Quality Strategy Implementation

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Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board	ESB 3.9.19	Discussion and decision
Trust Board Committee		
Trust Board		

Executive Summary

Context

This paper describes/presents the first draft of the implementation plan of the Quality Strategy (QS) 2019-2020 – in support of UHL achieving our vision of 'Becoming the Best' *Appendix A.* It identifies some of the known key milestones to making progress in our quality improvement approach, and in particular, giving people the skills to enable improvement, and covers the first 12 months (April 2019 – March 2020).

The planning approach has also produced a first draft of the associated risks and the management of this plan. This is an iterative document that will change with time.

Furthermore, we have also developed our 3 year view of what impact this implementation of the strategy will have across the organisation and how it will influence the way we execute improvement. This is an 'Action/Logic Model' and serves as a dashboard that describes what outcomes we should expect to be able to measure and report on. *Appendix B.*

This report focusses principally on the elements of Quality Strategy related to our QI methodology and giving people the skills to use it. The other main element, culture and

leadership, is reported primarily through the People Strategy, although this report does pull out the connections between the two.

Questions

1. **How will we build our approach to deliver the strategy?** – the six elements are focused on enabling a generative process that harnesses our collective expertise of the people in the organisation to co-produce a new culture that delivers the strategy, (please read pages 3 and 4 and also 10 and 11 of the Quality Strategy *Appendix A)*. The elements are:
    a) Understanding what is happening in our services
    b) Clear priorities and plans for improvement
    c) Embedding an empowered culture of high quality care, including patient empowerment
    d) The right kind of leadership
    e) Giving people the skills to enable improvement
    f) Working effectively with the wider system

    We have committed to a Culture and Leadership Programme (CLP –pages 8 to 10 of the Quality Strategy) which is central driver to our QS and the development of our People Strategy that you will be able to read more about at another time. Currently we have just completed the analysis of what staff have told us needs to be improved with respect to our culture and our approach to leadership; we have called this the discover stage. As a start and to role model a response to this CLP, the Trust Board has agreed to implement changes in the way that it and the Executive Boards operate. Leadership Walkabouts linked to Trust Board meetings and Thinking Days are the first changes that will be visible to many more staff across the Trust and provide an opportunity for the right kind of conversations.

    In addition, the Trust's 6th Annual Leadership Conference will take place on the 17th September and this event will bring together a range of leaders from across the organisation (approximately 350 people) to hear about how the QS will be implemented in these early stages, including an opportunity to learn more about how they as leaders can take action with both process and behaviour changes which are visible to staff. This even also marks the 10th Anniversary of the launch of our Trust Values.

2. **What are the fundamentals of our improvement methodology?**– (page 4 &5 of the Quality Strategy). Improvement and achieving quality is not a new ambition in this Trust or across the Health and Care system and historically there have been many attempts to introduce and to execute a chosen approach employing supporting tools. What has become increasingly clear over the past 10 -15 years of academic research into improvement and implementation science is the creation of new knowledge

about which methods work best with our culture and values in the Health and Care sector, not just in the NHS but globally. We have taken up a model which has been researched and developed by the Institute for Healthcare Improvement (IHI) which is built on the original work by Professor Edward Deming and the 'Model for Improvement' (MFI). His pioneering work brought our attention to the need to build our capability through the education and coaching of staff and to nurturing activities that organisations need to provide to sustain improvements. Much of this work is not just the technical skills of using improvement tools, but significantly it is about our fundamental mental attitudes to our working relationships, our habits and behaviours and our ability to co-produce something without a power hierarchy dictating form. Our strategy picks up in detail on all of these essential elements and they have become the focus of our ability to transform. The diagram in *Appendix C* is an illustration of how many elements are interconnected.

3. **How are we building our capability?** – we are working in partnership with an experienced training and coaching organisation provided from within the NHS. This will accelerate our learning ability in using the MFI and fast track us to build a range of experienced staff using the MFI tools blended with coaching in leadership behaviours and habits that facilitate the co-production of QI projects. At the same time, we have recruited a Head of Quality Improvement to lead the implementation of the QS and to recruit and develop a permanent QI team who will teach, coach and lead QI projects.

This first round of training in the use of the MFI commences in September 2019 and the programme of development is made up of:

Taster Sessions – a chance for all staff to meet with AQuA our partner and the UHL quality improvement team to hear about QI. They will see how to use some common tools and methods. This will introduce staff to the ambition and direction that UHL has set in order to continue on our improvement journey. This will give staff the chance to ask questions and hear about other QI support and opportunities are available to staff at UHL. We will meet with 180 staff over 3 days.

These taster sessions are supplemented in October 2109 to January 2020 by 2 cohorts (50) of:

Advanced Practitioner training - aims to develop individuals with existing quality improvement (QI) knowledge and support them to drive improvement at an individual, team and organisational level. Attendees will commence a local quality improvement initiative in order to apply their learning in practice. This programme will support staff to lead and facilitate QI by understanding the theoretical and technical requirements. Attendees will apply the concepts directly to a small, local improvement project that supports the organisation's strategic ambitions. Additional

programme opportunities include insight into the role of self with the Habits of an Improver, influencing the organisation with systems thinking/leadership, managing complexity and coproduction.

During an overlapping period from November – December 2019 we will also deliver 1 cohort (25) of:

QI for Medical Leaders - is aimed at medical staff with a basic understanding of Quality Improvement, and who are looking to develop their understanding of its application and influence within their environment. Designed by QI medical leaders, for medical colleagues, this programme will provide the key elements of Quality Improvement. Attendees will be fundamental in the evolution of the UHL QI leaning community.

In addition; we initiated Trust Board training in QI skills appropriate to their needs and the Trust Medical Leadership day on 20th September will focus on the implementation of the QS.

Our QI learning and development is not limited to the Trust, we will commence a series of collaboratives which are often multi-disciplinary and multi-agency QI projects across the heath and care system that operate over rapid cycles of 30, 90 and 120 days. The first of these will be focused on one of our priorities – 'safe and timely discharge'. We are currently reviewing the timing of implementation of this work due to pressures on bed capacity.

Conclusion

This paper provides an overview of how we are approaching the implementation of capability building, giving people the skills to enable improvement. It is one of the main elements of the QS and the first stage in a series of steps that the Trust will take over a period of three years to achieve its ambition.

Input Sought

We would welcome the Trust Board's input regarding the approach described. This is briefing paper, no specific action requested.

For Reference : Appendices: A, B C

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	
Safely and timely discharge	Yes
Improved Cancer pathways	
Streamlined emergency care	
Better care pathways	
Ward accreditation	

2. Supporting priorities:

People strategy implementation	Yes
Estate investment and reconfiguration	
e-Hospital	
More embedded research	
Better corporate services	
Quality strategy development	Yes

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)?

  None required.
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required

  No additional requirements to the PPI Strategy agreed by the trust Board in June 2019. The Trust PPI strategy details the approach to be adopted with respect to co-production and the training and development needs of 'Hospital Improvers'. Further collaboration with the Head of PPI to be arranged.
- How did the outcome of the EIA influence your Patient and Public Involvement ?

  N/A
- If an EIA was not carried out, what was the rationale for this decision?

  EIA is more appropriate to projects being implemented using the QS approach.

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	X	As Appendix D
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: December 2019

6. Executive Summaries should not exceed **5 sides** [My paper does comply]

SITUATION

The Trust does not have a universally understood approach to improving quality and the critical number of staff are not trained or experienced in undertaking quality improvement projects.

