## Board Assurance and Escalation Framework

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1. INTRODUCTION

Lincolnshire Partnership Foundation Trust (the Trust) has in place a governance process that includes a range of policies, systems and processes, which together comprise an integrated assurance and escalation framework (the Framework).

This document describes the Trust’s Board Assurance and Escalation Framework (BAEF) and demonstrates how the Trust’s quality systems and organisational learning is monitored by an effective committee structure. The processes also link to Monitor’s Quality Governance Framework, which is structured around four pillars: Strategy, Capabilities and Cultures; Process and Structures; and Measurements.

The BAEF provides the Board with assurance about how the organisation is able to identify, monitor, escalate and manage concerns in a timely fashion at an appropriate level.

2. PURPOSE

The BAEF describes the responsibility and accountability for the Trust’s governance structures and systems through which the Board receives assurance or escalated concerns/ risks related to quality of services, performance targets, service delivery and achievement of strategic objectives.

3. DEFINITION OF QUALITY

Quality in the NHS is defined in terms of three domains: Patient Safety, Patient Experience and Clinical Effectiveness (Darzi, 2008 NHS Next Stage Review, Department of Health 2008), which are now enshrined in the Health and Social Care Act 2012. Monitor considers that maintaining and improving quality is an important indicator of the effectiveness of governance within a Trust.

The Trust’s Quality Strategy outlines the Trust’s strong commitment to improving quality and safety; and the importance of being able to evidence this by positive treatment outcomes and continuously improving services. The strategy reinforces the Trust’s commitment to providing safe and effective services that embrace the 6 ‘Cs’ (care, compassion, courage, communication, competence and commitment). The Trust has fully implemented Duty of Candour (CQC Regulation 20, which came into force October 2014); within a culture of openness where staff have a duty to speak out if they have concerns about standards of care; and in which leadership is strong and accountable at all levels is clear, so reinforcing the Trust’s values and required standards.

4. THE TRUST BOARD

The Trust Board is responsible for ensuring robust quality governance processes are in place to:

- Ensure required standards are achieved
- Investigate and take action on sub-standard achievement
- Plan and drive continuous improvement
- Identify, share and ensure the delivery of good practice
- Identify and manage actual and potential risks to the quality of care
- Ensure there are clear roles, responsibilities and processes for managing quality and escalating and resolving issues
- Ensure appropriate information, which is subject to robust data quality controls, is used for assurance and decision making
- Ensure there is an open culture within the Trust that promotes learning which is supported by ‘Being Open’ and ‘Whistleblowing’ procedures.
To have the capability to fulfil this function the Board is required to provide leadership and have the necessary skills and knowledge. To provide assurance that the Board has the capability and competence an annual self-assessment and periodic (minimum 3 yearly) independent assessment is undertaken. In addition, an effective appraisal process for Board members is also in place.

5. RECEIVING ASSURANCE AND IDENTIFYING CONCERNS

The Trust has a number of systems and processes which support the delivery of high quality care and ensure good governance. These processes enable those responsible for delivering, monitoring and receiving care to provide assurance to the Trust Board and also identify and raise concerns.

5.1 Staff Duties and Involvement

The Trust has a number of policies and systems which mandate staff at all levels to be involved in monitoring quality and performance and to raise concerns about any issues. In addition to the Trust’s strong culture of support and clear accountability delivered through effective line management, these include:

- Trust policies and procedures, which include detail on reporting and escalation
- Quality Strategy
- The Whistle Blowing Procedure
- HR Policies
- Safeguarding Policy (Children and Vulnerable Adults)
- Clinical Care Policy (which includes sections on assessment and management of risk and incidents)
- Incident reporting and management policies
- Information Governance policies and processes
- Board visits to clinical areas
- Chief Executive Risk and Assurance Reviews, known as the Chief Executive’s Road Shows
- Staff Surveys
- Staff Friends and Family Test (FFT) feedback
- Staff stories to the Board
- Staff Partnership Forum
- Induction Programme
- Inspirational Leadership Programme
- Performance and Appraisal Development Process
- CQC and NHSLA compliance
- Internal 15 Steps / mock CQC visits schedule
- Trust Learning Lessons Bulletins

5.2 Patient, Carer and Public Involvement

The Trust actively seeks to work in partnership with service users, carers, governors, staff and the public; and welcomes their involvement and feedback on how they can become more involved in decision making processes. The Trust also encourages comments and/or concerns to be raised, formally or informally to support an open and transparent culture of communication and learning. The following are some of the mechanisms that support patient, carer and public feedback and involvement:

- Consultation and Public Involvement Policy
- PALS (Patient Advice and Liaison Service)
- Complaints – Formal and Informal
- Patient Opinion
- Service user and carer experience surveys, including the ‘Friends and Family Test’
- Service user and carer forums
- Involvement Committee
- Recovery College
- Healthwatch
- Local Authority - Health Overview and Scrutiny
- Patient-led assessments of the care environment – PLACE
- Managed Care Network and SHINE
- Ward Community Meetings
- Patient Stories to Board
- Governor drop-in sessions
- Annual Public Meeting
- Internal 15 Steps / mock CQC visits
- Peer Support roles

The Trust positively engages with service users, carers and the public and welcomes their involvement and feedback on how they can become more involved in decision making processes.

