NHS

Wrightington, Wigan and Leigh Teaching Hospitals

NHS Foundation Trust

Annual Report and Accounts

2024/25

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Annual report and accounts 2024/25

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Opening remarks from the Chair

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

Right from my start at WWL, I have admired the closeness of the working relationships that the Trust has with local partners. Thanks to the work of our Chief Executive, Mary Flemming, and her team I am pleased to report that this year we have seen significant growth in the collaboration and integration we now have with our local partners. As a result of these close working relationships, we have now been able to begin work with Wigan Council and NHS Greater Manchester Integrated Care Board (NHS GM ICB) to deliver our joint transformation programme - 'Better Lives'. The programme has been designed to make a rapid, meaningful and sustained improvement to the lives of residents, patients and health and care staff in Wigan. It supports a move away from a traditional hospital centric approach to healthcare with an increased focus on early prevention in the community, early and appropriate discharges from hospital and helping residents remain in their own homes for longer.

In short, the collaborative programme involving partners across primary care, social care, the voluntary sector, Wigan Council and NHS GM ICB will allow us to develop models of care which will bring social and health care together and deliver healthcare in a more sustainable way, supporting population health management and we hope, reducing the strain on the whole system.

Looking back over the previous year, we were grateful to see national industrial action come to an end in the latter part of 2024 and pleased to see amicable resolutions reached for all of our staff groups involved. The impact on services was significant however, with periods of action taking place every month until September 2024. Our GP colleagues in primary care continue to participate in collective action and at the start of 2025/26 BMA are balloting junior (now resident) doctors on further strike action.

In spite of the many challenges that we have seen over the year, our team's enthusiasm has not waivered and we have many achievements to celebrate. The first of which was being named as the cleanest acute trust in the country through Patient-Led Assessments of the Care Environment (PLACE)! The assessments, undertaken by local people, took place across all Trust sites including the Thomas Linacre Centre and six of our community premises and consider things such as privacy and dignity, food, cleanliness and general building maintenance.

Last year I highlighted that the Wigan borough has the largest armed forces community in the North West and the seventh largest population of veterans in England, with circa 22,000 serving personnel, veterans and families. I take great pride therefore in our new Royal Albert Edward Infirmary (RAEI) Veteran's Garden: created by staff and volunteers from the armed forces community for veteran staff, patients and their families to enjoy, whilst spending time outside of a clinical environment. Wigan's Mayor joined us to unveil the space as part of our D Day 80th anniversary commemorations.

In terms of this year's site developments, we are excited to have begun work with a third party to facilitate the construction of a new multi-storey car park on Freckleton Street in Wigan. This will significantly improve overall car parking capacity at RAEI, providing 356 additional spaces and enabling 21 additional blue badge spaces for patients and visitors at the site, ensuring those with the greatest need are in the closest proximity to services where possible. On 6 September Lisa Nandy, our Local Wigan MP, attended the groundbreaking of three new endoscopy units at RAEI which we hope to open to the public later in 2025.

I am pleased to report that in August 2024, Leigh Infirmary was awarded surgical hub accreditation by the national Getting It Right First Time (GIRFT) programme, this is WWL's second accreditation, following Wrightington Hospital achieving accreditation in 2023. We are proud not only of what a visible marker of quality and excellence this is but also of the role it will allow us to play in the associated

national plan to increase surgical capacity and reduce waiting times. The addition of our new Community Diagnostic Centre and Theatre 4 extension at Leigh has not only made the site a beacon for same day treatment but has helped us to further reduce health inequalities within our borough, by making it easier for more patients to physically access services.

I turn now to speak of my colleagues, beginning with WWL's Board of Directors, which comprises executive directors who lead the organisation operationally from day to day, as well as non-executive directors, who bring in external perspective and challenge. I am thankful to work with and be supported by such a talented and committed set of colleagues, including our Medical Director and Consultant Cardiologist Professor Sanjay Arya, who was named on the King's New Year's Honours list 2025 and awarded an OBE (Officers of the Order of the British Empire) for services to Black and Minority Ethnic Doctors and Healthcare in North-West England (Greater Manchester). This is a huge achievement and so well deserved.

We continue to work with our two development non-executive directors who are working with us in a development and voluntary capacity as part of the NHS Leadership Academy's NExT Director Scheme, which supports the creation of a pipeline of strong and diverse potential candidates for non-executive director roles in the NHS.

The WWL board is also supported and held to account by our Council of Governors. They play a key role in appointing our non-executive board members and this year have supported us to make three new appointments. Like our board, governors wanted to take positive action to increase the diversity of the Council and better represent groups which are currently underrepresented through their make-up. We therefore launched a pilot to fill several development governor positions, seeking to attract candidates from, or working with, underrepresented groups to join us for a partial tenure. We are already starting to see how effective these post holders are in supporting us to strengthen the Council's ability to engage more widely with the public, members and voluntary sector partners across the borough and also holding our board to account through a lens influenced by equality, diversity, inclusion and the need to narrow health inequalities. We know that meaningful engagement begins locally and hope that this pilot is the first stepping stone towards community-based governor engagement. Although they hold volunteer posts, our governors remain as committed as ever and I am pleased to be able to say that their relationship with myself and my colleagues remains one of support and collaboration.

After the signing of this report I will retire as Chair of WWL, a role I was honoured to fill and one that I loved. I do however want to leave a final message of my deepest thanks to our staff, volunteers and our governors, who work together as one team to support the health and care of our patients and communities. With every passing year, the pressures on NHS providers increase, but my colleagues continue to rise to each challenge that we face. They are passionate, they are dedicated and above all else they put people at the heart of their work. Once again, I wish to express my gratitude for their incredible efforts in serving the population of the Wigan borough. I will always be proud to have had the pleasure of working with you all.

Mark Jones
Chair
19 June 2025

PERFORMANCE REPORT

PERFORMANCE REPORT

Performance overview

The purpose of this overview of performance is to provide information on our organisation, its history and purpose. The Chief Executive also presents her perspective on our performance during the financial year 2024/25 and describes the key issues, opportunities and risks as determined by the board.

Who we are

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

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

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

Royal Albert Edward Infirmary is our main district general hospital site and is located in central Wigan. Here you will find our accident and emergency department as well as the majority of our in-patient services. There has been a hospital on this site since 1873 and it was named after the then Prince of Wales who officially opened it in 1875. This site is now over 150 years old.

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 in late 2024, a commemorative heritage plaque was unveiled at the hospital in his honour. Our surgeons of today have continued to enjoy a reputation for excellence, working from the site which is now over 90 years old.

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

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

Our Strategy 2030 sets out our vision to be a provider of excellent health and care services for our patients and the local community. To achieve that aim, we will support and empower our people to deliver high quality, patient-centred care. Each year we further enhance our approach to continuous improvement by embedding evidence-based methodologies and fostering a culture of improvement to guide us on our journey.

Review of the year

Once again there is much to be proud of at WWL this year. Whilst the NHS as a whole has made meaningful progress in its recovery, the legacy of the pandemic continues to impact operations and services. This year, like last, has brought the additional challenge of industrial action, inability nationally to meet the issues of an increase in demand for services and an ongoing backlog in elective care, without the optimal solutions of additional funding and an increase in staffing, means that we continue to make steady but slow progress.

We are grateful to our staff, who in some cases have worked more to help us in times of pressure and in many cases have worked in alternative and creative ways to help us to deliver the best possible care. They have effected change, lead transformation and embraced digital solutions, all in the context of a more collaborative 'integrated care' world. They also helped us to revise our Trust values in summer, telling us that we needed to make sure that we: put **people at the heart**; **listen and involve**; are **kind and respectful** and work as **one team**. Shaped by colleagues across the Trust, we see each day that these are the values that our staff are living by, authentically and because they are passionate about patient care.

We are pleased to see our joint transformation programme with Wigan Council and NHS GM ICB now in train. The 'Better Lives Programme' has four workstreams, two of which have already started (admissions avoidance and system visibility) and two of which will commence in phase 2 of the programme:

- Admission avoidance – improving access to and capacity of community services, with decision making at the front door to increase independence
- System visibility and active system leadership – creating one single data driven dashboard for system visibility across WWL/NHS GM ICB/Wigan Council to drive forward active system leadership
- Acute flow and length of stay – improving hospital flow through treatment and diagnostic progression, and optimising ward processes and ways of working
- One Wigan Community Model – defining and creating a community model to support care in the right settings, increasing independence

Whilst access times remain longer than they were before the pandemic, WWL has worked hard to reduce the length of time patients wait to receive their treatment against the national care standards in the Wigan locality. WWL has also provided the most mutual aid of any provider across Greater Manchester supporting the delivery of elective care to patients waiting across the system. This year, trusts were asked to work to eliminate waiters of 65 weeks or more by 31st March 2025 (rather than reducing the 18-week referral-to-treatment pathway). For WWL, this required an increased focus on waiting times particularly for patients waiting for gynaecology, dermatology, trauma and endocrinology services.

WWL have once again cared for a consistently high number of patients this year, in the backdrop of having the smallest general and acute bed base in Greater Manchester. This has had a resultant effect on our ability to ensure a consistent flow of patients through our accident and emergency department and impacted our ability to meet the four-hour care standard and the number of patients who are in our A&E department for longer than 12 hours. We hope that our 'Better Lives Programme' combined with step-down care initiatives such as our Virtual Ward and Home First service will help us to tackle this issue and reduce admissions and the number of patients residing in hospital, where they could be better cared for outside of hospital, which will make more beds available for those who have a greater need for hospital care. Whilst last year's metrics around access to services and quality are directly comparable with this year's, because of the unprecedented circumstances created by the global

COVID-19 pandemic, we are still in a period of recovery and we ask that you bear this in mind when considering our performance.

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

Access headlines	• **70.61%** performance against the Accident and Emergency four-hour wait target (target 71.4% to 78%; 2023/24: 68.92%) • **85.62% %** performance against two-week wait from referral to date first seen for all urgent cancer referrals (target 93%; 2022/23: 93.86%) • **56.02%** performance against the 18-week referral-to-treatment pathway as at March 2025 (target 92%; 2023/24: 52.07%) • **81.21%** performance against 6-week diagnostic standard (target 99%; 2023/24: 72.16%)
Quality headlines	• **1** MRSA bacteraemia during the year (threshold 0; 2023/24: 0) • **76** *C. difficile* infections against a threshold of 62 with **21** attributable to lapses in care (2023/24: 56 with 23 attributable to lapses in care) • **5** never events against a threshold of 0 (2023/24: 3) • Summary Hospital-level Mortality Indicator (SHMI) is 104.92 for rolling 12 months to December 2024 (average is 100) (Rolling 12 months to December 2023: 112.28)

As you will see from the staff report which begins on page 73, we place great importance on supporting our colleagues and we want to be an employer of choice in the local area. We take feedback from our workforce seriously and we undertake regular surveys to seek feedback. We have provided an analysis of the results of this year's national staff survey later in this report.

As well as commending our own staff, we also want to pay tribute to the staff from our partner organisations across Wigan. We believe that it is only through teamwork and joined-up ways of working that we will collectively be able to provide the right levels of care for our population. We are proud to be part of the Healthier Wigan Partnership, which brings the local council, NHS and community and voluntary organisations together and has committed to tackling health inequalities by transforming services in the community.

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

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

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

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

Principal risks faced and impact

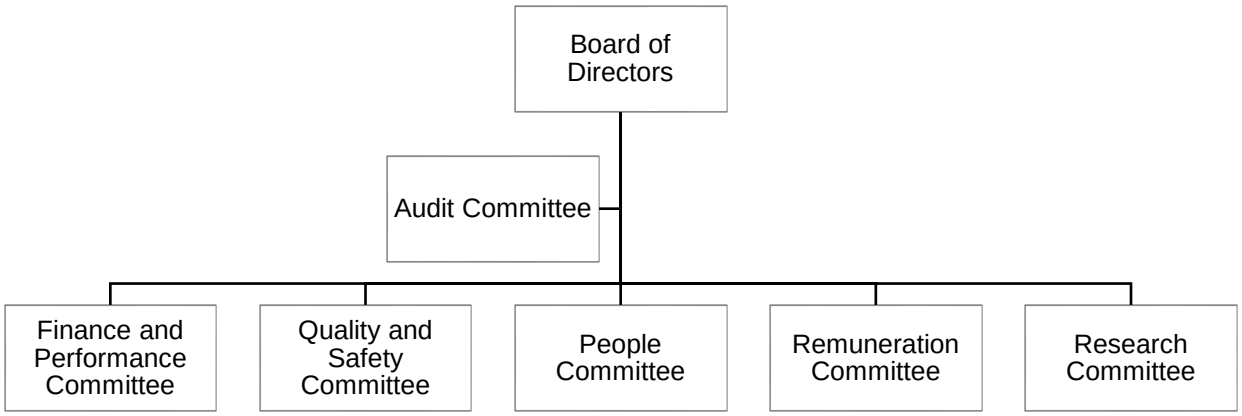
For more information on how we manage risk within the foundation trust, including the detail of the key risks that the organisation was exposed to during 2024/25 and those identified for 2025/26, please see the Annual Governance Statement which begins on page 102.

Mary Fleming
Chief Executive and Accounting Officer
19 June 2025

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 44 – 47.

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



Audit Committee

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

Finance and Performance Committee

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

Quality and Safety Committee

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

People Committee

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

Remuneration Committee

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

Research Committee

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

The Council of Governors, made up of elected governors from our public and staff membership and appointed governors from our key stakeholders, has a number of statutory functions and two general

duties – to represent the interests of members and the general public and to hold the non-executive directors to account for the performance of the board. More information on the Council of Governors is available on page 89.

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

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

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

We employ 7,133members of staff, all of whom play their part in delivering high quality, safe and effective patient care. Our Quality Account is published separately and provides much more detail on the quality improvements we are pursuing. Once completed, a copy will be able to be obtained from our website or on request from the corporate affairs team, please use the contact details included on the last page of this report.

Summary of our operational activity

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

		2024/25	2023/24*
Referrals	GP	103,444	90,127
	Other	104,531	97,614
	Total	**207,975**	**187,741**
In-patient activity	Elective/planned	8,519	6,943
	Day cases	40,984	36,587
	Non-elective	41,242	41,990
	Total	**90,745**	**85,520**
Outpatient activity	New appointments (attendances)	161,159	147,618
	Follow-up appointments (attendances)	348,245	326,348
	Total	**509,404**	**473,966**
Accident and emergency	**Total**	99,056(All) **85,437**(Type 1)	**100,052**(All) **88,079**(Type 1)
Walk-in centre	**Total attendances**	**49,152**	**51,458**

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

* The 2023/24 activity values have now been updated to include all activity - the figures published in our report for 2023/24 only included activity eligible under the Elective Recovery Funding (ERF) rules.

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 73 within the annual governance statement which commences on page 102.

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

Equality of service delivery to different groups

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

People and communities are at the heart of everything we do and we are dedicated to developing an organisational culture that embraces difference, valuing everyone's contribution, treating people with dignity and respect and increasing our understanding of what matters most for our patients by hearing about their lived experiences. That is why this year, we introduced 9 voluntary roles for lived experience partners. They meet regularly with our teams and offer an invaluable insight on what it is like to access and receive care with us.

As an NHS organisation we aim to provide our services to all groups equitably and fully embrace the requirements of the public sector equality duty to eliminate discrimination, advance equality of opportunity and foster good relations. This year we continued to embed and integrate the Equality Delivery System (EDS2022) for both service provision for patients and employment practice for staff. For domain 1 (patient services), equality evidence was collated against 4 patient outcomes for Orrell Ward, the Neonatal Intensive Care Unit and the Emergency Department for adults. Engagement with patients and the public was undertaken from November until January to obtain feedback and scores. Engagement included, encouraging service users and local community to complete the on-line feedback survey; visiting each of the service areas and undertaking 'real time' engagement; and attending key stakeholder meetings. Feedback and scores enabled each service to implement their own specific improvement recommendation proposals.

On 11 August 2024, Wigan Pride returned for a ninth year and we were pleased to once again march in the parade. Our Chief Nursing Officer, True Colours Staff Network and Patient Experience Team supported us to run our health information stall, with our patient experience and engagement team actively engaging with the local community to ascertain feedback about hospital services, reinforcing the message that WWL is an anchor institution which plays an active part in Wigan's local community and works continually to ensure that services are accessible.

During 2024/25, WWL continued to work in partnership with AccessAble, creating, developing and updating detailed on-line access guides for patients to all the Trust's sites. During November 2024, AccessAble revisited the Royal Albert Edward Infirmary site to resurvey and update access guides. NHS Friends and Family Test cards were also re-designed to enable feedback from further patient

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

We continually review the effectiveness of our interpretation and translation services to ensure that service users can be communicated with appropriately and effectively as timely as possible. The fundamental and unprecedented combined effects of the pandemic and the cost of living crisis have had an impact across the entire interpretation industry and hampered the national availability of linguists, especially those who traditionally provided face to face services. We have implemented an improvement plan to increase fulfilment rates and efficiencies and are reviewing the implementation of additional interpreting methods, including the pilot of video remote interpreting within targeted services.

A new dedicated workstream for patient access and experience was implemented to review WWL's approach to providing reasonable adjustments for service users, incorporating the requirements of the NHS England's Reasonable Adjustments Digital Flag Information Standard (and Accessible Information Standard).

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

Financial performance

During the financial year ending 31st March 2025, we delivered an adjusted financial performance deficit of £0.8m. Despite significant challenges during the year, this was in line with the agreed control total with the Greater Manchester ICB and NHSE.

When we consider the statutory financial accounts, the financial outturn for the 2024/25 financial year, including those items that are excluded from our control total due to national guidance, was a deficit of £28.4m (2023/24: £15.8m deficit). This includes impairments of £27.5m arising from re-valuation of land and buildings and impairment of assets, which are excluded from the adjusted financial position of £0.8m deficit.

2024/25 was the first year of our Financial Sustainability Plan, with a focus on financial improvement and reducing our underlying deficit of £7.4m. Material savings were delivered through our cost improvement programme (CIP) totalling £27.4m. Alongside tighter controls and reporting, this supported delivery of our financial plan for the year and reduction of the underlying deficit. We also received £13.4m of non-recurrent deficit support funding from GM ICB during the year.

We had a year-end cash balance of £18.1m, a decrease of £6.9m from the previous year. Within the cash position for the year, we received £14.0m of national funding for capital projects. Our Better Payment Practice Code improved in year, achieving 96.3% by value which is above the target of 95.0% (2023/24: 92.5%).

We invested £24m into our capital programme during 2024/25. This investment, which included the continuation of expansion of our Endoscopy departments and the completion of new theatres at Wrightington, will support productivity, reduction in waiting times and improve our hospital environment and services for patients' visitors and staff.

The annual accounts included within this report provide detailed information for our financial performance in 2024/25.

Income

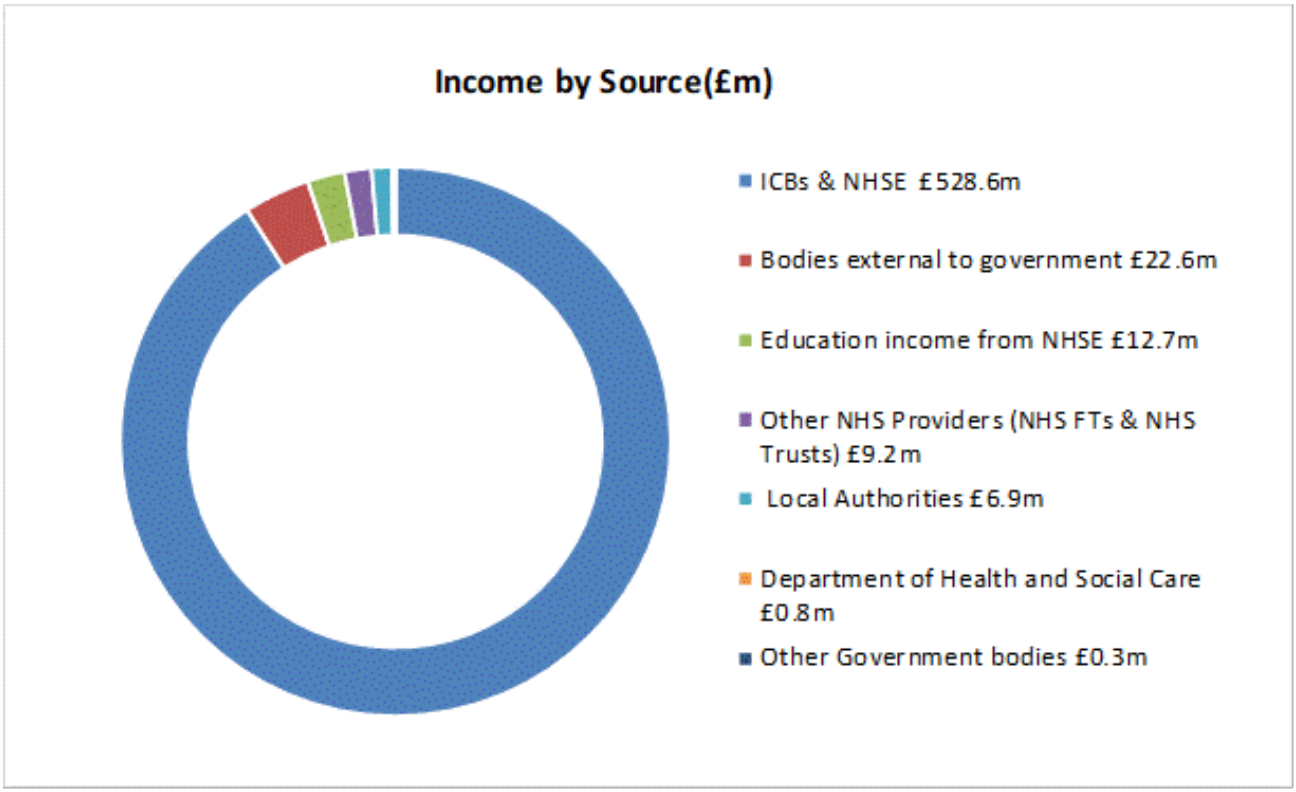
We generated £581.2m of income in 2024/25 compared with £523.1m of income in 2023/24; an increase of £58.1m or 11.1%. This increase was predominantly due to a £55.0m increase in funding from ICBs and NHS England, £1.1m increase in private patient income and £0.8m increase in operating income and more detail is provided below.

In 2024/25 the Aligned Payment Incentive (API) system continued. For all contracts we hold with commissioners over £0.5m, the payment is as per the API commissioning and comprises a variable and fixed element. Under the variable element, we are paid according to actual activity delivered against the elective recovery and unbundled targets.

Each year, the income we receive from the provision of goods and services for the purposes of the health service in England must be greater than the income we receive from the provision of goods and services for any other purpose. We have complied with that requirement in 2024/25.

Income by source

The chart below shows the split of our income by source during the year. Most of our income is received from government bodies with only £22.6m (3.9%) of the total £581.2m income received from bodies outside of the government.



