PenCHORD
The Peninsula Collaboration for Health Operational Research & Development

Appraising the current design of a quality equality impact assessment tool and opportunities for future research

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Executive Summary

Quality impact assessments are being used by National Health Service (NHS) clinical commissioning groups as part of the review process for cost improvement programmes. Quality impact assessment aims to ensure high levels of patient care are maintained during programmes of change and cost reduction. Approaches to quality impact assessment have included risk assessment and narrative descriptions of impact on quality.

The Northern, Eastern and Western Devon (NEW Devon) Clinical Commissioning Group (CCG) have developed an integrated quality equality impact assessment (QEIA) tool. The QEIA tool has been trialled and the NEW Devon CCG are seeking to develop and refine the tool further.

An overview of the QEIA tool is provided in this report and suggestions for immediate improvements that can be easily made to the tool have been suggested. These include changes to the naming conventions used within the tool, changes to the impact measurement scales and changes to the layout. All of the suggested changes aim to improve the usability and effectiveness of the QEIA tool building on the existing solid and excellent framework.

Areas for potential further research and development of the tool are also discussed with a number of research questions raised. Assessing the quality of impact in relation to patient care and healthcare service provision is a rich area of potential research that would be of great benefit to the healthcare sector in England and beyond.

Introduction

Background

One of the roles of the NHS clinical commissioning groups (CCG's) is to fund a series of cost improvement programmes (CIP's) each year. The CIP's are programmes of change to current practices and are proposed by clinicians or management within a commissioning region. A business case is formed by the clinician or manager proposing the CIP and they also undertake quality and equality impact assessments of the CIP as part of the development process.

Equality impact assessments of CIP's as public sector activities are a requirement of the Equality act 2010. Quality impact assessments (QIA's) became part of clinical commissioning during the restructuring of NHS England and the transition from primary care trusts to clinical commissioning groups. QIA's were instigated by the National Quality Board as part of the wider quality, innovation, productivity and prevention challenge to the NHS set out by government in 2010 [1].The use of QIA's sought to maintain the quality of care during the transition to CCG led regions while reducing NHS spending.

Quality impact assessments are required to be completed for all CIP proposals. Guidance on the quality impact assessment process was outlined by the National Quality Board in their 2012 publication 'How to: quality impact assess provider cost improvement plans' [2]. This document suggested that the impact of CIP's on quality be assessed along the dimensions of; patient safety, clinical effectiveness, patient experience and general parameters. The QIA process is designed to provide additional information to complement the cost saving information in the business case for

CIP proposals and to ensure that the quality of patient care is maintained during the annual CIP commissioning decision making process.

Examples of quality impact assessment in the NHS

The quality impact assessment process has been adopted by CCG's throughout England. In some instances it has been developed as a process of risk assessment for cost improvement programmes using prospective impact ratings and the likelihood of that impact being realised. These ratings have been formalised using risk matrices an example of which can be seen in Figure 1. Quality impact assessment ratings have been devised along a variety of dimensions including patient safety, treatment effectiveness, and patient experience. These dimensions have been extended and diversified deemed appropriate by individual Trusts. For example Leeds teaching hospitals use; impact on overall trust strategy, impact on clinical support services and trust/employee relations, to name but a few additional dimensions considered in the QIA process.

The QIA process used by some Trusts uses a tick box process such as the example provided in Figure 2 from NHS Harrow. This QIA process focuses on an assessment of risk associated with a CIP but does not produce a quantitative outcome.

Severity of Impact →

Likelihood of Occurrence ↓	Very Low	Low	Moderate	High	Very High
Very High	5	10	15	20	25
High	4	8	12	16	20
Moderate	3	6	9	12	15
Low	2	4	6	8	10
Very Low	1	2	3	4	5

Figure 1 *Risk matrix used for quality impact assessment adapted from Leeds teaching hospitals NHS trust, Trust board – private section, 27 June 2013, quality impact assessments, pg4 [3]*

The central commonality across all of these QIA tools is their focus on the risk of negative impact; the potential for positive impact does not appear to be as well represented. Appendix A contains a list of QIA tools from CCG's and Trusts across England and hyperlinks to view the policy documents online where the QIA tools are described.

NHS Harrow: Impact assessment tool for service change proposals
Mind in Harrow

Criteria	Red Flag	Amber Flag	Green Flag
SAFETY			
Harm	High risk of harm ☐	Medium risk of harm ☐	Low risk of harm ☒
Quality improvement	No quality improvement ☐	Moderate quality improvement ☒	High quality improvement ☐
EFFECTIVENESS			
Strength of evidence for stated clinical objectives	Limited evidence ☐	Modest evidence ☒	Good evidence ☐
COST			
Value for money	Limited evidence of vfm or evidence of poor vfm ☐	Evidence of modest vfm ☐	Evidence of good vfm ☒
Impact on current resource utilisation / PCT financial balance	Low impact) ☐	Moderate impact ☒	Significant impact ☐
BENEFITS			
To individual (health improvement, patient outcome & life expectancy)	No benefits ☐	Modest benefits ☒	High benefits ☐
To community (health inequalities)	No benefits ☐	Modest benefits ☒	High benefits ☐
NEED			
Prevalence	<0.1% prevalence ☐	0.1-10% prevalence ☐	>10% prevalence ☒
PATIENT ACCESS AND EXPERIENCE			
Patient & public access	Reduces access (including compromising national access targets ☐	Maintains access ☒	Improves access ☐
Patient experience	Reduces patient experience ☐	Maintains patient experience ☒	Improves patient experience ☐
Carer experience	Reduces carer experience ☐	Maintains carer experience ☒	Improves carer experience ☐
OTHER CRITERIA			
Impact on partners' sustainability	Has high impact on partners' sustainability ☐	Has modest impact on partners' sustainability ☒	Has no, or beneficial impact, on partners' sustainability ☐
Partners' acceptability	Low acceptability ☐	Moderate acceptability ☒	High acceptability ☐
Treatment or service options	Other options with better outcomes ☐	Other options with same outcomes ☐	No other options ☒
Feasibility	Unsustainable or significant risk of failure ☐	Probably sustainable, implementation feasible ☐	Sustainable, easily integrated. Clear implementation plan ☒
POLICY ALIGNMENT			
National policy, target or other statutory requirement – (PCT Commissioning Strategic Plan)	Not related to national policy or target ☐	Weak relationship to national policy or target ☐	Direct relationship to national policy or target ☒

Figure 2 *NHS Harrow impact assessment tool for service change proposals [4]*

The Northern, Eastern and Western Devon Clinical Commissioning Group Quality Equality Impact Assessment Tool

The quality equality impact assessment (QEIA) tool presented and discussed in this report has been developed by Mr Simon Polak, Head of nursing and quality for the Northern, Eastern and Western Devon (NEW Devon) Clinical Commissioning Group (CCG).