ACTIVITIES

MEASUREMENT	LEARNING	CAPABILITY BUILDING	**LEADERSHIP**	CULTURE	INNOVATION

SHORT TERM OUTCOMES: YEAR 1 END

Increased monitoring of work through measurement, understanding what is happening	Increase understanding of the use of the model for improvement	Increased proportions of staff can embed, sustain and measure improvement	Greater numbers of staff feel trained, coached and empowered to lead on projects	Greater no of staff feel empowered to initiate projects and participate	Improvement of patient safety outcomes in specific domains of focus: i.e. team climate
Improved understanding and use of measurement	Increased adoption and spread of the skills for improvement	Increased no of staff who can coach others to initiate and lead projects	Greater numbers of patients and public empowered to routinely be involved in steering projects	Greater no of staff report feeling happier with being involved	Improved cost savings from QI projects
Safety of care measurement improved	Increased understanding of the use of theory, evidence and investigation	Greater proportion of staff appreciate how language and behaviours impact outcomes in improvement teams	Greater no of staff reporting being well lead	Greater no of staff report improvements of teaming in their teams and between teams	Improved no of projects sustained
Process reliability measurement more widely understood	Increased spread of networks and groups who adopt and spread practice	Greater proportion of staff are able to identify behavioural role models	Leadership (including Execs and Trust Board) prioritise QI	Improved psychological safety and just culture	Improvements in the domains of safety; anticipation and prepared

MEDIUM TERM OUTCOMES: YEAR 2 END

Reduced variability in practices across the Trust and care system in delivery	Improvement capability embedded across the Trust	Team based approach and team working the norm at all levels	Culture of continual learning is embedded and sustained	Increased alignment of Trust priorities and policies with improvement goals	QI is everyone's business and priority
Increased; collaboration across the whole health care system, transparency, sharing and collective improvements			Greater levels of implementation of larger scale improvement projects which are sustainable, measureable and equitable		

LONG TERM OUTCOMES: YEAR 3 END

Patients and services users across the Trust's heath and care system; participate consistently in projects and experience higher quality care; and staff feel more optimistic in being successful with QI initiatives.

GOAL

By 2022 all projects will lead to sustainable improvements in the following domains of quality; safe, effective, person-centred, timely, effective and equitable

INTERNAL CONTEXT AND RESOURCES:

EXTERNAL FACTORS:

ASSUMPTIONS

- Continued political backing both internally and externally to sustain QI
- Continued available funding for resources to enable
- Improvement training of staff actually makes a difference
- Staff has capacity and time to do improvement even if they do not have the skills and knowledge
- Leadership team will flex and change over 3-5 years
- Allocated opportunity for staff to learn and develop is a key driver to retain staff
- Empowerment, feeling fulfilled and being involved in joint purpose
- Our care system partners collaborate with our QI offer
- Organisational Development is aligned
- Regulators recognise our strategic progress

Becoming the best

NHS
University Hospitals of Leicester
NHS Trust

Quality Strategy

2019-2022

March 2019

Our Values

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

We treat people how we would like to be treated

- We listen to our patients and to our colleagues, we always treat them with dignity and we respect their views and opinions
- We are always polite, honest and friendly
- We are here to help and we make sure that our patients and colleagues feel valued

We do what we say we are going to do

- When we talk to patients and their relatives we are clear about what is happening
- When we talk to colleagues we are clear about what is expected.
- We make the time to care
- If we cannot do something, we will explain why

We focus on what matters most

- We talk to patients, the public and colleagues about what matters most to them and we do not assume that we know best.
- We do not put off making difficult decisions if they are the right decisions
- We use money and resources responsibly

We are passionate and creative in our work

- We encourage and value other people's ideas
- We seek inventive solutions to problems
- We recognise people's achievements and celebrate success

We are one team and we are best when we work together

- We are professional at all times
- We set common goals and we take responsibility for our part in achieving them
- We give clear feedback and make sure that we communicate with one another effectively

One team shared values

CONTENTS

Appendices

1. INTRODUCTION – WHY DO WE NEED A QUALITY STRATEGY

Leicester's Hospitals has many strengths; notably a highly committed and caring workforce and a wide range of clinically excellent services. We also have a very large critical mass, having one of the largest catchment populations of any trust in the NHS.

Despite these inherent strengths, we have struggled to achieve and in particular to maintain high standards of performance, whether that be in respect of quality, operational performance or our finances. Rather, we are characterised by many pockets of excellence and sometimes improved performance which is then not sustained. Hence we have been judged by the Care Quality Commission (CQC) as "Requires Improvement" in two successive inspections.

There has been much research done into the characteristics of excellent or "outstanding" healthcare organisations. Most recently, these characteristics have been summarised by the CQC in their report "Quality Improvement in Hospital Trusts" (September 2018). This report seeks to learn from trusts which have shown significant, sustained improvement and are now judged to be "good" or "outstanding".

The key characteristics identified by the CQC are:

Clear strategic intent for QI - the QI (Quality Improvement) journey has to start at the top of the organisation, with board members and senior leaders jointly setting out the vision to provide the highest possible quality of care

Leadership for QI - The most important determinant of quality of care is leadership. These trusts have a strategic plan for QI, which is supported with unwavering commitment from the senior leaders, who model appropriate improvement-focused leadership *behaviours* and a visible, hands-on approach.

Building improvement skills at all levels – using a systematic framework to build improvement skills at all levels, to facilitate improvement work and to share learning.

Building a culture of improvement at all levels – building a culture of improvement, which enables all staff to make effective and sustainable improvements.

Putting the patient at the centre of QI – the CQC found tremendous synergy when patients, carers, people using services and the public are meaningfully involved and incorporated into QI, alongside an engaged, empowered and enabled workforce.

The system view - True improvement comes when QI is anchored in an understanding of the system and its purpose. It comes where all staff and leaders work together to align the component parts of the system, to achieve high-quality patient care across the end-to-end system. For this purpose by "system" we are referring to the Leicester, Leicestershire and Rutland health and social care system, or in some cases the wider sub-regional, regional or national system.

If we compare ourselves, candidly, with these characteristics, it soon becomes clear why we are where we are:

Strategic intent for QI – at a basic level, we do not have an over-arching Quality or Quality Improvement Strategy. Therefore we are not *organised* for or *focussed* on developing the key characteristics in a systematic and resilient way. Of course we have undertaken a great deal of activity which addresses at least some of the required areas, notably through the Quality Commitment approach and a wider range of interventions under the banner of the UHL Way. But overall, these initiatives do not represent a coherent package; hence their patchy impact has perhaps been inevitable.

2. THE PURPOSE OF THIS STRATEGY

The purpose of this strategy is to address the issues identified in the previous section and thus **to facilitate progress towards our ultimate goal - to deliver "Caring at its Best" to every patient, every time.** It provides a framework for conversations across the organisation; those conversations will be important so as to harness the collective expertise of the people in our organisation and to avoid a sense of imposition. Our work thus far has identified six core elements which will frame the conversations. These elements have a strong synergy with the CQC characteristics set out earlier but are also derived from other relevant research and guidance (for example by the Health Foundation, King's Fund and NHS Improvement) and internal consultation in order to develop a coherent work programme . The six elements are:

- Understanding what is happening in our services;
- Clear priorities and plans for improvement;
- Embedding an empowered culture of high quality care *(including patient empowerment);*
- The right kind of leadership;
- Giving people the skills to enable improvement;
- Working effectively with the wider system.

These core elements are described in more detail later in this document and are shown graphically in Appendix 1.