Income from patient care activities

Income generated from the provision of patient care totalled £552.0m in 2024/25, compared with £494.6m in 2023/24; an increase of £57.4m (11.6%). ICB and NHSE income accounts for £55.3m of the increase and relates to an increase in funding due to the cost uplift factor of £17.9m net of efficiency, £8.0m increase due to central pensions funding, £13.4m deficit support funding, £3.4m CDC funding and £10.6m additional ERF funding.

Greater Manchester ICB is the largest commissioner of services, contributing 78.5% (£433.5m) of our patient care income compared to 77% (£382.9m) in 2023/24.

Income from patient care (by nature)

Income from patient care (by nature)	2024/25 £m	2023/24 £m
Acute services		
Aligned payment & incentive (API) income - Variable (based on activity)	123.7	102.7
Aligned payment & incentive (API) income - Fixed (not variable based on activity)	304.2	288.5
High cost drugs income from commissioners	22.0	17.9
Other NHS clinical income*	5.5	7.0
Community services		
Aligned payment & incentive (API) income	55.9	48.4
Income from other sources (e.g. local authorities)	6.7	6.3
All trusts		
Private patient income	7.8	6.8
Pay award central funding	1.0	0.2
Additional pension contribution central funding	21.1	13.1
Other clinical income**	4.0	3.6
Total income from patient care activities	**551.9**	**494.5**

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

Other operating income

Other operating income received in year was £29.2m compared to £28.5m in 2023/24, which is an increase of £0.7m (2.5%). There has been an increase in other income of £2.2m, offset by a reduction of £0.6m Research and Development income and £0.6m reduction in Education and Training income.

Expenditure

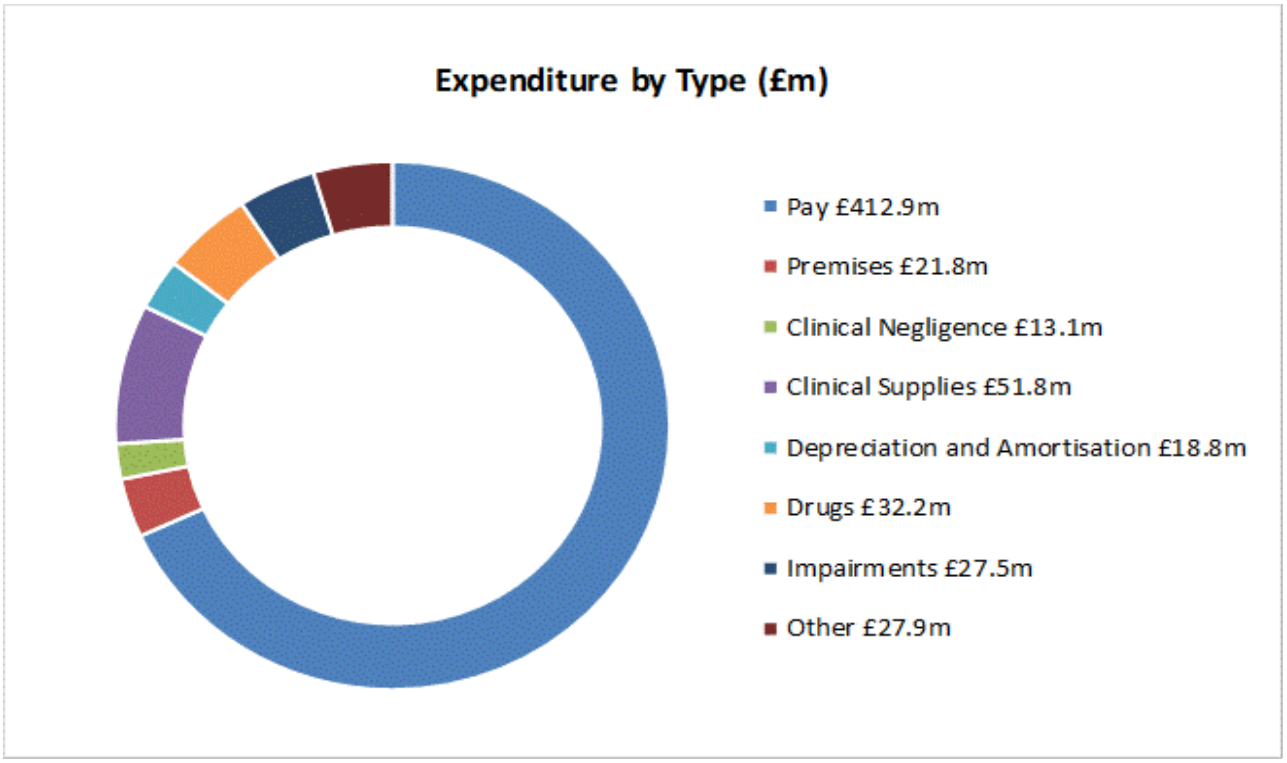
Operating expenditure for the 2023/24 financial year was £604.3m, compared to £534.4m for 2023/24, which was an increase of £69.9m (13.0%).

Employee expenses (pay) was the largest item at £412.9m (2023/24: £374.8m) which is 68.3% of operating expenditure. Within this figure, the amount spent on registered nursing, midwifery and health visiting staff was £115.4m (2023/24: £108.3m). Expenditure on medical staff was £99.0m (2023/24: £88.3m).

There is an increase in employee expenses of £38.1m. Pay expenditure has increased primarily due to the 2024/25 pay awards and reform (£24.9m) which were funded via the uplift to national tariff. There was also an increase in central pension contribution rate (£8.0m), for which there is a corresponding increase in income. There was a decrease of £4.1m associated with temporary staff which comprises bank and agency expenditure.

The largest items of non-pay expenditure included £32.2m spent on drugs (2023/24: £31.7m), £51.8m on clinical supplies (2023/24: £44.6m), £13.1m on the clinical negligence premium (2023/24: £12.3m) and £24.2m in premises costs (2022/23: £24.9m). Depreciation and amortisation of £18.8m and net impairments of £27.5m are included in the overall expenditure figure.

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



Cost improvement plans

In 2024/25, we achieved our cost improvement plan (CIP), delivering savings of £27.4m (2023/24: £24.4m), which further supported our steps towards financial recovery and future sustainability.

Despite an exceptionally challenging year, we delivered the full target with some divisions over-performing to support the wider position. In-year; £11.4m (42%) was delivered through recurrent schemes ensuring that we are making improvements to our underlying position.

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

One area of success in the delivery of 2024/25 CIP was a significant reduction in escalation costs within the Medicine division through both a reduction in temporary premium pay expenditure as well as the implementation of enhanced grip and control measures. From a transformational perspective the Commercial Opportunities Programme delivered £0.6m towards CIP delivery.

Capital investment

During the year we invested £24.0m (2023/24: £34.8m) in our capital programme including £0.1m of donated assets (2023/24 £0.2m), which have significantly improved services for both patients and staff. A summary of the capital investments undertaken in the year is provided below:

Capital investment scheme	Investment benefits	£m
Endoscopy expansion	Completion of the expansion of the Endoscopy department on the Leigh site, and continuation of the work to expand Endoscopy on the Wigan site. These developments will improve diagnosis, reduce waiting times and increase care capacity across the Wigan Borough.	6.9
New theatres at Wrightington	Completion of two new theatres on the Wrightington Site to improve productivity. Delivering high volume low complexity procedures to support a reduction in long waiting lists these new theatres also support the plans to de-commission out of date unproductive theatres.	6.2
Information technology	Continued investment in IT systems to raise digital maturity across our sites.	1.0
Medical equipment	The continued investment in medical equipment, including upgrades to scanners, x-ray machines, ultrasound, audiology, ophthalmology and endoscopy equipment.	4.2
Site improvements, upgrades and maintenance	Improvements, upgrades, and general maintenance to improve our hospital environment. Work also included the installation of LED lighting and removal of reinforced autoclaved aerated concrete to make our hospitals safer and more energy efficient.	5.7
Total (including donated assets)		**24.0**

Going concern

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

Mary Fleming
Chief Executive and Accounting Officer
19 June 2025

Performance analysis

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

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

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

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

Operational and clinical performance: Division of Medicine

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

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

The division also incorporates pharmacy services on all sites.

Unscheduled care

Throughout the year, we continued to see an increase the acuity of patients admitted through our accident and emergency department, which contributed to us being unable to maintain the delivery 4-hour performance above the target of 78%. In 2024/25, average daily attendances equated to 272 patients per day, compared to 274 average attendances per day in 2023/24. The higher complexity of patients combined with increased length of stay contributed to the pressures within the department and the number of patients waiting over 4-hours increased over the winter months in 2024/25. We use a business intelligence application which monitors hospital flow to monitor the acuity of patients attending. A patient's acuity level is based on how much care and treatment the patient is likely to need and whether they are likely to require admission.

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

- Ensuring early ambulance handovers to our accident and emergency department, to make sure that we rapidly respond to patients with high clinical acuity as well as freeing ambulance crews up to attend other calls.
- Continued delivery of our hospital discharge and flow programme which included developing our same day emergency care (SDEC) service, an improved frailty service at the front door and launching a ward improvement programme designed to ensure that our patients receive value adding care which progresses their journey towards discharge daily.
- Introduction of our system-wide Better Lives Programme supported by Newton Europe to help transform delivery of care across the borough. This programme has focussed initially on admission avoidance improvements to help the residents of Wigan stay well and receive care in the most appropriate place for their level of need.
- Continued development of Bryn North Ward as a Discharge Planning Unit. This model of step-down care is supported by intensive therapy and has helped us safely discharge up to an additional 28 patients per week.
- Continued focus on reducing delayed transfers of care in collaboration with our system partners.
- Work with system partners to publicly emphasise the need to continue to use services appropriately, signposting to other service such as NHS 111. We have continued to work with local partners to provide community-based services and early interventions to enable patients to be treated outside of the hospital setting when possible.
- Support provided by NHS England specialist teams – including the (Emergency Care Improvement Support Team) ECIST - to improve the flow of patients across the emergency department and the rest of the hospital.
- Implementation of an electronic bed management system that will further support the flow of patients across the hospital and help us to manage bed capacity effectively.

Looking forwards to 2025/26, we will work towards improvements in our 4-hour accident and emergency performance, together with an improvement in the reduction of patients waiting 12 hours or more in the department and an improvement in ambulance handover and turnaround times. We will continue to support delivery of the Newton Europe Better Lives Programme and engage with system partners to support safe and timely discharge.

Scheduled care

Continuing the trend of the last few years, in 2024/25 we saw a further increase in referrals to many of our scheduled care services.

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

on ensuring that no patient waited for longer than 65-weeks and therefore exceeded the national waiting list target for 2024/25.

To improve care for the significant number of diabetic patients within our borough, we have continued to develop a multidisciplinary foot service. We have increased the provision of diagnostic services through the Community Diagnostic Centre at our Leigh Infirmary site.

For the coming year, our scheduled care teams will continue to focus on ensuring that we see patients based on their clinical need, whilst at the same time reducing the waiting lists for our services. We aim to meet the national target to reduce waiting lists so that 60% of patients are provided with treatment within 18-weeks of referral. We will work with community partners and GPs to support a reduction in the number of referrals to hospital through community-based models of care and further expanding advice and guidance services.

Clinical governance

Despite the challenges seen throughout 2024/25, positive changes have been made to the division's clinical governance structure to improve the reporting and review of incidents, complaints and mortality and overall to improve patient outcomes. The clinical governance agenda within the division encompasses operational, medical and nursing colleagues who work as a triumvirate to deliver safe and effective care.

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

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

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

Operational and clinical performance: Division of Surgery

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

- Emergency and elective surgery
- Theatres, anaesthetics and the Intensive Care Units (ICU)
- Healthcare operations
- Maternity and child health

General Surgery including breast, colorectal, general and urology

The continued focus for our Division of Surgery this year remained the reduction in waiting times; we have been extremely successful, not just in reducing waiting times for our patients, but through offering mutual aid to other providers across Greater Manchester by allowing their long waiting patients to be transferred and treated by WWL in the areas of ear, nose and throat (ENT), oral surgery, urology and general surgery.

The additional capacity at our Leigh Infirmary site is instrumental in the division's ability to undertake this activity. This has now been recognised nationally with Leigh being named as a national surgical

hub. Additional capacity will also be available for hernia surgery next year with other providers potentially using our facilities to undertake this work.

Capacity at the Leigh site is integral in continuing to reduce overall waiting times as we continue to review cases and procedures undertaken on the acute site that could transfer to the hub.

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

The waiting times within our head and neck directorate continue to reduce and within ENT and oral surgery we have been able to see and treat hundreds of long waiting patients from across Greater Manchester. In order to facilitate some of this activity and maintain our waiting time reduction, towards the end of the year there have been regular theatre sessions held at Wrightington.

There remain significant pressures across GM for these specialities, and as such we are already working with the other providers to identify capacity and help facilitate the continued transfer of patients, this may include paediatric cases as the division is preparing to start paediatric surgery in ENT and oral surgery in the summer at our Leigh site. We are also working with colleagues at regional level to help facilitate more ophthalmology work as we look to pull back work from the independent sector.

Theatres and anaesthetics

Efforts to establish Leigh as a 'hub' have expanded capacity in general surgery, ophthalmology, and paediatrics. As we increase surgical activity, we must also expand anaesthetic and pre-operative support. One way in which this has been achieved is through moving to digital solutions and we now use an online platform that as a result has enabled us to increase our efficiencies in pre-operative work.

The divisions of surgery and specialist services are working closer together to not only support the anaesthetic challenges but also in facilitating additional surgical activity at Wrightington through the use of fallow theatres.

The environmental agenda remains extremely important and as part of our Green Plan we build on the work done this year to realise benefits of both sustainability and cost reduction.

Maternity and child health

Maternity

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

Theme 1: Listening to and working with women and families with compassion.

Theme 2: Growing, retaining, and supporting our workforce.

Theme 3: Developing and sustaining a culture of safety, learning, and support.

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care.

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

The CQC survey was published in November 2024 with WWL maternity services receiving an excellent report, the key findings being:

- The Trust has an overall positive score ranking 12th against 56 PICKER organisations, (ranked 55th in 2023)
- The Trust has an overall historic positive score ranking 1st against 56 PICKER Organisations, (ranked 58th in 2023)
- 97% of mothers felt that they were treated with respect and dignity
- 98% felt that they were treated with kindness and compassion during labour and birth
- 96% felt involved in decisions about their care during labour and birth

Multi-disciplinary training for maternity and obstetric teams is well embedded and follows version 2 of NHS England's Core Competency Framework to ensure that training is delivered to address significant areas of harm and to provide standardisation across all trusts. Training and development opportunities are always supported and encouraged at WWL. Assurance is provided to the regional oversight panels on a quarterly basis that the core competency standards are being met by all staff groups.

Year 6 of the Maternity (and Perinatal) Incentive Scheme has been completed with our maternity and neonatal services declaring compliance against all 10 safety actions this year.

Maternity services rolled out the National Respiratory Syncytial Virus Vaccination Programme in September 2024 . This is a vaccine offered to all pregnant women over 28 weeks gestation to help protect their newborn babies, based on advice from the Joint Committee on Vaccination and Immunisation (JCVI).

Pregnant women will also have greater access to other vaccinations, such as flu, pertussis and COVID-19 if required as they can be administered by our vaccination team, by either drop-in sessions, scheduled appointments or opportunistic administration at antenatal clinic appointments, which will significantly increase overall uptake of all vaccinations which have been low within the Wigan Borough for pregnant women as these have previously only been available in GP surgeries.

Child health

The Neonatal Unit (NNU) are pro-actively working with maternity services to participate in the NHS England 'MatNeoSip quality improvement project, demonstrating significant improvements in the 8 optimisation measures and the ongoing focus is on sustainability of these outcomes.

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

Surgical activity continues to increase, and we provide ENT, urology, maxilla facial, ophthalmology, and orthopaedic elective surgery. We also support emergency orthopaedic trauma and general emergency surgery. The service is currently reviewing the options to provide additional paediatric theatre lists within the surgical hub at Leigh Infirmary.

Provision of community paediatric outpatient services has been a significant challenge for the division, referral to treatment targets have been removed but children and young people are experiencing significant delays in treatment. This has been recognised as an area that requires improvement at regional level and subsequently there is neurodevelopmental pathway redesign in progress that WWL are actively participating in. The focus is to adopt a model based upon the THRIVE framework, which is an integrated, person centred, and needs led approach to avoid diagnosis. Internally the team are working on changes to the pathways to implement one-stop clinics. There has been a successful business case approved for the implementation of electronic prescribing that will have a significant benefit for patients and reduce our team's workload.

Healthcare operations

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

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

Similarly, supported by our colleagues in the data analytics and intelligence team, we are now using a digital form to support efficiency during the pre-operative period and improve theatre productivity; have supported digital robotic processes uploading referral letters into electronic health record and have supported other clinical divisions in implementing endoscopy developments and artificial intelligence/tele-dermatology services.

Operational and clinical performance: Specialist Services Division

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

- Trauma and orthopaedics
- Rheumatology
- Radiology
- Outpatients
- Oncology (cancer services)
- Dermatology

- Medical illustration; and
- Private patients and overseas visitors

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

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

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

Radiology

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

- General X-ray
- Computerised tomography (CT)
- Ultrasound
- Nuclear medicine
- Magnetic resonance imaging (MR)
- Breast screening and symptomatic breast imaging
- Vascular and non-vascular interventional radiology
- Bone densitometry (DEXA)
- Medical Illustration

Demand for diagnostic imaging continues to grow and we currently undertake over 330,000 examinations of increasing complexity per year. The expansion of imaging services at Leigh Infirmary as part of the national Community Diagnostic Centre (CDC) programme. This has delivered additional imaging capacity in CT, MR, X-ray and ultrasound. In addition to the CDC programme the service has also expanded breast imaging services to the Leigh site including the implementation of a symptomatic one-stop clinic. This project made a transformational change to how diagnostic imaging services are delivered with a strong focus on providing these tests across all trust sites within a 7-day operating model. Patients have rapid access to diagnostic tests which has supported the work to deliver early diagnosis for patients referred with suspected cancer. In addition to this vital work, the service has been able to provide increased scanning availability for patients referred on elective pathways. The CDC has also created a capacity gain at the Wigan site which has experienced the highest rate of growth in diagnostic demand specifically for CT and MR examinations requested as part of emergency or in-patient care. The CDC has provided new opportunities to re-design care pathways and has successfully implemented a one-stop service for patients that are referred with urological bleeding. The provision of additional MR capacity has permitted the service to commence MR guided breast biopsies which will allow patients to be

investigated locally within a shorter timeframe that avoids potentially lengthy referrals to the tertiary hospital in Liverpool. The additional capacity provided for specialist examinations within the CDC has permitted the service to provide mutual aid for patients requiring MR scans that have an implanted cardiac device that can experience lengthy delays to imaging. WWL has also been able to provide mutual aid for MR guided breast biopsy to neighbouring trusts and is anticipated to expand this throughout 2025/26.

Performance of the service against the national diagnostic waiting time 6-week referral to exam target has been challenging although the service has maintained strong performance in most measured tests and has delivered activity levels above the operational plan. Continued replacement of obsolete equipment has provided increased productivity and resilience. The performance position for non-obstetric ultrasound has proven more challenging due to a national shortage of sonographers and competition from the independent sector. A recovery plan has been enacted which has seen a reduction in breaches and accelerated in the later stages of the financial year.

The department supports clinical training for medical, obstetrics, gynaecology and radiology trainees and has an increasing portfolio of international trainees. We have created targeted training posts to support musculoskeletal intervention and breast imaging to contribute towards long-term resilience for specialities with identified skills deficiencies. Likewise, our successful sonographer training programme continues to expand and has enrolled students from the University of Leeds on the UK's first ultrasound undergraduate degree. The service has engaged with the North West of England Imaging Academy at Edge Hill University to participate in post-graduate education for radiologists and radiographers. The training portfolio is expected to expand to include training for support staff. WWL has supported the Imaging Academy in creating and delivering management and leadership training for imaging staff. The service has also participated in a Community of Practice for Reporting Radiographers which aims to shared best practice and learning across the North West region.

Radiographers who undertake general radiography training now rotate across our sites to ensure that there is a seamless service provision to match patient demand. Barriers to recruitment of radiographers, including a national high demand within the profession, have been mitigated by a wide range of recruitment initiatives including international recruitment, creation of apprentice radiographer posts. Two apprentice radiographers are now enrolled in training realising the directorate and trust ambition to act as an anchor institution, supporting people within our local communities to develop new skills and become registered health professionals. Both apprentices have progressed to the final year of training and are expected to quality with professional registration in 2026. The requirement to train a new workforce to replace the high number of staff that are due to retire has resulted in the service increasing the undergraduate intake from seven to ten students, meaning that the service has 32 radiographers in-training by the start of the 2025 academic year. Additional funding provided through the North West of England Imaging Academy has strengthened the wider need to develop clinical practice educators by providing funding to upskill clinical tutors and to implement a practice educator within cross-sectional imaging.

The service has a strong focus on clinical governance and proactive approach to risk management has allowed it to operate safely in compliance with regulatory requirements. A new approach to clinical governance has recently been adopted, with a focus on quality and safety.

Several general x-ray equipment devices across our sites were installed more than 20 years ago. Throughout 2024/25 there has been good process to replace some of the oldest devices. General radiography rooms have been replaced at the RAEI, Thomas Linacre and Wrightington Hospital sites.

The CT and MR departments are located at RAEI and Wrightington Hospital and perform around 54,000 CT and 33,000 MR examinations per year. The department comprises 4 CT and 4 MR scanners which operate over 7 days a week. To meet the increasing demand for acute CT the service was reconfigured to deliver a 24-hour on-site service which is responsive to the needs of clinicians and patients. The increasing demand for unscheduled CT scans and the emerging demand for MR scans in emergency clinical scenarios has required a review of service arrangements to deliver increased capacity and business planning has been undertaken to increase overnight staffing levels. In order to provide a responsive service for emergency care we have developed plans to deliver CT scanning within the footprint of the Emergency Department which could be achieved by installing a scanner with the annex extension. A new MR scanner is being installed at Wrightington Hospital which will have 3T magnet strength that optimises musculoskeletal imaging and cancer scanning. There service is expected to deliver activity from July 2025 and will be provided by WWL staff following the expiry of an independent sector partnership.

The CT department successfully developed a cardiac CT service which has negated the need for Wigan borough patients to travel to Wythenshawe for investigations to be carried out. This examination is in high demand due to its safety profile and convenience. The expansion of diagnostic capacity within our Community Diagnostic Centre at Leigh Infirmary has allowed the service to expand which has been supported by the recruitment of a cardiothoracic radiologist and a consultant cardiologist with an interest in cardiac imaging. There service had expanded to include patients that have undergone previous cardiac surgery which has improved the access time for this cohort of patients.

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

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

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

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

Trauma and orthopaedics

Whilst significant improvements have been realised, including against elective recovery, the trauma and orthopaedics directorate has unfortunately fallen short of its ambitious activity plan, set at the start of the year. Whilst success has been seen in the increased number of patients treated per day and with over 1100 more patients being operated on compared to last year; difficulties with the functionality of our oldest theatre stock disrupted the running of planned lists on multiple occasions early in 2024. The team however rose to the occasion to minimise the impact on patients and loss

of activity by working flexibly and creating alternative solutions to mitigate any loss. The opening of Theatre 11 was a long anticipated and a much welcomed addition to our existing theatre stock in November 2024. It helped to increase the number of patients treated and enabled us to better cohort subspecialties and utilise additional staff and stock to improve productivity and efficiency. We look forward to the improvements that the opening of Theatre 12, in March 2025, will offer. Following on from the success of the Regional Knee Network, we were thrilled to be appointed the centre of the Regional Elbow network in 2024/25 and look forward to maximising the opportunities that come with this for both our patients and those in the region.

