Lincolnshire Partnership
NHS Foundation Trust

Lincolnshire Partnership NHS Foundation Trust (LPFT)

Board Assurance and Escalation Framework

DOCUMENT VERSION CONTROL	
Document Type and Title:	Policy No 5a. with effect from 2/11/15 (former corporate governance document)
New or Replacing:	2.2
Document Reference:	5a
Version No:	2.3
Date Policy First Written:	January 2014
Date Policy First Implemented:	27 June 2014
Date Policy Last Reviewed and Updated:	February 2017
Implementation Date:	31 March 2017
Author:	Head of Quality & Patient Experience & Trust Secretary
Approving Body:	Board of Directors
Approval Date:	30 March 2017 (BoD meeting)
Committee, Group or Individual Monitoring the Document	Quality Committee
Review Date:	28 February 2019

CONTENTS

APPENDICES

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 Single Overview Framework (SOF) first published by NHS Improvement (NHSI) in September 2016.

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. NHSI and the Care Quality Commission (CQC) considers that maintaining and improving quality is an important indicator of the effectiveness of governance within a Trust; in essence being well-led

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); 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 Board of Directors 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
- Divisional Assurance Reviews
- Staff Surveys
- Staff Friends and Family Test (FFT) feedback
- Staff stories to the Board
- Staff Partnership Forum
- Induction Programme
- Leadership Programmes
- Performance and Appraisal Development Process
- CQC compliance
- Internal 15 Steps / mock CQC visits schedule
- Trust Learning Lessons Bulletins
- External accreditation such as AIMS and ECTAS
- The Staff Governors' role

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's issues process and log ~~drop-in sessions~~
- Annual Public Meeting
- Internal 15 Steps / mock CQC visits
- Peer Support roles
- Use of external support agencies in seeking patient and carer involvement

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
- NHS Improvement
- Care Quality Commission – Compliance Inspections
- Care Quality Commission – Mental Health Act Commissioner Inspections
- Care Quality Commission – Speciality Reviews
- 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 and ECTAS
- Information Governance Toolkit
- Benchmarking with other NHS providers
- Involvement in and learning from Domestic Homicide Reviews and Serious Case Reviews

- Coroner's Inquests
- Whistleblowing investigations

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 four clinical divisions. A 'ward to board' structure chart showing the relationship between clinical teams and the Board is available here . 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.

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.

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 of Directors at each of its meetings.

If required, the Trust's Communication Department will ensure that directors 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 of Operations. 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

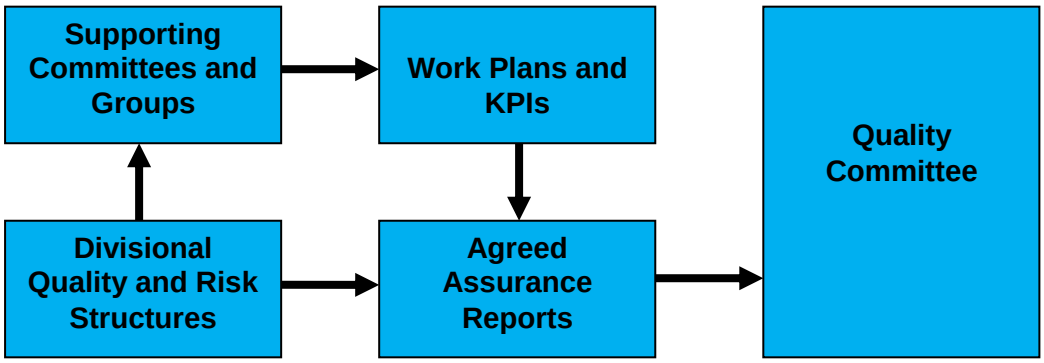
6.2 Committee Structure

To support the Board of Directors 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 sub-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. The structure chart is available The key committees for monitoring quality and performance are the Quality Committee, the Finance and Performance Committee and the Audit Committee

The Quality Committee is responsible for agreeing terms of reference and annual work programmes for its supporting groups and committees. The Quality Committee receives agreed assurance and escalation reports as defined in the forward plan for the committees, which include identification of risks to achieving the Trust's Strategic Objectives, Quality Priorities and CQC compliance.

Diagram 2 – Information Flow to the Quality Committee



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 Board of Directors Performance Reports and the Risk Reports are the key processes for providing assurance to the Board of Directors 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 the key performance indicators set out under five themes in the SOF and other regulatory standards. This is monitored and approved by the Board of Directors who maintain and approve the Board Assurance Framework.

6.4.1 Triggers for Under-Performance

Performance is monitored at each level in the organisation via the devolved management accountabilities and performance reports at department, divisional and board level.

All key metrics have defined key performance indicators (KPIs) which will identify under-performance. Where any KPIs are under-performing exception reporting and corrective action will be put in place.

6.4.2 Divisional Quality Governance Functions:

The Divisions have in place and maintain a number of systems and processes to support effective quality governance, monitoring and escalation of risk including:

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

- **Contract Monitoring** – Contract monitoring is managed within each Division, with assurance and escalation reported via the Operations, Performance and Clinical Governance Group.