The purpose of the NEW Devon QEIA tool

The QEIA tool assessed in this report was developed from the narrative quality impact assessment process previously in use until autumn 2014 when this latest version of QEIA tool was introduced at the NEW Devon CCG. Quality equality impact assessment is covered by the NEW Devon CCG quality equality impact assessment policy a copy of which is available in Appendix B. The QEIA tool aims to provide a numerical score for the impact of proposed CIP's on the quality of patient care along the dimensions of patient safety, effectiveness of the practice/treatment, patient experience and other impacts, while also providing a point for an equality and diversity assessment to be undertaken.

The QEIA tool was designed to support decision making as an extension to the existing QIA. In the first instance this was to help the clinician or manager proposing the CIP more systematically assess the potential impact of their CIP on the quality of patient care in a structured manner. For the clinical commissioning group (CCG) the QEIA was used to aid them in deciding which CIP's to fund. A numerical scoring system was devised to facilitate comparisons of impact quality between CIP proposals and for impact to be more readily visualised. Including a quantitative and narrative

assessment of impact alongside the standard business case for the CIP proposals was hypothesised to produce more informed decisions could be made by the CCG which would improve healthcare service provision. The full review process for CIP development and the role of QEIA in this process is diagrammatically represented in the NEW Devon CCG quality equality impact assessment policy Appendix B, page 32.

The CIP proposers and CCG decision makers are the immediate users of the QEIA tool and stakeholders in the QIA process. The patient is not a user of the tool but is an important stakeholder in the QIA process because the change proposed in the either directly or indirectly impact on the care that they receive. The dimensions of impact assessment are in relation to impact on the care of the patient in terms of patient safety, the effectiveness of the treatment carried out on the patient and the patients care experience. Currently the patient does not have any input into the assessment of impact so is not an active user group in the QIA process.

Purpose of the report

The QEIA tool has been through several revisions within the Devon partnership trust and has been used by the CCG during the 2014/2015 CIP development process. PenCHORD was approach by Simon Polak to provide an independent assessment of the QEIA tool. The QEIA tool developed by NEW Devon CCG is a departure from the QIA tools used by other NHS CCG's and trusts because it can provide a measurement of impact quality without deferring to a measurement of risk. As discussed in the section 'Examples of quality impact assessment in the NHS' above, current QIA tools measure impact on quality in terms of risk without focusing on the positive impacts of a CIP. It is not clear why risk is used as a measure of impact quality when the positive aspects of impact quality are often ignored by such measures.

The NEW Devon CCG QEIA tool provides an opportunity to study the use of QIA in decision making. 'Impact assessment' is a term commonly associated with environmental sciences and the study of change on environmental quality. It is in business, marketing and retail research that the term 'service quality' appears and is used in relation to the difference between consumers' expectations and actual service. Based on a preliminary search of the literature the impact of change on the quality of healthcare provision that the quality impact assessment process seeks to measure has not been a central research focus. A full literature review will be required to assess the extent of quality impact assessment research particularly in relation to healthcare; this is highlighted in the 'Further research' section of this report.

This report aims to provide an initial assessment of the tool's construction and suggest changes that could be made to improve the usability and usefulness of the tool. There is considerable potential to develop the tool further beyond these immediate changes. A key question is; how can the impact of cost improvement programmes on the quality of healthcare be most effectively assessed to better inform decision making? Further lines of research studying the role of the QEIA in the larger system and its role in informing decision making are discussed below.

Overview of the QEIA tool

The NEW Devon CCG QEIA tool was developed in Microsoft Excel. The tool comprises 13 pages with different functions. A menu page is provided to help the user navigate the tool and instructions given to help the user complete the tool.

Narrative descriptions of the CIP in general are requested on the menu page and safety impact assessment page. For the quality impact assessment there is space for the user to input a narrative description, supported by evidence, of the impact of their proposed change on patient safety, the effectiveness of treatment, the patient experience and other impacts that may arise as a result of the CIP.

For each aspect of the QIA the user is asked to provide an impact score based on a scale from -5 to 5 based on the scale and category descriptions given in a decision matrix (Appendix B, page 27). Category scale measures of the number of patients affected by the change on a weekly basis and the number of weeks per year a patient would be affected by the change are also requested. The category scale for these ratings can be seen in Figure 3.

Scoring matrix for no. of patients and timescale

1	1-50 patients	1	1-4 weeks
2	51-200 patients	2	5 - 12 weeks
3	201 - 500 patients	3	13 - 26 weeks
4	500 - 1000 patients	4	26 - 39 weeks
5	>1000 patients	5	>40 weeks

Figure 3 *Scoring categories for the number of patients impacted by a change per week and the length of time the change would impact on patients from the NEW Devon CCG QEIA tool.*

A text box is provided for the user to describe how the impact of the CIP on patient safety, treatment effectiveness and patient experience would be measured.

A separate page is provided for the user to complete an equality impact assessment (Appendix C). The equality impact assessment comprises the range of protected groups and for each the user to provide an impact score based on a similar scale to the QIA (Appendix B, pages 28-31), a rating of the number of people impacted by the CIP on a weekly basis using the scale in Figure 3 and a text box for notes on actions to be taken.

Scores for aspects of the QIA are calculated by multiplying the impact score by number of patients affected by the change rating and the number of weeks patients would be effected rating. This provides a score for each aspect of quality ranging from a minimum of -125 to a maximum 125.

Several total scores are then calculated from the individual quality impact assessment dimensions. A total impact score is calculated using absolute values (all impact scores are positive) excluding the other impacts score, a total quality score is calculated from the actual impact assessment scores (including negative values) excluding the other impacts score and an overall quality impact score which is the total quality score plus the other impacts score. An equality impact score and the

number of groups affected by the CIP are calculated for the equality impact assessment. These results are variously displayed on a results summary page and detailed results page in numerical and graphical form.

Further information on the use of the tool can be found in the NEW Devon CCG quality equality impact assessment policy in Appendix B.