Wrightington has continued to succeed as a Greater Manchester Trauma and Orthopaedics Elective Hub since July 2021, our improved efficiency and productivity also supports our colleagues in the region and WWL has accepted over 1000 mutual aid patients, operating on 470 of them, resulting in a shorter waiting time for all those patients than had they remained with their original Trust.

Operational successes such as the introduction of the “stand by on the day” policy has enabled trauma and orthopaedics to react swiftly to any short notice cancellations, filling these slots with stand by patients and enabling theatres to be maximised at all times. The launch of the “passed fit proportionate pool” for pre-operative patients has greatly equalised the numbers of passed fit patients per surgeon for the teams to draw on. Equally, the implementation of our “manager on the day” scheme was pivotal in avoiding and reducing cancellations on the day reducing the cancellation rate from 6.2% to 5.1% and saw us maintain <2% cancellation rate for non-clinical reasons which is the best position in the region. These along with many other improvements have contributed towards an improved throughput for trauma and orthopaedics where more patients were treated in 2024/25 than the previous year, treating on average 44 patients per day. We ended the year with only 0.1% of our waiting list waiting over 65 weeks, all of whom have been scheduled for April 2025.

Whilst improvements had been made with regard to intentions for ring-fenced staff for the hub and ring fenced beds for patients with a fractured neck of femur at RAEI, unprecedented demand and staff shortages has meant we have not been able to fully realise these ambitions resulting in a compromised ability to consistently move patients with a fractured neck of femur in a timely manner to an orthopaedic ward.

Rheumatology

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

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

Outpatient services

Outpatient services are provided at four sites and also support clinics managed by other organisations. All of our outpatient departments have been able to play an active part in the overall recovery programme and supporting both our Leigh and Wrightington Surgical Hubs. We have facilitated the provision of additional clinics and mutual aid across Greater Manchester. This has been aided by the use of virtual clinics which was adopted as part of COVID-19 recovery plans.

We have adopted projects piloted through the healthcare operations division such as:

- Digitisation of the Health Information System across outpatient settings
- Continued support and expansion of digital letters
- Support for specialties with the patient initiated follow-up programme of work

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

Dermatology and plastics

The dermatology and plastics services have seen a very challenging year, with unprecedented rates of referrals of both general dermatology conditions and suspected skin cancer. We have recruited our second substantive dermatology consultant in addition to a brand new substantive consultant nurse role and fixed term cancer pathway specialist. Despite these appointments, we remain heavily reliant upon locum consultants to maintain the service due to a national shortage of dermatology consultants.

We have implemented a substantive tele-dermatology service, whereby suitable patients referred on a suspected skin cancer pathway are triaged onto the tele-dermatology pathway. The pathway involves the patient attending an appointment in the tele-dermatology rapid access clinic within the medical illustration department at Leigh Infirmary, where high quality images are taken of the patient's suspected skin cancer. Following the photography appointment, a dermatology clinician reviews the images taken and provides an outcome by letter to the patient and the referring healthcare professional. The division were recognised at the annual staff 'STAR Awards' for the best example of research, innovation and improvement for this service. We have also recently implemented an artificial intelligence (AI) pilot in collaboration with Skin Analytics. The AI software is used to determine whether a lesion is benign, malignant or pre-malignant and has been incorporated into our tele-dermatology pathway.

The division overachieved this year on both its activity plan and income plan for dermatology and plastics.

Private patients and overseas visitors

In 2024/25 there has been a notable increase in private patient activity, reflecting both the shifting pattern in patient expectations and broader healthcare system pressures. As NHS wait times remain high and patients increasingly seeking timely access to healthcare, private patient activity continues to grow in demand, exceeding previous years activity levels. Volumes have risen significantly, driven by self-pay healthcare options and insurance backed care, particularly in specialities within orthopaedics, diagnostics and outpatient consultations.

Patients are not only looking for faster treatment but also prioritising choice. The trend is clear for us, that private healthcare is becoming an increasingly mainstream option and the growth seen in 2024/25 signals a structural change in how patients want to navigate their care.

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

Therapies

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

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

Our outpatient therapy team have worked extremely hard on improving the patient journey by taking on some of the work previously undertaken by surgical appliances. They have successfully reduced the waiting list for a knee brace from 7 months to 3-4 weeks. They have also used some of our Three Wishes charity's funds to obtain a Biodex machine which aids monitoring of patient recovery and allows them to return to work and play sports more safely. It will also improve research possibilities for the therapy and orthopaedic teams. Therapies have over-achieved on their outpatient activity figures for the year, which has been a joint effort with the teams at Wrightington and the community bases.

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

Trauma inpatient therapy services became part of specialist services division in August 2023. The last year has seen improvement in communication between teams, patients being seen over seven days in line with Chartered Society of Physiotherapy standards, an increased pool of staff for greater flexibility, improved training, supervision, peer support, increased continuity of care (particularly for outliers) and overall increased patient satisfaction.

Cancer services and oncology

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

Recovery to pre-pandemic performance levels remains challenging, although the impact of continuous improvement initiatives and investment are beginning to demonstrate tangible and sustainable performance gains. During the last 12 months the service has focussed on achieving compliant performance against the 28-day faster diagnosis standard (FDS). The FDS was introduced in 2021 and measures the number of patients referred from their GP with suspected cancer to be given either a cancer or non-cancer diagnosis within 28 days of referral. We have achieved our 77% performance target for the 2024/25 planning period and this will be stretched to a 80% performance target throughout 2025/26. The service has confidence that this will be achieved by continuing to deliver improvement plans and by focussing attention on delivering improved compliance against the best practice timed pathways. To support this work the service received funding to recruit a cancer transformation manager which has resulted in a significant improvement in the performance relating to the most challenged pathways, including breast and colorectal.

The service has prioritised reducing the number of patients waiting more than 62 days on an open cancer pathway without receiving a decision as to whether they should be treated or given a non-cancer diagnosis. Good progress has been made to reduce long waits in line with the activity planning trajectory, but it has proved challenging to sustain consistent performance during periods when we have been operating under significant pressure. The service has delivered a decreasing trajectory throughout 2024/25 and although it did not achieve its year-end target it did get back to its pre-pandemic position.

The performance against the 62-day treatment standard (for patients with a confirmed diagnosis of cancer) has been variable throughout 2024/25 with the Trust maintaining an average performance at 70% against the 85% target. Performance in the later half of 2024/25 has been strong with the service achieving an average of 80% against the 85% target. The service will continue to seek improvements toward the 85% target but is confident that the 75% target identified within the operational planning guidance will be achieved. Cancer services will support teams that are challenged by performance to increase the compliance against the combined target.

Substantial work has been undertaken to improve performance on the lower gastrointestinal pathway which has experienced considerable challenges. Working closely with colleagues in primary care has harmonised the compliance with faecal immunochemical testing (FIT) for patients with suspected bowel cancer. This has permitted the speciality to refine the referral pathway for patients with suspected colorectal cancer with a higher proportion of patients being referred straight to test for diagnostic procedures. The additional CT capacity provided by the new diagnostic centre has increased the monthly CT colonoscopy capacity from 70 to 100 patients which has deflected suitable patients away from endoscopy capacity. A substantial scheme of work to deliver reform through the use of multi-disciplinary teams within the colorectal speciality has seen notable improvements in efficiency and performance.

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

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

The Trust continues to collaborate with primary care and teams within Greater Manchester to deliver comprehensive cancer prevention screening services including breast and cervical cancer screening. The Wigan locality took part in the third phase of targeted lung health checks in 2024 with promising results for patients with early-stage lung cancer which was detected before symptoms developed.

The team has also been working with tumour-specific teams to implement personalised stratified follow-up pathways which will enable patients to manage their conditions more effectively following treatment, having direct access back into the hospital system if required but reducing the reliance on attending routine follow up appointments which creates additional capacity for new patients. The implementation of personalised stratified follow-up pathways has been supported by the rollout of the Infoflex IT system which is planned to expand across other specialities throughout 2025/26.

The cancer peer review process for all tumour specific teams was completed in December 2024. The reviews allow teams to provide an overview of their services, describe the key achievements and challenges they had experienced over the previous 12 months and to identify key service developments they would like to focus on over the coming year. The 2025 peer review audit cycle is due to commence in October with a focus on delivery against the objectives identified in the operational planning guidance and best practice timed pathways (BPTP).

Cancer treatments are delivered within the dedicated cancer care unit, supported by bi-monthly meetings with The Christie NHS Foundation Trust (the Christie) to discuss operational issues and key performance indicators. Activity has been steadily growing and increased as more patients have required treatment in the early recovery phase. There has been significant pressure in accommodating the high demand for treatment which has resulted in the transfer of care to the Christie site. Business planning is underway to increase the staffing capacity for haematology treatments which will create additional resource to treat patients with solid tumours.

Our forward planning includes working with The Christie on ideas to extend our existing premises and we are currently meeting with them frequently to look at the increasing patient activity and how we can continue to provide a great quality service. Expanding treatment capacity requires re-purposing of the current estate, although the team working within the cancer care unit have delivered plans to increase treatments delivered to patients in chairs, the lack of nursing staffing has not optimised the utilisation. The service was successful in a bid for funding to purchase new treatment chairs which are used to reduce bed occupancy on the unit and to allow more treatments to be administered within each session of work.

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

Operational and clinical performance: Division of Community

The Healthier Wigan Partnership set out a vision to radically transform local community-based health and care services. Across the borough, community based integrated health and social care services have been successfully built around seven neighbourhood areas. These areas have been based on naturally formed communities, each with a 30-50,000 registered population, and through these we plan delivery of our services to meet local needs. The neighbourhoods include health and care

partners working closer together, including community nursing, therapies, and adult social care - we call these integrated community services - alongside schools, children's services, mental health, police, housing and other public, voluntary and community sector partners, which are also aligned.

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

Children and families

WWL's 0-19 universal services health visiting team were highly commended in a UNICEF Baby Friendly report after successfully retaining their gold accreditation for UNICEFs Baby Friendly Initiative for the past four years.

The UNICEF UK Baby Friendly Initiative enables public services to better support families with feeding and developing close and loving relationships, so that all babies get the best possible start in life. The Baby Friendly accreditation programme is recognised and recommended in numerous government and policy documents across all four UK nations, including the National Institute for Health and Care Excellence guidance. The programme supports maternity, neonatal, community and hospital-based children's services to transform their care and works with universities to ensure that newly qualified midwives and health visitors have the strong foundation of knowledge needed to support families.

The Wigan borough is the only borough in England where health visiting, family hubs and maternity services are all gold accredited.

Virtual Ward

Our Virtual Ward opened in January 2022 and has been expanding its capacity ever since. In 2022/23 we had 40 virtual beds, and this increased to 150 by 2024/25. The Virtual Ward is an initiative aiming to reduce pressure on acute services by providing alternative care out in the community, allowing patients to be cared for and clinically monitored in their own home or residence, instead of in an acute setting. The Virtual Ward aims to improve the experience for patients by minimising lengthy admissions into hospital and improving hospital discharge and flow. During 2024/25 the service embedded several clinical pathways including cardiology, respiratory and general medicine. Patients are "stepped up" to the Virtual Ward from community referrers or "stepped down" on to the ward from the acute hospital. On average during 2024/25 the service supported over 200 new patients per month.

Intermediate Care at Home (IMC at Home)

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

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

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

The model has continued to expand during 2024/25 working in partnership with community bed-based services. This expansion has enabled the support of more people to receive rehabilitation in their own homes. In the last 12 months there we have seen a 32% increase in the number of people able to stay in their own homes following the care they have received from the IMC at Home service.

Community Assessment Unit

In 2023, a new frailty pathway was successfully implemented in our Community Assessment Unit (CAU). Frailty SDEC is a Same Day Emergency Care service for patients over 65 years of age who present in the Emergency Department or from care homes or their own residence. Presenting with one or more frailty related medical issues, such as delirium, Parkinson's Disease, a history of falls, immobility or incontinence.

The service assesses, diagnoses and treats referred patients with a view to discharging them on the same day. The team consists of geriatricians, advanced care practitioners, specialist tDuring 2024/25 we strengthened the clinical workforce and enhanced our medical model by recruiting GPs with a special interest in frailty. The number of patients seen via the frailty pathway has increased by 30% and we saw a 36% increase in the number of patients returning to their usual place of residence. The ethos of the service helps ensure that our frailer patients are being cared for by a specialist frailty team, and wherever possible we can maintain their independence for longer, in accordance with our Healthier Wigan Partnership vision.

Operational and clinical performance: Estates and facilities

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

- Capital projects
- Car parking and security
- Catering
- Community equipment
- Community services administration support

- Domestic services
- Energy management
- Environmental and sustainability
- Fire safety
- General office services
- Estates and facilities governance and risk
- Linen services
- Medical electronics and equipment loan store
- Community medical equipment department
- Operational estates
- Portering services
- Residential accommodation
- Sterile services and decontamination unit
- Stores
- Switchboard
- Waste

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

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

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

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

In earning the title of ‘cleanest acute hospital’ in the country for the second-year running, as awarded through PLACE 2023\24 and 2024\25, the domestic services team completed around 5,475 terminal infected cleans in infected clinical areas - information gathered through the patient flow system.

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

Our catering department make around 301,500 sandwiches each year and provide patient meals to every in-patient during each day of their stay. To accommodate an in-patient stay, the linen services team handle around 240,000 items of linen during a year.

To effectively manage theatre and other clinical activities the sterile services and decontamination unit (SSDU) sterilise around c226,000 trays of surgical instruments per annum, supplying to over 30 theatres. The two Endoscope reprocessing units (ERU) combined reprocess circa 27,000 flexible endoscopes per annum. SSDU maintains ISO 13485 accreditation and both ERU are audited to JAG

accreditation standards. 2024/25 external audits resulted in reporting zero non-conformances at any of the 3 sites. The plant rooms at SSDU and ERU departments have had failures within the year resulting in all three business continuity plans being successfully activated.

Switchboard continues to receive escalated calls to the Trust. During these unprecedented times reflected in our increased number of patients activity regarding the increase of WWL services the Trust's telecoms department answer around 480,490 calls per year – a monthly average of 40,040 calls.

Linen services has seen an increase in the usage of patient linen due to the higher patient attendances resulting in turnover of 2,021,220 pieces of linen for the year of 2024/25, manged through an in-house managed system, focusing on ensuring our patients receive the appropriate allocated linen for their detailed care package.

Stores have delivered 29,921 items of stock and packages to wards & departments during 2024-2025 providing a total 1,558 runs operating in an efficient stock managed process.

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

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

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

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

Contractual requirement	Our performance 2023/24
18.1 In performing its obligations under this Contract the Provider must take all reasonable steps to minimise its adverse impact on the environment and to deliver the commitments set out in delivering a 'Net Zero' National Health Service.	This is achieved through the Green Plan, Net Zero Strategy, Heat Decarbonisation Plan and moving forwards, will also be addressed by our Climate Change Adaptation Plan. We have carried out risk assessments in order to help mitigate the impacts of climate change and adapt to its effects. These are currently in the process of being compiled into a climate change action plan that will be integrated into decision making for any current or future developments.
18.2 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must:	
18.2.1 nominate a Net Zero Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position;	WWL's Net Zero Lead is the Deputy Chief Executive. The Operational Lead is the Sustainability Manager.

Contractual requirement	Our performance 2023/24
18.2.2 maintain and deliver a Green Plan, approved by its Governing Body, in accordance with Green Plan Guidance; and	Our Green Plan was approved by the board and published on 30 March 2022. This document acts as the annual summary on delivery of the plan and is updated at the start of the financial year. The Trust is currently finalising the 2025-2030 green plan. It will be submitted to board for approval ahead of the 31st of July 2025 deadline.
18.2.3 provide an annual summary of progress on delivery of that plan, covering actions taken and planned, with quantitative progress data, to the Co-ordinating Commissioner and publish that summary in its annual report.	The Trust annual sustainability report complies with SC 18.2.3 and our contracting approach for 2024/245has been confirmed as compliant by the ICB. It should be noted that due to the delays in release of data required to complete our carbon footprint and the time needed to convert the data into a footprint, the most up to date carbon footprint we have is for 2023/24 financial year. Typically, carbon footprints data requests commence in May and are completed for the previous financial year in June/July then sent to the board for approval.
18.3 The Provider must have in place clear, detailed plans as to how it will contribute towards a 'Green NHS' with regard to delivering 'Net Zero' National Health Service commitments in relation to:	
18.3.1 air pollution, and specifically how it will take action:	
18.3.1.1 to reduce air pollution from fleet vehicles, to offer and promote more sustainable travel options for service users, staff and visitors and to increase use of such options, in accordance with the NHS Net Zero Travel and Transport Strategy; and	We are engaged with our lease provider to review electric vehicle (EV) options. However, we have issues with available electrical capacity across our sites. To mitigate this, we are in discussions with the local authority and the private sector regarding the provision of a charging hub. The Trust is also exploring options to re-site the transport department. Key to discussions is the availability of electrical capacity to support the switch to EV. All of our leases are a minimum Euro 6 rated. The Trust operates an expenses policy that includes recompense for shared occupancy, bus, rail, electric vehicle, and bicycle travel.
18.3.1.2 to phase out fossil fuels for primary heating and replace them with less polluting alternatives.	The Trust has commissioned a heat decarbonisation plan and a bid to the Public Sector Decarbonisation Scheme to address shortfalls in capital funding. The Trust is also engaged with Carbon Energy Fund with a view to develop a compliant scope of works and tender. The Trust is aiming to bid in 2025/26.
18.3.2 climate change, and specifically how it will take action:	
18.3.2.1 to reduce greenhouse gas emissions from the Provider's Premises in line with targets in Delivering a 'Net Zero' National Health Service;	The Trust has a green plan, Net Zero Strategy and Net Zero steering group that all look to address, monitor and mitigate the targets set out in Delivering a Net Zero Health Service
18.3.2.2 in accordance with Good Practice, to reduce the carbon impacts of environmentally damaging gases used as anaesthetic agents and as propellants in inhalers, by reducing piped nitrous oxide waste, by eliminating the use	We have completed nitrous oxide audits and have ceased delivery of nitrous oxide via manifolds. We are addressing use of metered dose inhalers, and we are

Contractual requirement	Our performance 2023/24
of desflurane in line with guidance, by prescribing of lower greenhouse gas emitting inhalers where clinically appropriate, and by encouraging service users to return their inhalers to pharmacies for appropriate disposal; and	switching to dry powder inhalers where clinically appropriate. We have removed desflurane from use. We are exploring the donation of existing stock to organisations within the ICB that have permitted exemptions.
18.3.2.3 to adapt the provider's premises and the manner in which services are delivered to reduce risks associated with climate change and severe weather.	We are in the process of completing a climate change adaptation plan tool developed by Greener NHS. Alongside collation of exiting emergency preparedness, resilience, and response (EPRR) documentation, the output will be used to produce a Climate Change Adaptation Plan.
18.4 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must ensure that, as far as reasonably feasible, all electricity it purchases is from renewable sources.	The Trust endeavours to procure energy from a renewable source, where feasible. Currently this is not financially feasible.

Taskforce on climate related financial disclosures (TCFD)

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

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

Governance pillar

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

Climate related risks, opportunities and responsibilities will be addressed within our Climate Change Adaptation Plan which is currently in development. Opportunities and risks will also be addressed through our Green Plan which covers the period 2022-2025 and is currently being revised to extend to 2030. This updated version will be available from July 2025. The resilience of the organisation's strategy against different climate related scenarios is still being reviewed and is therefore not fully understood.

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

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

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

Strategy pillar

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

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

Risk management pillar

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

Climate-related risks have not yet been collated into a dedicated plan outlining the associated opportunities presented by climate change. We intend to have a climate change adaptation plan place in 2025. However, using the national risk register as a base, the Trust has assessed how each risk will be affected by climate change and applied this assessment to internal emergency and business continuity plans that aim to ensure the continued achievement of organisational objectives and delivery of health services to provide the mitigation needed.

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

Metrics and targets pillar

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

Historical trends for NHS Carbon Footprint and NHS Carbon Footprint Plus are provided within the Green Plan and annual sustainability report, back to 2019, the baseline year. The baseline year was set at 2019 as this was the year where datasets were comprehensive enough to calculate a carbon footprint to Greenhouse Gas Protocol Standards (GHGPS). We utilise GHPS as a methodology for our NHS Carbon Footprint. For our NHS Carbon Footprint Plus, we utilise a bespoke methodology, mapping purchase order and accounts payable spend against eClass codes and CenSA categories, which allows CenSA carbon footprinting to be applied to a product. There is a significant error margin in utilising this methodology, but we feel it is the most accurate methodology available to us and becomes more accurate as we incorporate individual supplier carbon footprints into the model.

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

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

Joint forward plans and capital resource plans

During 2024/25, we continued to exercise our responsibilities on capital planning through robust governance, including a Capital Strategy Group, which met monthly. This allowed us to monitor capital spend during the year to ensure effective utilisation of capital resources. Progress reports from key programmes are received so that risks to delivery can be assessed and mitigations put in place where required. The Capital Strategy Group also provides oversight to the development of the five-year capital plan, ensuring this is appropriately aligned to our strategy. The annual capital programme is aligned to the business plan and identified risks, noting that we are operating within a highly constrained capital environment. Capital expenditure limits and bids for national capital are managed on at ICS level, to a large extent. We are represented at all ICS wide capital planning discussions to ensure that our capital requirements and risks are considered within the overall Greater Manchester plans. The Finance and Performance Committee routinely seeks and receives assurance on capital expenditure and planning.

Health inequalities

Our partnership working brings opportunities to focus not just on provision of health services, but also on tackling the wider determinants of health and reducing health inequalities. One key approach to this is our role as active participant in the Wigan Community Wealth Building partnership, as one of the anchor Institutions within the borough. Through this, we are actively engaged in supporting improvements in the socio-economics of the borough by leveraging the economic clout we have as the largest employer and our significant spending power. Examples of tangible benefits include: development of a central training facility in partnership with Wigan and Leigh College, Edge Hill University, Wigan Council and WWL (the Rushton Building); an increase in the number of T-level placements at WWL and an increase in the number of apprentices.

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

In 2023/24, several reports have been commissioned to aid a greater understanding of health inequalities in relation to: patients who do not attend for appointments; attendances at our accident and emergency department; emergency admissions and waiting lists, including endoscopy waiting times. To provide assurance around the data used to understand inequality, a project was completed to assess and recommend improvements regarding ethnicity recording; recommendations are currently being implemented across highlighted areas and systems. WWL continue to progress the national requirements for health inequalities outlined within the 2024/25 priorities and operational planning guidance[1] by delivering key actions within our health inequalities analytics action plan, embedding protected characteristics into core apps and into local trust reporting and agreeing equity data priorities and recommendations for wider collaborative inequalities reporting. A 'did not attend' (DNA) predictor tool has been developed and is in place within outpatients; a further iteration is planned to make this even more effective, targeting those who DNA regularly.

