Board of Directors

27 May 2020, 13:30 to 15:00
By videoconference

Agenda

1
Chair and quorum

Information

Robert Armstrong

2
Apologies for absence

Information

Robert Armstrong

3
Declarations of interest

Information

Robert Armstrong

4
Minutes of the previous meeting

Approval

Robert Armstrong

Minutes - Board - Apr 2020.pdf (6 pages)

5
Chair and Chief Executive's opening remarks

Verbal item

Discussion

Robert Armstrong/Silas Nicholls

6
Committee chair's report from the Pandemic Assurance Committee

Verbal item

Information

Tony Warne

7
Update from the executive team

Verbal item

Information

Silas Nicholls

8
Looking to the future

Verbal item

Discussion

Silas Nicholls

9
Update on strategic alliance with Wigan Council and Edge Hill University

Verbal item

Information

Richard Mundon

10
Review of COVID-19 risk appetite statement

Approval

Paul Howard

Review of COVID-19 risk appetite statement.pdf (4 pages)

11
Consent agenda

11.1
Pandemic Assurance Committee terms of reference

Approval

PAC terms of reference.pdf (4 pages)

11.2
Scheme of Reservation and Delegation

Approval

Scheme of Reservation and Delegation.pdf (16 pages)

11.3
Board Diversity Policy

Approval

Board Diversity Policy 2020.pdf (4 pages)

11.4
NHSI board self-certifications

Approval

Provider licence self-certification.pdf (8 pages)

11.5
Remuneration Committee terms of reference

Approval

Remuneration Committee terms of reference.pdf (5 pages)

11.6
Finance report

Information

Finance report M1 2020-21.pdf (3 pages)

11.7
Financial governance – review of HFMA and internal audit guidance

Information

Financial governance.pdf (15 pages)

11.8
Register of directors' interests

Information

Register of directors interests.pdf (3 pages)

11.9
Directors' fit and proper person checks

Information

Directors' fit and proper person checks.pdf (3 pages)

11.10
Summary of referrals received by the Clinical Ethics Group

Information

Register of CEG cases received.pdf (2 pages)

12
Date, time and venue of next meeting:

- 5 June 2020, to follow Audit Committee (c.11.00am), by videoconference - single item agenda to approval annual report and accounts; and then
- 24 June 2020, 1.30pm, by videoconference

Information

Robert Armstrong

13

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS ("the Board")

HELD ON 29 APRIL 2020, 1.30PM

BY VIDEOCONFERENCE

Present:	Mr R Armstrong	Chair (in the Chair)
	Dr S Arya	Medical Director
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Lady R Bradley DL	Non-Executive Director
	Dr S Elliot	Non-Executive Director
	Ms M Fleming	Chief Operating Officer
	Mr M Guymer	Non-Executive Director
	Mrs L Lobley	Non-Executive Director
	Mr R Mundon	Director of Strategy and Planning
	Mr G Murphy	Acting Chief Finance Officer
	Mr S Nicholls	Chief Executive
	Ms H Richardson	Chief Nurse
	Prof T Warne	Non-Executive Director
In attendance:	Mrs N Guymer	Deputy Company Secretary
	Mr P Howard	Company Secretary
	Mrs L Sykes	Public Governor (observer)

Consecutive minute numbering has continued despite the change in organisational name from Wrightington, Wigan and Leigh NHS Foundation Trust on 1 April 2020

46/20 Chair and quorum

Mr R Armstrong took the chair and noted that due notice had been given to all directors and that a quorum was present. He therefore declared the meeting duly convened and constituted.

47/20 Apologies for absence

Apologies for absence were received from Mr I Haythornthwaite (Non-Executive Director).

48/20 Declarations of interest

No directors declared an interest in any of the items of business to be transacted.

49/20 Minutes of the previous meeting

The minutes of the previous meeting held on 25 March 2020 were **APPROVED** as a true and accurate record.

50/20 Overview from Chief Executive

The Chief Executive gave a verbal update on the current situation and advised that it was generally considered that the region was coming towards the end of the first phase of the NHS response to the COVID-19 pandemic. As a result, the Greater Manchester system had recently moved to Operational Pressure Escalation Level (OPEL) 2 from the previous OPEL 3. The next phase of the NHS response would focus on stabilisation and the need to consider different ways of working for an extended period of time had been acknowledged.

The Chief Executive advised that the number of patients in the hospital with COVID-19 remained relatively stable although the demand for critical care services had recently reduced. Note was made of the fact, however, that there had been an increase in the number of COVID-19 patients in local care and nursing homes.

The Chief Executive commented that concern had been expressed nationally around the reduced number of attendances at A&E and highlighted the communication campaign that had begun as a result. The intention to work closely with primary care colleagues to ensure proactive liaison with patients was also confirmed. The Chief Executive advised of the plan to resume the screening programme in the near future but highlighted the need to ensure that laboratory capacity is not overwhelmed as a result of reintroducing services at the same time as processing COVID-related samples. He also cautioned that the potential effects of any future relaxing of legal restrictions on movement were not yet known.

With regard to future planning, note was made of the fact that the recovery phase of the NHS response would be coordinated on a regional basis with individual organisations having little flexibility to deviate from the agreed approach. Confirmation had also been provided that the current command and control arrangements in place across the region would remain extant for a considerable period of time; most likely until 31 March 2021.

The Chair reminded the Board that efforts had been made to streamline the organisation's corporate governance arrangements to ensure the best use of directors' time. The Chief Executive commented that the next phase of the NHS response would be both clinically and managerially more complex and would require even more executive oversight.

In response to a question from Dr Elliot, the Chief Executive confirmed that the use of the newly created Bryn Ward would be flexible, in line with the prevailing situation. He also reminded the Board that the ward formed part of the national super-surge capacity plan and could potentially operate as a regional facility in the future.

Dr Elliot commented that he had recently circulated an article from the Health Service Journal which summarised a number of lessons learned from Italy around staff contamination, and in particular the fact that research had shown higher levels of sickness amongst staff on non-COVID wards in Italy than amongst those caring for patients in dedicated COVID areas. He therefore queried whether the foundation trust had considered this and the Chief Executive confirmed that staff across all non-COVID

areas had been advised to wear surgical masks and that other options around personal protective equipment would be considered once supply arrangements are more stable.

The Board received and noted the verbal update.

51/20 Update from Pandemic Assurance Committee

Prof Warne confirmed that the inaugural meeting of the Pandemic Assurance Committee had been held on 22 April 2020 and noted that the draft minutes of the meeting had been circulated to directors for information.

Prof Warne advised that the committee had received an overview of the processes that have been put in place to deal with the many changes that had become necessary as a result of COVID-19 to ensure staff and patient safety and to maintain oversight of the organisation. He acknowledged an absence of data being presented at the first meeting but confirmed that this was being reviewed outside the meeting with a view to ensuring that appropriate metrics are reported when the committee next meets. Mrs Lobley noted the usefulness of being able to compare the foundation trust's performance with other providers in the local area and confirmation was provided that this would be taken into account as part of the metrics. The Chief Executive assured the Board that key metrics are considered on a daily basis at local and regional level and commented that it could be useful to incorporate some regional information for further assurance. Prof Warne confirmed that the committee would be considering a draft performance report at its next meeting.

Lady Bradley commended the organisation on the flow of information to non-executive directors and also requested that some consideration be given to community matters by the committee. Prof Warne requested that any particular issues that directors would like the committee to cover are advised to him or the Company Secretary in advance to ensure that the committee is able to consider the suggestions.

The Medical Director confirmed that the foundation trust was participating in a national randomised evaluation of COVID-19 therapy trial and had performed well in comparison with others in recruiting patients to the trial.

The Chair noted the establishment of a Clinical Ethics Group by the foundation trust to provide an independent recommendation around clinical decision-making on occasions where there is no consensus amongst the clinical team caring for the patient or where concerns are raised around the proposed approach. Confirmation was provided that the group is available 24 hours a day. Mrs Lobley confirmed that she had recently reviewed the terms of reference and other background information on the group at the request of the Chair and noted that an assurance report would be presented to the next meeting of the committee.

The Chair also advised that he had requested a review of a recent piece of advice from NHS Providers by the Chief Finance Officer and Mr M Guymer to ensure that the

foundation trust continues to follow all best practice financial guidelines. A summary would be presented to the next meeting.

ACTION: Chief Finance Officer/Mr Guymer

The Board received and noted the verbal update.

52/20 Update from executive team

The Chair opened by commending the executive team on its management of the organisation during the pandemic to date and cited in particular the work involved in delivering the new Bryn Ward in such short timescales. He advised that he had undertaken a site visit earlier in the day and had been impressed with the standard of work. Particular note was made of the work of Mr Chris Knights, Deputy Director of Strategy and Planning, in coordinating the works.

The Director of Strategy and Planning provided an overview of the new 50-bed ward and thanked all contractors and subcontractors for their efforts in moving from concept to handover in just six weeks. He noted that the phasing and distribution of COVID-19 cases had not followed the original forecasts and that a change to the intended approach to using the facility had been agreed as a result. Once in use, the ward will be used to cohort COVID-19 positive patients, including those being treated with continuous positive airway pressure (CPAP). He summarised the processes of deep cleaning the ward and equipment testing and confirmed that planning was underway to decant the relevant patients into the ward once operational. The Medical Director confirmed that he and the Chief Nurse had approved the intended use of the ward.

The Chief Executive confirmed that robust support arrangements had been put in place for members of staff to support wellbeing, including the provision of psychological support and the procurement of an employee assistance programme. The need to continue this support for a considerable period of time was acknowledged. In response to a question from Prof Austin, the Chief Executive confirmed that staff continue to be supported to raise any concerns they may have and the Director of Workforce summarised the various ways in which this can be undertaken.

In response to a question from Mrs Lobley around the capacity of the infection control team to respond to the additional demands of Bryn Ward, the Chief Nurse confirmed that additional staffing had been secured and that there was sufficient capacity within the team as a result.

The Board received the report and noted the content.

53/20 Personal protective equipment and related matters

The Chief Operating Officer presented a report which had been circulated in advance of the meeting to provide assurance around the foundation trust's ability to provide personal protective equipment (PPE) for staff. She confirmed that a dedicated COVID-19 risk register had been developed and summarised the PPE-related risks that had been identified.

The Chief Operating Officer confirmed that the foundation trust monitors PPE stock levels on a daily basis through a dedicated central store and that on average a minimum of 4 days' stock is available, with additional deliveries being received on a daily basis and additional escalation methods being in place across Greater Manchester.

The Chief Operating Officer drew directors' particular attention to the fact that the foundation trust had taken the decision to provide personal issue reusable face masks to those staff who are required to wear FFP3 masks on a regular basis and the rationale for that decision was included within the report.

Confirmation was also provided that the foundation trust operates a robust mask fit testing programme and that staff are taught the correct way to don and doff the masks, as well as how to clean and store the reusable masks where relevant. Confirmation was also provided that no member of staff had been or would be asked to provide care for a patient who is suspected or confirmed as having COVID-19, or to work in areas where such patients are accommodated, without the appropriate personal protective equipment.

