HOW TO:
Quality Impact Assess Provider Cost Improvement Plans

National Quality Board

July 2012 to 31 March 2013

This publication has been produced by the National Quality Team on behalf of the National Quality Board.

To find out more about The How To Guides please visit the NQB web site

http://www.dh.gov.uk/health/category/policy-areas/nhs/nqb/

or email parmjit.kaur@nqb.nhs.uk

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The purpose of ‘How to’ guides

Recent failings in the health and social care system have highlighted the need for greater clarity about who is responsible for identifying and responding to failures in quality. The National Quality Board has addressed this through the publication of two reports

1. Review of early warning systems in the NHS (24 February 2010):- www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113020
2. Maintaining and improving quality during the transition: safety, effectiveness, experience (March 2011) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125234

But if we are clearer about our roles and responsibilities, then we also need a more consistent approach to how these difficult judgements about quality are made and to provide the managers and clinicians who have to make them with more guidance and support. How should we judge whether a service is failing or not? What tools might be used to better understand the situation, and what action should be taken as a result?

As part of the SHA to SHA Cluster Handover Assurance Process run in 2011, we sought to understand from each region what the current ‘best practice’ operating model for key aspects of quality is in their area, with a view to encouraging adoption across the country. Rather than try and produce one overarching model, we have worked with the NHS and key stakeholders to produce a series of practical ‘How to’ guides that directly relate to the key issues that NHS staff have suggested that further guidance would be helpful. These documents and a range of other resources can be found on http://www.dh.gov.uk/health/category/policy-areas/nhs/nqb/. These guides are not set in stone: they represent our best understanding of the most effective way of responding to quality concerns, and we would welcome feedback and comment so that we can continue to incorporate any learning and experience into the operating model for quality.

Quality is complex. It is systemic: that is, the delivery of high quality care depends upon many different parts of the system working together. Therefore, the most important part of any operating model for quality in the NHS must be the culture and behaviours that our respective organisations adopt within and between ourselves.

Proposed Operating Principles

- The patient comes first – not the needs of any organisation or professional group
- Quality is everybody’s business – from the ward to the board; from the supervisory bodies to the Regulators, from the commissioners to primary care clinicians and managers
- If we have concerns, we speak out and raise questions without hesitation
- We listen in a systematic way to what our patients and our staff tell us about the quality of care
- If concerns are raised we listen and ‘go and look’
- We share our hard and soft intelligence on quality with others and actively look at the hard and soft intelligence on quality of others
- If we are not sure what to decide or do, then we seek advice from others
- Our behaviours and values will be consistent with the NHS Constitution

Summary

This is one of a number of 'How to' guides issued by the National Quality Board (NQB). It has been specifically designed to help clinicians, managers and board members consider the impact of provider cost improvement plans (CIPs) on the quality of care provided for patients. **It is for use in the current system and as such acknowledges the role of the primary care trusts (PCTs) and strategic health authorities (SHAs).**

The guide promotes a systematic exploration of quantitative and qualitative intelligence and encourages the orderly triangulation of information to help assess the quality impact of CIPs. The general approach has also been fashioned to help facilitate clinical 'sign up' as well as generate an appreciation of the impact on patients and staff of any planned workforce reductions, service changes or other efficiency gains. In this context the guidance will also assist medical and nurse directors in the delivery of their specific responsibilities to approve provider CIPs as specified in the 2012/13 Operating Framework.

The role of clinicians, particularly medical and nurse directors is central to making all this happen. By working systematically through the various stages set out in the guide, medical and nurse directors can add weight to any judgements made about the quality impact assessment of provider cost improvement plans.

The guide will be amended in the autumn in preparation for the new NHS architecture and the demise of primary care trusts (PCTs) and SHAs.

Chapter one: Context

The overall value and proportion of turnover of provider cost improvement plans (CIPs) in many cases remains higher than that historically achieved. For most the quick wins and 'low hanging fruit' have now been taken and CIPs are more challenging to identify and deliver. Moreover, the national efficiency requirements remain in the area of 4 per cent and apply to tariff and non-tariff services alike. This is set against a backdrop where quality must remain at the heart of what we do whilst we also live within our means.

Monitor has responded to this environment by increasing the financial assumptions on efficiencies used in assessment for foundation trust status to between 4.2 - 5.0% in the assessor case and 5.0 - 5.5% in the downside case for acutes and for non acutes 4.2% - 5.0% in the assessor case and 4.7% - 5.5% in the downside case. These assumptions include allowance for the readmissions penalties, non-elective cap and variation from tariff. While applicants for foundation trust (FT) status are not required to demonstrate that these levels are achievable in their integrated business plan, they are required to justify departure from these assumptions. Monitor assesses the credibility of such departures.

Irrespective of whether the CIP is associated with an FT or non FT, it is perfectly possible to protect and enhance quality while also containing costs. But it is not a given and we cannot be complacent and assume that just because nobody wishes to compromise the quality of care that it will not happen. We have to actively put processes in place to ensure that there are no perverse or unforeseen consequences for quality of some planned service or efficiency changes. This is essential in a system as complex and interdependent as the NHS, where decisions in one part of the service can impact upon another with many co-dependencies that are not always easy to predict or assess.

CIP Process

Every autumn trusts begin to plan their annual CIP for the following financial year although there is acceptance that in-year programmes also feature as part of the planning cycle. Each trust will identify its projected income (from all sources) and estimate its projected expenditure, taking account of the requirements contained in each year's operating Framework. In addition to identifying the forthcoming priorities, the Operating Framework will identify a minimum percentage saving to be made (typically 2% - 4% of overall income). Every year there is an efficiency/productivity requirement set for the NHS and there is an annual expectation that savings and efficiencies will be made by each organisation.