5.3 **Commissioners of Services**

There are formal mechanisms by which commissioners can raise concerns. These include:

- Board to Board meetings
- Contract and Performance Review meetings
- CQUIN monitoring
- Quality Review meetings
- Complaints
- GP Concerns
- Serious Incidents
- Patient Safety Incidents reported via NRLS (National Reporting and Learning System)

5.4 **Internal and External Sources of Assessment and Assurance**

In addition to sources of assurance identified above, there are numerous internal and external sources which cover the range of the Trust’s activities and include:

- Internal Audit
- External Audit
- Monitor
- Care Quality Commission – Compliance Inspections
- Care Quality Commission – Mental Health Act Commissioner Inspections
- Care Quality Commission – Speciality Reviews
- NHSLA
- Health and Safety Executive
- Externally commissioned independent investigations e.g. Ombudsman and homicide investigations
- Clinical Audit
- National Audit
- Royal College reviews
- Accreditation, e.g. AIMS
- Information Governance Toolkit
- Benchmarking with other NHS providers
- Involvement in and learning from Domestic Homicide Reviews and Serious Case Reviews
- Coroner’s Inquests

V2 as at 30.1.15
The Trust also commissions external reviews of its activities where the need for additional independent assessments and assurance is identified.

6. TRUST INTERNAL SYSTEMS FOR MONITORING PERFORMANCE, DECISION MAKING AND ESCALATION

The Trust operates a process of ‘distributed leadership’ through the two clinical divisions. A ‘ward to board’ structure showing the relationship between clinical teams and the Board is included as Appendix 1. Each Division has its own structures for governing quality from its clinical teams, which report into the corporate structures and processes.

Processes for monitoring performance, managing risk, receiving assurance and escalating concerns are outlined below. These processes commence at team level, with assurance and escalation of risk managed as appropriate through to Board level. The diagram below defines the ‘Assurance and Escalation Pyramid’ and demonstrates the route assurance and escalation takes.

The Trust operates an Executive and an Operational on-call system which is used to seek advice and escalate issues of concern and/or high risk.

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**The timescale in which concerns are escalated or assurance provided varies according to the significance of the concern. This may be through routine monitoring systems defined below, or if required through the fast track* process.**

Senior Managers and Executive Directors use judgement to determine the timescale for escalation, influenced by the impact the issue has on the delivery of safe, high quality care or organisational reputation.

*The Trust Communications Department operates an as required, fast-track process for communicating with Board members.

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**Diagram 1 – Assurance and Escalation Pyramid**
6.1 Risk Registers

Risk Registers are maintained at divisional and corporate levels with the highest level risks reported to the Board each month.

If required, the Trust’s Communication Department will ensure Board members are informed on significant issues through the fast track process.

The Divisional Risk Registers are monitored via the Operational Governance Meeting chaired by the Director for Nursing and Quality. Highest level risks are reported to the Board and the Quality Committee by the Director for Nursing and Quality. These relate to issues with quality, safety or organisational reputation. Issues include, but are not limited to:

- Significant serious incidents, e.g. in-patient suicides, in-patient deaths where the care and treatment provided to the patient may have been a contributing factor, homicides by Trust service users.
- Significant complaints; and complaints which are difficult to manage.
- Significant claims.
- Incidents which have required a RIDDOR report and/ or resulted in a visit by the Health and Safety Executive (HSE).
- Forthcoming inquests where the Trust’s delivery of safe services may be criticised.
- Prevention of Future Death Reports from the Coroner.
- Non-compliance against Care Quality Commission (CQC) outcomes which have major impact.
- Receipt of any Improvement or Enforcement Notice from CQC, HSE or other regulator.

6.2 Committee Structure

To support the Trust Board in carrying out its duties effectively, committees reporting to the Board are formally established. The remit and terms of reference of these committees are reviewed each year to ensure robust governance and assurance arrangements are in place. Each committee receives a set of regular assurance reports from other committees and groups, as outlined within their terms of reference and provides summary reports to the Trust Board after each meeting. This provides an effective structure with defined information flows for monitoring performance, receiving assurance and identifying under performance and concerns which require escalation. This structure is detailed in Appendix 2 and the role and function of key committees is detailed in Appendix 3. The key committees for monitoring quality and performance are the Quality Committee, Audit Committee and Planning and Investment Committee. Ad-hoc additional meetings are convened as required.

The Quality Committee is responsible for agreeing terms of reference and annual work programmes for its supporting groups and committees. These are defined in Appendix 2. The Quality Committee also receives agreed assurance and escalation reports as defined in the forward plan for the committee, which include identification of risks to achieving the Trust’s Strategic Objectives, Quality Priorities and CQC compliance.
Internal Audits are used as part of the assurance and escalation framework. The Audit Committee has overall responsibility for monitoring the required action following audits. However, ensuring sustainable action is taken for an individual audit is the responsibility of the relevant committee.

6.3 Executive Team

Central to the Board Assurance and Escalation Framework is the Executive Team which meets weekly and is the executive discussion, development, transforming and decision-making forum. It has strong links to all relevant governance forums inside and outside the organisation.

6.4 Monitoring Quality and Performance Information to Provide Assurance and Escalate Concerns

Monitoring quality and performance information occurs at all levels of the Trust to provide ward / team to board reporting. The Planning and Investment Committee is responsible for developing the Trust’s Performance Management Framework. The monthly Risk Reports (Part 1 and Part 2) and the bi-monthly Heat Map are the key processes for providing assurance to the Board that the Trust is meeting internal and external targets for quality and performance. They are also the mechanisms for identifying under performance and documenting exception reports and action plans. These are reviewed by the Board and the Quality Committee, both of which may delegate actions to other committees and meetings as appropriate.

