

Annual Report and Accounts 2025/26



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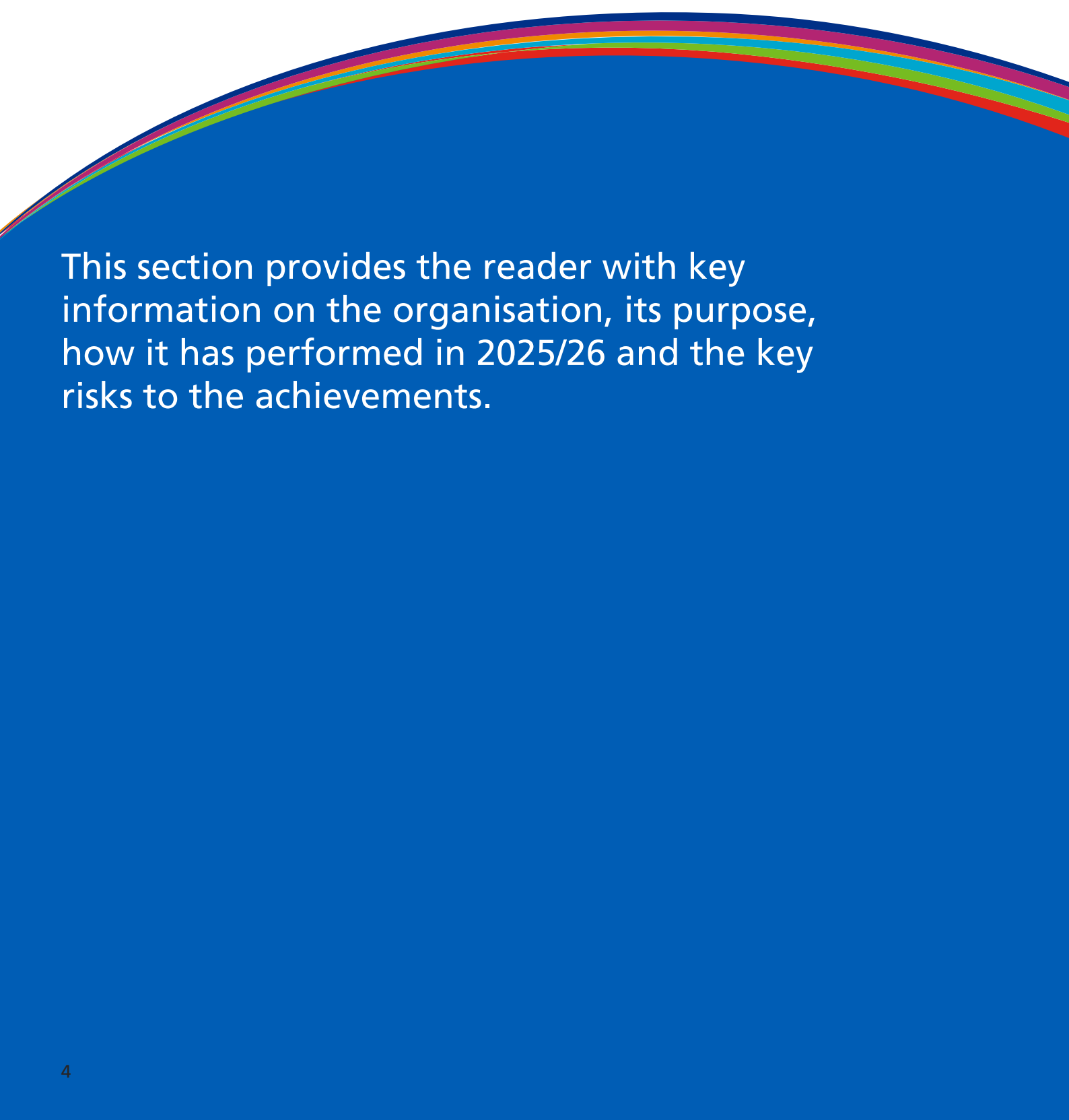
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Section 1 - Performance Report

1. Performance Overview



This section provides the reader with key information on the organisation, its purpose, how it has performed in 2025/26 and the key risks to the achievements.

1.1 Statement from the Chief Executive

I am pleased to present the third annual report of Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), which was formed when St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust came together on 1st July 2023.

This is my second annual report as Chief Executive of MWL, and this report reflects both the challenges and successes of 2025/26, and our plans for 2026/27.

It has been another very demanding year for the NHS. While waiting lists and waiting times are still too long, we have made significant progress. Very long waits over 78 weeks have been eliminated this year and we have reduced the number of patients waiting over 65 weeks to a very small number, mainly for highly specialised care.

Across our Urgent Care Pathways, including Emergency Departments, we achieved the interim standard of 78% of patients to be seen within four hours. This is important progress, but it still means that too many people are waiting longer than they should, and we know we need to do better.

The biggest challenge we have faced this year is patient flow. Our hospitals have been consistently full, and too many patients who are well enough to leave hospital have had to wait for services out of hospital to allow their discharge. This has a direct impact on patients waiting in our Emergency Departments, leading to long waits and patients being cared for in corridors. Our staff work incredibly hard in these situations, but this is not the standard of care we want to provide, and eradicating corridor care is a key priority for 2026/27.

Overall, we have delivered well in a number of areas. We met national standards for cancer care, delivered our financial plan, and continued to provide good quality care for our patients. However, we have not met all the standards we set ourselves. In particular, urgent care and diagnostics remain below where we need them to be, however, we have clear plans in place to improve this further during 2026/27.

We have continued to make good progress in bringing our services together as one Trust. This is complex work and takes time, but I am proud of the progress teams have made to ensure patients receive a consistent standard of care whichever of our sites they are treated at.

A major milestone this year was the decision to locate a single all age Emergency Department for Southport, Formby and West Lancashire at Southport Hospital. This gives us a clear direction for the future, although it will require significant investment and careful planning over a number of years.

We remain rated 'Outstanding' by the CQC, and inspections during the year have provided further reassurance about the quality of care we provide as a Trust.

There were four methicillin-resistant staphylococcus aureus (MRSA) bacteraemia cases and four Never Events during the year. We take these incidents very seriously. Each one has been fully investigated, and we have identified clear actions to reduce the risk of this happening again, particularly in areas such as surgical safety and medicines management.

I remain very proud of our staff, who continue to go above and beyond every day to deliver *5 Star Patient Care*.

R Cooper

Rob Cooper
Chief Executive

24 June 2026

1.2 Overview of the purpose and activities of the Trust

The Trust provides acute healthcare services at Whiston, Southport, Ormskirk and St Helens hospitals. Community and Intermediate Care services are delivered from Newton Hospital. The Trust also has an Urgent Treatment Centre, operating from the Millennium Centre, which is in the centre of St Helens, and a range of other community nursing services from clinics and GP surgeries across St Helens. MWL provides the community services for St Helens but works closely with Mersey Care NHS Foundation Trust, HCRG Care Group and Bridgewater Community Healthcare NHS Foundation Trust (which has become part of North Cheshire and North Mersey NHS Foundation Trust from 1 April 2026 following the merger of Bridgewater Community Healthcare NHS Foundation Trust, and Warrington and Halton Teaching Hospitals NHS Foundation Trust) in the other boroughs covered by the Trust's services.

Alongside our community and secondary care services, the Trust also provides primary care services from Marshalls Cross Medical Centre, which is located at St Helens Hospital.

The Trust delivers care to patients across five boroughs: St Helens, Sefton, Knowsley, West Lancashire, and Halton, and two Integrated Care Systems – NHS Cheshire and Merseyside, and NHS Lancashire and South Cumbria. The catchment population for MWL is approximately 650,000 people. There are also attendances from Liverpool, Warrington, and Wigan at our hospitals.

MWL hosts the Mersey Regional Burns and Plastic Surgery Unit at Whiston Hospital and the Regional Spinal Injuries Unit at Southport Hospital which provide care and treatment for patients from across Merseyside, Cheshire, North Wales, the Isle of Man, and other parts of the North West, serving a population of over 4 million. St Helens Hospital also houses one of the networked specialist neuro-rehabilitation wards for patients from the mid-Mersey area and is a Community Diagnostic Centre.

St Helens and Whiston hospitals were both constructed less than 20 years ago and continue to provide modern state of the art facilities under the Private Finance Initiative (PFI) agreement that is in place. Newton Hospital is of a similar age and is a community hospital managed by Community Health Partnerships and houses several Trust services as well as GP practices and other community services.

Southport and Ormskirk hospitals are both between 30 and 40 years old and the facilities in many cases do not meet current hospital building standards, but a multi-year programme of backlog maintenance is now in place to address the high-risk backlog maintenance and improve its condition.

The Trust's organisational structure is based around four Clinical Divisions (Medicine and Urgent Care, Surgery, Women and Children, and Clinical Support and Community Services) supported by the collective corporate services (Human Resources, Finance and Information, Estates and Facilities, Corporate Nursing, Governance and Risk, Informatics and Medicines Management).

The Trust acts as a Lead Employer for over 14,000 Resident Doctors in training across the country, on behalf of NHS England.

The Trust provides the payroll function for other organisations in Cheshire and Merseyside, delivering both a weekly and monthly payroll service.

The Trust also hosts the Mid-Mersey Digital Alliance which provides informatics services to other NHS bodies and GP surgeries.

The Trust employed an average of 10,646 whole time equivalent (WTE) staff during 2025/26. The Trust's turnover remained approximately £1bn in 2025/26.

Our catchment population

The areas served by the Trust range from urban and densely populated, to rural and sparsely populated. A significant proportion of the Trust's catchment area has a high level of health inequalities, with local people being generally less healthy than the rest of England, and a higher proportion suffering from at least one long-term health condition. Rates of smoking, cancer, obesity, and heart disease, related to poor general health and nutrition, remain significantly higher than the national average. Many areas also have high levels of deprivation, which has a strong correlation to health inequalities. The local population has not historically been ethnically diverse, although this is gradually changing.

The population in our catchment area is growing because of new housing developments, especially in Knowsley and areas of Southport, and urban regeneration but is also still ageing faster than the general population of the UK. This means there are proportionally more older people who are living in poor health.

These characteristics give rise to a population with greater health needs that require increased access to both health and social care.

Collaborative working

The Trust is part of the Cheshire and Merseyside Integrated Care System but also provides services to the population of West Lancashire which is part of the Lancashire and South Cumbria Integrated Care System. The Trust is a member of the Cheshire and Merseyside Provider Collaborative (CMPC) and is also a partner in four of the nine Place-Based Partnership Boards that are the constituent parts of Cheshire and Merseyside, and one that is part of Lancashire and South Cumbria.

The CMPC coordinates collaborative workstreams across the provider Trusts on clinical pathways and networks, elective recovery, diagnostic networks, workforce, and efficiency at scale.

The Trust also led on two neighbourhood health pilots as Sefton and St Helens were selected to become pioneers in Wave 1 of the National Neighbourhood Health Implementation Programme.

The programme aims to deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery through bringing together secondary care, primary care, social care, education, housing and the voluntary, community, faith and social enterprise sector.

1.3 The Trust's vision and objectives

The Trust vision is to deliver *5 Star Patient Care*. This is achieved by making incremental improvements to safety, care, pathways, communication, and systems. Each year the Board agrees objectives under these five domains to move the Trust towards the achievement of its vision.



The Trust Board agreed objectives for 2025/26 which were published in the 2024/25 Annual Report. The Trust objectives agreed for 2026/27 are summarised in the following table:

2026/27 Trust Objectives

5 STAR PATIENT CARE – Care

We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families

- Deliver Transitional Care – Keeping Mothers and Babies Together
- Ensure improvement and sustainability of nutritional & hydration standards for patients
- Eradicate corridor care and patient boarding

5 STAR PATIENT CARE – Safety

We will embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care

- All patients with a working diagnosis of sepsis will receive antibiotics in line with the NICE guidance
- Safer Surgery Every Time: embed WHO 5 Steps, NatSSIPs2 (safety checklists) and PSIRF consistently across all surgical sites
- Increase Infection Prevention Control awareness and adherence to best practice standards

5 STAR PATIENT CARE – Pathways

As far as is practical and appropriate, we will reduce variations in care pathways to improve outcomes, whilst recognising the specific individual needs of every patient

- Continue to improve the effectiveness of the discharge process for patients and carers
- Improve cancer pathways to deliver the national cancer performance standards
- Standardise pre-operative and admissions processes Trust-wide to improve readiness and reduce avoidable cancellations

5 STAR PATIENT CARE – Communication

We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services

- Support clinicians to spend more time with patients
- Enhance digital communications with patients
- Improve patient feedback

5 STAR PATIENT CARE – Systems

We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes

- Launch collaborative procurement for a single EPR for MWL in conjunction with North Cheshire and Mersey Healthcare Partnership
- Implement a single maternity information system (BadgerNet) across MWL to support consistent high-quality maternity care and improved data integration
- Develop a plan for community digital systems, initially focusing on the consolidation and standardisation of the Trust's community EPR platforms (EMIS)

DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE

We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients

- Strengthen core management and leadership skills focusing on our operational and nursing leaders in 2026/27
- Create a sustainable, preventative approach to workforce health, wellbeing and attendance, by reducing sickness, burnout and work-related stress through stronger prevention, early intervention and supportive working environments
- Embed compassionate, inclusive and accountable leadership at every level by ensuring all leaders and managers have the capability and confidence to lead change, manage performance fairly, support wellbeing and consistently role-model the Trust's Values and Behaviours in everyday practice
- Enable Staff Networks to play an active role in shaping policy, culture and workforce decisions, ensuring the voices and lived experiences of colleagues with protected characteristics drive meaningful improvements in their everyday experience
- Strengthen career development across MWL by creating transparent, supported routes for progression and expanding clear career pathways. We will ensure all staff have access to high quality learning and development opportunities, enabling them to grow their skills, receive meaningful guidance and development planning, and access the ongoing support they need to achieve their career ambitions

OPERATIONAL PERFORMANCE

We will meet and sustain national and local performance standards

- Deliver the NHS operational plan access and waiting time targets for 2026/27
- Improve theatre productivity in line with GIRFT recommendations and expand "Right Procedure, Right Place" (RPRP) delivery plans to release premium theatre capacity

FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY

We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money

- Deliver the agreed financial plan including outturn, cash balances and capital resourcing limits
- Work with partner organisations across the ICS to develop and deliver opportunities for collaboration at scale and increased efficiency
- Deliver the agreed capital schemes to deliver the capacity needed to meet service demand and a safe, high-quality environment for patients and staff

STRATEGIC PLANS

We will work closely with national and regional commissioning, provider and local authority partners to develop proposals to improve the clinical and financial sustainability of services

- Establish five strategic transformation programmes to deliver improvements for UEC, Surgery, Outpatients, Administrative Services and Community
- Work with the Cheshire and Merseyside Integrated Care Board Urgent Care Recovery Programme to achieve Non-Criteria to Reside (NCTR) rates of less than 15%
- Continue to deliver the Trust Health Inequalities Strategy
- Support the Neighbourhood Health Models of Care (Integrated Neighbourhood Teams)

1.4 Key issues and risks

The Chief Executive's opening statement highlights the key pressures that the Trust has experienced during 2025/26, and those pressures form the basis of the Trust's key risks for 2026/27.

Managing demand, supporting access to care in the right place, reducing waiting lists and waiting times continue to be key priorities for the NHS, but as the financial environment continues to be constrained further nationally, a focus on efficiency, transformation and productivity will increase in importance in 2026/27. Capacity and resources have therefore been identified as key risks.

The historic configuration of services between the Southport and Ormskirk hospital sites has for many years been recognised (by clinical senate and independent reviews) as being suboptimal and inefficient. The Shaping Care Together Programme was re-started following the formation of MWL in 2023 to put forward options for the optimum strategic service configuration between the two sites, focusing initially on urgent and emergency care provision. Neither Southport or Ormskirk hospitals currently have the capacity to accommodate all of the urgent and emergency care services, and it is therefore pleasing that a decision has been made on the future approach to services for these hospitals and communities. However, as indicated in the Chief Executive's letter, this will require investment, reconfiguration of estates and services, which will take time to fully deliver.

The Trust will continue to communicate and engage with staff in 2026/27 to cement the MWL identity and integrate ways of working across corporate and clinical teams, with the aim of improving systems and processes that will support both patients and staff across all services.

The board remains committed to realising the potential of MWL to improve care for our catchment population and provide greater opportunities for staff. Despite the financial challenges facing the NHS, the ICB and the Trust in the year ahead, the main purpose of the Trust will continue to be to deliver *5 Star Patient Care* and improved health outcomes for all our patients.

The Trust's general approach to managing risks is covered in detail within the Annual Governance Statement later in this document. This describes the Trust's Board Assurance Framework (BAF) which captures those principal risks that may threaten the achievement of the Trust's strategic and corporate objectives, and operational risks that may impact the day to day operation of the organisation. This approach enables the Board of Directors to assess whether there are appropriate and effective controls in place to support delivery of the Trust's strategic objectives.



2. Performance Analysis

The purpose of the Performance Analysis section of the Annual Report is to provide readers with a summary of the performance of the Trust over the year, including how the Trust measures performance. From this section readers will be able to gain an understanding of the performance of the Trust over this financial year.

2.1 Key activity and performance measures

		STHK				MWL (Combined STHK and S&O for 2022/23 as a comparator)		MWL	
Key access and quality targets	Target	19/20	20/21	21/22	22/23	22/23	23/24	24/25	25/26
% of urgent care patients seen within 4 hours (mapped)	95%	85.4%	87.3%	78.0%	74.4%	67.8%	74.9%	78.1%	78.2%
% of patients first seen within two weeks when referred from their GP with suspected cancer	93%	95.2%	91.3%	81.0%	83.5%	80.3%	78.1%	73.5%	65.1%
% of patients receiving cancer treatment within 62 days of GP referral	85%	80.2%	76.9%	66.2%	57.9%	76.9%	78.3%	79.7%	78.6%
% of admitted patients treated in 18 weeks of referral	92%	93.0%	76.6%	81.4%	68.0%	66.0%	60.8%	64.6%	66.5%
% waiting more than 6 weeks for a diagnostic test	1%	3.1%	24.5%	32.8%	34.7%	30.0%	12.2%	6.9%	13.4%
Hospital-acquired MRSA bacteraemia	0	1	2	2	0	1	6	6	4
C Difficile cases (Trust-attributed)**	<49	31	34	43	48	104	114	114	109

Activity Type		STHK				STHK + S&O*	MWL**	MWL	
	19/20	20/21	21/22	22/23	23/24	23/24	23/24	24/25	25/26
Outpatient 1st attendances	149,517	120,103	150,170	163,217	249,915	232,382	263,687	274,380	
Outpatient follow-up attendances	318,294	268,300	318,554	327,816	524,529	481,732	568,305	576,046	
Ward attenders	21,893	17,467	23,068	22,581	22,398	21,116	22,706	18,292	
Outpatient procedures	98,444	58,267	90,455	86,599	134,227	123,558	160,439	166,486	
Elective inpatients	6,206	3,725	5,556	5,342	7,913	7,374	9,114	9,296	
Day case	45,935	30,889	43,150	47,033	70,232	65,395	78,326	77,992	
Non-elective inpatients	69,315	62,324	68,077	75,012	110,410	103,629	112,308	115,969	
Non-elective inpatients (less Obstetrics)	56,458	49,771	54,166	61,254	95,062	88,844	97,323	102,101	
A&E attendances (inc. GPAU Atts)	119,181	102,404	121,809	116,203	210,870	188,695	207,009	212,392	
A&E attendances -	112,743	97,885	116,728	111,216	200,394	179,072	192,257	191,711	
Births	3,983	3,738	3,995	3,770	5,941	5,451	5,631	5,650	

*Total combined activity for both legacy organisations for all 2023/24

**Total years activity for STHK and legacy S&O activity from 01/07/23

2.2 Performance in 2025/26

This section provides a more detailed view of how the Trust has performed during 2025/26. Overall, performance has been mixed but we have done well in a number of areas.

National cancer standards were achieved in March 2026, we reduced the longest waits for planned care and were the best performing acute Trust in Cheshire and Merseyside, and we delivered our financial plan. Our workforce performance has also been strong, with high levels of training and appraisal completion.

However, we have not met all the standards expected of us. Urgent and emergency care performance was challenging for much of the year. This reflects sustained pressure on demand, high bed occupancy and challenges in discharging patients in a timely way.

Performance in diagnostics and planned care has improved but is still not where we want it to be. These remain key priorities for the Trust.

We have put a number of actions in place to address these issues, including increasing capacity in key areas, strengthening operational management, and working more closely with system partners to improve patient flow.

Quality of Care

Providing safe, high-quality care remains our top priority.

There were four Never Events during the year. While these are rare, each one represents a serious incident, and we are committed to learning from them. All cases have been fully reviewed, and actions have been taken to improve safety.

Overall, clinical outcomes remain good. Mortality is within expected levels, and we have continued to make progress in reducing harm from falls and pressure ulcers.

Patient experience remains positive, although we know we need to improve the timeliness of how we respond to complaints.

There are also some areas where we need to improve consistency, including clinical processes such as Venous Thromboembolism (VTE) assessment and early warning scores. These are a focus for improvement in the coming year.

Operational Performance

We have continued to focus on improving access to care and reducing waiting times.

We have made good progress in reducing the longest waits, including eliminating waits over 78 weeks and significantly reducing waits over 65 and 52 weeks. We delivered the Trust's plan for patients waiting less than 18 weeks for treatment achieving 66.5% versus a target of 63.7%. We made significant improvement in delivery of the national cancer standards during the year, achieving the national standards in March 2026. Our cancer Faster Diagnosis Standard (diagnosis within 28 days) performance for March 2026 was 80.5% versus a target of 77% and our cancer 62 day treatment standard performance was 86.3% against a target of 85%.

However, urgent and emergency care remains under significant pressure. Whilst our mapped A&E 4 hour performance was 79.5% against the 78% target in March 2026, only 75% of patients arriving via ambulance were handed over in 45 minutes and we had high numbers of patients waiting over 12 hours for a bed.

We are working with our partners across the system to improve this, particularly by reducing unnecessary admissions to hospital, reducing unnecessary delays in discharge and improving the way patients move through our services.

Workforce

Our staff are at the heart of everything we do.

We have continued to see strong performance in areas such as mandatory training and appraisals, which reflects good engagement across the organisation. As at March 2026, over 90% of our staff had received an appraisal against the trust target of 85% and 89.5% of staff were compliant with their mandatory training. Staff turnover has remained low, helping to maintain stability.

We have also continued to invest in our people through leadership development, cultural improvement work and equality and inclusion initiatives. In 2025/26 we launched our 'Leading Operational Excellence' programme for operational managers across the organisation with the aim to equip our operational managers with the skills and expertise that are needed for us to deliver *5 Star Patient Care*.

However, there are challenges. Sickness absence has been higher than we would like with overall sickness absence at 6.8% in 2025/26 against a Trust target of 5%. Sickness absence management remains a key priority in 2026/27, and we are taking action to address this, including targeted support for teams, improvements in recruitment processes and continued focus on staff wellbeing to ensure that we are supporting the workforce.

Financial Performance

We have delivered our financial plan for the year, reporting a £10.7m deficit in line with expectations.

We achieved our cost improvement programme, which has helped to ensure we remain financially sustainable while continuing to invest in services.

There are ongoing financial pressures across the NHS, including reliance on national support funding. We will continue to focus on efficiency, productivity and value for money in the year ahead.

Summary

In summary, we have made good progress in a number of areas during 2025/26, particularly in cancer care, financial delivery and reducing the longest waits.

However, we recognise that we have more to do. Urgent care, patient flow and waiting times remain key challenges. We will continue to focus on efficiency, productivity and value for money in the year ahead.

We have clear plans in place to address these, and we will continue to work with our partners to improve services for our patients.

2.3 Social, Human Rights, Diversity and Anti-Corruption

2.3.1 Equality and Diversity Obligations

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

Appropriate policies are maintained to ensure that the required standards are met; examples being:

- The Recruitment and Selection Policy is designed to inform management and staff how to conduct recruitment processes in an objective, fair and effective manner.
- The Equality and Diversity Policy is designed to provide employment equality. This ensures that no applicant or employee will receive less favourable treatment on the grounds that they possess a "protected characteristic" as defined by the Equality Act, or any other individual characteristic, for example, social class or carer status.
- The Patient Access policy ensures that all patients have access to care and treatment based on fair and objective criteria.

2.3.2 Health Inequalities

NHS England requires NHS Trusts to review the extent to which they have exercised their functions in line with NHS England's statement on information on health inequalities.

