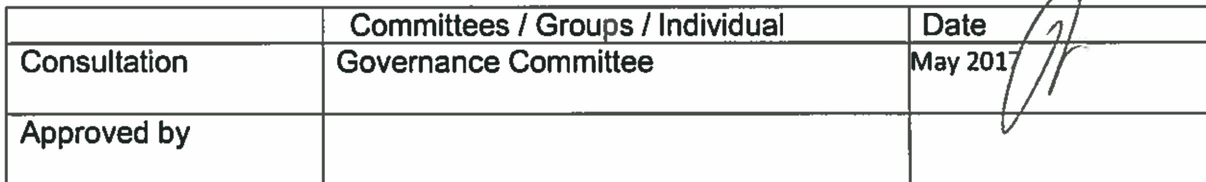
Tower Hamlets GP Care Group
Risk Management Policy

Date Issued	June 2017
Date to be reviewed	Periodically or if statutory changes are required
Title	Risk Management Policy
Supersedes	All previous Policies
This policy will impact on	All staff
Financial Implications	No change
Policy Area	Governance
Version No	3.0
Issued By	Governance Team
Author	Ruth Walters
Document Reference	
Effective Date	1st July 2017
Review Date	May 2018

Approval Record



	Committees / Groups / Individual	Date
Consultation	Governance Committee	May 2017
Approved by		

Risk Management Strategy

Introduction

Tower Hamlets GP Care Group (herein referred to as "THGPCG") is committed to minimising risks, both clinical and non-clinical to which it is exposed, through a comprehensive system of internal controls.

A number of developments have driven risk management, i.e. evolving Healthcare Commission then CQC methodologies, Standards for Better Health and now the CQC standards, the increasing need for the THGPCG Board to be assured of compliance with statute and mandatory authorisations, the quality and improvements of clinical services, and the safety of service users and staff.

The success of risk management is dependent upon its integration with all key activities of the organisation. Risk Management is the term applied to a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating and funding, monitoring and communicating risks associated with any activity, function or process in a way that will enable organisations to minimise losses and maximise opportunities

The system of internal control within THGPCG comprises three sub-systems: clinical, organisational and financial controls, however, risks do not always fit neatly into one category, nor do they always restrict themselves to one group of people, therefore, proactive risk management must become the embedded culture of the organisation and stakeholders, and remains everyone's responsibility.

This Strategy has been developed to assist in ensuring compliance with risk management standards promoted by the National Health Service Litigation Authority (NHSLA).

Phillip Bennett-Richards
<u>Chair & Clinical Director</u>

GP CARE GROUP CIC

Risk Management Strategy

1 Aim

1.1 A risk management process that is understood and adhered to by all staff.

An effective risk management system that manages and responds to risk ensuring:

- A common approach to risk assessment is maintained throughout THGPCG.
- The process is aligned to audit standards and considered best practice.
- Incident investigation arrangements are robust and consistent.
- There is a robust Risk Register process both locally and at a corporate level within THGPCG.
- Unified risk management training and record of attendance.
- Evidence of learning lessons from incidents, near misses and complaints.

1.2 A system that identifies and prioritises risks.

1.3 A system that ensures the Board is made aware of serious risks urgently.

2 Objectives

2.1 Strategy development – ensuring a clear definition of responsibility and accountability at all levels of the organisation.

2.2 Structure – ensuring well-defined committees and lead responsibilities, clear and up-to-date terms of reference, a committed and balanced membership and effective reporting and delegation.

2.3 Training – ensuring a link to strategic objectives and ensuring comprehensive coverage of mandatory training and performance monitoring of training as part of individual objectives, and linked to trends from the incident reporting system.

2.4 Incident reporting – promotion of reporting, trend analysis, ensuring follow-up action and learning takes place following every serious untoward event and promoting root cause analysis as a preferred method of investigating incidents and near misses.

2.5 Risk assessment – assessing risk at all levels in a consistent way, ensuring risk assessments are carried out routinely; ensuring risks are assessed and incorporated in business cases and included on the organisation's Risk Register as appropriate.