Current use of the QEIA tool

The current version of the NEW Devon CCG QEIA tool has been used during the autumn 2014 CIP development process as. During this time the QEIA was completed by the clinician or manager proposing the CIP with guidance and feedback from the tool creator Simon Polak. The QEIA tool was also reported to have been used during by the NEW Devon CCG to assess the CCG's own planning practices. This is an example of collaborative use with multiple persons completing the tool as a group to understand their own practices. The multiple uses of the QEIA tool indicate that its use may be applicable in other healthcare planning scenarios where the impacts of changes on the quality of care need to be assessed. Exploring the applicability and use of QIA and the QEIA tool in a variety of healthcare planning scenarios warrants further research and will be discussed later in the further research section below.

Three completed QEIA tool examples from the autumn 2014 CIP development process were reviewed to provide insight into how the tool has been completed by users. All three of these examples were CIP's impacting on small numbers of patients each week but over prolonged time periods. Although no strong conclusions can be drawn from a sample of three examples this may indicate a form of floor and ceiling effects. This is where the categories most commonly selected by the user are consistently at the extremes of the category scale; bottom (floor) or top (ceiling), for the on the number of patients and length of impact categories.

In two of the three examples the number of patients affected by a proposed change was different for the three main QIA dimensions of patient safety, treatment effectiveness and patient experience compared to the number of patients affected by the change for the other impacts assessment. The reason for this difference in the number of patients affected in each dimension was not clear.

Each of the three narrative information boxes for the QIA dimensions patient safety, treatment effectiveness and patient experience request evidence for the ascribed impact. Only one of the QEIA examples contained any references to evidence to support the assessment of the impact. The narrative descriptions in the other examples may have been based on evidence but no reference was made to the source of the information. Users completing the tool may be unaware of the need to reference evidence sources for the impact they are predicting or how to do this.

In one of the examples a QIA assessment section describes both positive and negative impacts. When the user has provided an impact score for this section a score of zero was used. This instance reflects an issue with using only a single score to measure impact in an assessment. The assumption is made that there will only be a positive or negative impact on quality not instances of both.

The NEW Devon CCG QEIA tool is able to capture information about the impact of change on quality and produce a quantitative score to accompany more descriptive qualitative information. From the completed QEIA tool examples there is still more that can be done to refine the usability and

effectiveness of the tool. The remainder of this report will provide suggestions for immediate changes that could be made to the tool and a future programme of work that could further develop the QEIA tool while providing a better understanding of the role and need for quality impact assessment in healthcare.

Suggested changes

Changes to the scoring system and measurement scales

There are a number of changes that could be made to the scoring system and measurement scales to make them more understandable, usable, reduce framing effects and improve the appropriateness of the scoring system. These are discussed below in general terms under sub-headings with more detailed information about specific changes included in appendices D, E, F and G.

Reference to risk and total score outcome scales

The scoring system in the QEIA tool makes a number of references to risk. Although the impact measurement scale has been adapted from a risk assessment measure, what is being measured by the QEIA is the impact of the proposed change on patient care quality, not risk to quality. To communicate to the user that the tool is measuring impact on quality and avoid any confusion, all reference to risk should be removed. If the tool were to measure risk only the neutral and negative aspects of the scoring system would be required because positive impacts do not represent a risk to patient care quality. Appendix D contains more detailed information on the alteration and creation of scales to more accurately depict the impact on quality score being measure and the integration of risk on alternative measurement scales.

Decision matrix

It is recommended that the colours be removed from the decision matrix and to aid in column differentiation the columns be coloured alternating light grey and white. Removing the varied colours will help people to read the text in the decision matrix; this is especially true for anybody that might be colour blind. The use of colour might also impact on the user's decision to choose a certain score due to previously learnt meaning that people associate with specific colours, it would be best to avoid suggestive colours to encourage impartial scoring by the user. The colours also do not form a suggestive continuum; they are currently random particularly with regard to the positive end of the decision matrix.

The scoring category names of catastrophic to excellence are also suggestive and may influence the users score choice. The names in Table 1 are suggested because they form a continuum and link to the scoring outcome scales suggested previously in Appendix D. These category names are also descriptive of what they are measuring.

Patient number and length of time of impact categories

The categories used to score the number of patients impacted by the proposed change per week and the length of time patients are impacted by the change are currently unequal as can be seen in figure 3. The manner in which the unequal categories have been applied to the QEIA tool means that

quality impact becomes non-linear when the impact score is multiplied by the number of patients impacted by the proposed change per week and the length of time patients are impacted by the change variables. In simple terms the use of steadily increasing category sizes unfairly weights impact in favour of smaller numbers of patients being impacted by the change and the change taking place over a short period of time.

Table 1 Suggested scale category names for the QEIA tool decision matrix.

Scale category name	Score
Very high positive impact	5
High positive impact	4
Medium positive impact	3
Low positive impact	2
Very low positive impact	1
No impact	0
Very low negative impact	-1
Low negative impact	-2
Medium negative impact	-3
High negative impact	-4
Very high negative impact	-5

Increasing the weighting for smaller numbers of patients and short timer periods does not seem to be appropriate for a measure of quality. It is possible that the opposite is true, he more patients that are impacted by a change the greater the impact on quality and the longer period of time that a change impacts on patients the greater the impact on quality.

It is suggested that a linear scale of equal categories be used until the scoring mechanism can be redesigned to account for unequal categories and provide greater resolution at the lower end of the scales for the two variables; patients impacted by the proposed change per week and the length of time patients are impacted by the change. Table 2 provides a liner category scale for these two variables with open upper limits. To provide a more accurate representation of the number of patients impacted by the proposed change and the length of time those patients will be impacted by the change, it is suggested that a box be added to allow the user to freely enter the number patients per week they expect to be impacted by the change and the actual number of weeks per year they expect the change to impact on patients.

Table 2 *Suggested patients impacted by the proposed change per week and the length of time patients are impacted by the change categories.*

Score	Number of patients category	Score	Length of time category
1	1 – 250	1	1 – 10
2	251 – 500	2	11 – 20
3	501 – 750	3	21 – 30
4	751 – 1000	4	31 – 40
5	>1000	5	>40

Naming conventions

When attributing names to scores, wording titles, headings and questions it is important to maintain consistency throughout the document so that the user can easily trace information from one part of the document to the other. This will aid them in correctly interpreting information and what is being requested of them with minimal ambiguity.

Score names

There is particular inconsistency and ambiguity in the naming of the total scores in the QEIA. This results from the use of different variations on the total score and as such requires clear and descriptive naming to be used, for example: In the QEIA tool summary section the score name "Total impact of change" should be changed because it does not appear elsewhere in the tool. This score refers to the total score of the quality impact assessments, using absolute values and excluding the other impacts score. To keep the name of this score in line with the other score name changes described in Appendix E it is recommended that it be changed to "Total quality impact score (using absolute values)".