The Trust Board approved a Health Inequalities Strategy 2025-2028 at its March 2025 Board along with a delivery plan for 2025/26. A review of the delivery plan was presented at the April 2026 Board alongside a delivery plan for 2026/27. The strategy has the following vision and objectives:

Health Inequalities Vision:

Reducing health inequalities by ensuring equitable access to our services and promoting preventable support in the community.

Health Inequalities Objectives:

The Trust will use its role to reduce health inequalities in the communities it serves by:

- Being a **provider** of quality health care
- Being an active **partner**
- Being an **employer** of choice
- Being an **anchor institution**

Health inequalities are “avoidable, unfair and systemic differences in health between different groups of people”. This means that some population groups have significantly worse health experiences and outcomes than others.

The Trust is a significant provider of services in six local authority areas across Merseyside and West Lancashire. Working with such a diverse range of partners has its challenges but also has benefits for learning and best practice. Around 50% of our patient populations come from areas of high deprivation and within the geographies we serve there are communities that endure significant health inequalities.



The table below highlights the extent of the challenges:

- Around 50% of our population live in the lowest quintile of deprivation
- In a majority of boroughs there is a decade between the life expectancy of people living in the most and least deprived areas
- The Merseyside boroughs have higher mortality rates
- Behavioural risk factors are much more prevalent in our boroughs
- Children do not have the best start in life

A Comparison of Places: Deprivation, Mortality, Risk Factors and Child Health

Place	England	North West	St Helens	Halton	Knowsley	Liverpool	Sefton	West Lancs
Deprivation								
IMD (2025) Rank out of 296	-	-	46	31	13	9	80	159
Health Inequalities								
Inequality in Male Life Expectancy at Birth (2022-24)	10.4 years	12.5 years	12.9 years	14.2 years	11.1 years	10.7 years	11.6 years	9.6 years
Inequality in Female Life Expectancy at Birth (2022-24)	8.0 years	10.1 years	8.9 years	11.1 years	9.6 years	8.1 years	11.1 years	6.9 years
Causes of death (per 100,000 population)								
Under 75 mortality rate from all causes (2023-25)	330.5	389.8	443.4	422.8	439.2	469.1	373.4	328.0
Mortality rate from CVD (2023-25)	221.3	243.2	247.6	272.2	259.3	254.0	228.8	240.8
Mortality rate from cancer (2023-25)	117.7	128.9	135.1	135.6	152.2	154.7	130.5	118.3
Mortality rate from suicide (2022-24)	10.9	13.6	15.1	15.4	12.3	15.2	12.3	11.1
Behaviour Risk Factors								
Hospital admissions for alcohol specific conditions (per 100,000 under 18 years) (2021/22-23/24)	22.6	25.6	60.5	26.6	23.1	26.8	24.9	24.3
Hospital admissions for alcohol specific conditions (per 100,000 all ages) (2023/24)	612	796	1122	922	1041	1152	862	426
Smoking prevalence (%) in adults (2024/25)	13.1	13.5	12.9	14.0	13.5	16.3	12.7	13.0
Percentage of physically active adults (aged 19+) (2024/25)	68	66.0	62.1	61.7	60.4	65.9	67.8	71.3
Percentage of adults overweight or obese (2024/25)	64.6	67.0	68.6	73.1	74.6	67.9	70.3	70.7
Child health								
Under 18s conception rate (per 1,000 aged 15-17) (2022)	13.9	16.8	20.9	25.7	12.3	18.2	16.7	15.6
Percentage smoking at time of delivery (2024/25)	6.1	6.5	8.4	9.4	8.2	6.4	5.9	4.5
Percentage of breastfeeding initiation (2023/24)	71.9	61.7	50.3	50.7	52.0	72.3	64.7	60.6
Infant mortality rate (per 1,000 live births) (2022-24)	4.2	4.6	3.4	3.4	3.2	5.0	4.3	3.4
Percentage MMR coverage for 2 doses (2024/25)	83.7	85.6	87.4	88.2	76.9	75.5	84.8	-
Year 6 prevalence of overweight (including obesity) (2024/25)	36.2	38.0	40.9	42.1	43.3	43.4	40.2	36.8
Percentage of children in relative low-income families (2024/25)	19.8	24.5	21.5	23.0	24.5	29.6	19.8	20.2

The challenges are stark and require a fundamental rethink in how the Trust as a provider, partner, employer, and anchor in the community can play a more influential role in turning the inequalities tide.

The Trust has had some notable successes regarding the prevention agenda and tackling health inequalities. We have developed a Health Inequalities Dashboard that can analyse activity across most of our points of delivery for patients living in our local places, overlaying this with demographic data to provide a picture of access and potential exclusion.

The Trust continues to work with partners to deliver our Warm Homes for Lungs program: using the fuel poverty dashboard to 'pull' patients into a community based respiratory service (those with high inhaler usage/multiple Emergency Department attendances) for clinical review, including spirometry and Fractional exhaled Nitric Oxide (FeNO). Patients also get support with improving their homes with grants and benefits advice. There is also a Warm Homes for Young Lungs project which is an enhanced localised offer at Children's Community Centres, with a mix of clinic appointments and drop-in sessions by all partners.

The Trust has reviewed progress of Year 1 of the Health Inequalities Strategy; the figure below shows a snapshot of progress across our four priorities:

Provider - Tobacco Dependency



Engaging with more than 3,500 patients 52.28% of patients admitted are screened. 41.3% are given a brief intervention and referred to stop smoking services.

Partner - Health Inequalities Dashboard



Dashboard developed for Urgent Care, Planned Care, Outpatients and waiting lists.

Employer - Bronze Award



Trust gained the Bronze Award for the National Anti-racist Framework.

Anchor - Health & Care Careers Hub



A High Street location to attract people into health and care jobs and upskill our local workforce.

The Health Inequalities Dashboard is providing useful insights into patient cohorts that access our services and those who may be potentially underserved. The figure below shows an example of the information we can extract from the dashboard.



The dashboard shows activity, in this case Outpatients appointments where the patient did not attend (DNAs) by where people live, ethnicity, gender, age and deprivation profiles. We have dashboards for A&E, emergency admissions, planned care, outpatients and waiting lists.

We are required to produce data for elective care and emergency care activity, which can be found in the below tables:

Elective activity vs pre-pandemic levels for under 18s and over 18s

Total activity	2025/26	2024/25	2019/20
Male under 18	765	748	838
Male over 18	41,350	41,845	37,874
Female under 18	624	573	633
Female over 18	45,857	45,447	39,628
Non-Binary under 18	0	0	0
Non-Binary over 18	1	4	1

Activity by deprivation (% from most deprived quintile)	2025/26	2024/25	2019/20
Male under 18	37.5%	33.7%	32.2%
Male over 18	27.0%	27.0%	26.4%
Female under 18	40.7%	36.3%	34.1%
Female over 18	29.3%	28.2%	28.2%
Non-Binary under 18	N/A	N/A	N/A
Non-Binary over 18	100%	75%	100%

Activity by ethnicity	2025/26	2024/25	2019/20
Male under 18 Minority Ethnic	22.3%	21.1%	22.3%
Male under 18 White British	77.7%	78.9%	77.7%
Male over 18 Minority Ethnic	13.1%	11.6%	9.5%
Male over 18 White British	86.9%	88.4%	90.5%
Female under 18 Minority Ethnic	20.5%	19.9%	14.7%
Female under 18 White British	79.5%	80.1%	85.3%
Female over 18 Minority Ethnic	11.7%	10.7%	8.8%
Female over 18 White British	88.3%	89.3%	91.2%
Non-Binary under 18 Minority Ethnic	N/A	N/A	N/A
Non-Binary under 18 White British	N/A	N/A	N/A
Non-Binary over 18 Minority Ethnic	0%	0%	0%
Non-Binary over 18 White British	100%	100%	100%

Emergency admissions for under 18s

Activity by deprivation (% from most deprived quintile)	2025/26	2024/25	2019/20
Male under 18	37.5%	33.7%	32.2%
Female under 18	40.7%	36.3%	34.1%
Non-Binary under 18	N/A	N/A	N/A

Activity by ethnicity	2025/26	2024/25	2019/20
Male under 18 Minority Ethnic	15.1%	14.0%	9.4%
Male under 18 White British	84.9%	86.0%	90.6%
Female under 18 Minority Ethnic	13.6%	13.9%	8.8%
Female under 18 White British	86.4%	86.1%	91.2%
Non-Binary under 18 Minority Ethnic	N/A	100%	N/A
Non-Binary under 18 White British	N/A	N/A	N/A

Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions, not number of teeth extracted)

Due to the very low numbers within the data for this indicator, they have not been included due to concerns around data de-anonymisation.

Smoking cessation

The Trust established a tackling tobacco dependency service in November 2023, operating across our acute inpatient settings. The service includes behavioural advice and provision of smoking cessation aids, including nicotine replacement therapy (NRT). During 2025/26 the team advised over 3,500 patients who identified as smokers, 41.3% of these patients agreed to a smokefree care plan and after 28 days and around 550 patients (17.6%) had quit smoking at 28-days.

The maternity service also provides in-house smoking cessation support. The majority of patients who smoke live in the most deprived areas of our Trust catchment population and we work closely with our community smoking cessation services to target support within the hospital and in the community. The in-house service makes onward referrals to community pharmacy or local authority smoking cessation services where appropriate.

The Tobacco and Vapes Act 2026 has now come into law and a working group has been established to consider how the Trust adopts the no smoking mandate within hospital sites.

2.3.3 Anti-Corruption and Anti-Bribery

The Trust is committed to the prevention, deterrence and detection of fraud, bribery and corruption in the NHS and has policies and procedures in place to ensure that we mitigate against them. This includes compliance with the NHS Fit and Proper Persons Framework, the Trust Standards of Business Conduct Policy, provisions in the Corporate Governance Manual and the Anti-Fraud, Bribery and Corruption Policy & Response Plan. The Trust also publishes a Trust Anti-Bribery Statement on its website to further demonstrate our commitment.

The Trust works closely with Mersey Internal Audit Agency (MIAA) who provide an Anti-Fraud Specialist and service to ensure that any act of fraud or bribery is investigated, and an annual report detailing the anti-fraud, bribery and corruption work undertaken is provided to the Audit Committee for assurance.



2.4 Environmental analysis

2.4.1 Task Force on Climate-related Financial Disclosures (TCFD) Compliance Statement

The Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, in line with 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, will be implemented in sustainability reporting until the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions, as these are calculated nationally by NHS England. The GAM has also adapted the requirements for scenario analysis in the strategy section of the TCFD disclosures to better fit the needs of the public sector.

The TCFD recommended disclosures, as interpreted and adapted by the GAM are provided below with cross referencing to relevant sections of the MWL Green Plan 2025-2028.

2.4.2 Governance

Board oversight

MWL has established a robust governance structure to oversee climate-related risks and opportunities. The Trust Board, supported by the Executive Committee and the Sustainability Group, is responsible for the strategic direction and oversight of the Trust's Green Plan implementation and sustainability initiatives. The Sustainability Group, chaired by the Deputy Director of Estates and Facilities, includes representatives from various departments and external stakeholders, ensuring comprehensive oversight and engagement by reporting net zero progress in the newsletter annually.

Management's role in assessing and managing climate-related issues

The Deputy Director of Estates and Facilities oversees the implementation of the Green Plan, ensuring alignment with national requirements and frameworks such as the NHS Net Zero commitment.

The NHS has committed to two targets:

- Achieve net zero on emissions controlled directly by the NHS (The NHS Carbon Footprint) by 2040, with the ambition to reach an 80% reduction by 2028-32
- Achieve net zero on emissions within NHS influence (The NHS Carbon Footprint Plus) by 2045, with the ambition to reach an 80% reduction by 2036-39

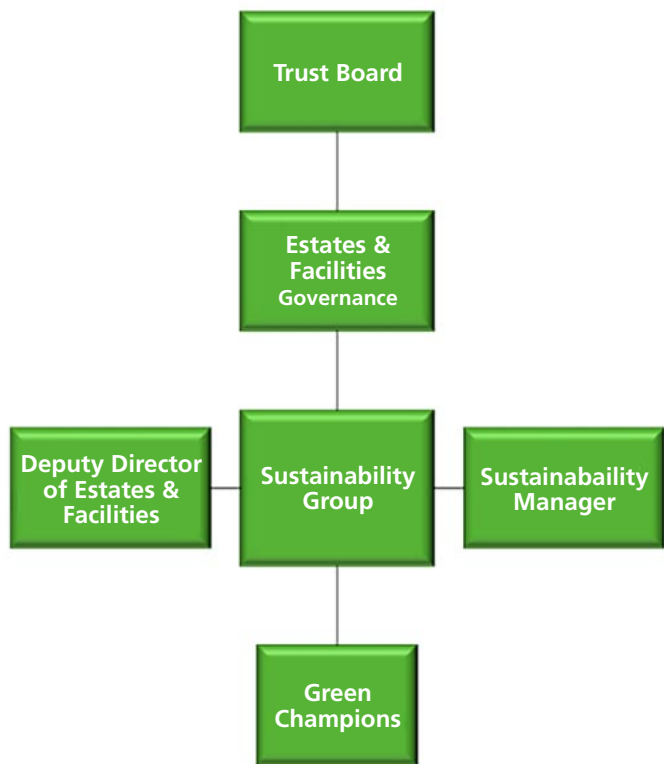
The Executive Team will ensure participation and support is given from all Divisions within the organisation through designated representatives who will champion the green plan workstreams, ensuring senior ownership across the organisation in working towards the carbon reduction targets.

The Sustainability Group will report to the Board via the Estates and Facilities Governance Council, which reports to the Finance and Performance Committee. The multi-disciplinary group will include as a minimum:

- Private sector Partners (New Hospitals, Gension, GE, Medirest and Vinci FM),
- Deputy Director of Estates and Facilities
- Quality and Compliance Manager
- Sustainability Manager
- Procurement Lead
- HR Lead
- Finance lead
- Divisional Leads

Quarterly reports and green plan metrics will be reported through this governance structure with an annual report produced for the Trust Board.

The following figure summarises the sustainable development implementation structure established by the Trust:



2.4.3 Strategy

MWL has developed and implemented a strategy to work towards the two targets for net zero emissions by 2040 and 2045.

Heat Decarbonisation Plans

The Trust has developed Heat Decarbonisation Plans for its four main sites, each detailing current consumption and carbon emissions, and highlighting projects that could cut emissions on site including detailed analysis of costs, deliverability etc.

Green Plan 2025-2028

In the last year, MWL has combined and updated the two green plans from each of the legacy organisations into a single document for the Trust. This document was signed off by the Board in 2025/26 and will be key for the next 3 years. The plan has evolved in line with delivering a Net Zero National Health and includes the 9 key aspects.

2.4.4 Risk Management

Processes for identifying, assessing and management climate-related risks

The Trust utilises a comprehensive framework to identify, assess and manage climate-related risks, based on its Green Plan. The Trust identifies various types and categories of climate-related risks, including physical risks such as extreme weather events (heatwaves, floods, droughts), transition risks related to the shift towards a low-carbon economy, and regulatory risks associated with evolving environmental legislation. These risks are assessed for their relative significance compared to other organisational risks, considering their potential size and scope.

Climate-related risks are deemed highly significant due to their potential impact on healthcare delivery, infrastructure, and financial performance. The Trust uses detailed energy audits, carbon hotspot analysis, and scenario analysis to identify and assess these risks. The framework includes regular reviews of energy consumption, carbon emissions, and the environmental impact of operations, facilitated by tools such as the NHS Estates Return Information Collection (ERIC). The Sustainability Group plays a critical role in monitoring these risks, coordinating structured meetings, and engaging with stakeholders to ensure comprehensive oversight and effective mitigation strategies. This structured approach enables the Trust to proactively manage climate-related risks and integrate them into its overall risk management processes, which are detailed in the Annual Governance Statement.

Risk mitigation

Key risk mitigation measures include the development of Heat Decarbonisation Plans, the implementation of energy-saving projects, and the promotion of sustainable travel and transport. The Trust also engages with local authorities and community partners to enhance resilience to climate-related events.

The Trust Emergency Preparedness, Resilience and Response (EPRR) Team have developed adverse weather plans along with local protocols to national heat wave plans, cold weather plans and multiagency flood plans in relation to the Civil Contingencies Act 2004 and from this have developed business continuity plans to include a response to flooding, unavailability of fuel, blackout etc.

2.4.5 Metrics and targets

Metrics used to assess climate-related risks and opportunities

The Trust employs a range of key metrics to measure and manage climate-related risks and opportunities in alignment with its Green Plan and overall risk management strategy.

Key metrics include:

- Carbon emissions (tonnes CO₂e)
- Energy use (kWh)
- Water consumption (m³)
- Waste volumes (tonnes)
- Active travel & fleet performance
- Metered Dose Inhalers

Historical trends of these metrics are tracked against a baseline year of 2008, chosen due to the greater quality in comparative carbon data following the Climate Change Act (2008). Methodologies employed to calculate these metrics include regular meter readings, the use of Stark logging and monitoring services, and the NHS Estates Return Information Collection (ERIC) program, which automatically calculates related CO₂e emissions. While the Green Plan does not explicitly mention internal carbon pricing, the Trust's approach to appraising and evaluating projects involves detailed energy audits and the consideration of financial savings from energy efficiency measures. These comprehensive metrics and methodologies ensure that the Trust effectively monitors and manages climate-related risks and opportunities, driving progress towards its net zero carbon goals.

Targets used to manage climate-related risk and opportunities

The Trust has set key climate-related targets to manage risks and opportunities, aligned with its Green Plan. These targets include both absolute and intensity-based formats. Intensity-based targets measure greenhouse gas (GHG) emissions relative to a unit of economic output, such as emissions per patient treated or per square meter of hospital space. The Trust aims to achieve net zero carbon emissions controlled directly by the NHS by 2040.

Headline interim targets include:



Progress against targets is measured using key performance indicators (KPIs) such as energy consumption, carbon emissions, water usage, and waste generation. Historical trends of these metrics are tracked to analyse progress and identify areas for improvement. Any updates to targets, such as restatements or revisions to baselines, are explained with a rationale to ensure transparency and accountability. This comprehensive approach enables the Trust to effectively manage climate-related risks and opportunities, driving progress towards its sustainability goals.

2.5 Financial performance in 2025/26

The Trust posted a year end deficit of £10.7m, taking the Trust's assessed cumulative deficit to £11.6m (Annual Accounts Note 35). Despite this deficit, the overall position reflects continued sound financial management and efficiency in the Trust within a landscape of continuing change and challenge.

The adjusted financial performance surplus/deficit in any given year is very closely related to the Trust's surplus/deficit, which can be seen in the Annual Accounts. It is the measure of financial performance (the 'bottom line') that is most closely monitored in the financial regime of NHS providers. The Trust's revised financial plan for 2025/26 included a £10.7m deficit as its adjusted financial performance. The Trust's performance against its 2025/26 financial plan, and the relationship between the two types of surplus/deficit, are shown in the table below.

	2024/25	
	Actual £m	Plan £m
Surplus/(deficit) per Annual Accounts		
Statement of Comprehensive Income (SoCI)	(60.1)	(6.1)
Remove net impairments [Annual Accounts note 6]	52.4	0.0
Remove SoCI impact of capital grants and donations	0.1	0.3
Remove IFRIC 12 scheme finance costs on an IFRS 16 basis	75.7	72.3
Add Back IFRIC 12 scheme finance costs on a UK GAAP basis	(79.3)	(77.2)
Adjusted financial performance surplus/(deficit)	(10.7)	(10.7)

2.5.1 Income

For the financial year 2025/26, the Trust received income totalling £1,021m, which is a 1.6% increase on the previous year.

Of the income received by the Trust, £914.4m (89.6%) came from patient care activities. Year on year there has been a 3.9% increase in income from patient care activities.

The largest source of patient-related income remains at a local level with Cheshire & Merseyside Integrated Care Board and Lancashire & South Cumbria Integrated Care Board.

The chart (right) depicts the Trust's total income for 2025/26, split by customer or commissioner type.

Most income comes from the Trust's local NHS partners.

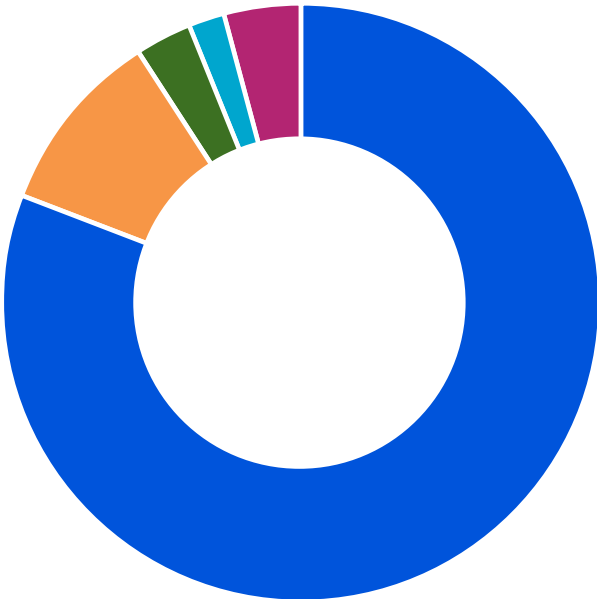
In accordance with Section 114A of the Health and Social Care Act 2012 (the 2012 Act), as amended by the Health and Care Act 2022, the NHS funding arrangements for NHS health care services and some public health services in England changed on the 1st April 2023 to conform with the NHS Payment Scheme 2023/25.

The 2023/25 NHS Payment Scheme enables different payment mechanisms to be used in different circumstances.

The majority of the Trust's NHS Patient Care Income for 2025/26 fell within the Aligned Payment and Incentives (API) payment mechanism. System envelope block top up funding arrangements continued in 2025/26, allocated at a Cheshire & Merseyside Integrated Care Board & Lancashire & South Cumbria Integrated Care Board level.

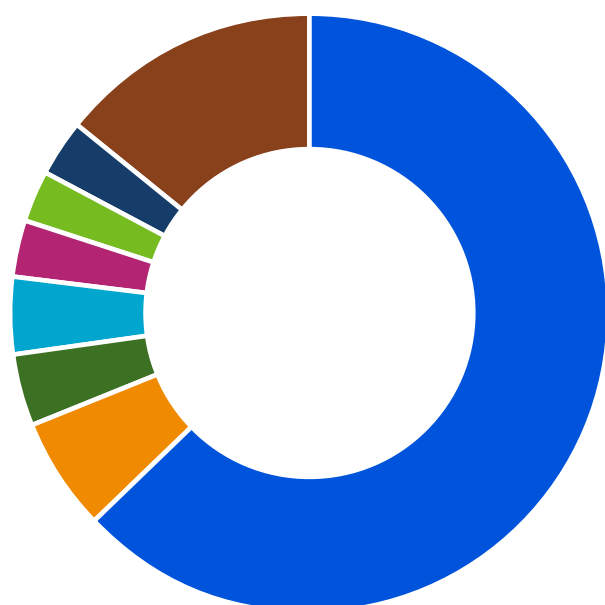
The remaining £106.7m (10.5%) of total operating income arose from a combination of sources. As in previous years, this included revenues from NHS England for the education and training of Resident Doctors, and services provided to other organisations, such as IT, HR, pharmacy, pathology services. In 2025/26, this other operating income also included PFI income support £20m.

£3.7m finance income was received in year.



Total income £1,021m

- 81% Integrated Care Boards
- 10% NHS England and its sub-entities
- 3% Bodies external to Government
- 2% NHS Providers (Trusts)
- 4% Other Government Bodies (including DHSC bodies, special health authorities, local authorities)



Total expenditure and losses £1,084.9m

63%	Pay
6%	Clinical supplies
4%	PFI
4%	Drugs
3%	Depreciation
3%	Finance costs
3%	CNST
14%	Other

2.5.2 Expenditure

The Trust incurred expenditure and losses totalling £1,084.9m. Staff pay – and the day-to-day purchasing of care related goods and services – continue to comprise most of the Trust expenditure.

The chart (left) depicts the main categories within total reported expenditure for 2025/26.

'Other' includes premises, training, leasing, professional fees and IT-related costs.

The Trust also experiences significant annual finance costs related to its PFI arrangements (£41.9m) and an annual clinical negligence insurance (CNST) premium of £28.7m. A further £31.6m in 2025/26 related to depreciation and amortisation, which are non-cash expenditures. They are charged annually to reflect the usage and consumption of capital assets which were purchased in this and previous years.