3. ORGANISATIONAL COMMITMENT

As identified by the CQC, success depends on complete commitment from the top level of the organisation to the approach set out in this strategy. This includes visible championing of the approach and changing the way in which we do things. It also depends on creating the head space for everyone to talk about how best to pursue this ambition – some actions that we need to take are more obvious – others are less clear and here we will need to create space for experimentation and learning. It will also involve stopping doing some things which do not contribute to the approach. The role of the Trust Board and our wider senior leadership is described in more detail in the "Right Kind of Leadership" section.

The Trust Board considered a draft of this Quality Strategy in public at its meeting on 7th February 2019. Following detailed discussion, Board members gave wholehearted, unequivocal and unanimous support to the Strategy.

4. OUR VALUES AND VISION

Although there is much that needs to be changed in our approach, our Values should remain consistent. This year, these Values are ten years old and they have stood the test of time:

- We treat people how we would like to be treated
- We do what we say we are going to do
- We are one team and we are best when we work together
- We focus on what matters most
- We are passionate and creative in our work

We use our Values actively: In recruitment, appraisal and an awards system. They will provide helpful continuity as we develop new approaches, although we will need to review how they are positioned, reinforced and used in our day-to-day work. As we become a quality improvement- led organisation we will need to think about how we translate these values into behaviours (e.g. what does being 'passionate and creative' really mean – how might our leadership and management approach enable and support creativity – what gets in the way?). These are conversations for us at every level and in every part of the organisation.

Our vision - Caring at its Best – is more problematic. It was probably initially intended to be a statement of intent i.e. we *aim to deliver* caring at its best. But in practice it is used as slogan or strapline (for example on our letterheads and posters) thus conveying the message that we claim that we *are delivering* caring at its best. If we define caring at its best as meaning to every patient every time, this is clearly not the case.

Following internal discussions, it has been agreed that we will retain "Caring at its Best" as our vision statement, reinforcing at every opportunity that this means *for every patient, every time.* This will be complemented by a further strapline which will clearly be improvement orientated. Following a voting process at the Chief Executive Briefing meetings on all three of our main sites (involving around 200 of our leaders), the strapline chosen is **"Becoming the Best"**. In practice, the strapline will become the brand name for the strategy. This is important as evidence from other organisations strongly indicates the advantage of having a universal improvement brand to reinforce the comprehensive nature of the approach. An appropriate logo will be developed to promote "Becoming the Best".

5. OUR IMPROVEMENT METHODOLOGY

One of the key factors in successfully embedding improvement is the adoption of a consistent methodology. As the CQC report states: "in organisations with a QI culture, we see that a clear and consistent method is in use and demonstrable across all areas of the organisation. Commitment to the chosen methodology has resulted in a sustained and embedded culture of QI. The key is not the choice of one methodology over another, but the commitment to a coherent systematic improvement methodology that is anchored in improvement science."

The common features that each methodology includes are:

- Applying "systems thinking" to understand the problem;
- Experimentation as a discipline for improvement;
- Hands-on, visible leadership as a fundamental practice;
- Learning from failure as a positive approach;
- A focus on key improvement principles over the tools themselves.

Notwithstanding the last of the above bullet points, we will need to identify which methodology to adopt across the organisation. The principal options are:

- Institute of for Healthcare Improvement "model for improvement";
- Lean in Healthcare;
- Haelo (from the NHS in the North-West).

We held an event on 13th February 2019 involving Executive Directors and a range of QI and OD subject-matter experts. At this event it was agreed that the IHI Model for Improvement

would be the chosen methodology, but our version of this would also include elements of Lean. A small sub-group has been tasked to describe what this will look like.

We are a highly research active Trust, recruiting over 10,000 patients into clinical trials each year, and with around 1:20 staff members contributing to this research effort. It is well documented that research active Trusts have better outcomes for patients (e.g. lower SHMI) and a more engaged workforce. Areas of research strength for us (cancer, cardiovascular, diabetes, renal, respiratory) also map onto busy and prominent areas of clinical service. The results of research provide evidence that should strongly underpin quality improvement. Indeed, researchers in the Trust work closely with academic partners and are studying not only new interventions and treatments for disease, but also novel pathways and process and improvement methodologies themselves.

Despite this, our research effort is not as visible to staff, patients and carers as it could be and it is not always obvious how research results alter practice. The process of implementing research based innovations into clinical practice can be slow, and thus there is often a gap between important research achievements and the translation of these research findings into quality improvements for patients. Even when this occurs efficiently, visibility may be limited. Thus the Quality Strategy will include the implementation of a refreshed approach across the Trust to raise awareness of our research and its role in supporting improvement activities.

Actions

Complete description of the chosen UHL quality improvement methodology

Integrate research activity with wider QI activity and raise awareness of this

6. CORE ELEMENTS

6a. UNDERSTANDING WHAT IS HAPPENING IN OUR SERVICES

In order to decide what needs to be improved, and to ensure the ongoing quality and safety of all of our services, it is clearly essential to understand what is happening in those services. Broadly speaking, the activities in this element can be divided into two categories:

- Quality control – data tracking, reporting and follow-up;
- Quality Assurance – internal and external inspection, corporate assurance structures and processes, accreditation, guidelines and standards.

We currently do a great deal of activity covering both these aspects, much of which is generated by external regulators and professional bodies. Examples include:

- Regular reports to boards and committees;
- Ad hoc/deep dive reports to boards and committees;
- Service dashboards (e.g. women's and children's, specialized services, #NOF);
- Peer review, accreditation and inspections (e.g. HTA, MHRA);
- Outcome measures – patient reported, clinician reported;

- National registries (e.g. hips, knees and cardiac);
- Mortality data (SHMI and HSMR) and outlier alerts;
- Patient feedback – complaints, FFT and other feedback;
- Staff and trainee feedback including GMC survey results;
- National clinical audit programme;
- Local clinical audits;
- Inspections by regulators (e.g. CQC and NHSI);
- Reviews by commissioners (quality visits);
- NHSI reviews (e.g. IP);
- Incident and claims data;
- Performance data (e.g. cancer waiting times);
- Workforce data;
- Safe nurse staffing data;
- Infection Prevention data;
- Performance against NICE standards;
- Measurement of care bundles (e.g. sepsis);
- Research activity and performance;
- Indicators drawn from quality schedule and CQUIN programmes - some organisational others at service level.

There are however a number of issues with our current approach. These include:

- Our clinical audit programme, whilst extensive, shows patchy results in terms of impact and is not always aligned to organisational priorities;
- We do not consistently use Statistical Process Control tools to properly understand variation;
- Reporting tends to be added to incrementally, with very little ever being stopped;
- There has been little systematic review of how the reporting fits together as a package and whether it covers the right ground – so we cannot see the full picture;
- It is unclear whether some reports are used in practice, or even read, by at least some of their intended audience;
- Significant resource is involved in producing reports and in the associated infrastructure;
- There have been instances of service failure which have remained undetected until a critical event(s).

Actions

A systematic review of our reporting structure and processes to ensure that they are fit-for-purpose and to eliminate non added value activity

Alignment of the our clinical audit programme to the Trust's quality objectives

A process to be introduced to ensure the basic quality and functioning of all our clinical services, combining both quality control and quality assurance elements

All strategies programmes to be required to adopt this element (i.e. a full understanding of the current position as the starting point)

6b. CLEAR PRIORITIES FOR IMPROVEMENT

For the last five years, our priorities for improvements in the quality and safety of our services have been set out in our Quality Commitment, which is the brand that we use for the priorities required to be identified through the national approach to Quality Accounts. The priorities are revised and updated each year through a formal process which takes account of:

- patient and public feedback;
- analysis of data e.g. mortality and implementation of care pathways such as pneumonia;
- priorities informed by regulators' concerns e.g. sepsis;
- the need to have a manageable number of priorities that have the greatest impact (i.e. affect the greatest population);
- priorities driven through the Quality Schedule and CQUIN process;
- the need to maximize opportunities to apply for improvement monies where available (e.g. NHSLA bids).

