University Hospitals of Leicester NHS
NHS Trust

Policy for Carrying out Quality Impact Assessments on Cost Improvement Programme schemes

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

This Policy has been updated to:

1) Reflect minor amendments to the Cost Improvement Programme Project Initiation Document template.

2) Reflect lessons learned from the 2021/22 Cost Improvement Programme quality impact assessment process.

3) Reflect the fact the Accountability Meetings are now referred to as Transformation Progress Meetings

KEY WORDS

CIP

Cost Improvement Programme

Cost Improvement Programme schemes

CIP schemes

PID

Project Initiation Document

QIA

Quality Impact Assessment

1 INTRODUCTION AND OVERVIEW

The University Hospitals of Leicester NHS Trust is committed to ensuring that its Cost Improvement Programme schemes are evaluated for their potential impact on quality. Quality Impact assessment is a continuous process to help decision makers fully think through and understand the consequences of possible and actual financial and operational initiatives.

Quality Impact Assessments should be completed as part of a Cost Improvement Programme scheme development and should consider patient experience, patient safety and clinical quality.

The purpose of this policy is to set out the responsibilities; process and format to be followed when undertaking a Quality Impact Assessment. There is a separate policy detailing the process for equality impact assessments.

2 SCOPE

This policy relates to Quality Impact Assessments that are to be undertaken when developing Cost Improvement Programme schemes.

It applies to all staff that undertake, scrutinise and challenge quality impact assessments.

3 DEFINITIONS AND ABBREVIATIONS

Transformation Progress Meetings	Held fortnightly with each CMG and corporate department, Transformation Progress Meetings chaired by the Director of Quality, Transformation and Efficiency Improvement provide a regular opportunity to review delivery against the CIP plan, risks to delivery and any impact on quality. Action logs for these meetings are overseen by the Transformation PMO.
CIP	Cost Improvement Programme
CMG Triumvirate	Clinical Director, Head of Nursing, Head of Operations
CIP tracker	An excel workbook which tracks the delivery of the CIP forecast and actuals against the CIP plan. Each CMG / Corporate area has a CIP Tracker on SharePoint which feeds into a main Tracker
EQB	Executive Quality Board
PID	Project Initiation Document

PMO	Project Management Office
QIA	Quality Impact Assessment
QC	Quality Committee

4 ROLES

The Chief Nurse and Medical Director are joint Executive leads for this policy.

The final responsibility for approving a QIA rests with the Chief Nurse and Medical Director.

Accountability for QIAs rests with the Trust's Board of Directors who must be assured that they are undertaken with the required level of diligence.

Role	Responsibility
Chief Nurse and Medical Director	The Chief Nurse and Medical Director each are required to review and approve all QIAs prior to the implementation of the related CIP scheme.
Transformation Programme Manager	The Transformation Programme Manager is responsible for undertaking a first level review of the QIA to ensure that it has been completed fully and that the true extent of the impact on quality is understood and has a means to be monitored. The Transformation Programme Manager will also ensure, in liaison with the Director of Quality Governance and the Head of Risk Assurance, that where appropriate, risks are captured on the Trust's Risk Register by the relevant CMG / Corporate area.
CMG Triumvirate / Corporate Director	The CMG Triumvirate or Corporate Director is responsible for approving the PID and QIA for each of their CIP schemes. In doing so the CMG Triumvirate / Corporate Director is ratifying that the paperwork has been completed correctly and full consideration has been given to any potential impact on quality as well as how non-financial indicators to measure success and non-financial indicators to track unintended consequences will be monitored. The CMG Triumvirate / Corporate Director is responsible for ensuring that each CIP scheme has sign off from local clinician(s) / staff who are required to implement the change.
Operational Lead	The Operational Lead is responsible for implementing the scheme.

Role	Responsibility
Transformation PMO	The Transformation PMO Is responsible for maintaining a clear audit trail of the submission and approval of PIDs and QIAs.
Director of Quality Transformation Efficiency Improvement	The Director of Quality Transformation Efficiency Improvement is responsible for oversight of the Trusts Cost Improvement Programme. Chair of the fortnightly CMG / Corporate Transformation Progress Meetings.