2.5.3 Capital expenditure

In order to address the long standing funding requirements of the Southport & Ormskirk hospital sites, NHS England provided £8m refurbishment funding in 2025/26. In addition to £8m received in 2024/25, this funding is helping contribute towards significant improvements in patient experience and safety on both sites.

Capital expenditure on tangible (for example, equipment), intangible (for example, software) and prepayment assets was higher than initial plan figures. The Trust secured £30.8m of additional Public Dividend Capital (PDC) funding in the year.

Leases increased capital expenditure through a technical £1.9m remeasurement on the value of existing leases – this did not impact on the Trust's cash expenditure but aims to fairly reflect the full value of assets in use within the accounts. New leases of £2.3m were agreed during the financial year.

At a headline level, the Trust's 2025/26 capital schemes totalling £54.6m, can be broken down as follows.

- **£25.2m Improvements to the Trust's built estate** including ongoing work to address backlog maintenance.
- **£8.0m Refurbishments** to Southport & Ormskirk hospitals.
- **£4.2m Private Finance Initiative** lifecycle replacement expenditure.
- **£4.7m Medical equipment** including replacement theatre equipment and diagnostic equipment.
- **£8.2m Information technology schemes**, including improvements funded by DHSC's Frontline Digitalisation programme.
- **£4.2m New leased equipment** & required accounting valuation of existing of leases.

2.5.4 Other financial results

The Trust's closing cash balance was £22.8m, which was a £12.6m increase from the start of the year. This was largely due to the receipt of NHS funding at the end of the financial year. During the year, the Trust maintained BPPC performance at over 91.5%, as shown in Note 31 to the Annual Accounts.

The Trust's borrowings at the 31st March 2026 (£487.3m) relate to its PFI and lease arrangements, which incorporate increases due to remeasurements following the introduction of accounting standard (IFRS16). These increased liabilities do not change the cash paid for the underlying contracts.

The Trust has a duty to pursue CIPs (cost improvement plans) which improve value for money - reducing costs and maximising income - whilst maintaining quality services. The Trust delivered efficiencies of £50.2m in 2025/26 (£48.2m recurrent full year effect, in line with the 25/26 target).

2.5.5 Financial forward look

The Trust's financial plan for 2026/27 achieves a surplus of £5.1m and adjusted financial performance balanced to nil. The plan includes an efficiency challenge of £49.7m, with schemes exceeding this identified for delivery in year.

The indicative capital expenditure plan 2026/27 is £42.2m.

The current plan is summarised below:

2026/27 PLAN	£m
Surplus/(Deficit)	5.1
Adjusted financial performance surplus/(deficit)	0
Assumed CIP achievement within the above deficit	49.7
Capital expenditure (capex)	42.2
PDC funding for capex schemes	32.2
Closing cash balance	3.3

Performance Report signed by

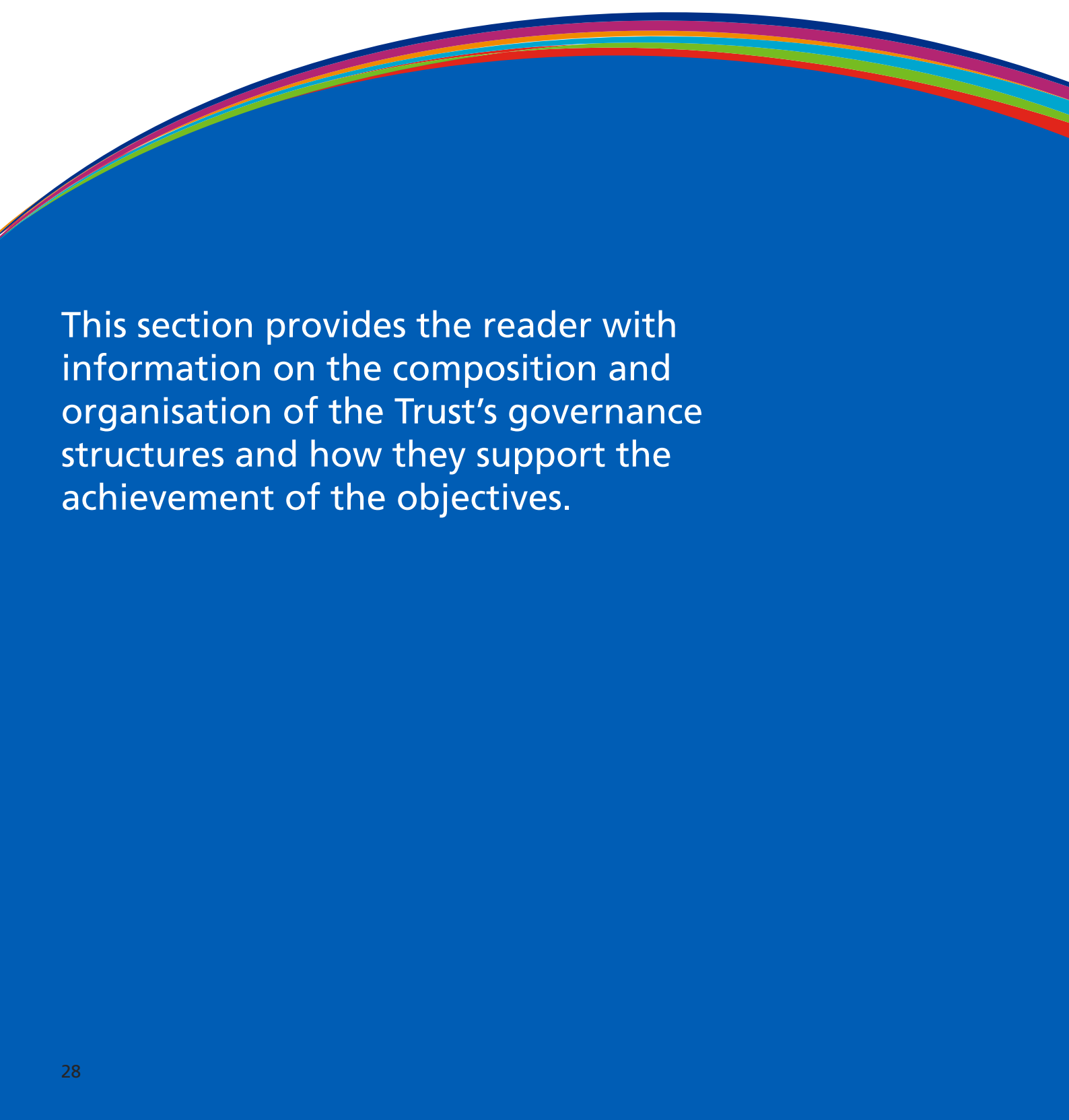
R Cooper

Rob Cooper
Chief Executive

24 June 2026

Section 2 - Accountability Report

3. Corporate Governance Report



This section provides the reader with information on the composition and organisation of the Trust's governance structures and how they support the achievement of the objectives.

3.1 Directors Report

3.1.1 The Board of Directors

The Trust is led by a Board of Directors that consists of both Executive and Non-Executive Directors (NED) with a Non-Executive Chairman. As at 31st March 2026, the Board consisted of the following people:

Steve Rumbelow – Chairman

Steve had a distinguished career in local government over 40 years, holding key roles at Manchester City Council, Leeds City Council, Ashfield District Council, and Rotherham Borough Council before becoming the Chief Executive of Burnley Council where he raised the town's profile and economic performance with a particular focus on advanced manufacturing and aerospace.

His most recent role was as Chief Executive of Rochdale Borough Council, where he gained experience of working strategically with the NHS as the Accountable Officer for the former Heywood, Middleton and Rochdale Clinical Commissioning Group (CCG), developing integrated health and social care services.

Steve became Chair of Mersey and West Lancashire Teaching Hospitals in May 2025.

Rob Cooper – Chief Executive

Rob has always worked in health and social care, starting his career in a care home, whilst completing his nursing degree at Liverpool University back in 1997.

He then went on to work in A&E, vascular surgery, and intensive care as a nurse, before moving into a site management role. This led to him joining the Trust in 2015 as Assistant Director of Operations for Medicine, before progressing to Director, then Managing Director (Strategy and Operations), and then being appointed to his current role as Chief Executive in 2024.

Anne-Marie Stretch – Deputy Chief Executive

Working in the NHS for 35 years, Anne-Marie has worked across a wide-range of HR roles in a variety of NHS settings. She joined the Trust as Director of Human Resources in 2003, becoming Deputy Chief Executive in 2010.

In addition to this, Anne-Marie was Managing Director at Southport & Ormskirk Hospital NHS Trust between September 2021 – July 2023.

Gareth Lawrence – Chief Finance Officer

Gareth started his career in the NHS 20 years ago, joining Alder Hey Children's Hospital as a Management Accounts Assistant, where he seized the opportunity to become a qualified accountant.

He has undertaken many finance roles at various Trusts, and in 2018 joined the Trust as Deputy Director of Finance, before progressing to Chief Finance Officer.

Sarah O'Brien – Chief Nursing Officer

Sarah started her career as a nurse at St Helens and Knowsley Teaching Hospitals NHS Trust in 1996. She spent 18 years at the Trust in various roles including Diabetes Research Nurse, Diabetes Nurse Consultant and Deputy Director of Nursing.

Over the last 10 years, she has worked across commissioning, local government and integrated care systems. Her most recent role being Chief Nursing Officer at Lancashire and South Cumbria Integrated Care Board.

Sarah became Chief Nursing Officer of MWL in July 2025.

Dr Simon Dowson – Chief Medical Officer

Simon trained at the University of Birmingham and qualified as a Consultant Paediatrician in 2009.

He has spent 17 years at Mid Cheshire Hospitals NHS Foundation Trust in various roles, his most recent being Deputy Chief Medical Officer for the last 3 years.

Simon became Chief Medical Officer of MWL in November 2025.

Lesley Neary – Chief Operating Officer

Graduating from university in 1997, Lesley took on a role as a computer programmer, before joining the NHS as a Database Developer in Liverpool Health Authority.

Lesley soon moved into operational performance at Sefton PCT, before joining NHS Improvement in Leeds as the Operational Lead for Emergency Care for the North of England. She took the Deputy Chief Operating Officer role at Lancashire Teaching Hospitals NHS Foundation Trust for 2 years, before joining Southport & Ormskirk Hospitals NHS Trust in 2021 as Chief Operating Officer and was subsequently appointed as the Chief Operating Officer upon the formation of MWL in July 2023.

Malise Szpakowska – Chief People Officer

Malise joined the Trust as HR Project Manager in 2014 and since then has worked in a number of senior management roles. She was appointed Chief People Officer in April 2025.

Nicola Bunce – Director of Corporate Services

Starting her career in 1987, Nicola took on her first role at Royal Hallamshire Hospital in Sheffield as a Higher Clerical Officer and very quickly went on to progress into a career in HR and business planning.

Nicola later relocated to the North West and worked in a number of different Trusts and NHS organisations, until joining the former St Helens and Knowsley Teaching Hospitals NHS Trust in 2013, and being appointed Director of Corporate Services in 2017.

Malcolm Gandy – Director of Informatics

With an NHS career spanning 25 years, Malcolm has held a number of senior leadership positions at different NHS Trusts across Greater Manchester, Cheshire and Merseyside.

Holding a postgraduate degree in Digital Health Leadership, Malcolm has demonstrated strong strategic leadership, digital strategy implementation, and innovation in technology usage within the healthcare sector. In 2022, he became the first Chief Information Officer (CIO) in the country to attain Level 3 Excellence in Informatics (Informatics Skills Development 'ISD' Networks) accreditation for his Trust.

Malcolm was appointed Director of Informatics at MWL in April 2024.

Gill Brown – Non-Executive Director and Deputy Chair

Gill brings extensive experience working in the NHS in a variety of clinical, corporate and research roles. Previous roles include governing body member for NHS Southport and Formby Clinical Commissioning Group and Chief Executive for Healthwatch Lancashire.

Gill also brings experience of social housing at Board level in Non-Executive Director roles.

As part of Gill's Non-Executive Director role, she is also the Trust's Maternity and Neonatal NED Safety Champion.

Steve Connor – Non-Executive Director

Steve brings extensive experience in governance, risk management and business development.

Before joining the Trust, he served as Audit Chair and Non-Executive Director at Wirral Community Health and Care NHS Foundation Trust, following a 30+ year career in senior commercial roles at Mersey Internal Audit Agency (MIAA).

Professor Minal Singh – Non-Executive Director

Minal is a Professor of Medical Education and Honorary Consultant Dermatologist with over 20 years' of experience. Minal has held senior roles at Manchester University Medical School and most recently, led the development of Edge Hill University's new medical school.

Alongside her academic leadership, Minal continues to practice as a Consultant Dermatologist in Salford and serves nationally as Education Vice President of the British Association of Dermatologists.

Lisa Knight – Non-Executive Director

Lisa Knight is currently Head of Innovation and Enterprise at Liverpool John Moores University.

Lisa is a senior academic and has significant leadership and governance experience, holding board-level roles across the NHS and the housing and charity sectors.

As part of Lisa's Non-Executive Director role, she is also the Trust's Wellbeing Guardian.

Dr Neil French – Non-Executive Director (University Nominated)

Neil works for the University of Liverpool, where he is Acting Faculty Director of Operations for Health and Life Sciences.

With a background in scientific research, including roles in UK biotechnology and a postdoctoral position at the Karolinska Institute, he brings extensive expertise in research leadership and clinical operations.

Carole Spencer – Non-Executive Director

Carole is an experienced strategy director with a career of over 25 years as an executive director in the NHS.

Having worked in healthcare across the North West, Carole brings experience of innovation and partnership working at a regional level.

Neil Fletcher – Associate Non-Executive Director

Neil has over 35 years' experience working in the NHS.

With a background as a Pharmacist, Neil has held several senior leadership roles at Lancashire Teaching Hospitals NHS Foundation Trust and East Lancashire Hospitals NHS Trust, including Chief Pharmacist and Divisional Director of Operations for Diagnostic and Clinical Support Services.

Dr Khalid Anis, MBE – Associate Non-Executive Director

Khalid has over 30 years' experience across healthcare, charity and public health organisations.

He's held a range of posts including Clinical Director and Public Health Consultant for NHS Heywood, Middleton and Rochdale and Clinical Lecturer at Eastman Dental Institute, part of the University College London.

Khalid currently works as a primary care dentist and non-clinical partner in a busy general medical practice.



The full composition of the Board and committee membership during 2025/26 was as follows:

	Position	Name	Term of Office	Committee Membership
Non-Executive Directors	Chair	Steve Rumbelow	Appointed May 2025	Remuneration Shaping Care Together Board
	Chair	Richard Fraser	Appointed May 2014, 2016, 2020, 2022 & 2023 Left April 2025	Remuneration
	Deputy Chair	Gill Brown	Appointed Non-Executive Director January 2020, 2022 & 2025 Appointed Deputy Chair July 2024	Audit Quality Remuneration
	Non-Executive Director	Lisa Knight	Associate NED from July 2019 then substantively appointed September 2022 & 2025	Remuneration Strategic People
	Non-Executive Director (university nominated)	Dr Neil French	Appointed February 2026	Charitable Funds Quality Remuneration
	Non-Executive Director (university nominated)	Prof Hazel Scott	Appointed November 2023 Left October 2025	Charitable Funds Quality Remuneration
	Non-Executive Director	Stephen Connor	Appointed February 2024	Audit Charitable Funds Finance & Performance Remuneration
	Non-Executive Director	Carole Spencer	Associate Non-Executive Director May 2024 then appointed substantively August 2024	Audit Finance & Performance Remuneration Strategic People
	Non-Executive Director	Claudette Elliott	Appointed March 2025 Left December 2025	Quality Remuneration Strategic People
	Non-Executive Director	Prof Minal Singh	Appointed March 2026	Quality Remuneration Strategic People
Executive Directors	Chief Executive	Rob Cooper	Appointed January 2017 as Director of Performance and Operations, appointed Managing Director from July 2023, appointed Chief Executive from December 2024	Executive Finance & Performance Quality Strategic People
	Deputy CEO	Anne-Marie Stretch	Appointed July 2003 stepped back from Director of Human Resources May 2024	Executive Finance & Performance Quality Strategic People

	Position	Name	Term of Office	Committee Membership
Non-Executive Directors	Chief Finance Officer	Gareth Lawrence	Appointed April 2022	Executive Charitable Funds Finance & Performance Quality Strategic People
	Chief Medical Officer	Dr Simon Dowson	Appointed November 2025	Executive Finance & Performance Quality
	Medical Director	Dr Peter Williams	Appointed July 2022 Left July 2025	Executive Quality Finance & Performance
	Chief Nursing Officer	Prof Sarah O'Brien	Appointed July 2025	Charitable Funds Executive Quality Strategic People
Associate Directors	Director of Corporate Services	Nicola Bunce	Appointed July 2017	Executive Quality Finance & Performance Strategic People
	Director of Informatics	Malcolm Gandy	Appointed April 2024	Executive Finance & Performance
	Chief Operating Officer	Lesley Neary	Appointed July 2023	Executive Charitable Funds Finance & Performance Quality Strategic People
	Acting Director of Nursing, Midwifery and Governance	Lynne Barnes	Appointed April 2024 Stepped down June 2025	Executive Quality Strategic People
	Chief People Officer	Malise Szpakowska	Appointed June 2024	Executive Finance & Performance Quality Strategic People
	Associate Non-Executive Director	Rani Thind	Appointed September 2021 and September 2024 Left September 2025	Quality Remuneration
	Associate Non-Executive Director	Neil Fletcher	Appointed April 2025	Charitable Funds Finance & Performance Quality Remuneration
	Acting Chief Medical Officer	Dr Ash Bassi	Appointed August 2025 Stepped down October 2025	Executive Finance & Performance Quality
	Associate Non-Executive Director	Dr Khalid Anis MBE	Appointed January 2026	Finance & Performance Remuneration

All Non-Executive Directors are considered to be independent on appointment and the process for the appointments of new Non-Executive Directors are led by NHS England, under delegated authority from the Secretary of State for Health and Social Care.

Directors are appraised each year to review their contribution over the previous twelve months and to set objectives linked to those of the Trust for the following year. The Chairman is appraised by the Deputy Chair in conjunction with NHS England and the Cheshire and Merseyside ICB using the NHS standard appraisal template. From 2024 the Trust adopted the NHS Directors Leadership Competency Framework for Director appraisals.

Any skills gaps and training or development requirements are also reviewed annually against the NHS England and Care Quality Commission (CQC) Well Led Framework to ensure continuous development and optimum functioning as a unitary board.

Board meetings were held in person, with the option for members to join virtually and most committee meetings were held virtually to enable inclusive participation of the staff from across the whole of MWL who are asked to attend committees.

3.1.2 Fit and Proper Persons requirements

The 2014 Health and Social Care Act imposed additional requirements on the posts of Directors to be 'Fit and Proper Persons' (FPPR), and in August 2023 NHS England published a Fit and Proper Person Test Framework in response to the recommendations of the 2019 Kark Review.

In assessing whether a person is of good character, the matters considered must include convictions, whether the person has been struck off a register of professionals, bankruptcy, sequestration and insolvency, appearing on barred lists and being prohibited from holding directorships under other laws. In addition, Directors should not have been involved or complicit in any serious misconduct, mismanagement or failure of care in carrying out a NHS regulated activity.

The Trust requires all Directors to make an annual declaration of compliance with the FPPR standards. In 2025/26, all Board members were required to complete a self-certificate to confirm compliance with these standards, and where appropriate external assessments, including Disclosure and Barring Service (DBS) checks, were undertaken. The results were scrutinised by the Trust Chairman who concluded that the Board members were, and remain, fit to carry out the roles they are in. This is evidenced in the Trust Board papers in June 2025 and the process will be repeated for 2026/27 in accordance with the guidance.

3.1.3 Statement on disclosure to auditors

So far as the Directors are aware, at the time of approving this Annual Report there is no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware. In addition, each Director has taken all of the steps that they ought to have taken to make themselves aware of any such information, and to establish that the auditors are aware of it.

3.2 Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place, and

- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the 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 my letter of appointment as an Accountable Officer.

R Cooper

Rob Cooper
Chief Executive

24 June 2026



3.3 Annual Governance Statement

3.3.1 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable Officer Memorandum*.

3.3.2 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 Mersey and West Lancashire Teaching Hospitals NHS 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 Mersey and West Lancashire Teaching Hospitals NHS Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

3.3.3 Capacity to handle risk

The Trust supports staff to identify and plan mitigations for risks to the delivery of the Trust's services and objectives. All risks are owned by an appropriate manager and reviewed regularly to ensure the mitigation plans are effective in reducing the level of risk exposure. There is a Risk Management Council that is part of the Trust's corporate governance arrangements, and the Trust also has a risk assurance framework to meet the needs of MWL.

The Trust's risk profile is reviewed by the Risk Management Council each month. The Council's membership includes representation from each of the Clinical Divisions and from corporate services, and is chaired by a member of the Executive Team. A report is then drafted by the Council Chair for presentation to the Executive Committee, this includes any risks rated as extreme (15-25), which have been escalated to the Corporate Risk Register and assigned to a member of the Executive Team for oversight. The Corporate Risk Register and Trust risk profile are reported to the Trust Board four times a year.

The involvement of the Executive Committee and the Board in regularly reviewing risks ensures that the level of exposure that the Trust is willing to tolerate (the risk appetite) is regularly tested. The risk appetite reflects the balance between the impact of the risk materialising and the opportunity cost of full mitigation.

A risk assurance framework was developed for MWL which details the organisational strategy for the management of risk and sets out the process for the management of risks. Guidance in undertaking risk assessment, identifying and reporting risks and untoward incidents is part of the induction process for all staff joining the Trust. Specific Training is also available for managers who have responsibility for managing their service or departmental risk registers and risk management is included as part of management development programmes. Guidance on risk reporting and management is also accessible to staff via the Trust intranet.

The Trust implemented a single risk management system in 2025/26 (InPhase) which streamlined the reporting of risk and has helped to embed the unified risk assurance framework.

3.3.4 The risk and control framework

The Trust promotes a culture of openness and encourages all staff and service users to actively report any issues, risks, incidents or near misses, where they feel inappropriate action may have occurred, or systems and practices could be improved. In this way, the Trust learns from incidents and can identify areas where there is opportunity for improvement.

The Trust also learns from others and bases its service pathways on best practice models, such as the recommendations of National Institute for Health and Care Excellence (NICE), Getting It Right First Time (GIRFT), Model Hospital and a range of other national guidance and benchmarking information.

Clinical risk assessments, incident reports, complaints, claims, patient feedback (for example via Friends and Family Test (FFT) feedback and national patient surveys), staff feedback (via the annual national staff survey, quarterly pulse survey and local surveys), and social media channels are other sources of information which support the Trust in identifying and responding to any emerging issues or underlying themes.

All staff have access to be able to register new risks or report incidents. Potential risks are identified and assessed (using the recognised National Patient Safety Agency (NPSA) 5 x 5 matrix of likelihood and consequence) and added to the register. The risk owner details controls and assurances that are within their remit and then re-assesses the risk to see whether these mitigations have reduced the risk score. The risk owner also identifies the relevant line manager to have oversight of the risk and to review the actions to support mitigation.

Incidents are also reported, investigated and categorised to identify any trends or themes and potential ongoing risks.

Risks with a score below 15 are managed at divisional or corporate department level. Each risk is allocated an appropriate review date and each month local governance meetings, with clinical and operational managers, consider the risk profile along with any that may be missing, and those requiring review. Frequent evaluation of risks takes place to ensure that the plans to mitigate risks are updated, and their impact on the risk scores recorded.

If, following review and mitigating action within the division or corporate department, the risk score is still 15 or above, it is automatically escalated to the Corporate Risk Register and "owned" by the most appropriate Director to see if more senior intervention can further mitigate the risk to the organisation.

The Trust's Cost Improvement Programme (CIP) plans are also risk rated and tracked through a quality risk assessment process and are not closed until there is evidence that implementing the scheme has not impacted the quality of care that the Trust provides.

On 31st March 2026, there were a total of 1015* risks on the MWL risk register. The table below shows the profile of the risk scores (between 1 and 25):

Very Low Risk			Low Risk			Moderate Risk				High/Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
14	52	29	84	7	197	95	201	52	258	9	7	7	0
95 = 9.39%			288 = 28.46%			606 = 59.88%				23 = 2.27%			

*The risk management systems (InPhase) are live systems so there will always be some risks reported but not scored

In 2025/26, the Risk Management Core Controls were reviewed by Mersey Internal Audit Agency (MIAA) as part of an Internal Audit, which resulted in an opinion of “High Assurance”. In summary, they concluded that the system of internal control was effectively designed to meet the system objectives, and the controls were consistently applied in all areas reviewed. The Risk Management Framework was up-to-date and included clear escalation and roles and responsibilities, and training was readily accessible to staff.