The Audit Committee and the Board undertake a quarterly review against all Monitor, CQC and other regulatory standards. This is monitored and approved by the Board in the monthly Board Assurance Framework.

6.4.1 Triggers for Under-Performance

Concerns in performance that could adversely affect quality and would trigger an exception report and action plan in the monthly Risk Report Part 1; and would also be highlighted in the bi-monthly Heat Map. This includes, but is not limited to:

- Performance below metric threshold for Heat Map CQC Outcomes performance.
- Significant variation from what is the expected norm e.g. a significant increase in the number of incidents or complaints; or evident triangulation of risk (such as high incidents of falls, decrease in Heat Map performance; and high incidence of violence and aggression incidents).
6.4.2 Divisional Quality Governance Functions:

Both Divisions have Governance Strategies (see Appendices 5 and 6) and maintain a number of systems and processes to support effective quality governance monitoring and escalation of risk including:

- **Provider Compliance Assessments**
  All in-patient and community teams maintain Provider Compliance Assessments (PCA) (the CQC’s tool for self-assessment against the CQC’s Regulations (the new regulations will come into force in April 2015 and will replace the existing CQC Essential Standards of Quality and Safety). A summary of PCA self-assessment is submitted bi-monthly for the Heat Map. Any concerns about performance in a team that cannot be resolved locally are escalated to divisional level; and further escalated by the division to the Operational Governance Group as required.

- **Division Performance Dashboards** – These are updated monthly and reported via divisional governance meetings, with assurance and escalation as required to the Operational Governance Group.

- **Contract Monitoring** – Contract monitoring is managed within each Division, with assurance and escalation reported via the Divisional Operations Business Meetings (General Adult Services Division and Specialist Services Division) chaired by the Director for Nursing and Operations.

- **Risk Identification** – Risks identified within Divisions are added, where appropriate, to the relevant Division’s risk register. The Divisional Risk Registers are monitored and reviewed at Divisional Management Meetings, with assurance and escalation reported by the divisions to the Divisional Operations Business Meetings.

- **Exception Reporting and Action Planning** – Exception reports and associated action plans are monitored divisionally, within the appropriate locality meeting, with assurance and escalation reported by the divisions via the Divisional Operations Business Meetings (General Adult Services Division and Specialist Services Division) chaired by the Director for Operations.

- **Forums** – Each Division has a Management Meeting, chaired by the associated General Manager, where performance is monitored, and action plans for under-performance are agreed and monitored.

6.4.3 Corporate Functions:

Corporate Governance structures are in place; and a series of key documents, structures and processes are in place that are reviewed and approved at least annually by the Audit Committee and the Board, these are set out below:

6.4.3.1 The Constitution

The enacting of the Health & Social Care Act 2012 (the Act) had a significant impact on the powers of NHS Foundation Trust Governors and the role of Monitor. This in turn impacted significantly on the Trust’s Constitution.

In April 2013 the Council of Governors and the Board of Directors approved a significantly changed Constitution that included the requirements set down in the Act and also to implement the significant changes to the classes within the Service User and Carer, Staff and Stakeholder constituencies, as approved by the Board of Directors and Council of Governors in late 2011. The new Staff and Service User and Carer classes
became effective on 1 October 2013 following the elections in 2013. The constitution is subject to regular review and amendments that are approved by both the Board of Directors and the Council of Governors.

6.4.3.2 The Standing Orders

The Standing Orders for both the Council of Governors and the Board of Directors are reviewed and revised in line with the requirements of the Constitution.

6.4.3.3 The Standing Financial Instructions

Standing Financial Instructions are maintained to protect the use of public money.

6.4.3.4 The Board Assurance Framework

The Board Assurance Framework enables the Board to set out a Framework from which it can assure itself that the Trust is delivering its Strategic Priorities and is compliant with regulatory requirements. The Framework draws on evidence from the work of the Board committees, as well as internal and external sources. The Framework is updated and approved by the Board of Directors, monthly, and reflects the risks identified within the risk register. The Assurance Framework also receives detailed scrutiny at the Audit Committee each quarter, whose attendees includes both internal and external auditors.

The format of the Board Assurance Framework was developed in late 2011 in response to the Quality Governance Review recommendations and was subject to a desk top review conducted by Internal Audit in early 2012. The Framework maps the risks to achievement of the priorities that are set out in the Forward Plan. It also maps risks of breaching standards and duties placed upon the Trust by the regulators.

6.4.3.5 The Risk Register

The Trust has a policy in place for the identification and management of risks. The Risk Register is updated by the Executive Team and approved by the Board of Directors each month.

6.4.3.6 Quality Governance Review

The Trust commissioned an external Quality Governance Review in July 2011. The recommendations from which were implemented throughout 2012 and subsequently maintained. An internal assessment against Monitor’s Quality Governance Framework was conducted and presented to the Quality Committee in 2012 and was reviewed and presented again in December 2013. A further external governance and capability review will be conducted in 2014.

6.4.3.7 Quarterly Self-Declarations to Monitor

A procedure is in place for the Audit Committee to scrutinise the quarterly self-declaration and to recommend to the Board of Directors any declarations or exception reports to be made. The Board of Directors considers all of the assurances and risks identified through the Risk Register, the Board Assurance Framework and the quarterly declaration reports before approving the signing of the self-declaration.