In response to a question from Mrs Lobley, the Chief Operating Officer confirmed that the centralised storage arrangements were working well and were allowing acute and community staff to access PPE in a straightforward way. In response to a supplementary question from Mrs Lobley, the Chief Executive noted that there had been some initial challenges around the availability of medication but that these had not had a detrimental impact on any patients. He noted that the key supply issue at the present time related to haemofiltration equipment but confirmed that arrangements were in place to transfer patients to other providers where necessary.

The Board received the report and noted the content.

54/20 Review of COVID-19 risk appetite statement

The Board confirmed that the COVID-19 risk appetite statement remains appropriate.

55/20 Consent agenda

The papers having been circulated in advance and the Board having consented to them appearing on the consent agenda, the Board RESOLVED as follows:

1. THAT a new common seal of the foundation trust, an image of which is included in the margin, be **ADOPTED** for use with effect from 1 April 2020.

2. THAT the finance report as at 31 March 2020 be received and noted.

56/20 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 27 May 2020, 1.30pm by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
29 Apr 2020	51/20	Update from Pandemic Assurance Committee	Review recent guidance from NHS Provider and provide summary update to next meeting of the Board	Chief Finance Officer/Mr Guymer	27 May 2020	Included on the agenda.

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Review COVID-19 risk appetite statement		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

In March 2020, the board approved a COVID-19 risk appetite statement and directed that it should be presented to each subsequent meeting to ensure its continuing appropriateness and relevant.

The statement is therefore attached for the board's review.

Risks associated with this report

The content of this report is intended to support organisational risk management by articulating the foundation trust's risk appetite in a dedicated statement.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☒	Partnerships

The WWL Way

COVID-19
Risk appetite statement

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Introduction

It is best practice for organisations to have in place an agreed risk appetite statement to direct and govern decision making at both Board and operational level. Risk appetite is defined as the level of risk that an organisation is willing to accept. An agreed risk appetite sets the framework for decision making across the organisation to ensure consistency of decisions and the embedding of an agreed organisational value base.

At Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust we recognise that complete risk control and avoidance is impossible but that risks can be minimised by making sound judgments and having a common understanding of the organisation's risk appetite and value set. We also recognise that exceptional times often call for an increased level of risk to be accepted and that the current threat posed by the global COVID-19 pandemic will require a different approach to decision making based on the balance of risk in any given circumstance. Notwithstanding, we recognise the importance of maintaining oversight of high risk incidents and we will continue to prioritise investigation and identification of areas of learning.

The Board of Directors wishes to support its directors, senior managers and other key decision makers throughout the pandemic by setting out a revised risk appetite statement. It is intended that this risk appetite statement will remain in place for as short a time as possible, and its continuing relevance will be assessed at each meeting of the Board until such a time as it is possible to return to normal operations.

The table below sets out our appetite for risk, with greater tolerance of risk in some areas depending on the context of the risk and the potential losses or gains. When making decisions in line with this risk appetite statement, consideration will also be given to the counterfactual scenario, i.e. the potential consequences of not proceeding with a particular approach.

Underlying principles

We care about each and every one of our patients and we will do our utmost to preserve life, protect our patients from further harm and to promote recovery.

All healthcare providers operate with a set of finite resources and difficult decisions must be taken in times of significant challenge to determine the most appropriate allocation of those resources. We will always make these decisions on a clinical basis, weighing up factors such as potential benefits against the clinical risk and considering the likelihood of success.

Where we have to take decisions during the COVID-19 pandemic that we would not normally take under normal circumstances and these negatively impact on patients, we will do our utmost to limit the negative impact to the smallest number possible. Regrettably, it is impossible for us to say that the decisions we may need to take will never have a negative impact on patient safety. We will operate along the well-established principle of triage in seeking to do the greatest good for the greatest number.

Our risk appetite

We have determined our risk appetite during the COVID-19 pandemic as follows:

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

This risk appetite statement has immediate effect from the date of signature and its continuing appropriateness will be reviewed at each meeting until it is either amended or withdrawn.

This statement was approved by the Board of Directors at its meeting on 25 March 2020.

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Robert Armstrong
Chair
For and on behalf of the Board of Directors

Appendix: Risk appetite matrix

RISK APPETITE: ➔	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	
	AVOID *"Avoidance of risk and uncertainty is a key organisational objective"*	**MINIMAL** *"Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential"*	**CAUTIOUS** *"Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward"*	**OPEN** *"Willing to consider all potential delivery options and choose whilst also providing an acceptable level of reward and VfM"*	**SEEK** *"Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)."*	**MATURE** *"Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust"*
Quality, innovation and outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision-taking authority. General avoidance of systems/technology development.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems/technology development to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/technology developments limited to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems/technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to "break the mould" and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently "breaking the mould" and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Financial/ Value for Money (VfM)	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls in place). Resources allocated without firm guarantee of return – "investment capital" type approach.	Consistently focused on the best possible return for stakeholders. Resources allocated in "social capital" with confidence that process is a return in itself.
Compliance and regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliance.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.

(Acknowledgement: Good Governance Institute)

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Terms of reference for the Pandemic Assurance Committee		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

The board has elected to cease the operation of its usual assurance committees during the foundation trust's response to COVID-19 and to replace those meeting with a single monthly assurance committee – the Pandemic Assurance Committee.

The attached terms of reference have been circulated for comment and reviewed by the committee. They are therefore presented for formal approval.

Risks associated with this report

There are no risks associated with this report.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☒	Partnerships

The WWL Way

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

PANDEMIC ASSURANCE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. The Pandemic Assurance Committee ("the Committee") is constituted as a committee of the Foundation Trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

1.2. The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. MAIN PURPOSE

2.1. Whilst there has been some relaxation of business as usual arrangements across all NHS organisations in response to the global COVID-19 pandemic, public sector organisations retain the requirement to carry out their functions effectively, efficiently and economically. The purpose of the Committee is to obtain assurances on behalf of the Board around a number of key areas:

(a) Patient safety;

(b) Staff safety and wellbeing;

(c) Key operational decisions and resource deployment;

(d) Finance; and

(e) Risk management

2.2. For the avoidance of doubt, the purpose of the Committee is to maintain a high-level overview of the key areas and to escalate any areas of concern to the Board. Day-to-day management of these areas is the responsibility of the Executive Directors.

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

(a) the foundation trust's Vice-Chair;

(b) the other Non-Executive directors;

(c) the Medical Director;

(d) the Chief Nurse;

(e) the Chief Operating Officer and

(f) the Director of Workforce.

3.2. The Foundation Trust's Vice-Chair shall chair the Committee.

3.3. A quorum shall be formed on the attendance of two (2) Non-Executive Directors and one (1) Executive Director.

3.4. Two named Governors shall be invited to join meetings of the Committee as observers to allow for effective holding to account. For the avoidance of doubt, the named Governors attend in their own right without the ability to delegate attendance to others. Confidentiality of discussions shall be maintained.

4. SECRETARY

4.1. The Company Secretary or his/her nominated deputy shall be secretary to the Committee.

5. ATTENDANCE

5.1. Only members of the Committee have the right to attend meetings of the Committee.

5.2. Other persons may be invited by the Committee to attend a meeting or part of a meeting so as to assist in deliberations.

6. FREQUENCY OF MEETINGS

6.1. Meetings shall be held on a monthly basis.

7. MINUTES AND REPORTING

7.1. Formal minutes shall be taken of all Committee meetings.

7.2. The Committee will report to the Board after each meeting.

8. PERFORMANCE EVALUATION

8.1. It is intended for the Committee to be time-limited, for as long as the business continuity arrangements arising from the global COVID-19 pandemic are in place. At the conclusion of

the committee's operation, or as part of the Board's annual performance review process (whichever is the sooner), the Committee shall review its collective performance.

9. REVIEW

9.1. These terms of reference of the Committee shall be reviewed by the Board when required, but at least annually.

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Scheme of Reservation and Delegation		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

The Scheme of Reservation and Delegation sets out the decisions and other matters that the Board of Directors and Council of Governors have reserved to themselves.

It also sets out the relevant matters delegated to committees by the board. It had originally been intended for this to be reviewed and updated in line with the changes to governance arrangements that were to be implemented from 1 April 2020. Given the delay, the document has not been updated and is presented for routine board review in the same way as other core governance documents which were presented in March and April of this year.

The board is recommended to approve the document as presented and to note that a review in line with changes to committee arrangements will be undertaken in-year.

Risks associated with this report

There are no risks associated with the content of this report.

Link(s) to The WWL Way 4wards

☐	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Scheme of Reservation and Delegation

Approved by the Board of Directors: [ ] 2020
Review date: March 2021

The WWL Way

Contents

Introduction 2

Matters reserved to the Council of Governors 3

Matters reserved to the Board of Directors and Council of Governors jointly 5

Matters reserved to the Board of Directors 6

Decisions and duties delegated by the Board of Directors to Committees 10

Introduction

Delegation of powers

The Foundation Trust has the power to delegate and to make arrangements for delegation and the Standing Orders for the Board of Directors sets out the detail of these arrangements. Under SO4 (Arrangement for the exercise of functions by delegation), the Board of Directors has the power to make arrangements on behalf of the Foundation Trust for the exercise of any of its powers by a committee of directors or by individual Executive Directors, subject to such restrictions and conditions as the Board of Directors thinks fit. This document sets out those areas of delegation and has effect as if incorporated into Standing Orders for the Board of Directors.

This document details the decisions and responsibilities reserved to the Board of Directors and those delegated to committees of the Board of Directors. It also sets out the decisions that are reserved to the Council of Governors. Such decisions are set out in legislation or best practice sector guidance and have been included for ease of reference and for completeness.

The committees that the Board of Directors has established are:

- Audit Committee
- Charitable Trust Committee
- Finance and Performance Committee
- People Committee
- Quality and Safety Committee
- Remuneration Committee

In addition, the Council of Governors has established the following committee:

- Nomination and Remuneration Committee

The powers which the Board of Directors has retained to itself with Standing Orders may in an emergency be exercised by the Chief Executive and Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

Disputes between the Board of Directors and Council of Governors

In the event of any unresolved dispute between the Council of Governors and the Board of Directors, the Chair or Secretary may arrange for independent professional advice to be obtained for the Foundation Trust. The Chair may also initiate an independent review to investigate and make recommendations in respect of how the dispute may be resolved.