In addition to the Risk Management Framework, the Board has identified the strategic risks that could impact the delivery of the organisation’s objectives, and these are captured in the Board Assurance Framework (BAF), which is considered by the Board four times per year.

Strategic concerns for MWL captured in the BAF on 31st March 2026 were:

- Systemic failures in the quality of care
- Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners
- Sustained failure to maintain operational performance/deliver contracts,
- Failure to maintain patient, partner and stakeholder confidence in the Trust
- Failure to work in partnership with stakeholders
- Failure to attract and retain staff with the skills required to deliver high quality services
- Major and sustained failure of essential estates assets and infrastructure
- Major and sustained failure of essential IT systems

Operational components of these strategic concerns are reflected in the MWL Risk Register. Those risks are monitored in line with the Trust’s Risk Management Framework with appropriate management and escalation.

In developing its plans for the organisation in 2026/27, the Board has assessed the future risks that will need to be managed. These continue to include recovering the elective activity backlog and reducing waiting lists in line with national targets, delivering both financial and activity plans in a challenged financial context for the NHS, integrating services, systems and policies for the new organisation, progressing the single operating model, and a shared culture for all our staff. There were also very specific risks associated with the fragile services at the legacy Southport & Ormskirk sites and the outstanding question of the strategic configuration of some key services between the Southport and Ormskirk hospitals, which were reviewed by the Shaping Care Together Programme in 2025/26 (see section 1.4).

Copies of the corporate risk register and Board Assurance Framework reports to the Trust Board are available on the Trust website:

<https://www.merseywestlancs.nhs.uk/trust-board-meetingsand-papers>

In 2025/26, MIAA also reviewed the BAF, with the objective of assessing whether the Trust maintained and used the assurance framework to support the overall assessment of governance, risk management and internal control. In the opinion of MIAA, the assurance level was “Requirements met” and MIAA concluded that the BAF is structured to meet the NHS requirements of assurance best practice model, the risk appetite is considered regularly and used to inform the management of the assurance framework, it is visibly used by the Trust, and clearly reflects the risks discussed by the Board.

Governance Framework of the organisation

The Board is collectively responsible for establishing a system of internal control and for putting in place arrangements for gaining assurance about the effectiveness of that system.

The Board has a Corporate Governance Manual which contains the Trust's standing orders, standing financial instructions, and scheme of reservation and delegation of powers, which set out the framework for the business conduct of the organisation. This was last reviewed and updated in February 2024 and approved by the Board, and remains valid until February 2027.

High standards of governance are maintained through the independence of the Non-Executive Directors (NEDs), achieved by the following:

- All NEDs are appointed for fixed terms ensuring a regular turnover and the introduction of new skills and experience,
- The non-executive membership of the Board outnumbers the executive element for all issues requiring a vote,
- The NEDs (including the Trust Chair) meet separately from the Executive Directors on occasion, to discuss Trust business,
- The composition of the Board is managed to ensure that the NEDs have a range of skills and experience that enables them to provide constructive challenge, fully understand the business of the Trust and participate in the Trust's governance arrangements. They are therefore able to hold the Executive Directors to account for the performance and delivery of the strategic agenda set by the Board,
- NEDs chair the Board and Board Committees (except for the Executive Committee), and through chair reporting, provide assurance to the Board that the Trust is effectively governed.

Changes to the Board during 2025/26

There were several changes to the Board during 2025/26.

Richard Fraser retired at the end of April 2025 after 11 years as Chair for St Helens and Knowsley Teaching Hospitals NHS Trust and since July 2023 for MWL.

Steve Rumbelow was appointed as Chair in May 2025.

Gill Brown was extended in her role as Non-Executive Director and Deputy Chair in December 2025 for a further 12 months.

Lisa Knight was extended in her role as Non-Executive Director in August 2025 for a further 12 months.

Professor Hazel Scott left the Board in October 2025 after two years as the university nominated Non-Executive Director following her retirement from the University of Liverpool.

Claudette Elliott was appointed as a Non-Executive Director in March 2025. She left the Trust in December 2025 following her appointment as Chair at Pennine Care NHS Foundation Trust.

Dr Neil French was appointed as a Non-Executive Director following nomination by the University of Liverpool in February 2026.

Professor Minal Singh was appointed as a Non-Executive Director in March 2026.

Dr Peter Williams stepped down as Chief Medical Officer in July 2025.

Dr Ash Bassi was appointed as Acting Chief Medical Officer in August 2025 and stepped down from the role in October 2025.

Dr Simon Dowson was appointed as Chief Medical Officer in November 2025.

Lynne Barnes stepped down from her role as Acting Director of Nursing, Midwifery and Governance in June 2025.

Professor Sarah O'Brien was appointed as Chief Nursing Officer in July 2025.

Nicola Bunce retired as Director of Corporate Services in March 2026.

Rani Thind left the Board in September 2025 after four years as an Associate Non-Executive Director for St Helens and Knowsley Teaching Hospitals NHS Trust and since July 2023 for MWL.

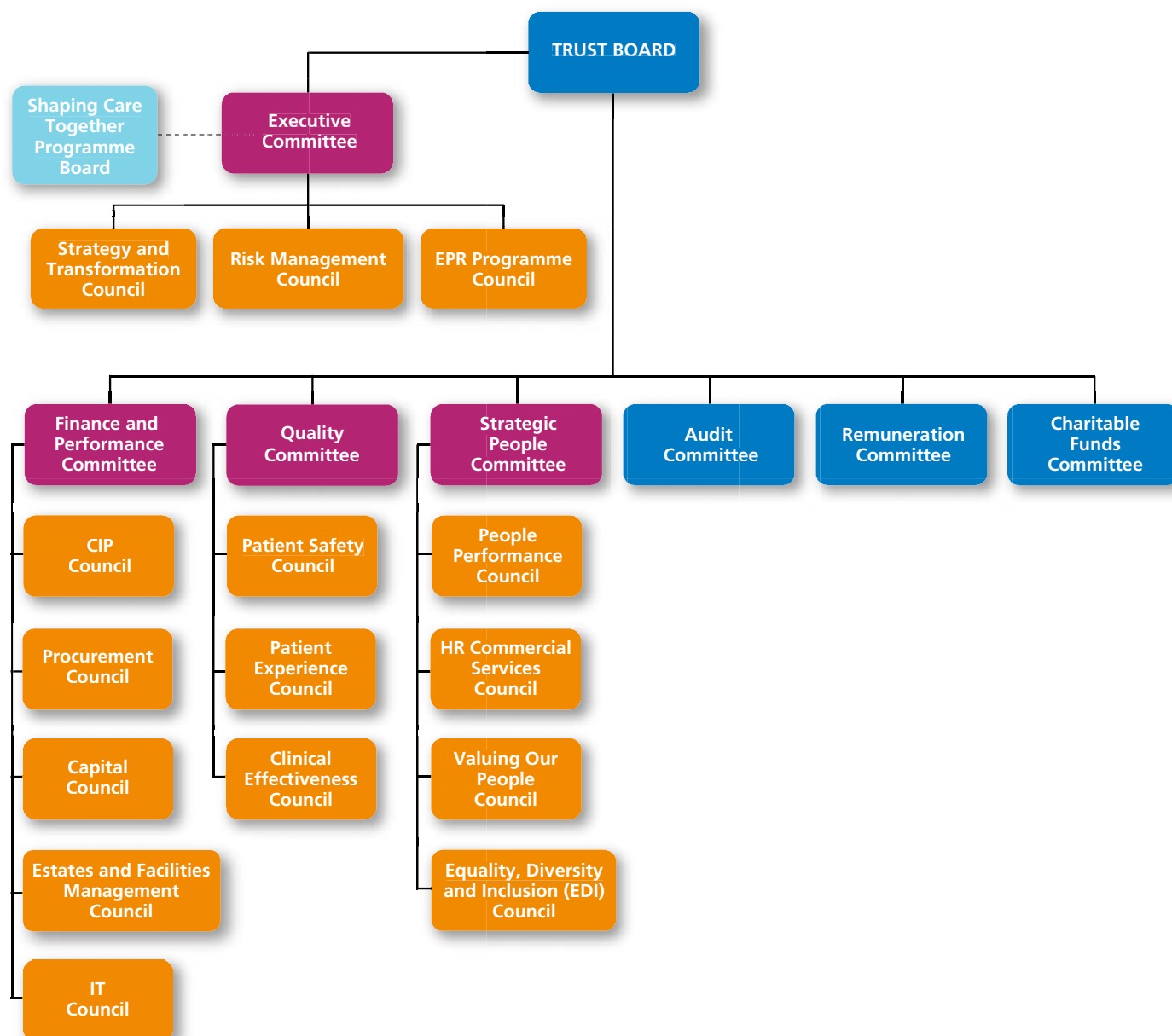
Neil Fletcher was appointed as an Associate Non-Executive Director in April 2025.

Dr Khalid Anis MBE was appointed as an Associate Non-Executive Director in January 2026.

Governance structure

The Trust has a robust internal governance structure which maintains the systems of internal control. A Board and Committee effectiveness review is undertaken annually to confirm that the structure remains fit for purpose.

The Trust has seven committees reporting to the Board in line with the following structure. Each assurance committee is supported in its work by Councils.



All committees except the Executive Committee are chaired by a Non-Executive Director. The Executive Committee is chaired by the Chief Executive. After each meeting the respective chair prepares a report to the Trust Board on matters considered on the agenda, the areas where assurance is being provided, and any issues requiring escalation for Board intervention or decision.

Remuneration Committee

The Remuneration Committee is comprised of the Chair and all the NEDs.

Its duties include approving the remuneration and terms of service for the Chief Executive and Executive Directors, and to consider the appointment of Executive Directors and other very senior managers (VSMs).

The Committee is required to meet at least once a year and during 2025/26 met on one occasion and conducted business via email (formal agreement of proposals previously discussed) on four other occasions. The meeting in April 2025 was quorate, and business via email was also quorate.

Audit Committee

The Audit Committee has a membership of three Non-Executive Directors, with the chair being a qualified accountant.

The Trust's external and internal auditors, the NHS Anti-Fraud Specialist and other officers are regularly invited to attend. In 2025/26 the Committee met on five occasions. All meetings were quorate.

The Audit Committee provides the Trust Board with independent and objective scrutiny of the financial systems and processes, risk management, and compliance with relevant legislation.

Through the agreement of an annual programme of independent audits, the Committee gains assurance that the data being provided to the Board, on which decisions are based, is accurate and complies with guidance.

This programme included key financial controls, Cost Improvement Plan processes, Board reporting, Council effectiveness, Board governance, Board Assurance Framework (BAF), Risk Management (Core Controls), Conflicts of Interest, Performance Management Framework, Emergency Preparedness, Resilience and Response (EPRR), Cyber Security, Data Security and Protection Toolkit, Third Party Providers, job planning, Electronic Staff Records (ESR) /Payroll, Recruitment, Infection Control, quality spot checks, Ward Accreditation, the Trust's Maternity Incentive Scheme submissions, Patient Activity Capture and InPhase.

These audits provide independent assurance to the Board that the quality and accuracy of information reported and systems in place are sufficiently robust to be relied on.

Quality Committee

The Quality Committee provides assurance to the Board on quality governance. Quality performance within the Trust is measured against a range of parameters, including patient safety, patient experience, clinical effectiveness, and some key workforce metrics such as safer staffing, and clinical skills mandatory training compliance. The performance metrics aligned to quality and quality governance are reported each month in the Committee Performance Report (CPR).

The Quality Committee usually meets each month (excluding August and December) to review all aspects of quality. During 2025/26 the Quality Committee met on ten occasions. All meetings were quorate.

The Quality Committee is made up of both Non-Executive and Executive members and is supported by the Patient Safety, Patient Experience, and Clinical Effectiveness Councils. Assurance reports from each of these Councils are reported to the Committee which include any matters for escalation.

Finance and Performance Committee

Like the Quality Committee, the Finance and Performance Committee is an assurance Committee that usually meets each month (excluding August and December) and reviews the financial and operational activity metrics reported in the CPR, reflecting the annual financial and operational plans and targets agreed by the Trust Board. During 2025/26 the Finance and Performance Committee met ten times. Members of the Committee include Non-Executive and Executive Board members, and all the meetings held during 2025/26 were quorate.

The Committee is also supported in its work by the Cost Improvement Plan, Procurement, Capital, Estates and Facilities Management, and IT Councils. Assurance reports from each of these Councils are reported to the Committee, which includes any matters for escalation.

Strategic People Committee

The Strategic People Committee is an assurance committee which oversees the delivery of the Trust's people strategy and the action plans arising from the annual staff survey, gender pay gap and Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports, and effectiveness of people management in the Trust. The Committee usually meets each month (excluding August and December) and is supported by the People Performance, HR Commercial Services, Valuing Our People, Equality, Diversity and Inclusion Councils, which provide assurance reports to the Committee and include any matters for escalation.

The Committee membership includes Non-Executive and Executive members and met ten times in 2025/26. All meetings were quorate.

Charitable Funds Committee

The Trust's Charitable Funds Committee normally meets at least three times a year and is responsible for managing the income and expenditure of any charitable and donated monies and assets held by the Trust, representing the Board as corporate trustees of the charitable funds. During 2025/26, the Committee met on three occasions, all of which were quorate.

The Committee actively promotes fundraising and the regular expenditure from funds and ensures that the Trust receives a reasonable rate of interest from investments made of the funds held in trust.

Executive Committee

The team of Executive and Associate Executive Directors, led by the Chief Executive, is the senior management decision making group within the Trust and is responsible for planning, organising, directing, and controlling the organisation's systems and resources to achieve the objectives and targets set by the Board.

The Executive Committee aims to meet each week, excluding at Christmas, and exercises the authority delegated to the Chief Executive and Directors to ensure that the organisation is effectively managed, decisions are made, and performance is monitored. In 2025/26, there were 46 formal Executive Committee meetings. On occasions the Executive Team hold time out or training/development sessions instead of a formal business meeting.

The Committee is supported in its work by the Strategy and Transformation Council, Risk Management Council and EPR Programme Council.

Board Meetings

The Trust Board meets in public ten times a year. The meetings are monthly, except August and December and in 2025/26 there was an Extraordinary Board meeting held in February 2026.

A second part of the Board meetings are held in private to discuss confidential issues such as the details of serious untoward incidents relating to patients, confidential staff matters, commercial decisions such as bidding to provide new services or to allow time for the Board to undertake development activities and formulate strategy.

All Trust Board meetings in 2025/26 were quorate.

Attendance by the Directors at the governance meetings is summarised in the following table:

Board Members		Trust Board	Audit Committee	Remuneration Committee	Finance & Performance Committee	Quality Committee	Strategic People Committee	Charitable Funds Committee	Executive Committee	Total	% Attendance
Name	Position	11	5	5	10	10	10	3	46	100	%
Steve Rumbelow	Chair	10		4						14 (14)	100%
Richard Fraser	Chair	1		1						2 (2)	100%
Gill Brown	Non-Executive Director	10	4	5	1	10		1		31 (33)	94%
Steve Connor	Non-Executive Director	10	5	5	10		1	2		33 (35)	94%
Claudette Elliot	Non-Executive Director	6		2		6	6			20 (23)	87%
Minal Singh	Non-Executive Director	0				1				1 (2)	50%
Hazel Scott	Non-Executive Director (University appointed)	4		1		0		1		6 (12)	50%
Neil French	Non-Executive Director (University appointed)	2		0				1		3 (3)	100%
Lisa Knight	Non-Executive Director	10		4			7			21 (26)	81%
Carole Spencer	Non-Executive Director	10	5	5	10		10			40 (41)	98%
Neil Fletcher	Associate Non-Executive Director	10		5	9	9		3		36 (38)	95%
Rani Thind	Associate Non-Executive Director	4		2		4				10 (11)	91%
Khalid Anis	Associate Non-Executive Director	3		0		3				6 (6)	100%

Board Members		Trust Board	Audit Committee	Remuneration Committee	Finance & Performance Committee	Quality Committee	Strategic People Committee	Charitable Funds Committee	Executive Committee	Total	% Attendance
Name	Position	11	5	5	10	10	10	3	46	100	%
Rob Cooper	Chief Executive	9			3	5	2		39	58 (87)	67%
Anne-Marie Stretch	Deputy Chief Executive	11			8	7	6		39	71 (87)	82%
Gareth Lawrence	Chief Finance Officer	11	5		7	9	8	3	39	82 (95)	86%
Sarah O'Brien	Chief Nursing Officer	6	1			6	2	2	30	47 (62)	76%
Lynne Barnes	Acting Director of Nursing, Midwifery and Governance	3	2			3	1	1	10	20 (24)	83%
Simon Dowson	Chief Medical Officer	4			3	4			15	26 (28)	93%
Ash Bassi	Acting Medical Director	1			1	2			11	15 (20)	75%
Peter Williams	Medical Director	4			3	4			13	24 (29)	83%
Nicola Bunce	Director of Corporate Services	11	5		10	10	10		40	86 (92)	93%
Lesley Neary	Chief Operating Officer	11			8	9	7	3	39	77 (90)	86%
Malise Szpakowska	Chief People Officer	10			9	9	10		36	74 (87)	85%
Malcolm Gandy	Director of Informatics	11	2		7				39	59 (72)	82%
Total attendance		172 (188)	29 (35)	34 (38)	89 (111)	101 (117)	70 (97)	17 (18)	350 (415)	828 (981)	84%

The attendance of Rob Cooper and Gareth Lawrence at Committee Meetings was impacted by required attendance at various regional financial performance and national leadership meetings.

The Board completed a programme of time-out and development events during 2025/26.

Purpose	Provider / Lead	Date
Board Away Day	Rob Cooper	June 2025
Board Away Day	Rob Cooper	February 2026

Individual Board members have attended a range of other training and development events to meet their personal development objectives. All new NEDs joining the Board attend the NHS Alliance NED induction programme.

To effectively carry out their duties Board members need to be able to probe the data conveyed in formal reports to the Board and its Committees and triangulate that with the softer intelligence gained through attendance at events, staff and carer listening sessions, and ward and department visits. These included a programme of Quality Ward Rounds and Team Talks that take place on all MWL sites.

The Board continued to receive patient stories, six times a year.

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator for health and social care in England and through monitoring and inspection makes sure that the public are provided with safe, effective, compassionate and high-quality care.

The Trust was required to register with the CQC and was granted registration without conditions. The Trust is fully compliant with the registration requirements of the CQC.

The CQC has not taken any enforcement action against Mersey and West Lancashire Teaching Hospitals NHS Trust during 2025/26.

The last report following the comprehensive inspection of St Helens and Knowsley Teaching Hospitals NHS Trust was published in March 2019, provided significant assurance to the Board of the quality of services being delivered. The overall Trust rating was 'Outstanding'.

On completion of the transaction, the CQC rating for the Trust was maintained for the new organisation and specific service ratings were transferred to the new organisation's registration. Overall, the Trust remains rated as 'Outstanding'.

Mersey and West Lancashire Teaching Hospitals NHS Trust is subject to periodic reviews by the Care Quality Commission. There had been three CQC inspections undertaken in 2025/26 and MWL continues to retain the overall outstanding CQC rating. The following services received announced inspections:

- Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) CQC Inspection on the Whiston Site on 30 April 2025.
- St Helens Urgent Care Treatment Centre (UTC) on 08 May 2025. This was one of our first inspections undertaken using the CQC's Single Assessment Framework and the CQC rated all key questions as 'Good', and the service is rated 'Good' overall.
- IR(ME)R CQC Inspection of Nuclear Medicine on the Whiston Site on 05 August 2025.

The results of those inspections did not impact the Trust's overall rating.

NHS England and the Provider Licence Conditions

The Trust has not been subject to any regulatory special interventions or support during 2025/26.

The Trust remained compliant with NHS Acts and the NHS Constitution. The Trust was granted a NHS Provider Licence in April 2023, which is available on the Trust's website.

Workforce Strategy and Workforce Safeguards

The Board has a local People Plan with agreed objectives for ensuring that the Trust can attract and retain the right number of staff with the necessary skills to deliver high quality patient care, and who are fully engaged and offered opportunities to develop their careers within the organisation. This strategy is aligned to the NHS People Plan. The MWL People Plan 2025-2028 was reviewed and approved by the Board in 2025.

To meet the Developing Workforce Safeguards recommendations, the Board approves the high level workforce plan each year as part of the annual operational planning cycle, which considers projected activity growth or workforce resource changes and agreed service developments.

The Trust also utilises a suite of scheduling systems to roster staff, plan activities and monitor staffing in line with patient acuity on a day-to-day basis. Nurse safer staffing information is reported to the Trust Board in the Integrated Performance Report, and detailed reports are also reviewed at the Executive and Quality committees. In addition, nurse staffing establishment reviews are undertaken to ensure compliance with the developing workforce safeguards guidance. MWL experienced higher than average levels of staff sickness and absence during 2025/26 but was similar to other acute Trusts in the North West.

The need for supplementary care (increased supervision including one-to-one observation of patients who are confused or at increased risk of falls) and corridor care in the Emergency Department increased the staffing requirements and were significant challenges at certain points during the year. Staffing levels were reviewed several times a day by operational and nurse managers to ensure that all wards had adequate staffing with staff working additional hours and the use of bank and agency staff to maintain patient safety. Additional nurse staffing establishment was approved to ensure safe staffing of mobilised escalation beds. Investment was also made in additional HCA staffing establishment to eliminate agency HCAs for supplementary care.

Detailed workforce key indicator reports are presented in a workforce dashboard to the Strategic People Committee, which include recruitment, vacancy and turnover information.

The Trust has a guardian of safe working who reports twice a year on the working hours and shift patterns of doctors in training.

Taken together, these activities mean that the Board is assured that staffing processes are safe, sustainable and effective.

Register of Interests/Managing Conflicts of Interest

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision making staff (as defined by the Trust with reference to guidance) within the past 12 months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance, which is captured within the Trust's Standards of Business Conduct policy.

The register of interests can be found here: <https://www.merseywestlancs.nhs.uk/register-ofinterests>

NHS Pensions

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.

Equality and Diversity Obligations

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

Appropriate policies are maintained to ensure that the required standards are met; examples being:

- The Recruitment and Selection Policy is designed to inform management and staff how to conduct recruitment in an objective, fair and effective manner.
- The Equality and Diversity Policy is designed to provide employment equality. This ensures that no applicant or employee will receive less favourable treatment on the grounds that they possess a "protected characteristic" as defined by the Equality Act, or any other individual characteristic, for example, social class or carer status.
- The Patient Access policy ensures that all patients have access to care and treatment based on fair and objective criteria.

The Strategic People Committee reviews and makes recommendations to the Board in respect of key regulatory and statutory workforce publications, in particular:

- Annual Gender/Minority Ethnic/Disability Pay Gap reports and action plans
- WRES/WDES reports and action plans

Climate change

The Trust has undertaken risk assessments on the effects of climate change and severe weather. In the last year, MWL has combined and updated the two green plans from each of the legacy organisations into a single document for the Trust. This document was signed off by the Board in 2025/26 financial year and will be key for the next 3 years. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. For further detail on the Trust's approach to climate related issues and Net Zero please see section 2.4 Environmental Analysis.



Board Assurance

Through the systems outlined in this report, the Directors are able to provide the necessary assurances to the Board that its annual and longer-term objectives can be met and risks to their achievement are being appropriately managed.

To support this view, the Trust also receives a significant amount of independent and external feedback from a range of sources that provides the Board with further assurance. Examples are summarised in the following paragraphs.

In accordance with Global Internal Audit Standards, the Director of Internal Audit (DoIA) is required to provide an annual opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management, and approved by the Audit Committee, which can provide assurance covering:

- Financial systems,
- Digital, cyber security, and Information Governance,
- Performance and Board reporting systems,
- Processes to ensure service quality,
- Processes underpinning management of the workforce,
- Governance risk and legal compliance of statutory functions.

For 2025/26, the Head of Internal Audit opinion provides 'Substantial Assurance' that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently, demonstrating the good governance of the Trust.

That opinion was based on:

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

The Trust's external Anti-Fraud Specialist (AFS) Annual Report for 2025/26 confirmed that the overall rating for MWL was "green" against the Government Functional Standard 013 for Counter Fraud. This standard establishes a series of requirements for how the public bodies it applies to should manage anti-fraud, bribery and corruption, and a green rating demonstrates that the Trust meets those requirements.