6.4.3.8 Quarterly Review of Compliance with Governance Arrangements

The Audit Committee receives a detailed quarterly report identifying:

- Any known breaches of the governance arrangements
- Compliance with Freedom of Information Requests
- Losses and compensations paid or due
- Current employee claims
- Declarations of receipt of hospitality from directors and staff
- Incidences of the use of the power to waive governance arrangements
- Legal Documents to which the Trust Seal has been affixed
- Care Quality Commission (CQC) Non-Core Standards, compliance
- Whistleblowing Matters
- Assurance Matters
- Governance issues that the Executive Directors believe should be brought to the attention of the Committee
- Declarations of interests from directors and governors where a conflict has presented

6.4.3.9 Reporting to the Board of Directors

All committees of the Board provide draft minutes and a key issues report to the next meeting of the Board of Directors. The papers of all Board committees (other than the Appointment & Terms of Service Committee) are available to all Directors.

6.4.3.10 Board Committees: Terms of Reference

The terms of reference for each committee are reviewed annually by the committee, amendments recommended by the Committee are approved by the Board of Directors.

6.4.3.11 Annual Report of the work of each Board Committee

Each Board committee presents an annual report to the Board of Directors.

6.4.3.12 Transparency & Openness

The Board of Directors has held its meetings in public since January 2012. Since January 2013 the meeting has commenced with a patient, carer or staff story. The minutes and reports of each of the Board Committees are received in public session. Agendas, minutes and papers are published on the Trust’s public website.

Only items of a ‘commercial in confidence’ or ‘personally identifiable’ nature are received in a private part of the meeting. The agenda and minutes of the private sessions of the Board of Directors are shared confidentially with the Governors.

6.4.3.13 Annual Report, Accounts & Quality Accounts

The Trust produces its annual reports and accounts each year. The Annual Governance Statement is produced and the Board has to confirm that the Trust is a going concern.

6.4.14 Integrated Business Plan (IBP)

The Trust maintains an up to date five year IBP. The plan puts in place a clear set of strategic priorities that are detailed in the Annual Forward Plan.

6.4.15 Forward (Annual) Plan

The Forward Plan is produced annually to determine the priorities for the coming year.

6.5 Risk Monitoring Escalation and Assurance Framework

Risks are scored using a standardised risk matrix (see Appendix 4) and a score and RAG rating applied. The RAG rating of the risk determines who owns and is responsible for
managing the risk. The Reporting and Management of Risk Policy describes the Trust's approach to managing risk in further detail.

Table 1 (below) details which risks are included in which tier of the risk register and Table 2 defines responsibility for managing risk.

**Table 1 – Risk Register Content**

<table>
<thead>
<tr>
<th>Risk Register Tier</th>
<th>Risk Level</th>
<th>Very Low Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
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<tr>
<td>Tier 1: Divisions</td>
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<td></td>
<td></td>
<td></td>
<td>All risks relating to the Divisions</td>
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<tr>
<td>Tier 2: Trust wide</td>
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<td></td>
<td></td>
<td>All trust-wide risks</td>
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<tr>
<td>Tier 3: Organisation</td>
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<td></td>
<td>High and extreme risks escalated from corporate services or divisions</td>
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**Table 2 – Responsibility for Managing Risk**

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Responsibility</th>
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| High       | • Reviewed by relevant Executive Director  
             • Reported to Board Monthly  
             • Reviewed by Quality and Risk Committee bi-monthly  
             • High Risks – authority to accept – relevant Executive Director  
             • Extreme Risks – authority to accept – Board of Director |
| Moderate   | • Reviewed by relevant Director/ Head of Department/ General Manager  
             • Reviewed by appropriate Division/ Corporate Group with responsibility for managing risk at least quarterly  
             • Reviewed by appropriate sub-committee of the Quality Committee at least quarterly  
             • Authority to accept risk - relevant Director/ Head of Department/ General Manager |
| Low and Very Low | • Reviewed by team managers through local meetings and mitigated or escalated as appropriate  
                      • Authority to accept risk – Team Manager |

The Trust has in place a number of reports designed to provide early warning of potential quality risks. These include:

- Heat Map
- Director visits to wards and departments
- Organisational development report
- Patient Experience report
- Performance report
- Finance report
- The introduction of service line reporting
6.6 **Quality Impact of Cost Improvement Schemes**

The Trust has a robust process for assessing and monitoring the quality impact of Cost Improvement Programmes (CIPs) using Monitor’s Best Practice Guidance:

- Identification of schemes
- Clinical risk assessment including equality impact assessment
- Approval process
- On-going monitoring

All potential CIPs are risk assessed for quality impact using the Trust’s Risk Assessment Matrix. Prior to approval each scheme is subject to ‘confirm and challenge’ sessions, initially within Divisions and then Senior Leadership Team, Executive Team and Quality Committees of the Board. From 2014 staff CIP quality review panels (cross section of staff grades and job roles represented) have been convened to confirm and challenge divisional CIP schemes. This additional process provides further assurance of CIP quality impact work undertaken by the Trust. In addition, the South West CCG Executive Nurse (on behalf of the CCGs) has been invited to attend the Board’s review of staff panel CIP quality reviews from 2014.

6.7 **Monitoring Compliance with Care Quality Commission (CQC) Standards**

All in-patient and community teams maintain Provider Compliance Assessments (PCA), the CQC’s tool for self-assessment against the CQC’s Regulations (the new regulations will come into force in April 2015 and will replace the existing CQC Essential Standards of Quality and Safety). PCA self-assessment ratings are reported bi-monthly via the Heat Map. The Heat Map also reports agreed metrics for monitoring the CQC’s Essential Standards of Quality and Safety; and performance against these are displayed alongside the PCA self-assessment scores in the Heat Map. This enables *ward / team to board* to monitor, assure, challenge and escalate risk and performance concerns.