Reports are shared with locality partners, and the Healthier Wigan Partnership Integrated Delivery Board (IDB) where WWL and Wigan Council continue to collaborate to progress focused work to reduce health inequalities and to continue to support decision making. For example, a joint piece of insight was completed to inform geographical placement of community based respiratory services.

Our 2025/26 plan has been subject to an equality impact assessment (EIA). In addition:

- EIAs are embedded within the trust's business Case requirements
- All our policies are subject to EIAs at regular intervals
- Service EIAs for existing services are reviewed every three years by service leads

We consistently employ EIAs as a tool to evaluate how policies, practices and our decisions affect different groups of people, ensuring fairness and preventing discrimination.

We support and deliver national programmes aimed at addressing health inequalities. The National Bowel Cancer Screening Programme, for example, plays a crucial role in addressing health inequalities by ensuring early detection and treatment of bowel cancer, particularly among underserved populations. Transformation programmes also complete an EIA, ensuring addressing health inequalities also features in relevant transformation programmes, for example, we use the Core20PLUS5 framework to target the most deprived 20% of the population and specific groups who experience poorer healthcare outcomes, thus ensuring equitable access to services.

Operational compliance: emergency preparedness, resilience and response

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

[1] NHS England » 2025/26 priorities and operational planning guidance

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

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

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

For 2024/25, we have assessed ourselves as having an EPRR assurance rating of 'substantial compliance' against the core standards. This was agreed by the Board of Directors at its meeting on 2nd October 2024.

ACCOUNTABILITY REPORT

ACCOUNTABILITY REPORT

Directors' report

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

Mark Jones, Chair | Appointment 1 Nov 2021 to 20 June 2025

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. Mark is due to retire on 20 June 2025.

Mary Fleming, Chief Executive | Permanent post

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

Prof Sanjay Arya, Medical Director | Permanent post

Sanjay is a consultant cardiologist by background, with interests in coronary artery disease, heart failure, arrhythmia, syncope and cardiac assessment for non-cardiac surgery and professional footballers. Sanjay was appointed Honorary Professor in Health and Wellbeing at the University of Bolton and is also the Undergraduate Clinical Lead for Edge Hill University's Medical School. This year he received an OBE (Officers of the Order of the British Empire) for his contributions to black and minority ethnic doctors and healthcare in Greater Manchester.

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

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

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

Rhona has 25 years' experience in the criminal justice system with the National Probation Service in Greater Manchester and Cheshire and in local government in the region, where she undertook director-level roles in children and family services. She has recently retired after 14 years as the Chief Executive of the charity ADS, Addiction Dependency Solutions, which has provided innovative substance misuse services for almost 50 years. Rhona continues her involvement with the charity as a trustee of the board. Before joining ADS, Rhona was seconded by HM Inspectorate of Probation to work for what is now the Care Quality Commission as a service inspector, conducting multiagency statutory inspections of Youth Offending Teams and local authority children's services. Rhona was appointed a Deputy Lieutenant for Greater Manchester in 2010.

Sarah Brennan | Chief Operating Officer | Permanent post

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

Tabitha Gardner, Chief Finance Officer | Permanent post

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

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

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

Simon Holden | Non-Executive Director (Independent) | Appointment 1 Jun 2025 to 30 May 2028

Simon was previously the Chief Finance Officer, and Deputy Chief Executive, for the Countess of Chester NHS Foundation Trust. He has held many senior posts within the NHS, including being the first Chief Executive of NHS Property Services, a national organisation, based in London and responsible to the Department of Health, with over 4,000 buildings, and employing 3,000 people, from its establishment in 2012, up until 2015. Simon joined the NHS as an Apprentice at Blackpool

Victoria Hospital, aged 18, and has over 40 years NHS finance experience. He has subsequently mainly undertaken a number of Finance Director roles both in Commissioning and Provider organisations. In addition, Simon has also undertaken a number of Non-Executive roles including Treasurer of Disability Positive (2004 to 2022), and Chairman of Pear Tree Primary Academy School (2005 to present). Simon is a Fellow of the Chartered Association of Certified Accountants (FCCA), and also a Fellow of the Royal Institute of Chartered Surveyors (FRICS).

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

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

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

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

Richard Mundon, Deputy Chief Executive | Permanent post

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

Kevin Parker Evans | Chief Nursing Officer | Permanent post

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

Juliette Tait, Chief People Officer | Permanent post

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

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

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

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

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

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

- Ian Haythornthwaite (Non-Executive Director to 31 Oct 2024)
- Paul Howard (Director of Corporate Affairs to 31 Dec 2024)
- Nigel Kee (Interim Chief Operating Officer from 8 Jul 2024 to 27 Sep 2024)
- Lynne Lobley (Non-Executive Director to 31 Dec 2024)
- Claire Wannell (Interim Chief Operating Officer to 30 Jun 2024)

Aydin Djemal and Hameeda Khan-Davey have worked with us as development non-executive directors during the year, on an unremunerated basis. They have taken part in formal board

meetings, providing input and challenge and have joined committee meetings on an ad hoc basis to gain additional experience in specific subject areas.

With the retirement in December 2024 of the Director of Corporate Affairs role, the trust decided to make an appointment at senior manager, rather than board level, to replace them. The individual appointed continues to discharge the duties of the Company Secretary.

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

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

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

Appointment and, if appropriate, removal of non-executive directors is the responsibility of the Council of Governors. When appointments are required to be made, usually for a three-year term, a Nomination and Remuneration Committee of the council oversees the process and makes recommendations as to appointment to the full council. The procedure for removal of the Chair and other non-executive directors is laid out in our constitution which is available on our website or on request from the corporate affairs team.

Division of responsibility

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

Declarations of interest

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

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

Independence of directors

The non-executive directors bring strong, independent oversight to the board and all non-executive directors are currently considered to be independent. We are committed to ensuring that the majority

of the voting members of our board is made up of independent non-executive directors who objectively challenge management.

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

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

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

Attendance summary

The tables below show the attendance at meetings for all directors in post during 2024/25.

Board of Directors

Name of director	A	B	Percentage attendance
Mark Jones, Chair	9	9	100%
Sanjay Arya, Medical Director	8	9	88%
Sarah Brennan, Chief Operating Officer (from 9 Sep 2024)	4	5	80%
Clare Austin, Non-Executive Director	8	9	88%
Rhona Bradley, Non-Executive Director	7	9	77%
Mary Fleming, Chief Executive	8	9	88%
Tabitha Gardner, Chief Finance Officer	9	9	100%
Julie Gill, Non-Executive Director	8	9	88%
Ian Haythornthwaite, Non-Executive Director (to 31 Oct 2024)	4	5	80%
Paul Howard, Director of Corporate Affairs† (to 31 Dec 2024)	5	6	83%
Simon Holden, Non-Executive Director (from 1 Jul 2024)	6	7	86%
Nigel Kee (from 8 Jul 2024 to 27 Sep 2024)	2	2	100%
Lynne Lobley, Non-Executive Director (to 31 Dec 2024)	5	6	83%
Anne-Marie Miller, Director of Communications and Stakeholder Engagement†	7	9	77%
Mary Moore, Non-Executive Director	8	9	88%
Richard Mundon, Director of Strategy and Planning, then Deputy CEO from 4 Dec 2024)	8	9	88%
Kevin Parker-Evans, Interim Chief Nurse, then Chief Nursing Officer (from 12 Jun 2024)	9	9	100%

Name of director	A	B	Percentage attendance
Juliette Tait, Chief People Officer	7	9	77%
Francine Thorpe, Non-Executive Director	8	9	88%
Claire Wannell, Interim Chief Operating Officer (to 30 Jun 2024)	2	2	100%
Mark Wilkinson, Non-Executive Director (from 1 Nov 2024)	4	4	100%

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

† Indicates non-voting director

Evaluating performance and effectiveness

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

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

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

Understanding the views of governors and members

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

Mandatory declarations required within the directors' report

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

In making these declarations, the directors confirm that they have made such enquiries of their fellow directors and of the foundation trust's auditors for that purpose and taken such steps (if any) for that

purpose, as are required by their duty as a director of the foundation trust to exercise reasonable care, skill and diligence.

REMUNERATION REPORT

I am pleased to present the remuneration report for the financial year 2024/25 on behalf of the foundation trust's two remuneration committees.

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

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

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

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

- The **annual statement on remuneration**, which sets out the major decisions on senior managers' remuneration as well as any substantial changes to senior managers' remuneration which were made during the year and the context in which those changes occurred and decisions have been taken;
- The **senior managers' remuneration policy**, which sets out information about our policy in a standardised format across the sector; and
- The **annual report on remuneration** which includes details about the directors' service contracts and sets out other matters such as committee membership, attendance and the business transacted.

Annual statement on remuneration

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

Non-executive directors

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

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

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

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

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

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

This year, I myself was reappointed in-year and retained my 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 on a spot salary which was set in line with our executive remuneration framework and NHSE guidelines, following review and scrutiny of the job description for this post by the Remuneration Committee, guidance and acceptable pay ranges. We reviewed that salary in-year and uplifted it to take account of performance in post and comparative data.

As a Consultant Cardiologist, the Medical Director is employed in accordance with the 2003 Consultant terms and conditions. He receives a management allowance for his non-clinical responsibilities which include acting as Medical Director, and this was uplifted by £1,382 (5%) to £29,003 per annum from 1 April 2024.

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

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

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

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

Progression to the next pay point also requires the following:

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

Those executive directors in post as at 31 August 2019 retain their historic pay arrangements. Each pay scale is uplifted each year; usually by the nationally recommended uplift for posts subject to Very Senior Manager pay arrangements. For 2024/25, an uplift of 5% was applied in line with national guidance to all pay scales.

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

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

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

Mark Jones
Chair
19 June 2025

Senior managers' remuneration policy

The table below sets out the component parts of our remuneration package for senior managers which comprises the senior managers' remuneration policy. We have not consulted with employees this year on the senior managers' remuneration policy and no remuneration comparisons were used, however, the enhancements to non-executive directors' remuneration have been reduced in line with national guidance. We are in process of reviewing the revised pay framework for very senior managers (VSM), which was issued in May 2025.

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

Element of pay	Purpose and link to strategy	How operated	Maximum opportunity	Description of performance metrics	Changes from previous year
(including the Chair)	experienced non-executive directors	directors is set by the Council of Governors having regard to guidance issued by NHS England. Non-executive directors do not participate in any performance-related schemes nor do they receive any pension or private medical insurance or taxable benefits	based on national guidance.		
Other fees payable to Non-Executive Directors or other items that are considered to be remuneration in nature	To attract and retain high quality and experienced non-executive directors	Enhancements are applied on appointment to the additional role. On initial application, this meant that one non-executive director received a small back-payment figure.	Deputy Chair: £2,000 Senior Independent Director: £2,000 Audit Committee Chair: £2,000	Appointments are be made in line with national NHS guidance on the remuneration of chairs and non-executive directors.	Yes

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

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

Policy on diversity and inclusion

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

The policy has at its heart the objective of ensuring that diversity and inclusion are taken into consideration when evaluating the skills, knowledge and experience needed for each board-level vacancy and that our recruitment processes encourage the emergence of candidates from diverse

backgrounds. This is in line with our wider organisational strategy which gives a firm commitment that everyone will have the opportunity to achieve their purpose.

During 2024/25 we have appointed one substantive female executive director post and one substantive male executive director post. We also appointed two male non-executive directors. As a result, the board is now made up of 10 (62.5%) female directors and 6 (37.5%) male directors (2023/24 (64.7%) female directors and (35.3%) male). One of our directors (6.25%) is from a black, Asian or minority ethnic background.

Service contract obligations

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

Policy on payment for loss of office

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

Statement of consideration of employment conditions elsewhere in the foundation trust

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

Annual report on remuneration

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

Executive directors

Name	Role	Start date	Unexpired term	Notice period
Mary Fleming	Chief Executive	8 Jan 2024	Permanent contract	6 months
Sanjay Arya	Medical Director	1 Apr 2017	Permanent contract	3 months
Sarah Brennan	Chief Operating Officer	9 Sep 2024	Permanent contract	3 months
Tabitha Gardner	Chief Finance Officer	2 Mar 2023	Permanent contract	3 months
Paul Howard‡	Director of Corporate Affairs	1 Apr 2020†	No longer in post	3 months
Nigel Kee	Interim Chief Operating Officer	8 Jul 2024	No longer in post	3 months
Anne-Marie Miller‡	Director of Communications and Stakeholder	1 Mar 2021	Permanent contract	3 months
Richard Mundon	Deputy Chief Executive	4 Dec 2024	Permanent contract	3 months
Kevin Parker-Evans	Chief Nursing Officer	12 Jun 2024	Permanent contract	3 months
Juliette Tait	Chief People Officer	14 Aug 2023	Permanent contract	3 months
Claire Wannell	Interim Chief Operating Officer	8 Jan 2024	No longer in post	3 months

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

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

‡ Indicates non-voting director

Non-executive directors

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

The Council of Governors is particularly mindful of the need to ensure independence and the progressive refreshing of the Board of Directors and takes this into account when making decision as to the reappointment of non-executive directors.

One non-executive post is held by an appointed representative of the trust's university medical school, Edge Hil University. This helps ensure that the trust benefits from the academic and clinical

expertise of the university at a strategic level, fostering collaboration and enhancing the quality of clinical education and research that we provide in partnership. Their role with the University enables them to be independent of the Trust's management teams.

Name	Start date in role	Start date of most recent term	Unexpired portion of current term	Notice period
Mark Jones Chair	1 Nov 2021	1 Nov 2024	2 years 5 months	3 months
Clare Austin Non-Executive	1 May 2019	1 May 2025	11 months	1 month
Rhona Bradley Non-Executive	1 Dec 2019	1 Dec 2022**	6 months	1 month
Julie Gill Non-Executive	1 Apr 2023	1 Apr 2023	10 months	1 month
Ian Haythornthwaite Non-Executive	9 Apr 2018	10 Apr 2024	No longer in post	1 month
Lynne Lobley Non-Executive	28 Mar 2018	1 Apr 2024	No longer in post	1 month
Simon Holden Non-Executive	1 Jul 2024	1 Jul 2024	2 years 1 month	1 month
Mary Moore Non-Executive	1 Dec 2023	1 Dec 2023	1 year 5 months	1 month
Francine Thorpe Non-Executive	1 May 2021	1 May 2021	1 year 10 months	1 month
Mark Wilkinson Non-Executive	1 Nov 2024	1 Nov 2024	2 years 5 months	1 month

* Appointed representative of the trust's university medical school
** The Council of Governors has recently agreed to extend this contract by 6 months

The work of our nominations and remuneration committees

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

Attendance during 20224/25 was as follows:

Name of director	A	B	Percentage attendance
Mark Jones	5	5	100%
Clare Austin*	3	5	60%
Rhona Bradley	5	5	100%
Julie Gill	4	5	80%
Ian Haythornthwaite	3	5	60%
Lynne Lobley	5	5	100%
Simon Holden	2	3	67%

Mary Moore	1	2	50%
Francine Thorpe	6	8	75%
Mark Wilkinson	0	0	--

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

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

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

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

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

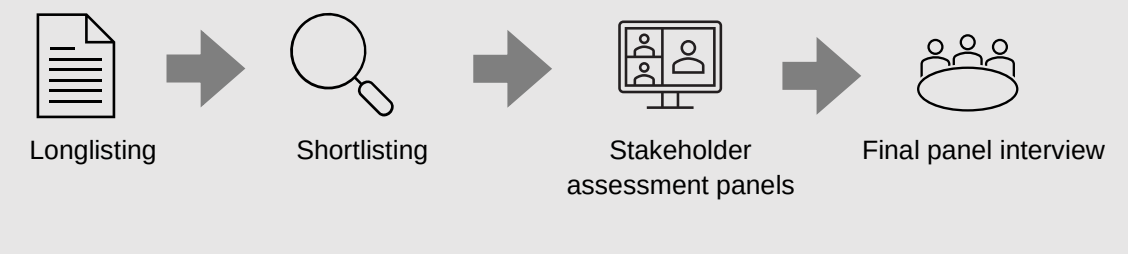
Name of committee member	A	B	Percentage attendance
Mark Jones, Chair	2	2	100%
Peter Allard, Public Governor	1	1	100%
Les Chamberlain, Public Governor	2	2	100%
Andrew Haworth, Public Governor	2	2	100%
Julie Hilling, Public Governor	0	1	0%
Malcolm Ryding, Public Governor	0	0	--
Andrew Savage, Staff Governor	2	2	100%
Bryonie Shaw, Appointed Governor	0	2	0%

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

The Director of Corporate Governance 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.

Two substantive non-executive director posts were appointed to during 2024/25. The committee was assisted with this appointment by Seymour John, a recruitment consultancy with significant experience in recruiting non-executive directors. In determining which firm to use to support the processes, a competitive pricing exercise was undertaken to ensure value for money. The committee was satisfied that the services received were objective and independent and a total fee of £12,500 was paid. Seymour John does not have any other connection with the foundation trust or individual directors. Our appointments process which was followed is summarised below:



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

The committee also supports our succession planning work. This year we continued to participate in the NHS Leadership Academy's NExT Director Scheme, which supports the creation of a pipeline of strong and diverse potential candidates for non-executive director roles and has a current focus on supporting women, people from local BAME communities, and disabled people with senior level experience into board level roles. We have two colleagues working with us through this programme as development non-executive directors.

Remuneration for the year to 31 March 2025

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

	Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Performance related bonuses (bands of £5000)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
Mark Jones, Chair	45 - 50	0	0	0	45 - 50
Mary Fleming, Chief Executive	205 - 210	100	0	282.5 - 285	490 - 495
Sanjay Arya, Medical Director†‡	325 - 330	0	0	0	325 - 330
Sarah Brennan, Chief Operating Officer (from 9 Sep 2024)	80 - 85	0	0	12.5 - 15	95 - 100
Kevin Parker-Evans Chief Nursing*^	155 - 160	600	0	197.5 - 200	355 - 360
Tabitha Gardner, Chief Finance Officer*	150 - 155	1,200	0	0	150 - 155
Juliette Tait, Chief People Officer	140 - 145	0	0	60 - 62.5	200 - 205
Richard Mundon, Director of Strategy and Planning*‡	130 -135	1,600	0	40 - 42.5	170 - 175
Anne-Marie Miller, Director of Communications and Stakeholder	105 - 110	2,300	0	0	105 - 110
Paul Howard, Director of Corporate Affairs (to 31 Dec 2024)*	80 - 85	2,000	0	20 - 22.5	100 - 105
Clare Austin, Non-Executive Director	10 - 15	0	0	0	10 - 15
Rhona Bradley, Non-Executive Director	10 - 15	0	0	0	10 - 15
Francine Thorpe, Non-Executive Director	10 - 15	0	0	0	10 - 15
Mary Moore, Non-Executive Director	10 - 15	0	0	0	10 - 15
Julie Gill, Non-Executive Director	10 - 15	0	0	0	10 - 15
Simon Holden, Non-Executive Director (from 1 July 2024)	5 - 10	200	0	0	5 - 10
Mark Wilkinson, Non-Executive Director (from 1 Nov 2024)	5 - 10	0	0	0	5 - 10
Ian Haythornthwaite, Non-Executive Director (to 31 October 2024)	10 - 15	0	0	0	10 - 15
Lynne Lobley, Vice-Chair and Non-Executive Director (to 31 Dec 2024)	10 - 15	0	0	0	10 - 15
Claire Wannell, Interim Chief Operating Officer to 30 Jun 2024)*	25 - 30	1,600	0	5 - 7.5	35 - 40

Nigel Kee, Interim Chief Operating Officer (8 July 2024 to 27 Sep 2024)	90 - 95	0	0	0	90 - 95

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

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

‡ During the period, Sanjay Arya undertook the role of Undergraduate Clinical Lead at Edge Hill University Medical School. His salary in the above table excludes the element of salary (£10-£15k) recharged to Edge Hill University.

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

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

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

All of the above directors were in post for the 12-month period to 31 March 2025 except where indicated. No annual performance or long-term performance-related bonuses were paid during the period. Taxable benefits relate to car lease benefit in kind.

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 2024

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

	Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Performance related bonuses (bands of £5000	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
Mark Jones, Chair	45 - 50	0	0	0	45 - 50
Silas Nicholls, Chief Executive (to 7 Jan 2024)	155 - 160	1400	0	0	155 - 160
Mary Fleming, Chief Executive (from 8 Jan 2024; Deputy Chief Executive to 7	170 - 175	0	0	10 - 12.5	180 - 185
Sanjay Arya, Medical Director†‡	305 - 310	0	0	0	305 - 310
Clare Austin, Non-Executive Director	10 - 15	0	0	0	10 - 15
Tracy Boustead, Chief People Officer (to 31 July 2023)	40 - 45	0	0	45 - 47.5	90 - 95
Rhona Bradley, Non-Executive Director	10 - 15	0	0	0	10 - 15
Steven Elliot, Non-Executive Director (to 30 Apr 2023)	0 - 5	0	0	0	0 - 5
Tabitha Gardner, Chief Finance Officer	150 - 155	0	0	127.5 - 130.0	280 - 285
Julie Gill, Non-Executive Director (from 18 Apr 23)	10 - 15	0	0	0	10 - 15
Terence Hankin, Non-Executive Director (from 1 July 2023 to 30 Nov	5 - 10	0	0	0	5 - 10
Ian Haythornthwaite, Non-Executive Director	15 - 20	0	0	0	15 - 20
Paul Howard, Director of Corporate Affairs	105 - 110	2200	0	25 – 27.5	135 - 140
Lynne Lobley, Vice-Chair and Non-Executive Director	15 - 20	0	0	0	15 - 20
Anne-Marie Miller, Director of Communications and Stakeholder*	110 - 115	1200	0	12.5 – 15	120 - 125
Mary Moore, Non-Executive Director (from 1 Dec 2023)	0 - 5	0	0	0	0 - 5
Richard Mundon, Director of Strategy and Planning‡	115 - 120	600	0	0	115 – 120
Juliette Tait, Chief People Officer (from 14 Aug 2023)	85 - 90	0	0	95 -97.5	180 - 185
Francine Thorpe, Non-Executive Director	10 - 15	0	0	0	10 - 15
Rabina Tindale, Chief Nurse (to 31 Dec 2023)	110 - 115	0	0	0 – 2.5	110 - 115

Claire Wannell, Interim Chief Operating Officer (from 8 Jan 2024 to	95 - 100	2100	0	20 – 22.5	120 - 125
Kevin Parker-Evans Chief Nursing Officer (from 8 Jan 2024) ^	35 - 40	0	0	127.5 – 130	165 - 170

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

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

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

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

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

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

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

Pension entitlements for year-ended 31 March 2025

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 6.7% CPI on the opening cash equivalent transfer value at 31 March 2025 has been applied. The following pension entitlement tables are subject to audit.

