounting Officer

20 June 2022

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 NHS Teaching Hospitals 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 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

Active leadership from managers at all levels to ensure effective risk management is a fundamental part of an integrated approach to quality, corporate and clinical governance, performance management and assurance. Our Risk Management Group is usually chaired by me and it reviews all risks scoring 15 and above (more information on the scoring methodology used is provided below). Chairing the Risk Management Group allows me to get a good oversight of the arrangements but also allows me and other executive colleagues to reinforce the importance of this issue and the need for clear line of sight to the executive team.

The board and its committees receive and scrutinise the risks to achieving our corporate objectives through the board assurance framework. At the start of the year we updated the way in which we present our board assurance framework and, in doing so, we had regard to the views of our internal auditor and NHS benchmarking information that was made available to us.

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

As part of the on-boarding process, all new members of staff are required to attend a mandatory induction and undertake e-learning training covering key elements of risk management within two months of their appointment. This is also supplemented by local induction. The training is designed to provide an awareness and understanding of the risk management strategy, the risk management process and to give practical experience of completing risk assessment paperwork. Additional training is made available to all levels of staff, covering areas such as fire safety, health and safety, moving and handling, resuscitation and first aid.

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

The risk and control framework

Our risk management framework was updated in September 2021 and supports consistent and robust identification and management of opportunities and risks within desired levels across the trust, which in turn supports 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 determines and continuously assesses 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 ensures that planning and decision-making reflect 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, and the overall aim aim is to understand our overall risk profile. We use a range of techniques for identifying specific risks that may potentially impact on one or more objectives. Risk prioritisation is supported by risk assessment, which incorporates risk analysis and risk evaluation.

Evaluation of risk

The evaluation of risk is undertaken to determine whether the risk level is within our risk appetite and therefore tolerable, or whether the risk requires further control measures to reduce its level, known as risk treatment. The evaluation process takes account of 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 between 1 and 5, and these are then multiplied to provide an overall risk score. Risks which score 15 or above are reviewed by the Risk Management Group on a monthly basis. Our willingness to accept a risk which scores higher than our risk appetite or tolerance level will depend on which of the principal objectives is at risk and the positive or negative impact that the risk would have on objectives, if it were to materialise. Risk evaluation must therefore be 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 us to make an informed decision on accepting levels of risk.

Control of risk

Selecting the most appropriate risk treatment options 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 just economic considerations and considers all of our obligations, commitments and the views of our partners.

Our 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 will be implemented, so that arrangements are understood by those involved and effectiveness can be monitored. Where appropriate, we develop contingency, containment, crisis, incident and continuity management arrangements and communicate these to support resilience and recovery if risks materialise. Monitoring plays an important role before, during and after the implementation of risk treatments, and ongoing, continuous monitoring supports our 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. 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, I as the Accounting Officer and the wider board receive unbiased information about the trust's principal risks and how management is responding to those risks.

Risk appetite

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

A risk leader from the Executive Management Team is designated for each high-level risk on the board assurance framework and appropriate managers are designated for all other risks. Risk

leaders ensure that their risk management plan addresses the risks identified and are required to monitor the status of their risks through the relevant meetings.

The current risk appetite statement, correct as at the date of signing this report, is as follows:

Quality, innovation and outcomes	We have a **LOW** appetite for risks which materially have a negative impact on patient safety. We have a **LOW** appetite for risks that may compromise the delivery of outcomes without compromising the quality of care. We have a **SIGNIFICANT** appetite for innovation that does not compromise the quality of care.
Financial and value for money	We have a **MODERATE** appetite for financial risk in respect of meeting our statutory duties. We have a **MODERATE** appetite for risk in supporting investments for return and to minimise the possibility of financial loss by managing associated risks to a tolerable level. We have a **MODERATE** appetite for risk in making investments which may grow the size of the organisation.
Compliance/ regulatory	We have a **MODERATE** appetite for risks which may compromise our compliance with statutory duties or regulatory requirements.
Reputation	We have a **MODERATE** appetite for actions and decisions that, whilst taken in the interest of ensuring quality and sustainability of the patient in our care, may affect the reputation of the organisation.

The key quality governance committee is the Quality and Safety Committee which is chaired by a non-executive director. This committee seeks assurance that high standards of care are provided and ensures that there are adequate and appropriate governance structures, processes and controls in place across the organisation. Groups which report into the Quality and Safety Committee include dedicated groups around safeguarding, medicines management, infection control and health and safety.

The quality of performance information is assessed at divisional and corporate levels through the quality executive committee structures and divisional quarterly performance reviews. Information data quality is reviewed by the Data Quality Group.

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

The core services that were inspected were:

- surgery;
- critical care; and
- maternity

We are proud that our overall provider level was found to be Good with all sites being rated as either Good or Outstanding. We continue to maintain regular contact with our lead inspector and quarterly

engagement meetings are held, where emerging issues can be discussed and addressed at an early stage.

Our major risks are included on the board assurance framework, which included the following for 2021/22:

Patients:	▪ Human factors training - releasing Ward Managers to undertake training; ▪ Harm Free Care - avoidable pressure ulcers; ▪ Clinical services – acute kidney injury (AKI) and sepsis services are currently single nurse led over a 5-day working week. ▪ Clinical Services - recognition, screening and treatment of the deteriorating patient ▪ Clinical Services - Consultant cross-cover from Northern Care Alliance for the AKI service ▪ Clinical Services - Limited resources in relation to training and development for staff ▪ SHMI - Discharge and return to hospital ▪ SHMI - Primary and Secondary Care Pathway
People:	▪ Health and wellbeing - participation in preventative and restorative wellbeing activities ▪ Fairness and compassion - locality-wide workforce EDI strategy ▪ Recruitment and retention - learning Needs Analysis requirements ▪ Fairness and compassion - workforce EDI expertise and supporting infrastructure ▪ Culture - participation in the programmes
Performance:	▪ Financial sustainability: allocations and efficiencies ▪ Financial sustainability: efficiency targets ▪ Estates strategy - capital funding ▪ Core (or core +) activity exceeding the funding available ▪ Estates strategy - clinical strategies are still under development ▪ Estate strategy - net carbon zero requirements ▪ Elective services - Waiting List
Partnerships:	▪ Elective Hub – capital ▪ Partnership working – decision-making ▪ University Teaching Hospital – research capability funding ▪ Partnership working – local structural changes ▪ Elective Hub - staffing

These risks are likely to remain the same for FY2022/23.

Data security

The information governance work programme and performance against the national Data Security and Protection Toolkit and risks associated with data security are closely monitored by the Senior Information Risk Owner Group, which is chaired by the Director of Strategy and Planning as the nominated director for information risk and the Senior Information Risk Owner.

As a public authority, we have appointed a Data Protection Officer in accordance with the requirements of the Data Protection Act 2018. This post operates independently and reports directly to the board.

In line with best practice guidance from NHS England and NHS Improvement, we undertook an externally-facilitated review of leadership and governance using the NHS well-led framework during 2021/22. The review was undertaken by Deloitte LLP and the total cost of the review was £49,032. No major concerns were identified and we developed an action plan as a result, which we are monitoring through our public board meetings.

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

The review team acknowledged the recent period of transition given that the composition of the board had changed over the past year, but commented that the foundations are in place to evolve into a high performing board. The team commented that we follow good practice in several areas, including the development of our strategy, the launch of initiatives aimed at positively influencing culture and the refreshing of our risk management arrangements described earlier in this statement. Our committee structure was acknowledged to be in line with good practice, although some suggestions to improve effectiveness were shared, including an additional focus on the digital agenda.

In terms of areas of focus, the review team suggested that improvements in accountability from senior leaders should be a key priority for us, and a number of helpful suggestions as to how this could be achieved were provided. The team also observed a requirement for us to reset the relationship between the board and governors and to increase NED visibility across the organisation and we are looking to take these forward during FY2022/23.

Principal risks to compliance with the NHS foundation trust licence condition

The board has not identified any principal risks to compliance with provider licence condition FT4. This condition covers the effectiveness of governance structures, the responsibilities of directors and committees, the reporting lines and accountabilities between the board, its committees and the executive team.