- **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 Operations, Performance and Clinical Governance Group.

- **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 Operations, Performance and Clinical Governance Group chaired by the Director for Operations.

- **Forums** – Each Division has a Management Meeting, including the Divisional Manager, Clinical Director and Quality Improvement & Assurance, 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

Foundation trusts are required to have in place a constitution which is complaint with the requirements laid down in the NHS Act 2006 as amended by the Health and Social Care Act 2012. The Constitution sets down the principal and proposes under which the Trust will operate, and determines the corporate governance of the Trust.

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 quarterly by the Board of Directors, 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.

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 at each of its meetings.

6.4.3.6 Well-Led Governance Review

The Trust commissions a well led governance review every three years. This review is based on a framework set out originally by Monitor and maintained by NHSI. The review is undertaken by an external reviewer and considers the Trust's quality of: strategy and planning, capability and culture, processes and structures and measurement.

6.4.3.7 Self-Assessment against the SOF

A quarterly procedure is in place for the Audit Committee to scrutinise the the Trust's performance against the key themes in the SOF 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 self-assessment reports before reaching a conclusion on performance.

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 two years.

6.5 Risk Monitoring Escalation and Assurance Framework

Risks are scored using a standardised risk matrix (see Appendix 1) 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

Risk Level		Very Low Risk	Low Risk	Moderate Risk	High Risk
Risk Register Tier	Tier 1: Divisions	All risks relating to the Divisions			
	Tier 2: Trust wide	All trust-wide risks			
	Tier 3: Organisation				High and extreme risks escalated from corporate services or divisions

Table 2 – Responsibility for Managing Risk

Risk Level	Responsibility
High	• Reviewed by relevant Executive Director • Reported to every Board of Directors meeting • High Risks – authority to accept – relevant Executive Director • Extreme Risks – authority to accept – Board of Director
Moderate	• Reviewed by relevant Director/ Head of Department/ Divisional 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:

- Early warning Tool
- Director visits to wards and departments
- Patient Experience report
- Integrated Performance report
- Finance report
- Service line reporting

6.6 Quality Impact of Cost Improvement Schemes

The Trust has in place a robust process for assessing and monitoring the quality impact of Cost Improvement Programmes (CIPs)

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 via a panel including Trust managers, patients and carers representatives and commissioners. This process provides assurance of CIP quality impact work undertaken by the Trust. A similar panel conducts a retrospective review of the impact that CIPs have had.

7. OUTPUTS FROM BOARD ASSURANCE AND ESCALATION FRAMEWORK

Using the information defined within this Board Assurance and Escalation Framework, see (Appendix 2) the Trust Escalation Processes flowchart, this supports the Trust Board in the development of, and provides assurance for:

- Annual Report
- Annual Quality Report
- Annual Governance Statement
- Compliance with the KPIs set out in the SOF
- Care Quality Commission compliance
- Counter Fraud
- Security Management

Appendix 1 – 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.

Risk Grading Matrix (Likelihood x Impact/Consequence					
Likelihood/ Consequence	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1. Rare	**1**	**2**	**3**	**4**	**5**
2. Unlikely	**2**	**4**	**6**	**8**	**10**
3. Possible	**3**	**6**	**9**	**12**	**15**
4. Likely	**4**	**8**	**12**	**16**	**20**
5. Almost Certain	**5**	**10**	**15**	**20**	**25**

Risk Level	Principal Risk Owner
Very Low Risk	Team Leader
Low Risk	Team Leader
Moderate Risk	Directorate General Manager/ Head of Department/ Executive Team
High Risk	Board of Directors

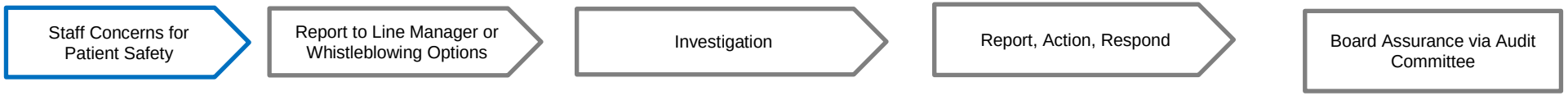
TRUST ESCALATION PROCESSES Appendix 2

The Trust has Policies, (Web Link- http://www.lpft.nhs.uk/about-us/accessing-our-information/new-policies) that encourage staff to manage risks and concerns.
The Policies are all designed to support escalation of unresolved risks and concerns clicking on the left hand box will take you to the details policy.

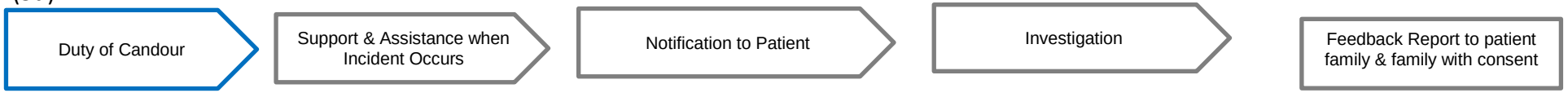
(5a)

(5b)

(5c)



(5d)



(5e)