NHS
North Central London
Clinical Commissioning Group

Quality Impact Assessment Guidance and Template

Version Control

Current Version:	**1.0**
Date (dd/mm/yyyy):	20/05/2021
Updated by:	Dee Malone

Change control:			
Version Reference	**Change Summary**	**Issue Date (dd/mm/yyyy)**	**Change author**
1.0	NCL Guidance draft	17/06/2021	Dee Malone

Approved by:			
Version Reference	**Approver**	**Approval Date (dd/mm/yyyy)**	**Outcome**

Introduction

NHS North Central London Clinical Commissioning Group (NCL CCG) is committed to ensuring that commissioning decisions, business cases and any other business plans are evaluated for their impact on both quality and equality.

This policy details the process to be undertaken in order to assess the impact on quality of commissioning decisions, QIPP plans, organisational Cost Improvement Plans, Business Cases and any other plans for change.

Purpose

The purpose of this policy is to set out the responsibilities, process and format to be followed when undertaking a quality impact assessment.

The objective of the Quality Impact Assessment (QIA) is to provide a review/benchmark that all risks and benefits to quality and service improvements have been considered at the planning Stage of the project and periodically refreshed throughout the business cycle.

The CCG requires the QIA template to be completed (or refreshed if appropriate) for the following, but not limited to;

1) New projects/transformational work/service redesign, including pilots, with or without financial benefits.
2) Designing of new pathways.
3) Where existing service specification and/or contracts are being altered, with or without financial benefits.
4) Where services are being re-procured, even without any changes to the service specification.
5) Commissioning and de-commissioning of services.

This will ensure that the impact of the project on quality and service will be accurately assessed and managed. It will also enable the transformation team to assess the impact against any planned provider CIP's and any known performance issues known by the quality team.

There is a separate policy detailing the process for equality impact assessments.

Overview of Quality Impact Assessment (QIA)

A QIA must be considered at the planning Stage of the project and periodically refreshed throughout the business cycle. This will ensure that the impact of the project on quality and service delivery will be accurately assessed and managed. It will also enable the relevant commissioning team to assess the impact against any planned provider Cost Improvement Plan's (CIPs) and any known performance issues known by the quality team.

This tool involves an initial assessment (Stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Stage 1: an initial QIA assessment must be completed at the scoping Stage for all projects. The project lead will share this with the Quality team, who will provide scrutiny and comment at their monthly Performance meeting.

The QIA consists of 8 categories, each category must be assessed at Stage 1. Where a potentially negative risk score is identified and is greater than or equal to 8, this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring (≥) 8 at this point will need to undergo a further detailed assessment as advised by the Quality Team.

Stage 2: Where risks have been identified as (≥) 8 the QIA must be reviewed and completed in full by the project group alongside the completion of the Project Initiation Document (PID) and Service Specification, and to reflect the latest intelligence available at the time.
The completed QIA must be shared with the Quality team by the project lead who will provide scrutiny and comment at their monthly Performance meeting.

QIA will form part of the Quality report to the Governing Body.

For both stages of the QIA, the Clinical Lead and Project Lead are required to sign off and approve the QIA, prior to sharing with the Quality team for final sign off.

Context

Following the report into Mid Staffordshire NHS Trust there has been an increased focus on the impact on quality of Cost Improvement Programmes (CIPs) and Quality, Innovation, Productivity and Prevention (QIPP) programmes.

In February 2010 Monitor described a best practice approach to quality assurance as detailed below [1]:

([1] Consultation on an update to the Guide for Applicants – Quality Governance – Monitor 5 – Feb 2010)

1. Identify Potential CIPs	2. Assess potential impact on quality and cost	3. Approve plans	4. Assess actual impact on quality
• The majority of CIPs should be based on changes to current processes, rather than 'top-slicing' current budgets • Where possible, CIPs should be expected to have a neutral or positive impact on quality as well as reducing costs • At a minimum, CIPs should not put registration at risk by bringing quality below essential common standards	• CIPs should be categorised by potential impact on quality • CIPs with significant potential impact on quality should be subject to an assessment of their impact on quality covering safety, clinical outcomes and patient experience, which could include: ○ Analysis of current processes ○ KPI benchmarking ○ Historical evidence • All CIPs should be subject to a detailed assessment of their financial impact in line with current practice	• Clinicians understand and accept CIPs and approved plans have appropriate clinical ownership (e.g. relevant clinical director) • Board assurance is required that CIPs have been assessed for quality (potentially via direct approval for highest potential impact CIPs) • There must be an appropriate mechanism in place for capturing front-line staff concerns	• All CIPs should be subject to an ongoing assessment of their impact on quality, post roll-out ○ Identify key measures of quality covering safety, clinical outcomes and patient experience ○ Monitor each measure before and after implementation ○ Take action as necessary to mitigate any negative impact on quality

In June 2012, the National Quality Board supplemented this guidance [2] with greater detail on how it would expect Trusts to manage the impact on quality of service improvement. In particular, the document:

- Emphasises the importance that the QIA process is Board led.
- Describes the role of commissioners in the QIA process, notably in the formation of a "star chamber" as the hub of the process.
- Sets out an example of best practice at Trust level.
- Recommends that Trusts follow the National Workforce Assurance Framework
- Provides a check-list for the governance of QIAs

([2] HOW TO: Quality Impact Assessment Provider cost Improvement Plans – National Quality board – June 2012)

When and how often a quality impact assessment should be undertaken?