The priorities in the Quality Commitment are generally clearly articulated and expressed quantitatively wherever possible. There is also a comprehensive tracking and reporting process in place.

The Quality Commitment is a well-established and well recognised approach within the Trust. However, there have been instances where the goals contained in the Quality Commitment have not been achieved, or have not been sustained. The diagnosis is that this reflects issues with the overall way in which the organisation approaches quality improvement. Addressing the areas of weakness is the purpose of this strategy.

This strategy is intended to provide a framework for all improvement activity across our organisation. Therefore it will be expected that all improvement programmes meet the same standards as the Quality Commitment has done in terms of:

- Systematic and rigorous identification of priorities;
- Quantified and time-bound goals;
- Clear tracking, reporting and escalation processes.

This will be driven by the adoption of a standard improvement methodology across the Trust (see Section 5).

An additional issue is that a large number of quality improvement priorities are currently identified through the Quality Account and CQUIN processes. Although in isolation each of these priorities will be each be valid, having a large number has a dilution effect which impacts on the most important priorities as identified in the Quality Commitment. It should be noted however that some CQUIN priorities are nationally mandated.

The other programmes and strategies which currently exist also have clear action plans, although the identification of quantified, time-bound goals is perhaps the characteristic which is observed least consistently. **The proposed future relationship between our existing programmes is described in Section 7.**

Actions

Seek to minimise the number of quality improvement priorities which are not part of the core programme

All strategies/programmes to be required to clearly identify their plans for improvement in accordance with the above criteria

6c. THE RIGHT KIND OF LEADERSHIP

The CQC report "Quality Improvement in Hospital Trusts" states that "the most important determinant of quality of care is leadership. These trusts have a strategic plan for QI, which is supported with unwavering commitment from the senior leaders, who model appropriate improvement-focused leadership behaviours and a visible, hands-on approach."

There are three key aspects of leadership which need to be right in order to support our journey to excellence. These are:

- Skills acquisition;
- Development, inclusivity and talent management;
- Behaviours.

The aspect with which we have arguably had least success is behaviours. There is substantial anecdotal evidence that the behaviours of our leaders are not consistent and do not always drive or encourage the right culture of continuous improvement. This issue and the actions to address it are addressed more fully in Section 6d of this strategy. It is important to note that leadership here includes the Trust Board itself. One approach that may well be helpful is the IHI High Impact Leadership Model, which covers how leaders think, what leaders do and where leaders focus their efforts.

The engagement of our clinical leadership will be a crucial part of our improvement process. It is essential that clinicians or all disciplines understand that the adoption of a quality improvement approach is not a threat but rather a complement to existing approaches such as clinical audit and research. This appreciation will very much depend on our clinical leadership understanding, embracing and promoting the approach, in the same way as the broader leadership community will need to.

Our detailed approach to leadership development, inclusivity and talent management will be set out in the forthcoming People Strategy. Skills acquisition is addressed in Section 6e of this strategy and the delivery aspect of this will be included in the People Strategy. A

draft of the People Strategy has been considered at a Trust Board Thinking Day and the final version will be considered by the Trust Board at its March 2019 meeting alongside the final version of this Quality Strategy. There is full alignment between these two documents.

A key aspect of developing the right kind of culture and leadership is having the right approach to equality and diversity. We have been making progress on this, focussing initially on race equality, through the implementation of the Equality and Diversity Integrated Action Plan. This now forms part of the People Strategy and will continue to be driven through the CEO-chaired Equality and Diversity Board.

Actions

- **Revise People Strategy and present to PPP Committee and Trust Board**
- **Require all strategies/programmes to follow the leadership approach described in the People Strategy**
- **Consider the IHI High Impact Leadership model as part of our QI methodology choice**

6d. EMBEDDING AN EMPOWERED CULTURE OF HIGH QUALITY CARE

Essentially, successful, sustained improvement requires not only the right skills/methodology but also the right culture. Such a culture is characterised by features such as:

- Trust boards working hard to create a culture where staff feel valued and empowered to suggest improvements and question poor practice;
- Staff are empowered to drive improvement and break down barriers between teams;
- Leadership models QI behaviours;
- All staff understand the purpose of the organisation and actively focus on improvement in "value streams";
- Obstacles to improvement are dealt with and organisational systems and processes are aligned to facilitate this.

Feedback from our CQC inspections indicates that our staff have a good understanding of the values and vision of the organisation. But scores for engagement and empowerment remain moderate. This is despite a five year Listening into Action (LiA) programme and the more recent broadening into the UHL Way, including Better Teams. Where LiA and Better Teams have been deployed (which is on 200+ projects) there have frequently been good or excellent results. But the use of these tools has not succeeded in changing the culture of the organisation *across the board*. Three particular issues can be identified: Firstly, if the culture of an area is particularly difficult (especially if the issues relate to leadership style) our current tools have struggled to address this. Secondly, the tools have mainly been used in areas which have volunteered to participate and so the most difficult issues/areas may have been missed. The first two issues are most likely a product of the third i.e. the UHL Way is a (good) set of tools rather than a whole organisation strategy for improvement. This would suggest that a more radical or fundamental approach is required, hence this Quality Strategy.

We are currently participating in the Culture and Leadership Programme (CLP). This is described in more detail in the People Strategy but it will be central to the Quality Strategy. The programme includes an extensive diagnostic phase and then identification of specific interventions. These interventions will then form the key actions within this element of the Quality Strategy.

The CLP has an extended timescale and it will be important to see visible change as soon as possible following the "launch" of this strategy. To facilitate this, we will use the "Culture Web" tool (Johnson and Scholes) to identify a range of quick win, high visibility, changes that we can make whilst we undertake the comprehensive diagnostic and intervention development involved in the CLP. A schematic of the Culture Web is at Appendix 2. It is likely that these quick wins will include changes to the way in which the key elements of the corporate architecture (Board, Thinking Days, Committees, and Executive Boards) are organised. This is so as to lead from the top and ensure that we are having the right kind of conversations to impact positively on the culture of the organisation.

A further vital element of the cultural agenda is the way in which we work with patients and the public. As mentioned in Section 6, patients need to be at the heart of QI activity. This cannot be said to be the case within our organisation at present. There is also a further piece development work to do to identify how we can considerably "upscale" patient and public involvement, using the principles in the "ladder" produced by NHS England.

The importance of patient involvement is such that we have considered whether it would be appropriate to have a core element of this strategy specifically for it. We have however concluded that it will be more impactful to apply the principle of involvement to all of the six elements; see section 10 for more detail.

Actions

- **Participation in the Culture and Leadership Programme and development of key interventions**
- **Use the Culture Web to identify early quick wins/ high visibility changes to support strategy launch**
- **All strategies/ programmes will be required to consider cultural issues/interventions in their development**
- **All strategies/programmes to be subject to a set of patient/ public involvement tests/questions**

6e. GIVING PEOPLE THE SKILLS TO ENABLE IMPROVEMENT

In order to ensure that a standard improvement methodology is used effectively and embedded across the organisation, it is self-evident that people need to have skills in the deployment of that methodology. But not everyone needs to have the same level of skills so a "pyramid of capability" will be developed. An example of such a pyramid is at Appendix 3.

It will be necessary to be very explicit about the skills required at each level and to mandate acquisition of those skills (unless already possessed). Once again, this is will be very different from our previous approach, where skills acquisition has, at least to some extent,

been voluntary and therefore patchy. It should be noted here that such an approach is resource-intensive (see Section 12).