The board is satisfied with the timeliness and accuracy of information to assess risks to compliance with the foundation trust's licence and the degree of rigour of oversight it has over performance.

Corporate governance statement

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

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

Risk management

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

From 1 April 2015, all NHS organisations were required to demonstrate how they are addressing race equality issues in a range of staffing areas through the nine-point Workforce Race Equality Standard metric. This standard has been fully embedded within current practice. We are also continuing to work closely with Wigan Borough Clinical Commissioning Group 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 the organisation through incident reporting. This is openly encouraged throughout the organisation and a 'just culture' is promoted.

We are in the top 25% of NHS organisations in relation to patient safety incidents reported to the National Reporting and Learning System and we report higher-than-average numbers of near misses. We consider this to be a positive position as it demonstrates that we have a strong culture of reporting and learning from incidents. Our approach to incident management is set out in our incident reporting policy. Identification and investigation of serious incidents and never events is undertaken by the Executive Scrutiny Group which is chaired by the Chief Nurse and attended by the Medical Director.

During the year, we have recruited to a dedicated Head of Risk post and our internal auditors have undertaken an audit of our risk management arrangements and we are grateful to them for the rigour with which they have done so. The findings of this audit allowed us to:

- Review and update our risk management strategy, policies and procedures;
- Undertake a review and redesign of our Datix risk register module to improve the quality of risk recording and forge links between the board assurance framework and the corporate risk register;
- Revise the format and remit of the Risk Management Group to focus more on assurance;
- Review governance arrangements, including an annual corporate risk register report which is presented to the board; and
    - Implement a trust-wide risk management training programme supported by risk guide documents.

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 Wigan Borough Clinical Commissioning Group's Locality Plan on the delivery of integrated care pathways.

We facilitate lay representation on a number of our key committees, including having governors on our Quality and Safety, Finance and Performance and People Committees. Governors also participate in PLACE visits, which is a nationally recognised system for assessing the quality of the patient environment, and they usually join with an executive and non-executive director in undertaking leadership and safety walks on a regular basis, although we have been unable to facilitate these in-year due to the national restrictions in place.

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 action can be agreed.

The board has oversight of workforce strategies via the People Committee which meets quarterly. This committee seeks assurance on our strategic priorities and any key themes. The People Committee also approves overarching strategies that fundamentally lead to safe, sustainable and effective staffing, such as our Recruitment and Retention Strategy and Apprenticeship Strategy. The board is sighted on the NHS Long Term Plan, specifically in relation to digital development and has implemented eJob Planning for medical staff. We will also consider expansions to eRostering and eJob Planning for wider workforce groups should capital resource funding be available via any bidding process. This will enable broader reporting on all staffing groups, thus providing additional assurance to the board.

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

The People Committee also oversees our wider talent management, leadership development and training initiatives designed to create resilience and capacity within the workforce. Our Nursing, Midwifery, Therapy and Care Staff Strategy reinforces this work in respect of the nursing, midwifery and therapy workforce and delivery of patient care and also defines our approach to vacancy gaps and turnover.

Nurse staffing is reported to the board at each meeting. 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.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the foundation 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 members' pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

The foundation trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The foundation trust ensures that its obligations under the Climate Change Act and the adaption 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, although this year it has been difficult to do so in the traditional way given the uncertainties around future financial years. Our arrangements include ensuring the financial plan is achievable, ensuring the delivery of efficiency requirements, compliance with our provider licence and the co-ordination of financial objectives with corporate objectives as approved by the board:

- objectives are approved and monitored through a number of channels, including regular review of the foundation trust's financial position by a dedicated Finance and Performance Committee;
- approval of annual budgets by the board;
- formal acceptance of annual budgets by delegated budget holders;
- monthly reporting to the board, via its committees, on key performance indicators covering quality and safety, finance, and workforce targets;
- scrutiny of divisional performance against objectives at committees;
- regular divisional performance reviews;
- reporting to NHS England and NHS Improvement and compliance with our provider licence;
- service transformation managed by a dedicated Transformation Team;
- in-year cost pressures are rigorously reviewed and challenged, and alternatives for avoiding cost pressures are always considered; and
- a robust assessment process for business cases.

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

- value for money is an important component of the internal and external audit plans that provides assurance to the board regarding processes that are in place to ensure effective use of resources;
- on-going benchmarking and tenders of operations occur throughout the year to ensure the competitiveness of service;
- we use numerous data sources in order to undertake comparative analysis. This analytic either provides assurances or helps identify opportunities for improvement in care provision;
- service line reporting is used by divisional managers to seek to improve financial performance;
- CQUINs are negotiated and signed off by clinical, operational and finance directors and operational leads are assigned for each scheme; and
- An on-line intelligence tool allowing individual budget holders to see their in-month and cumulative budget performance.

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

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

Information governance

Our information governance team reviewed 1,386 information incidents between 1 April 2021 and 31 March 2022, and we reported 25 incidents to the Information Commissioner's Office (ICO) during this period. Of these, 24 were closed by the ICO with no further action being taken. 1 incident remains open with the ICO and we also have an outstanding open incident from 2020/21.

The incidents reported to the ICO related to serious breaches of confidentiality and security where patient information had been shared inappropriately and in contravention of data protection legislation. Examples include a letter containing sensitive information being sent to an incorrect address, information disclosed to a family member in error, information shared via email to an incorrect recipient and inappropriate access of information. We continue to use software which proactively searches for potential instances of inappropriate access and these are followed up by members of our information governance team.

In 2021/22 we submitted three improvement plans as part of our Data Security and Protection Toolkit submission in June 2021. These improvement plans were monitored by the Senior Information Risk Owner Group and we submitted completed improvement plans in January 2022, thus meeting the standards for the 2021/22 return.

The information governance team works across the organisation to offer guidance and to support the implementation of remedial actions to address any shortfalls in controls where identified, in order to manage risk. All information governance incidents are reported on Datix, our incident management system, which aligns with regulatory requirements.

Data quality and governance

We are proud to be a data-driven organisation and we were recently recognised by the International Data Corporation by winning the Data-Powered Business Award 2021. That said, we realise that to make effective use of information, we need to put controls and procedures in place to ensure that the data which underpins our decisions is high quality.

The Data Analytics and Assurance team produces apps that highlight errors and inconsistencies in data, providing a level of transparency and allowing service managers to make improvements and develop procedures to address the issue at source.

It is the responsibility of all staff to ensure timely and accurate capture of information to ensure high data quality, as defined in our Data Quality Policy. However, we have a dedicated data quality team, responsible for advising on how we can make improvements to our data quality and providing analysis to identify issues that may have otherwise gone unnoticed. We are also taking steps towards implementing robotic process automation to further reduce the likelihood of error when processing data and to ensure data consistency between our different IT systems.

Our elective waiting list and waiting time data is highly scrutinised by the clinical divisions using numerous applications developed by the Data Analytics and Assurance team. The same team also monitors performance and compliance at an organisational level to ensure the data in the application is accurate.

Review of effectiveness

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

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

- the board assurance framework provides evidence of the process of the effectiveness of controls that manages the principal risks to the organisation
- the Board of Directors, Audit Committee, Quality and Safety Committee, the Risk Management Group and the Executive Scrutiny Group advise me on the implications of the results of my review of the effectiveness of the system of internal control. These committees also advise outside agencies in relation to serious events
- all the relevant committees within the corporate governance structure have a timetable of meetings and a reporting structure to enable issues to be escalated
- the board monitors and reviews the board assurance framework at each meeting. Risks noted on the board assurance framework are reviewed by the Finance and Performance Committee,

People Committee and Quality and Safety Committee as appropriate to their areas of focus and overall responsibility is retained by the Board of Directors

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

- the Audit Committee reviews performance against the NHS Foundation Trust Code of Governance

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

- 2 internal audits undertaken in 2021/22 were given limited assurance, relating to private patients and overseas visitors and to pressure ulcers, and management actions have been put in place to address the issues raised. Of the 46 recommendations issued by the internal auditors during the year, all were accepted by management. 11 of the recommendations were described as high-risk recommendations and were addressed immediately, with follow-up on the recommendations taking place.