References used within this document:

HSCA 2003	Health and Social Care (Community Health and Standards) Act 2003
HSCA 2012	Health and Social Care Act 2012
MCC	Model Core Constitution
NHSA 2006	National Health Service Act 2006
NHS FT Code	NHS Foundation Trust Code of Governance

Matters reserved to the Council of Governors

Matters reserved to the Council	Reference(s)
General enabling provisions	
The Foundation Trust is to have a Council of Governors. The Council of Governors links the Foundation Trust to its members and community to ensure engagement and involvement of the public in relation to the services provided by the Foundation Trust.	Sch. 1 HSCA 2003; HSCA 2012
Strategy, plans and budget	
Providing its views to the Board of Directors when the Board is preparing the document containing information about the Foundation Trust's forward planning	Sch. 7, para 27(3) NHSA 2006
Reviewing the Membership Engagement Strategy and the policy for the composition of the Council of Governors and of the Non-Executive Directors and when appropriate make recommendations for the revision of the constitution.	
Regulation and control	
Responding as appropriate when consulted by the Board of Directors in accordance with the Foundation Trust's constitution.	
Requiring and receiving the declaration of Governors' interests that may conflict with those of the Foundation Trust and determining the extent to which that member may remain involved with the matter under consideration.	
Adopting Standing Orders for the Council of Governors.	
Approving the Code of Conduct for Governors.	
Holding the Non-Executive Directors to account individually and collectively for the performance of the Board of Directors.	
Representing the interests of the members of the Foundation Trust as a whole and the interests of the public.	S.151(6) HSCA 2012
Requiring one or more directors to attend a meeting if necessary to obtain information about the performance of the corporation or the directors' performance of their duties.	S.151(6) HSCA 2012
Deciding whether to propose a vote on the performance of the corporation or the directors' performance of their duties..	
Deciding whether to refer a question to any panel established by NHS Improvement.	
Appointments and removals	
Appointment and, where necessary, removal of the Chair and other Non-Executive Directors	
Approval of the appointment of the Chief Executive by the Non-Executive Directors.	
Appointment and, where appropriate, removal of the Foundation Trust's external auditor.	
Agreement of any additional services to be provided by the external auditor.	
Determining the remuneration, allowances and other terms and conditions of office of the Non-Executive Directors.	

Matters reserved to the Council	Reference(s)
Annual report and accounts Receiving the annual report and accounts and any report of the external auditor on them.	Sch.7, para 28(1) NHSA 2006
Other Approval of an application by the Foundation Trust for a merger, acquisition, separation or dissolution. Approval of the Foundation Trust entering into a significant transaction as defined in the Foundation Trust's constitution. Review the composition of the Council of Governors.	

Matters reserved to the Board of Directors and Council of Governors jointly

Matters reserved to the Board and Council jointly	Reference(s)
Corporate governance	
Approval of changes to the foundation trust's constitution	S.161 HSCA 2012
Approval of significant transactions as defined in the constitution	Constitution

Matters reserved to the Board of Directors

Matters reserved to the Board	Reference(s)
General enabling provisions	
An NHS Foundation Trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions.	S.47 NHSA 2006
An NHS Foundation Trust must exercise its functions effectively, efficiently and economically.	S.63 NHSA 2006; NHS FT Code supporting principle A.1.h.
The constitution must provide for all the powers of the corporation to be exercisable by the Board of Directors on its behalf	Sch. 1, HSCA 2003; sch. 7 NHSA 2006
The constitution must provide for all the powers of the corporation to be exercisable by the Board of Directors on its behalf	
The Board of Directors may determine any matter, for which it has delegated or statutory authority, it wishes in accordance with its statutory powers, constitution or licence.	MCC 4.3, 4.3
Strategy and management	
Responsibility for the overall management of the Foundation Trust (and group where applicable) in compliance with its licence, constitution, legislation, regulatory guidance and contractual obligations	NHS FT Code supporting principle A.1.d, MCC 26
Approval of the Foundation Trust's values, long-term objectives and strategy	NHS FT Code supporting principles A.1.e, A.1.f
Approval of annual plans, including annual budgets	SFIs
Approval of proposals for action on significant non-clinical litigation against or on behalf of the foundation trust	SFIs
Responsibility for ensuring the quality and safety of health care services, education, training and research delivered by the Foundation Trust.	NHS FT Code supporting principle A.1.g
Approval of the annual operating and capital expenditure budgets and any material changes to them.	
Oversight of the Foundation Trust's operations ensuring: ▪ Competent and prudent management ▪ Sound planning ▪ An adequate system of internal control ▪ Adequate accounting and other records ▪ Compliance with statutory and regulatory obligations, including the provider licence	
Review of performance in the light of the Foundation Trust's strategy, objectives, business plans and budgets and ensuring that any necessary corrective action is taken	
Review of performance in the light of the Foundation Trust's strategy, objectives, business plans and budgets and ensuring that any necessary corrective action is taken	NHS FT Code principle A.1.4; supporting principle A.4.b
Extension of the Foundation Trust's activities into new operational or geographic areas or decisions to cease to operate all or any material part of the Foundation Trust's business	Ss.45-47 NHSA 2006

Matters reserved to the Board	Reference(s)
Delegation of authority	
Subject to any directions to the contrary by NHS Improvement or the Foundation Trust itself, any of the powers of the Board of Directors may be delegated to a committee of directors or to an executive director.	MCC 4.3
Structure and capital	
Changes relating to the Foundation Trust's capital structure including reduction of capital	
Major changes to the Foundation Trust's corporate structure	
Changes to the Foundation Trust's management and control structure	
Any changes to the Foundation Trust's status as a Foundation Trust	
Establishment of subsidiary companies, joint ventures or partnership arrangements	s.46(5) NHSA 2006
Financial reporting and controls	
Approval of the annual report and accounts including the annual governance statement and the remuneration report	S.27 HSCA 2003, s.27 NHSA 2006, Audit Committee Handbook
Approval of any significant changes in accounting policies or practices	
Approval of the foundation trust's annual report, quality report and annual accounts.	
Approval of the annual report and accounts for any funds held on trust.	
Receipt of the annual management letter from the external auditor and agreement of any proposed action, taking account of advice received where appropriate from the Audit Committee	
Internal controls	
Ensuring maintenance of a sound system of internal control and risk management	NHS FT Code supporting principles C.2.a, C.2.b, Audit Committee Handbook
Approval of Standing Orders for the Board of Directors, this Scheme of Reservation and Delegation and Standing Financial Instructions, including variations of the same	
Decisions relating to the suspension of Standing Orders	
Receipt of Register of Directors' Interests	
Receipt and regular review of the board assurance framework	
Approving the terms of reference for all committees reporting to the board	
Ensuring compliance with the foundation trust's provider licence	
Contracts	
Approval of major capital projects	Ss.45 to 47 NHSA 2006
Approval of contracts which are material strategically or by reason of size, entered into by the Foundation Trust or a subsidiary in the ordinary course of business	
Approval of contracts of the Foundation Trust or any subsidiary not in the ordinary course of business	Ss. 45 to 46 NHSA 2006

Matters reserved to the Board	Reference(s)
Policies	
Approve policies relating to risk and strategic development.	
Communication	
Approval of resolutions and corresponding documentation to be put forward to members at an Annual Members' Meeting	
Approval of all mandatory corporate reports to the Department of Health and Social Care or regulators	
Corporate governance matters	
Board membership and other appointments	Sch. 7 NHSA 2006; NHS FT Code provision B.2.1, B.2.3
Changes to the structure, size and composition of the Board of Directors following recommendations from the Nomination and Remuneration Committee	
Ensuring adequate succession planning for the Board of Directors and senior management	NHS FT Code supporting principle B.2.c
Appointment of the Senior Independent Director (in consultation with the Council of Governors)	NHS FT Code provision A.4.1
Membership and chair arrangements for Board committees	
Appointment of Deputy Chief Executive	
Appointment or removal of Company Secretary	
Appointments to boards of subsidiary companies	
Undertake a formal and rigorous annual review of its own performance, that of its committees and individual directors	NHS FT Code supporting principles B.6.a
Determine the independence of directors	NHS FT Code provision B.1.1
Review of the Foundation Trust's overall corporate governance arrangements	
Review of use of the Foundation Trust's common seal	MCC 47.2
Approval of the written division of responsibilities between the Chair and the Chief Executive.	NHS FT Code provision A.2.1
Approval of terms of reference of committees	NHS FT Code provision A.2.1
Receiving reports from board committees on their activities	NHS FT Code provision A.2.1
Approval of changes to this schedule of matters reserved to the Board of Directors	NHS FT Code provision A.1.1
Approval of changes to Standing Orders for the Board of Directors and Standing Financial Instructions.	
Maintenance of a schedule of the specific third-party bodies in relation to which the NHS Foundation Trust has a duty to co-operate.	NHS FT Code provision E.2.1

Matters reserved to the Board	Reference(s)
Monitoring Receiving reports from the Chief Finance Officer on financial performance. Receiving reports from the Medical Director and Chief Nurse on clinical performance and quality. Receiving reports on actual and forecast activity and income from contracts. Oversight of operations and compliance with statutory and regulatory obligations.	

Decisions and duties delegated by the Board of Directors to Committees

Committee	Delegation
Audit Committee	The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee shall: 1. Critically review all risk and control related disclosure statements (in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances) prior to endorsement by the Board. 2. Review the foundation trust's process of corporate governance to ensure that due consideration is being given to the process of reviewing the Board Assurance Framework to monitor progress towards the achievement of corporate objectives. 3. Ensure a procedure is in place to identify, manage and measure key risks facing the Trust. 4. Ensure that the Trust has an appropriate framework in place to review all policies including compliance with relevant regulatory, statutory, legal and code of conduct requirements and guidance relevant to the corporate governance of the Trust. 5. Establish a procedure to report to the Council of Governors and within the Annual Report on the supply of non-audit services provided by the external auditor. 6. Consider the adequacy of policies and procedures covering fraud corruption and bribery as set out by the NHS Protect. 7. Consider the Annual Report, Quality Report and Financial Statements before recommending approval to the board. 8. Advise the board on any risks or concerns which might have material effect on the organisation. 9. Conduct an annual review of all aspects of the Board Assurance Framework to ensure that the principles are embedded in the organisation. 10. Review the foundation trust's processes for monitoring information governance and clinical audit 11. Conduct a bi-annual review of the corporate risk register to ensure that the processes for escalation of risks are operating appropriately. 12. Scrutiny of the foundation trust's Gifts and Hospitality Register, providing appropriate challenge and receiving assurances regarding the processes related to declarations of gifts and hospitality.