Actions

- **Develop a UHL skills pyramid (potentially using the NHSI Dosing Guide)**
- **Identify staff at each level of the pyramid**
- **Develop and implement delivery programme**
- **All strategies/programmes will be required to evidence their use of the chosen methodology**

6f. WORKING EFFECTIVELY WITH THE WIDER SYSTEM

The CQC have observed that truly patient-centred care cannot come from a single organisation view, but with the recognition that high-quality care is only delivered when all parts of the health system work effectively together. Health and social care organisations are complex, adaptive systems. QI methods recognise this, and help leaders and teams lead systematic improvement in this context. Moving beyond organisational and functional boundaries and traditional hierarchies requires systems thinking. Clarity on the purpose of QI focuses improvement activity on delivering high-quality patient care, and often results in wider consideration of patient experience and their journey into and through healthcare services. As improvement teams experiment and problem solve, the patient journey is understood across internal and external organisational boundaries. Ultimately this leads to collaboration and improvement across functional boundaries to improve patient care – where improvement teams are thinking and working across the system.

Within Leicester, Leicestershire and Rutland, there have been, and continue to be, good examples of collaborative, cross-boundary, improvement work. Examples include the frailty and multi-morbid pathway improvement programme and the work to reduce the number of stranded patients and improve discharge processes. There has also been substantial co-ordination of leadership development work so as to ensure that different parts of the system have a common approach, thus facilitating further collaboration. Having said that, there is no common QI methodology universally in use and there are undoubtedly cultural issues that get in the way of progress.

Actions

- **Work with the wider system to encourage the adoption of a common QI methodology and use of the 6 core elements/drivers approach (to become the LLR Way)**
- **Review the CQC interim report on whole system reviews for lessons from elsewhere**
- **Identify a clear programme of cross-system improvement activity**
- **Widen participation of our staff in system-wide projects**
- **Require all strategies and programmes to consider the system-level elements/implications of their work**

7. APPLYING THE CORE ELEMENTS – A UNIFIED PROGRAMME OF IMPROVEMENT

We currently have five Strategic Objectives. These are:

Primary Objective:

- Safe, high quality, patient-centred, efficient care.

Secondary Objectives:

- Our people;
- Research and education;
- Partnerships and integration;
- Strategic enablers.

These objectives are accompanied by a summary description of what each involves. They are the means by which we seek to deliver our Five Year Plan – Delivering Care at its Best and are complemented by our Annual Priorities which are set out in our Annual Operating Plan and categorised under each objective.

We also have a range of strategies as follows. Some of these are in development or being revised/ updated:

- Quality Commitment;
- E-hospital;
- Reconfiguration;
- Efficiency/ Productivity Financial (recovery);
- People;
- Estates;
- Performance/ Operational Improvement (ED, RTT, Cancer);
- Research;
- Education;
- System working;
- Nursing;
- Communications and engagement;
- Patient and Public Involvement;
- Quality (this strategy).

It will be noted that there are three strategies listed here which do not currently exist. These are Efficiency/Productivity/Financial (where we have a Productivity Improvement Programme but not a strategy as such, and then a separate Financial Recovery Strategy, Performance/Operational Improvement (where similarly we have action plans but not a strategy) and System Working. Note also that the Quality Commitment is a rolling improvement programme rather than a quality strategy.

Whilst through the above approach we have in place a coherent set of plans for change and improvement, the different elements of these plans in practice operate fairly separately. Thus there are separate plans within the Quality Commitment, the operational improvement programmes such as Emergency Care, the Productivity Improvement Programme and so on. Our various strategies also have their own implementation plans.

Although efforts have been made to ensure that all these plans are "joined up", they cannot be described as a fully integrated package.

Following discussion, it is now recommended that we move to a "unified programme" approach. This will involve a single programme incorporating all the key things that we need to do and of course using the overall approach set out in this strategy. Since the Trust Board considered the draft of this strategy, further work has been undertaken on what a "unified programme" could look like. The focus has been on using our priorities for 2019/20 as the basis for discussion. These will be considered elsewhere on the agenda of the March Trust Board meeting but the essential features are:

- A small set of Quality Priorities;
- A small set of Supporting Priorities;
- Management of these priorities through a single programme approach, with universal application of the core elements and QI methodology;
- A smaller set of supporting programmes/strategies (the key activities of which in any year will feature in the above annual priorities).

As a consequence of this unified approach, separate programme brandings (including the Quality Commitment) will no longer be used.

It should be noted that the principal risk with the unified programme approach is that it becomes too diffuse. This is of concern as evidence from elsewhere indicates that it is best to focus on a small number of key priorities in order to maximise impact. To avoid this, the number of Quality and Enabling priorities in any one year will be kept as small as possible. A key element of this will be to organise our work around a clear, compelling, goal.

The development of the unified programme will be at the heart of the 2019/20 planning process. As part of this, discussions are taking place via Executive Boards, Trust Board Thinking Days and ultimately the Trust Board itself. Once the Annual Operating Plan has been finalised, a narrative document similar to the "Delivering Caring at its Best" document will be produced in April 2019 to complement the formal Annual Operating Plan.

As referenced above, there will still be a need for topic-specific strategies to support the unified programme. But all programme and strategic activity will:

- **be required to use the six core elements as their basic structure, so as to ensure a consistent approach.** Each strategy must include a driver diagram which starts with these elements in order to demonstrate compliance;
- **be required to use the improvement methodology developed as part of the implementation of this Quality Strategy.**

The Annual Operating Plan will continue to describe the key actions that will be taken within each of our priorities in any given year, as well as key activity, financial and service development plans.

8. THE FUTURE OF THE UHL WAY

The UHL Way has been developed over the last three years and currently comprises:

- Better Engagement (Listening into Action);
- Better Teams;
- Better Change (our current improvement methodology);
- UHL Academy;

- Pulse Check.

The successes and limitations of LiA and Better Teams have been described earlier in this strategy. Better Change has not by any means been universally adopted. And the UHL Academy has delivered much useful development activity but this has not been positioned within an overarching approach. Thus the UHL Way has essentially been a set of tools rather than a comprehensive strategy. Many of these tools will continue to be used within the approach set out in this strategy, but within a much more explicit and rigorous overall approach. Thus the branding identified through the process described in Section 4 will be used and the UHL Way brand will no longer be used.

9. ENGAGEMENT AND COMMUNICATION

It is hopefully self-evident that engagement with both patients and staff is central to every element of this strategy. There will therefore be no separate "engagement plan", but rather engagement will be embedded within our core activities in implementing this strategy. An example of this is the diagnostic phase of the Culture and Leadership Programme, which involves a range of specific engagement activities.

Conversely, it will be very important that we consistently and relentlessly communicate what is happening about every element of this strategy, and also what is happening within the unified programme described in Section 7. This will require careful planning, rigorous execution and appropriate resourcing.

Actions

Develop a Quality Strategy Communications and Engagement Plan

10. PATIENT INVOLVEMENT AND ENGAGEMENT

The involvement of patients, their families and carers will form a central component of this strategy. This is consistent with our ambition to encourage an organisational culture in which the patient voice is at the very centre of our service development, management and evaluation. This commitment mirrors the CQC's clear expectations that users of our services are "actively engaged and involved in decision-making to shape services and culture".

The methodology advocated in this strategy will encourage all quality improvement initiatives to begin with a consideration of who needs to be involved, and how that will be accomplished. Thus discussions about a specific strategy or programme could include:

- What intelligence have you captured from patients about what is happening in this service?
- How have you gathered the views of patients about their experience through the whole system?
- How have you involved patients in determining your priorities for improvement?
- How will you involve patients, their families and carers in this work?
- How will you ensure that patients are able to participate in your discussions to enable meaningful participation in your work?
- What will be the scope for patient input to influence the outcome of the project?