At this stage there will inevitably be a gap between a trust's projected income and expenditure. The trust then plans how it will close that gap, which may involve a number of measures and will not necessarily require cuts in services. CIPs are not necessarily about cuts or closures but rather the focus is usually on improving efficiency. Gaps can be filled in several ways and it may for example, include a plan to increase income.

All CIPs are subject to change and need to be dynamic documents since revisions in policy or circumstances require adjustments to the CIP during the year. Only a trust board can best determine

how to deploy its resources within a CIP and we must not lose sight of the fact that ultimately, the board of the organisation is responsible for preparing a plan which is deliverable and not detrimental to the quality of patient care.

All of this reinforces the need to focus on the impact on quality of the savings schemes identified as part of CIPs. There is also a need for commissioners to establish that a quality impact assessment (QIA) has been completed and approved by provider boards. Moreover, the 2012/13 Operating Framework[1] makes clear the requirement for NHS trusts that all CIPs should be agreed by provider medical and nurse directors. Commissioning and SHA medical and nurse directors similarly need to be assured.

The Operating Framework also sets out the requirement for a single national approach for SHA quality assurance of cost improvement plans.

"While funding over the Spending Review period will increase in real terms, the QIPP challenge has identified the need to achieve efficiency savings of up to £20 billion over the same period, to be reinvested in services to provide high-quality care. The NHS is on track in 2011/12 to meet QIPP objectives. Currently this is weighted towards central actions, including pay and administrative cost reductions and local efficiency programmes. For future years, delivering the additional efficiency savings and quality improvements will require the NHS to focus on delivering transformational change through clinical service redesign. For 2012/13, we need to build on the progress made in delivering efficient organisations and, through the reinvestment of those efficiencies, start to deliver transformational service change while maintaining the gains already made. Where cost improvement programmes are required, these must be agreed by Medical Directors and Directors of Nursing, involve patients in their design and include in-built assurance of patient safety and quality. A single national process is being developed so that all SHA clusters take a consistent approach to their quality assurance of cost improvement plans. This will be part of a broader common operating model for quality and safety that is being developed by the National Quality Team"[1]

These requirements do not apply to FTs since the Department of Health and the Secretary of State have no powers of direction in this area. However, Monitor would regard the failure of FT board members, including medical and nurse directors, to agree plans as a sign of poor governance.

1. NHS 2012/13 Operating Framework section 1.9

Chapter two: The guide

Provider Responsibilities

The guide has been designed for use by commissioners, their clinicians, managers and board members and provides a specific framework for the quality impact assessment of provider CIPs. Although applicable across the aforementioned organisations, the guide has been produced in full recognition that the quality impact assessment of CIPs is the primary responsibility of provider boards. The focus on commissioner and SHA responsibilities therefore, should not over shadow the primary role of provider boards to quality impact assess their own CIPs. The provider board is responsible for bringing together all the available information to ensure that a sufficiently granular level of triangulation and assessment is formally undertaken and reported to the board.

Although the contribution of the medical and nurse directors is crucial, it is the collective responsibility of the board to ensure that a full appraisal of the quality impact assessment is completed and recorded and that arrangements are put in place to monitor work going forward. Given the dynamic nature of CIPs this exercise should not be a one off application for the board but should feature as core business on a frequent and regular basis throughout the year.

The National Quality Board publication, *Good Governance for Quality: a guide for provider boards*[2] is particularly relevant and should be considered as part of the preparation and delivery of the quality impact assessment.

Focus and application

The guide is best used in conjunction with more general assurance processes already in place to assess the performance of providers. It can also sit alongside, and complement, the delivery of local QIPP imperatives where these do not form part of individual CIPs. In essence the guide has been designed to assist commissioners and SHAs to complete a systematic assessment of provider CIPs which, in turn, supports rational and proportionate decision making.

By adopting this approach each commissioner will be able to demonstrate the systematic application of assessment criteria and thereby enable the breadth and depth of scrutiny required to adequately assess CIPs.

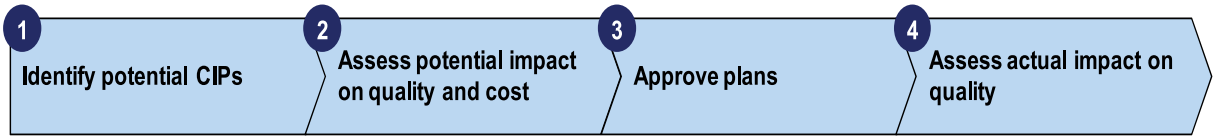
This will help commissioners and SHAs in the current system to recognise any adverse impact on patient care at an early stage and give them the chance to intervene if necessary to protect patients, staff and / or services.

As for provider boards, application of the guide should not be regarded as a one off process but will require attention throughout the period of cost improvement once plans have been accepted. Any work generated by provider boards should be used to inform the external assurance process rather than simply be taken at face value. The risk of false assurance is too great unless actual scrutiny by commissioners and SHAs takes place.

2. Good Governance for Quality: a guide for provider boards. March 2011

The approach set out in this document is reflective of the guidance issued by Monitor to providers as described in the *Amendments to Applying for NHS Foundation Trust status – Guide for applicants* (July 2010)[3] and the recently published *Delivering sustainable cost improvement programmes – January 2012*[4]. The following three tables provide a useful overview and a number of useful case studies are set out in the second of the two publications.