	Real increase in pension at 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 2025 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2025 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2024 £000	Cash Equivalent Transfer Value at 31 March 2025 £000	Real increase in Cash Equivalent Transfer Value £000
Sanjay Arya Medical Director	0	0	10 - 15	0	131	173	27
Juliette Tait Chief People Officer	2.5 - 5	0	30 - 35	0	389	469	49
Tabitha Gardner Chief Finance Officer	0	0	45 - 50	115 - 120	977	1032	0
Mary Fleming Chief Executive	12.5 - 15	25 - 27.5	75 - 80	195 - 200	1471	177	0
Paul Howard Director of Corporate Affairs	0 – 2.5	0	20 - 25	40 - 45	364	414	16
Anne-Marie Miller Dir. of Communications	0	0	30 - 35	0	407	435	0
Richard Mundon Director of Strategy and Planning	0 – 2.5	0	30 – 35	0	515	596	41
Sarah Brennan, Chief Operating Officer	0 – 2.5	0	25 - 30	0	334	380	10
Claire Wannell Interim Chief Operating Officer	0 – 2.5	0	5 - 10	0	62	84	4
Kevin Parker-Evans* Chief Nursing Officer	7.5 – 10	17.5 - 20	35 - 40	85 - 90	479	684	170

Pension entitlements for year-ended 31 March 2024

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

In accordance with guidance issued by the NHS Business Services Authority, an increase of 10.1% CPI on the opening cash equivalent transfer value at 31 March 2024 has been applied.

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

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

Cash Equivalent Transfer Values

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

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31st March 2025.

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 2025 was 25 (2024: 26).

The total number of directors in office as at 31 March 2025 was 16 (2023: 17).

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

The total amount of expenses reimbursed to 5 directors during the year was £2,454 (4 directors, £1,294 in 2023/24).

The total amount of expenses reimbursed to 7 governors during the year was £380 (5 governors, £265 in 2023/24).

Fair pay multiples

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

The banded remuneration of the highest paid director of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust in the financial year 2024/25 was £325-£330k (2023/24: £305-£310k). This is an increase of 6.5% (2023/24, 15%). The relationship to the remuneration of the organisation's workforce is disclosed in the below table, which is subject to audit.

2024/25	**25th percentile**	**Median**	**75th percentile**
Salary component of pay	£24,071	£36,483	£54,972
Total pay and benefits excluding pension benefits.	£26,118	£38,699	£56,689
Pay and benefits excluding pension: pay ratio for highest paid director.	12.5	8.5	5.8

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

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £13k to £499k (2023/24 £13k to £381k). The percentage change in average employee remuneration (based on total for all employees, including bank and agency staff, on an annualised basis divided by full time equivalent number of employees) between years is 6.2% (2023-24, 10.1%). 5 employees received remuneration in excess of the highest-paid director in 2024-25, (2023-24, 6).

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. The 2024-25 figures include payments for the junior doctor pay award, an element of which is arrears for 2023-24 therefore the ratios may not be consistent with the pay policies for the Trust when taken as a whole.

Mary Fleming
Chief Executive and Accounting Officer
19 June 2025

STAFF REPORT

The wellbeing of our staff remains a key focus for us in 2024/25. We continue to develop and promote our financial wellbeing offer through the financial wellbeing partners we work with to support those staff who find themselves in economic hardship. WWL work closely with credit unions that support ethical lending which also meets our commitment to work with suppliers who align with our anchor institution principles. This approach not only helps our employees but also contributes to broader social and economic values. The programme includes but is not limited to:

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

Other avenues of support that we provide to our staff as part of this programme include:

Looking after our people

- Launching our People & Culture Strategy which will provide structured organisational development solutions for teams and leaders to support them in strengthening engagement, teamworking or culture
- Offering leadership development opportunities in line with our People and Culture Strategy – that underpin three key areas; leading self, leading others, and leading for improvement are core principles of effective leadership
- Further developing our appraisal strategy to foster high-quality conversations around personal development and career progression. This will help our staff recognise how their work contributes to the success of the organisation and supports their growth
- Offering a coaching programme to develop leadership capability at all levels
- Launch of a staff volunteering scheme that affords staff the opportunity to volunteer during work hours, supporting personal development, enriching staff experiences, and giving back to the local community

Supporting our people

- Providing holistic wellbeing support to staff, supporting staff with both physical and mental wellbeing and longer-term health difficulties
- Developing support, guidance, and training for staff and leaders to assist employees with disabilities or health conditions; including creating tailored wellbeing plans with a focus on workplace adjustments that aim to remove barriers in the workplace, ensuring an inclusive and supportive environment for all
- Offering proactive health and wellbeing support to staff, including screening tools, health checks and physiotherapy services
- Continuing to provide Trauma risk management (trim) as part of our supporting people after critical events (SPACE) service. Our TRiM practitioners provide support to colleagues who have experienced a traumatic incident at work and can refer into other services if needed

We have continually fostered and enhanced positive partnerships, both within our divisions and with our staff colleagues, as well as with external health and social care partners across the borough. Notably, we have developed strong connections with Wigan and Leigh College and Wigan Council,

who share close ties with WWL. Through these collaborative efforts, we have united to provide highest-quality healthcare services to the population we serve.

Learning and development

In June 2023, we relaunched our appraisal approach and in 2024, we continued to refine the “My Route Plan” appraisal to incorporate our new shared WWL values. This ensures that all staff have access to an appraisal that supports their development, recognises their contributions, and identifies opportunities for further growth.

Our staff have access to a learning management system, The Learning Hub, which provides access to all learning and development opportunities. It enables us to efficiently highlight mandatory learning requirements and offer a range of learning resources ensuring that staff have the opportunity to maintain their skills and knowledge within their role. Leaders can also access information about their staff and teams learning and development, allowing them to take a proactive approach in supporting their career development.

In partnership with Wigan and Leigh College, our Talent for Care Strategy continues to offer placement and employment opportunities for individuals across the borough who are not in education, training, or employment. Through these opportunities, WWL provides valuable employability skills and training aimed at securing future employment. These programmes are crucial in attracting the next generation of NHS workers and fulfilling our role as an anchor institution in the local community.

Leadership development will be an area of focus throughout 2025 with a newly developed leadership programme which will focus on three key areas of leading self, leading others, and leading for improvement, which are core principles of effective leadership and aim to create leaders who inspire growth at personal, team, and organisational levels.

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Staff experience and engagement

At WWL, we are committed to ensuring our staff have a positive experience and feel supported throughout their careers. Our shared values form the core of our organisational culture, shaping how we engage with one another and with those who use our services. These values are the cornerstone of our aim to become a provider of outstanding health and care services for both our patients and the local community. As we continue to grow and develop our people and culture, these shared values are crucial to our progress and will be evident in all that we do.

We believe every staff member’s voice is important, and we are dedicated to providing opportunities to listen to our staff in both formal and informal ways. This includes staff surveys, networks, trust-wide forums, the Freedom to Speak Up Guardian service, and regular listening events and focus groups, particularly where we are making changes. We are committed to encouraging and supporting staff to speak up safely and our goal is to create a culture where speaking up is a fundamental part of our work and that our staff are supported to raise concerns.

One of our primary staff feedback mechanisms is the annual National Staff Survey, along with the National Quarterly Pulse Surveys. All staff members are encouraged to share their views and experiences through an anonymous survey, with results analysed by division, subdivision, staff group, and protected characteristics to identify areas where change is most needed. The survey findings are presented to the Board of Directors, helping to shape trust-wide strategic priorities for

development. These results are then shared with divisional leadership teams, who use them to create annual action plans aimed at enhancing staff experience within their respective areas. In 2023/24, we strengthened our governance structure to ensure that action plans responding to staff feedback are regularly monitored through executive sponsors and divisional assurance processes. We are committed to keeping staff informed about how their feedback is being acted upon through our programmes of work, ensuring we close the feedback loop. This transparency helps staff see that their feedback is being heard and acted on, further strengthening our dedication to making meaningful improvements based on what's most important to our staff.

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

Our Community of Inclusion Staff Networks, including the True Colours Network, DaWN (Disability and Wellbeing Network) and FAME (For All Minority Ethnicities) Network, provide an important platform for amplifying the voices of staff from protected and underrepresented groups. Additionally, our "wellbeing champions" and "staff engagement associate" networks all play a vital role in shaping our People & Culture Strategy and developing new strategies, policies or processes, with over 650 staff members actively participating in these networks.

The NHS staff survey

We achieved a 35% response rate (2,535 respondents) in the 2024 National Staff Survey, a 2% decrease from 2023 and in line with our response rate in 2022. There is work to do to increase the response rate in future surveys to align with the sector average of 51%.

The results from the National Staff Survey revealed that whilst there has been a significant incline in results pertaining to 7 of the People Promises and themes, the majority of results are still in line or better than the sector scores for similar organisations, including morale, 'we are safe and healthy', 'we are compassionate and inclusive', 'we each have a voice that counts', 'we work flexibly', and we are recognised and rewarded.

Two People Promise scores are significantly better than the sector, 'we are safe and healthy' (6.18) and morale (6.05), with our morale score being the best in Greater Manchester. There are three themes which scored worse than the sector, including 'we are always learning', 'we are a team' and 'staff engagement'.

As in 2032, the highest scoring People Promise for 2024 is 'we are compassionate and inclusive' (7.17) and the lowest 'we are always learning' (5.27).

Staff recommending the Trust as a place to work has dropped significantly by 4.3% and is now lower than the sector (WWL 59.1%; sector 61.3%). Staff feeling happy with the standard of care if a friend or relative needed treatment, has declined this year by 3.8% and remains significantly worse than the sector (WWL 58.7%; sector 64.9%).

Within the 2024 results we are most proud of:

- We are top in Greater Manchester for the theme 'morale' and above the sector (acute and community trusts) for the fourth year running
- We continue to score highest in Greater Manchester for ‘we are Safe and Healthy’
- Key improvements this year in perceptions of staff from black, Asian and minority ethnic groups and those with long-term conditions, feeling they have more opportunities for career development
- Staff with a long-term health condition feel less pressure to come to work despite not feeling well enough

However, we can see that we need to be better at:

- Developing and supporting our leaders to create compassionate and inclusive cultures that focus on improvement and learning
- Supporting our staff with long-term health conditions to ensure they feel valued and have a sense of belonging and that we are making workplace adjustments to support them in their roles
- Improving how staff with long-term health conditions and those from black, Asian and minority ethnic groups experience working at WWL - our programme of work that began last year will continue to support this
- Eliminating discrimination, bullying and harassment, particularly for staff from black, Asian and minority ethnic groups
- Continuing to ensure that pathways to jobs with greater responsibility are clear and give all staff equal opportunity to progress
- Empowering staff to suggest and make changes, feel heard and work as 'One Team'
- There has been a slight decline in staff feeling secure to raise any concerns, including raising concerns about unsafe clinical practice, and confidence that the organisation will address these concerns

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

	2024/25		2023/24		2022/23		Improvement/ deterioration
	WWL	Sector average	WWL	Sector average	WWL	Sector average	
Response Rate	**35%**	**51%**	**37%**	**45%**	**35%**	**43%**	**Deterioration**
Top 5 ranking scores							
13b) In the last 12 months I have personally experienced physical violence at work from managers.	11.2%	14.1%	0.4%	0.8%	0.4%	0.8%	Deterioration
(13c) In the last 12 months I have personally experienced physical violence at work from other colleagues.	1.0%	2.2%	1.0%	2.0%	1.3%	2.0%	No change
(17b) In the last 12 months, I have personally been the target of unwanted behaviour of a sexual nature in the workplace from a manager / team leader or other colleagues	2.8%	3.7%	3.2%	3.9%	n/a	n/a	No change
(16c03) Experienced discrimination on grounds of religion.	1.8%	6.7%	5.3%	5.4%	5.6%	4.9%	improvement
(17a) In the last 12 months, I have personally been the target of unwanted behaviour of a sexual nature in the workplace from	6.5%	7.9%	5.6%	8.0%	n/a	n/a	deterioration

patients / service users, their relatives or other members of the public.							

	2024/25		2023/24		2022/23		Improvement/ deterioration
	WWL	Sector average	WWL	Sector average	WWL	Sector average	
Bottom 5 ranking scores							
(12e) I often / always feel worn out at the end of my working day / shift	39.6%	42.3%	38.9%	43.1%	40.9%	47%	No change
(12c) My work often / always frustrates me	36.9%	35.5%	35.6%	36.5%	35.8%	40.4%	No change
(23b) The appraisal/review helped me to improve how I do my job	23.2%	27.9%	22.6%	26.6%	19.7%	22.7%	No change
(12a) I often / always find my work emotionally exhausting	32.2%	33.5%	31.1%	33.9%	33.9%	37.3%	No change
(23d) The appraisal / review left me feeling that my work is valued by my organisation	29.3%	33.7%	31.3%	33.5%	27.4%	30.6%	No change

At question level, 16 scores are in the top-20% range of similar organisations, relating to themes such as work demands, pay, physical violence, discrimination, and unwanted sexual behaviour. There are 72 scores that are in the intermediate-60% and 20 in the bottom-20%, clustered around

recognition, leadership, teamwork, learning and development opportunities, and support with workplace adjustments.

People Promises Trend 2024-2025

National Staff Survey: Improvement Plans

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

- Infographics and communications of key areas of strengths and improvement shared via WWL global email, newsletters, and staff forums
- The executive team will lead a series of listening events with staff to inform action plans to improve staff and patient experience
- Organisational development support to divisional leaders to make improvements in their areas
- Development of trust wide people actions and divisional People Promise action plans to improve staff experience
- Monitoring of action planning via divisional assurance processes and the EDI Strategy Group
- Regular assurance reports submitted to People Committee;

Key strategic actions to respond to our people's feedback in the National Staff Survey 2024/25 include:

- A new People and Culture Strategy was launched in the first few months of 2024/25 which follows a three-year timeframe to strengthen the staff voice and speak up culture; develop leadership capabilities to empower leaders to create positive workplace cultures; to become intentionally inclusive in everything we do; and commit to growth and development of our people and supporting our local community by widening access to opportunities within WWL
- Embedding the new WWL values and behaviour framework
- Launch of our Leadership Development Programme
- Focussing on our Freedom to Speak Up Guardian service and strengthening speak up culture
- Continuation of our Global Majority Nursing Programme
- A new approach to wellbeing, including new wellbeing policy which promotes proactive wellbeing support
- Launch of a sexual misconduct policy and promotion of the Sexual Safety Charter
- Launch of a civility response framework- supporting early resolution options for staff
- Promotion of our newly branded staff networks
- Launch and promotion of a new flexible working policy

For 2025/26, we aim to continue to improve our staff feedback mechanisms by:

- Increasing response rates and yielding better data breakdown to support divisional action planning;
- Encouraging informal feedback processes by implementing a streamlined and supportive approach to line manager and staff conversations
- Strengthening the partnership with staff networks and staff side colleagues to co-design new programmes of work under the new People and Culture Strategy

2023/24, 2022/23 and 2021/22

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

Promise/ Theme	2024/25 WWL	2024/25 Combined trusts	2023/24 WWL	2023/24 Combined trusts	2022/23 WWL	2022/23 Combined trusts
Promise 1: Diversity and equality	8.14	8.01	8.21	8.03	8.22	8.02
Promise 2: Recognition	5.94	5.90	6.06	5.89	5.84	5.70
Promise 3: Raising concerns	6.38	6.42	6.47	6.40	6.44	6.36
Promise 4: Health and safety climate	5.72	5.51	5.80	5.44	5.55	5.17
Promise 4: Burnout	5.18	5.00	5.29	4.98	5.11	4.80
Promise 4: Negative experiences	7.98	7.78	8.01	7.77	7.83	7.62
Promise 5: Appraisals	4.36	4.96	4.41	4.80	3.99	4.39
Promise 6: Flexible working	6.25	6.15	6.35	6.10	6.23	5.91
Promise 7: Team working	6.62	6.68	6.72	6.67	6.62	6.57
Promise 7: Line management	6.77	6.81	6.85	6.78	6.75	6.63
Morale	6.12	5.94	6.23	5.90	6.03	5.68
Staff engagement	6.79	6.85	6.93	6.87	6.90	6.76
Advocacy	6.64	6.80	6.79	6.80	6.71	6.63

Equality, diversity and inclusion

Our 2022-26 Equality, Diversity and Inclusion Strategy is centred around increasing diversity and accessibility, eliminating inequality, and improving experience for protected groups. We will continue to ensure that our staff and service users are in a safe, inclusive and accessible environment where there is a true sense of belonging and that our services are accessible to all communities across the borough of Wigan.

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

Our EDI strategy and key programmes of work provide us with a framework for taking action to promote an inclusive culture including:

- Supporting our staff with disabilities and health conditions through activities and development of new policies that address the implementation of reasonable adjustments as a supportive and compassionate approach to wellbeing
- Creating safe and inclusive spaces for staff to speak up through the provision of our Freedom to Speak Up Guardian and a Speak up Safely Campaign
- Creating a cultural development plan to support our global majority staff, ensuring their employment experience provides a sense of belonging and inclusion and eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur
- Successful roll-out of active bystander training to over 1000 colleagues, equipping staff with the skills to support others, challenge inappropriate behaviour and microaggressions, and foster a more inclusive and respectful environment
- Promotion of WWL's EDI calendar which highlights key dates and events that raise awareness and fostering a more inclusive workplace by recognising cultural, religious, and social occasions throughout the year
- Continuing to provide EDI training for all of our leaders, ensuring leaders are role modelling inclusive leadership which drives positive change and supports diverse teams effectively

We have a comprehensive suite of workforce policies, developed and reviewed in partnership with staff representatives and our trade union colleagues, covering areas such as recruitment, learning and development, wellbeing at work (including attendance), dignity at work, and performance management. These policies ensure fair consideration for all staff and ensure applicants with disabilities and health conditions are supported with workplace adjustments throughout their careers. Staff networks representing protected and minority groups are also involved in the policy approval process and help inform equality impact assessments to ensure there are no adverse effects or inequalities for different groups. We keep our workforce informed through weekly bulletins, executive vlogs, and monthly staff briefings led by our executive directors. Additionally, executive-led forums with staff side colleagues address workforce concerns, share staff stories, and foster continuous improvement in policies and processes, while also providing opportunities for consultation and negotiation on new initiatives and programmes of work.

WWL staff inclusion and diversity networks

WWL community
Celebrating our diversity – together

We are proud to have three Community of Inclusion staff networks that provide a supportive space for colleagues to share their lived experiences. These networks promote diversity, equity, and inclusion by offering safe spaces for networking and learning. They help create an inclusive culture at WWL, welcoming all staff, whether they share a protected characteristic or not. Additionally, our networks offer valuable insights into staff experiences and our EDI strategy, ensuring staff have a voice in shaping programmes of work to improve their experience.

TRUE COLOURS community

The True Colours Network is WWL's LGBT+ Network, bringing together community members and allies to celebrate diversity and address health inequalities. The network plays a key role at Wigan Pride and will continue to support both patients and staff on health promotion and inequities faced by the LGBT+ community.

Our DaWN (Disability and Wellbeing Network) has played a major role in raising awareness of disabilities and long-term health conditions among staff. The network has been instrumental in shaping our wellbeing policy, which focuses on supporting staff to stay well at work. This includes removing barriers for staff with disabilities and health conditions and providing the necessary adjustments through inclusive and compassionate conversations to help maintain attendance at work.

The FAME (For All Minority Ethnicities) Network, the largest staff network at WWL, consisting of members and allies, promotes cultural diversity through events like international nurse welcome sessions, multi-faith celebration events, South Asian Heritage Month, and Black History Month. The network continues to encourage inclusion and recognise the diverse makeup of our workforce.

Gender pay gap report

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

Mandatory disclosures within the staff report

Workforce gender profile as at 31 March 2025

Directors:	10 female (63%), 6 male (38%)
Senior managers:	274 female (72%), 106 male (28%)
Employees:	5740 female (80), 1,393 male (20%)
(by headcount, senior managers are band 8a and above)	

Workforce diversity profile as at 31 March 2025 (per indicator nine of the NHS Workforce Race Equality Standard)

Directors:	14 white (88%), 1 BME (6%), 1 not stated (6%)
Senior managers:	346 white (91%), 27 BME (7%), 7 not Stated (2%)
Employees:	5779 white (81%), 1157 BME (16%), 197 not stated (3%)
(by headcount, senior managers are band 8a and above)	

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

Sickness absence data

Sickness absence data for NHS organisations is published online by NHS Digital. The table below shows the figures for January to December 2024 which is required to be disclosed in an organisation's annual report:

Figures converted by the Department of Health and Social Care to best estimates of required data items			Statistics produced by NHS Digital from the Electronic Staff Record data warehouse	
Average FTE	**Adjusted FTE days lost to Cabinet Office definitions**	**Average Sick Days per FTE**	**FTE-Days available**	**FTE-Days Lost to Sickness Absence**
6,365	79,333	12.5	2,323,152	128,695

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

Staff turnover

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

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

Consultancy

We spent £0.7m on consultancy fees during the year in support the Better Lives Programme, a joint transformation programme with Wigan Council and NHS GM ICB.

Occupational health

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

Counter-fraud and corruption

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

corruption. All staff are required to successfully complete a mandatory e-learning anti-fraud module every three years and continuous fraud awareness campaigns are undertaken via the intranet, news articles and presentations.

Health and Safety

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

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

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

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

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 2024/25.

Relevant union officials

Number of employees who were relevant union officials during the relevant period:	19
Full-time equivalent employee number:	17.25

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	16
51-99%	1
100%	2

Percentage of pay bill spent on facility time

Total cost of facility time:	£133,000
Total pay bill:	£376,156,000
Percentage of total pay bill spent on facility time:	0.04%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total facility time hours	27.3%

Employee costs (subject to audit)

	Permanent	Other	2024/25 Total	2023/24 Total
	£000	£000	£000	£000
Salaries and wages	292,139	2,047	294,186	264,470
Social security costs	28,690		28,690	27,350
Apprenticeship levy	1,399		1,399	1,343
Employer contributions to NHS pension scheme	32,148		32,148	29,701
Employer contributions paid by NHSE	21,132		21,132	13,115
Termination benefits	741		741	67
Temporary staff - external bank / agency /contract	0	34,651	34,651	38,744
Total staff costs	376,249	36,698	412,947	374,790
Costs capitalised as part of assets	478	446	924	1,994

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

	Permanent	Other	**Total 2024/25**	Total 2023/24
	(Number)	(Number)	(Number)	(Number)
Medical and dental	639	75	714	686
Administration and estates	1,533	20	1,553	1,543
Healthcare assistants and other support staff	723	8	731	726
Nursing, midwifery, and health visiting staff	2,673	336	3,009	3,055
Scientific, therapeutic and technical staff	1,012	39	1,051	1,003
Healthcare science staff	5	1	6	5
Other	11	0	11	11
Total average numbers	6,596	479	7,075	7029
Number of employees (WTE) engaged on capital projects	28	7	34	35

Reporting of compensation schemes: exit packages 2024/25 (subject to audit)

Exit package cost band	Number of compulsory redundancies	Number of other departures	Total number of exit packages
<£10,000	1	42	43
£10,001 to £25,000	0	9	9
£25,001 to £50,000	3	8	11
£50,001 to £100,000	0	4	4
Total number of exit packages by type:	4	63	67
Total resource cost:	£94,995	£860,044	£955,039

Reporting of compensation schemes: exit packages 2023/24

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

In 2023/24, all 41 non-compulsory departure packages related to payments made in lieu of notice.