If patients are to be meaningfully involved this needs to happen as early as possible and throughout the life of a project, rather than presenting patient representatives with a *fait accompli* for endorsement. Through this strategy we are making a commitment for "co-production" with patients from the outset. Such an approach recognises that the vital "business intelligence" our patients can provide will positively influence our quality improvement journey and help us to provide the best hospital services for our local population.

Actions

Update the Patient and Public Involvement Strategy to align with the Quality Strategy

Work with our Patient Partners to determine how best to use their expertise within the approach described in this strategy

11. GOVERNANCE AND MANAGEMENT ARRANGEMENTS

We have recently introduced a new Accountability Framework for our Clinical Management Groups and Corporate Directorates. A partial Well-Led review (incorporating a Board Review) has also been undertaken which indicated broadly that our assurance systems and processes were fit for purposes. These two elements of our corporate architecture will therefore remain in place. However, as referenced earlier, it will be important to change the *conversations* that take place within those structures so that they focus on the things that are important within the framework provided by this strategy.

Following discussion at the event with Executive Directors and QI/ OD subject matter experts on 13th February, the following governance structure will be adopted:

- The programme board for the Quality Strategy itself will be the **Executive Strategy Board**. This board will report progress direct to the **Trust Board** through the Chief Executive's Report;
- An **Expert Reference Group** will be established to advise on the implementation and further development of the strategy;
- A **Change Network** will be established; this will be a much larger group, representing a cross-section of the organisation. This is part of the approach used by the Culture and Leadership Programme in order to assist with the diagnostic phase and cultural shift;
- The Executive Planning Meeting will provide oversight of the progress of the Quality Strategy Implementation Plan (see Section 13), ensuring that it is core business.

The implementation of this strategy and the unified programme approach described in Section 7 will have significant implications for the organisation of our teams and for lead roles. This for two principal reasons:

- We will be seeking to work in a more integrated way, which implies more integration of, or at least closer working between, the teams involved;
- We will need to add capacity/skills if we identify deficits.

On the basis that form should follow function, we will identify the appropriate future team structure and lead roles once we have developed the unified programme. It will be necessary to do this reasonably quickly in order to maintain the momentum which has

developed as we have been working on this strategy, and which is indeed manifested in much of our existing improvement activity.

Actions

- **Convene the Expert Reference Group**
- **Develop the Change Network**
- **Implement EPM, ESB and Trust Board programme management and reporting**
- **Identify team roles and structures once the unified programme has been developed**

12. RESOURCE REQUIREMENTS

As previously identified in this strategy document, there is a considerable amount of existing activity already being undertaken which is relevant to the approach described here. Thus there will be significant scope to both continue existing work and to redeploy existing resource to focus more closely on the core elements identified here. However, the Executive Team has concluded that it will not be possible to effectively implement this strategy within existing resources. The key areas which have so far been identified that are thought will require additional resource include:

- Key corporate roles;
- Improvement skills training;
- Communications;
- Patient involvement;
- Business intelligence;
- External specialist support.

In order to generate sufficient financial headroom to properly resource this strategy, the Executive Team has agreed to incorporate a £1m indicative investment as part of 2019/20 financial planning. The deployment of this investment will be agreed by the Executive Strategy Board.

Actions

- **Undertake further resource requirement analysis and produce formal costing**
- **Confirm Trust Board support for £1m investment through 2019/20 Financial Plan approval**

13. MEASURING SUCCESS

It will of course be important to be able to measure whether this strategy is working. Given that the aim of the strategy is to ensure that we deliver caring at its best to every patient every time, success can be judged in multiple ways. If we are judged to be "Good" or "Outstanding" overall by the CQC, this would certainly be regarded as success. But there will be a range of measures which we can monitor in term of our journey towards our goal. We already measure many of these e.g. mortality rates, harm indicators, achievement of

performance targets, patient satisfaction, staff satisfaction. It is proposed that we should select a relatively small number of metrics to form a Quality Strategy Dashboard, to be regularly reported to the Trust Board as part of updates on the progress of this strategy.

In addition to the Quality Strategy Dashboard, we will develop a comprehensive Quality Strategy implementation plan to manage and monitor the actions set out in this strategy and others that are developed as we go forwards. A report on progress against this plan will once again form part of reporting to the Trust Board.

Actions

- **Develop Quality Strategy Dashboard**
- **Develop Quality Strategy Implementation Plan**

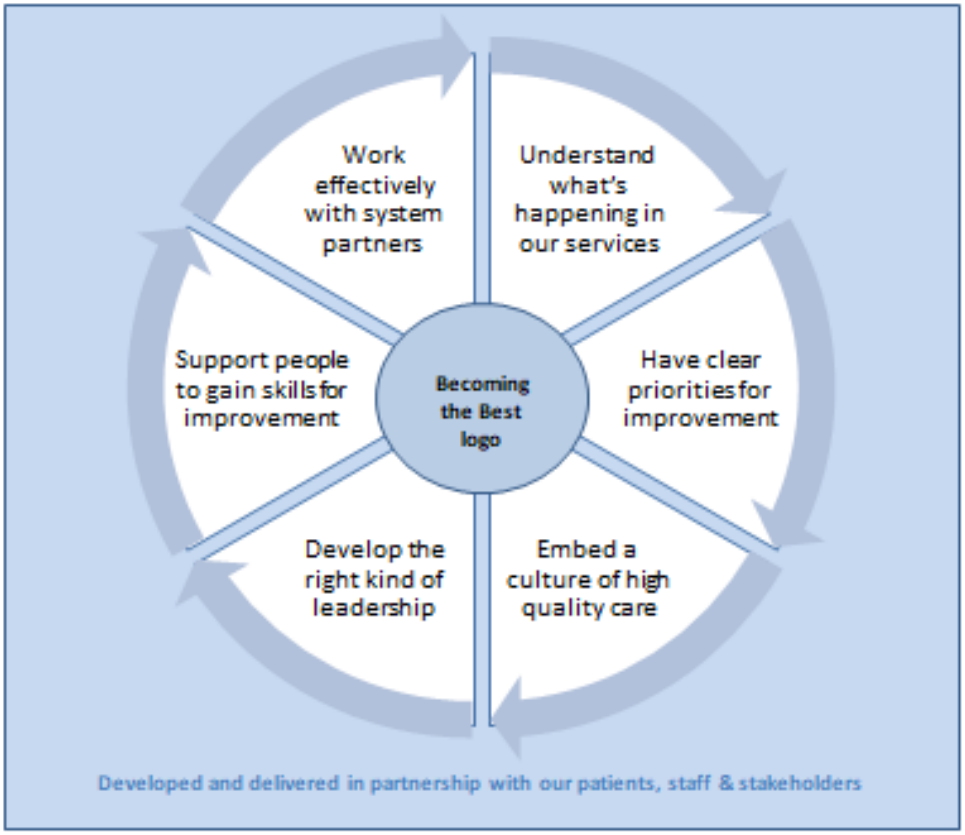
14. NEXT STEPS

This strategy is intended to provide a clear framework for how we will achieve our goal for delivering caring at its best to every patient, every time, and thus become at outstanding organisation. In doing so, it seeks to candidly address those things that have held us back up to now, and explicitly to learn from best practice elsewhere.