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 (e.g. commissioning decisions, business cases, projects and other business plans). Impact assessments must be undertaken as part of the development and proposal stage of developing business plans and should also be reviewed regularly by the project leads, as part of reviewing the actual impact throughout the implementation stage and during the final review after the business plan has been implemented.

What should be considered as part of the Impact Assessment?

The Impact Assessment template outlines the questions to be considered under the three domains of quality:

1. Patient safety
2. Clinical effectiveness
3. Patient experience

Process for assessing potential risks to quality and equality

As part of the impact assessment, project leads are required to consider any risks which should be added to the CCG risk register. High risks may need to be escalated to the Board Assurance Framework.

Definitions

Quality	Quality can be defined as embracing three key components: • Patient Safety – there will be no avoidable harm to patients from the healthcare they receive. This means ensuring that the environment is clean and safe at all times and that harmful events never happen. • Clinical Effectiveness – the most appropriate treatments, interventions, support and services will be provided at the right time to those patients who will benefit. • Patient Experience – the patient's experience will be at the centre of the organisation's approach to quality.
Impact Assessment	An impact assessment is a continuous process to ensure that possible or actual business plans are assessed and the potential consequences on quality are considered and any necessary mitigating actions are outlined in a uniformed way.

Roles and responsibilities

NCL CCG Accountable Officer	The Accountable Officer has ultimate responsibility for quality across the organisation.
NCL CCG Executive Director of Quality	Responsible for ensuring that appropriate risk management processes are in place to mitigate and manage risk at both service and organisational level.
NCL CCG Director of Quality and Chief Nurse	Responsible for ensuring that Quality Impact Assessments are effectively considered as part of discussions and decisions about QIPP and Cost Improvement Programmes, business cases and other business plans.
NCL CCG Governing Body	Each Board member is responsible for ensuring that financial and operational initiatives and service redesign (e.g., QIPP, Cost Improvement Programmes, business cases and other business plans) have been evaluated for their impact on quality and have assured themselves that minimum standards will not be compromised. They will also assure themselves that the impact on quality on an on-going basis is monitored appropriately.

Monitoring

Standard	**Source of Assurance/Timescale**	**Responsibility**
Impact assessments are required to accompany all business case proposals.	Papers for meetings should be scrutinised. Those submitted without impact assessments completed must be returned to project lead before being progressed.	All Directors.
Impact assessments are monitored and reviewed regularly by the project lead.	Regular review via programme dashboard Directorate meeting, and as a minimum every six months until the project / pilot has gone live.	All Directors.
Directorate Risk registers contain appropriate risks in relation to the potential impact on business plans.	Relevant Executive Director.	All directors
Review provider quality through the CCGs Oversight	Regular reviews CSU leads/CRM/CQRG/Forward Planner /performance meetings	All Directors

A question and answer series can be found in Appendix 1.

Checklist

The following should be considered when carrying out a Quality Impact Assessment (QIA):

Patient Safety

- What is the impact on partner organisations and any aspect of shared risk?
- Will this impact on the organisation's duty to protect children, young people and adults?
- Impact on patient safety?
- Impact on preventable harm?
- Will it affect the reliability of safety systems?
- How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections to patients is reduced?
- What is the impact on clinical workforce capability care and skills?

Clinical Effectiveness

- How does it impact on implementation of evidence based practice?
- How will it impact on clinical leadership
- Does it reduce/impact on variation in care provision?
- Does it affect supporting people to stay well?
- Does it promote self-care for people with long term conditions?
- Does it impact on ensuring that care is delivered in the most clinically and cost effecting setting?
- Does it eliminate inefficiency and waste by design?
- Does it lead to improvements in care pathways?

Patient experience

- What is the impact on protected characteristics, such as race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience?
- What impact is it likely to have on self-reported experience of patients and service users? (Responses to national/local surveys/complaints/PALS/incidents)?
- How will it impact on the choice agenda?
- How will it impact on the compassionate and personalised care agenda?

Appendix 1

Quality Impact Assessments – Question and Answer

What does "duty of quality" mean?