Illustrative action plan for applicants



- 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

3. Amendments to Applying for NHS Foundation Trust status – Guide for applicants (July 2010)

4. Delivering sustainable cost improvement programmes – January 2012.

Additional guidance on recommended analytical approaches

Approach	Description	Comments
Current processes	▪ Review of current processes to identify where waste exists and how it can be eliminated to reduce costs without compromising quality ▪ Reducing variation is also very powerful	▪ Could include Lean analysis, time and motion studies, staff interviews ▪ Generally considered to be the most insightful piece of analysis
KPI benchmarking	▪ Benchmark analysis of relevant operational 'inputs' to quality relative to peers and guidance (e.g. Royal College)	▪ Nurse/bed ratio, average length of stay[1], bed occupancy, bed density and doctors/bed are examples of operational efficiency metrics which can be markers of quality ▪ Useful as a prompt for discussions (e.g. 'Is it really feasible to reduce nurse headcount when our nurses/bed ratio is already in the bottom decile relative to our peers?') ▪ However, limitations of this approach must be recognised: no direct link between operational inputs and quality outputs; hard to set peer group, generally poor quality data ▪ Currently, benchmarking data is generally more available and useful for Acute trusts than for Mental Health trusts
Historical evidence	▪ Analysis linking operational changes (e.g. nurses/bed reductions) to quality outputs	▪ Analysis could be based on internal evidence (e.g. historical trends or on different wards) or external evidence (e.g. published reports on experience in other Trusts/ countries) ▪ However, important to recognise limitations of links between operational inputs and quality outputs

1 Relevant as an indicator of quality when paired with readmission rates

Suggested indicators to assess actual impact of CIPs on quality

ILLUSTRATIVE

Quality

Safety
- Infection rate (MRSA, C Diff)
- Medication errors
- Slips, trips and falls
- Adverse events (e.g. SUIs)

Clinical effectiveness
- Readmission rate
- Mortality rate

Patient experience
- Average length of stay
- Patient satisfaction (measured through discharge survey)
- Patient complaints
- Waiting times

General
- Staff willingness to recommend hospital to friends and family
- Staff satisfaction
- Staff turnover / absentee rate
- Bank and agency staff level
- Bed utilisation

NOTE: These are intended to be example indicators. Applicants should select (and justify) indicators they consider to be most relevant to them

Birmingham Children's Hospital NHS Foundation Trust has produced a methodology and supporting documentation which largely mirrors the guidance issued by Monitor. The chief executive of the Trust is happy to share this approach as a practical operating model.

Birmingham Children's Hospital NHS Foundation Trust

'Anyone who thinks this is just about spreadsheets and databases is wrong: it's an overall approach. That's why we've developed a system that ensures that every decision that's made to reduce costs at Birmingham Children's Hospital is discussed, quality assured and signed off by clinicians locally, as well as by our Lead Nurse and Medical Director. This has meant a broader group than ever before has driven how we redesign services and release costs: helping us approach the future with a greater confidence.

To be successful we've needed a lot of hard work and focus by everyone involved as well as clear and strong leadership, but the rewards in terms of innovation make that additional effort well worthwhile'. – Sarah-Jane Marsh, Trust Chief Executive

Details of the Trust's methodology are set out at **Annex A**.

Contact with the Trust on matters of detail is encouraged and can be made to;

- Dr Vin Diwakar, Chief Medical Officer (vinod.diwakar@bch.nhs.uk)
- David Melbourne, Chief Finance Officer (david.melbourne@bch.nhs.uk)

Chapter three: Governance

It is important that at whichever level the impact assessment is being undertaken, by provider, commissioner or SHA, the board and chief executive must endorse the process. They must support the medical and nurse directors to work collaboratively with other key colleagues such as the finance and performance directors, to complete the assurance process. In this regard the process should be formally adopted by the board and underpinned by clear governance arrangements which confirm lines of accountability through to the board, and which fully acknowledges the primary responsibility of boards to satisfy themselves on matters of detail. The 'lines of sight' between the commissioner and SHA with regard to reporting and performance expectations, should be documented, unambiguous and transparent.

Good practice also dictates that business of this nature is best transacted in public through regular board meetings and other relevant public facing events such as the social partnership forum, LINks, HealthWatch and oversight and scrutiny committees. The involvement of patients/service users and clinical senates is also important and will help bolster the overall validity of the process.

Governance Check List

- ✓ Has the chief executive agreed the governance arrangements and secured board endorsement?
- ✓ Are the medical and nurse directors engaged and leading the process?
- ✓ Is the board reporting regime clear and widely promoted i.e. is there transparency of process?
- ✓ Are the arrangements for providing assurance to the board, commissioners and Monitor in the case of FTs, both about the delivery of the CIP and the ongoing validity of the quality impact assessment clear and documented?
- ✓ Is the management team formally engaged and committed to matrix working / information exchange?
- ✓ Are quality impact assessment reports generated and circulated regularly to stakeholders?
- ✓ Are all stakeholders such as HealthWatch, LINks, overview and scrutiny committees, social partnership forums briefed and engaged?
- ✓ Are arrangements in place to ensure that quality is assessed as part of monthly performance reviews to ensure integration with finance, workforce and performance assessment?
- ✓ Have "cross-over reviews" been designed into the governance process to help assess the cumulative impact of CIPs and to keep a search for any unintended consequences or known risks which are not being adequately mitigated?
- ✓ Is there a robust facility for front line staff to confidentially report concerns about CIP schemes and their potential negative impact on quality, patient experience or safety or indeed on staff?

Chapter four: Beginning the process

Given the responsibility of commissioning and SHA medical and nurse directors to satisfy themselves that providers have adequately designed and applied CIPs with due regard to quality, it is strongly recommended that they establish and lead, at commissioning and SHA levels, a small group comprising staff from areas such as quality, workforce, finance and performance to help undertake the assessment. This approach can be regarded as a 'Star Chamber' and is recommended over the virtual exchange of information, since there is no substitute for face to face discussion when assessing soft intelligence against quantitative data.