The two other variations on this score name are; "Total quality impact score" for the score using the actual values but excluding the other impacts score and "Total quality impact score (inc. other impacts score" for the score using actual values and including the other impacts assessment score. The main part of the score name remains consistent and it is only the description of the components comprising the score that change. This maintains the name consistency and description because the numbers that make up the score are always similar.

All of the suggested changes to the score names are detailed in Appendix E.

Titles and headings

In the same way that the names of the outcome scores for the QEIA tool should be descriptive and meaningful to the user, so should the titles and headings also be sufficiently descriptive. For example the titles on each of the quality impact assessment pages currently use only the words; Safety, Effectiveness, Experience or Other impacts. By adding the word "assessment" to each of these titles e.g. "Safety Assessment", the user can be certain that they are looking at the correct assessment page and not some other aspect of the tool relating to safety. Some of the other changes detailed in Appendix F refer to changes in grammatical tense and more descriptive titles and headings.

Other suggested changes

Several other suggested changes to the QEIA tool are proposed and the details of these changes can be found in Appendix G.

The first of these changes is to the wording in the instructions box on the menu page of the QEIA tool and aims to provide clearer instructions to the user. One way in which this can be achieved is by numbering the assessments and menu buttons in the order of preferred completion. A variety of different possible orders and layouts of the menu buttons are provided in Appendix G.

It was observed in the 'Current use of the QEIA tool' section that only one of the examples had provided referenced evidence for the impacts of their proposed change programme. One way to help users decide what evidence they will provide and decision makers to assess the evidence being provided in the QEIA tool would be to introduce an evidence hierarchy outline or diagram. In Appendix F it is suggested that the narrative description text box headings explicitly ask that references be provided for evidence of possible impact. It may be useful to provide some referencing guidelines for the user alongside the evidence hierarchy to ensure all necessary information is included during the QIA.

Further Research

Questions arising from appraisal of the tool

Earlier in this report the following question was proposed; how can the impact of cost improvement programmes on the quality of healthcare be most effectively assessed to better inform decision making? There are a number of more specific research questions that would help towards answering this question. These centre on the system(s) in which the QEIA tool is used, the tool users and the QEIA tool itself.

The systems of QEIA tool use

The wider system(s) in which the QEIA tool sits provides the context for its use. Useful questions to ask about these systems might be:

- What is the formal process from development to implementation for cost improvement programmes?
- In what other situations can the QEIA tool be used?
- Who are the stakeholders within these systems and what is their role?
- What is the understanding and perspective of the various stakeholders on the quality impact assessment process?
- How does the QEIA tool assist in the QIA process and how can it assist in other relevant processes? What role does the QEIA tool play?

Understanding how these systems function both in terms of the formal processes and from the perspective of the stakeholders within the systems would provide the context for the quality impact assessment process. The formal systems will denote how the QEIA tool is expected to be used and the perspective of the stakeholders will provide insight into how the QEIA tool is actually used. The perspective of the stakeholders can be used to capture information about factors impacting on their use of the tool for example in terms of barriers and enablers.

The QEIA tool user - Proposer

It is the QEIA tool user who must enter information into the tool and make a variety of judgements about what information they enter into the tool. Questions that will guide further research relating to the user and their use of the tool are:

- Are users able to make consistent judgements when using the quantitative aspects of the QEIA tool?

- Do different stakeholder groups quantitatively score CIP's (or other projects) in the same way? If not what factors, such as cognitive biases, might be affecting their appraisal of the CIP or other project.
- Are users able to unambiguously understand all aspects of the QEIA tool?
- How do users understand/perceive the QEIA tool in relation to the larger processes in which it is used?
- What are the potential contexts for use of the QEIA tool (e.g. independent completion, group completion, comparative use) and how do the different contexts impact on completion of the tool?

The QEIA tool currently involves aspects of subjective judgement in the scoring process. It will be necessary to understand if the users are able to make consistent judgements over time which will help improve the scoring system. Consistency is also important between stakeholder groups because there is the possibility that the person proposing the project may score impact quality differently to somebody else in the appraisal system perhaps due to an overestimation of a proposals positive impact. Such an overestimation may occur due to their wish for the project to succeed and would indicate the presence of a cognitive bias in the use of the tool. Such biases can be accounted for once they have been identified.

The QEIA tool user – The decision maker

The decision maker in relation to the QEIA tool is the user who appraises the information after it has been submitted by the proposer. The decision maker is expected to make judgements based on the contents of the QEIA tool. In the case of CIP approval the QEIA tool information is not used in isolation to inform decision making. The QEIA tool information is considered alongside the business case for the CIP proposal. Understanding how the QEIA tool informs decision making can be guided by the following questions:

- What factors might be effecting the decision makers' appraisal of the QEIA tool and the information contained within the tool?
- How do decision makers perceive the quality of the data derived from the QEIA tool and how does this compare to other data available to the decision maker?
- How does quality impact information change decision making and why?
- How do decision makers deal with conflicting information when appraising CIP's and other projects?
- Is risk a useful to the quality impact assessment process and how does risk differ from impact quality.

These questions relate to how the QEIA tool user making decisions based on the data within the tool understands and uses that information to inform the decision that they are making. Of particular importance and interest will be studying the role of the quality impact data in relation to financial data in the case of CIP proposals. Understanding whether the combination of these two types of data lead to more effective decision making or how they could lead to more effective decision making if this is not currently optimal, particularly in the case of conflicting information, seems central to well informed clinical commissioning decisions.

Research directly informing specific refinements to the QEIA tool

There are some refinements that could be made to the QEIA tool that would require further research to be undertaken. Questions guiding this research would include:

- How can the QEIA tool interface and architecture be adapted and optimised for use as a standalone programme and/or app?
- Can and should the narrative reporting of impact be replaced with more specific questions relating to particular aspects of impact that are pertinent to patient safety, treatment effectiveness, patient experience and other impacts?
- Are the patient number and length of impact categories appropriate?
- Can the patient number and length of impact variable become continuous variables within the scoring process?
- How should the scoring mechanism be adapted to take account of any changes to the questions, patient number variable and length of impact variable?
- Should positive and negative impacts be included in the scoring mechanism for each aspect of the quality impact assessment?
- How can the impact measurement scale be refined to improve user responses and reflect expected impacts across a variety of contexts of use?
- How should the outputs of the QEIA tool be visualised to most effectively facilitate understanding and decision making?