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

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

Highly paid off-payroll worker engagements as at 31 March 2025, earning £245 per day or greater	
Number of existing engagements as at 31 March 2025:	17
Of which, the number that have existed:	
For less than one year at time of reporting:	9
For between one and two years at time of reporting:	5
For between two and three years at time of reporting:	1
For between three and four years at time of reporting:	1
For four or more years at time of reporting:	1

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2025:	50
Of which:	
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	46
Subject to off-payroll legislation and determined as out-of-scope of IR35*	4
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 2024 and 31 March 2025	
Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year:	1
Number of individuals that have been deemed board members and/or senior officials with significant financial responsibility during the financial year. (This figure includes both off-payroll and on-payroll engagements)	21

There was 1 off payroll appointment for the interim Chief Operating Officer engaged that lasted 3 months. Interim cover was required for this post for six months until the post was appointed to substantively. Initially the interim post was appointed to internally and vacated part way through, mitigating the need for external engagement, but with no other internal candidates, external engagement was considered to be the best option to ensure the stability of the Board.

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

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

Mary Fleming
Chief Executive and Accounting Officer
19 June 2025

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

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

The NHS Foundation Trust Code of Governance contains guidance on good corporate governance. NHS England recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for any non-compliance with the code should be explained. This "comply or explain" approach has been in successful operation for many years in the private sector and within the NHS foundation trust sector. There are no provisions within the NHS Foundation Trust Code of Governance that we did not comply with during 2024/25.

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

Council of Governors

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

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

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

Decisions made by our Council of Governors include:

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

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

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

Our Council of Governors comprises 28 governor posts:

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

The following table provides detail of the attendance during 2024/25 of those governors who remain in post as at the date of writing:

Name	Constituency/organisation	Term of office ends (see note 1)	Attendance 2023/24 (see note 2)
Public governors			
Peter Allard	Public: Wigan	2025	100%
Alan Boardman	Public: Leigh	2025	60%
Alan Baybutt	Public: Wigan	2027	80%
Andrew Bullen	Public: Makerfield	2026	80%
Les Chamberlain	Public: Makerfield	2025	80%
Pauline Gregory	Public: Wigan	2027	100%
Ken Griffiths	Public: Makerfield	2026	20%
Andrew Haworth	Public: Leigh	2027	100%
Mustapha Koriba	Public: Rest of England and Wales	2025	80%
Lisa Lymath	Public: Rest of England and Wales	2025	40%
Malcolm Ryding	Public: Rest of England and Wales	2027	100%
Linda Sykes	Public: Leigh	2027	100%
Philip Woods	Public: Makerfield	2026	100%
Staff governors			
Ali Al-Chalabi	Staff: All other staff	2026	100%
Julie Barrett	Staff: Nursing and Midwifery	2026	60%
George Ghaly	Staff: Medical and Dental	2027	100%
Michelle Hartley	Staff: Nursing and Midwifery	2024	100%
Andrew Savage	Staff: All other staff	2026	100%
Appointed governors			
John Cavanagh	Foundation Trust volunteers	2027	80%

Name	Constituency/organisation	Term of office ends (see note 1)	Attendance 2023/24 (see note 2)
George Davies	Wigan Council	2026	60%
Rupal Lovell-Patel	University of Central Lancashire	2027	100%
David Humphries	Local Medical Committee and CCG	2026	40%
Axel Kaehne	Edge Hill University	2026	60%
Jonathan Kerry	Integrated Care Board	2027	33%
Bryonie Shaw	Age UK Wigan Borough	2027	80%

Notes:

1. The term of office of all governors ends at the conclusion of the annual members' meeting in the year shown.
2. There were five formal meetings of the Council of Governors during 2024/25 in addition to informal workshops and briefing sessions. The attendance figures above are calculated on the basis of formal meetings only. One of these meetings was called at short notice and this may have impacted on governors' ability to attend on that occasions.

The Council of Governors appoints a lead governor each year. Andrew Savage was appointed to this role on 21 January 2025.

Council of Governors' register of interests

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

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 substantive non-executive directors on behalf of the Council of Governors, as outlined on page 62.

Training and development for governors

During 2024/25, 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, workshops provided by the Greater Manchester Integrated Care Board and internal workshops and induction sessions.

Communicating with governors

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

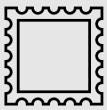
Email

governors@wwl.nhs.uk

Telephone

0300 707 2186

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



Post

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

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

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

The following directors have attended a Council of Governors meeting during 2024/25:

- Clare Austin
- Rhona Bradley
- Mary Fleming
- Tabitha Gardner
- Julie Gill
- Simon Holden
- Mark Jones
- Mary Moore
- Richard Mundon
- Kevin Parker-Evans
- Francine Thorpe
- Mark Wilkinson

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

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

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

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

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

Our membership

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

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

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

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

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

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

The membership figures have significantly reduced as a result of this exercise, however, voter turnout at our last governor election was the highest that we have ever seen, which shows that we have already made progress with our aim of cultivating a more engaged membership. The table below provides a summary of our membership as at 31 March 2025 and comparative figures for the previous year have also been provided.

Constituency	No. members as at 31 Mar 2025	No. members as at 31 Mar 2024	Change
Public: Leigh	110	1,764	-1,654
Public: Makerfield	185	1,919	-1,734
Public: Wigan	200	2,377	-2,177
Public: Rest of England and Wales	205	2,507	-2,302

Constituency	No. members as at 31 Mar 2025	No. members as at 31 Mar 2024	Change
Staff: Medical and Dental	416	406	+10
Staff: Nursing and Midwifery	1974	2108	-134
Staff: All other staff	4209	4652	-443
Total members:	**7299**	**15,733**	**- 8434**

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

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

The Audit Committee

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

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

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

- Progress with the implementation of actions arising from internal audit reviews in previous years. Updates were also provided to the Board of Directors and confirmation was provided in-year by the internal auditors that Trust had made good progress with the implementation of recommendations;
- Limited assurance internal audit reports around use of enhanced care and patients' property, on which the committee was briefed during the year.
- High assurance levels were allocated to internal audits of safeguarding; general ledger, accounts payable, accounts receivable, treasury management and risk management core controls

KPMG became our external auditors during 2022 following a tender exercise which was conducted in 2020/21. This contract was extended to the maximum term of five years. The Council of Governors

therefore considered the matter of appointing an auditor at its meeting in January 2025. Once again, it agreed to appoint KPMG, based on feedback from market testing, a review of the auditor's performance and consideration of their independence. No non-audit services were provided by KPMG during 2024/25.

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

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

Audit Committee membership and attendance during 2024/25 was as follows:

Name	A	B	%
Clare Austin	5	5	100%
Rhona Bradley	4	5	80%
Ian Haythornthwaite (Chair)	3	3	100%
Simon Holden	3	3	100%
Mary Moore	4	5	80%

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

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

The Remuneration Committee

The Board of Directors has established a Remuneration Committee. Its responsibilities include consideration of matters relating to the remuneration and terms and conditions of office of the executive directors. The committee comprises all non-executive directors and is chaired by Mark Jones. Attendance information is provided on page 61.

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

The committee also supports our succession planning work. During the year, the Remuneration Committee of the Board reviewed our succession planning, as part of a submission process to NHS England. It had positive assurance that the Trust has appropriate and robust succession planning for any short and medium-term absences in the Executive team; that there was an appropriate depth of talent available supporting the Executive team; and that colleagues supporting Executive Directors were being appropriately developed to maximise their potential, in line with their ambitions. was the first time we had been asked to submit a succession planning return to the ICB. Our participation in the NHS Leadership Academy's NExT Director Scheme supports the creation of a pipeline of strong and diverse potential candidates for non-executive director roles and has a current focus on supporting women, people from local BAME communities, and disabled people with senior level experience into board level roles. We now have two colleagues working with us through this programme as development non-executive directors.

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

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

The Nomination and Remuneration Committee

The Council of Governors has established a Nomination and Remuneration Committee. Its responsibilities include consideration of matters relating to the appointment, remuneration and other terms and conditions of service of the non-executive directors and providing recommendations to the Council of Governors for consideration. Membership and attendance information is provided on page 62.

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

Assurance Committees

The Finance and Performance Committee met seven times during 2024/25 and membership and attendance was as follows:

Name	A	B	%
Rhona Bradley	6	7	86%
Sarah Brennan	2	4	50%
Tabitha Gardner	7	7	100%
Julie Gill (Chair)	7	7	100%
Ian Haythornthwaite	1	3	33%
Simon Holden	6	6	100%
Nigel Kee	2	2	100%
Richard Mundon	6	7	86%

Francine Thorpe	6	7	86%
Claire Wannell	0	1	0%

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

The People Committee met six times during 2024/25 and membership and attendance was as follows:

Name	A	B	%
Clare Austin	5	6	83%
Sanjay Arya	5	6	83%
Julie Gill	5	5	100%
Lynne Lobley (Chair)	5	6	83%
Mary Moore	4	6	67%
Kevin Parker-Evans	6	6	100%
Juliette Tait	5	6	83%
Mark Wilkinson (Chair)	2	2	100%

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

The Quality and Safety Committee met six times during 2024/25 and membership and attendance was as follows:

Name	A	B	%
Sanjay Arya	2	6	33%
Rhona Bradley	5	6	83%
Lynne Lobley	2	4	50%
Mary Moore	6	6	100%
Kevin Parker-Evans	5	6	83%
Francine Thorpe (Chair)	5	6	83%
Mark Wilkinson	2	3	67%

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

The Research Committee met four times during 2024/25 and membership and attendance was as follows:

Name	A	B	%
Sanjay Arya	1	4	25%
Clare Austin (Chair)	4	4	100%
Anne-Marie Miller	3	4	75%
Richard Mundon	3	4	75%

Kevin Parker-Evans	2	4	50%
Lynne Lobley	3	3	100%
Francine Thorpe	2	4	50%
Mark Wilkinson	2	2	100%

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

NHS England's system oversight framework

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

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

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

Segmentation

WWL is currently placed in segment 2 of NHSI's Single Oversight Framework (providers offered targeted support; potential support needed in one or more of the five themes but not in breach of licence and/or formal action is not needed) as notified by NHS England. This segmentation information represents the position as at 5 March 2025. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website.

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

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

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

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

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

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

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

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

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

Mary Fleming
Chief Executive and Accounting Officer
19 June 2025

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

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

Following the introduction of the integrated care model, along with several other trusts in our region, WWL became a member of the Greater Manchester Integrated Care Partnership (GMICP). We also continue to be a member of our local care organisation, the Healthier Wigan Partnership (HWP), along with other key health and care providers across primary, community, mental health, social care. Both of these organisations have developed their own assurance frameworks which work similarly to our own in monitoring achievement of and risks related to our wider regional and local objectives. Our board receives a summary of the quarterly Wigan locality assurance framework at

each meeting. Our Head of Risk has monthly locality risk meetings with the ICB's Risk Manager, Head of Planning, Governance and Strategy (Wigan) and the Audit Manager from Wigan Council, which inform the content of this document. Currently, our board receives both a partnerships report and a system partnerships report annually, facilitating oversight of how we work collaboratively with our regional and local partners. These documents, along with the 'partnerships' section of our board assurance framework, inform our board of any risks around partnership working.

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

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

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

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

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

Risk management core controls are included in our internal audit plan cycle, with our 2026 audit result being one of high assurance.

The risk and control framework

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

determine and continuously assess the nature and extent of the principal risks that the trust is exposed to and is willing to take to achieve its objectives - its risk appetite – and ensure that planning and decision making reflects this assessment.

Identification of risk

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

Evaluation of risk

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

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

Control of risk

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

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

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

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

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

Risk appetite

Within the Risk Management Framework, risk appetite is referred to as a concept. Within this concept, we refer to optimal and tolerable risk positions. The optimal risk position is the level of risk with which the trust aims to operate. The tolerable position is the level of risk which the trust is willing to operate, given current constraints. The Board of Directors agrees the risk appetite and risk tolerance levels for the trust as part of the annual strategic planning process.

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

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

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

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

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

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

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

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

Our major risks are included on the board assurance framework and included the following for 2024/25:

Patients	**Sepsis recognition, screening and management**
	A risk of the under diagnosing of patients with sepsis, due to health care professionals failing to recognise sepsis in the deteriorating patient, which may have resulted in patients not receiving sepsis 6 treatment within one hour of triggering for sepsis.
	Harm free care - avoidable pressure ulcers
	A risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.
	Complaint response rates
	A risk that complaints received may not be responded to and acted upon within our agreed timeframes, due to operational pressures, resulting in missed targets, unresolved complaints and adverse publicity.
People	**Workforce sustainability**
	A risk that we may not have delivered the workforce sustainability agenda objective, due to issues with staff retention and keeping colleagues well in work, that may have resulted in an increase in sickness absence, vacancies, time to hire challenges and an increase in employee relations cases.
	Staff Engagement
	A risk that we may not deliver the cultural development agenda objective, due to a lack of staff engagement and low morale.
	Workforce equality, diversity and inclusion
	The Trust took significant steps to fill ongoing qualified nursing gaps through the recruitment of over 405 internationally educated nurses and there was a risk that we would not retain this valued workforce.

Performance	**Financial performance: failure to meet agreed income/expenditure position**
	A risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties.
	Financial Sustainability: Efficiency targets
	A risk that the CIP plan will not be achieved and/or will not be cash releasing, resulting in a significant overspend.
	Capital funding
	A risk that of inadequate capital funding to enable priority schemes to progress. Due to uncertainties around capital funding arrangements the strategy could assume that more investment can be made than is available.
	Cash balance
	A risk a that the Trust may have insufficient cash balance to meet normal business activities on a day-to-day basis, due to cash balances potentially becoming too low.
	Elective services
	A risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner.
	Urgent and emergency care services
	A risk to urgent and emergency care delivery due to consistently operating above 92% occupancy levels.
Partnerships	**Supporting widening access to employment for local residents**
	A risk that access to funding for support initiatives which support widening access to employment for local residents is less certain, due to pressures on the Trust's financial position, which may impact on delivery of the objective.
	Partnership working CCG changes
	A risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.
	Estate strategy net carbon zero requirements
	A risk that the Trust will not meet its net zero commitments and climate change will have an impact on the Trust delivering services, that cannot be mitigated.
	University Teaching Hospital University Hospital Association criteria
	A risk that all the criteria that the University Hospital Association have specified may not be met, due to uncertainty regarding achieving the required core number of university Principal Investigators, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.

We work to continuously develop the skills of our board members and this year have held workshops covering 'health inequalities' and the 'AQUA Advancing Quality Programme'; self-assessments on 'continuous improvement' and 'freedom to speak-up', as well as a session on our Better Lives Programme, at which we were joined by leaders from our local care organisation and colleagues supporting us all to deliver this. This year saw us welcome several new board members to WWL and we have now begun a board development programme delivered by the NHS Leadership Academy to support the strong cohesion that I can already see developing within our new team. In line with best practice guidance from NHS England, our next review will be scheduled to take place in 2026.

Principal risks to compliance with the NHS foundation trust licence condition

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

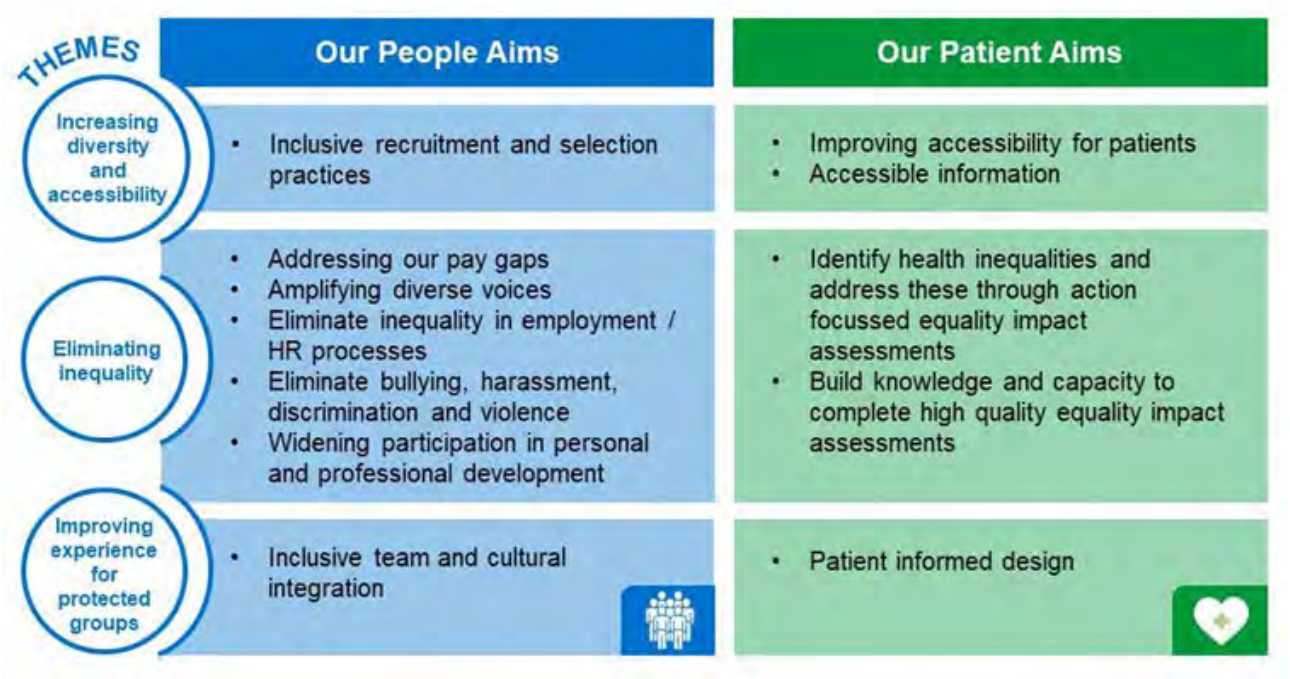
The board is satisfied with the timeliness and accuracy of information to assess risks to compliance with the foundation trust's licence and the degree of rigour of oversight it has over performance. This is supported by the conclusion of our external auditor as part of their value for money work, which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

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

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

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

Our EDI Strategy has the following key aims:



The EDI lead will ensure the EDI workstreams are aligned to the EDI Strategy People and Patient aims and objectives to ensure consistency of strategic priorities and to allow monitoring progress

through the EDI Strategy group. This action provides an assurance to the People Committee that all key EDI actions are being overseen and implemented by the EDI Strategy Group and workstreams.

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

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

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

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

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

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

Key stakeholders, including patients, our public and staff membership and local partner organisations are engaged in service developments and changes. We are also working across the local health economy including engagement with ICS colleagues on the delivery of integrated care pathways. We have worked with partners within the Wigan locality to create a system risk register which is reviewed on a quarterly basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Objectives are approved and monitored through a number of channels, including regular review of the foundation trust's financial position by a dedicated Finance and Performance Committee

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

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

- Value for money is an important component of the internal and external audit plans that provides assurance to the board regarding processes that are in place to ensure effective use of resources

- On-going benchmarking and tenders of operations occur throughout the year to ensure the competitiveness of service
- We use numerous data sources in order to undertake comparative analysis. This analytic either provides assurances or helps identify opportunities for improvement in care provision
- Service line reporting is used by divisional managers to seek to improve financial performance
- Commissioning for Quality and Innovation schemes are negotiated and signed off by clinical, operational and finance directors and operational leads are assigned for each scheme and
- An on-line intelligence tool allowing individual budget holders to see their in-month and cumulative budget performance.
- Benefits realisation reviews are carried out for business cases at an appropriate time, post investment

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

NHS Shared Business Services has processes and procedures in place which are compliant with central government standards as outlined in the information assurance maturity model and the NHS information governance assurance framework and it provides annual updates on the testing of controls and operations within its shared business facilities in the form of an International Standard on Assurance WWL are part of the Trust Provider Collaborative, which has governance processes in place as part of the operating model for the Greater Manchester Integrated Care System (NHS GM ICS). The Trust's annual operation plan is developed in an integrated way, as part of the overall NHS GM ICS plan.

WWL has worked with partners through the Healthier Wigan Partnership System Board to develop the Wigan Locality Plan. This sets out the priorities to improve the health of our population, reduce health inequalities and make best value from our resources. It is based on an understanding of the needs of our residents that has been developed through the joint strategic needs assessment. The Healthier Wigan Partnership Board oversees progress against delivery of these priorities across the following workstreams: population health; maternity, children & young people; planned care; long term conditions, cancer & end of life; mental health; urgent and emergency care; and primary care networks.

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

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

Our control and assurance processes for information governance include:

- A network of information asset owners, covering patient and staff personal data systems
- A trained Caldicott Guardian, a trained Senior Information Risk Owner and a trained Data Protection Officer
- A risk management and incident reporting process and related risk register
- Mandatory data security and protection training for all staff
- An annual confidentiality code of conduct signing
- Data protection, information security, artificial intelligence, records management and confidentiality policies
- A quarterly report to the board summarising key information governance activities and compliance with requirements (including the Data Security and Protection Toolkit/Cyber Assessment Framework, General Data Protection Regulation arrangements and incidents)

Our information governance team have reviewed 1,411 incidents between 1 April 2024 and 1 March 2025. After triaging and reviewing, we escalated 17 incidents to the Information Commissioner's Office (ICO). Of these 17 incidents, 2 remain open with the ICO, while all others have been closed.

The incidents that were reported to the ICO were related to serious breaches of confidentiality and security, whereby personal data had been shared inappropriately or there had been a contravention of data protection legislation. Examples include a phishing attempt on a trust account, letters containing sensitive information being sent to an incorrect address and information released incorrectly by a sub-processor. The final quarter of 2024/25 has seen a steady decrease in the volume of incidents meeting the severity for reporting to the Information Commissioner.

For 2024/25 The Trust is undertaking work to complete the annual self-assessment, the Cyber Assessment Framework. This assessment, previously known as the Data Security and Protection Toolkit, is due to be completed by 30th June 2025. We also received a first stage audit by our internal auditors and are currently awaiting the results.

The information governance team continue to work alongside and support colleagues and departments throughout the organisation, offering guidance and support. The team act to ensure that the Trust is legislatively compliant with all relevant data protection legislation and ensuring compliance with new emerging technologies, to mitigate risk. All information incidents are reported via Datix, which aligns with regulatory requirements.

Data quality and governance

Acknowledging the importance of high-quality data in effective decision-making, our organisation has implemented rigorous controls and procedures. Our Data Analytics and Assurance team has developed applications designed to identify errors and inconsistencies within our data. In 2024/25 we have implemented an assurance framework for all mandatory and statutory returns to ensure compliance against national guidance.

These initiatives enhance organisational transparency, enabling service managers to implement necessary changes. Consequently, these procedural adjustments address issues at their inception, thereby contributing to overall process improvement.