The Star Chamber approach, if formally adopted, will offer a useful method for completing the various aspects of the quality impact assessment. It relies on collaboration between staff to identify critical indicators to inform the overall assessment. Such triangulation of information and perspectives also helps promote process reliability and validity.

The standards for information exchange set out in the *NHS Early Warning Systems*[5] document should be adhered to as a measure of good practice.

As outlined above the commissioner and SHA have different roles and the expectation is that the commissioner would undertake a quality impact assessment and report to the SHA. The SHA would still be expected to adopt a process similar to the Star Chamber to both validate the commissioner assessment(s) and to complete an overview of the locality and any cross cluster or sector issues. For example, cross boundary or service issues including those relating to social care and independent sector provision.

Composition of a Star Chamber

The exact composition of a Star Chamber is for local determination but should include of key directors and other core staff to help guarantee that no vital information is over looked. The presence and commitment of directors will help ensure proportionate and fair decision making although the need for expert input, including that from the clinical senate and post-graduate medical dean, for example, is recommended and is best judged to suit the issues at hand. Moreover, liaison with the CQC and Monitor at an early stage to exchange and validate information is essential. Matters of indemnity for some expert contributors may have to be considered dependent on the nature and source of the input required.

5. NHS Early Warning Systems - www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113020

Suggested Membership of a Star Chamber

- Medical and Nurse Directors * Co – Chair
- Finance Director
- Director of Workforce
- Director of Performance
- Head of Patient Safety
- Head of Quality Observatory
- Secretariat / analytical expertise

NB – consider involvement of expert contributors and the role of the CQC and Monitor.

***Chairing should be consistent in the event the 'Star Chamber' continues beyond a single meeting.**

Membership of the Star Chamber must be pitched at director level if it is to serve as a reliable forum for robust and challenging conversations concerning both qualitative and quantitative data/ intelligence about individual provider organisations (see chapter 5). The importance of face to face debate rather than a simple reliance on virtual data exchange cannot be over stated. The opportunity to listen carefully to soft intelligence in the context of hard data is invaluable and needs to be given weight in the overall assurance process.

Appropriate administrative support to facilitate reliable record keeping and the generation of bespoke reports should be identified at the outset. Having reliable information management systems and associated document control processes in place will improve the overall reliability of the work, especially at the point of handover between organisations.

The chance that working documents will be accessed in the future or be subject to audit is fairly likely, particularly in the event of an adverse incident or negative organisational profile arising once commissioners and/or SHAs have assured themselves that specific CIPs were acceptable. For medical and nurse directors this will be particularly important given their board responsibilities for sign off of the quality impact assessments and the associated factors governing their respective professional registration with the General Medical Council and Nursing and Midwifery Council.

Star Chamber should...

- Operate to the standards set out in the NHS Early Warning Systems publication
- Be clinically led but not unduly dominated by clinicians – quality is everyone's business
- Involve a broad range of contributors
- Ensure all contributions are valued and have currency
- Provide a solid basis for peer review and critique which supports open and constructive challenge
- Facilitate comparative analysis of information and trends to create an informed picture based on facts and appropriate judgement, including consideration of soft intelligence
- Enable exploration of the inter-relationship between variables and the resultant testing of hypotheses i.e. using data/intelligence to identify lines of enquiry, cues for action or prompts for intervention
- Offer a transparent and timely process for the validation of plans in the context of assumptions applied by providers
- Challenge the efficacy of CIPs in the context of any as possible unintended or adverse consequences for patient care
- Provide a reliable audit trail for future reference

Two stages

The quality impact assessment can follow a number of routes to accommodate local circumstances but there are two principal stages recommended as a minimum;

Stage one – creating a baseline

In essence, stage one encourages an overt focus on matrix working to help promote open debate about a given provider so that a balanced and overarching assessment can be achieved as the basis for subsequent monitoring of CIPs. The exercise will flush out at an early stage any potential or actual risks associated with the implementation of provider CIPs. The ultimate goal at this point is to create a suitable opportunity to critique provider CIPs and where necessary, request revisions to the original CIP in order to safeguard patients or staff.

To kick start this process and at the outset of the financial year, the commissioner should examine all known data about providers including material on quality, patient safety/experience, activity, finance, workforce and performance metrics to create a baseline against which the CIP can be judged as plans unfold in year.

Consideration of integrated performance and specific quality dashboards in the context of soft intelligence is crucial if a balanced and fair judgement process is to be concluded by experienced and senior staff, notably by directors. A specific review of the relevant Care Quality Commission's Quality Risk Profiles (QRP) must be included at this stage. It is also advisable to reflect on the NICE quality standards as a source of measures and indicators to help ensure that quality is not compromised as a result of CIP delivery.

In this way robust consideration can be given to data such as serious incident reporting rates/trends, never events, safety thermometer patient harms, key performance indicators on quality and infection rate profiles.

There is also a variety of qualitative data sources which will need to be referenced such as staff feedback, patient stories, trainee voice, outcomes of external inspection visits; senior leadership changes and any adverse media interest which, when used to moderate the quantitative data available, may suggest higher or lower levels of risk. An assessment of the impact of organisational change on quality, patient safety and experience is also important.

At this stage the commissioner and, where appropriate the SHA, should not hesitate to visit the provider to ascertain more facts and to check the reality of the situation at the point of service impact if they are unconvinced about the robustness or integrity of the information supplied by the provider. Meeting staff, staff side representatives and patients is an essential part of any site visit. Indeed, Monitor stresses the importance of having in place an appropriate mechanism for capturing any concerns front line staff may have about CIPs.