Committee	Delegation
Audit Committee (continued)	In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it, as well as reference to the foundation trust's Risk Register. The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and board. This will be achieved by: ▪ consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal (including involvement in the selection process when/if a provider is changed); ▪ review and approval of the internal audit strategy, operational plan, reporting system, training for audit committee members and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework; ▪ consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise resources; ▪ ensuring that the internal audit function is suitably qualified adequately resourced and has appropriate standing within the organisation; and ▪ annual review of the effectiveness of the internal audit. The Committee shall review the work and findings of the external auditor appointed by the Council of Governors having taken account of the recommendations of the Audit Committee and consider the implications and management's responses to their work. This will be achieved by: ▪ consideration of the appointment, costs and performance of the external auditor, to be overseen by an task and finish group of the Council of Governors, chaired by the Audit Committee Chair; ▪ Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure coordination, as appropriate, with the other external auditors in the local health economy; ▪ discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; and ▪ review of all external audit reports, including their opinion on the annual report and accounts and agreement of the annual audit letter before submission to the board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to any reviews by Department of Health and Social Care Arms' Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Committee	Delegation
Audit Committee (continued)	In addition, the Committee will review the function of other committees including key concerns/risks highlighted by that committee, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality and Safety Committee and any risk management committees that are established. In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on a biannual arrangement of the assurance that can be gained from the corporate risks register and Board Assurance Framework.
Finance and Performance Committee	The key strategic responsibilities of the Committee are: 1. To monitor the financial position of the foundation trust, including approving the key financial assumptions to be used in strategic and business planning for recommendation to the board. 2. To monitor activity and the impact of any major changes in the economic, political and regulatory environment, and the associated financial risks. 3. To consider investment and divestment from services. 4. To monitor strategic cash flow, cash levels and liquidity. 5. To formulate the borrowing strategy for board approval. 6. To identify and review external financing arrangements/vehicles e.g. borrowing, joint ventures, PFI. 7. To identify, evaluate and recommend for board approval opportunities for strategic commercial partnerships. 8. To review the long-term capital investment plans. 9. To consider proposals for acquisition and disposal of assets. 10. Evaluation of strategic issues related to income e.g. contract negotiations, commissioning, CQUIN, tendering for new services, risks from competition. 11. To review the contractual framework relating to any material commercial relationships. 12. Monitoring of the implementation of service and site transformation and investment plans. 13. To consider the definition of core activities and non-core activities.
People Committee	The purpose of the committee is to approve the Workforce Strategy for the organisation and annual prioritised people objectives, to ratify human resources policies and procedures and to provide assurance to the board on workforce-related issues, taking account of local and national agendas. The key strategic objectives of the Committee are: 1. To ensure that the foundation trust has a workforce which is able to deliver sustainable, high quality, safe, effective care for our patients. 2. To provide assurance to the board on workforce issues, taking account of local and national agendas. 3. To monitor the implementation and relevance of the Workforce Strategy and People Promise. 4. To monitor and provide assurance to the board on the specific workforce risks identified within the Board Assurance Framework or corporate risk register and workforce-related corporate objectives

Committee	Delegation
	5. To monitor delivery of progress of the Workforce Strategy and mandated strategy. 6. To ensure strategic alignment of the foundation trust's people agenda within the long-term plan, national people plan and mandated standards.
Quality and Safety Committee	The key role of the Committee is to act as a scrutiny and assurance committee, to enable the board to obtain assurance that high standards of care are provided by the Foundation Trust and in particular that adequate and appropriate governance structures, processes and controls are in place throughout the Foundation Trust to: 1. promote safety and excellence in patient care; 2. monitor compliance with agreed standards, pathways and checklists; 3. identify, prioritise and manage risk arising from clinical care; 4. ensure the effective and efficient use of resources through evidence-based clinical practice; 5. protect the health and safety of foundation trust employees; 6. ensure consistency is maintained across all quality governance measures; and 7. ensure regulatory compliance, particularly in relation to CQC and NHS Improvement requirements.
Remuneration Committee	The purpose of the Remuneration Committee is to determine the remuneration and conditions of service of the Chief Executive, other executive directors and, exceptionally, other staff on Very Senior Manager pay arrangements. The key objectives of the Committee are to: 1. Determine the remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including: a. all aspects of salary (including any performance-related elements/bonuses); b. provisions for other benefits, including pensions and cars; and c. arrangements for termination of employment and other contractual terms. 2. Ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; 3. Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate and to advise and oversee appropriate contractual arrangements for such staff; The Committee shall seek the opinion of the Secretary of State when considering making an appointment or salary increase which is in excess of the Prime Minister's salary.
Charitable Trust Committee	The foundation trust is the sole charity trustee of the charitable funds in its corporate capacity. WWL NHS FT is the body that would be liable for any misapplication or mismanagement of WWL Charitable funds. The corporate trustees of charitable funds have powers under section 11 of the Trustee Act 2000 to appoint and delegate to agents. This power includes appointing a Charitable Trust Committee, whose members are not confined to its board members.

Committee	Delegation
	The Foundation Trust has appointed a committee to administer their charitable funds and those serving on the Committee are acting as agents of the foundation trust. As the foundation trust is the trustee, it must retain direct control of key decision making. Decisions are ratified and approved by the corporate trustee at separate meetings in which only charity business is carried out. The Committee sets the strategy and policy for the charitable fund(s) and sets the budget(s). The Committee should set spending priorities and criteria for individual spending decisions for each fund. It is the responsibility of the trustee to ensure that spending decisions taken by its agents are proper decisions that comply with the trustee's framework. The Committee will: 1. Agree the purpose and strategy of the Charity. 2. Approve arrangements for expenditure from the funds, including delegation to divisional representatives. 3. Determine the Charities investment strategy. 4. Agree all material fund raising initiatives. 5. Produce an annual report outlining all the charity's key achievements and areas of specific patient/public interest.

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Board Diversity Policy		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

Attached is a draft Board Diversity Policy which has been considered by both the Remuneration Committee (which is responsible for executive director recruitment) and the Council of Governors' Nomination and Remuneration Committee (which is responsible for non-executive director recruitment).

The board is recommended to approve the document as presented.

Risks associated with this report

The content of this report aims to support the foundation trust in ensuring that all board-level appointments are made on merit and with appropriate safeguards to ensure that candidates from different backgrounds are encouraged.

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☒	People	☐	Partnerships

The WWL Way

Board Diversity Policy

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

1. Introduction and scope

1.1. At Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust we are committed to the principles of equality, diversity and inclusion, both across the organisation and at board level. We recognise the benefit and value of diversity and we are committed to the creation of an inclusive culture where everyone has the opportunity to achieve their potential.

1.2. This policy applies specifically to the Board of Directors and there are separate policies which cover diversity and inclusion across our wider workforce.

2. How appointments are made

2.1. The appointment of executive directors is the responsibility of the Remuneration Committee, which comprises all non-executive directors and the Chief Executive (except in relation to the appointment of a Chief Executive where it comprises the non-executive directors alone) and the committee acts under delegated authority from the board. The appointment of a Chief Executive also requires the approval of the Council of Governors.

2.2. Non-executive directors are appointed by the Council of Governors at a general meeting. Recommendations as to appointment are provided by a dedicated committee, the Nomination and Remuneration Committee, which oversees the recruitment process on the council's behalf.

2.3. The Remuneration Committee's terms of reference require it to regularly review the structure, size and composition of the board (including the balance of skills, knowledge and experience) and to make recommendations to the board or the Nomination and Remuneration Committee of the Council of Governors for any changes.

2.4. The terms of reference of the Nomination and Remuneration Committee require it to periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors and, having regard to the views of the board and relevant guidance on board composition, make appropriate recommendations to the Council of Governors.

3. Policy statement

3.1. We believe that a broad range of skills, backgrounds, knowledge and experience is a key component of an effective board.

3.2. All appointments to the board will be made on merit against objective criteria, in the context of the overall balance of skills and backgrounds that the board needs to maintain in order to remain effective. Protected characteristics will be taken into consideration generally when evaluating the skills, knowledge and experience desirable to fill each board-level vacancy.

3.3. This policy sets out the process to be followed by the Remuneration Committee (for executive director vacancies) and the Council of Governors through its Nomination and Remuneration Committee (for non-executive director vacancies) during the recruitment process in order to attract candidates from diverse backgrounds who would enhance the balance of skills and backgrounds on the board.

4. Encouraging candidates from different backgrounds

4.1. The relevant committee will encourage the participation of candidates from diverse and under-represented backgrounds during recruitment processes in the following ways:

- when using an executive search firm, we will seek to engage one that is a signatory to the Executive Search Firms' Voluntary Code of Conduct;
- we will ensure that the brief given to the search firm (where used) and the candidate information pack include appropriate emphasis on diversity of skills and background, independence of approach and other personal qualities in addition to the usual requirements around career experience and compatibility with the values and behaviours of the organisation with a view to enhancing the overall effectiveness of the board;
- we will work with the search firm (where used) to design an inclusive search process that is open and accessible to candidates from any background and which encourages the widest possible field, and we will do this ourselves where the vacancy is managed in-house;
- we will encourage the search firm (where used) to produce long lists which include candidates from under-represented backgrounds of appropriate merit, and we will do so ourselves where the vacancy is managed in-house;
- we will consider high-performing senior executives from under-represented backgrounds who may not have previous board experience in executive and non-executive director roles, subject to the requirement for potential candidates to meet minimum requirements;
- we will ensure that all voting members of the final interview panel have completed appropriate training in recruitment which includes issues such as unconscious bias; and
- we will ensure that our interview panels are in themselves diverse.

4.2. Both committees are responsible for considering succession plans for directors and when non-executive directors are coming towards the end of their fixed term of office the Nomination and Remuneration Committee considers whether to recommend their reappointment to the Council of Governors. In carrying out these responsibilities, the committees shall have regard to this policy and the composition and skills requirements of the board at that time.

5. Responsibilities of the Chair

5.1. The Chair will ensure that boardroom diversity is considered as part of the annual evaluation of the board's effectiveness.

5.2. The Chair will ensure that a bespoke and comprehensive induction programme is provided to each new director which aims to address any gaps in a new director's knowledge and which is designed to be inclusive.

5.3. The Chair will take on an ongoing mentoring role for new directors, and may arrange for buddying arrangements to be implemented, with the agreement of the new director and the proposed buddy. As part of this arrangement, the potential for reverse mentoring will also be taken into account.

6. Monitoring and reporting

6.1. The annual report of the foundation trust shall include information on the policy on diversity and inclusion used by the committee, including the policy objectives and how this links with the foundation trust's strategy. It will also include information on how the policy has been implemented and progress on achieving objectives.

7. Review

7.1. This policy shall be reviewed by the Board of Directors on an annual basis.

7.2. The policy will continue to be informed by guidance from relevant reviews conducted in other sectors, such as the Hampton-Alexander Review (2020) on gender and the Parker Review (2020) on ethnicity.

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Provider licence self-certification		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

Each year, NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, and specifically conditions G6, CoS7 and FT4. The deadline for self-certification of conditions G6 and CoS7 is 31 May 2020 and the deadline for self-certification of condition FT4 is 30 June 2020.

Whilst an excel document is provided by NHS Improvement to facilitate this self-certification, the format does not lend itself well to review by the board. The content has therefore been duplicated in this report and it is proposed that, following approval by the board, the content will be inserted into the NHS Improvement template and the relevant signatures applied.

The attached content has been reviewed by the executive team and the board is recommended to approve the submissions as shown.

There is no requirement to submit the self-certifications to NHS Improvement. Rather, NHS Improvement will undertake an audit of a sample of FTs to confirm that they have self-certified.

Risks associated with this report

Self-certification is a mandatory requirement and this report mitigates the risk of non-compliance.

Link(s) to The WWL Way 4wards

☐	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

1. GENERAL CONDITION 6

The declaration for General Condition 6 is given below, and the board is required to respond either "confirmed" or "not confirmed".

"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

The board is recommended to direct that a response of "**CONFIRMED**" is provided. Information in support of this recommendation is contained in annex 1 to this report.

2. CONTINUITY OF SERVICES CONDITION 7

There are three declaration options available to the board and these are given below:

(a) After making enquiries, the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate; or

(b) After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services; or

(c) In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

If required, the board is recommended to respond **"CONFIRMED"** to declaration (a), above and to respond **"NOT CONFIRMED"** to declarations (b) and (c) above. Information in support of this recommendation is contained in annex 1 to this report.

The board is also required to provide a statement of the main factors taken into account when making the above declaration. It is recommended that the content of annex 1 relating to condition CoS7 is provided as the text of this statement.