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

The Trust's resources are managed within a financial governance framework that incorporates systems of financial control, budgetary control and the financial responsibilities for individuals outlined within the Trust's Corporate Governance Manual. Financial and quality governance arrangements incorporate benchmarking activities and an internal audit function to ensure the economic, efficient and effective use of resources, including value for money. Performance is monitored by the Trust's Board, with more detailed scrutiny taking place across committees and councils. The CIP Council met throughout 2025/26 and reported to the Finance and Performance Committee.

There are a range of measures and benchmarking tools used in the monitoring process which are specifically reviewed by the Finance and Performance Committee and support the development of improvement plans. Some benchmarking continued to be suspended nationally in 2025/26, for example, there has been a delay to the Model Hospital Weighted Activity Unit (WAU) being updated. Nevertheless, the Trust has continued to monitor its performance against prior year figures at all levels in the organisation. For example, the Trust's Procurement Steering Council continues to report performance data against past Model Hospital data to maintain control over unwarranted variation, and the Procurement team has continued to use the national Spend Comparison Service (SCS) and Advise Inc as leverage to reduce costs and for assurance as to prices paid.

The Trust is also part of the Cheshire & Merseyside procurement price benchmarking project to further aid reviews, drive improvements and gain assurance.

The Trust continues to provide payroll, pensions and employment services to Trusts across Cheshire and Merseyside and NHS clients in the South East of England and has Lead Employer contracts nationally for Resident Doctors and Dentists, providing value for money for the NHS and contributing to system wide efficiencies.

The Trust have appointed an external auditor, which followed the required procurement processes, and was approved by Audit Committee. The Trust's external auditor forms annual overall conclusions on whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. The auditor's findings for 2025/26 can be found in the Independent Auditor's Report to the Directors of Mersey and West Lancashire Teaching Hospitals NHS Trust within this Annual Report and Accounts which is published on the Trust's website.

3.3.6 Information Governance

Information Governance (IG) is the set of standards and processes for ensuring that organisations comply with the laws and regulations regarding handling and dealing with personal information. It provides a framework for employees to deal with the many different information handling requirements in line with Data Protection legislation. The Trust has clear policies and processes in place to ensure that information, including patient information, is handled legally, securely, efficiently, and effectively.

The Trust uses the Data Security and Protection Toolkit (DSPT) to benchmark and measure its IG and IT security controls, also known as the IG Assessment Report. All organisations that have access to personal information must provide assurances that they are practising good Information Governance and IT Security and use the DSPT to evidence this by the publication of annual assessments.

The DSPT is an online tool covering topics such as staff responsibilities, training, continuity planning, data breaches, detecting cyber security events. The DSPT transitioned in September 2024 from measuring performance against the National Data Guardian's 10 Data Security Standards to align with the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF). This CAF-aligned DSPT aims to improve data security by emphasising informed decision-making and understanding of information risks within healthcare organisations. This was the first major change to the DSPT since its introduction in 2018, changing the assessment significantly to focus on cyber security.

The new CAF-aligned DSPT is split into 47 contributing outcomes, each of which are supported by indicators of good practice, grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'. This is a move away from evidencing against 'assertions.'

To achieve 'standards met,' NHS organisations must meet the expected achievement level set by NHS England (who are responsible for the DSPT) for each outcome.

The Trust submitted the DSPT assessment at the end of June 2025 for the 2024/25 submission and was able to submit evidence items for all but one of the 'outcomes.' The Trust therefore submitted a "standards not met" rating.

As a result of significant changes to the DSPT, NHSE expected the majority of organisations would not be able to implement the required changes in time for the 2024/25 submission and therefore most would not achieve "standards met". The "standards not met" rating for 2024/25 is therefore not an indication of significant internal control issues at the Trust.

Mersey Internal Audit Agency (MIAA) audited a number of the outcomes and evidence items. In line with the 'standards not met' submission, the Trust received the rating of 'Moderate Assurance' against its DSPT, reflecting the one outcome that requires further evidence and assurance (MultiFactor Authentication).

Multi-Factor Authentication - Outcome not Achieved

Evidence required:

- Organisations must enforce Multi-Factor Authentication (MFA) on all remote user access to all systems.
- Organisations must enforce MFA on all privileged user access to externally hosted systems.
- Organisations should enforce MFA on all privileged user access to all other systems except as permitted in the 'Exceptions' section of the MFA policy.

At the time of the Trust's DSPT submission, an MFA Policy was not in place and therefore this outcome was not met. NHSE clarified the requirements for this outcome in May 2025 (following cyber-attacks at various NHS bodies other than MWL which compromised personal data and caused significant patient and clinical harm) which did not allow the Trust sufficient time to ensure there was a robust MFA Policy in place that had been reviewed and approved via the Trust's governance routes.

As required, when an organisation submits an assessment with the outcome of 'standards not met,' the Trust provided an Improvement Plan to NHSE, which was accepted and then moved the Trust to 'Approaching Standards' for the 2024/25 DSPT.

The Trust has assigned specific roles to ensure the Information Governance framework continues to be adhered to and remains fully embedded. The Director of Informatics is the Senior Information Risk Owner (SIRO) who is responsible for reviewing and reporting on the management of information risk to the Trust Board. The Trust has a Caldicott Guardian who is the designated individual responsible for ensuring confidentiality of personal information. In addition, the SIRO and Caldicott Guardian oversee the Information Governance Framework and there is an Information Governance Steering Group (IGSG), which is accountable to the Informatics Council and, ultimately, the Trust Board. Its main purpose is to support and drive the Information Governance agenda and provide the Board with the assurance that effective Information Governance best practice mechanisms are in place within the Trust.

There is also a requirement for a Data Protection Officer (DPO), who is responsible for monitoring internal compliance and informing and advising the Trust on data protection obligations, the Trust has an appointed DPO.

The Trust's Data Protection Officer, SIRO and Caldicott Guardian are appropriately qualified, trained, registered, and accredited.

The Trust has a duty to report any incident regarding breaches of the Data Protection Act to the Information Commissioner's Office (ICO) and for the financial year 2025/26 there was 1 reportable incident. The ICO were informed of the lessons learned and of the action plan the Trust had put in place at the time of the incident. To date no further actions have been received from the ICO. Other incidents that were reported throughout the year did not score highly and, therefore, no further escalation was required, and they were managed locally.

The results for the 2025/26 DSPT assessment is not available as the submission for the DSPT assessment for 2025/26 is required in June 2026 and the outcome will not be available before publication of the annual report is required.

3.3.7 Data quality

The Trust continues to be committed to ensuring accurate and up-to-date information is available to communicate effectively with others, such as General Practitioners, involved in delivering care to patients. High quality data is a vital pre-requisite in supporting the Trust to provide efficient, safe and effective care to patients, support better decision-making, service improvements and enable achievement of key performance indicators.

Data quality is fully embedded across the organisation, with robust governance arrangements in place to ensure the effective management of data processes. An example of this would be the weekly patient tracking list reviews by operational teams.

Data quality audits are also undertaken by MIAA across numerous operational teams across the Trust as part of their ongoing internal audit cycle. As part of the Elective Recovery Programme, the validation of the waiting lists now includes validations carried out by the operational and clinical teams.

There is a dedicated Data Quality team who have an agreed work plan to review key data streams and the audit outcomes support the Trust in reporting an accurate position for the national standards.

There are some national data quality reports routinely reported and monitored across the Trust, as follows:

- Waiting Times (National RTT Waiting List Data Quality Dashboards) – this provides transparency about the quality of the Trust's waiting list submissions.
- National Data Quality Dashboards (feeds into the Data Quality Maturity Index [DQMI]) – this provides transparency about the data quality for the following datasets:
 - Admitted Patient Care (APC)
 - Community Services (CSDS)
 - Emergency Care (ECDS)
 - Maternity Services (MSDS)
 - Outpatient (OP)

In addition, specific data items are monitored across the Trust to ensure accuracy and completeness, as follows:

- Blank/invalid NHS number
- Unknown or dummy practice codes
- Blank or invalid registered GP practice
- Patient postcode
- Waiting times

As part of the robust governance framework for data quality, a Data Quality Forum meeting takes place monthly and reports to the Information Steering Group (ISG).

The ISG meeting is a monthly group which provides a robust qualitative foundation for information management to support the clinical/management requirements of the Trust and reports into the Executive Team on a monthly basis.

Membership of the Data Quality Forum consists of representatives from individual departments across the Trust. The forum sets out to achieve improved data quality across the Trust and ensure compliance with the Quality Account and the Data Quality policy.

This will be achieved through:

- Standardisation of data entry auditing completed across departments
- Monitoring of the completion of data entry audits across departments
- Collation of evidence of audit completion and timely submission to the Quality Account
- Feedback on audit outcomes to members of the group
- Highlighting potential training areas to the relevant members of the group

3.3.8 Review of effectiveness

Effectiveness of the system of internal control

As Accountable 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 Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the audit committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Annual meeting effectiveness review

Each year, the Board and each of its committees undertakes an effectiveness review comprising of:

- A review by the Chair and lead Director
- A review of the meeting structure, membership, and reporting arrangements
- A review of attendance
- Feedback from members
- A review of the Terms of Reference and workplan

The conclusion of these reviews, reported to the Audit Committee, is to ensure that the purpose, remit and organisation of the Trust Board and its Committees remain appropriate and provides the necessary assurance that the Trust is effectively and appropriately managed.

The reviews for 2025/26 were undertaken between February and April 2026, and the findings reported to the individual committees and to the audit committee, and the reporting structure and Terms of Reference were reviewed by the Board in May 2026. The Board and all committees were assessed as remaining effective and fit for purpose.

3.3.9 Conclusion

No significant internal control issues have been identified or reported in the annual governance statement for 2025/26.

Annual Governance Statement signed by

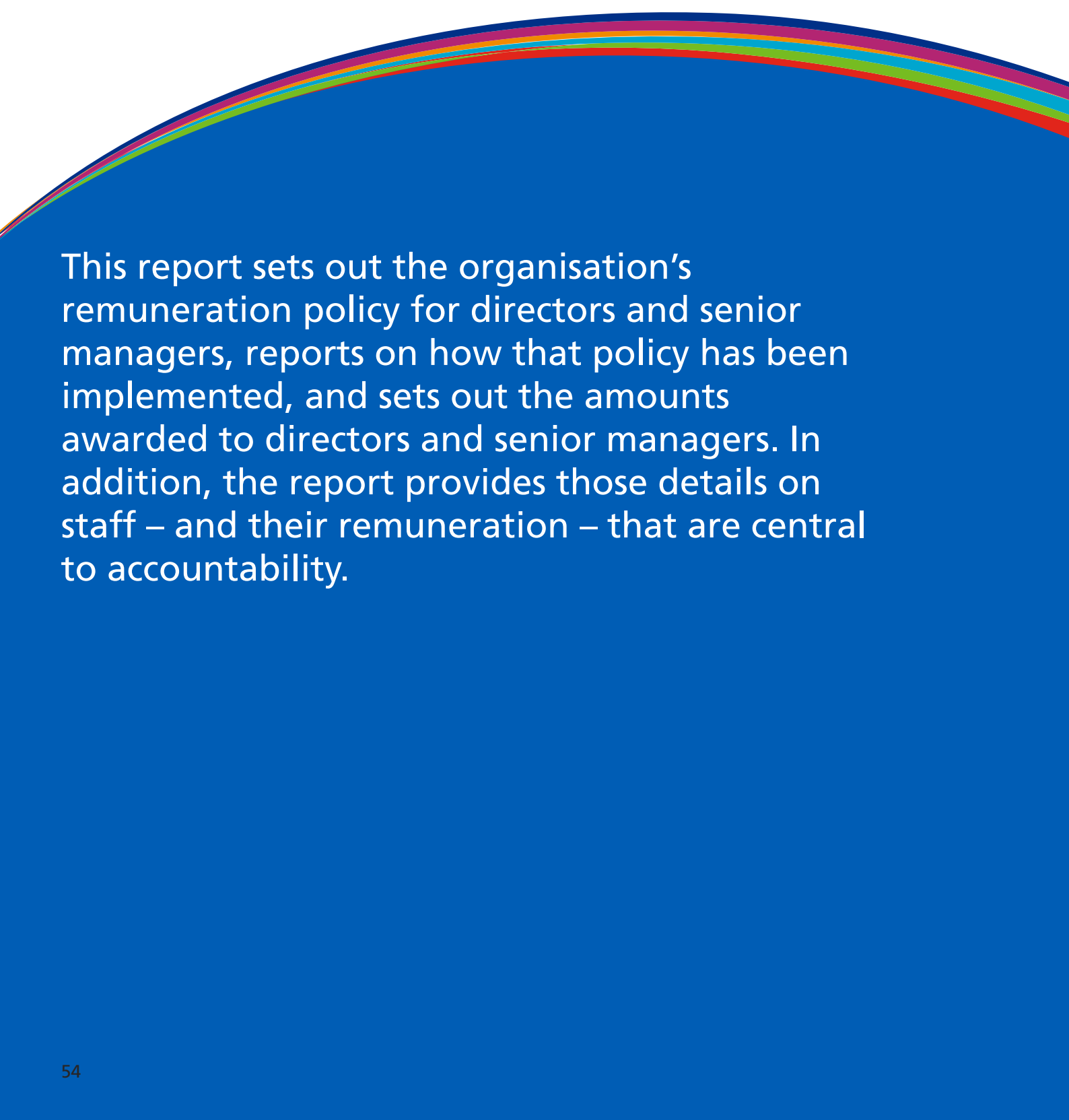
R Cooper

Rob Cooper
Chief Executive

24 June 2026



4. Remuneration and Staff Report



This report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented, and sets out the amounts awarded to directors and senior managers. In addition, the report provides those details on staff – and their remuneration – that are central to accountability.

4.1 The Trust's approach to its workforce and staffing

The Trust's People Plan 2025-2028 builds on previous successes and outlines the Trust's commitment to fostering a culture based on our values of kindness, inclusivity and openness where staff can thrive while delivering *5 Star Patient Care*. The plan is aligned with national NHS priorities, including the NHS Long Term Workforce Plan and the NHS People Promise, and focuses on four key ambitions:

- Fostering a Culture of Wellbeing and Support
- Developing an Inclusive and Diverse Workforce
- Embracing Innovation and Career Development
- Enhancing Workforce Planning and Partnerships

More information on the workforce safeguards is included in the Annual Governance Statement.

4.2 Staff composition and equality, diversity, and inclusion

At the end of 2025/26, the Trust directly employed over nine and a half thousand whole time equivalent (WTE) staff of which 42% were doctors and nurses, 31% were clinical support staff, and the remaining 27% were non-clinical support staff. 6,703 staff were full time employees and 4,506 were employed less than full time.

Turnover of staff across the year as a rolling average was 12.13%.

The number of senior managers employed by the Trust on 31 March 2026 was 62 (52.81 WTE) including all directors who attend the Trust Board and other senior managers at the Trust who have responsibility for controlling major activities and delivering statutory responsibilities. All senior managers are employed on NHS Agenda for Change (AfC), or the national Very Senior Manager (VSM) pay and contractual conditions. The senior manager calculation is based on those that report to a Director or are a Deputy Director, based on the NHS Digital definition.

The following table includes all staff on the Trust's payroll except for temporary staff (such as agency and bank staff), junior doctors in training recharged from other payrolls, and staff recharged from other organisations. This information is a snapshot rather than the average across the year and does not align to section 4.5.

The below includes Associate Non-Executive Directors and all Associate Executive Directors. Not all associate directors attend the Board.

Staff numbers (31st March 2026)	Male		Female		All staff	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
Non-executive directors	4	0.36	4	0.25	8	0.61
Directors	6	6	8	7.5	14	13.50
Other senior managers (AfC Bands 8D and above)	14	14	26	24.7	40	38.70
All other staff	2289	2151.98	8859	7582.41	11148	9734.39
TOTAL	2313	2172.34	8897	7614.86	11210	9787.20

79% of the total MWL workforce is female.

The Trust meets its obligations under equality, diversity, and human rights legislation through control measures, with appropriate policies as described in the Annual Governance Statement. This year the Trust adopted a new Anti-Racism Statement as part of its commitment to being proactively anti-racist as well as successfully achieving the North West Anti-Racism Framework (Bronze) award. The Trust continued to maintain existing membership of the Disability Confident Charter (Level 3 - Leader), the Armed Forces Covenant, Defence Employers Commitment (Gold), Veterans Aware, TUC Dying to Work Charter, NHS Sexual Safety Charter, and the NHS Rainbow Badge.

In the annual Equality Delivery System (EDS) assessment, the Trust received the overall score of "Achieving", as well as showing year on year improvements in the Workforce Disability Equality Standard (WDES), the Workforce Race Equality Standard (WRES) and the Gender Pay Gap. The annual analysis of the workforce profile showed year on year increases in the proportion of disabled; lesbian, gay, bisexual and other sexuality (LGBO); and ethnic minority staff. The reports of which are available on the Trust website as part of the publication scheme.

The Trust continues to support 7 staff networks (Armed Forces/Veterans, carers, disabled, ethnic minority, LGBTQIA+, menopause, and women) and has delivered a calendar of events, activities, and training to celebrate our community and help raise awareness of equality, diversity and inclusion in the workforce and for patients. This has included our first LGBTQIA+ Health Inequalities Conference, and the introduction of Active Bystander training, and Cultural Competence training, open to all staff.



4.3 Sickness absence

The Trust's 2025/26 sickness absence data is available from NHS Digital at the following link:

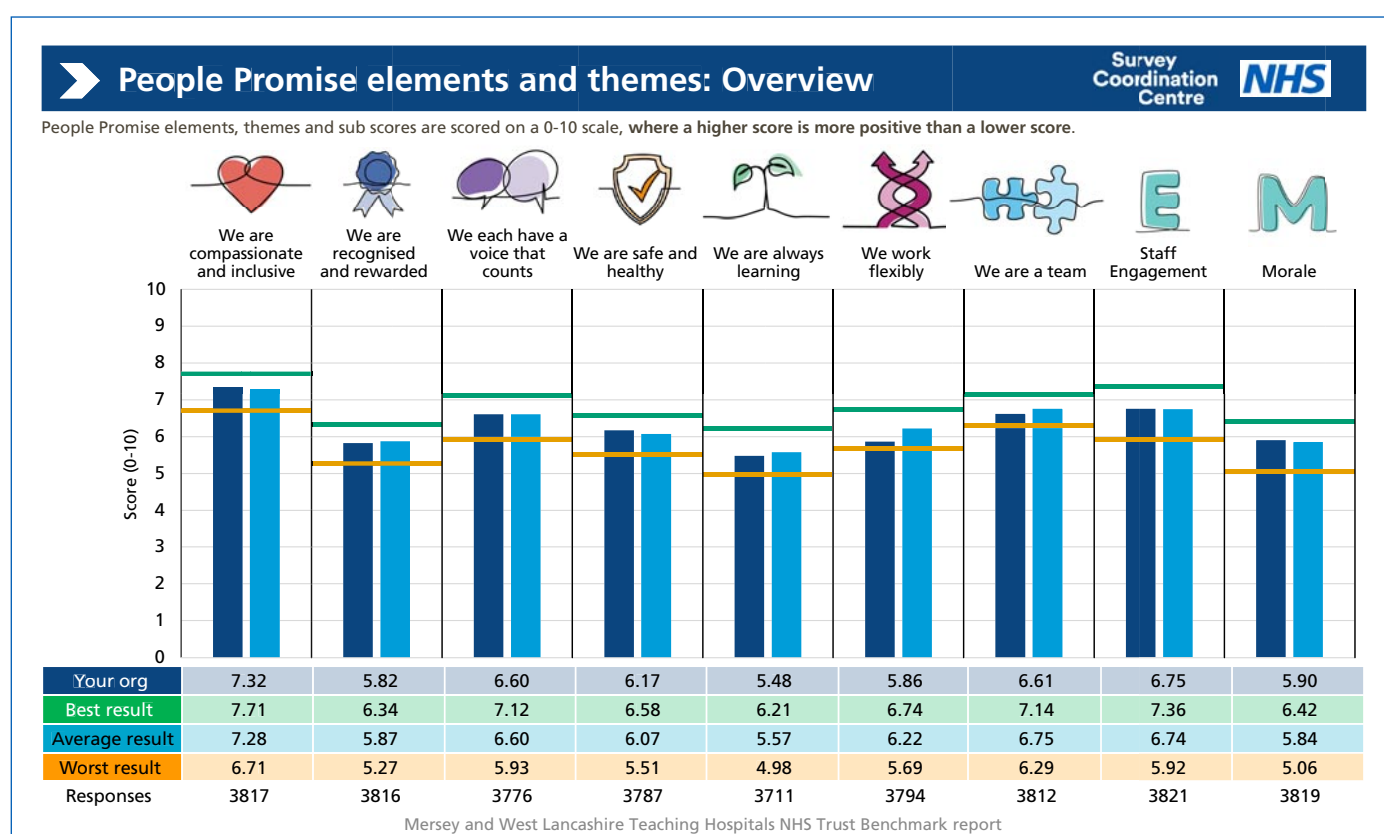
<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>

4.4 NHS Staff Survey 2025

A total of 3,855 staff responded (35% response rate) to the NHS Staff Survey for 2025, which was slightly lower than the previous year although this is in line with the national trend of lower response rates.

MWL performs above the national average in four People Promise themes, is average in one, and below average in four, with 'We Work Flexibly' notably underperforming against the national, regional, and local position. The Trust is compared nationally to a group of 121 Acute, and Acute & Community Trusts.

The table below shows an overview of NHS Staff Survey scores for each theme and element.



When looking at individual questions, staff remain extremely positive about the standard of care provided by the Trust ranking it as the top Acute Trust in the North West.

In response to the survey results, the Trust is adopting a new Theory of Change approach to define long-term improvements in culture, behaviour and staff experience, with a number of priority actions for 2026.

The full Staff Survey report and breakdown by staff groups are available on the NHS Staff Survey Website at the following link: <https://www.nhsstaffsurveys.com/results/local-results/>

More detailed analysis and action plan was presented to Trust Board in March 2026.

4.5 Staff costs and average employee numbers

Analysis of staff costs 2025/26

	Permanently employed £000	Other £000	Total £000
Salaries Salaries & Wages	474,225	49,764	523,989
Social Security Costs	58,882	-	58,882
Apprenticeship Levy	2,529	-	2,529
Employers Contributions to NHS Pensions	57,899	-	57,899
Pension cost – employer contributions paid by NHSE on provider's behalf	37,977	-	37,977
Pension cost – other	126	-	126
Temporary staff (including agency)	-	12,531	12,531
Total staff costs	631,638	62,295	693,933
Of which:			
Costs capitalised as part of assets	564	-	564

Average number of employees (WTE basis)

	Total 2025/26 No.	Permanent 2025/26 No.	Other 2025/26 No.
Medical and dental	1,334	1,222	112
Ambulance staff	-	-	-
Administration and estates	2,572	2,473	99
Healthcare assistants and other support staff	1,717	1,354	363
Nursing, midwifery and health visiting staff	3,349	3,149	200
Nursing, midwifery and health visiting learners	-	-	-
Scientific, therapeutic and technical staff	1,473	1,433	40
Healthcare science staff	196	194	3
Social care staff	4	4	-
Other	-	-	-
Total average numbers	10,646	9,829	817
Of which:			
Number of employees (WTE) engaged on capital projects	27	27	0

Both tables are subject to audit.

Staff on outward secondment are not included in the average number of employees. Non-Executive directors are excluded from this table.

4.6 Off-payroll engagement

Under HM Treasury guidance, the Trust is required to disclose information about off-payroll engagements at a cost of more than £245 per day and that last for more than six months, as follows.

Total number of existing engagements as of 31st March 2025	2
Of which.....	
Number that have existed for less than one year	0
Number that have existed for between 1 and 2 years	0
Number that have existed for between 2 and 3 years	0
Number that have existed for between 3 and 4 years	0
Number that have existed for 4 years or more	2

Total number of new engagements, or those that reached six months in duration, between 1 April 2025 and 31 March 2026	0
Of which...	
Number assessed as <i>within the scope of</i> IR35	0
Number assessed as not <i>within the scope of</i> IR35	0
Number engaged directly (via PSC contracted to the Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Total number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year including on payroll and off-payroll engagements	26
Of which...	
Number of off-payroll engagements of 'board members, and/or senior officers with significant financial responsibility', during the financial year	0

4.7 Senior managers' remuneration policy

The definition of 'senior managers' for the purpose of the following disclosures, according to the Department of Health and Social Care Group Accounting Manual (GAM) 2025/26, is those staff with *'authority or responsibility for directing or controlling major activities within the group body. This means those who influence the decisions of the entity as a whole, rather than the decisions of individual directorates or departments'*. The Chief Executive has confirmed that, in this context, the Trust's voting executive directors and certain high-level senior officers, together with the Non-Executive Directors, are its 'senior managers'.