The Trust has a programme of Board Governance Assurance visits to clinical areas, which are reported via the Quality Committee and Board. A further programme of quality governance visits are conducted involving Governor, *Group of 1,000* (service user / carer representative), Quality Governance / Compliance Team; and where possible a staff representative from a different clinical area to support development. All quality governance visits include the principles of the 15 Steps Challenge. Evidence of best practice as well as compliance concerns are identified, disseminated (as appropriate) and escalated where required. Compliance related action plan monitoring is reported to the Quality Committee.

7. **OUTPUTS FROM BOARD ASSURANCE AND ESCALATION FRAMEWORK**

Using the information flows defined within this Board Assurance and Escalation Framework supports the Trust Board in the development of, and provides assurance for:

- Annual Report
- Annual Quality Report
- Annual Governance Statement
- Monitor Compliance Statements
- Monitor Targets
- Compliance with Monitor Risk Assessment Framework
- Care Quality Commission compliance
- National Health Service Litigation Authority
- Health and Safety Executive
- Counter Fraud
- Security Management
Appendix 1 – Trust ‘Board to Ward’ Structure

Trust Board

General Adult Services Division

- Improving Access to Psychological Therapies (Steps2Change Derbyshire & Lincolnshire)
- Acute Care (acute assessment & home treatment team)
  - Acute inpatient care and Triage Car
  - Rapid Response
  - Recovery College
- ECT service
- Community Mental Health Teams (including early intervention in psychosis (STEP) & Assertive Outreach)
- Adult Psychology Service
- Chaplaincy
- Armed forces veterans mental health services
- Sexual assault referral centre, Spring Lodge
- Social care services (Section 75)
- Independent Living Team (Social Care)
- Volunteer service
- Single Point of Access (SPA)
- Dynamic Psychotherapy Service
- Supporting People Team

Wards and Teams

Specialist Services Division

- Dementia and Specialist Older Adult Mental Health Services
  - Rehabilitation
  - Drug & alcohol recovery
  - Dynamic Psychotherapy
  - Forensic
  - Learning disabilities
  - Neuropsychology
  - Chronic fatigue syndrome
  - Eating Disorders
  - Child & adolescent mental health services
    - Community teams
      - Inpatient, outreach & day care
      - Children looked After
      - Primary mental Health
      - Youth offending service nurse specialists

Wards and Teams

Corporate Functions

- Office of Chairman and Chief Executive
- Finance Department
- Estates & Facilities
- Information Department
- Human Resources
- Facilities
- Quality & Risk Team
- Marketing, Communications & Business Development
- Project & Performance Support
- Research & Audit Team
- Clinical Systems

Teams

V2 as at 30.1.15
Appendix 2 – Trust Committee Structure - open link by highlighting, right click and ‘open hyperlink’

## Appendix 3 - Role and Function of Key Committees

<table>
<thead>
<tr>
<th>Committee</th>
<th>Membership</th>
<th>Frequency</th>
<th>Principal Functions</th>
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| Audit Committee | 4 Non-Executive Directors  
|                | Director of Finance  |
|                |                                                                           | Quarterly  | The Committee is authorised by the Board of Directors to:-  
|                |                                                                           |            | Oversee the establishment and maintenance of an effective system of internal control, and management reporting;  
|                |                                                                           |            | Ensure that there are robust processes in place for the effective management of clinical and corporate risk to underpin the delivery of the Trust's strategic objectives;  
|                |                                                                           |            | Oversee the effective operation and use of Internal Audit;  
|                |                                                                           |            | Encourage and enhance the effectiveness of the relationship with External Audit;  
|                |                                                                           |            | Oversee the corporate governance aspects that cover the public service values of accountability, probity and openness. Delegated to review and approve the Annual Accounts as designated by the Board and provide assurance on; Integrated Governance, Risk Management and Internal Control; Internal & External Audit; Counter Fraud and Security Management; Financial Reporting;  
|                |                                                                           |            | Reviewing and approving the Annual Accounts as designated by the Board.  
|                |                                                                           |            | Receiving the Board Assurance Framework from the Quality and Risk  
|                |                                                                           |            | Approving internal and external audits plans, reviewing progress against these and receive assurance on actions taken following audits.  
|                |                                                                           |            | Reviewing key assurance documents such as the Quality Accounts and Annual Governance Statement.  
|                |                                                                           |            | Receiving reports on gifts, hospitalities and sponsorship.  
|                |                                                                           |            | Discussing implications of the Bribery Act 2010; and monitoring Counter Fraud and Security Management investigations.  
| Quality Committee | 4 Non-Executive Directors  
|                | Medical Director  
|                | Director of Nursing & Operations  
|                | Director of Strategy & Performance  
|                | Director of Organisational Development  
|                | 2 General Managers  
|                | Clinical Directors  
|                | Deputy Director of Nursing & Clinical Governance  
|                | Head of Quality & Patient Experience  |
|                |                                                                           | Bi-monthly | The Committee is established to provide assurance to the Board that:  
|                |                                                                           |            | appropriate and effective governance mechanisms are in place for all aspects of quality including patient experience, health outcomes and compliance with national, regional and local requirements.  
|                |                                                                           |            | The Committee is authorised by the Board of Directors to ensure that:  
|                |                                                                           |            | there are robust processes in place for the effective management of quality;  
|                |                                                                           |            | effective structures are in place to support quality, that these structures operate effectively and that action is taken to address areas of concern;  
|                |                                                                           |            | The purpose of the Committee is to provide assurance that robust Quality and Risk systems are in place throughout the Trust and that they are working effectively.  
|                |                                                                           |            | Receive clinical governance reports from each Division providing assurance on actions taken to manage key risks and quality improvements  
|                |                                                                           |            | Review of the Board Assurance Framework and high level risks with detailed scrutiny of specific risks  
|                |                                                                           |            | Receiving assurance on Care Quality Commission compliance and action taken following inspections and QUEST reviews  
|                |                                                                           |            | Receiving reports from other Groups and Committees that support the quality agenda  
|                |                                                                           |            | Review of the Trust's Quality Strategy and Quality Accounts;  
|                |                                                                           |            | Approve the Trust’s Risk Management, Clinical Audit and Research Strategies;  