The Head of Internal Audit Opinion for the period 1 April 2021 to 31 March 2022 provides substantial assurance that there is a good system of internal control designed to meet the organisation's objectives and that controls are generally being applied consistently. This opinion was provided in the context that we have progressed in a number of areas and in particular the Head of Internal Audit noted that continued enhancements have been made to the risk management framework as well as the board assurance framework, although further improvements to the board assurance framework are required including ensuring that the board assurance framework is strategically focused and includes all actions being taken to address gaps in controls and assurances; note was made of the fact that these improvements are being progressed. In addition, note was made of the significant improvements made as a result of a previous internal audit.

The internal audit plan has been refocused, reprioritised and reprofiled due to the continued impact of COVID-19 and operational pressures being experienced. In considering the overall opinion, the targeted and effective use of internal audit as part of the system of internal control has been considered. Internal audit resource has been directed into known risk areas and the risk-based approach we have adopted supports the overall opinion of substantial assurance.

Throughout the year, we had to continue alternative ways of working in response to the COVID-19 situation. Staff continued to work from home in significant numbers using a now well-established and well-embedded approach and we also ensured a risk-assessed presence on site as a fallback. The impact of these changes on the overall system of control was therefore minimal.

Conclusion

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

Silas Nicholls
Chief Executive and Accounting Officer

20 June 2022

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

Silas Nicholls
Chief Executive and Accounting Officer

20 June 2022

INDEPENDENT AUDITOR'S REPORT.

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 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 state of the Trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

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 Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to 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 Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

- Reading Board and Audit Committee minutes.

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

- Reviewing the Trust's accounting policies.

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

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

We did not identify any additional fraud risks.

In determining the audit procedures we took into account the results of our evaluation of some of the Trust-wide fraud risk management controls.

We also 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 entries made to unrelated accounts linked to the recognition of expenditure and other unusual journal characteristics.

- Assessing significant estimates for bias.

- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

- Assessing the existence and accuracy of recorded expenditure through specific testing over accruals.

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

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

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

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

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

The Trust is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

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

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

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

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

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. 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.
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.
- in our opinion that report has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on pages 86 and 87, 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 dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

We have nothing to report in this respect.

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

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of 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 issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the relevant NHS regulatory body 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 Trust incurring unlawful expenditure, or is about to take, or has taken, a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

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

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. 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 the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

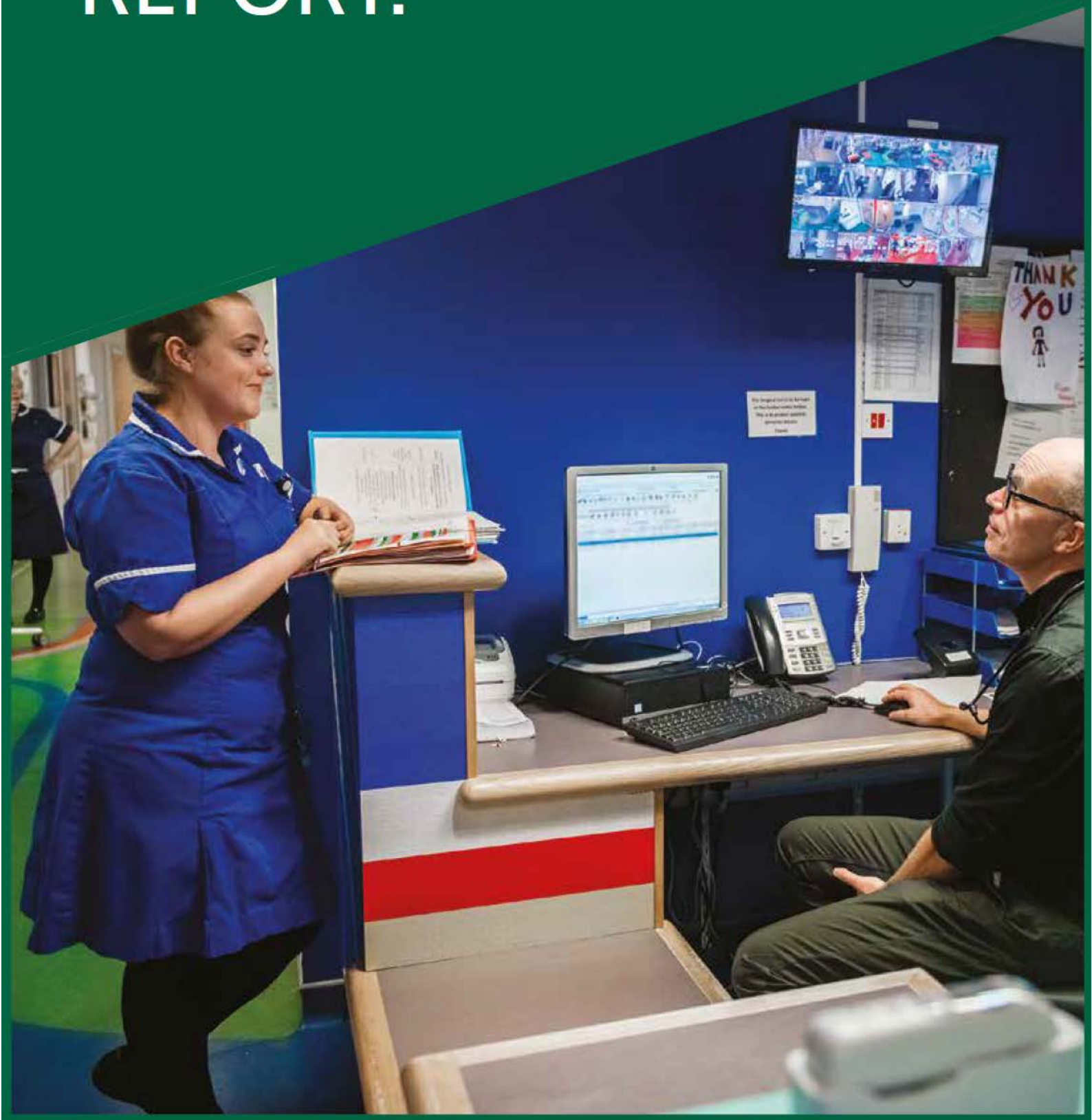
CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

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

21 June 2022

FINANCIAL REPORT.



Foreword to the accounts

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2022, have been prepared by Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed .....

Silas Nicholls
Chief Executive

Date **20 June 2022**

Statement of Comprehensive Income for the year ended 31 March 2022

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	2	451,213	383,588
Other operating income	3	25,976	71,202
Total operating income from continuing operations		**477,189**	**454,790**
Operating expenses	4	(474,687)	(463,795)
Operating surplus/(deficit) from continuing operations		**2,502**	**(9,005)**
Finance costs			
Finance income	7	56	(3)
Finance expenses	8	(312)	(332)
PDC dividends payable		(4,093)	(3,309)
Net finance costs		**(4,349)**	**(3,644)**
Loss on disposal of fixed assets	9	(311)	(64)
Gains from transfers by absorption	27	11	103
(Deficit) for the year		**(2,147)**	**(12,610)**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments	11	(2,861)	(3,208)
Revaluations	12	4,093	5,266
Other reserve movements		4	0
Total comprehensive expense for the year		**(911)**	**(10,552)**

The accompanying notes form part of these financial statements.

Statement of Financial Position as at 31 March 2022

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	10	5,729	1,902
Property, plant and equipment	11	203,647	193,498
Receivables	15	652	1,031
Total non-current assets		**210,028**	**196,431**
Current assets			
Inventories	14	3,001	3,281
Receivables	15	13,644	11,718
Non-current assets held for sale	16	0	310
Cash and cash equivalents	17	54,085	45,044
Total current assets		**70,730**	**60,353**
Current liabilities			
Trade and other payables	18	(78,520)	(63,712)
Other liabilities	19	(3,304)	(402)
Borrowings	20	(1,588)	(1,008)
Provisions	22	(3,796)	(3,820)
Total current liabilities		**(87,208)**	**(68,942)**
Total assets less current liabilities		**193,550**	**187,842**
Non-current liabilities			
Other liabilities	19	(186)	(266)
Borrowings	20	(13,923)	(14,192)
Provisions	22	(2,369)	(2,926)
Total non-current liabilities		**(16,478)**	**(17,384)**
Total assets employed		**177,072**	**170,458**
Financed by			
Public dividend capital		117,458	109,933
Revaluation reserve		22,624	21,788
Income and expenditure reserve		36,990	38,737
Total taxpayers' equity		**177,072**	**170,458**

The accompanying notes form part of these financial statements.