Irrespective of whether or not a site visit is made, over reliance on bureaucratic processes must be avoided since it could lead to incomplete or false assurance at best or a missed opportunity to protect patients and staff at worst.

The summation of the work should be reported formally to the respective commissioner and SHA boards and shared with the relevant provider(s). The principles of transparency and candour should prevail as an adjunct to reliable reporting and assurance.

Specific SHA Responsibility

The SHA has a lead role to assess the output of the assessments completed by individual commissioners in the context of wider system activities and plans. This means the SHA has to make sense of the overall position and assure itself that baseline reports completed by the commissioners are accurate and reliable. Adopting a Star Chamber approach and associated processes is a reliable way in which to make sure face to face discussions and peer review takes place as a basis for formal reporting to the board.

In the event that this initial consideration identifies a material patient safety problem then consideration must be given, in collaboration with the provider and commissioner, to brief the Care Quality Commission. Similarly, Monitor should be informed when a FT or NHS trust at an advance stage of FT application is involved.

Prompts for direct action by the SHA include;

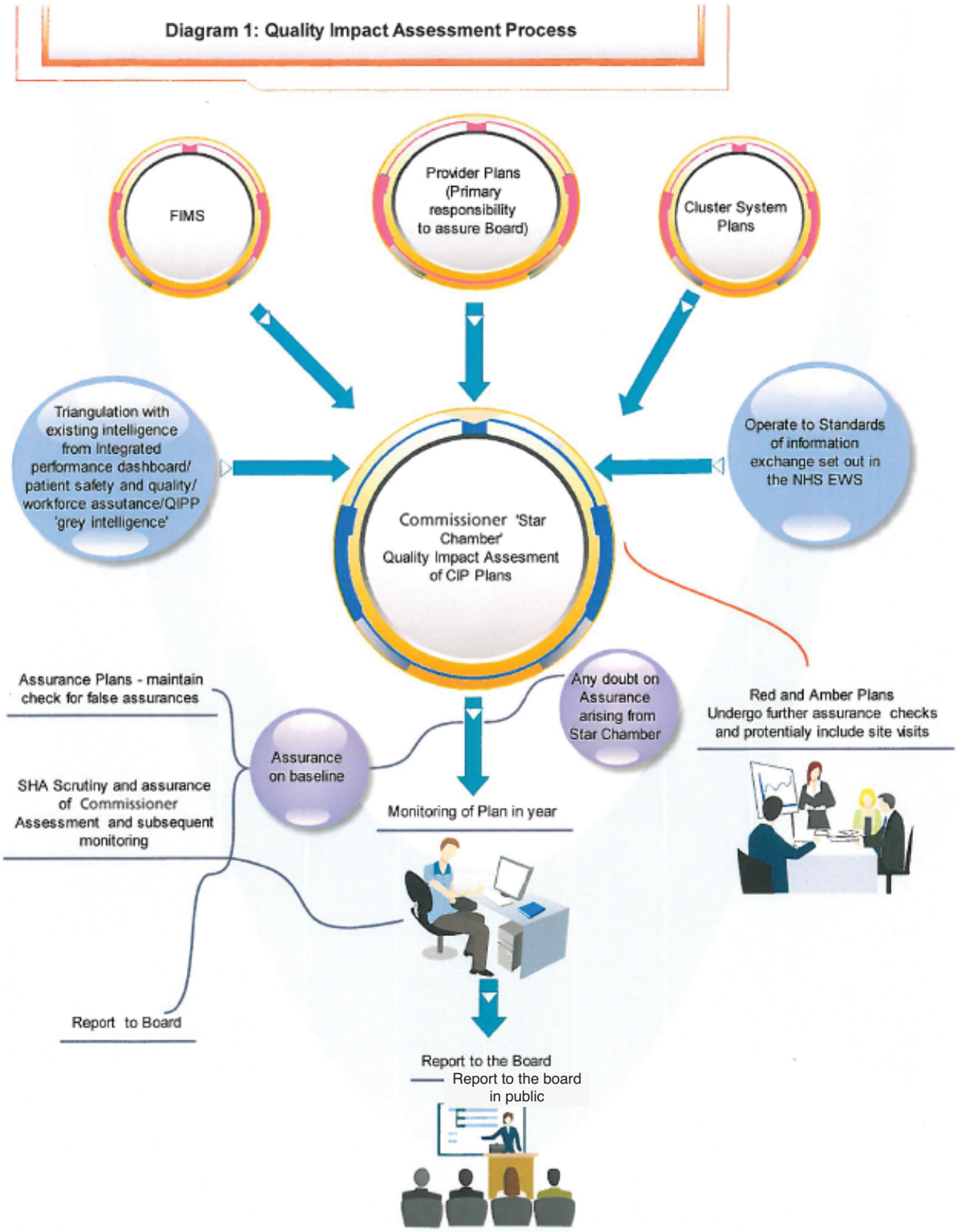
- Unacceptable or immediate risks to patients which requires swift intervention and where the commissioner needs support to help remediate the situation
- Serious and sustained failures against any of the performance areas
- Improvement is too slow and the commissioner is not effecting change through established performance management routes
- Public confidence in a service or provider is failing and the situation is beyond that which the commissioner can manage
- Monitor or CQC requests the SHA intervenes

Stage two – surveillance and intervention

Routine monitoring of performance against plan through the application of integrated performance and patient safety/experience dashboards and connected processes, dominates at this stage. Performance will normally be through commissioners, with the medical and nurse directors leading the ongoing quality impact assessment.

Intervention should be taken by the commissioners and by the SHA where the situation warrants it.

A schematic depiction of the quality impact assessment process and the role of a Star Chamber are illustrated in Diagram 1.