One aspect of developing the QEIA tool further would be to take it from an Excel based tool to a standalone web based program and/or mobile application. This change would facilitate ease of use, data collection and interface optimisation. Further developments to the scoring system and impact scales beyond the suggested changes described in this report would require further research and more time so their effectiveness and usability can be ensured.

Ideas for future projects

There are several research projects that could be undertaken in relation to the further development of the QEIA tool and quality impact assessment in healthcare. The project ideas described in this section build on the questions raised in the previous section.

Projects

1) A literature search (iterative or systematic) could be conducted of prior research pertaining to; impact assessments, alternative tools and measurement approaches used, quality of impact and service quality. This would provide a currently unavailable breadth of information to inform the further development of the QEIA tool.
2) Hard and soft systems analysis of the CIP process and QEIA tool use. This project would seek to understand the system and user questions related to the use of the quality impact assessment and specifically the QEIA tool. A stakeholder analysis could also be undertaken to identify the stakeholders in the quality assessment processes and their role within these processes. The addition of a needs assessment to the stakeholder analysis could be used to identify important considerations for the redesign of the QEIA tool in relation to each

stakeholder group. The findings of a needs assessment would also highlight other contexts of use for the QEIA tool from the perspective of potential user groups.

3) A series of lab experiments could be designed to understand the variations in judgement and decision making in quality impact assessment. These experiments could explore factors related to the source of the information, the role of information conflict and resolution of cognitive dissonance and any other factors that are identified in project 2 by the hard and soft systems analyses.
4) Field and/or lab experiments could be used to determine the inter-rater reliability of the QEIA tool and the test re-test reliability to identify variation between and within users of the QEIA tool.
5) A study of subjective user perceived data quality and its impact on QEIA tool completion and decision making could be undertaken. It is possible that quality impact data is seen as lower quality data by decision makers which would impact on their appraisal and use of that information.
6) Conducting a study to understand the impact on quality types commonly associated with patient safety, treatment effectiveness, patient experience and other impacts in healthcare would provide information for the alteration of the narrative aspects of the QEIA tool. Identifying consistent characteristics would provide dimensions along which more detailed assessment of the general categories (patient safety etc.) could be assessed.
7) A secondary analysis of previous CIP (or other project) proposals where quality impact assessment was or might have been applicable could be used to determine appropriate patient number and length of impact categories. This project would also determine if the use of continuous variable data would be more appropriate and how the QEIA scoring mechanism could be altered to accommodate these.
8) An internship or knowledge transfer partnership (KTP) could be created to translate the QEIA tool into a web based and/or mobile application. This project would begin with a conceptual redesign of the current QEIA tool during which the application development process would also be planned. If a candidate with skill/interest in conducting behaviour research as well as computer science expertise can be found they could also assist with the other projects. This project would synthesise all of the insight gained through this programme of research into the redesign and optimisation of the QEIA tool.

Figure 4 is an idealised timeline for a programme of work which would integrate all of the projects described above. The programme would begin with the literature review which would then inform the other projects. The hard and soft systems analysis would follow the literature review and the findings of which would further inform projects 3, 5, 6 and 7. Projects 3, 5, 6 and 7 could be conducted in any order. This work would be aided by the intern/KTP associate from project 8 and this project would develop the QEIA tool platform as an on-going task. Finally project 4 would test the reliability of the redesigned tool and refine the tool until it was fit for purpose.

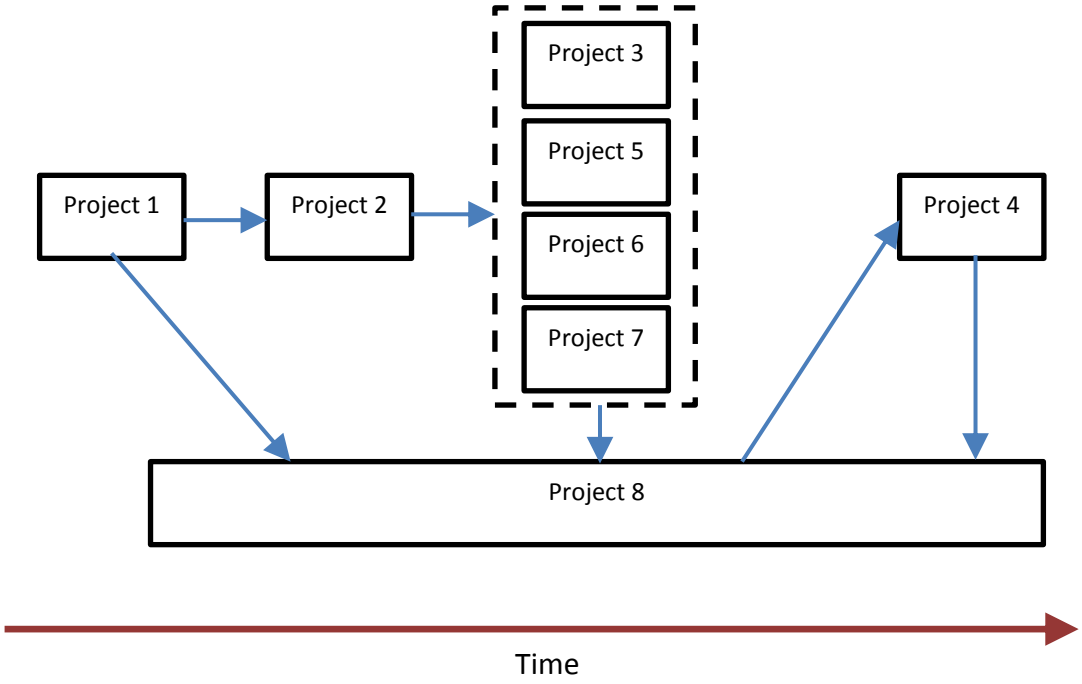


Figure 4 Idealised project order and timeline for future research project ideas.