2.6 Communication – ensure there is an appropriate framework in place for the dissemination of best practice and reporting of risks, this will include partner organisations on problems of mutual concern. In particular, dissemination of learning, via the Quality, Safety & Governance Safety Committee of serious incident learning points both from this and other organisations.

2.7 Performance – developing of a range of performance indicators that will assist in management performance, and indicate progress towards strategic risk goals.

2.8 Financial management – to help inform the annual planning process for Annual Operating Plan through the identification of risk which require a resource commitment or pose a threat to internal control procedures.

3 Strategic Framework for Risk Management

The corporate responsibility for meeting the aims and objectives of risk management ultimately rests with the THGPCG Board. The framework that supports risk management is set out below:-

3.1 THGPCG **Board** has corporate responsibility for meeting the aims and objectives for risk management and is responsible for the management of significant risk utilising the THGPCG Corporate Risk Register.

3.2 The **Quality, Safety & Governance Committee** is a sub-committee of the Board, chaired by an Non-Executive Director and assists in providing strategic direction for the risk management process.

3.3 The **Audit Committee** is a sub-committee of the Board, chaired by a Non-Executive Director and is responsible for reviewing the effectiveness of internal control and risk management system, including financial risk.

3.4 The **Executive Management Team (EMT)** is chaired by the Chief Executive and is responsible for co-ordinating and ensuring that strategic and operational objectives are implemented in line with the Risk Management Strategy and Health and Safety statutory requirements and provides a conduit to escalate significant risk generated at operational level to the Board. The EMT will have a balanced membership that reflects the services provided by THGPCG thus allowing advice and guidance on specific risk issues to be communicated in either direction.

3.5 The **Information Governance Group** is a subgroup of the Quality, Safety & Governance Committee and is chaired by the Senior Information Risk Officer. This group is taken in its widest context to be the framework, structure and process to ensure the security, confidentiality and integrity of THGPCG data and information, including consideration of information risk.

4 Accountability & Responsibility

4.1 The **Chief Executive** has overall accountability to the Board for risk management and will ensure that the responsibilities for the management and co-ordination of risk are clear, and that the aims and objectives for risk management outlined in this strategy are implemented.

4.2 The **Chief Operating Officer** is responsible for service delivery and the management of clinical risks.

4.3 The **Finance Director** is accountable to the Chief Executive for managing the strategic development and implementation of financial risk management, together with the responsibility for compliance with the Data Protection and Freedom of Information Acts.

4.4 The **Finance Director** is responsible for creating an anti-fraud culture within THGPCG and undertaking investigations into allegations or suspicions of fraud and / or corruption.

4.5 The **Security Management Specialist** (nominated network manager) reports to the Chief Executive and is responsible for creating a pro-security culture within THGPCG, undertaking investigations into any security breaches and liaising with external agencies (i.e. the police regarding any such breaches).

4.6 The **Director of Quality Assurance** is the Executive Lead for the clinical and non-clinical risk management and health and safety processes.

4.7 The **Director of Quality Assurance** has responsibility for providing direction and support for and facilitating the effective management of risk, for maintaining the Risk Register and disseminating all relevant new legislation, guidance and supporting documentation.

4.8 The **Director of Quality Assurance** is responsible for seeing effective processes in reporting, managing, analysing and learning from complaints and claims are in place.

4.9 **Executive Directors** are responsible for ensuring appropriate and effective risk management processes are in place and ensure all necessary risk assessments are undertaken and entered onto the Risk Register. Directors shall ensure that all staff must be given the necessary information, training, resources and supervision to enable them to work safely. These responsibilities extend to anyone affected by the organisation's operations, including sub- contractors, patients, visitors, members of the public, etc. Directors will ensure all managers under their direction who manage staff, attend managers mandatory training, in particular the Risk Management module. This will ensure that the risk management strategy and processes are communicated throughout their areas of responsibility.

4.10 All **Employees** are provided with information and offered training in risk management/assessment commensurate with their responsibilities. In addition, managers must ensure all staff are aware of this Strategy and supporting policies. It is expected that employees will participate, whenever required, in the risk management process and support line managers by attending mandatory and statutory training, complete incident/accident forms every time an adverse event or near miss occurs, report all defects, report all complaints and communicate a dangerous situation to anyone who could be at risk.