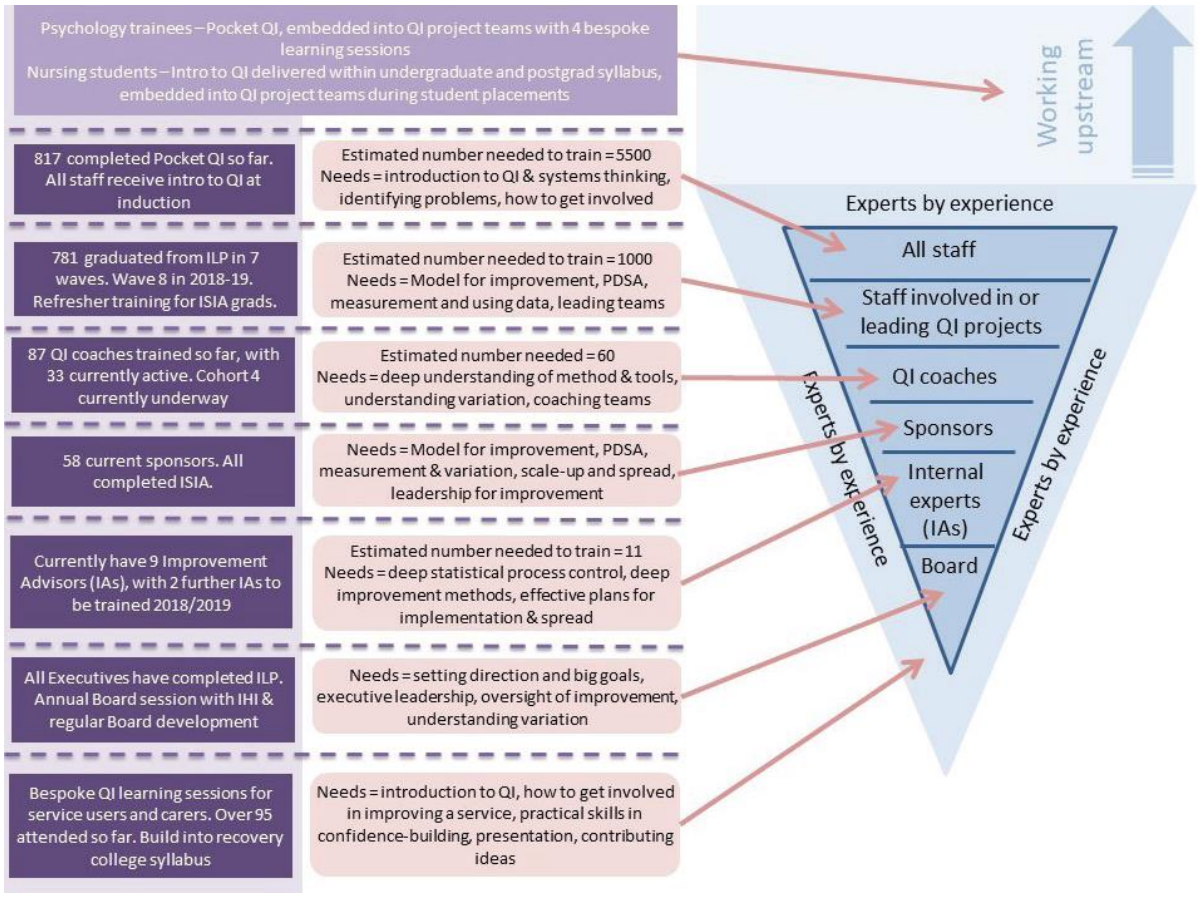
Although "**what"** we need to do is clear, we will need to continuously engage our patients and staff in developing the "**how".** These conversations will be central to our approach as we go forward.

Following approval, this strategy, the QS Implementation Plan will be developed, incorporating the actions identified in this document (to describe how we will improve). This will run in parallel to the development of the 2019/20 Annual Operating Plan which will describe the unified improvement programme (to describe what we will be improving).

APPENDIX 1 – QUALITY STRATEGY CORE ELEMENTS

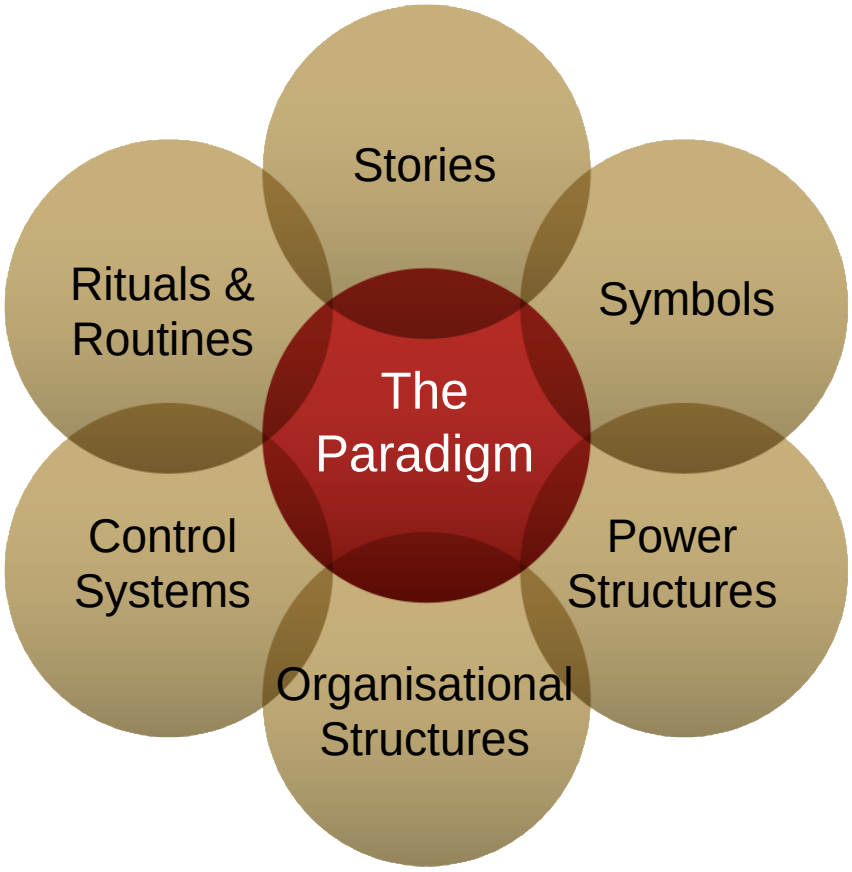


APPENDIX 2 – AN EXAMPLE SKILLS PLANNER



Courtesy of East London Foundation NHS Trust

APPENDIX 3 – THE CULTURE WEB



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ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਨੰਬਰ 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