Chapter five: Conducting a Star Chamber

As outlined above the first stage involves the comprehensive triangulation of an array of qualitative and quantitative data to form a baseline. The outputs feed into the continued monitoring and assessment process and on the basis that if provider boards have managed the situation well, the level of intervention required of the commissioner and/or the SHA should be minimal. However, early triggers or cues for further scrutiny of CIPs identified should be used as a prompt to review providers in some detail rather than wait for the submission of additional data or qualification of the initial assessment.

The judgement made should be fair, transparent and proportionate and is best taken by board directors in line with formal governance arrangements. Devolving responsibility to sub-board level staff for the stages of assessment beyond straightforward data compilation and analysis is likely to compromise the integrity of the process. In addition the degree of judgement required about the acceptability of the assessment or need for further examination of the situation is best done by experienced directors, principally, but not exclusively the medical and nurse directors.

When undertaking the initial assessment of provider CIPs, the Star Chamber or other similar technique, should consider receiving a presentation by the provider chief executive or medical /nurse directors rather than simply receive a report. Open dialogue and inclusive behaviours will assist the process. There should be an operating principle of 'no surprises'.

Consideration should also be given to reviewing the following areas - see overleaf;

- Track record of delivery of savings plans – specifically in terms of the proportion of the plans for previous years delivered
- The relative scale of the CIP in terms of cash value, CIP as a % of turnover (as an indicator of the challenge presented by the scale of the CIP required) and the level of unidentified CIP as an indicator of the level of planning already undertaken
- The extent of change to the organisation's footprint arising from the level of Transforming Communtiy Services (TCS) transaction value
- Triangulation of available data to ascertain whether the reported numbers align (between the FIMS plan, any other plan documents, and detailed CIPs as submitted to the provider board)
- Whether activity, workforce and savings plans are aligned – do the assumptions correlate?
- Do CIP plans, as presented to the board, contain sufficient granularity?
- Has each CIP scheme been risk assessed and RAG rated? Has the risk assessment been reviewed for impact on staff, impact on quality of services, ability to deliver, ensuring that all 3 areas have been separately assessed?
- Evidence of comprehensive risk assessment process on the quality impact assessment completed for schemes with a potential impact on quality. This should include assessment of schemes in terms of patient experience, safety and clinical outcomes
- Have organisations used the Monitor Quality Assessment Framework to quality assure their CIPs?
- Evidence that unintended consequences have been assessed and mitigating actions clearly expressed for the risks identified
- Have the trust medical and nurse directors explicitly and formally signed off the CIP? (For the SHA have the commissioner medical and nurse directors fulfilled their joint responsibilities and signed off the plans/quality impact assessment?)
- Has the provider board formally approved the detail and risk assessment of the CIP?
- Is there sufficient level of transparency with regard to public, staff and patient engagement?

An outline agenda for a Star Chamber is set out in the table below.

Agenda Item	
Welcome and scene setting – confirm the context and task in hand	Chair
Presentation of the provider CIP	Provider CEO/Director
Presentation of commissioner (or SHA) assessment of the provider CIP	Commissioning Director
Interpretation and consideration of the integrated dashboard	Director of Performance
Interpretation of the data by discipline – performance, quality, finance and workforce in the context of the provider CIP. Begin triangulation of data sources through debate and peer review / challenge	Lead Directors
Agree risk rating(s)	All
Confirm any additional information or action required.	All
Agree monitoring arrangements	All
Summarise agreements	Chair

Table one: outline agenda for a Star Chamber

The outcome of the review for each provider should include a narrative outlining the rationale for two separate RAG ratings which identify the level at which the commissioner (initially, prior to SHA sign off) is assured about:

- **The level of detail and accuracy of the plans** – is the documentation well presented, comprehensive, logical and evidence based? Is it convincing?
- **The standard of evidence supporting the quality impact assessment** – is clearly articulated, robustly presented, reliable and signed off by the medical and nurse directors at the three levels of governance – provider, commissioner and SHA?

The chair of the Star Chamber should write to the provider chief executive to explain the outcome of the assessment and RAG rating, including any specific requests for aspects of the CIP not to be implemented to protect quality pending further discussion/ review.

Chapter six: National Workforce Assurance Framework

Application of the National Workforce Assurance Framework is recommended *(SHA workforce directors will be able to advise anyone who is unfamiliar with the Framework)* to help secure assurance about the level of current and predicted workforce. The Framework is best applied as workforce plans are submitted to the commissioner and SHA, including monitoring of performance against the current plans. Critical to this is the synthesis of workforce, activity and finance information to ensure that the workforce identified is reflective of commissioned activity and that reasonable assumptions about productivity and the provision of safe services have been made, and that the planned workforce is affordable.

A vast range of indicators are used to understand the workforce impact on quality, patient safety and experience. These included specific workforce measures such as sickness absence, temporary staffing spend, staff appraisal, staffing ratios and staff turnover. Correlation takes place between activity and workforce changes as a measure of productivity. As a consequence trends over time are exposed to understand the basis for productivity changes identified. In summary, application of the Workforce Assurance Tool will bolster the quality impact assessment of CIPs by adding further scope for triangulation of intelligence.

Monitoring

The monitoring of the quality impact of the CIPs must be maintained throughout the year as part of the general performance regime of providers undertaken by commissioners and SHAs. Regular reviews of performance by provider should be shared on at least a quarterly basis with the board using an integrated performance approach, although there should be a constant state of vigilance which does not simply rely on reporting points in the year.