The primary financial statements on pages 110 to 113 and the notes on pages 114 to 154 were approved by the Board of Directors and authorised for issue on 20 June 2022 and signed on its behalf by Silas Nicholls, Chief Executive

Signed ..... **20 June 2022**
Silas Nicholls, Chief Executive

Statement of Changes in Equity for the year ended 31 March 2022

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2020	**99,466**	**20,686**	**50,391**	**170,543**
(Deficit) for the year	0	0	(12,610)	**(12,610)**
Other transfers between reserves	0	(737)	737	**0**
Impairments	0	(3,208)	0	**(3,208)**
Revaluations	0	5,266	0	**5,266**
Transfer to retained earnings on disposal of asset	0	(219)	219	**0**
Public dividend capital received	10,467	0	0	**10,467**
Taxpayers' equity at 31 March 2021	**109,933**	**21,788**	**38,737**	**170,458**

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	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus/(deficit)		2,502	(9,005)
Non-cash income and expense			
Depreciation and amortisation	4	10,799	9,226
Net impairments and (reversals) of impairments	4	2,432	6,504
Income recognised in respect of capital donations (non-cash)	3	(252)	(715)
Decrease in receivables and other assets		(1,812)	7,973
Decrease/(Increase) in inventories		280	1,262
Increase in payables and other liabilities		10,635	11,480
Decrease in provisions		(610)	4,014
Other movement in operating cashflows		(3)	0
Net cash generated from operating activities		**23,971**	**30,739**
Cash flows used in investing activities			
Interest received		28	13
Purchase of intangible assets		(4,306)	(1,197)
Purchase of property, plant, equipment and investment property		(15,389)	(35,643)
Receipt of cash donation to purchase capital assets		180	10
Sales of property, plant, equipment and investment property		363	0
Net cash used in investing activities		**(19,124)**	**(36,817)**
Cash flows used in financing activities			
Public dividend capital received		7,525	10,467
Loans received		1,247	1,460
Loans paid		(930)	(4,226)
Other interest paid		(289)	(321)
PDC dividend paid		(3,359)	(3,427)
Net cash used in financing activities		**4,194**	**3,953**
Increase in cash and cash equivalents		**9,041**	**(2,125)**
Cash and cash equivalents at 1 April		45,044	47,169
Cash and cash equivalents at 31 March	17	**54,085**	**45,044**

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Foundation 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 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

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

1.1 Accounting convention

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

1.2 Going concern

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

1.3 Joint arrangements

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

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

1.4 Critical accounting judgements and key sources of estimation uncertainty

1.4.1 Critical judgements in applying accounting policies

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

Operating segments

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

Interests in other entities and joint arrangements

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

The Foundation Trust has assessed its existing contracts and collaborative arrangements for 2021/22, and has determined that the arrangements which would fall within the scope of IFRS 10, IFRS 11 Joint Arrangements or IFRS 12 Disclosure of Interests in Other Entities, are the NHS Foundation Trust's subsidiary charity, the NHS Foundation Trust's investment into the Community Health Investment Plan (CHIP) and three joint operations (Note 13).

Consolidation

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

Where the fund balances held by the Charity are deemed to be of a significant value to require consolidation, then those balances will be consolidated into the Foundation Trust Accounts. There is no consolidation for 2021/22.

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 2021/22 with a revaluation date of 31 March 2022.

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 2022 is £209m (£195m, 2020/21).

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 healthcare services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

NHS Injury Cost Recovery Scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pensions Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.6 Other forms of income

Apprenticeship service income

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

Income from sale of non-current assets

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same ways as government grants.

1.7 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy are recognised in the period in which the service is received from employees including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

NHS Pensions

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

National Employment Savings Trust (NEST)

NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body (NDPB) operating at arm's length from government, and it reports to Parliament through the Secretary of State for Work and Pensions.

This alternative scheme is a defined contribution scheme, provided under the Foundation Trust's 'automatic enrolment' duties for a small number of employees who are excluded from actively contributing to the NHS pension scheme. Under a defined contribution plan, an entity pays fixed contributions to a separate entity (a fund) and has no obligation to pay further contributions if the fund does not hold sufficient assets to pay employee benefits.

The Foundation Trust is legally required to make a minimum contribution for opted-in employees who earn more than the qualifying earnings threshold, and the cost to the Foundation Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. That is, employer's pension costs of contributions are charged to operating expenditure as and when they become due.

1.8 Other expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

● it is held for use in delivering services or for administrative purposes;
● it is probable that future economic benefits will flow to, or service potential be provided to the Foundation Trust;
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and
● the item has a cost of at least £5,000; or
● collectively a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, for example, plant and equipment then these components are treated as separate assets and depreciated over their own useful economic lives.

All property, plant and equipment is measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

The carrying value of other existing assets will be written off over their remaining useful lives, and are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS13 Fair Value Measurement, if it does not meet the requirements of IAS40 Investment Property or IFRS5 Non-current assets held for sale.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated at the point it becomes classified as Held for Sale. Assets in the course of construction are not depreciated until the assets are brought into use. Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by a qualified valuer recognised in accordance with RICS.

Property, plant and equipment is depreciated over the following useful lives:

Buildings excluding dwellings	10 to 70 years
Dwellings	14 to 48 years
Plant and Machinery	10 to 20 years
Vehicles	10 to 13 years
Furniture and fittings	15 years
Medical and other equipment	15 years
Information Technology	8 years

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenditure, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenditure.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

- the impairment charged to operating expenses; and
- the balance in the revaluation reserve attributable to that asset before impairment.

An impairment arising from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that give rise to the loss are reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Assets under construction

Assets under construction are measured at cost of construction less any impairment loss, as at 31 March. Assets are reclassified to the appropriate category when they are brought into use.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as Held for Sale and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust and where the cost of the asset can be measured reliably.

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated historical cost and the value in use where the asset is income generating.

Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets re-classified as held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS13 Fair Value Measurement, if it does not meet the requirements of IAS40 Investment Property or IFRS5 Non-current assets held for sale.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Foundation Trust intends to complete the asset and sell or use it;
- the Foundation Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset; and
- the Foundation Trust can measure reliably the expenses attributable to the asset during development.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Intangible assets are amortised over the following useful lives:

Websites	8 years
Development expenditure	8 years
Software	8 years

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. All inventories are measured using the First In, First Out (FIFO) method other than drugs which are measured using the weighted average cost method.

1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Foundation Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and liabilities are subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable. After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Foundation Trust recognises an allowance for expected credit losses.

The Foundation Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are the probability weighted losses expected from credit loss events occurring within a defined period. Probabilities are determined based on experience and knowledge obtained through the debt collection process.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Foundation Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.14 Leases

Finance leases

The Foundation Trust does not have any finance leases.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.15 Provisions

The Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

Short term rate: 0.47% (-0.02%, 2020/21)
Medium term rate: 0.70% (0.18%, 2020/21)
Long term rate: 0.95% (1.99%, 2020/21)

For post-employment benefits including early retirement provisions and injury benefit provisions the HM Treasury's pension discount rate of -1.30% in real terms (-0.95%, 2020/21) is used.

1.16 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Foundation Trust pays an annual contribution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the NHS Foundation Trust is disclosed in Note 22.1 but is not recognised in the NHS Foundation Trust's accounts.

1.17 Non-clinical risk pooling

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 Contingent assets and contingent liabilities

A contingent assets is a possible asset that arises from past events and whose existence will only be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Foundation Trust. A contingent asset is disclosed in Note 23 where an inflow of economic benefits is probable.

A contingent liability is:

● a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of Foundation Trust, or

● a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed in Note 23 unless the possibility of payment is remote.

Where the time value of money is material, contingent assets and contingent liabilities are disclosed at their present value.