4.11 **Specialist Advisors** including the Safeguarding team, Infection Control Team and other specialist teams may be consulted for advice as required.

4.12 The **Chief Executive** is responsible for ensuring appropriate standards which conform to statutory requirements, and which minimise risks.

4.13 **Senior HR Advisors** advise senior management on the risk of litigation associated with employment law via an external contract with Peninsula.

5 Risk Management Process & Risk Register

5.1 **Risk** is all about the "chance" of something happening that will have an impact upon objectives. The risk can be thought of in terms of the possible consequences and likelihood of it happening. There are risks associated with any activity, function or process.

5.2 The basic principles of the Risk Management Process can be applied to any sort of risk, whether clinical or non-clinical. THGPCG has adopted the NPSA risk matrix as its standard method of assessing the level of risk across the organisation. Each service will initially carry out an assessment of risk. This assessment will look at the risks affecting the service in a holistic manner, i.e. this assessment will be an overarching assessment of their area. It will not only address clinical issues but also environmental and risk involving non-clinical activity (Health and Safety, Workforce Development, Finance, etc). Nominated Risk Assessors will receive training in order to assist them carry out these assessments.

5.3 The **Local Risk Register** is a log of risks of all kinds that threaten THGPCG's success in achieving its declared objectives. This enables risks to be assessed, quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated. The **Corporate Risk Register** will contain escalated risks from the SMT which cannot be managed locally and is part of the Board Assurance Framework.

5.4 **Incident Reporting** – all accidents and incidents will be reported in accordance with the organisation's Incident Reporting and Investigation Policy & Procedure, using a common report form or the electronic web-based report form. All incidents will be graded using the methodology shown in the Incident Reporting and Investigation Policy & Procedure. Teams will report all incidents using DATIX.