5 POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

A QIA must be undertaken for all Cost Improvement Programme schemes. The majority of QIAs will be undertaken as part of the annual planning cycle when Cost Improvement Programmes are agreed with CMGs and Corporate areas. QIAs may also be completed when further in-year Cost Improvement Programmes are agreed.

5.1 The Quality Impact Assessment Tool

The Trust's Quality Impact Assessment Tool is embedded in the *Cost Improvement Programme Project Initiation Document.*

The QIA is structured around the six CQC domains: Safe, Caring, Effective, Responsive, Well-Led and Use of Resources. The QIA also includes prompts which reflect the CQC's Inspection Frameworks.

The QIA captures both indicators to measure success and indicators to measure any potential negative impact on quality (balancing measures) as well as who or what forum will have oversight of and monitor these indicators.

A copy of the *Cost Improvement Programme Project Initiation Document* with the embedded QIA Tool can be found in Appendix A.

The QIA refers to an Impact Matrix, which is intended to reflect both our current regulatory framework and our organisational risk appetite and provides practical examples of effects that map to levels of impact ranging from insignificant through to extreme.

A copy of the Impact Matrix can be found in Appendix B.

5.2 QIA review and approval

A flowchart describing the PID and QIA submission and approval process is attached as Appendix C.

A PID and QIA should be completed for CIP schemes and will indicate whether the scheme is:

- CIP Budget Reduction - current year new schemes
- CIP Budget Reduction - prior year full year effect
- Cost avoidance
- Productivity improvement
- Other run rate reduction

Once completed, the PID and QIA must be approved by the CMG triumvirate / Corporate Director through an appropriate governance forum, for example, (but not limited to) the CMG Quality and Safety Board. The CMG / Corporate Director is responsible for ensuring that an audit trail of any CIP scheme PID and QIA approvals or rejections is maintained.

Once approved by the CMG triumvirate / Corporate Director, the CMG / corporate area is responsible for submitting the PID and QIA to the Transformation PMO through SharePoint.

The CMG / corporate area is responsible for ensuring that the PID and QIA has been completed to an appropriate standard and that the CMG / Corporate CIP tracker reflects the status of the PID and QIA approval process.

The PMO is responsible for checking that the PID and QIA has been completed to an appropriate standard and will reject any PID and QIA not meeting this standard with feedback.

The CMG / Corporate area will be expected to re-work and reapprove the PID and QIA again through an appropriate governance forum before submitting to the Transformation PMO for further review.

6 TRAINING AND EDUCATION REQUIREMENTS

Guidance and support on the completion of PIDs and QIAs is be provided by the Transformation PMO.

Drop in ‘open surgeries’ are provided by the Transformation PMO for anyone completing or submitting a PID and QIA.

‘Blueprint’ PIDs and QIA have been developed to:

a) provide CMGs with well completed examples to refer to

b) for cross cutting work streams to facilitate an early view of the cumulative potential impact on quality

7 PROCESS FOR MONITORING AND COMPLIANCE

The Transformation PMO will ensure that:

a) An annual lessons learned review of the previous year's QIA process is undertaken

b) This policy is reviewed and updated in light of that lessons learned review

c) Quarterly reports are submitted to EQB and QC setting out:

i. Progress with the PID and QIA approval process
ii. Any risks to or potential impact on quality identified in the previous quarter
iii. Any cumulative impact on quality or unintended consequences identified in the year to date

8 EQUALITY IMPACT ASSESSMENT

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

None

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This policy will be reviewed annually to reflect the lessons learned from the previous year's CIP QIA process. The Transformation Programme Manager wil be responsible for undertaking the lessons learned review and making changes to this policy if required. All changes to:

a) This policy

b) The CIP PID and QIA Tool

c) The Impact Matrix

will all be subject to full version control.

COST IMPROVEMENT PROGRAMME
2022 – 23

PROJECT INITIATION DOCUMENT (PID)

Scheme summary.