V2 as at 30.1.15
| Planning & Investment Committee | 4 Non-Executive Directors
Director of Finance
Director of Strategy & Performance
Director of Nursing & Operations
Director of Organisational Development | Quarterly | The Committee is authorised by the Board of Directors to:

- Oversee the development and implementation of the Integrated Business plan (IBP) and Forward Plan;
- Oversee the development and implementation of the Financial Plan to meet business objectives, statutory and regulatory obligations;
- Develop Trust plans for changes in the financial regime;
- Scrutinise capital and revenue business cases;
- To scrutinise proposed business partnering arrangements;
- To scrutinise the Information Management and Technology strategy, plans and performance.

The Committee gives detailed consideration to the Trust's financial issues to provide the Trust Board with assurance that all issues are being appropriately managed and escalated where necessary.

Review the Finance Strategy reflecting the wider and local health economy context Service Line Reporting;

Review the Performance Strategy to reflect quality performance, mechanisms to provide the Board with assurance on the outcomes;

Review progress with implementation of a robust business intelligence system;

Receive reports on service user and carer feedback and agreeing improvements on reporting mechanisms to provide assurance to the Board on action taken;

Monitor the Trust's capital position to ensure the overall capital programme was delivered including oversight of Trust property which is on the market for disposal;

Determination of key financial assumptions to underpin Financial Plans.
Appendix 4 – Risk Assessment Matrix

Each risk is assessed using a standardised matrix. The guide to defining the likelihood and consequence of each risk is defined within the Risk Management Policy. The level of risk determines the Principal Risk Owner. For all risks on the Board Assurance Framework, the Principal Risk Owner is an Executive Director.

<table>
<thead>
<tr>
<th>Likelihood/Consequence</th>
<th>Insignificant 1</th>
<th>Minor 2</th>
<th>Moderate 3</th>
<th>Major 4</th>
<th>Catastrophic 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Unlikely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>3. Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>4. Likely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>5. Almost Certain</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Principal Risk Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Low Risk</td>
<td>Team Leader</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Team Leader</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>Directorate General Manager/ Head of Department/ Executive Team</td>
</tr>
<tr>
<td>High Risk</td>
<td>Board of Directors</td>
</tr>
</tbody>
</table>
# Appendix 5 – Specialist Services Division Clinical Governance Strategy

## 1.0 Background

### 1.1 Clinical Governance

Clinical Governance is a framework through which NHS organisations are accountable for clinical performance. It exists to safeguard high standards of care, and provide an environment in which excellence can flourish. Clinical Governance underpins quality and continuous improvement, and is an integral part of the vision, systems and processes to deliver services. It is essential that appropriate organisational management arrangements are adopted by the Specialist Services (SS) Division, which recognise clinical governance as a key organisational responsibility. This strategy document describes the relationships and responsibilities, which form the framework for the development, management and assurance of clinical governance systems within the organisation.

### 1.2 The Division

The Division aims to ensure that equitable provision of high quality, safe, clinically effective services exist, whilst involving service users to ensure that they receive a positive experience. This protocol aims to provide a framework of expectations across the Specialist Service Division to highlight the importance of a structured approach to Clinical Governance, and to describe the processes of assurance and communication to focus efforts on quality improvement.

### 1.3 With the continuous development of both internal and external regulation via the Care Quality Commission (CQC), National Health Service Litigation Authority (NHSLA), internal auditors, Monitor and others, it is imperative that there are robust mechanisms in place to inform and assure the Trust that services are of high quality and continuously improve.

## 2.0 Specialist Services Division

### 2.1 The SS Division

The SS Division is one of two clinical Divisions within Lincolnshire Partnership Foundation Trust. The other Division is the General Adult Services Division. SS consists of a range of teams that provide access to specialist services to children and adults that are assessed as requiring specialist mental health in-put. Specialist services also provide physical healthcare interventions within the prison service and provides specialist drug and alcohol intervention teams. Specialist Services provides both in patient and community based treatments.