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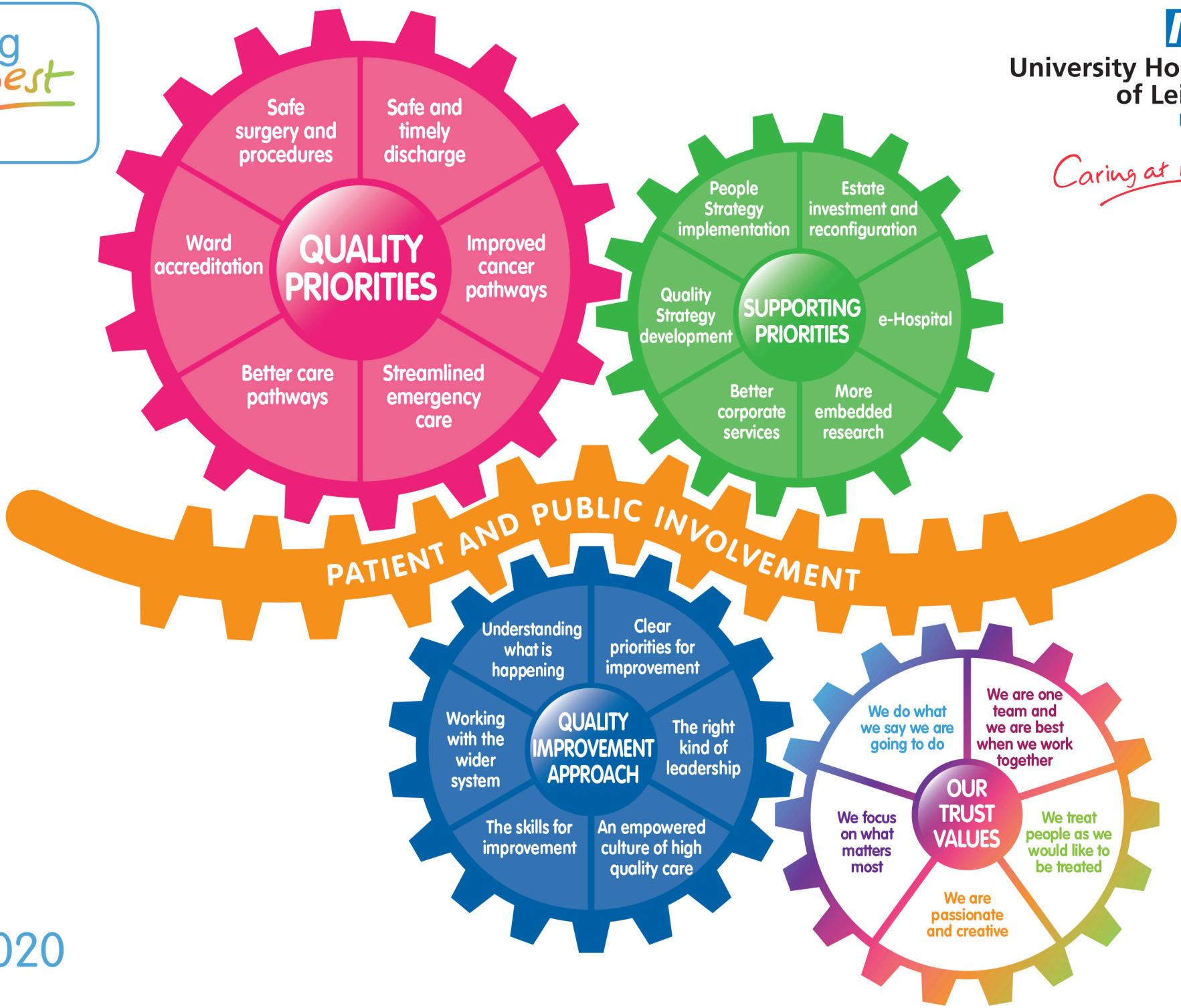

Year 1
2019-2020

2019/20 Board Assurance Framework – August updated by Colin Moorhouse

Review date:	**July 2019**	**Executive lead(s):**	**CEO**	**Lead Executive Board:**	**ESB**	**Lead TB sub-committee & date reviewed:**	**TB**					
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time											
PR Event (PR4)	**Failure to deliver the Quality Strategy to plan**											
BAF tracker - month	**APR**	**MAY**	**JUN (Q1)**	**JUL**	**AUG**	**SEP (Q2)**	**OCT**	**NOV**	**DEC (Q3)**	**JAN**	**FEB**	**MAR (Q4)**
BAF rating (L x I)	3 x 4 = 12	3 x 4 = 12	3 x 4 = 12	2 x 4 = 8	2 x 4 = 8	2 x 4 = 8						
Target rating (L x I)			3 x 4 = 12			2 x 4 = 8			2 x 4 = 8			2 x 4 = 8
Rationale for score:	It is possible that the implementation of the Quality Strategy is delayed at this early stage due to the lack of infrastructure in place, with major impact on the Trust given the strategic importance of delivery for the Trust.											

Key threats / opportunities	**Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice**	**Gaps in control / assurance**	**Actions**	**Lead**	**Due Date**
• Lack of Trust-wide engagement; • Resources to support Head of QI; • Expectations (time frames to deliver improvement); • Resources to back fill to front line roles; • Delivery infrastructure and engagement with the Culture and Leadership Programme.	1. Comms and engagement strategy in place and being enacted. 2. Quality Strategy infrastructure agreed at Exec level and at CMG level.	1. Comms & engagement: Ensuring that key messages are cascaded through organisation. 2. Quality Strategy infrastructure: a. Potential for delay in recruitment / agreed methodology. b. BTB hub: Resistance to change may hamper speedy progress. c. QI capability building tool; Life QI required to enable learning, and to record new knowledge. d. Ensure sufficient data analysis capacity. 3. Alignment to priorities: As QI resource is not yet in place, there may be a delay in the development of some priorities. 4. Culture and Leadership Programme: Staff do not engage of are not released from duties to take part.	1. Head of Comms to be appointed. Comms feedback loops in place and monitored monthly, linking in with head of QI. 2. Infrastructure under development: a. Head of recruitment & QI to lead and monitor recruitment, with weekly report to CE. b. Director of Productivity engaged to lead process with exec support. c. Options paper to be presented to execs in Sept. d. Discovery of status to be monitored by CM. 3. Gaps largely filled through existing QI trained staff until BTB team in place. See a & 50% of QI Team estimated to be in post by Dec 19. 4. All leadership encouraged to release staff to attend sessions via CE briefing and followed up by email.	TJ CW BS RV CM CM CM BK	Aug 2019. Weekly Weekly Sept 2019 Quarterly 2019 Dec 2019

BAF Scoring process:

- **Likelihood of Risk Event - score & example descriptors**

1	2	3	4	5
Extremely unlikely	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Extremely unlikely to happen except in very rare circumstances. Less than 1 chance in 1,000 (< 0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1 chance in 100 & 1 in 10 (1-10% probability). Evidence of potential threats with some gaps in control	Likely to happen in many but not the majority of circumstances. Between 1 chance in 10 & 1 in 2 (10 - 50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1 chance in 2 (>50% probability). Evidence of substantial threats with significant gaps in control.

How to assess the likelihood score: The likelihood is a reflection of how likely it is the risk event will occur (with the '**current** controls' / '**target** actions' in place).

- **Impact / Consequence score & example descriptors**

Risk Sub-type	1	2	3	4	5
	Rare	**Minor**	**Moderate**	**Major**	**Extreme**
REPUTATION - **loss of public confidence / breach of statutory duty / enforcement action** - **Harm (patient / non-patient - physical/ psychological)** - **Service disruption**	No harm. Minimal reduction in public, commissioner and regulator confidence Minor non-compliance with CQC Negligible disruption – service continues without impact	Minor harm – first aid treatment. Minor, short term reduction in public, commissioner and regulator confidence. Single breech of regulatory duty Temporary service restriction (delays) of <1 day	Moderate harm – semi permanent /medical treatment required. Significant, medium term reduction in public, commissioner and regulator confidence. Single breach of regulatory duty with Improvement Notice Temporary disruption to one or more Services (delays) of >1 day	Severe permanent/long-term harm. Widespread reduction in public, commissioner and regulator confidence. Multiple breeches in regulatory duty with subsequent Improvement notices and enforcement action Prolonged disruption to one or more critical services (delays) of >1 week	Fatalities/ permanent harm or irreversible health effects caused by an event. Widespread loss of public, commissioner and regulator confidence. Multiple breeches in regulatory duty with subsequent Special Administration or Suspension of CQC Registration / prosecution Closure of services / hospital

How to assess the consequence score: The impact / consequence is the effect of the risk event if it was to occur.