Scheme name		**CIP tracker ref**	
PID date		**Version No**	1.0
CMG/ Corporate		**Speciality / service**	
Operational lead		**Finance lead**	
Starting when?		**Part of a Cross Cutting Work stream?**	
PYE (Net) £	£	**FYE (Net) £**	£
Recurrent?	☐ Recurrent	☐ Non-Recurrent	
Type of saving	☐ CIP Budget Reduction - current year new schemes ☐ CIP Budget Reduction - Prior Year Full Year Effect ☐ Cost Avoidance ☐ Productivity Improvement ☐ Other Run Rate Reduction		
Does the scheme propose a change to the nurse staffing skill mix / establishment?	☐ Yes ☐ No	**If 'Yes' has the scheme been approved by the Chief Nurse in accordance with the *Nurse Establishment Review Standard Operating Procedure*?**	☐ Yes ☐ No
PID Status	☐ In draft (for CMG sign off) ☐ Draft submitted to PMO ☐ Rejected by PMO ☐ Withdrawn (scheme no longer viable)	☐ Submitted for QIA ☐ Submitted to Chief Nurse & Medical Director ☐ Approved by Chief Nurse & Medical Director ☐ Rejected by Chief Nurse & Medical Director	

Scheme overview

What is the scheme?	
How will it be achieved?	
Dependencies	

Enablers or investment required	
In scope / out of scope	

Scheme financials

Financial calculations to support the scheme	These should be captured in the 2022/23 CIP tracker: Link to CIP 2022/23 Trackers

Key actions to deliver the scheme

	High level actions to deliver the scheme
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Scheme Quality Impact Assessment	Describe any potential **NEGATIVE** impact that the scheme may have on each quality domain **Where there are none, please write 'None'**	Describe how you will **MITIGATE** any negative impact that the scheme may have on each quality domain **Where there are none, please write 'None'**	**Consequence of any negative impact after mitigation** 1 = Insignificant 2 = minor 3 = moderate 4 = major 5 = Extreme **See Impact Matrix**	Describe any potential **POSITIVE** impact that the scheme may have on each quality domain **Where there are none, please write 'None'**
SAFE • Patients kept safe and safeguarded from abuse • Patients supported to stay safe; risks are assessed and monitored • Staff have the info they need to deliver care and treatment • Proper & safe use of medicines • High standards of cleanliness and hygiene are maintained • Systems prevent/protect from healthcare associated infections				
EFFECTIVE • Patient's needs assessed • Care and treatment delivered in line with legislation and evidence based guidance • Services benchmarked and compare well • Staff have the skills and knowledge to deliver effective care and treatment • Staff, teams and services work within and across organisations to deliver effective care and treatment • Patients supported to live healthier lives • Consent to care and treatment sought in line with legislation / guidance				

Scheme Quality Impact Assessment	Describe any potential **NEGATIVE** impact that the scheme may have on each quality domain **Where there are none, please write 'None'**	Describe how you will **MITIGATE** any negative impact that the scheme may have on each quality domain **Where there are none, please write 'None'**	**Consequence of any negative impact after mitigation** 1 = Insignificant 2 = minor 3 = moderate 4 = major 5 = Extreme **See Impact Matrix**	Describe any potential **POSITIVE** impact that the scheme may have on each quality domain **Where there are none, please write 'None'**
CARING • Patients treated with kindness, respect and compassion • Patients express their views and are involved in making decisions about their care and treatment • Privacy and dignity respected and promoted				
RESPONSIVE • Patients receive personalised care • Services take account of difference needs and choices • Patients can access care and treatment in a timely way • Concerns and complaints are listened and responded to and used to improve quality of care				

Scheme Quality Impact Assessment	Describe any potential **NEGATIVE** impact that the scheme may have on each quality domain **Where there are none, please write 'None'**	Describe how you will **MITIGATE** any negative impact that the scheme may have on each quality domain **Where there are none, please write 'None'**	**Consequence of any negative impact after mitigation** 1 = Insignificant 2 = minor 3 = moderate 4 = major 5 = Extreme **See Impact Matrix**	Describe any potential **POSITIVE** impact that the scheme may have on each quality domain **Where there are none, please write 'None'**
WELL-LED • Leadership capacity and capability • Clear vision and strategy with plans to deliver • Culture of high quality sustainable care • Clear responsibilities, roles and systems of accountability • Clear and effective process for managing risks • Information is appropriate, accurate, used and processed effectively and challenged and acted on • Patients, public, staff and external partners are engaged / involved in supporting high quality sustainable services • Robust systems and processes for learning and continuous improvement and innovation				
USE OF RESOURCES • Clinical services operate productively • The workforce is used effectively • Clinical support services are used effectively • Corporate services, procurement, estates and facilities are managed to maximise productivity • Financial resources are well managed				

Scheme indicators to measure success

What (non-financial) indicators will you monitor to measure success?