3. FOUNDATION TRUST CONDITION 4

The board is required to respond to a number of statements in order to self-certify against condition FT4, as well as providing detail of the risks and mitigating actions. The statements, and the proposed responses are provided overleaf:

Statement	Response and detail of risks and mitigating actions
1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed** ▪ Compliance with NHS Foundation Trust Code of Governance regularly assessed and reported within the annual report. ▪ The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Company Secretary who has accountability for its maintenance). ▪ There are no material conflicts of interest in the Board. ▪ All governors' elections and by-elections are held in accordance with election rules. ▪ Systems and controls assurances are obtained via the Audit Committee. ▪ An independent review of leadership and governance using the well-led framework has recently been completed, with no material concerns having been highlighted. An action plan has been developed to ensure that good practice and other recommendations are implemented and embedded within the organisation ▪ The most recent CQC inspection report (published February 2020) rates the foundation trust as "good" in all areas, including well-led ▪ The most recent Use of Resources inspection undertaken by NHS Improvement rated the foundation trust as "good" ▪ More complete explanations about systems of corporate governance are set out in the annual governance statement and the foundation trust's annual report. ▪ The Company Secretary maintains an overview of corporate governance developments within the NHS and across wider sectors, and good practice is shared through established regional and national Company Secretaries Networks ▪ The Director of Governance maintains an overview of wider governance developments and good practice is shared through established networks.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Confirmed** ▪ Compliance with NHS Foundation Trust Code of Governance is assessed each year as part of the annual reporting process. ▪ Any guidance requirements are routinely assessed and implemented as necessary - overview of guidance provided by MIAA and Deloitte in updates received at each Audit Committee meeting. Assurance and advice is provided as required by the Audit Committee
3. The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation."	**Confirmed** ▪ Board committees established with clear lines of reporting. ▪ Terms of Reference in place for all Board and other committees and groups within the Trust which are regularly reviewed and updated where necessary. These set out remit of each type of meeting, membership, attendance by others, quorum requirements and reporting responsibilities. ▪ Chairs report to the board to escalate assurance and concerns in line with reporting structure. ▪ Clear delegation of actions to committees. ▪ Annual Governance Statement in place which identifies areas of potential risk and mitigating actions. ▪ Scheme of Delegation and robust Standing Financial Instructions in place
4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality	**Confirmed** ▪ Risk Management Strategy in place and regularly reviewed. ▪ Board Assurance Framework used extensively at each committee and board meeting ▪ Datix risk management system in place. ▪ Use of internal and external audit services to investigate any areas of concern. ▪ Quality and Safety Committee annually reviews compliance against the fundamental standards ▪ Self-assessments against CQC key lines of enquiry are undertaken by wards and teams. ▪ Inpatient and other CQC surveys utilised with action plans put in place where necessary.

Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	▪ Royal College reviews undertaken where appropriate or necessary. ▪ Contracts for services agreed with clinical commissioning groups. ▪ Finance and Performance Committee considers detailed financial performance report at each meeting ▪ Performance report considered at each Board meeting. Detailed performance discussed at quarterly divisional performance reviews. ▪ Comprehensive agendas for Board meetings circulated to directors in advance of each meeting ▪ Service and Value Improvement Plans in place which are risk assessed for quality ▪ Standing Financial Instructions and Standing Orders in place ▪ Counter Fraud specialist reports to the Audit Committee ▪ In relation to point (f) and (g), the Trust's annual report and operational plan have set out a number of high level risks facing the Trust and ways in which these are being mitigated. ▪ Points as set out in 1), 2) and 3) above apply.
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate,	**Confirmed** ▪ The Medical Director and the Chief Nurse are both appropriately professionally qualified and accountable to their professional body (in addition to the Trust). ▪ NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce, governance and organisational development. ▪ Collectively, the NED component of the Board is suitably qualified to discharge its functions. ▪ Quarterly Safe, Effective Care (SEC) report presented to Quality & Safety Committee and commissioners and shared with the Board. ▪ Quality and Safety Committee – chaired by a NED – Terms of Reference include reporting from Divisional Quality Executive Committees,

comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Safeguarding Committee, Medicine's Strategy Board and Infection Prevention and Control. ▪ Clinical Audits – the Trust participates in national audits and also local audits. Audit reports are submitted to relevant committees or groups. ▪ Learning from national reports with comparative reports undertaken and action plans devised and implemented. ▪ National reports and benchmarking e.g. NICE guidelines and patient safety alerts. ▪ Monthly leadership safety walk rounds undertaken by Executive directors, Non-Executive Directors and Governors. ▪ PLACE assessments ▪ Processes in place to escalate and resolve issues - Risk and Environmental Management Committee (REMC) established with reporting line to Quality & Safety Committee ▪ The executive team is supported by a cadre of appropriately-qualified and capable deputies and recruitment to vacant posts is currently underway
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed** ▪ The Medical Director, Chief Nurse and Chief Finance Officer are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust). ▪ All Executive Directors' performance and competencies are reviewed through annual appraisals. ▪ Collective & individual skill-sets reviewed as part of board development ▪ Chairman receives an annual performance appraisal from the Senior Independent Director, ▪ NEDs receive an annual performance appraisal from the Chairman who advises the governors ▪ NEDs have been appointed by the Council of Governors as advised by the governors' Nominations and Remunerations Committee ▪ NEDs individually bring extensive experience and expertise from many different areas of

	private and public sector activity including finance, commerce, governance, and, OD. . Collectively, the NED component of the Board is suitably qualified to discharge its functions. ▪ Once in post, each NED undergoes an internal induction to facilitate an understanding of the Trust, its operations and strategic direction. ▪ Thereafter, on-going training to develop existing and new skills relevant to the NED role is undertaken by attendance at external conferences and workshops as required. ▪ NED progress is monitored by the Chair via one to one meetings including a formal annual appraisal session at which achievements against objectives for the preceding year are evaluated and new goals for the forthcoming year and a personal development plan are established. ▪ This is supplemented by a number of Board away days throughout the year to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues. ▪ Divisions are led by experienced and capable teams consisting of a Divisional Director of Operations, Divisional Medical Director and Head of Nursing. ▪ Safer staffing levels on wards are reported to Board monthly and are monitored and are included on the wards' quality board.

Annex 1: Information in support of G6 and CoS7 declarations

Condition G6

There is no requirement on the self-certification form to show any evidence or mitigation, however, if required under audit, the following should be taken into consideration:

- The Board and supporting Committees and Groups (Audit Committee, Quality & Safety Committee, People Committee, Finance and Performance Committee and the Risk and Environmental Management Group) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance.

- The CQC undertook a comprehensive inspection of services in 2019 and published their report in February 2020. The foundation trust was rated as "Good" in all domains and there were areas of excellent practice.

- Governors hold Non-Executive Directors (individually and collectively) to account for the performance of our Board of Directors by ensuring that they act so that WWL does not breach its provider licence. Governors receive details of meetings, agendas and approved minutes of each Board of Directors' Meeting and regularly attend to observe directors in action.

Condition CoS7

The board made a going concern declaration in the annual report and accounts 2018/19 (the most recently-approved) and intends to make the same declaration in the 2019/20 report and accounts, following detailed consideration of the content.

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Terms of reference for the Remuneration Committee		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

The foundation trust is required to have a Remuneration Committee, whose role is set out in primary legislation.

The terms of reference of the Remuneration Committee have been reviewed and are attached for information. They follow a template provided by NHS Providers in its *Compendium of Good Governance* publication and have been updated to reflect the new organisation identity.

The board is requested to approve them as presented. Following approval, they will be published on our website as required by the NHS Foundation Trust Code of Governance.

Risks associated with this report

Approval of the terms of reference and publication on the website mitigates the risk of non-compliance with provisions B.2.10 and D.2.1 of the NHS Foundation Trust Code of Governance.

Link(s) to The WWL Way 4wards

☐	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. The Remuneration Committee ("the Committee") is constituted as a standing committee of the foundation trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

1.2. The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. MAIN PURPOSE

2.1. The main purpose of the Committee is to be responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration, allowances and other conditions of service.

2.2. When appointing the Chief Executive, the Committee shall be the committee described in Schedule 7, paragraph 17(3) of the National Health Service Act 2006 ("the Act"). When appointing the other executive directors, the Committee shall be the committee described in Schedule 7, paragraph 17(4) of the Act.

3. APPOINTMENTS ROLE

The Committee will:

3.1. Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board and the Nomination and Remuneration Committee of the Council of Governors as applicable with regard to any changes.

3.2. Give full consideration to and make plans for succession planning for the Chief Executive and other executive directors, taking into account the challenges and opportunities facing the foundation trust and the skills and expertise needed on the Board in the future.

3.3. Keep the leadership needs of the foundation trust under review at executive level to ensure the continued ability of the foundation trust to operate effectively in the health economy.

3.4. Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.

3.5. When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates, the Committee shall use open advertising or the services of external advisors to facilitate the search, consider candidates from a wide range of backgrounds and consider candidates on merit against objective criteria.

3.6. Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

3.7. Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

3.8. Consider any matter relating to the continuation in office of any executive director, including the suspension of termination of service of an individual as an employee of the foundation trust, subject to the provisions of the law and their service contract.

4. REMUNERATION ROLE

The Committee will:

4.1. Establish and keep under review a remuneration policy in respect of executive directors and any senior managers on locally determined pay.

4.2. Consult the Chief Executive about proposals relating to the remuneration of the other executive directors.

4.3. In accordance with all relevant laws, regulations and foundation trust policies, decide and keep under review the terms and conditions of office of the foundation trust's executive directors and any senior managers on locally determined pay, including:

(a) salary, including any performance-related pay or bonus;

(b) provisions for other benefits, including pensions and cars;

(c) allowances;

(d) payable expenses; and

(e) compensation payments.

4.4. In adhering to all relevant laws, regulations and foundation trust policies:

(a) establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the foundation trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the foundation trust;

(b) use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors and senior managers on locally determined pay, while ensuring that increases are not made where either the foundation trust's performance or individual performance do not justify them; and

(c) be sensitive to pay and employment conditions elsewhere in the foundation trust.

4.5. Monitor, and assess the output of the evaluation of the evaluation of the performance of individual executive directors and consider this output when reviewing changes to remuneration levels.

4.6. Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

4.7. Monitor the level and structure of remuneration for the first layer of management below board level and make associated recommendations to the Chief Executive for consideration.

5. MEMBERSHIP

5.1. The membership of the Committee shall consist of:

(a) The foundation trust Chair;

(b) The other non-executive directors;

And in addition, when appointing executive directors other than the Chief Executive,

(c) The Chief Executive.

5.2. The foundation trust Chair shall chair the Committee.

6. SECRETARY

6.1. The Company Secretary shall be secretary to the Committee.

7. ATTENDANCE

7.1. Only members of the Committee have the right to attend meetings of the Committee.

7.2. At the invitation of the Committee, meetings shall normally be attended by the Director of Workforce.

7.3. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

7.4. Any non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

8. FREQUENCY OF MEETINGS

8.1. Meetings shall be called as required, but at least once in each financial year.

9. MINUTES AND REPORTING

9.1. Formal minutes shall be taken of all Committee meetings.

9.2. Once approved by the Committee, the minutes should be circulated to the Board unless it would be inappropriate to do so.