Serious incidents and patient experience data should be continuously monitored for important triggers, alerts or trends which could suggest unintended or negative consequences for patients and/or staff. Detailed reference to patient safety/experience metrics is crucial and should include for example, mortality rates, patient experience indicators, trainee voice, safety thermometer harms, complaints, media profiles, patient choice data, compliance with CAS alerts and adult/child safeguarding reports. Active consideration of the national quality dashboard, Care Quality Commission's quality risk profiles and the ongoing application of the NHS Early Warning Systems will enhance the process.

Chapter seven: Conclusion

By applying this guidance and adopting a Star Chamber type approach a robust, systematic and inclusive assurance process of the impact of provider CIPs on quality, patient safety/experience can be achieved. That stated, the guidance is not a catch-all and must be applied by senior leaders across the various levels of the NHS who recognise and can deal with the complex and dynamic nature of the subject matter.

There is also a need to recognise that the current system of PCTs and SHAs will only exist for 2012/13. We must therefore, prepare the way for handover and legacy as we move to the new architecture but above all we must remain vigilant to the inherent risks to quality associated with periods of significant organisational change and stay focussed on the application of the NHS Early Warning Systems.

In this context we must ensure that any issues raised from the quality impact assessment must be included in the handover to the successor organisation(s), this is described in detail in - *How to: Maintain Quality during the Transition: Preparing for handover*[6]

6. How to Guide - Preparing for handover - http://www.dh.gov.uk/health/2012/05/handover-guide/

Annex A: Brimingham Children's Hospital
Assessing the Quality Impact of CIPs

Once form is completed please email to: - cip.pmo@bch.nhs.uk

Scheme Number:
Scheme Details

BCH CIP Scheme PID Details

lease complete all fields highlighted in green: -

Service *		Project Lead *	
Scheme Type *		Project Owner *	
Scheme Category *		Finance Lead *	
Scheme Area *		HR Lead (If App) *	
Directorate		Executive Owner *	

Scheme Name *

Context - Overview of Scheme

Current State

Target State

What needs to be done and when *

Tasks/ Milestones	Expected Date

Who is affected by the change *

Stakeholders	Impact of Change

When will scheme be implemented * | Confidence Factor (as %) *

Risks

Details	Rating

Issues

Details	Significance

Assumptions

Details	Impact if Untrue

Dependencies

Details	Impact

Financials

Benefits Expected in CIP Year	£ -	Recurrent Annual Benefit	£ -
Enabling Costs	£ -	Nett CIP Year Saving	£ -

Signed - Project Lead _____ Date _____

Signed - Finance Owner _____ Date _____

Scheme Financials

Scheme Number: Scheme Details

lease complete all fields highlighted in yellow: -

Breakdown of Savings

Pay	WTE	Year 1 Saving Value (£)	Recurrent Saving Value (£)
Consultants			
Junior Medical Staff			
Nursing			
Scienific/ Professional/ Technical			
Clinical Support Staff			
Non-Clinical Staff			
Agency Staff			
Other - Staff			
Total Staffing	0.00	£ -	£ -

Breakdown of Enabling Costs

Staffing - Cost Type	WTE	Cost (£)
Consultants		
Junior Medical Staff		
Nursing		
Scienific/ Professional/ Technical		
Clinical Support Staff		
Non-Clinical Staff		
Agency Staff		
Other - Staff		
Total Staffing	0.00	£ -

Non-Pay	Year 1 Saving Value (£)	Recurrent Saving Value(£)
Drug Costs		
Clinical Supplies & Services		
Non-Clinical Supplies & Services		
Other Saving		
Total Non-Staffing	£ -	£ -
Total Savings	£ -	£ -

Non-Staffing Enabling Costs	Costs (£)
Drug Costs	
Clinical Supplies & Services	
Non-Clinical Supplies & Services	
Other Cost	
Total Non-Staffing	£ -
Total Costs	£ -

Income Generation

Description	Year1 Saving Value (£)	Recurrent Saving Value (£)
Total Income	£ -	£ -

Year 1 Saving

Month	Saving Value (£)
April	
May	
June	
July	
August	
September	
October	
November	
December	
January	
February	
March	
Total	£ -

Once form is completed please email to: - Project Lead

BCH CIP Scheme
Quality Impact Assessment

Scheme Number:
Scheme QIA

Please complete all fields highlighted in green: -

Scheme Name			
Scheme Overview			
Project Lead		**Division**	
Clinician Completing QIA			
Quality Indicator(s)			
KPI Assurance - Sources & Reporting to Monitor Quality Indicator(s)			

	Details	Consequence	Likelihood	Score
Patient Safety				
Clinical Effectiveness				
Patient Experience				

	Details
Mitigation	

Overall Risk Score	

Signed - Clinician		Date	
Signed - Chief Medical Officer		Date	
Signed - Chief Nurse		Date	
Comments - Chief Medical Officer Chief Nurse			

Scheme No	Scheme Name	Division	Clinician	Patient Safety Desc	Patient Safety Score	Clinical Effectiveness Desc	Clinical Effectiveness Score	Patient Experience Desc	Patient Experience Score	Overall Score	CMO/CNO Status	Overall Status

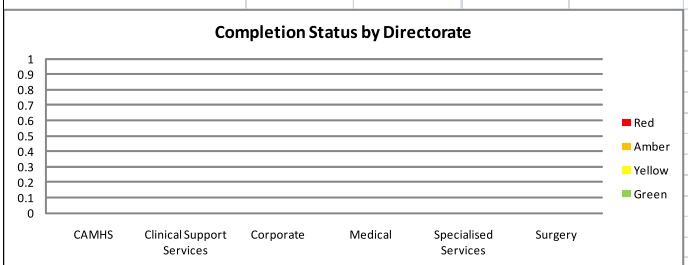
QUALITY IMPACT ASSESSMENT STATUS REPORT

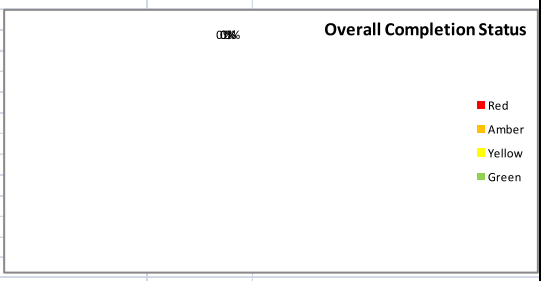
Report Summary | **Report Date** | **23/02/2012**