1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at: https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.20 Value added tax

Most of the activities of the Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Corporation tax

As an NHS Foundation Trust, Wrightington, Wigan and Leigh Teaching NHS Foundation Trust is specifically exempted from corporation tax through the Corporation Tax Act 2010. The Act provides that HM Treasury may dis-apply this exemption only through an order via a statutory instrument (secondary legislation). Such an order could only apply to activities which are deemed commercial, and arguably much of the Foundation Trust's other operating income is ancillary to the provision of healthcare, rather than being commercial in nature. No such order has been approved by a resolution of the House of Commons. There is therefore no corporation tax liability in respect of the current financial year.

1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Foundation Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 Transfers by Absorption

Where a DHSC group body is the recipient in the transfer of a function, it recognises the assets and liabilities received as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition (i.e. the recipient and exporter of the assets and liabilities recognise the same values). The corresponding net credit / debit reflecting the gain / loss is recognised within income / expenses, but outside of operating activities.

1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases: will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

Estimated impact on 1 April 2022 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	27,201
Additional lease obligations recognised for existing operating leases	(27,201)
Net impact on net assets on 1 April 2022	**0**
Estimated in-year impact in 2022/23	**£000**
Additional depreciation on right of use assets	(4,487)
Additional finance costs on lease liabilities	(258)
Lease rentals no longer charged to operating expenditure	4,798
Other impact on expenditure	(159)
Estimated impact on surplus / deficit in 2022/23	(106)
Estimated increase in capital additions for new leases commencing in 2022/23	**1,706**

IFRS 14 Regulatory Deferral Accounts: Not UK endorsed. Applies to first time adopters of IFRS after 1 April January 2016. Therefore, not applicable to DHSC group bodies.

IFRS 17 Insurance contracts: [new standard] (2023/24) – work has not yet started on understanding the full impact of this new standard in the NHS, however on the basis that the Foundation Trust does not issue insurance contracts it is unlikely that this standard will impact the Foundation Trust accounts.

IFRS - International Financial Reporting Standards
IFRIC – International Financial Reporting Interpretation Committee

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by source)

Income from patient care activities received from:

	2021/22 £000	2020/21 £000
NHS England	36,755	35,251
Clinical Commissioning Groups	396,934	332,416
NHS Foundation Trusts	4,711	4,395
NHS Trusts	37	8
Local Authorities	5,820	7,422
Department of Health and Social Care	143	0
NHS other (including Public Health England)	123	244
Non NHS: private patients	4,459	2,349
Non NHS: overseas patients (chargeable to patient)	141	160
NHS injury scheme (ICR)*	823	816
Non NHS: other	1,267	526
Total income from activities	**451,213**	**383,588**

*NHS injury scheme income is subject to a provision for doubtful debts of 23.76% (22.43%, 2020/21) to reflect expected rates of collection.

Note 2.2 Income from patient care activities (by nature)

	2021/22 £000	2020/21 £000
Acute services		
Block contract / system envelope income	370,003	309,994
High cost drugs income from commissioners (excluding pass through costs)	1,743	547
Other NHS clinical income*	11,023	10,101
Community Services		
Block contract / system envelope income	40,329	37,644
Income from Other Sources (e.g. local authorities)	5,777	6,180
Additional income		
Private patient income	4,459	2,350
Elective recovery fund	4,142	0
Additional pension contribution central funding **	11,143	10,308
Other clinical income***	2,594	6,464
Total income from activities	**451,213**	**383,588**

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

**From 1 April 2019 the employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge). Since 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** Other clinical income relates largely to income from the NHS Injury Cost Recovery Scheme (ICR) for third party injury claims.

Note 2.3 Overseas visitors

	2021/22 £000	2020/21 £000
Income recognised this year	141	160
Cash payments received in-year	65	26
Amounts added to allowance for impaired contract receivables	114	29
Amounts written off in-year	68	61

Note 3 Other operating income

	2021/22 £000	2020/21 £000
Other operating income from contracts with customers:		
Research and development (contract)	1,854	1,225
Education and training (excluding notional apprenticeship levy income)	11,258	12,142
Non-patient care services to other bodies	2,484	2,545
Reimbursement and top up funding *	618	41,476
Income in respect of employee benefits accounted on a gross basis**	3,659	2,266
Other contract income***	3,922	4,012
Other non-contract operating income		
Education and training - notional apprenticeship levy income	522	336
Receipt of capital grants and donations	0	618
Charitable and other contributions to expenditure	268	131
Contribution to expenditure - consumables donated from DHSC****	1,292	6,354
Rental revenue from operating leases	96	96
Other	3	0
Total other operating income	**25,976**	**71,202**

*During 2020/21 the Foundation Trust received national Funding from NHSE/I and the Department of Health and Social Care to support the impact on income and expenditure of COVID. For the current year this funding has been included within block contract/system envelope funding as detailed in Note 2.2.

**Income in respect of employee benefits accounted for on a gross basis relates to recharges of staff costs for which there is a corresponding employee expense in operating expenses.

***Other contract income of £3.9m (£4m, 2021/22) includes car parking income, catering income, pharmacy income, staff accommodation rental and other miscellaneous income recharged to other NHS bodies.

**** During the year, the Foundation Trust received personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Foundation Trust has accounted for the receipt of these at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. A corresponding expenditure entry has been recorded in Note 4.

Note 3.1 Additional information on contract revenue recognised in the period

	2021/22 £000	2020/21 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	0	149

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:

	2021/22 £000	2020/21 £000
Income from services designated as commissioner requested services	439,952	376,235
Income from services not designated as commissioner requested services	11,261	8,170
Total	**451,213**	**384,405**

Note 4 Operating expenses

	2021/22 £000	2020/21 £000
Purchase of healthcare from NHS and DHSC bodies	2,299	2,482
Purchase of healthcare from non-NHS and non-DHSC bodies	3,493	6,364
Employee expenses - executive directors	1,605	1,506
Employee expenses - non-executive directors	181	174
Employee expenses - staff *****	295,321	287,405
Employee expenses - temporary staff	35,023	26,858
Supplies and services - clinical*	37,905	37,430
Supplies and services - general	3,412	4,878
Drug costs (inventory consumed & non-inventory purchases)	26,863	22,560
Inventories written down	88	168
Establishment	3,318	4,023
Transport	2,299	3,367
Premises	24,108	24,305
Movement in credit loss allowance: contract receivables/contract assets	870	193
Change in provisions discount rate	(45)	(59)
Operating lease expenditure (net)	5,171	5,340
Depreciation on property, plant and equipment	10,300	8,712
Amortisation on intangible assets	499	514
Net Impairments**	2,432	6,504
Audit fees payable to the external auditor		
audit services - statutory audit****	121	96
Internal audit and local counter fraud services	164	141
Clinical negligence	12,210	11,231
Legal fees	824	1,629
Insurance	393	468
Education and Training	1,885	3,654
Redundancy and other mutually agreed resignation schemes	0	44
Losses, ex gratia & special payments*****	718	1,013
Other***	3,230	2,796
Total	**474,687**	**463,795**

* During the year, the Foundation Trust received personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Foundation Trust has accounted for the receipt of these at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. The total value transacted within supplies and services - clinical is £1.3m (£6.3m. 2020/21). A corresponding Income entry has been recorded in Note 2.3.

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

***Other expenditure of £3.2m (£2.7m, 2021/22) includes car parking and security costs, dilapidation costs and other miscellaneous expenditure charges.

****Audit fees inclusive of VAT, note 4.1 refers.

***** Prioir year re-stated in respect of corrective overtime paymets, further details can be found in note 26.

Note 5 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	238,543	236,013
Social security costs	22,836	20,660
Apprenticeship levy*	1,074	1,020
Employer's contributions to NHS pensions	25,577	23,706
Employer's contributions to NHS pensions paid by NHSE on behalf of the Foundation Trust (6.3%)**	11,143	10,308
Temporary staff***	35,023	26,858
Total staff costs	**334,196**	**318,565**
Costs capitalised as part of assets	1,534	1,771

*The Apprenticeship Levy requires all employers operating in the UK, with a pay bill over £3m each year, to invest in apprenticeships. The Foundation Trust is required to pay a levy of 0.5% of it's pay bill, less an allowance of

**From 1 April 2019 the employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge).Since 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** During the year temporary staff costs increased by £8m and this primarily related to bank expenditure for registered nurses and support to nursing staff.