9.3. The Committee will report to the Board after each meeting.

9.4. The Committee shall receive and agree a description of the work of the Committee, its policies and all executive director emoluments in order that these are accurately reported in the required format in the foundation trust's annual report and accounts.

10. PERFORMANCE EVALUATION

10.1. As part of the Board's annual performance review process, the Committee shall review its collective performance.

11. REVIEW

11.1. The terms of reference of the Committee shall be reviewed by the Board when required, but at least annually.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Finance Report

Month 1 ending 30th April 2020

The WWL Way

Contents

Performance on a Page 3

Performance on a Page

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	35,007			35,007		
Expenditure	(34,004)			(34,004)		
Financial Performance	0			0		
Cash Balance	66,066			66,066		
Capital Spend	7,036			7,036		

Key Messages:

- NHSI/E have been very clear to NHS organisations that financial governance must remain during the Covid pandemic. Informing the Public of the Trust's financial position is part of our governance and assurance process and as such the Financial Board Report will continue to be produced and issued.

- National operational planning was suspended mid-March therefore the Trust does not have a budget approved by NHSI.

- The Trust is reporting a break even position in Month 1 and year to date. This is as per the instruction from NHSI due to the block funding and financial arrangements in place during the Covid pandemic.

- Cash is £66.1m at the end of Month 1 which is £27.6m better than plan.

- Capital spend is £7.0m year to date. This includes £5.4m on Covid associated projects which will be fully reimbursed via non-interest bearing PDC.

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Financial governance – review of HFMA and internal audit guidance		
Presented by:	Acting Chief Finance Officer	**Purpose:**	Information

Executive summary

As discussed at the previous meeting, the Healthcare Financial Management Association and Mersey Internal Audit Agency have produced a number of guidance documents for use by organisations to help provide a sense-check that governance processes are proportionate and effective.

The attached report considers each of the areas of this guidance and provides significant assurance that the foundation trust has effective financial governance processes in place.

The board is recommended to receive this report and note the content.

Risks associated with this report

The content of this report is intended to provide assurance in relation to the potential risks surrounding financial governance.

Link(s) to The WWL Way 4wards

☐	Patients	☒	Performance
☐	People	☐	Partnerships

Purpose

The purpose of this paper is to provide assurance that the Trust has reviewed and amended where applicable its Financial Governance processes and procedures in light of the COVID-19 pandemic.

Background

The COVID-19 pandemic has had a significant impact on how businesses operate and whilst there has been some relaxing of 'business as usual arrangements', public sector bodies are still required to abide by the stewardship requirements of *Managing Public Money* and have a statutory duty to carry out their functions effectively, efficiently and economically.

The NHS will be called to account for its stewardship of public funds once the pandemic is over and NHS Improvement continue to stress the need for good governance during this period.

The Healthcare Financial Management Association and Mersey Internal Audit Agency have produced a number of guidance documents for use by organisations to help sense check governance processes are proportionate and effective. The documents outline key areas for consideration in respect of financial governance processes that could potentially be affected by the pandemic. This paper has been prepared using these guidance documents.

Financial governance considerations

Area for consideration		Organisation's Response
Approval	Authorised Signatories	
	• Are additional authorised signatories required to ensure 'contingency'/ cover arrangements for when staff are absent or operating remotely? • Are arrangements in place to allow remote authorisation rather than requiring physical signatures? • Are such electronic signatures held securely and is there an appropriate audit trail in place?	Approval of expenditure is undertaken electronically via Oracle and a sufficient number of approvers are set up within the system to support cover arrangements where necessary. Electronic signatures are available for approval of word or PDF documents to facilitate remote authorisation. These are held in a secure locations with access granted to only small number of individuals. The Trust also uses DocuSign which is a secure portal for authorising contract documents remotely.

Area for consideration		Organisation's Response
	Delegated Limits	
	• Do Scheme of Reservation and Delegation limits need to be amended to reflect any changes in working practices? These may include; ○ Order/ requisition authorisation levels (Potentially more people may need to be given the authority to authorise orders and requisitions); ○ Approval of bank/agency/locum staff (NHSE/I reporting requirements remain); ○ Requirements for quotations/tenders and waivers (Most SFIs require quotations or full tender. It will no longer be possible for supplies relating to COVID-19. New arrangements must be clearly documented); ○ Authorisation of overtime and expenses. ○ Authorisation of capital expenditure.	A number of amendments to the Trust's Standing Financial Instructions were approved by the Board on 25th March 2020. These included changes to: • Process for unbudgeted critical expenditure • Amendments to tender/waiver process for COVID-19 expenditure • Signing of contracts • Increases to approval limits • COVID-19 staff related appointments There have been no changes to the process for approval of overtime, expenses and capital expenditure.
	Extended Delegated Authority	
	• Has the Scheme of Delegation been reviewed to determine what should happen in the absence of a director or staff member to whom powers have been delegated? (e.g. consider if it is appropriate for the deputy director of finance to take on the responsibilities of a director of finance rather than another director) • Has the organisation considered horizontal delegation? (e.g. if a ward manager is not available then it may be appropriate for another ward manager to authorise transactions)	The Trust has in place a management structure which supports delegation of duties in the event of any absence. All Executive Directors have formally nominated deputies for the purposes of business continuity/resilience. To support ward managers who have had to spend increasing amounts of time on direct patient care additional resources have been deployed particularly in the area of keeping absence returns up to date as this is key intelligence when planning operational response options

Area for consideration		Organisation's Response
	Documenting Approval and Decisions	
	• Where a hard copy signature is usually required, have alternatives been considered e.g. e-mail or electronic authorisation and if so have appropriate controls been established? • Where an electronic system is already in place, has consideration been given to any new arrangements that may need to be established e.g. addition of new signatories? • Will the electronic system hierarchy need to be changed or a work around outside the system need to be introduced (provided adequate controls are maintained)? • Where key decisions have been made in relation to COVID-19 have these been adequately documented (accepting there is a balance to ensure the decision-making process is not slowed down)? • Has this documentation been held in an appropriate place, where it can be accessed at a later date? (e.g. on shared drives or in hard copy files rather than on local computer drives or emails) • Where waivers are required, is there adequate authorisation and documentation in place?	Email approvals and electronic signatures have been implemented where a hard copy signature is required but cannot be obtained. These changes relate mainly to payroll information such as assignment change forms and new starter form. All information is emailed to the payroll team via the manager. The Trust has set up a Central Command Team in response to the COVID-19 pandemic. 4 sub groups meet weekly and report into this team. All meetings are minuted. A log of actions taken and decisions made are recorded by each sub group and circulated to the members after each meeting. This information is fed back to the Central Command Team. Where waivers are required these are completed and approved in accordance with the waiver procedure The Trust Acting CFO participates in all regional and national DoF virtual meetings to ensure the Trust remains abreast of the latest guidance. Briefing materials are shared with all relevant teams.
Expenditure	COVID-19 Expenditure	
	• Is there a nominated individual responsible for capturing COVID-19 Expenditure? Has this been communicated to relevant staff?	A new cost centre code has been established to record all revenue expenditure incurred in respect of COVID-19. Subjective codes in accordance with the national chart of accounts are being used to record separate expenditure categories.

Area for consideration		Organisation's Response
	• Has the process to determine COVID-19 costs, costs centres and the evidence required been agreed and clearly communicated? • Is appropriate coding being applied to identify specific costs relating to COVID-19 for other expenditure e.g. oxygen supply, additional ventilators (may be some capital costs)? • Is appropriate coding being applied to identify specific costs relating to COVID-19 in relation to payroll, agency and consultancy? • Is there a process in place to capture additional staff costs paid (including bank/agency costs and 'lost time') because staff are self-isolating and unable to work from home (these may have to be captured outside of the core financial system)? • Are other COVID-19 related costs, such as the costs of cancelled annual leave being captured so that, if necessary, payment can be made to discharge the liability if the time cannot be given once the pandemic is over? • Has a decision been taken as to whether opportunity costs of COVID-19 are going to be captured in real time or whether these will be calculated once the pandemic is over? • Are quotations/ tender arrangements that may need to be waived for COVID-19 expenditure adequately documented?	This revised process has been communicated to all budget holders and prior approval for use of this code is required from the Acting Deputy Chief Finance Officer. A process has been implemented to capture and recode expenditure which cannot be coded to the COVID-19 cost centre at source. This is managed by the Divisional Finance Managers in close liaison with budget holders. This in includes monitoring of all temporary spend (bank, agency and local pay variations). The annual leave provision was revised at the end of the financial year to reflect cancelled annual leave in February and March. Staff are being encouraged to take annual leave in the new financial year to prevent staff burnout. There are plans to review the full cost and opportunity cost to the Trust once the pandemic is over. NHSI have indicated that the full cost review is being explored as part of the PLICS cost collection. SFI's have been amended to reflect the changes to quotation tender arrangements as a result of COVID-19.

Area for consideration		Organisation's Response
	COVID-19 Capital Spend – Below £15m	

	• Has a revised approval process been established for such capital spend to fast track decisions? (Guidance states that formal business cases no longer have to be prepared, but local delegated authority arrangements should continue).
	• Does the revised decision-making process ensure that decisions are fully documented? (This could be summary meeting notes/ actions with a list of those present either in person or virtually).
	• Where additional capital expenditure is required has consideration been given the NHSE&I guidance to ensure these costs can be reclaimed. The organisation will need to ensure it can demonstrate;
	  ○ The proposed expenditure is clearly linked to delivery of COVID-19 response;
	  ○ Where applicable, the asset is capable of being delivered within the expected duration of the outbreak;
	  ○ In the case of modifications to estate, the works must be capable of being completed within the expected duration of the outbreak.
	• Where cash funding is required, does the process ensure that NHSE&I approval is sought via regional offices and, where necessary, the national team?
		There has been no change to the approval process for capital expenditure. All COVID-19 related capital expenditure is approved in accordance with national guidance.
		
		All key decisions are discussed and recorded and have had full engagement with local and regional NHSI colleagues which has ensure the Trust has fully recovered all capital costs to date.

	Area for consideration	Organisation's Response
	COVID-19 capital spend above £15m	

	• Is there a process in place to ensure that the NHSE&I regional office is contacted for such expenditure?
	• Where additional capital expenditure is required has consideration been given the NHSE&I guidance to ensure these costs can be reclaimed. The organisation will need to ensure it can demonstrate;
	  ○ The proposed expenditure is clearly linked to delivery of COVID-19 response;
	  ○ Where applicable, the asset is capable of being delivered within the expected duration of the outbreak;
	  ○ In the case of modifications to estate, the works must be capable of being completed within the expected duration of the outbreak.
		There has been no change to the approval process for capital expenditure. All COVID-19 related capital expenditure is approved in accordance with national guidance.
		
		A robust process is in place for ensuring that all expenditure both revenue and capital is accurately recorded and is clearly linked to delivery in response to COVID-19.
		
		Examples of delivery include the delivery of Bryn Ward.

	Non-COVID-19 emergency capital spend	
	• Has the processes to support emergency capital for Non-COVID-19 items remained the same?	At present there has been no change in process for Non COVID-19 emergency capital spend. However, NHSI have indicated that governance for non-COVID capital spend may change and the Trust is in dialogue with NHSI regarding the possible changes.
	Travel and Subsistence	
	• Have staff been reminded of the NHS organisation's policies and processes with regards to claiming travel and subsistence?	The 3 month limit for submission and approval of travel and subsistence claims has been extended to 4 months. There has been no requirement to make any further changes to the process for claiming travel and subsistence.