Division

Division	Status			
	Red	Amber	Yellow	Green
CAMHS	0	0	0	0
Clinical Support Services	0	0	0	0
Corporate	0	0	0	0
Medical	0	0	0	0
Specialised Services	0	0	0	0
Surgery	0	0	0	0
Totals	0.00%	0.00%	0.00%	0.00%

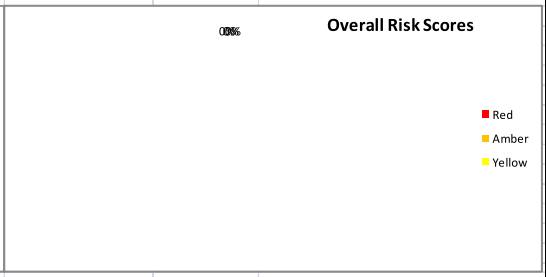
Rating Key	
Red	QIA not completed
Amber	QIA Passed to CMO/CNO
Yellow	CMO/CNO review Shows More Info Required
Green	CMO/CNO review Complete, Signed Off





Division

Division	Risk Score		
	Red	Yellow	Green
CAMHS	0	0	0
Clinical Support Services	0	0	0
Corporate	0	0	0
Medical	0	0	0
Specialised Services	0	0	0
Surgery	0	0	0
Totals	0.00%	0.00%	0.00%

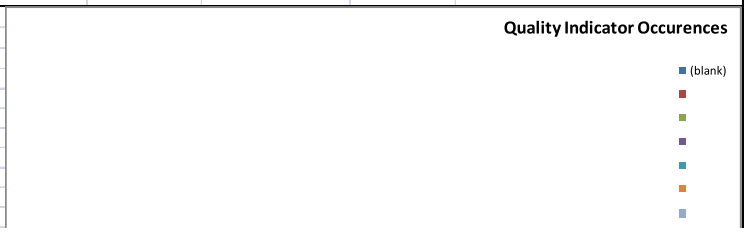


Top 10 Schemes by Risk Score

Scheme Title	Division	Risk Score

Top 10 Identified Quality Indicators

Quality Indicator	Occurences
(blank)	0



Once form is completed please email to: - Project Lead

BCH CIP Scheme
Quality Impact Assessment

Scheme Number:

Please complete all fields highlighted in green: -

Scheme Name	PID Scheme test 3,		
Scheme Overview			
Project Lead		**Project Owner**	
Clinician Completing QIA	dfhhdghgdhd		
Quality Indicator(s)	234234 234234 656556		
KPI Assurance - Sources & Reporting to Monitor Quality Indicator(s)	5436536 456456456 5		

	Details	Consequence	Likelihood	Score
Patient Safety	346rgsdfgfg	4	5	20
Clinical Effectiveness	sgesdfgs453yg	4	5	20
Patient Experience	ergrest45	2	5	10

	Details
Mitigation	dfgdfhadjh5ey3

Overall Risk Score	17

Signed - Clinician		Date	
Signed - Director of Quality & Governance		Date	
Comments - Director of Quality & Governance			

Once form is completed please email to: - Project Lead

BCH CIP Scheme
Quality Impact Assessment

Scheme Number:

Please complete all fields highlighted in green: -

Scheme Name	PID Sheme test 2, service redesign		
Scheme Overview			
Project Lead	Noah Jones	**Project Owner**	Joan Norman
Clinician Completing QIA	ertytytytyty		
Quality Indicator(s)	uioiuoiouio uiouiou iououio		
KPI Assurance - Sources & Reporting to Monitor Quality Indicator(s)	hjkhjkh hjkhjkh hjkhjkh		

	Details	Consequence	Likelihood	Score
Patient Safety	rtyrty	3	3	9
Clinical Effectiveness	rtyrty	2	3	6
Patient Experience	thyrtyrty	2	4	8

	Details
Mitigation	hfgjhyrjyrj

Overall Risk Score	8

Signed - Clinician		Date	
Signed - Director of Quality & Governance		Date	
Comments - Director of Quality & Governance			

Once form is completed please email to: - Project Lead

BCH CIP Scheme
Quality Impact Assessment

Scheme Number:

Please complete all fields highlighted in green: -

Scheme Name	First test detail for Scheme PID, freeze recruitment for Betty Wont		
Scheme Overview	Don't start recruitment until final review in March 2020Betty Wont has been on long term sick for last 72 monthsRole has been successfully covered by colleagues		
Project Lead	Bill Gates	**Project Owner**	Bill Hedge
Clinician Completing QIA	sdfsdfd		
Quality Indicator(s)	qwe qwewqe		
KPI Assurance - Sources & Reporting to Monitor Quality Indicator(s)	qweq fsdf		

	Details	Consequence	Likelihood	Score
Patient Safety	errewr	2	4	8
Clinical Effectiveness	wererw	4	4	16
Patient Experience	erwerrwer	3	4	12

	Details
Mitigation	rtrgdfgdfg

Overall Risk Score	12

Signed - Clinician		Date	
Signed - Director of Quality & Governanc		Date	
Comments - Director of Quality & Governance