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 4 early retirements agreed on the grounds of ill-health during the year (3, 2020/21). The cost of these ill-health retirements, £234k (£197k, 202/21) is borne by the NHS Business Services Authority - Pensions Division.

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

	2021/22 £000	2020/21 £000
Salary	1,359	1,282
Employer's pension contributions	153	170
Taxable benefits	1	1
Total	**1,513**	**1,453**
Non-executive directors' remuneration *	181	174
Total	**1,694**	**1,627**
The total number of directors accruing benefits under the NHS Pension Scheme	8	11

* Non-executive directors are not members of the NHS Pension Scheme.

Further details of directors' remuneration can be found in the remuneration section of the Annual Report.

Note 4.1 Auditor remuneration

Audit fees receivable by the external auditor in respect of the statutory audit amounted to £101k in 2021/22 (2020/21, £80k)

There was no other auditor remuneration during the current or prior year.

Note 4.2 Limitation on auditor's liability

There is a £1m limitation on auditor's liability for external audit work carried for the financial years 2020/21 and 2021/22.

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.

	2021/22		2020/21	
	Number	£000	Number	£000
Non-NHS				
Trade invoices paid in the period	65,601	217,751	59,601	205,932
Trade invoices paid within target	61,231	199,981	56,486	194,718
Percentage of trade invoices paid within target	**93.3%**	**91.8%**	**94.8%**	**94.6%**
NHS				
Trade invoices paid in the period	1,932	36,231	1,897	37,343
Trade invoices paid within target	1,648	29,939	1,709	31,880
Percentage of trade invoices paid within target	**85.3%**	**82.6%**	**90.1%**	**85.4%**
Total				
Trade invoices paid in the period	67,533	253,982	61,498	243,275
Trade invoices paid within target	62,879	229,920	58,195	226,598
Percentage of trade invoices paid within target	**93.1%**	**90.5%**	**94.6%**	**93.1%**

Note 7 Finance income

	2021/22 £000	2020/21 £000
Interest on bank accounts	56	(3)
Total	**56**	**(3)**

Note 8 Finance expenses

	2021/22 £000	2020/21 £000
Interest expense		
Loans from the Department of Health and Social Care	283	310
Total interest expense	**283**	**310**
Other finance costs - unwinding of discount	29	22
Total	312	332

Note 9 Gains and losses on disposal of assets

	2021/22 £000	2020/21 £000
(Loss) on disposal of assets	(311)	(64)
Total	**(311)**	**(64)**

The loss on disposal of assets arose as a result of a loss on sale of Aspull Clinic, Note 16, and various items of medical equipment becoming beyond economic repair.

Note 5.3 Employee benefits

An accrual in respect of annual leave entitlements carried forward at the Statement of Financial Position date of £4.6m has been provided for within the accounts (£3.2m, 2020/21). There were no other employee benefits during

Note 6 Operating leases

Note 6.1 Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust as a lessee

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	5,171	5,340
Total	**5,171**	**5,340**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	4,995	5,095
- later than one year and not later than five years;	15,282	16,882
- later than five years.	13,461	16,212
Total	**33,738**	**38,189**

The Foundation Trust leases various premises, primarily to accommodate administrative functions, under operating leases at market rates, for periods up to 5 years.

The Foundation Trust also leases equipment and vehicles for periods not exceeding 7 years.

Leased equipment chiefly comprises complex medical equipment used in the delivery of healthcare. The majority of vehicle leases are rolling 'monthly hire' arrangements for transport between Foundation Trust sites.

Where applicable, break clauses in the Foundation Trust's lease contracts have been taken into account in the calculation of future minimum lease payments.

Note 6.2 Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust as a lessor

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	96	96
Total	**96**	**96**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease receipts due:		
- not later than one year	96	96
- later than one year and not later than five years;	385	385
- later than five years.	217	313
Total	**698**	**794**

Note 10 Intangible assets

Note 10.1 Intangible assets - 2021/22

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

Note 10.2 Intangible assets - 2020/21

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation/gross cost at 1 April 2020	**12,615**	**713**	**44**	**13,372**
Additions	1,080	0	0	1,080
Impairments charged to Operating Expenses	(739)	0	0	(739)
Valuation/gross cost at 31 March 2021	**12,956**	**713**	**44**	**13,713**
Amortisation at 1 April 2020	**10,664**	**704**	**16**	**11,384**
Provided during the year	502	7	5	514
Impairments charged to operating expenses	(87)	0	0	(87)
Amortisation at 31 March 2021	**11,079**	**711**	**21**	**11,811**
Net book value at 31 March 2021	**1,877**	**2**	**23**	**1,902**
Net book value at 1 April 2020	**1,951**	**9**	**28**	**1,988**

Note 10.3 Intangible assets financing 2021/22

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

Note 10.4 Intangible assets financing 2020/21

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Purchased	1,823	2	23	1,848
Donated	54	0	0	54
NBV total at 31 March 2021	**1,877**	**2**	**23**	**1,902**

Note 11 Property, plant and equipment

Note 11.1 Property, plant and equipment - 2021/22

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

Note 11.2 Property, plant and equipment - 2020/21

	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 2020	**8,643**	**115,608**	**1,907**	**15,665**	**48,137**	**195**	**36,042**	**442**	**226,639**
Transfers by absorption	0	0	0	0	103	0	0	0	103
Additions	0	19,457	10	5,296	6,526	0	3,226	85	34,600
Impairments	(278)	(9,477)	(326)	(1,101)	0	0	0	0	(11,182)
Reversals of impairments	430	(468)	38	0	0	0	0	0	0
Reclassifications	0	12,616	0	(12,616)	0	0	0	0	0
Revaluations	444	4,395	243	0	0	0	0	0	5,082
Tranfers to assets held for sale	(78)	(232)	0	0	0	0	0	0	(310)
Disposals/derecognition	0	0	0	0	(1,543)	0	0	0	(1,543)
Valuation/gross cost at 31 March 2021	**9,161**	**141,899**	**1,872**	**7,244**	**53,223**	**195**	**39,268**	**527**	**253,389**
Accumulated depreciation at 1 April 2020	**0**	**2,472**	**18**	**0**	**32,817**	**160**	**19,224**	**273**	**54,964**
Provided during the year	0	3,800	74	0	1,687	9	3,122	20	8,712
Impairments	0	(2,131)	9	0	0	0	0	0	(2,122)
Revaluations	0	(119)	(65)	0	0	0	0	0	(184)
Disposals/derecognition	0	0	0	0	(1,479)	0	0	0	(1,479)
Accumulated depreciation at 31 March 2021	**0**	**4,022**	**36**	**0**	**33,025**	**169**	**22,346**	**293**	**59,891**
Net book value at 31 March 2021	**9,161**	**137,877**	**1,836**	**7,244**	**20,198**	**26**	**16,922**	**234**	**193,498**
Net book value at 1 April 2020	**8,643**	**113,136**	**1,889**	**15,665**	**15,320**	**35**	**16,818**	**169**	**171,675**

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

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned	9,200	142,352	1,949	7,244	21,214	43	17,674	203	199,879
Donated	0	1,959	0	0	1,787	0	14	8	3,768
NBV total at 31 March 2022	**9,200**	**144,311**	**1,949**	**7,244**	**23,001**	**43**	**17,688**	**211**	**203,647**

Note 11.4 Property, plant and equipment financing - 2020/21

	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	9,161	137,853	1,836	7,244	19,507	26	16,922	234	192,783
Donated	0	24	0	0	691	0	0	0	715
NBV total at 31 March 2021	**9,161**	**137,877**	**1,836**	**7,244**	**20,198**	**26**	**16,922**	**234**	**193,498**

Note 11.5 Impairment of assets

	2021/22 £000	2020/21 £000
Net impairments charged to operating (deficit) / surplus resulting from:		
Abandonment of assets in the course of constructior	0	1,102
Other	0	652
Changes in market price	2,432	4,750
Impairments charged to operating (deficit) / surplus	2,432	6,504
Impairments charged to the revaluation reserve	2,861	3,208
Total net impairments	**5,293**	**9,712**

Note 12 Revaluations of property, plant and equipment

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

A desk top valuation was undertaken during 2021/22 with a revaluation date of 31 March 2022.