References

1. Department of Health National Quality Board. (2011). Maintaining and improving quality during the transition: Safety, effectiveness, experience. Downloaded on 23 Janurary 2015, from: https://www.gov.uk/government/publications/maintaining-and-improving-quality-during-the-transition-safety-effectiveness-experience
2. Department of health National Quality Board. (2012). How to: Quality impact assess provider cost improvement plans. Downloaded on 23 January 2015, from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf
3. Leeds teaching hospitals NHS Trust. (2013). The Leeds teaching hospitals NHS Trust Trust board – Private section 27 June 2013 Quality Impact Assessments. Downloaded on 23 January 2015, from: http://www.leedsth.nhs.uk/uploads/tx_lthboardmeetings/26.1_-_QIA_Framework_-_June_2013.pdf
4. NHS Harrow. NHS Harrow: Impact assessment tool for service change proposals Mind in Harrow. Downloaded on 23 January 2015, from https://www.harrow.gov.uk/www2/documents/s69400/36.Appendix_4_Vol_Orgs_Impact_Assessment_Harrow_Mind.pdf

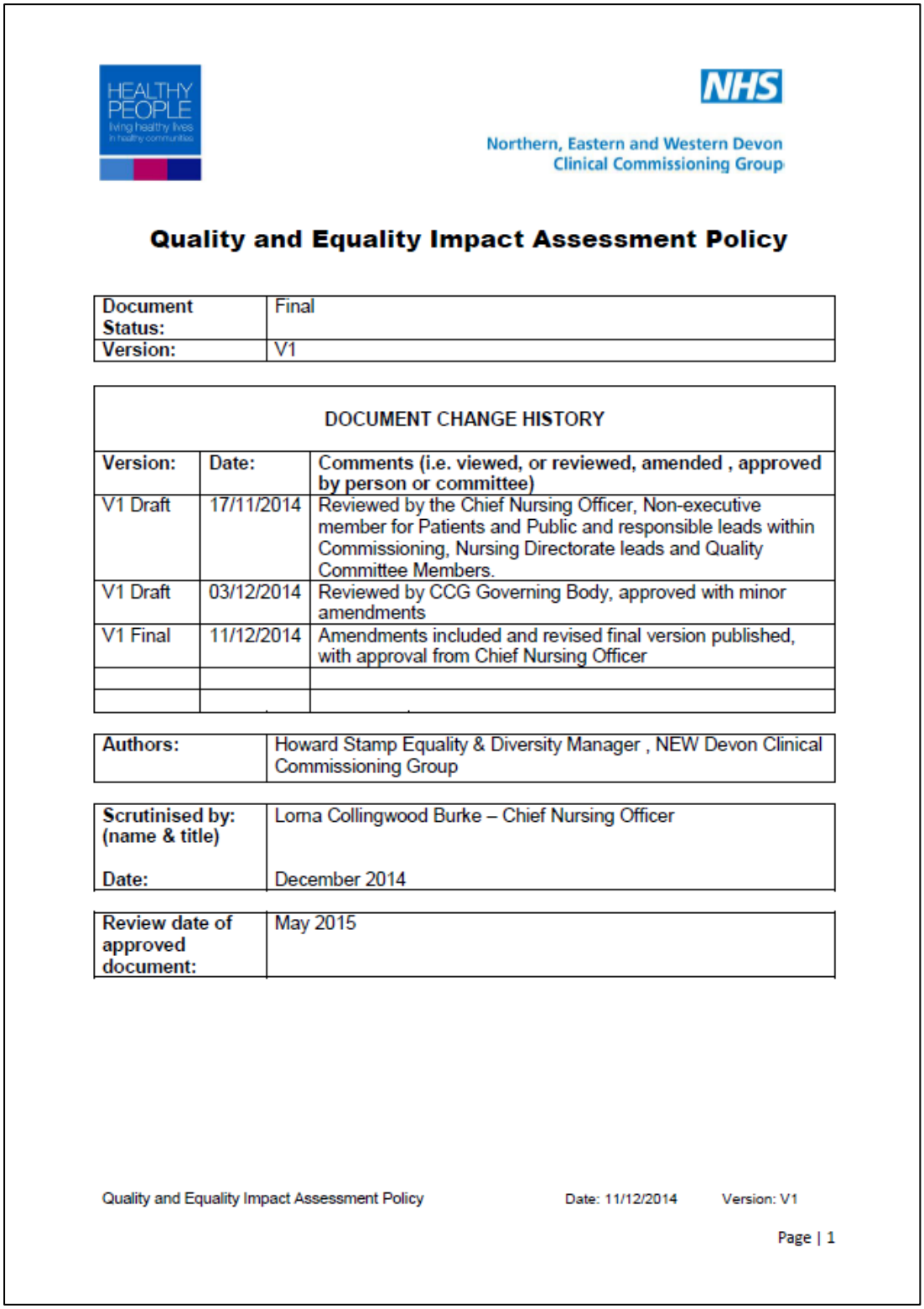
Appendix A

List of quality impact assessment tool documents from NHS England clinical commissioning groups and trusts

CCG/Trust	Link to QEIA tool	Basis of tool
Leeds teaching hospitals	http://www.leedsth.nhs.uk/uploads/tx_lthboardmeetings/26.1_-_QIA_Framework_-_June_2013.pdf	Risk
Bury, Heywood, Middleton and Rochdale, Oldham and North Manchester, Tameside and Stockport	http://www.buryccg.nhs.uk/Library/Board_Papers/AI-22-CIP-Sign-Off-Process.pdf	No tool
Yorkshire ambulance service	http://www.yas.nhs.uk/Publications/board_meeting_documents/2012-13/Att-2012-07-31/Quality_Impact_Assessment_Procedure.pdf	Non-numerical subjective assessment
Surrey and Sussex	http://www.surreyandsussex.nhs.uk/wp-content/uploads/2013/02/3.2-Cost-Improvement-Plans-QIA.pdf	Risk
Harrow	https://www.harrow.gov.uk/www2/documents/s69400/36.Appendix_4_Vol_Orgs_Impact_Assessment_Harrow_Mind.pdf	Non-numerical subjective assessment
Nene and Corby	http://www.corbyccg.nhs.uk/modules/downloads/download.php?file_name=388.	Risk

Appendix B

Northern, Eastern and Western Devon NHS Clinical Commissioning Group Quality and Equality Impact Assessment Policy



HEALTHY PEOPLE
living healthy lives in healthy communities

NHS
Northern, Eastern and Western Devon Clinical Commissioning Group

Quality and Equality Impact Assessment Policy

Document Status:	Final
Version:	V1

DOCUMENT CHANGE HISTORY		
Version:	**Date:**	**Comments (i.e. viewed, or reviewed, amended , approved by person or committee)**
V1 Draft	17/11/2014	Reviewed by the Chief Nursing Officer, Non-executive member for Patients and Public and responsible leads within Commissioning, Nursing Directorate leads and Quality Committee Members.
V1 Draft	03/12/2014	Reviewed by CCG Governing Body, approved with minor amendments
V1 Final	11/12/2014	Amendments included and revised final version published, with approval from Chief Nursing Officer