### 2.2 Due to the wide and complex mix of services within the Trust and SS as well as the disparate nature of Lincolnshire, clear processes to ensure robust Clinical Governance and well-defined and effective communication are essential. In order to achieve this, the Trust and Division have a number of meetings and forums with defined links to ensure an organised process for both information sharing and discussion of all aspects of clinical governance at all levels of the organisation.
3.0 Communication

Board

Trust Operations Governance and Quality Group

Quality Committee

SS Operational Management Meeting

Bi-monthly steering groups for each service line

Trust Governance meetings
- Risk Review Group
- NICE Implementation
- Safeguarding Committee
- Health and Safety Committee
- Patient Safety Group

Agenda areas:
- Each individual service areas governance, quality and risk
- Risk register
- Health and safety reports action plans
- CQC reports and action plans
- Incidents and trends
- Lessons learnt
- Safeguarding
- NICE guidelines
- Project updates
- Making Every Contact Count
- National and Local policy/developments

Medicines Management Group
- Patient Safety Meeting

Monthly locality team meetings
- Team brief
- Annual appraisal
- Six weekly supervision

Contracting Meetings
- CQUINs
- Performance reports
- Financial Information

20 V2 as at 30.1.15
3.1 The division meeting structures aims to provide a structured focussed approach to all aspects of governance and ensure information and communication is undertaken in a timely manner. All agendas are split into Finance and Performance, Quality including effectiveness and patient experience and staff engagement.

The Operational Management Team meeting is chaired monthly by the General Manager with heads of service, business managers and team leaders in attendance. The OMT mirrors the Directorate meeting chaired by the Director of Nursing and Operations. This ensures that communication is clear and explicit.

The SS steering groups are held bi-monthly and chaired by the General Manager. Membership of steering groups is made of up lead allied health professionals, associate and or clinical director, consultants, band 7 team leaders and Matrons, business manager and head of service. All steering groups have a standard template meeting agenda that mirrors the OMT and directorate meeting. Service specific agenda items are added by members and discussed.

3.2 In addition to this it is important that assurance is provided outside of the formal meeting process that communication flows are timely and consistent. It is therefore essential that individuals and teams are clear about the reporting and escalation process and what should be passed on and in what way. The following table identifies this however; there are clear escalation procedures for safeguarding available in all areas.

<table>
<thead>
<tr>
<th>No further action</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line manager /person in charge and record</td>
<td>Can the manager resolve it?</td>
</tr>
<tr>
<td>Manage record feedback</td>
<td>Report onwards – level of escalation dependent on seriousness of incident – for resolution and/or information</td>
</tr>
</tbody>
</table>
| Onward reporting required? | Yes

No

No

Yes

Yes

No

21 V2 as at 30.1.15
## A G E N D A

<table>
<thead>
<tr>
<th>No.</th>
<th></th>
<th>Lead</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Apologies:</td>
<td>Chair</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>Minutes of the Last Meeting</td>
<td>Chair</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>Matters Arising / Schedule of Actions</td>
<td>Chair</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td><strong>Business</strong></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td></td>
<td>Operations Business Agenda</td>
<td>Business Managers</td>
</tr>
<tr>
<td>4.2</td>
<td></td>
<td>IBPs</td>
<td>Business Managers</td>
</tr>
<tr>
<td>4.3</td>
<td></td>
<td>PMO</td>
<td>Business Managers / Project Leads</td>
</tr>
<tr>
<td>4.4</td>
<td></td>
<td>Budgets (including bank/agency)</td>
<td>Team Leaders</td>
</tr>
<tr>
<td>4.5</td>
<td></td>
<td>CIP’s</td>
<td>Team leaders</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td><strong>Governance &amp; Quality</strong></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td></td>
<td>Operations Governance &amp; Quality Agenda</td>
<td>General Manager</td>
</tr>
<tr>
<td>5.2</td>
<td></td>
<td>Clinical Strategy – local</td>
<td>Team Leaders</td>
</tr>
<tr>
<td>5.3</td>
<td></td>
<td>Patient Experience Report</td>
<td>Team Leaders</td>
</tr>
<tr>
<td>5.4</td>
<td></td>
<td>SUI Tracker / Action Plans</td>
<td>Team Leaders</td>
</tr>
<tr>
<td>5.5</td>
<td></td>
<td>Safeguarding Committee</td>
<td>General Manager / Champions</td>
</tr>
<tr>
<td>5.6</td>
<td></td>
<td>Risk Register</td>
<td>Team Leaders</td>
</tr>
</tbody>
</table>
6. **Staff Engagement**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Appraisals</td>
<td>Team Leaders</td>
</tr>
<tr>
<td>6.2</td>
<td>Making a Difference (MAD)</td>
<td>All</td>
</tr>
<tr>
<td>6.3</td>
<td>Cultural Barometer</td>
<td>Team Leaders</td>
</tr>
<tr>
<td>6.4</td>
<td>Staff Survey</td>
<td>General Manager</td>
</tr>
<tr>
<td>6.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.6</td>
<td>Specialist Rolling Sickness Report</td>
<td>Team Leaders</td>
</tr>
</tbody>
</table>

7. **Date and Time of Next Meeting**
# Appendix 6 – General Adult Services Division Clinical Governance Strategy

## 1.0 Background

1.1 Clinical Governance is a framework through which NHS organisations are accountable for clinical performance. It exists to safeguard high standards of care, and provide an environment in which excellence can flourish. Clinical Governance underpins quality and continuous improvement, and is an integral part of the vision, systems and processes to deliver services. It is essential that appropriate organisational management arrangements are adopted by the General Adult Service (GAS) Division, which recognise clinical governance as a key organisational responsibility. This strategy document describes the relationships and responsibilities, which form the framework for the development, management and assurance of clinical governance systems within the organisation.

1.2 The Division aims to ensure that equitable provision of high quality, safe, clinically effective services exist, whilst involving service users to ensure that they receive a positive experience. The strategy will provide a framework of expectations across the General Adult Service Division to highlight the importance of a structured approach to Clinical Governance, and to describe the processes of assurance and communication to focus efforts on quality improvement.