The accurate and timely capture of data is the responsibility of all staff members, ensuring its integrity is maintained. We have an integrated Data Quality team that offers guidance on enhancing data quality and undertakes audits to ensure operating procedures are adhered to. Regular data analysis enables the team to uncover insights that might otherwise remain undetected by data users. This

tight integration with divisional teams and analysts ensures that focus and priority are appropriately directed.

Our Data Recording Quality Committee supervises data quality matters, ensuring their resolution and directly reporting to the Caldicott Committee. Representation from across the organisation guarantees transparency and includes input from all stakeholders.

In the most recent period, our Data Analytics and Assurance team introduced updated versions of specific data quality dashboards, such as a community data quality dashboard which focuses on data captured from our SystemOne community electronic patient record.

Review of effectiveness

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

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

- The board assurance framework provides evidence of the process of the effectiveness of controls that manages the principal risks to the organisation
- The Board of Directors, Audit Committee, Risk Management Group and the Executive Scrutiny Group advise me on the implications of the results of my review of the effectiveness of the system of internal control. These committees also advise outside agencies in relation to serious events
- All the relevant committees within the corporate governance structure have a timetable of meetings and a reporting structure to enable issues to be escalated
- The board monitors and reviews the board assurance framework at each meeting. Risks noted on the board assurance framework are reviewed by the Finance and Performance Committee, People Committee, Quality and Safety Committee and Research Committee as appropriate to their areas of focus and overall responsibility is retained by the Board of Directors
- The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation’s activities - both clinical and non-clinical - that supports the achievement of the organisation’s objectives
- Internal auditors review the board assurance framework and the effectiveness of the system of internal control as part of the internal audit work to assist in the review of effectiveness. The internal auditors reviewed the assurance framework and concluded that our assurance framework meets the requirements set out in NHS guidance, is visibly used by the organisation and clearly reflects the risks discussed by the board
- Through our internal audit plan, we aim to ensure that each area of service is reviewed on a two-to-four-year basis. The plan is set annually with input from our executive team. It is in

part informed by an annual risk assessment, conducted by our auditors and in part based on mandated audits which are due, as illustrated by our continuous audit cycle. Our internal auditors completed 12 audits this year, the findings of each being reported to our Audit Committee

- 2 audits from our 2024/25 audit plan were given limited assurance, relating to the use of enhanced care and patients' property and management actions have been put in place to address the issues raised
- Of the 31 recommendations issued by the internal auditors during the year, all of which were accepted by management. 5 of the recommendations were described as high-risk recommendations, 20 have been actioned with 17 remaining and 6 of these relating to prior financial years.

The overall opinion for the period 1st April 2024 to 31st March 2025 provides substantial assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

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

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

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

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

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

The 2024/25 internal audit plan has been delivered with the focus on the provision of our Head of Internal Audit Opinion. This position has been reported within the progress reports across the financial year. Review coverage has been focused on:

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

Conclusion

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

Mary Fleming
Chief Executive and Accounting Officer
19 June 2025

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

Mary Fleming
Chief Executive and Accounting Officer
19 June 2025

INDEPENDENT AUDITORS 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 2025 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

- Enquiring of management, the Audit Committee and internal audit as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

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

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

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

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

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries posted to unrelated accounts linked to the recognition of expenditure, revenue or cash.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Assessing the completeness of recorded expenditure through inspecting a sample of expenditure invoices around the year end and carrying out a search for unrecorded liabilities to determine whether expenditure has been recognised in the correct accounting period.

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

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

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

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

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

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

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

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

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

Other information in the Annual Report

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

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

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

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 100 the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

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

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

We have nothing to report in this respect.

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

As explained more fully in the statement set out on page 100, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

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

Statutory reporting matters

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

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

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

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

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of the financial statements of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

Timothy Cutler

for and on behalf of KPMG LLP

Chartered Accountants

1 St Peter's Square

Manchester

M2 3AE

26 June 2025

FINANCIAL REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Annual Accounts for the year ended 31 March 2025

Foreword to the accounts

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2025, 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 .....

Mary Fleming
Chief Executive

Date **19 June 2025**

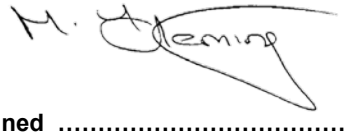
Statement of Comprehensive Income for the year ended 31 March 2025

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	2	551,966	494,610
Other operating income	3	29,248	28,480
Total operating income from continuing operations		**581,214**	**523,090**
Operating expenses	4	(604,280)	(534,355)
Operating deficit from continuing operations		**(23,066)**	**(11,265)**
Finance costs			
Finance income	7	1,903	2,088
Finance expenses	8	(1,634)	(1,425)
PDC dividends payable		(4,813)	(4,855)
Net finance costs		**(4,544)**	**(4,192)**
Loss on disposal of fixed assets	9	(771)	(323)
Deficit for the year		**(28,381)**	**(15,780)**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments	11	(4,986)	(2,374)
Revaluations	12	7,503	1,987
Other reserve movements		0	3
Total comprehensive expense for the year		**(25,864)**	**(16,164)**

Statement of Financial Position as at 31 March 2025

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	10	4,936	5,620
Property, plant and equipment	11	208,226	224,027
Right of use assets	13	29,517	33,452
Receivables	16	788	868
Total non-current assets		**243,467**	**263,967**
Current assets			
Inventories	15	3,805	3,332
Receivables	16	20,846	19,169
Cash and cash equivalents	18	18,070	24,945
Total current assets		**42,721**	**47,446**
Current liabilities			
Trade and other payables	19	(58,349)	(66,126)
Other liabilities	20	(8,173)	(8,678)
Borrowings	21	(6,607)	(7,565)
Provisions	23	(1,046)	(1,160)
Total current liabilities		**(74,175)**	**(83,529)**
Total assets less current liabilities		**212,013**	**227,884**
Non-current liabilities			
Other liabilities	20	0	(63)
Borrowings	21	(36,124)	(39,923)
Provisions	23	(1,967)	(2,141)
Total non-current liabilities		**(38,091)**	**(42,127)**
Total assets employed		**173,922**	**185,757**
Financed by			
Public dividend capital		162,605	148,576
Revaluation reserve		22,825	20,973
Income and expenditure reserve		(11,508)	16,208
Total taxpayers' equity		**173,922**	**185,757**

The primary financial statements on pages 2 to 5 and the notes on pages 6 to 50 were approved by the Board of Directors and authorised for issue on 19 June 2025 and signed on its behalf by Mary Fleming, Chief Executive.



Signed ……..…… 19 June 2025
Mary Fleming, Chief Executive

Statement of Changes in Equity for the year ended 31 March 2025

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

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

Public dividend capital

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	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(23,066)	(11,265)
Non-cash income and expense			
Depreciation and amortisation	4	18,756	17,222
Net impairments and (reversals) of impairments	4	27,458	5,323
Income recognised in respect of capital donations (non-cash)	3	(115)	(141)
(Increase) / decrease in receivables and other assets		(1,118)	12,908
(Increase) / decrease in inventories		(473)	361
Decrease in payables and other liabilities		(3,962)	(16,812)
Decrease in provisions		(329)	(834)
Other movement in operating cashflows		0	2
Net cash generated from operating activities		**17,151**	**6,764**
Cash flows used in investing activities			
Interest received		1,967	2,041
Purchase of intangible assets		(318)	(1,194)
Purchase of property, plant, equipment and investment property		(26,110)	(30,918)
Sales of property, plant, equipment and investment property		0	2
Net cash used in investing activities		**(24,461)**	**(30,069)**
Cash flows used in financing activities			
Public dividend capital received		14,029	17,956
Loans paid		(1,351)	(1,446)
Capital element of lease liability repayments		(5,164)	(4,689)
Interest element of lease liability repayments		(1,363)	(1,128)
Other interest paid		(236)	(253)
PDC dividend paid		(5,480)	(5,287)
Net cash used in financing activities		**435**	**5,153**
Decrease in cash and cash equivalents		**(6,875)**	**(18,152)**
Cash and cash equivalents at 1 April		24,945	43,098
Cash and cash equivalents at 31 March	18	**18,070**	**24,945**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust - Annual Accounts 2024/25

1. Accounting policies

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

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

1.1 Accounting convention

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

1.2 Going concern

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

1.3 Joint arrangements

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

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

1.4 Critical accounting judgements and key sources of estimation uncertainty

1.4.1 Critical judgements in applying accounting policies

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

Operating segments

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

Interests in other entities and joint arrangements

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

The Foundation Trust has assessed its existing contracts and collaborative arrangements for 2024/25, and has determined that the arrangements which would fall within the scope of IFRS 10, IFRS 11 Joint Arrangements or IFRS 12 Disclosure of Interests in Other Entities, are the NHS Foundation Trust's subsidiary charity, the NHS Foundation Trust's investment into the Community Health Investment Plan (CHIP) and three joint operations (Note 14).

Consolidation

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

Where the fund balances held by the Charity are deemed to be of a significant value to require consolidation, then those balances will be consolidated into the Foundation Trust Accounts. There is no consolidation for 2024/25.

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 full valuation was undertaken during 2024/25 with a revaluation date of 31 March 2025.

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 2025 is £213.2m (£229.6m, 2023/24).

1.5 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

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

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

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS15. Payment for CQUIN and BTP on non-elective services is included in the fixed criteria element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2024/25, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

NHS Injury Cost Recovery Scheme

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

1.6 Other forms of income

Grants and donations

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

Income from sale of non-current assets

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

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.7 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

National Employment Savings Trust (NEST)

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

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

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

1.8 Other expenses

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

1.9 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	5 to 20 years
Vehicles	10 to 13 years
Furniture and fittings	15 years
Medical and other equipment	5 to 15 years
Information Technology	5 to 10 years

Revaluation gains and losses

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

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

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

Impairments

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

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

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

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

Assets under construction

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

De-recognition

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

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

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

Donated and grant funded assets

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

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

1.10 Intangible assets

Recognition

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

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

Measurement

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

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

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

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

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Amortisation

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

Intangible assets are amortised over the following useful lives:

Websites	8 years
Development expenditure	8 years
Software	8 years

1.11 Inventories

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

1.12 Cash and cash equivalents

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

1.13 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets and liabilities are subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

Impairment of financial assets

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

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

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

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

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

De-recognition

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

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

1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Initial recognition and measurement

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

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

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

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.15 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 2025:

Short term rate: 4.03% (4.26%, 2023/24)
Medium term rate: 4.07% (4.03%, 2023/24)
Long term rate: 4.81% (4.72%, 2023/24)

For post-employment benefits including early retirement provisions and injury benefit provisions the HM Treasury's pension discount rate of 2.40% in real terms (2.45%, 2023/24) is used.

1.16 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Foundation Trust pays an annual contribution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the NHS Foundation Trust is disclosed in Note 23.1 but is not recognised in the NHS Foundation Trust's accounts.

1.17 Non-clinical risk pooling

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

1.18 Contingent assets and contingent liabilities

A contingent assets is a possible asset that arises from past events and whose existence will only be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Foundation Trust. A contingent asset is disclosed in Note 24 where an inflow of economic benefits is probable.

A contingent liability is:

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

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

A contingent liability is disclosed in Note 24 unless the possibility of payment is remote.

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

1.19 Public dividend capital

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

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

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

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

1.20 Value added tax

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

1.21 Corporation tax

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

1.22 Third party assets

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

1.23 Losses and special payments

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

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

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.24 Transfers by Absorption

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

1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

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

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

IFRS 17 Insurance contracts: [new standard] (2025/26) – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements: issued in April 2024 and applies to periods beginning on or after 1 January 2027. The standard has not yet been adopted by FRAB for inclusion within the FREM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

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:

	2024/25 £000	2023/24 £000
NHS England*	32,750	35,454
Integrated Care Boards	495,627	437,621
NHS Foundation Trusts	5,065	4,831
NHS Trusts	2	0
Local Authorities	6,714	6,615
NHS other (including UKHSA & MHRA)	0	1
Non NHS: private patients	7,839	6,782
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	25	98
Injury cost recovery scheme	1,052	907
Non NHS: other**	2,892	2,302
	551,966	**494,610**

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% in April 2019, and further increase to 23.7% from April 2024 (excluding administration charge). Since 2019/20, NHS providers have continued to pay over contributions at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

** Non NHS: other income relates to income from other territorial bodies and First Contact Practitioner income that are not deemed to be within the NHS England accounting boundary.

Note 2.2 Income from patient care activities (by nature)

	2024/25 £000	2023/24 £000
Acute services		
Income from commissioners under API contracts - variable element*	123,651	102,695
Income from commissioners under API contracts - fixed element*^	304,216	288,523
High cost drugs income from commissioners (excluding pass through costs)^	22,017	17,938
Other NHS clinical income**	5,489	6,971
Community Services		
Income from commissioners under API contracts*	55,928	48,441
Income from Other Sources (e.g. local authorities)	6,716	6,331
Additional income		
Private patient income	7,839	6,781
National pay award central funding	976	189
Additional pension contribution central funding ***	21,132	13,115
Other clinical income****	4,002	3,626
Total income from activities	**551,966**	**494,610**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Other NHS clinical income includes NHS income outside the API contract for a range of services.

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% in April 2019, and further increase to 23.7% from April 2024 (excluding administration charge). Since 2019/20, NHS providers have continued to pay over contributions at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

**** Other clinical income relates largely to income from the NHS Injury Cost Recovery Scheme (ICR) for third party injury claims, First Contact Practitioner income not deemed within the NHSE England acocunting boundary.

^ Prior year figures have been re-apportioned for consistency with 2024/25 income categorisation.

Note 2.3 Overseas visitors

	2024/25 £000	2023/24 £000
Income recognised this year	25	98
Cash payments received in-year	24	40
Amounts added to allowance for impaired contract receivables	0	6
Amounts written off in-year	8	72

Note 3 Other operating income

	2024/25 £000	2023/24 £000
Other operating income from contracts with customers:		
Research and development (contract)	1,880	2,483
Education and training (excluding notional apprenticeship levy income)	15,723	16,273
Non-patient care services to other bodies	1,638	1,548
Income in respect of employee benefits accounted on a gross basis*	2,286	2,141
Other**	6,790	4,741
Other non-contract operating income		
Education and training - notional apprenticeship levy income	692	666
Receipt of capital grants and donations	115	141
Charitable and other contributions to expenditure	17	206
Contribution to expenditure - consumables donated from DHSC***	0	194
Rental revenue from operating leases	108	87
	29,248	**28,480**

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

**Other contract income of £6.8m (£4.7m, 2023/24) includes car parking income, catering income, pharmacy income, staff accommodation rental and other miscellaneous income recharged to other NHS bodies.

*** Consumables donated from DHSC in the prior year was for personal protective equipment from the Department of Health and Social Care at nil cost. There are no equivalent schemes in 2024/25.

Note 3.1 Additional information on contract revenue recognised in the period

	2024/25 £000	2023/24 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	8,678	0

Note 3.2 Income from activities arising from commissioner requested services

Under the terms of its provider license, the Foundation Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25 £000	2023/24 £000
Income from services designated as commissioner requested services	535,339	481,759
Income from services not designated as commissioner requested services	16,627	12,851
Total	**551,966**	**494,610**

Note 4 Operating expenses

	2024/25 £000	2023/24 £000
Purchase of healthcare from NHS and DHSC bodies	2,465	2,173
Purchase of healthcare from non-NHS and non-DHSC bodies	3,642	5,237
Employee expenses - non-executive directors	164	159
Employee expenses - staff	376,556	333,913
Employee expenses - temporary staff	34,651	38,744
Supplies and services - clinical*	51,750	44,605
Supplies and services - general	5,250	5,298
Drug costs (inventory consumed & non-inventory purchases)	32,164	31,659
Inventories written down	33	27
Consultancy	733	0
Establishment	5,387	3,617
Transport	1,551	2,909
Premises	24,178	24,915
Movement in credit loss allowance: contract receivables/contract assets	305	21
Change in provisions discount rate	47	(293)
Depreciation on property, plant and equipment, and RoU assets	17,754	16,326
Amortisation on intangible assets	1,002	896
Net Impairments**	27,458	5,323
Audit fees payable to the external auditor***		
audit services - statutory audit	171	155
other auditor remuneration	2	0
Internal audit and local counter fraud services	143	174
Clinical negligence	13,075	12,280
Legal fees	843	519
Insurance	537	483
Education and Training	2,746	3,428
Redundancy and other mutually agreed resignation schemes	741	72
Losses, ex gratia & special payments	26	118
Other****	905	1,597
Total	**604,280**	**534,355**

* The Foundation Trust received personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Foundation Trust has accounted for the receipt of these at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. The total value transacted within supplies and services - clinical is £0.0m (£0.2m. 2023/24). A corresponding Income entry has been recorded in Note 2.2.

** Further details of net impairments can be found in Note 11.

*** Audit fees payable to the external auditor inclusive of VAT was £171k during the year (£155k, 2023/24) and £143k (£128k, 2023/24) exclusive of VAT.

****Other expenditure of £0.9m (£1.6m, 2023/24) includes changes in provisions for personal injury benefits and other claims, and other miscellaneous expenditure charges.

Note 4.1 Other auditor remuneration

Other assurance services payable to the external auditor was £2k (£0k, 2023/24) during the year.

Note 4.2 Limitation on auditor's liability

There is a £1.0m limitation on auditor's liability for external audit work carried for the financial years 2024/25 and 2023/24.

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.

	2024/25		2023/24	
	Number	£000	Number	£000
Non-NHS				
Trade invoices paid in the period	72,017	277,555	70,363	274,349
Trade invoices paid within target	68,297	268,374	66,061	253,096
Percentage of trade invoices paid within target	**94.8%**	**96.7%**	**93.9%**	**92.3%**
NHS				
Trade invoices paid in the period	1,986	45,484	1,842	38,499
Trade invoices paid within target	1,820	42,598	1,670	36,300
Percentage of trade invoices paid within target	**91.6%**	**93.7%**	**90.7%**	**94.3%**
Total				
Trade invoices paid in the period	74,003	323,039	72,205	312,848
Trade invoices paid within target	70,117	310,972	67,731	289,396
Percentage of trade invoices paid within target	**94.7%**	**96.3%**	**93.8%**	**92.5%**

Note 5 Employee benefits

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	294,927	264,537
Social security costs	28,690	27,350
Apprenticeship levy*	1,399	1,343
Employer's contributions to NHS pensions	32,148	29,701
Employer's contributions to NHS pensions paid by NHSE on behalf of the Foundation Trust (9.4%)**	21,132	13,115
Temporary staff	34,651	38,744
Total staff costs	**412,947**	**374,790**
Costs capitalised as part of assets	924	1,994

*The Apprenticeship Levy requires all employers operating in the UK, with a pay bill over £3.0m each year, to invest in apprenticeships. The Foundation Trust is required to pay a levy of 0.5% of it's pay bill.

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% in April 2019, and further increase to 23.7% from April 2024 (excluding administration charge). Since 2019/20, NHS providers have continued to pay over contributions at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Total staff costs in 2024/25 are £412.9m (£374.8m, 2023/24) which is an increase of £38.1m. This primarily relates to the impact of the 2024/25 pay award (£20.6m), additional government agreements for pay reform and structures (£4.2m) and increase in central pension contribution rate (£8.1m).

Temporary staffing expenditure reduced compared to the previous year (£34.2m, 2024/25; £38.7m, 2023/24), which is due to bank rate standardisation and reduced usage, particularly associated with delivery of care in temporary escalation spaces.

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 14 early retirements agreed on the grounds of ill-health during the year (5, 2023/24). The cost of these ill-health retirements, £1,600k (£635k, 2023/24) is borne by the NHS Business Services Authority - Pensions Division.

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

	2024/25 £000	2023/24 £000
Salary	1,510	1,459
Employer's pension contributions	177	172
Taxable benefits	9	9
Total	**1,696**	**1,640**
Non-executive directors' remuneration *	153	159
Total	**1,849**	**1,799**
The total number of directors accruing benefits under the NHS Pension Scheme	10	11

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

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

Note 5.3 Employee benefits

The Foundation Trust's policy in relation to annual leave for staff states that full annual leave entitlement must be taken in the financial year to support health and wellbeing. However, in recognition that some statutory annual leave will not be taken in year (e.g. for staff on maternity leave) an accrual of £0.3m is included in trade and other payables.

Note 6 Operating lease income

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

	2024/25 £000	2023/24 £000
Operating lease income		
Minimum lease receipts	108	87
Total	**108**	**87**

	31 March 2025 £000	31 March 2024 £000
Future minimum lease receipts due:		
- not later than one year	108	87
- later than one year and not later than five years;	432	545
- later than five years.	27	0
Total	**567**	**632**

Note 7 Finance income

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

	2024/25 £000	2023/24 £000
Interest on bank accounts	1,903	2,088
Total	**1,903**	**2,088**

The interest received on bank accounts decreased during the year due to several changes in the Bank of England base rate.

Note 8 Finance expenses

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

	2024/25 £000	2023/24 £000
Interest expense		
Loans from the Department of Health and Social Care	230	250
Interest on lease obligations	1,363	1,128
Total interest expense	**1,593**	**1,378**
Other finance costs - unwinding of discount	41	47
Total	**1,634**	**1,425**

The interest on lease obligations increased as a result of new lease arrangements arising from Right of Use Asset additions in 2024/25 and the remeasurement of existing leases with that includes annual rent increases in line with RPI, refer to Note 13.

Note 9 Gains and (losses) on disposal of assets

	2024/25 £000	2023/24 £000
Gains on disposal of assets	0	2
(Loss) on disposal of assets	(771)	(325)
Total	(771)	(323)

The Foundation Trust disposed of a number of assets during the year which resulted in a loss. The gains on disposal of assets in 2023/24 arose as a result of a profit on sales of equipment.