Indicator	Baseline	Target	Trajectory	Controls /oversight (who / what forum will have oversight of and monitor this indicator?)

Scheme indicators to measure any potential negative impact on quality (balancing measures)

What indicators (non-financial) will you monitor to track any unintended consequences?

Indicator	Baseline	Threshold	Controls / oversight (who / what forum will have oversight of and monitor this indicator?)

Impact Matrix

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
Safe **By safe, we mean people are protected from abuse* and avoidable harm. e.g.** • Hospital acquired infection / pressure ulcers (+ / -) • Slips, trips & falls (+ / -) • Abuse* (physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory • Medication error (+ / -) • Surgical error (+ / -) • Timely & accurate patient information (+ / -)	No harm / no abuse No hospital acquired infections Near miss Prevented patient safety incident	Minimal harm e.g. requires first aid treatment Non-permanent harm Missed or incorrect dose of non-critical medicine / administration error not resulting in harm Grade 1 pressure ulcer Staff member requiring time off work <7 days Patient sent for invasive procedure without proper prep or notes (Angios/ Cath Labs/ Theatres/Vascular access)	Significant but not permanent harm Slips, trips and falls leading to e.g. fractured clavicle, laceration requiring suturing Hospital acquired infection Missed or incorrect doses of critical medication or treatment / administration error resulting in moderate harm / adverse reaction to medication Grade 2 - 3 pressure ulcer Staff member requiring time off work 7-14 days	Long term or permanent harm Chronic pain (continuous, long term pain of more than 12 weeks as a result of the incident) Slips, trips and falls leading to e.g. brain injury, hip fractures where the patient is unlikely to regain their former level of independence Psychological harm, impaired or sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days). Infection outbreak Multiple missed or incorrect doses of critical medication or treatment / administration error resulting in severe permanent harm / long term harm / severe allergic reaction Grade 4 pressure ulcer Staff member requiring time off work >14 days	Death, irreversible health effect or life changing effect Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services) Multiple / ongoing infection outbreaks Multiple missed or incorrect doses of critical medication or treatment /administration error resulting in fatalities / permanent harm or irreversible health effects Systematic treatment errors affecting several patients resulting from miscalibration of equipment eg. Radiotherapy Reportable radiation incidents. RPA involved.

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
Caring **By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect. e.g .** • Single sex accommodation (+ / -) • DOLS / DNACPR / Consent (+/-) • Patient satisfaction (+ / -)	N/A	N/A	Single sex accommodation breach	Inappropriate enforcement /care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS) Repeated single sex accommodation breach	Systematic failure to provide an acceptable standard of care Systematic failure to provide Single sex accommodation
Responsive **By responsive, we mean that services meet people's needs.** e.g. • Backlogs (+ / -) • WLIs (+ / -) • End of Life Care plans (+ / -) • Interpreters (+ / -) • Patient choice (+ / -) • Patient satisfaction (+ / -) • Patient pathways	Negligible disruption	Minor disruption to the delivery of the service/activity. No stoppage of activities as a result. Recovery will be swift. Patients Follow up Clinic rebooked later due to a Diagnostics Reporting delay	Moderate disruption to the delivery of the service/activity. Any stoppage to activities not breaching the "Maximum Tolerable Period of Disruption" as set out in the service's Business Continuity Toolkit. Resumption and recovery may take time. 12 hour trolley wait Cancelled operation Patients not re-booked within 28 days following cancellation of surgery Operation cancelled on the day Growing backlog for >4 months (demand exceeding capacity)	Major disruption to the delivery of the service/activity. Stoppage to activities breaching the "Maximum Tolerable Period of Disruption" as set out in the service's Business Continuity Toolkit. Resumption and recovery may take significant time. Multiple 12 hour trolley waits Repeated cancelled operations Multiple patients not re-booked within 28 days following cancellation of surgery Multiple operations cancelled on the day Failure to appropriately prioritise patients on a waiting list / failure to appropriately manage long term follow ups Multiple clinically inappropriate	Extreme disruption to the delivery of the service/activity. Stoppage to activities breaching the "Maximum Tolerable Period of Disruption" as set out in the service's Business Continuity Toolkit. Resumption and recovery may not be possible.