1.3 With the continuous development of both internal and external regulation via the Care Quality Commission (CQC), National Health Service Litigation Authority (NHSLA), internal auditors, Monitor and others, it is imperative that there are robust mechanisms in place to inform and assure the Trust that services within the Division are of high quality and continuously improve.

## 2.0 General Adult Services

2.1 The GAS Division is one of two clinical Divisions within Lincolnshire Partnership Foundation Trust. The other Division is the Specialist Services Division. GAS consists of a broad range of teams that provide services to adults with mental health problems across Lincolnshire within a variety of community and in-patient settings. These include services for people with long term mental health problems as well as individuals in crisis and service users needing access to psychological therapies.

2.2 Due to the wide and complex mix of services within the Trust and GAS as well as the disparate nature of Lincolnshire, clear processes to ensure robust Clinical Governance and well-defined and effective communication are essential. In order to achieve this, the Trust and Division have a number of meetings and forums with defined links to ensure an organised process for both information sharing and discussion of all aspects of clinical governance at all levels of the organisation.
Agenda areas:
Each individual service areas governance, quality and risk
Risk register
Health and safety reports action plans
CQC reports and action plans
Incidents and trends
Lessons learnt
Safeguarding
NICE guidelines
Project updates
Making Every Contact Count
Making Experiences count
National and Local policy/developments

Trust Governance meetings (see link Trust’s Organisational Structure).
try/organisation%20chart%20as%20at%2016.1.14.docx

These include:
Risk Review Group
Patient Safety Meeting
NICE Implementation
Social care liaison meeting
Safeguarding
Managed care network meeting
Health and Safety Meeting

Board

Trust Operations Governance and Quality Group

GAS Business, Governance And Quality Meeting

Quality Committee

Divisional Governance meetings:
Weekly Senior Leadership Team meeting
Safeguarding Forum
SPA Project meeting
S75 review group

IAPT Governance:
IAPT Leadership meetings
IAPT Development meeting
Team and performance meetings

Integrated Teams Governance:
Leadership meetings
Team meetings

Acute/24 hour services Governance:
Acute care Leadership meetings
Ward and Team Meetings
3.0 Communication

3.1 The meeting structure above provides a direct process for formal information sharing from board to ward/team and ward/team to board. It is essential however that the information provided is comprehensive and accurate. The Division continues to work hard both internally and with other departments such as the performance team in order to achieve this.

3.2 In addition to this it is important that assurance is provided outside of the formal meeting process that communication flows are timely and consistent. It is therefore essential that individuals and teams are clear about the reporting and escalation process and what should be passed on and in what way. The following table identifies this, however additional education of staff in conjunction with the risk department, is required to ensure that there is a clear understanding of what constitutes an incident and who should be informed.
### Business, Governance and Quality Meeting

**DATE**  
13.30 – 16.00  
Boardroom, United House, Lincoln

**AGENDA**

*Guest speakers*

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Apologies for absence:</strong></td>
</tr>
<tr>
<td>2.</td>
<td><strong>Minutes of the last meeting:</strong></td>
</tr>
<tr>
<td></td>
<td>Matters arising from the minutes</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Service Reports</strong></td>
</tr>
<tr>
<td></td>
<td>2 key points from report to be discussed</td>
</tr>
<tr>
<td></td>
<td><em>Acute:</em></td>
</tr>
<tr>
<td></td>
<td>Inpatient Areas (GH)</td>
</tr>
<tr>
<td></td>
<td>Crisis and 24 hour service (AL)</td>
</tr>
<tr>
<td></td>
<td>HIPS (AP)</td>
</tr>
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<td></td>
<td>RR (AP)</td>
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<tr>
<td></td>
<td><em>Community – Integrated teams:</em></td>
</tr>
<tr>
<td></td>
<td>West (AH)</td>
</tr>
<tr>
<td></td>
<td>S &amp; SW (JMcL)</td>
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<tr>
<td></td>
<td>East (BM)</td>
</tr>
<tr>
<td></td>
<td>IAPT South (MH)</td>
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<td></td>
<td>IAPT North (ST)</td>
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<tr>
<td></td>
<td>Derbyshire steps2change (CC)</td>
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<tr>
<td></td>
<td>Psychology (Dr TS)</td>
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<td>Psychotherapy (Dr GF)</td>
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<td>Veterans (SD)</td>
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<td>Supporting People (TY)</td>
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<td>4.</td>
<td><strong>Organisational Developments</strong></td>
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<tr>
<td></td>
<td><em>(Business Managers)</em></td>
</tr>
<tr>
<td>5.</td>
<td><strong>Managers update</strong></td>
</tr>
<tr>
<td></td>
<td>Team Brief</td>
</tr>
<tr>
<td></td>
<td>Making Experiences count</td>
</tr>
<tr>
<td></td>
<td>HR update</td>
</tr>
</tbody>
</table>
6. **Quality**  
Modern Matron update  
Medication  
NICE Guidelines

7. **Risk**  
Changes to or any new Risks  
Risk register (for info)

8. **Patient Experiences**  
SUI Incidents in the last month  
Incident Report & Trends

9. **Compliance**

10. **Safeguarding**

11. **Any other Business**

12. **Date and Time of next meeting:**  
DATE  
1.30 – 3.30 pm – Boardroom United House, Lincoln

**PAPERS FOR INFO**

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