Note 10 Intangible assets

Note 10.1 Intangible assets - 2024/25

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation/gross cost at 1 April 2024	**18,452**	**713**	**36**	**19,201**
Transfers by absorption	0	0	0	0
Additions	318	0	0	318
Reclassifications	51	(51)	0	0
Disposals/derecognition	(3,816)	0	0	(3,816)
Gross cost at 31 March 2025	**15,005**	**662**	**36**	**15,703**
Amortisation at 1 April 2024	**12,847**	**713**	**21**	**13,581**
Provided during the year	997	0	5	1,002
Reclassifications	43	(51)	8	0
Disposals/derecognition	(3,816)	0	0	(3,816)
Amortisation at 31 March 2025	**10,071**	**662**	**34**	**10,767**
Net book value at 31 March 2025	**4,934**	**0**	**2**	**4,936**
Net book value at 1 April 2024	**5,605**	**0**	**15**	**5,620**

Note 10.2 Intangible assets - 2023/24

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation/gross cost at 1 April 2023	**17,833**	**713**	**44**	**18,590**
Additions	1,232	0	0	1,232
Disposals/derecognition	(613)	0	(8)	(621)
Valuation/gross cost at 31 March 2024	**18,452**	**713**	**36**	**19,201**
Amortisation at 1 April 2023	**12,564**	**713**	**29**	**13,306**
Provided during the year	896	0	0	896
Disposals/derecognition	(613)	0	(8)	(621)
Amortisation at 31 March 2024	**12,847**	**713**	**21**	**13,581**
Net book value at 31 March 2024	**5,605**	**0**	**15**	**5,620**
Net book value at 1 April 2023	**5,269**	**0**	**15**	**5,284**

Note 10.3 Intangible assets financing 2024/25

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Purchased	4,872	0	2	4,874
Donated	62	0	0	62
NBV total at 31 March 2025	**4,934**	**0**	**2**	**4,936**

Note 10.4 Intangible assets financing 2023/24

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Purchased	5,529	0	15	5,544
Donated	76	0	0	76
NBV total at 31 March 2024	**5,605**	**0**	**15**	**5,620**

Note 11 Property, plant and equipment

Note 11.1 Property, plant and equipment - 2024/25

	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 2024	**10,772**	**155,784**	**8,928**	**3,069**	**68,049**	**222**	**48,730**	**545**	**296,099**
Additions	0	12,462	20	5,921	3,552	0	11	0	21,966
Impairments	(4,301)	(30,336)	(7,183)	0	0	0	0	0	(41,820)
Reversals of impairments	548	5,849	0	0	0	0	0	0	6,397
Revaluations	2,650	(205)	21	0	0	0	0	0	2,466
Reclassifications	0	8,444	0	(8,444)	0	0	0	0	0
Disposals/derecognition	0	0	0	(546)	(6,040)	(21)	(1,798)	(98)	(8,503)
Valuation/gross cost at 31 March 2025	**9,669**	**151,998**	**1,786**	**0**	**65,561**	**201**	**46,943**	**447**	**276,605**
Accumulated depreciation at 1 April 2024	**0**	**4,530**	**106**	**0**	**36,776**	**198**	**30,095**	**367**	**72,072**
Provided during the year	0	5,480	198	0	3,474	6	2,871	26	12,055
Impairments	0	(3,977)	(205)	0	0	0	0	0	(4,182)
Reversals of impairments	0	1,203	0	0	0	0	0	0	1,203
Revaluations	0	(4,939)	(98)	0	0	0	0	0	(5,037)
Disposals/derecognition	0	0	0	0	(5,819)	(21)	(1,794)	(98)	(7,732)
Accumulated depreciation at 31 March 2025	**0**	**2,297**	**1**	**0**	**34,431**	**183**	**31,172**	**295**	**68,379**
Net book value at 31 March 2025	**9,669**	**149,701**	**1,785**	**0**	**31,130**	**18**	**15,771**	**152**	**208,226**
Net book value at 1 April 2024	**10,772**	**151,254**	**8,822**	**3,069**	**31,273**	**24**	**18,635**	**178**	**224,027**

Note 11.2 Property, plant and equipment - 2023/24

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2023	**9,647**	**147,146**	**8,763**	**507**	**66,547**	**222**	**47,292**	**546**	**280,670**
Additions	0	19,745	0	2,706	3,373	0	2,217	0	28,041
Impairments	0	(13,642)	0	0	0	0	0	0	(13,642)
Reversals of impairments	0	2,516	0	0	0	0	0	0	2,516
Revaluations	1,125	(171)	166	0	0	0	0	0	1,120
Reclassifications	0	190	(1)	(144)	(12)	0	1	(1)	33
Disposals/derecognition	0	0	0	0	(1,859)	0	(780)	0	(2,639)
Valuation/gross cost at 31 March 2024	**10,772**	**155,784**	**8,928**	**3,069**	**68,049**	**222**	**48,730**	**545**	**296,099**
Accumulated depreciation at 1 April 2023	**0**	**3,886**	**7**	**0**	**35,515**	**189**	**27,745**	**343**	**67,685**
Provided during the year	0	4,818	189	0	3,028	9	2,895	26	10,965
Impairments	0	(2,712)	0	0	0	0	0	0	(2,712)
Reversals of Impairments	0	(717)	0	0	0	0	0	0	(717)
Revaluations	0	(778)	(89)	0	0	0	0	0	(867)
Reclassifications	0	33	(1)	0	1	0	2	(2)	33
Disposals/derecognition	0	0	0	0	(1,768)	0	(547)	0	(2,315)
Accumulated depreciation at 31 March 2024	**0**	**4,530**	**106**	**0**	**36,776**	**198**	**30,095**	**367**	**72,072**
Net book value at 31 March 2024	**10,772**	**151,254**	**8,822**	**3,069**	**31,273**	**24**	**18,635**	**178**	**224,027**
Net book value at 1 April 2023	**9,647**	**143,260**	**8,756**	**507**	**31,032**	**33**	**19,547**	**203**	**212,985**

Note 11.3 Property, plant and equipment financing - 2024/25

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned	9,669	147,908	1,785	0	29,974	18	15,768	131	205,253
Donated	0	1,793	0	0	1,156	0	3	21	2,973
NBV total at 31 March 2025	**9,669**	**149,701**	**1,785**	**0**	**31,130**	**18**	**15,771**	**152**	**208,226**

Note 11.4 Property, plant and equipment financing - 2023/24

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned	10,772	151,254	6,973	3,069	30,078	24	18,630	155	220,955
Donated	0	0	1,849	0	1,195	0	5	23	3,072
NBV total at 31 March 2024	**10,772**	**151,254**	**8,822**	**3,069**	**31,273**	**24**	**18,635**	**178**	**224,027**

Note 11.5 Impairment of assets

	2024/25 £000	2023/24 £000
Net impairments charged to operating (deficit) / surplus resulting from:		
Other	13,747	0
Changes in market price	13,711	5,323
Impairments charged to operating (deficit) / surplus	27,458	5,323
Impairments charged to the revaluation reserve	4,986	2,374
Total net impairments	**32,444**	**7,697**

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 full valuation was undertaken during 2024/25 with a revaluation date of 31 March 2025.

As a result of this valuation some land and buildings have seen an increase in value totalling £7.5m (£3.1m, 2023/24).

In addition, some land and buildings have decreased in value totalling £23.9m. £18.9m has been charged to operating expenditure offset by the reversal of previous impairments totalling £5.2m to give a net reduction on expenditure of £13.7m and £5.0m charged to the revaluation reserve for the reversal of previous gains.

The net effect of these changes in value amounts to an overall decrease in land and buildings of £13.7m.

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.

In addition, the Foundation Trust has impaired a number of buildings which were intended to support admissions into the hospital. We have continued to see increasing pressure on the urgent and emergency care services which have highlighted that these properties are not delivering the benefits expected. The total value of the impairment was £13.7m.

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

Note 13 Leases - The Foundation Trust as a lessee

Note 13.1 Right of use assets - 2024/25

	Buildings excluding dwellings	Plant & machinery	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**38,558**	**5,317**	**43,875**
Additions	167	1,474	1,641
Re-measurements of the lease liability	(8)	131	123
Valuation/gross cost at 31 March 2025	**38,717**	**6,922**	**45,639**
Accumulated depreciation brought forward	9,521	902	10,423
Depreciation provided during the year	4,692	1,007	5,699
Accumulated depreciation at 31 March 2025	**14,213**	**1,909**	**16,122**
Net book value at 31 March 2025	**24,504**	**5,013**	**29,517**

Note 13.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the Statement of Financial position. A breakdown of borrowings is disclosed in Note 21.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April 2024	**34,651**	**33,406**
Lease additions	1,641	5,239
Lease liability remeasurements	123	695
Interest charge arising in year	1,363	1,128
Lease payments (cash outflows)	(6,527)	(5,817)
Carrying value at 31 March 2025	**31,251**	**34,651**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure, disclosed in Note 4.

Cash outflows in respect of leases recognised on the Statement of Financial Position are disclosed in the reconciliation above.

Note 13.3 Maturity analysis of future lease payments at 31 March 2025

	Total 31 March 2025 £000	Total 31 March 2024 £000
Undiscounted future lease payments payable in:		
- not later than one year;	6,400	6,146
- later than one year and not later than five years;	23,445	22,564
- later than five years.	5,715	10,329
Total gross future lease payments	**35,560**	**39,039**
Finance charges allocated to future periods	(4,309)	(4,388)
Net lease liabilities at 31 March 2025	**31,251**	**34,651**
Of which:		
- Current	5,194	6,146
- Non-Current	26,057	28,505

Note 13.4 Leases - other information

The Foundation Trust leases various premises, to accommodate community services and administrative functions at market rates for periods up to 25 years, with a net liability of £26.4m (2023/24, £30.4m)

Leased equipment comprises complex medical equipment used in the delivery of healthcare £4.8m (2023/24, £4.3m).

Note 14 Disclosure of interests in other entities

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

The Foundation Trust does not attribute levels of risk significantly above 'business as usual' with these arrangements, as the operators are all partner NHS bodies and local authority organisations, working together within the same healthcare and community operating environment. In practical terms, this translates to longstanding related party relationships based in contracts and transactions, collaborative working, shared objectives and common policies.

The Foundation Trust's joint operations are detailed below.

Pathology at Wigan & Salford (PAWS)

The Foundation Trust works collaboratively with Northern Care Alliance NHS Foundation Trust to provide pathology services to both Trusts. The intention of the arrangement is to reduce running costs through centralisation and provide resilience in each trust's pathology services. The majority of activity is carried out at a Salford site, with an essential services laboratory remaining at the Wigan site.

The Foundation Trust retains the rights to assets contributed at the start of the arrangement, and new equipment is split between both trusts when purchased. As the 'host' partner, Northern Care Alliance NHS Foundation Trust retains the obligation to pay suppliers' invoices, recharging Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust for its share of PAWS-related expenditure (£12.1m in year and £11.7m, 2023/24).

Sterile Services Decontamination Unit (SSDU)

In this joint working arrangement with Northern Care Alliance NHS Foundation Trust, both Foundation Trusts receive sterile services, which chiefly involves the decontamination of surgical instruments. The arrangement is similar to PAWS in that the Foundation Trusts intend to reduce running costs through centralisation, provide resilience in each organisation's sterile services, and create income through selling services to other providers in the local health economy. The majority of activity is carried out at a site in Bolton with a small service retained at the Leigh site.

The Foundation Trust retains the rights to assets contributed to the arrangement. As the 'host' partner, Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust retains the obligation to pay the majority of suppliers' invoices, recharging Northern Care Alliance NHS Foundation Trust, for its share of SSDU-related expenditure (£2.8m in year and £2.7m, 2023/24).

Well Being Partners

This arrangement is jointly operated by Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (the 'host' operator) and Lancashire Teaching Hospitals NHS Foundation Trust. The collaboration is designed to provide resilience to each of the operators' occupational health services and to create income through selling services to other bodies. The activity is carried out at both Foundation Trusts' sites with additional outreach clinics. The Foundation Trust's share of expenditure for the year was £0.6m (£0.7m, 2023/24).

Note 15 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	1,444	1,458
Consumables	2,041	1,690
Energy	144	139
Other	176	45
Total inventories	**3,805**	**3,332**

Inventories recognised in expenses for the year were £35.9m (£35.2m, 2023/24).

Note 16 Trade and other receivables

Note 16.1 Trade and other receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables invoiced/non-invoiced	15,006	13,345
Allowance for impaired contract receivables	(1,458)	(1,524)
Prepayments (non-PFI)	4,813	4,141
Interest receivable	157	221
VAT receivable	783	2,172
Other receivables	1,545	814
Total current trade and other receivables	**20,846**	**19,169**
Non-current		
Allowance for impaired contract receivables	(37)	(68)
Other receivables	825	936
Total non-current trade and other receivables	**788**	**868**
Of which receivables from NHS and DHSC group bodies:		
Current	7,272	6,718
Non-Current	674	661

Note 16.2 Allowances for credit losses - 2024/25

	Contract receivables and contract assets £000
Allowances as at 1 April 2024 - brought forward	1,592
New allowances arising	478
Reversals of allowances	(173)
Utilisation of allowances (write offs)	(402)
Allowances as at 31 March 2025	**1,495**

Note 16.3 Allowances for credit losses - 2023/24

	Contract receivables and contract assets £000
Allowances as at 1 April 2023 - brought forward	1,668
New allowances arising	550
Reversals of allowances	(529)
Utilisation of allowances (write offs)	(97)
Allowances as at 31 March 2024	**1,592**

Note 17 Assets held for Sale

The Trust did not hold any assets for sale at the end of the financial year.

Note 18 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024/25 £000
At 31 March 2024	**24,945**
Net change in year	(6,875)
At 31 March 2025	**18,070**
Broken down into	
Cash in hand	6
Cash with the Government Banking Service	18,064
Total cash and cash equivalents	**18,070**

Note 18.1 Third party assets held by the NHS foundation trust

During the year the Foundation Trust held cash relating to monies held on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in note 18. The Foundation Trust also holds in the normal course of business consignment inventories which comprise orthopaedic prosthesis. These are held on Foundation Trust premises and still owned by the supplier. The Foundation Trust is only obliged to pay for these assets when they are used.

	31 March 2025 £000	31 March 2024 £000
Monies held on behalf of patients	0	2
Consignment inventories	10,169	8,619
Total third party assets	**10,169**	**8,621**

Note 19 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	14,010	15,407
Capital payables	4,373	8,633
Accruals	24,598	28,377
Receipts in advance	8	506
Social security costs	3,400	3,464
Other taxes payable	3,634	3,010
PDC dividend payable	0	124
Pension contributions payable	4,467	4,078
Other payables	3,858	2,527
Total current trade and other payables	**58,349**	**66,126**
Of which payables to NHS and DHSC group bodies:		
Current	4,258	4,496

Note 20 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income : contract liabilities	8,173	8,678
Total other current liabilities	**8,173**	**8,678**
Non-current		
Deferred income : contract liabilities	0	63
Total other non-current liabilities	**0**	**63**

Note 21 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Loans from the Department of Health and Social Care	832	838
Other loans*	581	581
Lease liabilities	5,194	6,146
Total current borrowings	**6,607**	**7,565**
Non-current		
Loans from the Department of Health and Social Care	9,195	9,964
Other loans*	872	1,454
Lease liabilities	26,057	28,505
Total non-current borrowings	**36,124**	**39,923**

*Other loans relate to public sector energy efficiency loans with Salix Finance Limited. These loans are interest-free and have financed a number of energy-saving schemes throughout the Foundation Trust. Repayments are phased to match the projected savings from the schemes. Details of the loans from the Department of Health and Social Care are detailed in Note 26.

Note 22 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Lease Liability £000	Total £000
Carrying value at 31 March 2024	**10,802**	**2,035**	**34,651**	**47,488**
Cash movements:				
Financing cash flows - payments and receipts of principal	(769)	(582)	(5,164)	**(6,515)**
Financing cash flows - payments of interest	(236)	0	(1,363)	**(1,599)**
Non-cash movements:				
Additions	0	0	1,641	**1,641**
Lease liability remeasurements	0	0	123	**123**
Change in effective interest rate	230	0	1,363	**1,593**
Carrying value at 31 March 2025	**10,027**	**1,453**	**31,251**	**42,731**

Note 23 Provisions

	Total £000	Other legal claims £000	Pensions: injury benefits £000	Other £000
At 1 April 2024	3,301	257	1,644	1,400
Change in the discount rate	41	0	47	(6)
Arising during the year	412	137	85	190
Utilised during the year	(442)	(68)	(125)	(249)
Reversed unused	(374)	(85)	(289)	0
Unwinding of discount	75	0	41	34
At 31 March 2025	**3,013**	**241**	**1,403**	**1,369**
Expected timing of cash flows:				
- not later than one year;	1,046	241	110	695
- later than one year and not later than five years;	490	0	417	73
- later than five years.	1,477	0	876	601
Total	**3,013**	**241**	**1,403**	**1,369**

The amounts provided for employer's/public liability claims disclosed within other legal claims, are based on actuarial assessments received from NHS Resolution (NHSR) as to their value and anticipated payment date.

Other provisions relate to clinicians pension tax reimbursement claims and dilapidation costs. Dilapidation costs are costs attributable to putting lease property back to its original pre-let state.

Note 23.1 Clinical negligence liabilities

At 31 March 2025, £153.4m was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (£138m, 2023/24).

Note 24 Contingent assets and liabilities

	31 March 2025 £000	31 March 2024 £000
Amounts recoverable against liabilities	(54)	(61)
Net value of contingent liabilities	(54)	(61)

Amounts recoverable against liabilities relates to amounts paid by the Foundation Trust for employers and public liability claims managed through NHS Resolution. These amounts relate to overpayments made against claims.

The Trust has no contingent assets.

Note 25 Contractual capital and lease commitments

	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	2,844	7,902
Leases	1,906	0
Total	**4,750**	**7,902**

Contractual capital commitments mainly relate to committed expenditure in respect of the Foundation Trust's development of the Endoscopy unit, digital systems and work committed for site improvements. The lease committment relates to the replacement of a MRI scanner.

Note 26 Financial Instruments

Note 26.1 Financial risk management

Liquidity risk

The Foundation Trust's net operating costs are incurred under annual service level agreements/contracts with and Integrated Care Boards (ICBs) which are financed from resources voted annually by Parliament. The Foundation Trust received income from its commissioners via API Contracts. Monthly payments were received from the ICB and NHS England based on these funding arrangements and this reduced liquidity risk.

The Foundation Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form. Liquidity is monitored by the Board on a monthly basis by the review of cash flow forecasts for the year.

The Foundation Trust has one loan financed by the Independent Trust Financing Facility. This loan of £16.5m is repayable over 25 years at 2.24% fixed interest rate. Repayments on the loan commenced in December 2016. Repayments are built into the Foundation Trust's cash flow plans for the year and there is no risk that a number of significant borrowings could become repayable at one time and cause unplanned cash pressures.

The Foundation Trust has one energy efficiency loan with Salix Finance Limited which is interest-free and has been invested in energy-efficiency saving schemes. The savings from these schemes are matched to the loan repayment and therefore there is no risk of unplanned cash pressures.

The loan repayment schedule is contained within the maturity of financial liabilities table Note 26.4.

Interest rate risk

All of the Foundation Trust's financial assets and financial liabilities carry nil or fixed rates of interest other than the Foundation Trust's bank accounts which earn interest at a floating rate. The Foundation Trust is not exposed to significant interest rate risk.

Credit risk

The main source of income for the Foundation Trust is from ICBs in respect of healthcare services provided under agreements. The credit risk associated with such customers is very low.

Cash required for day to day operational purposes is held within the Foundation Trust's Government Banking Services (GBS) account. This service has minimal credit risk as balances are regularly swept into and held by the Bank of England.

The Foundation Trust regularly reviews debtor balances, and has a comprehensive system in place for pursuing past due debt. Non-NHS customers represent a small proportion of income, and the Foundation Trust is not exposed to significant credit risk in this regard.

The carrying amount of financial assets represents the maximum credit exposure. Therefore, the maximum exposure to credit risk at the Statement of Financial Position date was £15.5m (£12m, 2023/24) being the total of the carrying amount of financial assets excluding cash.

There are no amounts held as collateral against these balances.

Currency risk

The Foundation Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Foundation Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

Note 26.2 Carrying value of financial assets	**31 March 2025**	**31 March 2024**
	Held at amortised cost £000	**Held at amortised cost £000**
Carrying values of financial assets as at 1st April		
Trade and other receivables excluding non financial assets	15,495	11,825
Cash and cash equivalents at bank and in hand	18,070	24,945
Carrying values of financial assets as at 31st March	**33,565**	**36,770**

Note 26.3 Carrying value of financial liabilities

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2025	
Loans from the Department of Health and Social Care	10,027
Other borrowings	1,453
Obligations under leases	31,251
Trade and other payables excluding non financial liabilities	46,495
IAS37 provisions which are financial liabilities	3,013
Total at 31 March 2025	**92,239**

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2024	
Loans from the Department of Health and Social Care	10,802
Other borrowings	2,035
Obligations under leases	34,651
Trade and other payables excluding non financial liabilities	55,450
IAS37 provisions which are financial liabilities	3,301
Total at 31 March 2024	**106,239**

Note 26.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2025 £000	31 March 2024 £000
In one year or less	55,510	64,343
In more than one year but not more than five years	28,586	29,347
In more than five years	13,892	18,251
Total	**97,988**	**111,941**

Note 27 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise.

The Foundation Trust incurred the following losses and special payments during the financial year.

	2024/25		2023/24	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Overpayment of salaries	4	4	0	0
Bad debts and claims abandoned	98	391	102	96
Stores losses and damage to property	15	44	12	116
Total losses	**117**	**439**	**114**	**212**
Ex-gratia payments	48	66	55	103
Total special payments	**48**	**66**	**55**	**103**
Total losses and special payments	**165**	**505**	**169**	**315**
Compensation payments received	0	0	1	17

Note 28 Transfers by absorption

There were no transfers by absorption during the year.

Note 29 Related party transactions

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. NHS Improvement (NHSI), does not prepare group accounts; instead, NHSI prepares NHS Foundation Trust Consolidated Accounts, for further consolidation into the Whole of Government Accounts. NHSI has powers to control NHS Foundation Trusts, but its results are not incorporated within the consolidated accounts, and it cannot be considered to be the parent undertaking for Foundation Trusts. Although there are a number of consolidation steps between the Foundation Trust's accounts and Whole of Government Accounts, the Foundation Trust's ultimate parent is HM Government.

Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they fall under the common control of HM Government and Parliament. The Foundation Trust's related parties therefore include Department of Health and Social Care as the parent company, other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies, non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Foundation Trust has had a number of transactions with WGA bodies. Where the total transactions with a given counterparty are collectively significant, they are listed below. The Foundation Trust's related parties therefore include other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Foundation Trust has had a number of transactions with WGA bodies. Listed below are those entities for which the total transactions or total balances with the Foundation Trust have been collectively significant or potentially material to the other body.

NHS Greater Manchester Integrated Care Board	NHS England
HM Revenue and Customs	NHS Resolution
Wigan Metropolitan Borough Council	NHS Business Services Authority

Public dividend capital (PDC) transactions with the Department of Health and Social Care

The Foundation Trust made PDC dividend payments to the Department of Health totalling £5.5m (£5.3m, 2023/24), and is reporting a year-end PDC receivable totalling £0.5m (£0.1m PDC payable, 2023/24).

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 2025 was £1,232k (£1,216k, 2023/24) with net incoming resources before transfers of £289k (£27k, 2023/24).

During the year the Charity incurred expenditure of £324k (£141k, 2023/24) in respect of goods and services for which the Foundation Trust was the beneficiary.

Other related parties

The Foundation Trust has interests in 3 joint operations with related parties as disclosed in Note 14 and has a related party relationship with NHS Shared Business Service.

Key management personnel

During the financial year under review, no member of either the Board or senior management team, and no other party closely related to these individuals, has undertaken any material transactions with the Foundation Trust.

One Executive Director is related to a Board Member of Manchester University NHS Foundation Trust. The Foundation Trust has entered into a number of transactions with the organisation which are considered to be "at arms length".

One Non- Executive Director is the Director of Place at NHS Cheshire and Merseyside ICB and a Governer at Edge Hill University. 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

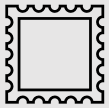
If you have any queries regarding this report, or wish to make contact with any of the directors or governors, please contact Steve Parsons, Director of Corporate Governance and Company Secretary, using the contact details below:

Email

company.secretary@wwl.nhs.uk

Telephone

01942 822027



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