As a result of this valuation some land and buildings have seen an increase in value totalling £7.9m.

In addition, some land and buildings have decreased in value totalling £9.1m. £6.3m has been charged to operating expenditure offset by the reversal of previous impairments totalling £3.9m to give a net impact on expenditure of £2.4m.

The net effect of these changes in value amounts to an overall decrease in land and buildings of £1.2m.

Assets revalued have been written down to their recoverable amount within the Statement of Financial Position, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for that asset and, thereafter, to expenditure - impairment of property plant and equipment. Increases in value have been credited to the revaluation reserve unless circumstances arose whereby a reversal of an impairment was necessary. In these circumstances this has been netted off against impairments in expenditure.

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.

Note 13 Disclosure of interests in other entities

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

The Foundation Trust does not attribute levels of risk significantly above 'business as usual' with these arrangements, as the operators are all partner NHS bodies and local authority organisations, working together within the same healthcare and community operating environment. In practical terms, this translates to longstanding related party relationships based in contracts and transactions, collaborative working, shared objectives and common policies.

The Foundation Trust's joint operations are detailed below.

Pathology at Wigan & Salford (PAWS)

The Foundation Trust works collaboratively with Salford Royal NHS Foundation Trust to provide pathology services to both Trusts. The intention of the arrangement is to reduce running costs through centralisation and provide resilience in each trust's pathology services. The majority of activity is carried out at a Salford site, with an essential services laboratory remaining at the Wigan site.

The Foundation Trust retains the rights to assets contributed at the start of the arrangement, and new equipment is split between both trusts when purchased. As the 'host' partner, Salford Royal NHS Foundation Trust retains the obligation to pay suppliers' invoices, recharging Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust for its share of PAWS-related expenditure (£10.8m in year and £9.1m, 2020/21).

Sterile Services Decontamination Unit (SSDU)

In this joint working arrangement with Salford Royal NHS Foundation Trust, both Foundation Trusts receive sterile services, which chiefly involves the decontamination of surgical instruments. The arrangement is similar to PAWS in that the Foundation Trusts intend to reduce running costs through centralisation, provide resilience in each organisation's sterile services, and create income through selling services to other providers in the local health economy. The majority of activity is carried out at a site in Bolton with a small service retained at the Leigh site.

The Foundation Trust retains the rights to assets contributed to the arrangement. As the 'host' partner, Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust retains the obligation to pay the majority of suppliers' invoices, recharging Salford Royal NHS Foundation Trust, for its share of SSDU-related expenditure (£2.5m in year and £2.4m, 2020/21).

Well Being Partners

This arrangement is jointly operated by Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (the 'host' operator), Lancashire Teaching Hospitals NHS Foundation Trust and Bolton NHS Foundation Trust. The collaboration is designed to provide resilience to each of the three operators' occupational health services and to create income through selling services to other bodies. The activity is carried out at all three Foundation Trusts' sites with additional outreach clinics. The Foundation Trust's share of expenditure for the year was £0.4m (£0.7m, 2020/21).

Community Health Investment Plan (CHIP)

The Foundation Trust has invested £20m into CHIP, a joint initiative with Wigan Borough Council to fund the construction of community facilities which will help to stem demand into the hospital and improve the overall health and wellbeing of the population of the Wigan borough.

During the year the Trust transferred £4m from cash and cash investments to support the construction of cycle lanes within the Wigan Borough. This concludes the community heatlh investment plan ageed with Wigan Borough Council.

Note 14 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	1,245	1,268
Consumables	1,641	1,869
Energy	102	92
Other	13	52
Total inventories	**3,001**	**3,281**

Inventories recognised in expenses for the year were £28m (£27m, 2020/21).

Note 15 Trade and other receivables

Note 15.1 Trade and other receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables invoiced/non-invoiced	9,011	6,772
Allowance for impaired contract receivables	(1,772)	(971)
Prepayments (non-PFI)	3,659	3,619
Interest receivable	28	0
PDC dividend receivable	0	293
VAT receivable	1,592	1,271
Other receivables	1,126	734
Total current trade and other receivables	**13,644**	**11,718**
Non-current		
Allowance for impaired contract receivables	(51)	(62)
Other receivables	703	1,093
Total non-current trade and other receivables	**652**	**1,031**
Of which receivables from NHS and DHSC group bodies:		
Current	3,839	3,560
Non-Current	489	817

Note 15.2 Allowances for credit losses - 2021/22

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

Note 15.3 Allowances for credit losses - 2020/21

	Contract receivables and contract assets £000
Allowances as at 1 April 2020 - brought forward	1,011
New allowances arising	221
Reversals of allowances	(28)
Utilisation of allowances (write offs)	(171)
Allowances as at 31 March 2021	**1,033**

Note 16 Assets held for Sale

The Trust did not hold any assets for sale at the end of the financial year. Aspull Clinic, held for sale at the end of 2021 at a value of £310k was sold for £232k during the course of the year. The associated loss on disposal £78k, is disclosed within Note 9.

Note 17 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.

	2021/22 £000
At 31 March 2021	**45,044**
Net change in year	9,041
At 31 March 2022	**54,085**
Broken down into	
Cash in hand	6
Cash with the Government Banking Service	54,079
Total cash and cash equivalents	**54,085**

Note 17.1 Third party assets held by the NHS foundation trust

During the year the Foundation Trust held cash relating to monies held on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts. The Foundation Trust also holds in the normal course of business consignment inventories which comprise orthopaedic prosthesis. These are held on Foundation Trust premises and still owned by the supplier. The Foundation Trust is only obliged to pay for these assets when they are used.

	31 March 2022 £000	31 March 2021 £000
Monies held on behalf of patients	6	0
Consignment inventories	6,596	6,955
Total third party assets	**6,602**	**6,955**

Note 18 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	15,767	11,839
Capital payables	13,489	6,929
Accruals	37,343	34,519
Social security costs	3,540	3,318
Other taxes payable	2,815	2,414
PDC dividend payable	441	0
Other payables	5,125	4,693
Total current trade and other payables	**78,520**	**63,712**
Of which payables to NHS and DHSC group bodies:		
Current	6,593	6,222

Note 19 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income : contract liabilities	3,304	402
Total other current liabilities	**3,304**	**402**
Non-current		
Deferred income : contract liabilities	186	266
Total other non-current liabilities	**186**	**266**

Note 20 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from the Department of Health and Social Care	845	851
Other loans	743	157
Total current borrowings	**1,588**	**1,008**
Non-current		
Loans from the Department of Health and Social Care	11,502	12,271
Other loans	2,421	1,921
Total non-current borrowings	**13,923**	**14,192**

Other loans relate to public sector energy efficiency loans with Salix Finance Limited. These loans are interest-free and have financed a number of energy-saving schemes throughout the Foundation Trust. Repayments are phased to match the projected savings from the schemes. Details of the loans from the Department of Health and Social Care are detailed in Note 25.

Note 21 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Total £000
Carrying value at 31 March 2021	**13,122**	**2,078**	**15,200**
Cash movements:			
Financing cash flows - payments and receipts of principal	(769)	1,086	**317**
Financing cash flows - payments of interest	(289)	0	**(289)**
Non-cash movements:			
Application of effective interest rate	283	0	**283**
Carrying value at 31 March 2022	**12,347**	**3,164**	**15,511**

Note 22 Provisions

	Total £000	Other legal claims £000	Pensions: injury benefits £000	Other £000
At 1 April 2021	6,746	367	2,234	4,145
Change in the discount rate	(45)	0	(45)	0
Arising during the year	2,470	271	90	2,109
Utilised during the year	(2,029)	(113)	(119)	(1,797)
Reversed unused	(1,006)	(159)	(191)	(656)
Unwinding of discount	29	0	29	0
At 31 March 2022	**6,165**	**366**	**1,998**	**3,801**
Expected timing of cash flows:				
- not later than one year;	3,796	366	118	3,312
- later than one year and not later than five years	2,369	0	1,880	489
- later than five years.	0	0	0	0
Total	**6,165**	**366**	**1,998**	**3,801**

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 pathology service staffing changes jointly agreed with Salford Royal NHS Foundation Trust, employment tribunal claims, clinicians pension tax reimbursement claims, Agenda for Change HCA claims and dilapidation costs. Dilapidation costs are costs attributable to putting lease property back to its original pre-let state.