This falls outside the current definitions of the domains of quality (Patient Experience, Patient Safety, and Clinical Effectiveness), but does exist as an expectation in its own right when commissioners discharge their duties. The Health Act 1999 (and 2003) introduced it as a statutory requirement for services commissioned and provided by all NHS Trusts, delivered through the implementation of appropriate clinical governance. In the context of the QIA, this duty therefore relates to overall approach to clinical governance and that if is addressed and incorporated as part of the impact assessment. The following questions would then address individual areas within an overall clinical governance framework.

What does "compliance with the NHS Constitution" mean?

The Constitution, developed as part of the NHS Next Stage Review led by Lord Darzi back in 2010 and last updated on 26 March 2013, sets out key principles that form the backbone of the NHS. These principles concern comprehensive services available to all, clinical excellence, patients first, partnership across boundaries and value for money.

This question aims in general terms to assess whether the impact of the service reform/project proposed in any way goes against the grain of what the constitution proposes. The impact could be positive, negative, or a combination of the two. Since the tool is designed to be an overview of quality impact, the response should consider briefly but not assess in great detail what impact the service reform/project may have on these principles.

What does "personalised and compassionate care" mean?

The inclusion under Patient Experience of personalised and compassionate care effectively refers back to a February 2011 report by the Health Service Ombudsman into the care of older people, and more recently the vision outlined in the NHS Long Term Plan.
Commissioners need to consider whether their proposed service redesign / projects could impact upon capability to provide personalised and compassionate care. This could relate to carrying out patient assessment (e.g. does proposal change approach to this to better engage patients and better ensure), or person centred care planning (do outputs or outcomes relate to make improvements in this area for patients?).

Can impact ratings for the same impacts shown both here and in project risk logs (within Project Initiation Documents) vary?

There may well be some differences between impact ratings shown on the QIA and those shown on the risk register (within the PID) since within the QIA they encompass solely quality, but within PID also incorporate productivity and financial saving for the CCG. This is not necessarily an issue since the purpose of the impact rating is to assist only in assessing negative quality impacts and therefore whether further Stage 2 review is necessary.

How will positive impact indicators be used once the QIA has been completed?

It is expected that these will be inserted within both Project Initiation Documents and project workbooks. They will need to be designed and articulated in such a way as to be subject to monitoring against thresholds and monthly variance as defined within the project workbook format. They should also be carefully designed so as to ensure that they are quality focused and do not relate to productivity for example.

The QIA should also steer away from reliance upon quality indicators that are not locally measurable and for which there is an understood time lag, e.g. changes in condition prevalence rates in general practice which are not managed locally.

It is recommended that this process specifies at least two, but no more than four, quality indicators for each project within the overall programme. It is recognised that some identified quality indicators may not form part of service specification and consequently PID where these have already been agreed (particularly if the service reform or project is already live). These should be subject to monitoring review at least quarterly (see question below about QIA review). It is also recognised that, in some cases, there may be subsequent difficulty experienced in actually being able to measure pre-defined and agreed indicators. Best practice would therefore dictate that all potential issues in relation to data collection and impact on monitoring should be determined and resolved in advance of final agreement of service specification and PID.

Should an assessment always contain negative impacts?

The QIA should always aim to assess and describe potential negative impacts and potential unintended consequences to add more weight to the assessment overall. It is not especially necessarily that there should always be a negative impact scoring 8 or more on the risk rating in order to purposefully prompt further review at stage 2, but should be evident that negative impacts have at least been considered and risk rated (in line with the risk management strategy) without deliberately steering the assessment to be wholly positive. It is not necessarily the case that inclusion of negative impacts will unduly influence whether or not a service reform / project continues to proceed as part of the QIPP programme. As regards positive impacts, these do not need to be individually risk rated.

From what perspective should the QIA be completed? The perspectives of commissioners, patients or QIPP can greatly vary.

The QIA should be completed to reflect all of these perspectives and explain how this would impact on expected benefits, which could be positive, negative, or a combination (a “neutral” category for impact which provides balance can be used although is not stated as an option within the current version of the tool). An example comes from community cardiology and plans withdrawal of home visits by community heart failure nurses. If patients currently in receipt of services in the community at home have to attend a clinic setting as an alternative (either acute or community), there may be negative patient perceived impact as the offer of home based support is being withdrawn. Yet this may be clinically beneficial to their care and endorsed by clinicians. The thought process which draws out this conclusion of “neutral” impact would need to be explained.

Should there be an expectation that the QIA will be periodically reviewed, especially in circumstances where identified quality indicators do not form part of the service specification or project workbook?

It would be recommended that, if this were the case, then the QIA would be best reviewed in isolation at least quarterly as part of project monitoring. Quarterly review can also address and update any changes to performance indicators which have been agreed in light of experience, for example during mobilisation and commencement. It is further recommended that any additional indicators identified through this process are monitored through a quarterly highlight report. Project managers will therefore need to have determined how these indicators are to be monitored and reported, likely in conjunction with providers where they are delivering on behalf of commissioners.