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
			Whole patient cohorts delayed due to systematic Diagnostic reporting delays. Appointment cancelled due to lack of interpreter Clinically inappropriate bed move for a patient in the last stages of life	bed move for a patient in the last stages of life	
Effective **By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. e.g.** • Compliance with NICE guidance (+ / -) • Extend LoS or increased readmissions • Out of date / lack of / non-compliance with SOPs • Staff training & education required to undertake their roles & responsibilities (+ / -) • Clinical supervision (+ / -) • Benchmarking against comparable peers (+ / -)	N/A	Single breach of NICE guidelines (or where derogation agreed , breach of Trust policy) Increase in length of stay by 1-3 days	Out of date / lack of / non-compliance with SOP Failure to complete essential to role training Increase in length of stay by 4-15 days External review or assessment of a clinical service resulting in immediate actions and recommendations	Multiple breaches of NICE guidelines (or where derogation agreed, breach of Trust policy) Increase in length of stay by >15 days Failure to address or resolve immediate actions and recommendations from an external review or assessment of a clinical service	N/A
Well led **By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair**	Inspection or audit resulting in a small number of recommendations which focus on minor quality improvement issues	Inspection or audit resulting in recommendations made which can be addressed by low level of management action	Inspection or audit resulting in challenging recommendations that can be addressed with appropriate action plan or an Improvement Notice	Inspection or audit resulting in enforcement / prohibition action, low rating or Critical report	Inspection or audit resulting in prosecution, zero rating or severely critical report

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
culture **e.g.** • Capacity & capability (+ / -) • Strategy & planning (+ / -) • Succession planning & business continuity (+ / -) • Wellbeing (+ / -) • Stress (+ / -) • Staff satisfaction (+ / -) • Assessment and accreditation • Statutory duties (+ / -)		Minor, short term reduction in public, commissioner and regulator confidence Multiple deceased patients included in survey mailing. Single breach of regulatory duty Adverse local media coverage <3 days Staff member requiring time off work <7 days	Significant, medium term reduction in public, commissioner and regulator confidence Single breach of regulatory duty with Improvement or Warning Notice Adverse local media coverage >3 days Staff member requiring time off work 7-14 days	Widespread reduction in public, commissioner and regulator confidence Large volumes of patient activity (a whole weekly clinic) not recorded on systems that support business decision-making and payment. Multiple breaches in regulatory duty with subsequent Improvement or Warning Notices and enforcement action Adverse national media coverage <3 days Activation of Major Incident Plan (by provider, commissioner or relevant agency) Staff member requiring time off work >14 days	Widespread loss of public, commissioner and regulator confidence External submission of data leading to a False or Misleading Information Offence. Multiple breaches in regulatory duty with subsequent Special Administration or Suspension of registration / prosecution Adverse national media coverage >3 days

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
Use of resources **By use of resources we mean delivering value for money, evidencing both efficiency and effectiveness. e.g.** • Fraud (+ / -) • Breach of Data protection & data security (+ / -) • External review (+ / -) • Peer review (e.g. GIRFT) (+ / -) • Environment • Research and innovation • IM&T	0 - £50K annual impact	£50k - £100K annual impact Single data breach; internal dissemination of data without appropriate consent	£100k – £1m annual impact External review or assessment resulting in immediate actions and recommendations Single data breach; external dissemination of data without appropriate consent + ICO reportable Co-morbidities to describe patient complexity frequently omitted from clinical documentation	£1m - £5m annual impact Failure to address or resolve immediate actions and recommendations from an external review or assessment Multiple data breaches / data breach; dissemination of large scale data at department level externally / deliberate (when proved); breach of data for personal gain; potential media involvement; ICO reportable Special Measures (finance or quality)	Annual loss > £5 million impact Extreme data breach of total data held by the Trust sent externally either through accident or deliberate means; wide scale reputational damage / media involvement; ICO reportable Special Measures (finance & quality)

Appendix C

A Project Initiation Document (PID) must be completed for all CIP schemes. The purpose of the PID is to ensure that the scope of the CIP scheme is fully understood and that any impact on quality has been appropriately evaluated and will be monitored throughout the life cycle of the scheme.

All PIDs must be reviewed by both the Director of Quality Governance and the Chief Nurse and Medical Director before being approved