The level of remuneration paid to the Chairs and Non-Executive directors of NHS trusts is set by the Secretary of State for Health. Executive directors of the Trust are employed on contracts of service and are substantive members of the Trust. The Chief Executive post is a standard NHS contract with no time element included and is reviewed by the Trust's Remuneration Committee on an annual basis.

The Chief Executive and other Executive Directors' posts are subject to national competition if they become vacant. The Directors' VSM contracts can be terminated by either party with up to six months' notice. The Trust's disciplinary policies apply to Executive Directors, including the sanction of summary dismissal for gross misconduct.

No senior manager is entitled to severance payments or termination payments beyond those accruing for redundancy, in line with Trust policy, or for pay in lieu of notice. The Remuneration Committee has no plans to introduce incentive payments or rewards to Executive Directors, unless this becomes national policy. Pay awards are made in line with DHSC guidance, and the Remuneration Committee reviews the remuneration of Executive Directors on a regular basis, using a variety of benchmarking tools and a robust performance appraisal process.

The Trust confirms that it has complied with the remuneration framework and VSM pay framework. Where national approval was required for a pay case during the reporting year (following the introduction of the new VSM pay framework), the organisation confirms that such approval was both sought and obtained.

4.8 Further remuneration disclosures which are subject to audit

The remaining disclosures are subject to audit.

4.8.1 Salaries and benefits of the Trust's senior managers

Salaries and benefits of senior managers

	2025/26				2024/25			
	Salary & fees (in bands of £5,000) £000	Taxable benefits (to the nearest £100) £	Pension-related benefits (in bands of £2,500) £000	Total (in bands of £5,000) £000	Salary & fees (in bands of £5,000) £000	Taxable benefits (to the nearest £100) £	Pension-related benefits (in bands of £2,500) £000	Total (in bands of £5,000) £000
Steve Rumbelow Chair (Started 1/5/25)	55 - 60	1,400	n/a	55 - 60				
Richard Fraser Chair (Finished 30/4/25)	0 - 5	0	n/a	0 - 5	50 - 55	0	n/a	50 - 55
Rob Cooper Chief Executive Officer (from 1/12/24), previously Managing Director, Strategy and Operations	210 - 215	0	195 - 197.5	405 - 410	175 - 180	0	135 - 137.5	310 - 315
Ann Marr OBE Chief Executive (Retired from post 30/11/24)					140 - 145	0	n/a	140 - 145
Anne-Marie Stretch Deputy CEO	105 - 110	0	0	105 - 110	120 - 125	0	0	120 - 125
Gareth Lawrence Chief Finance Officer	175 - 180	0	745 - 747.5	920 - 925	150 - 155	0	0	150 - 155
Dr Simon Dowson ¹ Chief Medical Officer (Started 10/11/25)	80 - 85	0	57.5 - 60	140 - 145				
Dr Ash Bassi ² Interim Chief Medical Officer (1/8/25 to 31/10/25)	70 - 75	0	17.5 - 20	85 - 90				
Dr Peter Williams ³ Chief Medical Officer (Left post on 31/7/25)	80 - 85	0	0	80 - 85	230 - 235	0	110 - 112.5	345 - 350
Professor Sarah O'Brien Chief Nursing Officer (Started 30/6/25)	125 - 130	0	135 - 137.5	260 - 265				
Lynne Barnes Acting Chief Nursing Officer (ended 29/6/25)	30 - 35	0	0	30 - 35	125 - 130	0	110 - 112.5	240 - 245

	2025/26				2024/25			
	Salary & fees (in bands of £5,000) £000	Taxable benefits (to the nearest £100) £	Pension-related benefits (in bands of £2,500) £000	Total (in bands of £5,000) £000	Salary & fees (in bands of £5,000) £000	Taxable benefits (to the nearest £100) £	Pension-related benefits (in bands of £2,500) £000	Total (in bands of £5,000) £000
Sue Redfern Director of Nursing, Midwifery and Governance (Left post 30/11/24)					65 - 70	0	n/a	65 - 70
Malise Szpakowska Chief People Officer (from 1/4/25), previously Acting Chief People Officer	135 - 140	0	32.5 - 35	170 - 175	100 - 105	0	27.5 - 30	130 - 135
Nicola Bunce Director of Corporate Services (Retired 31/3/26)	130 - 135	0	0	130 - 135	110 - 115	0	0	110 - 115
Dr Kate Clark Director of Strategy	200 - 205	0	30 - 32.5	230 - 235	200 - 205	0	53.5 - 55	250 - 255
Lesley Neary Chief Operating Officer	150 - 155	0	25 - 27.5	175 - 180	130 - 135	0	n/a	130 - 135
Malcolm Gandy Director of Informatics (from 2/4/24)	145 - 150	0	0	145 - 150	135 - 140	0	247.5 - 250	385 - 390
Dr Khalid Anis Associate Non-Executive Director (from 1/1/26)	0 - 5	0	n/a	0 - 5				
Geoffrey Appleton Non-Executive Director (Deputy Chair) (Left June 2024)					0 - 5	0	n/a	0 - 5
Gill Brown Non-Executive Director	15 - 20	200	n/a	15 - 20	10 - 15	0	n/a	10 - 15
Ian Clayton Non-Executive Director (RIP November 2024)					5 - 10	0	n/a	5 - 10
Stephen Connor Non-Executive Director (from February 2024)	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
Claudette Elliot Non-Executive Director (from 1/4/25 to 31/12/25)	5 - 10	0	n/a	5 - 10				
Neil Fletcher Associate Non-Executive Director (from 1/4/25)	10 - 15	500	n/a	10 - 15				

	2025/26				2024/25			
	Salary & fees (in bands of £5,000) £000	Taxable benefits (to the nearest £100) £	Pension-related benefits (in bands of £2,500) £000	Total (in bands of £5,000) £000	Salary & fees (in bands of £5,000) £000	Taxable benefits (to the nearest £100) £	Pension-related benefits (in bands of £2,500) £000	Total (in bands of £5,000) £000
Dr Neil French ⁴ Non-Executive Director (from 1/2/26)	0 - 5	0	n/a	0 - 5				
Lisa Knight Non-Executive Director	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
Professor Hazel Scott ⁴ Non-Executive Director (Left 30/9/25)	5 - 10	0	n/a	5 - 10	10 - 15	0	n/a	10 - 15
Professor Minal Singh Non-Executive Director (Started 9/3/26)	0 - 5	0	n/a	0 - 5				
Carole Spencer Associate Non-Executive Director (from 1/5/24 to 31/7/24) and Non-Executive Director (from 1/8/24)	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
Rani Thind Associate Non-Executive Director (Left 30/9/25)	5 - 10	0	n/a	5 - 10	10 - 15	0	n/a	10 - 15

General Notes:

¹ Some individuals were affected in the prior year by the Public Service Pensions Remedy where their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.

² Negative values are not disclosed in this table but are substituted with a zero.

Specific Notes:

¹ The element of this salary that relates to his role as Board Director falls in the range £15k - £20k

² The element of his salary that relates to his role as Board Director falls in the range £0k - £5k

³ The element of his salary that relates to his role as Board Director falls in the range £30k - £35k (2024/25) and £10k - £15k (2025/26)

⁴ Nominated by the University of Liverpool

Unless otherwise indicated, all the senior managers in the table were in post for the twelve-month period to 31 March 2026. In this section, remuneration is included only for the period during which each individual was deemed to be a senior manager and includes remuneration for duties that are not specifically part of their 'senior manager' role.

Taxable benefits relate to expenses reimbursed to the senior managers that are potentially within scope for taxation and are assessed and processed by the Trust's payroll function. No annual performance-related bonuses or long-term performance-related bonuses were paid during the period.

Pension-related benefits relate wholly to NHS Pensions schemes. They are calculated using a national standard formula and reflect the real increase in pension at retirement age (depending on the scheme) within the year multiplied by a valuation factor of 20. This may be added to the real increase in lump sum, depending on the scheme. The resultant figure represents an estimate of the lifetime benefit of the annual increase. These figures exclude the estimated impact of the employee's own contributions.

No exit packages have been agreed or paid relating to 'senior managers'. No payments were made to past senior managers, other than those related to ongoing employment in other roles, where applicable.

The table on the following page shows the pension benefits of those senior managers in receipt of such benefits. Non-Executive directors do not receive pensionable remuneration. All pension benefits relate to NHS Pensions.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).



Pension benefits of senior managers

	2025/26						
	(a) £000	(b) £000	(c) £000	(d) £000	(e) £000	(f) £000	(g) £000
Rob Cooper Chief Executive Officer (from 1/12/24), previously Managing Director, Strategy and Operations	10 - 12.5	17.5 - 20	50 - 55	130 - 135	873	181	1,093
Anne-Marie Stretch Deputy CEO	0	0	0	0	2,145	0	0
Gareth Lawrence ⁷ Chief Finance Officer	32.5 - 35	82.5 - 85	30 - 35	80 - 85	0	656	672
Dr Simon Dowson ⁶ Chief Medical Officer (Started 10/11/25)	2.5 - 5	5 - 7.5	55 - 60	135 - 140	1,018	59	1,213
Dr Ash Bassi ⁶ Interim Chief Medical Officer (1/8/25 to 31/10/25)	0 - 2.5	0 - 2.5	60 - 65	145 - 150	1,264	20	1,388
Dr Peter Williams ⁶ Chief Medical Officer (Left post on 31/7/25)	0	0	55 - 60	135 - 140	1,257	0	1,222
Professor Sarah O'Brien ⁶ Chief Nursing Officer (Started 30/6/25)	5 - 7.5	12.5 - 15	75 - 80	190 - 195	1,502	146	1,742
Lynne Barnes ⁶ Acting Chief Nursing Officer (from 19/4/24 to 29/6/25)	0	0	35 - 40	85 - 90	831	0	813
Malise Szpakowska Chief People Officer (from 1/4/25), previously Acting Chief People Officer	2.5 - 5	0	10- 15	0	115	15	148
Nicola Bunce Director of Corporate Services (Retired 31/3/26)	0	0	0	0	0	0	0
Dr Kate Clark Director of Strategy	2.5 - 5	0	70 - 75	170 - 175	1,498	38	1,585
Malcolm Gandy Director of Informatics (from 2 April 2024)	0 - 2.5	0	45 - 50	105 - 110	1,027	0	1,060
Lesley Neary ⁸ Chief Operating Officer	0 - 2.5	0	0 - 5	0	0	16	29

(a) Real increase in pension at pension age (bands of £2,500)

(b) Real increase in pension lump sum at pension age (bands of £2,500)

(c) Total accrued pension at pension age on 31 March 2026 (bands of £5,000)

(d) Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)

(e) Cash equivalent transfer value (CETV) at 1 April 2025 (to the nearest £1,000)

(f) Real increase in CETV (to the nearest £1,000)

(g) CETV at 31 March 2026 (to the nearest £1,000)

	2024/25						
	(a) £000	(b) £000	(c) £000	(d) £000	(e) £000	(f) £000	(g) £000
Rob Cooper Chief Executive Officer (from 1/12/24), previously Managing Director, Strategy and Operations	5 - 7.5	10 - 12.5	40 - 45	110 - 115	685	122	873
Anne-Marie Stretch Deputy CEO	0	0	80 - 85	230 - 235	2,138	0	2,145
Gareth Lawrence ⁷ Chief Finance Officer	0	0	0	0	436	0	0
Dr Simon Dowson ⁶ Chief Medical Officer (Started 10/11/25)							
Dr Ash Bassi ⁶ Interim Chief Medical Officer (1/8/25 to 31/10/25)							
Dr Peter Williams ⁶ Chief Medical Officer (Left post on 31/7/25)	5 - 7.5	7.5 - 10	55 - 60	150 - 155	1,056	109	1,257
Professor Sarah O'Brien ⁶ Chief Nursing Officer (Started 30/6/25)							
Lynne Barnes ⁶ Acting Chief Nursing Officer (from 19/4/24 to 29/6/25)	5 - 7.5	7.5 - 10	35 - 40	95 - 100	661	103	831
Malise Szpakowska Chief People Officer (from 1/4/25), previously Acting Chief People Officer	0 - 2.5	0	5 - 10	0	80	13	115
Nicola Bunce Director of Corporate Services (Retired 31/3/26)	0	0	55 - 60	160 - 165	1,484	0	0
Dr Kate Clark Director of Strategy	2.5 - 5	0 - 2.5	65 - 70	170 - 175	1,330	55	1,498
Malcolm Gandy Director of Informatics (from 2 April 2024)	10 - 12.5	27.5 - 30	40 - 45	110 - 115	700	262	1,027
Lesley Neary ⁸ Chief Operating Officer							

- (a) Real increase in pension at pension age (bands of £2,500)
(b) Real increase in pension lump sum at pension age (bands of £2,500)
(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000)
(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)
(e) Cash equivalent transfer value (CETV) at 1 April 2024 (to the nearest £1,000)
(f) Real increase in CETV (to the nearest £1,000)
(g) CETV at 31 March 2025 (to the nearest £1,000)

Notes:

- CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 30th June 2023.
- Some individuals were affected in the prior year by the Public Service Pensions Remedy where their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.
- Negative values are not disclosed in this table but are substituted with a zero.
- For Pension scheme members over the national retirement age, or no longer contributing, a CETV calculation is not applicable.
- Pension scheme members benefits are not split by the NHS Pension agency in staff sharing arrangements. Hence, full accrued the full accrued benefit would be shown.
- The real increase in pensions (a), lump sum (b) and CETV (f) here represent a proportion of the full year value in the prior year given they were Board Directors for part of that year.
- Opted out of the NHS Pension Scheme at the end of June 2023 and rejoined the scheme on 1st June 2025.
- Chose not to be covered by the pension arrangements during the prior year but joined the scheme on 1st June 2025.
- The Trust does not make any contributions to personal stakeholder pensions.

4.8.2 Exit packages

NHS trusts are required to disclose summary information of the full costs of staff exit packages which have been agreed in the year. This is subject to audit.

Staff Exit packages

Exit package cost band	2025/26 Number of compulsory redundancies Number	2025/26 Cost of compulsory redundancies £	2025/26 Number of other departures Number	2025/26 2024/25 Cost of departures £	2025/26 Total number of exit packages Number	2025/26 Total cost of exit packages £
< £10,000			27	90,909	27	90,909
£10,001 - £25,000			3	34,649	3	34,649
£25,001 - £50,000			5	152,142	5	152,142
£50,001 - £100,000			3	189,967	3	189,967
TOTAL	0	0	38	467,666	38	467,666

Exit package cost band	2024/25 Number of compulsory redundancies Number	2024/25 Cost of compulsory redundancies £	2024/25 Number of other departures Number	2024/25 2024/25 Cost of departures £	2024/25 Total number of exit packages Number	2024/25 Total cost of exit packages £
< £10,000			13	28,160	13	28,160
£10,001 - £25,000						
£25,001 - £50,000						
TOTAL	0	0	13	28,160	13	28,160

Exit packages: non-compulsory 'other departure' payments

	2025/26 Agreements Number	2025/26 Total value of agreements £000	2024/25 Agreements Number	2024/25 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	3	59	0	0
Mutually agreed resignations (MARS) contractual costs	9	311	0	0
Contractual payments in lieu of notice	26	98	13	28

No non-contractual exit packages, which require HM Treasury pre-approval, were made in either 2024/25 or 2025/26.

4.9 Fair Pay Disclosures

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation against the 25th percentile, median (50th percentile) and 75th percentile remuneration of the organisation's workforce. In this context, the median is defined as the total remuneration of the staff member who lies in the middle of the linear distribution of staff, excluding the highest paid Director. The highest paid Director is, at 31st March, a 'senior manager' as defined previously in 4.5 Senior managers' remuneration policy.

The banded remuneration of the Trust's highest paid Director, the Chief Executive in the financial year 2025/26 (2024/25 Medical Director) was £210,000 to £215,000 (2024/25 £230k to £235k MD). Based on the midpoint of the band, this was 5.49 times (2024/25 6.36 times) the median remuneration of the workforce, which was £38,682 (2024/25 £36,573).

There was a 100% decrease in performance pay and bonuses (2024/25 96% increase) change from the previous financial year in respect of the highest paid director.

In 2025/26, 49 employees received remuneration in excess of the highest paid Director (2024/25, 26 employees). Their remuneration in 2025/26 ranged from £327,552 to £212,843. These employees are members of the medical workforce, and the pay figures do not reflect actual paid salary, but rather, the calculated annualised, full-time equivalent salary as described below.

2025/26 calculations exclude Non-Executive Directors as per the GAM guidance, previous years calculations have included them as per guidance.

There was a 9% decrease (2024/25 2% increase) change from the previous financial year in respect of the highest paid Director in the mid-point of the remuneration band.

There was an average 5% increase (2024/25 15%) change from the previous financial year in respect of total remuneration of the employees, taken as a whole. The total remuneration for all employees on an annualised basis, excluding the highest paid Director, divided by the full-time equivalent (FTE) number of employees (also excluding the highest paid Director).

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

In this Fair Pay section, remuneration figures are based on the annualised, full time equivalent remuneration at 31st March 2026, and they therefore may vary from actual annual pay per individual.

The reduction in the median total is driven by the national Agenda for Change pay deal, the calculation of average payments of overtime and pay during annual leave under agenda for change terms and conditions section 13.9 and corrective payments.

The relationship to the separate ratios (25th percentile, median and 75th percentile) for the total staff remuneration against the mid-point of the banded remuneration of the highest paid director, is disclosed in the below tables:

25-26	25th Percentile	Median	75th Percentile
Total Remuneration	£29,043	£38,682	£51,273
Salary Component of Total Remuneration	£26,598	£38,682	£44,439
Pay Ratio Information Remuneration	7.32:1	5.49:1	4.14:1
Pay Ratio Salary Component	7.99:1	5.49:1	4.78:1

24-25	25th Percentile	Median	75th Percentile
Total Remuneration	£27,298	£36,573	£49,256
Salary Component of Total Remuneration	£23,615	£36,483	£48,526
Pay Ratio Information Remuneration	8.52:1	6.36:1	4.72:1
Pay Ratio Salary Component	9.85:1	6.37:1	4.79:1

Accountability Report signed by

R Cooper

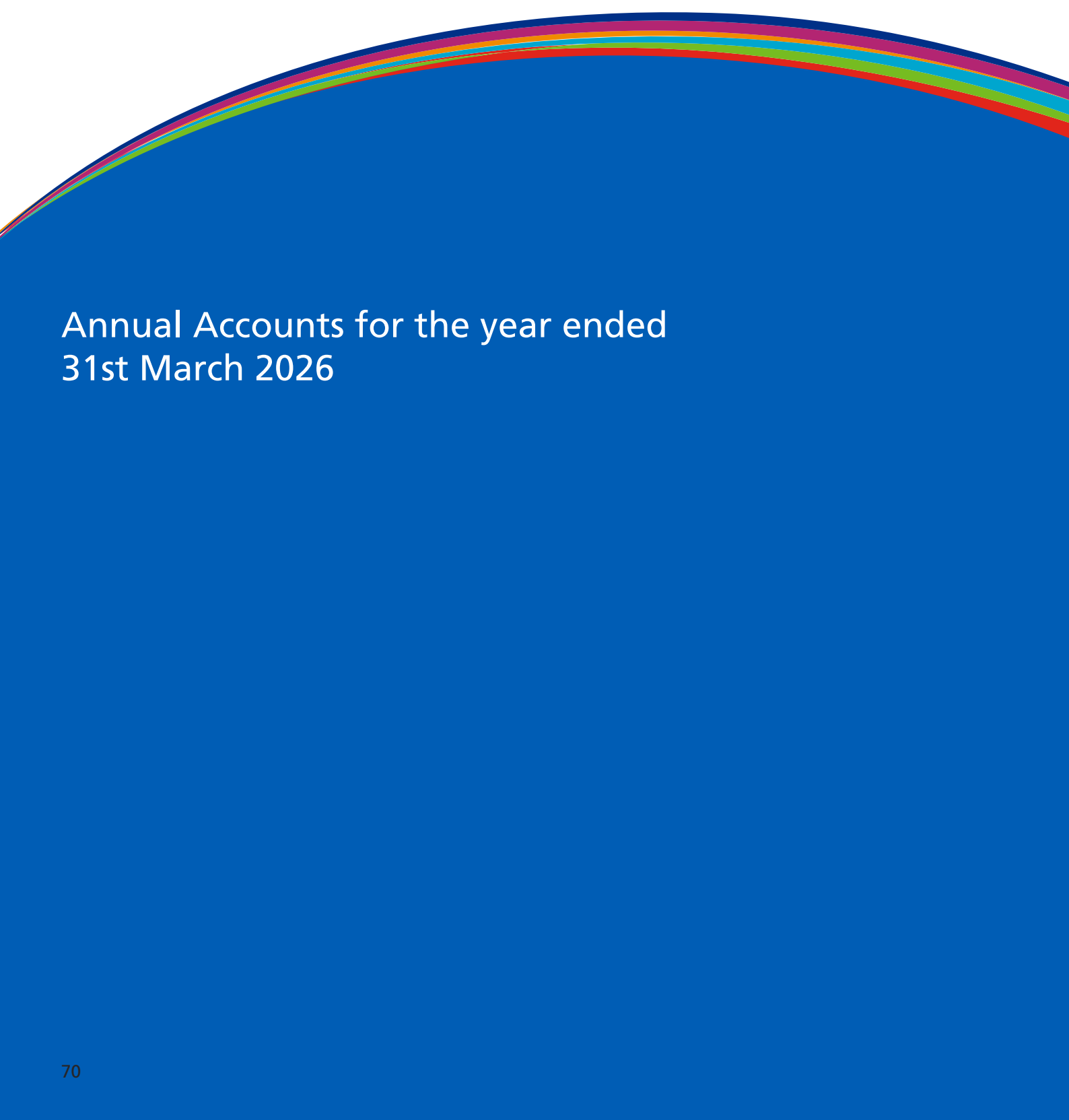
Rob Cooper
Chief Executive

24 June 2026



Section 3 - Annual Accounts 2025/26

5. Annual Accounts



Annual Accounts for the year ended
31st March 2026

5.1 Statement of the director's responsibilities in respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the Directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts. The Directors 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 trust's performance, business model and strategy.

By order of the Board, signed by



Rob Cooper
Chief Executive

Date 24 June 2026



Gareth Lawrence
Director of Finance & Information

Date 24 June 2026

5.2 Independent auditor's report

Independent auditor's report to the directors of Mersey and West Lancashire Teaching Hospitals NHS Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Mersey And West Lancashire Teaching Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2026, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, the Notes to the Accounts, including Accounting policies and other information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusion relating to going concern

We are responsible for concluding on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust.

In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of directors

As explained more fully in the Statement of directors' responsibilities in respect of the accounts, the directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the Trust's policies and procedures relating to:
 - the identification, evaluation and compliance with laws and regulations;
 - the detection and response to the risks of fraud; and
 - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of improper revenue recognition within other operating income and improper expenditure recognition in non-pay variable expenditure management where risks were not rebutted. We determined that the principal risks were in relation to:
 - management override of controls through inappropriate journal entry;
 - variable 'other operating' income outside of fixed contracts; and
 - variable non-pay expenditure.
- Our audit procedures involved:
 - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
 - journal entry testing, with a focus on year end and post year-end journals; material journals across the year; year-end and post year-end adjustments to income and expenditure; self-approved journals and journals posted by senior management
 - challenging assumptions and judgements made by management in its significant accounting estimates in respect of manipulation of income and expenditure that are variable
 - sample testing of other operating income, and non-pay expenditure to supporting evidence
 - testing and receipts and payments after the year-end to confirm income and expenditure had been accounted for in the correct period
 - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the risks relating to management override of controls and the risk of fraud in revenue and expenditure recognition. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
 - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
 - knowledge of the health sector and economy in which the Trust operates
 - understanding of the legal and regulatory requirements specific to the Trust including:
 - the provisions of the applicable legislation
 - NHS England's rules and related guidance
 - The applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
 - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
 - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – 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 to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust, the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(2A)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Mersey and West Lancashire Teaching Hospitals NHS Trust for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's directors 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 Trust and the Trust's directors as a body, for our audit work, for this report, or for the opinions we have formed.