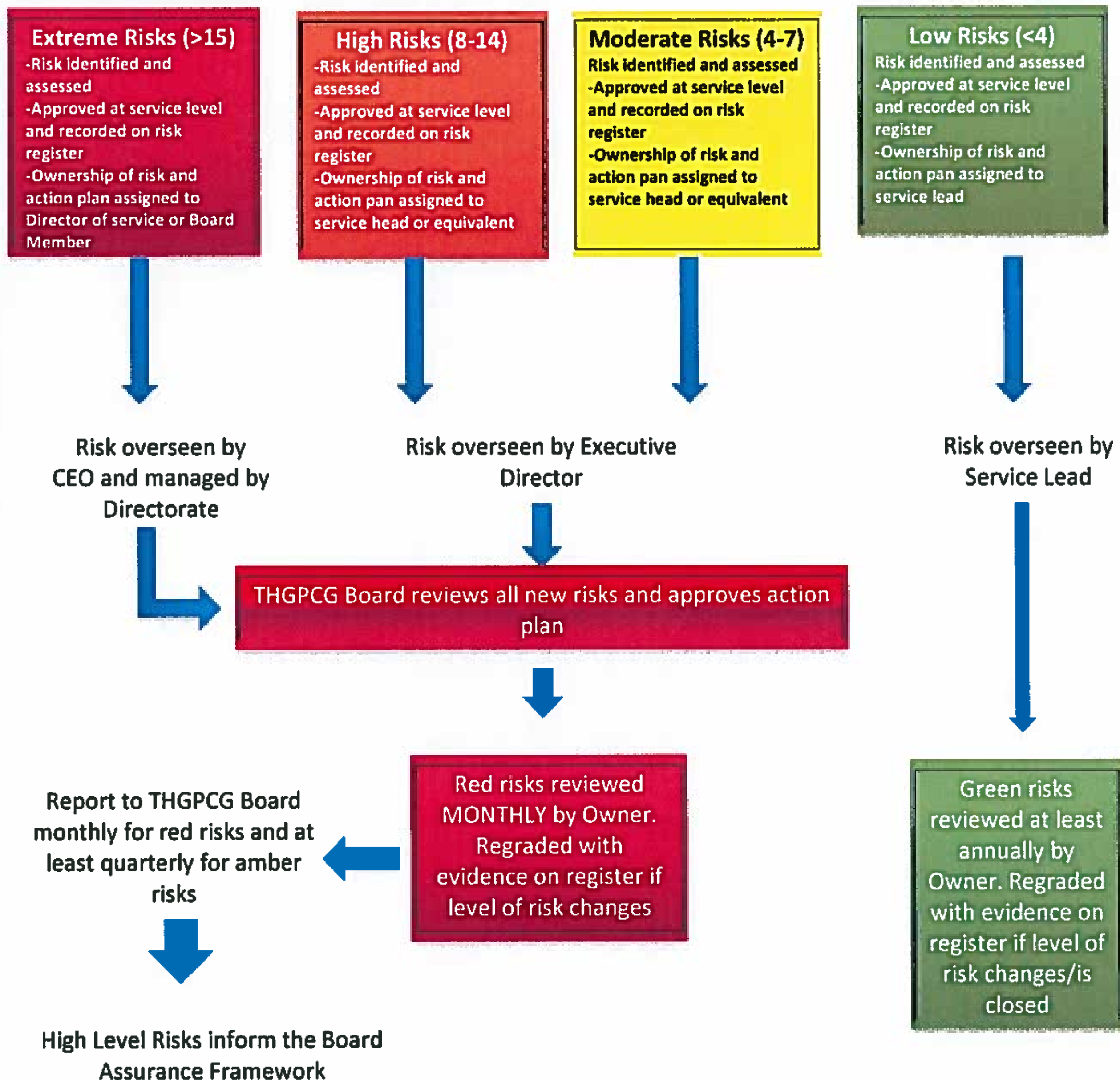
5.5 Risk Rating

Consequence		Likelihood	
1	Negligible	1	Rare
2	Minor	2	Unlikely
3	Moderate	3	Possible
4	Major	4	Likely
5	Catastrophic	5	Almost certain

Likelihood \ Consequence	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Category	Risk Score
Low	< 4
Moderate	4 - 7
High	8 - 14
Extreme	> 15

5.6 Risk Management Process Chart



6 Management of Risk Locally whilst Recognising Diversity

6.1 Explicit is the need to recognise that THGPCG comprises of a number of diverse service areas, reflecting the diverse needs and expectations of its patients/clients. THGPCG recognises that the holistic approach for risk management must be responsive and dynamic if it is to meet the challenges of rapid regional and global change, which should be managed with appropriate support.

6.2 THGPCG Board is committed to an open and honest approach in all matters. THGPCG's Whistle-Blowing and Duty of Candour policies support this approach.

7 Training

7.1 **All staff** - an introduction to risk management and risk assessment is included in THGPCG induction programme. Other specific health and safety, risk management training programmes take place, which further inform staff locally how to identify, assess, record and manage risks. Managers are to ensure that their staff attends mandatory training and that systems are put in place to rectify non-attendance. The Quality, Safety & Governance Committee will review the compliance with statutory and mandatory training quarterly via the Bluestream dashboard and manual reports.

7.2 **Health and Safety Risk Assessors** – a one day training course covering risk assessment, risk management strategy, risk registers and the escalation of risk. Managers are required to nominate Health and Safety Risk Assessor(s) in order to assist them with this specific area of work. This in no way delegates managers' responsibilities.

7.3 **Managers** - specific training in risk management and risk assessment will be provided for managers by way of managers' mandatory training.

7.4 **Board Members and Executive Directors** – training in aspects of risk management for THGPCG Board members will be made available as required.

8 Monitoring

The progress of risk identification, assessment and control measures will be regularly audited by:

8.1 A documented programme of audits involving onsite inspection of service locations risk assessments and risk registers to ensure the process of assessment and escalation is being followed.

8.2 The appropriate Director will record all risks escalated to the Executive Management Team and ensure entry onto the Corporate Risk Register if required for review by the Governance Sub-Committee on a monthly basis.

8.3 The Board will receive the Corporate Risk Register on a quarterly basis.

9 Review

The Risk Management Policy will be reviewed annually.