Area for consideration		Organisation's Response
	• Has the level at which personal expenses (including subsistence) will be reimbursed been reviewed? • Where appropriate has new guidance been issued to all staff to reflect changes to allowances and processes during COVID-19? • Where staff require accommodation (as they have been asked to stay away from home in order to continue to work) are arrangements in place to allow these to be booked centrally? • Does the authorisation of overtime and expenses continue to be recorded in advance? • Once claims have been received are these only processed once they have been validated i.e. have the appropriate authorisation and original receipts?	The Trust has secured hotel accommodation in the locality at less than 50% than the national rates that were offered and is managed through the Trust Hotel Services Manager following a recommendation from the relevant line manager. The Trust has well established payment processes that have been retained during the pandemic and to date all payrolls have run on time Validation of all claims continues to be undertaken with approval of overtime and expenses being completed prior to any payment being made with.
	Payroll/Timesheets and E Rostering	
	• Is all overtime authorised in advance and formally signed off once complete? • Are existing controls for the sign off of E Rosters and Timesheets still operating? • Are payroll processes in place to set up and capture COVID-19 temporary/fixed term staff and ensure they are removed from the payroll once their employment with the organisation has ceased?	All overtime is authorised in advance and signed off once completed. Existing payroll controls remain in place for all e-rostering and ESR processes. Fixed term contracts are set up within ESR to expire at the end of the contract term, at this point pay is automatically stopped. All staff appointed as a result of COVID-19 are being coded to the COVID-19 cost centre in line with the extant national guidance
	Bank and Agency/ Locums Usage	

Area for consideration		Organisation's Response
	• Are framework agencies being utilised wherever possible? • Is the use of bank and agency staff/ locums appropriately approved in advance? • Are the hours worked by bank and agency/ locums formally signed off by an appropriate individual at the end of each shift? • Are appropriate checks being completed to ensure the invoices received in relation to the above match the hours requested and hours completed and the rates agreed? • Is the use of agency/locum staff still being reported to NHSE/I?	There have been no changes to how the trust engages locum and agency workers. A direct engagement model is provided by NHSP and all agencies within this model are on framework. A break glass policy is in place where the requirement to fill a shift cannot be done via a framework agency. All timesheets are checked and approved before payment is made and this is undertaken via the NHSP portal. The operational planning process for 20/21 has been suspended and this includes the requirement for Trusts to manage their agency expenditure against an agreed agency ceiling. Whilst the Trust is not formally reporting agency spend to NHSI this area of spend is still being monitored and reported internally.
Stock & Asset Management	Supplier Management	
	• Are existing arrangements for the establishment of new suppliers being maintained or has the process been revised to ensure the quick delivery of supplies? • If the process has been revised, are controls sufficient to protect against fraud and is an audit trail in place to document why that supplier is used? • Are supplier change requests confirmed using verified contact information? • Are arrangements in place to ensure suppliers are paid promptly during this time, without exposing the organisation to unacceptable risk?	Process revised to ensure speedy delivery of supplies required for response to COVID-19 including suspension of supplier declaration questionnaire. Risk of associated fraud relatively low as payments to suppliers primarily only made on receipt of goods. Auditable evidence available although not necessarily consolidated at present – some work to be completed retrospectively. Supplier change requests continue to be dealt with under usual verification process. Outstanding supplier invoices are reviewed on a weekly basis to ensure that these are being approved for payment and the Trust has

Area for consideration		Organisation's Response
	• Is cumulative supplier spend being monitored regularly, particularly with respect to spend against new suppliers that have been put in place due to COVID-19 to ensure that any new company engaged, where reduced due diligence has occurred, is not taking advantage of the current position?	moved to 2 supplier payment runs per week to ensure suppliers are being paid promptly. Spend is being submitted to the National Spend Comparison service, which will allow benchmarking and supplier spend to be monitored.
	• Where practicable are robust claw back agreements in place to be able to recover funds that are paid out incorrectly?	We have adhered to the national guidance and only paying 25% upfront where appropriate. All orders placed are subject to the standard NHS Terms and Conditions.
	Management of Stock	
	• Has the frequency and timing of stocktakes been considered for stock that will be in high demand e.g. protective equipment, hand sanitiser and toilet rolls?	The PPE store conducts a daily stock take and uploads data to Adviseinc Stockwatch and more recently NHS Foundry. This includes burn rates and predictions on numbers of days stock holding.
	• Where inventory is held and managed from central stores has consideration been given to reducing or limiting the quantity of some items that can be requisitioned at any one time to reduce the risk of unused stock being held on some wards while others are running short?	The Trust established a secure centralised PPE store at the outset of the pandemic to manage and distribute all PPE on a PUSH basis rather than a pull basis thereby ensuring the appropriate stock is issued.
	• Have stock items been reassessed to identify the appropriate levels that will now be required to ensure supplies are sufficient and don't impact on patient care?	The recent use of the NHS Foundry portal allows identification of burn rates to ensure supplies are sufficient.
	• Have stock items been reviewed to identify those that will not be in such high demand or not needed during this crisis?	None critical stock items remain the responsibility of the wards and departmental level and associated budget holders. As such they will have maintained the appropriate stock levels.
	• Where such items have been identified, have stockroom facilities been reviewed and these items moved (and stored securely) to enable storage and quicker access to essential stock?	N/A A centralised PPE store has been established to serve the whole trust therefore ensuring essential stock is appropriately reviewed, moved and stored.

Area for consideration		Organisation's Response
	• What arrangements have been established for patients with on-going conditions that may need consumables (medicines, dressing) but they are being seen at home or virtually? • Where inventory is moved to other organisations for partners, are records kept of where these items are being sent to ensure they are appropriately accounted?	Community nursing teams continue to support our patients in the community Greater Manchester has established mutual aid processes and the agreement in line with national guidance is that there is no cross charging as all costs incurred are being recovered by the monthly financial "true up" arrangements
	Asset Register	
	• Where possible, are fixed asset registers being kept up to date? • Are new assets being tagged and documented in the fixed asset register? • Where applicable are new assets being coded as specific to COVID-19? • Is a local asset register being maintained by all managers with staff working from home to ensure that all IT equipment is traceable and where appropriate returned after the COVID-19 lockdown? • Has this local asset register been shared and checked by IT teams at the earliest opportunity? • Is are process in place to review local asset registers to confirm accuracy and completeness? • Are processes in place to monitor the return of IT equipment after the COVID-19 lockdown?	Fixed asset registers are being kept up to date. All COVID-19 capital purchases are being coded to specific COVID-19 capital codes. IT Services has a full asset register known as a Configuration Management Database for all IT assets connecting to the network, whether from home or internally. Once devices have been configured by IT Services the ongoing management of the devices resides with departments. A log has been maintained of all IT equipment that has been issued to all teams who are working from home and this will be monitored and checked when staff return to the office.

Area for consideration		Organisation's Response
	Banking	
	• Are bank account signatories sufficient to cover arrangements in the event of a significant number of absences? • Are electronic signatures held securely for the bank account signatories in cases where physical signature cannot be obtained? (An audit trail should be documented). • Do banking arrangements need to be reviewed to try to eliminate the need to go to the bank?	There are only a very small number of instances where bank signatures are required (mainly for the approval of direct debit payments) All bank signatories are up to date and sufficient enough to cover arrangements in the event of a number of absences. Electronic signatures are held for all bank signatures and are held securely by nominated staff. The Trust does not have any arrangements in place which require access to a local branch of its bank.
	Credit Cards	
	• Is there a record of who has an organisation credit card and is this up to date? • Are receipts being retained for all credit card purchases? • Are all statements being reviewed and where appropriate challenged promptly? • Are all items being coded correctly particularly if they are specific to COVID-19?	An up to date record is maintained of all credit cards that are currently in issue. A robust system is in place for ensuring that credit card purchases are only used where another form of payment is not available. All uses are logged and valid receipts/invoices required to support purchase. All items of COVID-19 expenditure are being appropriately coded to the specific COVID-19 cost centre.
	Processes	
	• Has the organisation made a decision to no longer invoice the commissioners as payments will now be made automatically by commissioners?	Operational planning for 202/21 has been suspended and in accordance with guidance issued by NHSE & NHSI the Trust has suspended invoicing for contracted and non-contracted activity.

Area for consideration		Organisation's Response
	• Are all procedure notes in place and readily accessible to all including electronically, particularly creditors and payroll? • Are procedures being developed as and when required to support system changes/ new systems and are these adequately approved, documented and disseminated to relevant staff?	Invoices in respect of other recharges are being raised in accordance with guidelines issued by GM. All procedure notes for finance are up to date and readily accessible to all members of the team. Changes to processes and procedures are notified to the teams via email so that a written record is maintained.
	Access to the Network	
	• Have arrangements been made to ensure finance staff working remotely can access the organisation's financial software systems securely e.g. use of VPNs? • Have IT functions disseminated guidance about remote working and logging onto secure systems to ensure finance staff working remotely are aware of processes for accessing the organisation's financial software systems securely?	All staff working from home have access to the Trust network via a secure VPN. A number of user guides for remote working have been issue by the IT team including how to access Trust emails without logging onto the trust network; and the use of Microsoft Teams for meetings and calls.

	Area for consideration	Organisation's Response
Routine Processess	**Annual Accounts and Annual Reports**	
	• Has the accounts timetable been updated to reflect new deadlines? • Are arrangements in place to review the annual report once the revised guidance is published? • Has it been agreed which forum will approve and sign off the accounts?	The Trust incorporated the revised DHSC timetable for the completion of its accounts. The deadline for submission of the draft Annual Accounts was amended from 24th April to 27th April and the accounts were submitted in accordance with this deadline. Implementation of IFRS16 has been deferred for a further year and the Trust has amended its accounts to reflect this. A revised date of 25th June has been set for the submission of the final accounts and Audit Committee has been rescheduled to sign off the accounts in sufficient time to meet this deadline.
	2020/21 budget	
	• Has the 2020/21 budget been set in line with latest guidance? • Have arrangements been reviewed to ensure that this is appropriately approved in line with the organisation's Corporate Governance Manual? • Has it been agreed which forum will approve and sign off the budget?	The operational planning process for 20/21 has been suspended with NHS organisations including the Trust moving to a block contract payment 1st April. This arrangement is in place until 31st July and should allow the Trust to provide a break even position during this period. A budget paper was approved by the executive team for the 20/21 budget. This was based on the draft plan submission to NHSI with amendments for the specific changes due to the covid-19 financial arrangements. The budget has been set at cost centre level. The budgetary monitoring process will still be in place during this time with month end reporting continuing as normal. Budget holders will receive their budget statements and other reports through the DFM system every month by working day 10. A communication has been sent to all budget holders and to the Divisional Directors of Operations

Area for consideration		Organisation's Response
		to detail the approach being taken to financial reporting during the pandemic.
	CIP	
	• Have 2020/21 CIPs been reviewed to identify which schemes are relevant and useful to continue? • Where a decision is made for a programme to cease is this clearly documented?	The Director of Strategy and Planning discussed the 2020/21 SAVI (CIP) programme with the Trust Board in March. The programme has been suspended to allow operational leads to focus on the response to covid-19. This covered both internal and system wide efficiencies. As the Trust enters the recovery phase the approach for the current year will be revisited by the Transformation Team and consideration given to which schemes could continue.
	Month end processes	
	• Has a month end process been established to ensure that the organisation can claim on a monthly basis for COVID-19 spend? • Are other month end processes and reporting, including cash flow forecasting still in place?	The process for reclaiming COVID-19 expenditure is built into the monthly return that is submitted to NHSI and forms part of the finance monthly reporting procedure. All month end processes and procedures including cash flow forecasting balance sheet monitoring and reporting of income and expenditure are still being maintained.
	Cash Flow	
	• Are routine cash flow reviews and forecasting arrangements in place to ensure sufficient cash is available to enable the prompt payment of suppliers?	There has been no change to how the Trust monitors and manages it cash position. Cash balances are reviewed and forecasts updated on a weekly basis. The Trust currently has high levels of cash and all suppliers are being paid promptly.