Michael Green

Michael Green, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
Manchester
24 June 2026

5.3 Annual Accounts for the year ended 31st March 2026

Annual Accounts 2025-26

5.3.1 Statement of Comprehensive Income (SoCI)

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	3	914,393	879,856
Other operating income	4	106,719	120,299
Operating expenses	6, 8	(1,051,781)	(1,012,071)
Operating surplus/(deficit) from continuing operations		<u>(30,669)</u>	<u>(11,916)</u>
Finance income	10	3,717	4,635
Finance expenses	11	(33,131)	(40,804)
Net finance costs		<u>(29,414)</u>	<u>(36,169)</u>
Surplus / (deficit) for the year from continuing operations		<u>(60,083)</u>	<u>(48,085)</u>
Surplus / (deficit) for the year		<u>(60,083)</u>	<u>(48,085)</u>
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(10,939)	(3,218)
Revaluations	15	5,227	3,251
Total other comprehensive income for the period		<u>(5,712)</u>	<u>33</u>
Total comprehensive income / (expense) for the period		<u>(65,795)</u>	<u>(48,052)</u>

5.3.2 Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	12	21,577	21,396
Property, plant and equipment	13	412,182	441,768
Right of use assets	16	28,062	33,749
Receivables	18	25,771	21,738
Total non-current assets		487,592	518,651
Current assets			
Inventories	17	9,615	8,365
Receivables	18	87,599	83,337
Cash and cash equivalents	19	22,800	10,187
Total current assets		120,014	101,889
Current liabilities			
Trade and other payables	20	(63,143)	(73,171)
Borrowings	22	(25,690)	(19,606)
Provisions	23	(763)	(896)
Other liabilities	21	(8,002)	(7,853)
Total current liabilities		(97,598)	(101,526)
Total assets less current liabilities		510,008	519,014
Non-current liabilities			
Borrowings	22	(461,650)	(468,711)
Provisions	23	(4,170)	(4,870)
Total non-current liabilities		(465,820)	(473,581)
Total assets employed		44,188	45,433
Financed by			
Public dividend capital		398,168	333,618
Revaluation reserve		22,812	28,524
Income and expenditure reserve		(376,792)	(316,709)
Total taxpayers' equity		44,188	45,433

The notes on subsequent pages form part of these accounts.

Accounts signed by:

R Cooper

Rob Cooper
Chief Executive

Date 24 June 2026

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2025				
- brought forward	333,618	28,524	(316,709)	45,433
Surplus/(deficit) for the year	-	-	(60,083)	(60,083)
Impairments	-	(10,939)	-	(10,939)
Revaluations	-	5,227	-	5,227
Public dividend capital received	64,550	-	-	64,550
Taxpayers' equity at 31 March 2026	398,168	22,812	(376,792)	44,188

5.3.4 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				
- brought forward	297,140	28,491	(268,624)	57,007
Surplus/(deficit) for the year	-	-	(48,085)	(48,085)
Impairments	-	(3,218)	-	(3,218)
Revaluations	-	3,251	-	3,251
Public dividend capital received	36,478	-	-	36,478
Taxpayers' equity at 31 March 2025	333,618	28,524	(316,709)	45,433

5.3.5 Information on reserves

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 trust, is payable to the Department of Health as the public dividend 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 trust.

5.3.6 Statement of Cash Flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(30,669)	(11,916)
Non-cash income and expense:			
Depreciation and amortisation	6.1	31,649	32,667
Net impairments	7	52,372	28,083
Income recognised in respect of capital donations	4	(72)	(301)
(Increase) / decrease in receivables and other assets		(5,827)	(12,659)
(Increase) / decrease in inventories		(1,250)	1,089
Increase / (decrease) in payables and other liabilities		(14,630)	(12,728)
Increase / (decrease) in provisions		(843)	784
Net cash flows from / (used in) operating activities		30,730	25,019
Cash flows from investing activities			
Interest received		3,673	4,634
Purchase of intangible assets		(3,914)	(13,998)
Purchase of PPE and investment property		(44,168)	(31,698)
Receipt of cash donations to purchase assets		72	301
Net cash flows from / (used in) investing activities		(44,337)	(40,761)
Cash flows from financing activities			
Public dividend capital received		64,550	36,478
Movement on other loans		-	(211)
Capital element of lease rental payments		(6,266)	(6,501)
Capital element of PFI, LIFT and other service concession payments		(14,694)	(11,129)
Interest paid on lease liability repayments		(522)	(570)
Interest paid on PFI, LIFT and other service concession obligations		(16,848)	(16,796)
Net cash flows from / (used in) financing activities		26,220	1,271
Increase / (decrease) in cash and cash equivalents		12,613	(14,471)
Cash and cash equivalents at 1 April - brought forward		10,187	24,658
Cash and cash equivalents at 31 March	19.1	22,800	10,187



5.3.7 Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the 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.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 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.

Note 1.3 Interests in other entities

The Trust is the corporate trustee of MWL NHS Charity. It has assessed its relationship with the Charity and determined them to be subsidiaries, as it has the power to realise economic returns and other benefits from the Charity. The Trust has reviewed the value of the Charity's' fund balances at 31 March 2026 and does not consider these to be material to the Trust. Consequently, consolidated financial statements, incorporating the accounts of both the Trust and the Charity ('group accounts') have not been prepared for the year ended 31 March 2026.

Note 1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions which create a risk of material uncertainty. These judgements, estimates and assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates, and underlying assumptions are regularly reviewed. Revisions to estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of revision and future periods if the revision affects both current and future periods.

Critical accounting judgements

Listed below are areas where management has made judgements, apart from those involving estimations, in the process of applying the Trust's accounting policies, which are deemed most significant to the amounts recognised in the financial statements:

Segmental Reporting

IFRS 8 Operating Segments requires additional annual accounts disclosures for certain significant business streams ('reportable segments') which engage in distinct business activities and whose operating results are regularly and separately reviewed by the entity's 'chief operating decision maker' (CODM). As the Trust's CODM, the Trust's Board of Directors does regularly review the performance of the Trust's operational Care Groups, whilst reviewing the financial position of the Trust as a whole, in its decision-making framework. However, these Care Groups are not judged to comprise distinct reportable segments, as they share similar economic characteristics, having similar locations, outputs and customers, and operating within the same funding and regulatory environment. At an operational level, the workforce is flexibly deployed and assets are shared across the divisions in providing services and delivering the Trust's objectives. The accompanying financial statements have consequently been prepared under one single reporting segment, that is, 'the provision of acute healthcare'.

Asset Valuation

There are two further critical areas of judgement relating to the Trust's land and building ('estate') assets which may materially affect the financial statements:

The GAM requires that the valuation of the Trust's specialised buildings is based on a modern equivalent asset (MEA) with the same productive capacity as the property being valued. As in recent years, the Trust has opted to interpret the MEA basis as pertaining to two single combined hospital facilities ('single alternative site model'), one covering the traditional Whiston and St Helens boundaries and the other covering Southport and Ormskirk traditional boundaries and this fundamentally affects valuation processes, generally reducing floor space and asset carrying values.

The Trust's PFI assets are valued at depreciated replacement cost. For the former St Helens and Knowsley estate, these exclude VAT, consistent with previous years. This critical judgement to exclude VAT arises because any re-provision of service would involve a similar PFI arrangement, for which VAT would be recoverable. Recoverable VAT on the net book value of the PFI estate would be approximately £48.7m.

Key source of estimation uncertainty

The following is a key source of estimation uncertainty at the end of the reporting period that presents significant risk of causing a material adjustment to the carrying amount of assets or liabilities within the next financial year:

Asset Valuation

The total balance of intangible and tangible fixed assets and right of use assets as at 31 March 2026 is £461.8m, of which £349.2m relates to revalued estate assets.

Where non-estate assets are of low value and/or have short useful economic lives, such as operational equipment, they are carried at depreciated historical cost (cost less any accumulated depreciation) as this is not considered to be materially different from fair value. The lives of equipment assets are estimated using historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Intangible software licences are depreciated over the shorter of the term of the licence and the useful economic life. These are types of estimation, but they are less likely than the valuation of estate assets to present a significant risk of causing material misstatement.

The value and remaining useful lives of estate assets are estimated by the Trust's valuer, Cushman & Wakefield. Valuations are carried out annually and are performed in accordance with the Royal Institute of Chartered Surveyors' RICS Valuation – Global Standards ('Red Book Global Standards') and other relevant RICS guidance notes, primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. In particular, land and building assets are valued as two single combined hospital facilities ('single alternative site model'), as described in the previous section. The composition of this alternative replacement model requires the operation of significant levels of professional estimation by the valuer.

Cushman & Wakefield has highlighted to the Trust that the valuation is not subject to 'material valuation uncertainty' as a result of the pandemics impact on property markets transaction volume / conditions. The valuer has also highlighted an uncertainty into future periods relating to the changing regulatory environment regarding building safety following the Grenfell fire, but this is not specifically related to the NHS or the Trust.

The 1st April 2025 valuation was a "desktop" valuation following a full revaluation last year end for both Whiston and St Helens hospitals and Southport and Ormskirk hospitals. The performance of the 1st April 2025 desktop valuation was based on a RICS Building Cost Information Service All-in Tender Price Index (BCIS TPI) published on 31 March 2025 and no significant correction to this is anticipated. This valuation was subsequently updated as at 31 March 2026. The Trust's valuation also depends on the BCIS Location Factor applied, and an estimation of external / economic obsolescence levels.

Because the Trust undertakes annual revaluations of estate assets, estimation uncertainty relating to asset lives and depreciation does not present significant risk of causing material adjustments. As the Trust does not currently pay PDC dividend, there are no cash implications to valuation. However, as in previous years, the Trust's reliance on valuation methods does present a risk of causing a material adjustment to the carrying amount of non-current assets.

Property plant and equipment

The Independent valuers use indices and knowledge from the Trust (including obsolescence factors and compliance with standards) to derive a modern equivalent asset valuation.

Accruals

Accruals are made in the accounts, for example, in expenditure where an invoice has not been received and therefore an estimated amount is put into expenditure based on past invoicing trends.

Provisions

Public and employer liabilities plus other legal provisions are calculated using a percentage likelihood of a successful claim.

NHS England have provided a calculation for the provision liabilities arising from the 2019/20 clinicians' pensions compensation scheme at £826k.

Central employer pension contribution

Providers are required to account for the additional expenditure arising from the 9.4% pension contributions paid by NHS England and the related income on a gross basis.

For Mersey & West Lancashire Teaching Hospitals NHS Trust this pension contribution is £37.97m for 2025/26.

Note 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 Trust accrues income relating to performance obligations satisfied in that year. Where the 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 NHS 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 the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed 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. 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.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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 Pension's 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.

Note 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 grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

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.

Lead Employer

The Trust administers a significant Lead Employer scheme, delivering payroll services for doctors in training at a number of NHS bodies in England and Wales. The Trust pays the trainee doctors and recharges their pay costs to the host body at which they were working in that period. In line with IFRS 15 – Revenue from Contracts with Customers, the pay costs and corresponding recovery of those costs are not shown as expenditure and income in the Statement of Comprehensive Income (SoCI).



Note 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due. 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.

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. This alternative scheme is provided under the Trust's 'automatic enrolment' duties to the small number of employees who choose this scheme. NEST levies a contribution charge and an annual management charge which is paid for from employee contributions. There are no separate employer fees levied by NEST. The 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 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.

Note 1.8 Expenditure on other goods and services

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.

Note 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 trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

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 to replace a component of such item 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.

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie 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 value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the 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.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful 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. Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

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 expenses, 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 expenses. 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 of 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 (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure 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.

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 useful 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.



Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	80
Dwellings	1	36
Plant & machinery	1	30
Transport equipment	1	7
Information technology	1	15
Furniture & fittings	1	15

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the 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 trust and where the cost of the asset can be measured reliably.

Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

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

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	1	10
Software licences	5	7

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 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 the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, 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 or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as 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 Trust recognises an allowance for expected credit losses.

The 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).

For individual debts for which there exists objective evidence of credit impairment since initial recognition, such that the Trust anticipates it is unable to collect amounts due ('stage 3' impairment), credit losses at the reporting date are measured as the difference between the debt's gross carrying amount and the present value of the estimated future cash flows discounted at the financial debt's original effective interest rate. This normally equates to the difference between the invoice value and expected receipts for the Trust's trade receivables. Credit losses are then charged to operating expenditure within the Statement of Comprehensive Income, and reduce the net carrying value of the debt in the Statement of Financial Position. When there is no reasonable expectation of recovery, the credit loss is transacted as a permanent 'write-off'.

Derecognition

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

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

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

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

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

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised. Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year.

A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. 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.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 23.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the 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 when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 24 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 24.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined 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.

Note 1.18 Value added tax

Most of the activities of the 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.

Note 1.19 Corporation tax

As an NHS trust, Mersey and West Lancashire Teaching Hospitals NHS Trust is exempt from corporation tax.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 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.

Note 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 that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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.

Note 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.



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

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £440.2m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £349.1m at 31 March 2026.

Note 2 Operating Segments

The Trust has an internal divisional structure based on specialties and functions. There are 5 divisions - Medicine & Urgent Care, Surgery, Womens & Childrens, Corporate, and Clinical Support Services & Community.

The operating results of the Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Trust Board. The Trust Board review the financial position of the whole organisation in their decision making process, rather than individual divisions included in the totals.

Under IFRS8 segmental reporting, the Trust is required to report separate segments only where one of the quantitative thresholds is reached: 10% of revenue, profit/loss or assets; unless this would result in less than 75% of the body's revenue being included in reportable segments.

The Trust has reviewed the thresholds and concluded that as all the contractual income for the Trust is held within the Corporate Division and that as this accounts for 90% of total revenue that only one division exceeds the 10% revenue threshold and therefore only one operating segment needs to be reported.

Currently the Trust is viewed as having one segment which is healthcare.

Income, expenditure, assets, liabilities and cash flows of providing that healthcare service is included in primary statements of these financial statements.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 3.1 Income from patient care activities (by nature)

	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	232,707	216,995
Income from commissioners under API contracts - fixed element*	514,538	500,531
High cost drugs income from commissioners	32,652	31,053
Other NHS clinical income	48,156	42,614
Community services		
Income from commissioners under API contracts*	33,529	27,462
Income from other sources (e.g. local authorities)	51	44
All services		
Private patient income	3,668	2,950
National pay award central funding***	-	1,730
Additional pension contribution central funding**	37,977	34,740
Other clinical income	11,115	21,737
Total income from activities	914,393	879,856

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2025/26	2024/25
	£000	£000
Income from patient care activities received from:		
NHS England	70,978	70,054
Integrated care boards	826,302	794,116
Other NHS providers	457	491
Local authorities	5,273	5,266
Non-NHS: private patients	3,668	2,950
Non-NHS: overseas patients (chargeable to patient)	-	20
Injury cost recovery scheme	1,890	1,554
Non NHS: other	5,825	5,405
Total income from activities	914,393	879,856
Of which:		
Related to continuing operations	914,393	879,856

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	-	20
Cash payments received in-year	-	3

Note 4 Other operating income

	Contract income £000	2025/26 Non- contract income £000	Total £000	2024/25 Contract income £000	Non- contract income £000	Total £000
Research and development	2,146	-	2,146	1,317	-	1,317
Education and training	29,726	899	30,625	29,015	1,009	30,024
Non-patient care services to other bodies	26,095		26,095	34,869		34,869
Receipt of capital grants and donations and peppercorn leases		72	72		301	301
Other income	47,781	-	47,781	53,788	-	53,788
Total other operating income	105,748	971	106,719	118,989	1,310	120,299

Of which:

Related to continuing operations	106,719	120,299
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Non-contract income is recognised in accordance with standards other than IFRS 15.

Notional apprenticeship levy income is non-contract income under Education and training.

Non-patient care services income relates to services provided to other NHS bodies, including pathology, CIPHA scheme incomes, IT and HR / payroll services.

Other income includes PFI support, pharmacy sales, car parking income, incomes from a regional bank staff service and Lead Employer fees.

Note 5.1 Transaction price allocated to remaining performance obligations

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.



Note 6.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	7,710	8,251
Purchase of healthcare from non-NHS and non-DHSC bodies	14,042	10,578
Staff and executive directors costs	686,964	664,674
Remuneration of non-executive directors	177	168
Supplies and services - clinical (excluding drugs costs)	62,924	66,927
Supplies and services - general	7,937	8,240
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	47,260	49,028
Consultancy costs	602	738
Establishment	9,306	9,174
Premises	40,745	46,000
Transport (including patient travel)	1,936	2,185
Depreciation on property, plant and equipment	27,916	29,316
Amortisation on intangible assets	3,733	3,351
Net impairments	52,372	28,083
Movement in credit loss allowance: contract receivables / contract assets	164	974
Increase/(decrease) in other provisions	-	1,314
Change in provisions discount rate(s)	(135)	15
Fees payable to the external auditor		
audit services - statutory audit	276	300
Internal audit costs	199	199
Clinical negligence	28,741	25,436
Insurance (as a policy holder)	-	58
Research and development	1,377	1,323
Education and training	7,639	6,940
Expenditure on short term leases	119	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	41,927	40,909
Other	7,850	7,890
Total	1,051,781	1,012,071
Of which:		
Related to continuing operations	1,051,781	1,012,071

Audit fees include irrecoverable VAT.

Clinical negligence costs relate to the Trust's annual contribution to NHS Resolution under its risk-pooling scheme.

Other expenditure includes professional fees, interpreting services, recruitment fees and costs relating to sterilisation and decontamination.

Note 6.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 7 Impairment of assets

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	52,372	28,083
Total net impairments charged to operating surplus / deficit	52,372	28,083
Impairments charged to the revaluation reserve	10,939	3,218
Total net impairments	63,311	31,301

Note 8 Employee benefits

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	523,989	512,019
Social security costs	58,882	46,132
Apprenticeship levy	2,529	2,404
Employer's contributions to NHS pensions	95,876	87,979
Pension cost - other	126	149
Temporary staff (including agency)	12,531	21,980
Total gross staff costs	693,933	670,663
Of which		
Costs capitalised as part of assets	564	531

Details regarding the remuneration of senior managers can be found in the remuneration section of the Annual Report.

Note 8.1 Retirements due to ill health

During 2025/26 there were 9 early retirements from the trust agreed on the grounds of ill-health (11 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £711k (£1,193k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

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.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 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.

Note 10 Finance income

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

	2025/26 £000	2024/25 £000
Interest on bank accounts	3,717	4,635
Total finance income	3,717	4,635

Note 11.1 Finance expenditure

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

	2025/26 £000	2024/25 £000
Interest expense:		
Interest on lease obligations	525	570
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	16,851	16,795
Remeasurement of the liability resulting from change in index or rate	15,745	23,429
Total interest expense	33,121	40,794
Unwinding of discount on provisions	10	10
Total finance costs	33,131	40,804

Note 12.1 Intangible assets - 2025/26

	Software licences £000	Information technology £000	Intangible assets under construction £000	Total £000
Cost at 1 April 2025 - brought forward *	9,126	16,241	2,140	27,507
Additions	348	3,153	413	3,914
Reclassifications	-	(5,424)	5,424	-
Disposals / derecognition	(1,371)	(686)	-	(2,057)
Cost at 31 March 2026	8,103	13,284	7,977	29,364
Amortisation at 1 April 2025 - brought forward	3,680	2,431	-	6,111
Provided during the year	1,633	2,100	-	3,733
Disposals / derecognition	(1,371)	(686)	-	(2,057)
Amortisation at 31 March 2026	3,942	3,845	-	7,787
Net book value at 31 March 2026	4,161	9,439	7,977	21,577
Net book value at 1 April 2025	5,446	13,810	2,140	21,396

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 12.2 Intangible assets - 2024/25

	Software licences £000	Information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024				
- as previously stated	27,260	7,866	5,012	40,138
Additions	1,624	7,829	-	9,453
Reclassifications	-	2,872	(2,872)	-
Disposals / derecognition	(19,758)	(2,326)	-	(22,084)
Valuation / gross cost at 31 March 2025	9,126	16,241	2,140	27,507
Amortisation at 1 April 2024				
- as previously stated	21,595	3,249	-	24,844
Provided during the year	1,843	1,508	-	3,351
Disposals / derecognition	(19,758)	(2,326)	-	(22,084)
Amortisation at 31 March 2025	3,680	2,431	-	6,111
Net book value at 31 March 2025	5,446	13,810	2,140	21,396
Net book value at 1 April 2024	5,665	4,617	5,012	15,294

Note 13.1 Property, plant and equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025									
- brought forward	17,434	358,368	134	11,943	74,104	358	20,377	965	483,683
Additions	-	26,537	-	9,610	6,587	96	3,515	150	46,495
Impairments	(2,689)	(9,507)	-	-	-	-	-	-	(12,196)
Reversals of impairments	-	1,257	-	-	-	-	-	-	1,257
Revaluations	5,251	(52,666)	(39)	-	-	-	-	-	(47,454)
Reclassifications	-	10,242	-	(10,242)	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(5,911)	-	(3,139)	(19)	(9,069)
Valuation/gross cost at 31 March 2026	19,996	334,231	95	11,311	74,780	454	20,753	1,096	462,716
Accumulated depreciation at 1 April 2025									
- brought forward	-	23	-	-	31,136	81	10,251	424	41,915
Provided during the year	-	8,973	4	-	9,193	51	3,213	100	21,534
Impairments	4,905	48,432	35	-	-	-	-	-	53,372
Reversals of impairments	-	(4,537)	-	-	-	-	-	-	(4,537)
Revaluations	47	(52,689)	(39)	-	-	-	-	-	(52,681)
Disposals / derecognition	-	-	-	-	(5,911)	-	(3,139)	(19)	(9,069)
Accumulated depreciation at 31 March 2026	4,952	202	-	-	34,418	132	10,325	505	50,534
Net book value at 31 March 2026	15,044	334,029	95	11,311	40,362	322	10,428	591	412,182
Net book value at 1 April 2025	17,434	358,345	134	11,943	42,968	277	10,126	541	441,768

Nearly 50% of the Trust's building assets and 2% of Plant and machinery (equipment) assets relate to on-SoFP PFI contracts (see Note 27). The Trust did not hold any surplus assets in either the current or prior year. The Trust undertakes periodic reviews of its asset register. Disposals / derecognition balances in both 2025/26 and 2024/25 relate to the identification of assets that were no longer owned or in use. In the main, these were assets which had reached the end of their economic life and were therefore fully depreciated with a net book value of £nil prior to derecognition.

Note 13.2 Property, plant and equipment - 2024/25

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2024									
- as previously stated	16,729	347,239	230	38,410	129,653	953	35,016	3,617	571,847
Additions	-	13,302	-	9,728	7,152	4	1,358	31	31,575
Impairments	-	(3,200)	-	(19)	-	-	-	-	(3,219)
Reversals of impairments	-	(1)	-	2	-	-	-	-	1
Revaluations	705	(35,123)	(96)	-	-	-	-	-	(34,514)
Reclassifications	-	36,178	-	(36,178)	-	-	-	-	-
Disposals / derecognition	-	(27)	-	-	(62,701)	(599)	(15,997)	(2,683)	(82,007)
Valuation/gross cost at 31 March 2025	17,434	358,368	134	11,943	74,104	358	20,377	965	483,683
Accumulated depreciation at 1 April 2024									
- as previously stated	-	308	11	23	84,247	628	22,727	3,013	110,957
Provided during the year	-	9,338	6	-	9,636	52	3,521	94	22,647
Impairments	-	24,914	79	3,789	-	-	-	-	28,782
Reversals of impairments	-	(699)	-	-	-	-	-	-	(699)
Revaluations	-	(33,834)	(96)	(3,789)	(46)	-	-	-	(37,765)
Reclassifications	-	23	-	(23)	-	-	-	-	-
Disposals / derecognition	-	(27)	-	-	(62,701)	(599)	(15,997)	(2,683)	(82,007)
Accumulated depreciation at 31 March 2025	-	23	-	-	31,136	81	10,251	424	41,915
Net book value at 31 March 2025	17,434	358,345	134	11,943	42,968	277	10,126	541	441,768
Net book value at 1 April 2024	16,729	346,931	219	38,387	45,406	325	12,289	604	460,890

Note 13.3 Property, plant and equipment financing - 31 March 2026

	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 - purchased	15,044	130,605	95	11,311	30,667	297	10,324	445	198,788
On-SoFP PFI contracts and other service concession arrangements	-	202,753	-	-	8,806	-	-	-	211,559
Owned - donated/granted	-	671	-	-	889	25	104	146	1,835
Total net book value at 31 March 2026	15,044	334,029	95	11,311	40,362	322	10,428	591	412,182

Note 13.4 Property, plant and equipment financing – 31 March 2025

	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 - purchased	17,434	126,086	134	11,943	30,900	246	9,998	382	197,123
On-SoFP PFI contracts and other service concession arrangements	-	231,323	-	-	10,329	-	-	-	241,652
Owned - donated/granted	-	936	-	-	1,739	31	128	159	2,993
Total net book value at 31 March 2025	17,434	358,345	134	11,943	42,968	277	10,126	541	441,768

Note 14 Donations of property, plant and equipment

In 2024/25, the Trust recognised donated asset additions of £72k.