Authors:	Howard Stamp Equality & Diversity Manager , NEW Devon Clinical Commissioning Group

Scrutinised by: (name & title)	Lorna Collingwood Burke – Chief Nursing Officer
Date:	December 2014

Review date of approved document:	May 2015

Quality and Equality Impact Assessment Policy Date: 11/12/2014 Version: V1

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Equality Impact Assessment			
Who does the proposed piece of work affect?	Staff	✓	
	Patients	✓	
	Carers	✓	
	Public	✓	
Have the legal implications been considered?	✓		
		Yes	**No**
1. Will the proposal have any impact on discrimination, equality of opportunity or relations between groups?		✓	
2. Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?			✓
3. Will there be a positive benefit to the users or workforce as a result of the proposed work?		✓	
4. Will the users or workforce be disadvantaged as a result of the proposed work?			✓
5. Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?			✓
If the answer to any of the above questions is yes (other than question 3) or you are unsure of your answers to any of the above you should provide further information using **Screening Form One**			
If an equality assessment is not required briefly explain why and provide evidence for the decision. An Equality Impact Assessment is not required for this policy; the reason for this is that the policy outlines the new process of which the CCG Equality Impact assessment will be carried out for changes in commissioning. Therefore it is expected for the policy to have an indirect impact of discrimination and equality of opportunity through the increased use of Quality and Equality Impact Assessments.			

NEW Devon CCG has made every effort to ensure this policy does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability. This policy will apply equally to full and part time employees. All NEW Devon CCG policies can be provided in large print or Braille formats if requested, and language line interpreter services are available to individuals of different nationalities.

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Linked strategies, policies and other documents	National Quality Board, How To: Quality Impact Assess Provider Cost Improvement Plans, 2012
	NEW Devon CCG Equality & Diversity Policy, 2013
	NEW Devon CCG Equality & Diversity Strategy, 2014
	A Refreshed Equality Delivery System for the NHS, EDS2, November 2013
	NEW Devon CCG Commissioning Framework

NEW Devon CCG Quality & Equality Impact Assessment Blank Template: Click Here

1. Introduction

1.1 The purpose of this policy is to provide staff working within NHS Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) with a framework to ensure that Quality and Equality Impact Assessments are clearly defined and embedded within the organisation. The policy will also provide guidance on the NEW Devon CCG developed Quality & Equality Impact Assessment tool.

1.2 The QEIA process provides a focus on quality, encompassing learning from reports such as Berwick, Keogh and Francis. It is to be used alongside the financial and business case for any proposed change. It is not designed to replicate these and should be considered a balance to the financial case.

1.3 The NEW Devon CCG has taken the decision to combine Quality and Equality Impact Assessments into one tool that can be used to assess both areas. The quality impact has then been broken down into categories as outlined by Darzi principles, namely Safety, Experience, Effectiveness as well as other impacts for example, organisational reputation. This allows NEW Devon CCG staff to complete one impact assessment covering dual responsibilities of quality and equality.

1.4 The Quality and Equality Impact Assessment tool tests the impact of a proposed change in service provision on the quality of patient care and in addition the impact of that change on other parts of the health and social care system. Impact is tested through an evidence supported narrative account and a guided rating scale. Impact is rated using a scale from negative to positive to allow for risks and benefits to be quantified. The total quantity of impact is calculated through an estimate of the number of patients affected and the total time they will be affected.

1.5 It is advised that when completing a Quality and Equality Impact Assessment for the first time, to contact your locality lead for Patient Safety & Quality for advice and guidance as well as the Equality & Diversity Lead for questions relating to the equality impact section.

1.6 The Quality and Equality Impact Assessment Tool is available on the NEW Devon CCG intranet; this will be updated regularly to ensure the most recent version is always available. The Intranet version should be the only one used to ensure the most recent version.

2. Quality Impact Assessment process

2.1 The CCG requires a Quality and Equality Impact Assessment for all changes to commissioning services, including service redesign and any areas of NEW Devon CCG business where it is appropriate to assess the impact of the proposed piece of work. It is to be completed by the lead member of staff responsible for the proposed work or delegated and reviewed as appropriate.

2.2 Where a large scale change is proposed the tool will be used for each individual component of the proposed change. It is the responsible lead for the QEIA who will make a judgement as to which components will need to be assessed individually.

2.3 For example, for a CCG wide proposal or large ongoing programme of change, it may be appropriate to complete one impact assessment at the early stages of the programme with additional, more detailed versions being completed as appropriate throughout the programme. These additional versions may focus on a specific area of the change, or the impact of change within a specific NEW Devon CCG locality.

2.4 Once completed the QEIA should be submitted for review together with any service change proposal, business case or business justification to the Nursing Directorate through the Safety Systems mailbox (d-ccg.safetysystems@nhs.net). The QEIA will be reviewed, feedback provided as necessary and a central record kept of all QEIAs completed within NEW Devon CCG.

2.5 Following review by the Nursing Directorate and amendments made to the QEIA should then be submitted to QEIA review group, together with any service change proposal, business case or business justification. Large scale change will be considered by the Governing Body or delegated authority such as the Locality/Partnerships Board or Quality Committee. No change should commence without approval through the relevant Nursing Directorate lead and CCG authority. The review and approval processes are also outlined in section 9 of this policy.

2.6 All service closures for whatever reason would automatically receive a QEIA for review by NEW Devon CCG Governing Body and signed off by the Chief Nursing Officer regardless of the QEIA scoring.

3. Assessment, Rating and Evidence

3.1 Each domain requiring assessment (e.g. Safety, Experience, Effectiveness, and Equality) requires the responsible lead to record a narrative in support of the assessment.

3.2 This should be accompanied by suitable evidence which may include for example NICE guidance, published papers, locally produced data, patient or carer generated information or professional opinion. Objective evidence should be favoured and validated for the area of change being considered. Evidence should be sensitive in predicting the end state following the proposed change. Where estimates or professional judgement are informing evidence this needs to be clearly identified.

3.3 The level and quality of evidence will be judged by the review body with each domain requiring a numerical rating based on the rating scales provided within the tool.

4. Weighting

4.1 Provision is made within the QEIA tool for weighting of the score domains relative to one another. This would not normally be used but does allow for relative weighting of one domain over another.

4.2 For example, it may be felt that for a particular case the score for 'safety' should carry greater weight than other domains. Thus the weighting for other domains may be reduced by a suitable amount. Assuming safety is the dominant domain a decision may be made that the experience domain should be rated at 75% of the safety domain. However, an adjustment to the weighting of the scoring would always require agreement by the Quality Committee.