REPORT

AGENDA ITEM: 11

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Register of directors' interests		
Presented by:	Company Secretary	**Purpose:**	Information

Executive summary

The Register of Directors' Interests as at 12 May 2020 is appended to this report for review by the board, in line with best practice. Directors are reminded of the need to declare any interests at the time they arise and to declare any potential conflicts of interest in any business to be transacted by the board or any committees served. Further information is available from the Company Secretary on request.

The board is also required to identify in the annual report each non-executive director that it considers to be independent; both in terms of character and judgment and whether there are any relationships or circumstances which are likely to affect or appear to affect the director's judgment.

In previous years the board has determined that all non-executive directors are independent and there have been no significant changes to bring to the board's attention this year.

Risks associated with this report

There are no risks associated with the content of this report.

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☒	People	☐	Partnerships

The WWL Way

Register of directors' interests as at 12 May 2020

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Name	Role	Any interest or position held in any firm, company or business which has or is likely to have a trading or commercial relationship with the FT	Interest in an organisation providing health and social care services to the NHS	Position of authority in a charity or voluntary organisation in the field of health and social care	Any connection with any organisation, entity or company considering entering into a financial arrangement with the FT	Details of any secondary employment (executive directors only)
NON-EXECUTIVE DIRECTORS						
ARMSTRONG, Robert	Chair	Vice-Chair, Belong at Home Limited (CRN: 06802726)	Vice-Chair, Belong at Home Limited (CRN: 06802726); Director, Borough Care Services Limited (CRN: 02603702)	Co-Chair of Governance, Centre of Excellence Safety of Older People CIC (Reg. No.: 12554455)	Nil	N/A
AUSTIN, Clare	Non-Executive Director	Associate Dean, Research and Innovation and Director of Medical Education, Faculty of Health and Social Care, Edge Hill University	Nil	Nil	Associate Dean, Research and Innovation and Director of Medical Education, Faculty of Health and Social Care, Edge Hill University	N/A
BRADLEY, Rhona	Non-Executive Director	Nil	Non-Executive Director, Home Group Housing Authority	Chief Executive and Company Secretary, Addiction Dependency Solutions (CRN: 01990365, charity number: 702559) | Director and trustee, The London Pathway (CRN: 07210798, charity number: 1138741)	Nil	N/A
ELLIOT, Steven	Non-Executive Director	Cancer lead, NHS Salford CCG | Partner is a director of Health First ALW and Wigan GP Alliance LLP (Reg. No.: OC411316)	Non-Executive Director at Health First ALW CIC (Reg. No. 07576630); Partner is a director of Health First ALW and Wigan GP Alliance LLP (Reg. No.: OC411316)	Nil	Cancer lead, NHS Salford CCG | Medical Advisor, NHS England | GP Partner, Westleigh Practice | Partner is director of Wigan GP Alliance LLP (Reg. No.: OC411316)	N/A
GUYMER, Michael	Non-Executive Director	Director, OneRedwood Limited (CRN: 08599564)	Nil	Member, NHS Procurement Customer Board | Chair, NHS Northern Procurement Customer Board	Nil	N/A
HAYTHORNTHWAITE, Ian	Non-Executive Director	Nil	Nil	Nil	Nil	N/A
LOBLEY, Lynne	Non-Executive Director (Senior Independent Director)	Nil	Nil	Nil	Nil	N/A
WARNE, Anthony	Non-Executive Director (Vice-Chair)	Nil	Professor Emeritus, Universirty of Salford; Non-Executive Director, Blackpool Teaching Hospitals NHS FT	Nil	Nil	N/A

Name	Role	Any interest or position held in any firm, company or business which has or is likely to have a trading or commercial relationship with the FT	Interest in an organisation providing health and social care services to the NHS	Position of authority in a charity or voluntary organisation in the field of health and social care	Any connection with any organisation, entity or company considering entering into a financial arrangement with the FT	Details of any secondary employment (executive directors only)
EXECUTIVE DIRECTORS						
ARYA, Sanjay	Medical Director	Nil	Wife is General Practitioner In Bolton	Member of Executive Committee, British International Doctors' Association and Bihar Jharkhand Medical Association	Nil	Private practice (out of hours)
BALSON, Alison	Director of Workforce	Nil	Nil	Nil	Nil	Nil
FLEMING, Mary	Chief Operating Officer	Nil	Nil	Nil	Nil	Nil
MUNDON, Richard	Director of Strategy and Planning	Nil	Nil	Nil	Nil	Nil
MURPHY, Gerard	Acting Chief Finance Officer	Nil	Nil	Nil	Nil	Nil
NICHOLLS, Silas	Chief Executive	Nil	Nil	Nil	Nil	Nil
RICHARDSON, Helen	Chief Nurse	Nil	Nil	Nil	Nil	Nil

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Directors' fit and proper person checks		
Presented by:	Company Secretary	**Purpose:**	Information

Executive summary

It is a requirement of the foundation trust's provider licence that no "unfit person" may be appointed as a director without the written approval of NHS Improvement. The foundation trust is also required to ensure that its directors' contracts contain a provision permitting summary termination in the event of them being or becoming an unfit person (this is included in all contracts) and to enforce that provision promptly upon discovering them to be an unfit person, except with the written approval of NHS Improvement.

Similarly, Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires the foundation trust not to appoint or have in place as a director someone who does not meet the requirements stated within the Regulation. This requirement also extends to those fulfilling a similar role and assurance on this wider point is provided via the Quality and Safety Committee each year, as part of a cycle of reviews of compliance with standards.

All directors complete a "fit and proper person" declaration each year to confirm their continuing compliance with the requirements. In addition, independent checks against information in the public domain are undertaken each year. The results of these checks are shown in the attached table and the board can be assured that no areas of concern have been identified.

Risks associated with this report

The content of this report is intended to mitigate the risk of breaching the terms of the foundation trust's provider licence or the Regulation shown above.

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☒	People	☐	Partnerships

The WWL Way

Directors' fit and proper person checks 2020

Name	Role	Search of register of disqualified directors	Search of bankruptcy and insolvency register	Search of register of disqualified and removed charity trustees	General search of public information via internet search engine	Professional registration checks[1]
NON-EXECUTIVE DIRECTORS						
ARMSTRONG, Robert	Chair	No match	Entry for matching name. Case reviewed and different person. No match	No match	No issues identified	N/A
AUSTIN, Clare	Non-Executive Director	No match	Entry for matching name. Case reviewed and different person. No match	No match	No issues identified	N/A
BRADLEY, Rhona	Non-Executive Director	No match	No match	No match	No issues identified	N/A
ELLIOT, Steven	Non-Executive Director	No match	Three entries for name with a surname spelling variation. All cases reviewed and different people. No match	No match	No issues identified	N/A
GUYMER, Michael	Non-Executive Director	No match	No match	No match	No issues identified	N/A
HAYTHORNTHWAITE, Ian	Non-Executive Director	No match	Entry for matching name. Case reviewed and different person. No match	No match	No issues identified	N/A
LOBLEY, Lynne	Non-Executive Director (Senior Independent Director)	No match	No match	No match	No issues identified	N/A
WARNE, Anthony	Non-Executive Director (Vice-Chair)	No match	No match	No match	No issues identified	N/S

Name	Role	Search of register of disqualified directors	Search of bankruptcy and insolvency register	Search of register of disqualified and removed charity trustees	General search of public information via internet search engine	Professional registration checks[1]
EXECUTIVE DIRECTORS						
ARYA, Sanjay	Medical Director	No match	No match	No match	No issues identified	GMC registration confirmed. No fitness to practise issues identified.
BALSON, Alison	Director of Workforce	No match	No match	No match	No issues identified	CIPD membership confirmed.
FLEMING, Mary	Chief Operating Officer	No match.	Entry for matching name. Case reviewed and different person. No match	No match	No issues identified	N/A
MUNDON, Richard	Director of Strategy and Planning	No match	No match	No match	No issues identified	N/A
MURPHY, Gerard	Acting Chief Finance Officer	Entry for matching name but case reviewed and different person. No match	Two entries for the same name. Both cases reviewed and different people. No match	No match	No issues identified	CIPFA membership confirmed.
NICHOLLS, Silas	Chief Executive	No match	No match	No match	No issues identified	N/A
RICHARDSON, Helen	Chief Nurse	No match	Three entries with matching or similar names. All cases reviewed and different people. No match	No match	No issues identified	NMC registration confirmed. No fitness to practise issues identified.

[1] Professional registration checks are undertaken for posts where such registration was included in the person specification as an essential requirement of the role. Fitness to practice checks are also undertaken for those with clinical registration.

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	27 May 2020
Subject:	Register of referrals received by the Clinical Ethics Group		
Presented by:	Company Secretary	**Purpose:**	Information

Executive summary

It was agreed at the Pandemic Assurance Committee on 13 May 2020 that a high-level summary of cases referred to the Clinical Ethics Group would be reported to the board each month.

The attached table summarises the referrals that have been received from the group commencing on 23 April 2020 to 19 May 2020.

Risks associated with this report

There are no risks associated with the content of this report.

Link(s) to The WWL Way 4wards

☒	Patients	☐	Performance
☒	People	☐	Partnerships

The WWL Way

Register of referrals made to the Clinical Ethics Group
23 April 2020 to 19 May 2020

Ref.	Date of referral	Time of referral	Urgent or routine referral	Date CEG convened	Time CEG convened	Summary of case	CEG recommendation	Issues escalated to management
CEG-001	1 May 2020	2045hrs	Urgent	1 May 2020	2120hrs	Request for elderly parents to be allowed to visit patient receiving end-of-life care where death was considered to be imminent. Balancing risk to the visitors against desire to visit their relative.	Recommended that visiting be permitted provided risks are explained and PPE is available and can be provided.	Noted that there are conflicting visiting policies in existence. Management to address and have one single policy.
CEG-002	3 May 2020	0942hrs	Retrospective for assurance	7 May 2020	0800hrs	Request to review the care of a now deceased patient, with particular reference to the DNACPR decision-making	Noted that the referral did not require consideration of ethics in the current sense but comments on the case provided to the Medical Director by way of peer review. No concerns around decision-making or documentation identified.	Nil.