Note 15 Revaluations of property, plant and equipment

The value and remaining useful lives of land and building assets are estimated by the Trust's valuers Cushman & Wakefield. Their independent valuations are carried out in accordance with the Royal Institute of Chartered Surveyors' RICS Valuation – Global Standards ('Red Book Global Standards'), and other relevant RICS guidance notes, by RICS-qualified valuers. Valuations are carried out primarily on the basis of depreciated replacement cost (modern equivalent asset (MEA) basis) for specialised operational property. The Trust has opted to interpret the MEA valuation basis, which estimates the cost of a modern replacement asset with equivalent productive capacity to the asset being valued, as pertaining to two combined hospital facilities (one for Whiston and St Helens and one for Southport and Ormskirk acute hospital sites) situated at alternative sites.

Revalued assets are 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. Thereafter, the loss is charged to operating expenditure - net impairments. Increases in value are credited to the revaluation reserve unless circumstances arise whereby a reversal of an impairment is necessary. In these circumstances this has been credited to operating expenditure - net impairments.

The useful economic 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. The lives of assets determined at recognition are disclosed within the accounting policies (Note 1.9). Recorded actual useful economic lives of non-land assets as at 31 March 2026 range from nil to the following maximum lives:

Buildings excluding dwellings	80 years
Plant and machinery	30 years
Transport equipment	7 years
Furniture and fittings	15 years
Information technology equipment	15 years

Note 16 Leases – Mersey and West Lancashire Teaching Hospitals NHS Trust as a lessee

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

Note 16.1 Right of use assets - 2025/26

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2025						
- brought forward (restated)	43,305	3,893	81	-	47,279	27,312
Additions	2,314	-	-	-	2,314	186
Remeasurements of the lease liability	4,322	-	-	-	4,322	1,862
Disposals / derecognition	(2,777)	-	-	-	(2,777)	(2,777)
Valuation/gross cost at 31 March 2026	47,164	3,893	81	-	51,138	26,583
Accumulated depreciation at 1 April 2025						
- brought forward (restated)	10,050	3,734	8	(262)	13,530	7,005
Provided during the year	5,655	706	21	-	6,382	2,685
Impairments	4,695	(1,420)	-	262	3,537	157
Disposals / derecognition	(373)	-	-	-	(373)	(373)
Accumulated depreciation at 31 March 2026	20,027	3,020	29	-	23,076	9,474
Net book value at 31 March 2026	27,137	873	52	-	28,062	17,109
Net book value at 1 April 2025	33,255	159	73	262	33,749	20,307

Note 16.2 Right of use assets - 2024/25

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024						
- brought forward	43,679	3,517	11	1,805	49,012	23,494
Prior period adjustments	(4,463)	260	(11)	(1,805)	(6,019)	-
Valuation / gross cost at 1 April 2024 - restated	39,216	3,777	-	-	42,993	23,494
Additions	-	-	81	-	81	-
Remeasurements of the lease liability	4,089	116	-	-	4,205	3,818
Valuation/gross cost at 31 March 2025	43,305	3,893	81	-	47,279	27,312
Accumulated depreciation at 1 April 2024						
- brought forward	8,877	2,737	10	1,256	12,880	4,568
Prior period adjustments	(4,463)	260	(11)	(1,805)	(6,019)	-
Accumulated depreciation at 1 April 2024 - restated	4,414	2,997	(1)	(549)	6,861	4,568
Provided during the year	5,636	737	9	287	6,669	2,437
Accumulated depreciation at 31 March 2025	10,050	3,734	8	(262)	13,530	7,005
Net book value at 31 March 2025	33,255	159	73	262	33,749	20,307
Net book value at 1 April 2024	34,802	780	1	549	36,132	18,926

The gross opening balances for valuation/cost and accumulated depreciation at 1 April 2024 have been restated to show the correct historical disclosure for cost and depreciation. There is no change to the opening net book value of Right Of Use assets at 31 March 2025.

Note 16.3 Revaluations of right of use assets

Any remeasurements of right of use assets are done by applying the revaluation model in IAS 16.

Note 16.4 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 22.1.

	2025/26 £000	2024/25 £000
Carrying value at 1 April	30,587	32,802
Lease additions	2,314	81
Lease liability remeasurements	4,322	4,205
Interest charge arising in year	525	570
Lease payments (cash outflows)	(6,788)	(7,071)
Carrying value at 31 March	28,556	30,587

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.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets is £0k and is included within revenue from operating leases in note 4.

Note 16.5 Maturity analysis of future lease payments

	Total 31 March 2026 £000	Of which leased from DHSC group bodies: 31 March 2026 £000	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000
Undiscounted future lease payments payable in:				
- not later than one year;	6,221	2,598	5,844	2,552
- later than one year and not later than five years;	15,903	9,957	15,664	10,726
- later than five years.	8,151	5,258	10,782	7,642
Total gross future lease payments	30,275	17,813	32,290	20,920
Finance charges allocated to future periods	(1,719)	(760)	(1,703)	(921)
Net lease liabilities at 31 March 2026	28,556	17,053	30,587	19,999

Note 17 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	4,407	3,604
Consumables	4,935	4,522
Energy	273	239
Total inventories	9,615	8,365

Inventories recognised in expenses for the year were £64,106k (2024/25: £69,198k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).



Note 18.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	64,159	60,784
Allowance for impaired contract receivables / assets	(2,239)	(2,194)
Prepayments (non-PFI)	8,703	9,592
Interest receivable	435	391
VAT receivable	2,458	3,553
Other receivables	14,083	11,211
Total current receivables	87,599	83,337
Non-current		
Contract receivables	2,079	1,706
Allowance for impaired contract receivables / assets	(512)	(393)
Prepayments (non-PFI)	483	181
PFI prepayments - capital contributions	501	-
PFI lifecycle prepayments	22,425	19,361
Other receivables	795	883
Total non-current receivables	25,771	21,738
Of which receivable from NHS and DHSC group bodies:		
Current	44,757	34,570
Non-current	795	883

The majority of the Trust's debt relates to the Trust's provision of healthcare, and recharge invoicing (Other receivables) related to the Trust's administration of a Lead Employer payroll service for doctors in training at a number of NHS bodies.

The carrying amounts of Receivables approximate to fair value.

Note 18.2 Allowances for credit losses

	2025/26 Contract receivables and contract assets £000	2024/25 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	2,587	1,614
Changes in existing allowances	164	974
Utilisation of allowances (write offs)	-	(1)
Allowances as at 31 Mar 2026	2,751	2,587

The Allowance for credit losses chiefly relates to NHS Injury Compensation Recovery (ICR) scheme debts, in addition to trivial expected credit losses relating to the Trust's non-government trade debt. The Trust's approach is detailed in Note 1.13

Contractual cash flows have been modified without derecognition of the receivable / financial asset (IFRS 7, para 35J)

Collateral of other credit enhancements have been pledged to the provider or the provider has taken possession of such collateral (IFRS 7, para 35K and 38)

Amounts written off in the year are still subject to enforcement activity (IFRS 7, para 35L).

Note 18.3 Exposure to credit risk

The Trust's exposure to, and management of, credit risk is discussed in Note 28.

Note 19.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025/26 £000	2024/25 £000
At 1 April	10,187	24,658
Net change in year	12,613	(14,471)
At 31 March	22,800	10,187
Broken down into:		
Cash at commercial banks and in hand	82	85
Cash with the Government Banking Service	22,718	10,102
Total cash and cash equivalents as in SoCF	22,800	10,187

Note 19.2 Third party assets held by the trust

Mersey and West Lancashire Teaching Hospitals NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2026 £000	31 March 2025 £000
Bank balances	4	4
Total third party assets	4	4

The Trust also occasionally holds patients' property on-site, which has been handed over for safekeeping. The value of such assets cannot be measured, and these assets are also not included in the Trust's reported balances.

Note 20.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	9,322	7,338
Capital payables	23,243	18,492
Accruals	28,059	40,716
Social security costs	163	42
Other taxes payable	956	787
Pension contributions payable	115	37
Other payables	1,285	5,759
Total current trade and other payables	63,143	73,171

Of which payables from NHS and DHSC group bodies:

Current	7,113	7,047
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Other payables includes NHS Pensions contributions to be paid over, and other arrangements whereby the Trust holds funds which are to be paid over to third parties, which do not relate to the procurement of goods and services.

The carrying amounts of Trade and other payables approximate to fair value.

Note 20.2 Early retirements in NHS payables above

There were no payables to buy out the liability for early retirements over 5 years in 25/26 or 24/25.

Note 21 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	8,002	7,853
Total other current liabilities	8,002	7,853

Note 22.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Lease liabilities	5,691	5,400
Obligations under PFI, LIFT or other service concession contracts	19,999	14,206
Total current borrowings	25,690	19,606
Non-current		
Lease liabilities	22,865	25,187
Obligations under PFI, LIFT or other service concession contracts	438,785	443,524
Total non-current borrowings	461,650	468,711

Note 22.2 Reconciliation of liabilities arising from financing activities

	Other loans £000	Lease Liability £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	(0)	30,587	457,730	488,316
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(6,266)	(14,694)	(20,960)
Financing cash flows - payments of interest	-	(522)	(16,848)	(17,370)
Non-cash movements:				
Additions	-	2,314	-	2,314
Lease liability remeasurements	-	4,322	-	4,322
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	15,745	15,745
Application of effective interest rate	-	525	16,851	17,376
Carrying value at 31 March 2026	-	28,556	458,784	487,339

	Other loans £000	Lease Liability £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	211	32,802	445,431	478,443
Cash movements:				
Financing cash flows - payments and receipts of principal	(211)	(6,501)	(11,129)	(17,841)
Financing cash flows - payments of interest	-	(570)	(16,796)	(17,366)
Non-cash movements:				
Additions	-	81	-	81
Lease liability remeasurements	-	4,205	-	4,205
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	23,429	23,429
Application of effective interest rate	-	570	16,795	17,365
Carrying value at 31 March 2025	-	30,587	457,730	488,316

Note 23.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Other £000	Total £000
At 1 April 2025	1,400	2,989	322	1,055	5,766
Change in the discount rate	(25)	(110)	-	(63)	(198)
Arising during the year	36	10	136	-	182
Utilised during the year	(168)	(211)	(80)	(31)	(490)
Reversed unused	(114)	(121)	(51)	(104)	(390)
Unwinding of discount	4	6	-	53	63
At 31 March 2026	1,133	2,563	327	910	4,933
Expected timing of cash flows:					
- not later than one year;	172	233	327	31	763
- later than one year and not later than five years;	811	1,070	-	108	1,989
- later than five years.	150	1,260	-	771	2,181
Total	1,133	2,563	327	910	4,933

Pensions - early departure costs relates wholly to the cost to the Trust of early retirements. For both this and Pensions - injury benefits, the most significant uncertainty is the life expectancy of the Trust's ex-employees.

Legal claims contain provisions for employment-related cases of £90k (2024/25: £90k). For certain employment-related claims, reimbursement may be due to the Trust from third parties. The remaining balance of £237k (2024/25: £232k) comprises employer's liability and public liability claims for which there is also a corresponding contingent liability of £95k (2024/25: £67k) disclosed in Note 24. The amount provided for employer's / public liability claims is based on assessments received from NHS Resolution (NHSR) as to their value and anticipated payment

The Other provision balance includes the Trust's commitment to compensate clinicians on retirement for the effects on their pension income of managing certain tax charges through NHS Pensions' 'Scheme Pays' plan. The Trust has recognised an offsetting asset which reflects the commitment of NHS England and the government to fund such payments as they arise. This means there is nil effect on Trust expenditure for this provision. There was also a provision of £826k (2024/25: £917k) for obligations under pensions regulations.

The timings of cash flows are based on expected payment periods (Pensions) and the expected settlement date of claims (Legal claims and Other), which can be difficult to forecast.

Note 23.2 Clinical negligence liabilities

At 31 March 2026, £319,944k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Mersey and West Lancashire Teaching Hospitals NHS Trust (31 March 2025: £284,893k).

Note 24 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	(95)	(67)
Gross value of contingent liabilities	(95)	(67)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(95)	(67)

Contingent liabilities are not included within the Trust's financial statements. A contingent liability of £97k exists at 31 March 2025 for potential third party claims in respect of employer's liability and public liability claim excesses (2024/25 £67k). The Trust is engaged in minor legal processes and proceedings for which there is significant uncertainty regarding outcomes, and payments are not deemed probable. For certain employment-related claims, reimbursement may be due to the Trust from third parties.

The Trust has no contingent assets to disclose in this or the prior year.

Note 25 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	271	4,072
Intangible assets	200	3,771
Total	471	7,843

Note 26 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made. There were no other financial commitments in 2025/26 (2024/25: £nil)

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

The Trust's main PFI arrangement is between the Trust and New Hospitals (St Helens & Knowsley) Limited, the latter being the special purpose vehicle currently acting for Medirest and Vinci. The main scheme commenced in 2006 and was to provide two new hospitals at the Trust's sites in St Helens and Whiston. All construction was complete in November 2012 and the contract term runs to August 2047.

For the duration of the arrangement, Vinci will provide hard facilities management (hard FM) services, while soft FM services are currently provided by Medirest and are subject to scheduled market testing, next occurring in June 2028. At the end of the arrangement the ownership of the buildings will pass to the Trust. Under IFRIC12 as interpreted for the public sector, the assets are treated as assets of the Trust. The substance of the contract is that the Trust has a lease and payments comprise service charges, an interest payment and principal repayment. The price base is uplifted annually by the Retail Price Index, with the base RPI set in December 2002.

The PFI arrangement also incorporates a managed equipment service (MES) provided by GE which expires in 2026. The legal title of equipment remains with GE for the duration of the contract, passing to the Trust at the end of the contract term. At that point, the Trust will purchase all functioning MES equipment at a price equivalent to the current net book value.

The Trust also has two managed service contracts transferred from the former Southport & Ormskirk Hospital NHS Trust. One for energy management and the other for radiology equipment. Both of these contracts are accounted for as On-SOFP service concession arrangements.



Note 27.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2026 £000	31 March 2025 £000
Gross PFI, LIFT or other service concession liabilities	646,768	656,057
Of which liabilities are due		
- not later than one year;	36,083	30,519
- later than one year and not later than five years;	115,056	116,798
- later than five years.	495,629	508,740
Finance charges allocated to future periods	(187,984)	(198,327)
Net PFI, LIFT or other service concession arrangement obligation	458,784	457,730
- not later than one year;	19,999	14,206
- later than one year and not later than five years;	13,463	58,064
- later than five years.	425,322	385,460

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	1,522,447	1,553,973
Of which payments are due:		
- not later than one year;	81,142	75,923
- later than one year and not later than five years;	286,227	286,176
- later than five years.	1,155,078	1,191,874

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	80,807	79,480
Consisting of:		
- Interest charge	16,851	16,795
- Repayment of balance sheet obligation	14,694	11,129
- Service element and other charges to operating expenditure	41,927	40,909
- Capital lifecycle maintenance	4,271	4,178
- Addition to lifecycle prepayment	3,064	6,469
Total amount paid to service concession operator	80,807	79,480

Note 28 Financial instruments

Note 28.1 Financial risk management

Liquidity Risk

The Trust's net operating costs are normally incurred in delivering healthcare under annual contracts with Place and Integrated Care Boards (ICBs), which are ultimately funded from resources voted annually by Parliament.

Credit Risk

The Trust minimises its exposure to credit risk arising from deposits with banks and financial institutions through implementing its Treasury Management procedures. Cash required for day to day operational purposes is held within the Trust's Government Banking Services (GBS) account.

The Trust has and expects a very low level of debt write-off as the majority of its invoices by value relate to public sector bodies. The Trust regularly reviews debtor balances, and has a comprehensive system in place for pursuing past-due debt. Aged debts are regularly assessed and proactive credit control is in place, including referral to debt recovery agents when internal efforts are exhausted and pursuit is deemed cost-effective. Every quarter, aged debts are presented to the Trust's Audit Committee for further scrutiny.

The main source of income for the Trust is from NHS England and ICBs in respect of healthcare services provided under contractual agreements. The credit risk associated with such customers is minimal. Non-NHS customers (for example, private patients and prescription charges) typically have a higher rate of write-off, but represent a small proportion of income. Therefore, the Trust is not exposed to significant credit risk from its customers.

The movement in the Allowance for credit losses during the year is disclosed in Note 18. The Trust's approach to the impairment of financial assets is detailed in Note 1.13.

The carrying amount of financial assets represents the Trust's maximum level of credit exposure. Therefore, the maximum exposure to credit risk at the Statement of Financial Position date was £60.2m, being the total of the carrying amount of financial assets excluding cash (Note 29.2). There are no amounts held as collateral against these balances.

Market Risk

The Trust is a domestic organisation with its transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations. The Trust does not invest for capital appreciation. All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest other than the Trust's bank accounts which earn interest at a floating rate; the Trust is not exposed to significant interest rate risk.

Note 28.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026		Total book value £000
Trade and other receivables excluding non financial assets		78,800
Cash and cash equivalents		22,800
Total at 31 March 2026		101,600

Carrying values of financial assets as at 31 March 2025		Total book value £000
Trade and other receivables excluding non financial assets		72,388
Cash and cash equivalents		10,187
Total at 31 March 2025		82,575

All of the Trust's financial assets are classified as held at amortised cost and are measured accordingly. The Trust's financial assets have carrying values which are not significantly different from their fair values.

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026		Total book value £000
Obligations under leases		28,556
Obligations under PFI, LIFT and other service concession contracts		458,784
Trade and other payables excluding non financial liabilities		60,229
Total at 31 March 2026		547,569

Carrying values of financial liabilities as at 31 March 2025		Total book value £000
Obligations under leases		30,587
Obligations under PFI, LIFT and other service concession contracts		457,730
Trade and other payables excluding non financial liabilities		72,305
Total at 31 March 2025		560,622

All of the Trust's financial liabilities are classified as held at amortised cost, and are measured accordingly. The Trust's financial liabilities have carrying values which are not significantly different from their fair values.

Note 28.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2026 £000	31 March 2025 £000
In one year or less	102,533	108,668
In more than one year but not more than five years	130,959	132,462
In more than five years	503,780	519,522
Total	737,272	760,652

The Trust is required to include in this note future cash flows for finance charges. Because of these additional finance charges, this note's total balances exceed Total financial liabilities per Note 28.3.

Note 28.5 Fair values of financial assets and liabilities

The book value (carrying value) is considered to be a reasonable approximation of fair value.

Note 29 Losses and special payments

	Total number of cases Number	2025/26 Total number of cases £000	Total number of cases Number	2024/25 Total number of cases £000
Losses				
Stores losses and damage to property	223	287	248	192
Total losses	223	287	248	192
Special payments				
Ex-gratia payments	25	85	50	180
Total special payments	25	85	50	180
Total losses and special payments	248	372	298	372

Note 30 Related parties

Whole of Government Accounts (WGA) and consolidation

NHS England prepares consolidated NHS provider accounts which do not contain its results or those of its constituent bodies, as it is not a parent body of NHS trusts or foundation trusts. The Department of Health and Social Care (DHSC) is the parent department of all NHS providers, including Mersey and West Lancashire Teaching Hospitals NHS Trust. The Department of Health and Social Care uses the provider sub-consolidation as part of the DHSC group accounts, which are ultimately then further consolidated into the Whole of Government Accounts. Although there is a number of consolidation steps between the Trust's accounts and Whole of Government Accounts, the Trust's ultimate parent is HM Government.

WGA Bodies

All bodies within the scope of Whole of Government Accounts are considered to be related parties as they fall under the common control of HM Government and Parliament. The Trust's related parties therefore include other NHS bodies, local authorities, and central government entities. During the year, the Trust has had a number of transactions with WGA bodies. Listed below are those entities other than DHSC for which the total transactions or total balances with the Trust have been collectively significant or potentially material to the other body.

NHS England (including sub-entities), NHS Cheshire & Mersey ICB, NHS Lancashire & South Cumbria ICB, NHS Greater Manchester ICB, Mersey Care NHS Foundation Trust, Warrington and Halton Teaching Hospitals NHS Foundation Trust, HM Revenue & Customs, NHS Pension Scheme, Cwm Taf Morgannwg University Health Board, NHS Resolution.

Transactions with DHSC

The Trust received capital PDC of £42.6m (2024/25: £36.4m) and £21.9m revenue PDC (2024/25: £nil) from DHSC, and incurred no PDC dividend expenditure in 2025/26 (2024/25: £nil).

Allowance for credit losses - related parties

No related party debts have been written off by the Trust in 2025/26 (2024/25: £nil). The Trust's Allowance for credit losses includes no balance in relation to its related parties (2024/25: £nil).

Charitable related parties

MWL NHS Charity is effectively a subsidiary of the Trust and therefore considered a related party. The Trust is the Charity's corporate trustee, which means that the Trust's Board of Directors is charged with the governance of the Charity. The Charity's sole activity is the funding of capital and revenue items for the benefit of the Trust's patients.

The Charity's total funds balance as at 31 March 2026 was £1.52m. During the year, the Charity incurred expenditure of £0.34m in respect of goods and services for which the Trust was the beneficiary, and to reimburse the Trust for support costs relating to administration.

Other related parties

Aside from the Trust's Charity, the Trust has no subsidiaries or associates.

Note 31 Better Payment Practice code

	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	111,075	373,377	133,295	385,649
Total non-NHS trade invoices paid within target	97,799	345,471	113,357	355,478
Percentage of non-NHS trade invoices paid within target	<u>88.0%</u>	<u>92.5%</u>	<u>85.0%</u>	<u>92.2%</u>
NHS Payables				
Total NHS trade invoices paid in the year	8,962	81,048	8,473	66,316
Total NHS trade invoices paid within target	8,513	75,568	8,128	63,020
Percentage of NHS trade invoices paid within target	<u>95.0%</u>	<u>93.2%</u>	<u>95.9%</u>	<u>95.0%</u>

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 32 Capital Resource Limit

	2025/26 £000	2024/25 £000
Gross capital expenditure	57,045	45,314
Less: Donated and granted capital additions	(72)	(301)
Charge against Capital Resource Limit	<u>54,569</u>	<u>45,013</u>
Capital Resource Limit	54,570	45,013
Under / (over) spend against CRL	<u>1</u>	<u>-</u>

Note 33 Adjusted financial performance

	2025/26	2024/25
	£000	£000
Surplus / (deficit) for the period per SOCI	(60,083)	(48,085)
Remove net impairments not scoring to the departmental expenditure limit	52,372	28,083
Remove I&E impact of capital grants and donations	518	276
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	75,735	82,945
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	(79,269)	(77,947)
Adjusted financial performance surplus / (deficit)	<u>(10,727)</u>	<u>(14,728)</u>

Note 34 Breakeven duty financial performance

	2025/26
	£000
Adjusted financial performance surplus / (deficit)	(10,727)
IFRIC 12 breakeven adjustment	3,534
Breakeven duty financial performance surplus / (deficit)	<u>(7,193)</u>

Note 35 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		225	296	305	700	1,150	(2,551)	(9,551)	4,861
Breakeven duty cumulative position	2,807	3,032	3,328	3,633	4,333	5,483	2,932	(6,619)	(1,758)
Operating income		236,411	252,944	263,864	278,572	288,448	301,674	313,287	349,934
Cumulative breakeven position as a percentage of operating income		1.3%	1.3%	1.4%	1.6%	1.9%	1.0%	(2.1%)	(0.5%)

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2024/25
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	5,001	(597)	4,351	(2,618)	697	7,131	(1,897)	(14,728)	(7,193)
Breakeven duty cumulative position	3,243	2,646	6,997	4,379	5,076	12,207	10,310	(4,418)	(11,611)
Operating income	383,587	402,158	446,792	511,310	524,352	585,938	817,389	1,000,155	1,021,112
Cumulative breakeven position as a percentage of operating income	0.8%	0.7%	1.6%	0.9%	1.0%	2.1%	1.3%	(0.4%)	(1.1%)





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