Note 22.1 Clinical negligence liabilities

At 31 March 2022, £298m was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (£240m, 31 March 2021).

Note 23 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Amounts recoverable against liabilities	(87)	(120)
Net value of contingent liabilities	**(87)**	**(120)**

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 24 Contractual capital commitments

	31 March 2022	31 March 2021
	£000	£000
Property, plant and equipment	1,408	1,560
Total	**1,408**	**1,560**

Contractual capital commitments mainly relate to committed expenditure in respect of the Foundation Trust's development of theatres at the specialist hospital at Wrightington, frontline digitisation, medical equipment and other site improvements.

Note 25 Financial Instruments

Note 25.1 Financial risk management

Liquidity risk

The Foundation Trust's net operating costs are incurred under annual service level agreements/contracts with Clinical Commissioning Groups (CCGs) which are financed from resources voted annually by Parliament. As a result of COVID, the Foundation Trust received block funding from its commissioners and a top up payment to break even during the first half of the year. Block payments and top up funding at an Integrated Care level were allocated in the second half of the year. Monthly payments were received from the CCG and NHS England based on these funding arrangements and this reduced liquidity risk.

The Foundation Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form. Liquidity is monitored by the Board on a monthly basis through the calculation of the Use of Resources Metric as required by NHS Improvement and by the review of cash flow forecasts for the year.

The Foundation Trust has one loan financed by the Independent Trust Financing Facility. This loan of £16.5m is repayable over 25 years at 2.24% fixed interest rate. Repayments on the loan commenced in December 2016. Repayments are built into the Foundation Trust's cash flow plans for the year and there is no risk that a number of significant borrowings could become repayable at one time and cause unplanned cash pressures.

The Foundation Trust has a number of energy efficiency loans with Salix Finance Limited. These loans are interest-free and have been invested in energy-efficiency saving schemes. The savings from these schemes are matched to loan repayments and there is therefore no risk that these borrowings will cause unplanned cash pressures.

The loan repayment schedule is contained within the maturity of financial liabilities table Note 25.4.

Interest rate risk

All of the Foundation Trust's financial assets and financial liabilities carry nil or fixed rates of interest other than the Foundation Trust's bank accounts which earn interest at a floating rate. The Foundation Trust is not exposed to significant interest rate risk.

Credit risk

The main source of income for the Foundation Trust is from CCGs 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 £8m (£15.1m, 2020/21) 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 25.2 Carrying value of financial assets

	Held at amortised cost £000
Carrying values of financial assets as at 31 March 2022	
Trade and other receivables excluding non financial assets	8,065
Cash and cash equivalents at bank and in hand	54,085
Total at 31 March 2022	**62,150**

	Held at amortised cost £000
Carrying values of financial assets as at 31 March 2021	
Trade and other receivables excluding non financial assets	7,426
Cash and cash equivalents at bank and in hand	45,044
Total at 31 March 2021	**52,470**

Note 25.3 Carrying value of financial liabilities

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

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2021	
Loans from the Department of Health and Social Care	13,122
Other borrowings	2,078
Trade and other payables excluding non financial liabilities	54,348
IAS37 provisions which are financial liabilities	50
Total at 31 March 2021	**69,598**

Note 25.4 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 2022 £000	31 March 2021 £000
In one year or less	75,825	55,651
In more than one year but not more than five years	7,362	6,991
In more than five years	8,556	9,509
Total	**91,743**	**72,151**

Note 26 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.

	2021/22		2020/21	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	0	0	0	0
Bad debts and claims abandoned	78	80	153	170
Stores losses and damage to property	10	141	7	83
Total losses	**88**	**221**	**160**	**253**
Special payments	0	0	0	0
Ex-gratia payments	84	777	47	1,041
Total special payments	**84**	**777**	**47**	**1,041**
Total losses and special payments	**172**	**998**	**207**	**1,294**
Compensation payments received	0	0	0	0

Following the judgement of the Court of Appeal in *Flowers v East England Ambulance Services NHS Trust*, which stated that regularly worked overtime and additional standard hours should be taken into account when calculating pay during annual leave, The NHS Staff Council agreed a framework in respect of corrective payments to eligible employees. These payments which related to ther period 1 April 2019 and 31 March 2021 were paid in September 2021.

In accordance with HM Treasury Managing Public Money, these payments totalling £0.7m (restated 2022-21 £0.9m) have been classified as special payments for which parliamentary approval was sought on behalf of NHS organisations by NHS England.

Funding of £0.8m amount to support these payments was provided by NHS England during 2020/21.

Ongoing pay costs are not special payments as these reflect determined entitlement under employment contracts.

Note 27 Transfers by absorption

During the course of the year the Foundation Trust received critical care beds totalling £11k from Manchester University Hospital Foundation Trust. These have been transacted in the accounts as a transfer by absorption.

Note 28 Related party transactions

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. NHS Improvement (NHSI), does not prepare group accounts; instead, NHSI prepares NHS Foundation Trust Consolidated Accounts, for further consolidation into the Whole of Government Accounts. NHSI has powers to control NHS Foundation Trusts, but its results are not incorporated within the consolidated accounts, and it cannot be considered to be the parent undertaking for Foundation Trusts. Although there are a number of consolidation steps between the Foundation Trust's accounts and Whole of Government Accounts, the Foundation Trust's ultimate parent is HM Government.

Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they fall under the common control of HM Government and Parliament. The Foundation Trust's related parties therefore include Department of Health and Social Care as the parent company, other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies, non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Foundation Trust has had a number of transactions with WGA bodies. Where the total transactions with a given counterparty are collectively significant, they are listed below. The Foundation Trust's related parties therefore include other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Foundation Trust has had a number of transactions with WGA bodies. Listed below are those entities for which the total transactions or total balances with the Foundation Trust have been collectively significant or potentially material to the other body.

NHS Wigan Borough CCG	NHS England	NHS Business Services Authority
HM Revenue and Customs	NHS Resolution	Health Education England
NHS West Lancashire CCG	NHS Bolton CCG	NHS Chorley and South Ribble CCG
NHS Manchester CCG	NHS St Helens CCG	Wigan Metropolitan Borough Council
NHS Pensions Agency		

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 £3.3m (£3.4m, 2020/21), and is reporting a year-end PDC payable totalling £0.4m (£0.3m PDC receivable, 2020/21).

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 2022 was £1,308k (£1,420k, 2020/21) with net outgoing resources before transfers of £115k (£353k, 2020/21).

During the year the Charity incurred expenditure of £323k (£183k, 2020/21) in respect of goods and services for which the Foundation Trust was the beneficiary.

Other related parties

The Foundation Trust has interests in 4 joint operations with related parties as disclosed in Note 13 and has a related party relationship with NHS Shared Business Service.

Key management personnel

During the financial year under review, no member of either the Board or senior management team, and no other party closely related to these individuals, has undertaken any material transactions with Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.

One Non Executive Director is a cancer lead at NHS Salford CCG and a Medical Advisor at NHS England. The Foundation Trust has entered into a number of transactions with both organisations which are considered to be "at arms length".

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

One Non Executive Director is the Chair of the Countess of Chester Hospital NHS Foundation Trust. The Foundation Trust has entered into a number of transactions with this organisation which are considered to be at "arms length".

Key management personnel are identified as Executive Directors and Non-Executive Directors of the Foundation Trust. Details of their remuneration and other benefits can be found in Note 5.2 and the remuneration section of the Annual Report.

Further information

If you have any queries regarding this report, or wish to make contact with any of the directors or governors, please contact Paul Howard, Director of Corporate Affairs and Company Secretary, using the contact details below:

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