5. Quality Impact Assessment Tool

5.1 The Quality Impact Assessment tool has been developed with the following core components described below, these are to be evaluated against the three following areas:

- Qualitative narrative
- Evidence based data such as Public Health Joint Strategic Needs Assessments (JSNA) or performance
- Assessment of impact

5.2 The core components of the tool are as follows :

- Safety – Rating the impact of the proposal on patient safety
- Effectiveness – Rating the impact of the proposal on the clinical effectiveness of patient care
- Experience – Rating the impact of the proposal on the patient experience of care delivery
- Other Impacts – Rating the impact of the proposal on other services, patient groups, staff or reputation of the organisation.
- Equality & Diversity – Rating the impact on those in specific group as outlined in the Equality Act 2010 and also including other hard to reach groups.

6. Completion of the Quality and Equality Impact Assessment Tool

4.2 The Quality and Equality Impact Assessment tool may be completed by a workgroup in addition to the responsible manager and include patients and public to improve the proposal. The tool is then used as part of and throughout the process rather than as a review once the proposal is completed.

6.1 The Quality and Equality Impact Assessment tool includes guidance on completion and embedded notes throughout to assist in completion of the tool. The tool requires assessment of each of the core components.

6.2 Each component includes a narrative section that allows the assessor to complete a narrative account of embed a further document. This section should include any evidence including JSNAs to support the narrative.

6.3 Each component should be rated by the assessor using the scales included within the QEIA tool. These scales include:

- Impact Score – This is a rating of the impact scoring matrix (appendix 1 & 2) It runs from positive impact e.g. benefit, to negative impact e.g. deficit
- Number of patients affected – This refers to the total number of patient affected by the change over a period of one week.
- Timescale of change – This refers to the likely duration of change. For short term change select the timescale from the options. For permanent change the rating of more than 40 weeks should be used.

7. Monitoring Impact

7.1 The tool is used to monitor the impact of three processes:

- The monitoring of key performance indicators and proxies identified in the tool.
- Re-testing the proposal using the tool to capture actual data and scores against the predicted position.
- The tool can be used to update the QEIA at key milestones of implementation, identifying changes in the impact predictions.

7.2 The approach to monitoring impact should be identified in the change proposal and within the tool itself and is subject to review by the identified review body.

8. Assessing the Impact

8.1 The QEIA Summary tab brings together the scoring for all core components into a single table and graphical representation.

8.2 Impact is calculated using the core components of the tool, there are four scores displayed:

- Total score – this is the absolute score of the impact assessment representing the scale of impact. This score should be used to determine the review level.
- Overall quality – this score is the sum of the three domains of quality (safety, effectiveness & experience). This score should be used to judge the relative impact of the proposed change.
- Other impacts – this is the overall score of the other impacts identified within the tool.
- Equality Impact – this score outlines the number of groups affected and the overall impact score, any negative impact should be raised with the Equality & Diversity lead for the CCG.

8.3 A section is also included on how the impact will be measured and monitored with time. This may include narrative accounts, embedded documents and should make reference to objective, measureable indicators including JSNAs.

9. Interpreting the scores

9.1 All completed QEIA's must be reviewed by the QEIA review group.

9.2 The review date and outcome of the review meeting should be recorded in the front of the QEIA tool.

9.3 The individual safety, effectiveness, experience and equality scores guide the completion of actions to mitigate or enhance the assessed impact. The review body will need to take into account the scale of benefit or harm assessed based on the score matrix. This will give a narrative equivalent to the score.

The information below details a scoring example that identifies an experience score of -40.

Experience score rated @ **-4**	Numbers of patients rated @ **2**	Number of weeks affected rated @ **5**	Overall score: **-4 x 2 x 5 = -40**
From Decision matrix			Review body interpretation
Multiple complaints/ independent review Low performance rating Critical report	10 – 50 patients	>40 weeks	Severe level of scrutiny and complaint for a significant number of patients over a prolonged period

9.4 The overall quality score sums the advantages and disadvantages of safety, effectiveness and experience. This is an overall score with positive scores balancing negative scores to gain an insight into the overall effect on quality as a whole of the change proposal.

9.5 The other impacts score represents the impacts of the change proposal on factors other than quality of patient care/service. It is included to balance the quality score and give insights into the impact that the change will have on a range of other services, patient groups and reputation which will not have been included in the overall quality calculations.

9.6 The total impact of change score measure gives the impact of all impacts measured, including the overall quality and other impacts. This should describe the total impact of the scheme on the patient quality and other areas.

10. Appendix 1 – Impact Scoring for Patient, Safety, Effectiveness & Experience

			Safety	Effectiveness	Experience
-5	Negative	Catastrophic	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients	Totally unacceptable level or effectiveness of treatment	Gross failure of experience if findings not acted on inquest/ombudsman inquiry Gross failure to meet national standards
-4		Major	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Non-compliance with national standards with significant risk to patients if unresolved	Multiple complaints/ independent review Low performance rating Critical report
-3		Moderate	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident	Treatment or service has significantly reduced effectiveness	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards
-2		Minor	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Overall treatment suboptimal	Formal complaint (stage 1) Local resolution Single failure to meet internal standards
-1		Negligible	Minimal injury requiring no/minimal intervention or treatment. No time off work	Peripheral element of treatment suboptimal	Informal complaint/inquiry
0	Neutral	Neutral	No effect either positive or negative	No effect either positive or negative	No effect either positive or negative
1	Positive	Negligible	Minimal benefit requiring no/minimal intervention or treatment.	Peripheral element of treatment optimal	Informal positive expression/inquiry
2		Minor	Minor benefit, requiring minor intervention Reduction in length of hospital stay by 1-3 days	Overall treatment optimal	Letter of praise Local recognition Meets internal standards
3		Moderate	Moderate benefit requiring professional intervention Reduction in length of hospital stay by 4-15 days	Treatment has significantly improved effectiveness	Letter of praise to board Local recognition Repeatedly meets internal standards
4		Major	Major benefit leading to long-term improvement/reduction in disability Reduction in length of hospital stay by >15 days Improvement in management of patient care with long-term effects	Compliance with national standards with significant benefit to patients	Multiple letters of praise / positive independent review Repeatedly exceeds internal standards
5		Excellence	Incident leading to enhanced benefit Multiple permanent benefit or irreversible positive health effects	Totally acceptable level of effective treatment	Consistently exceeds local and national standards of experience verified by external scrutiny.

11. Appendix 2 – Impact scoring for other impacts

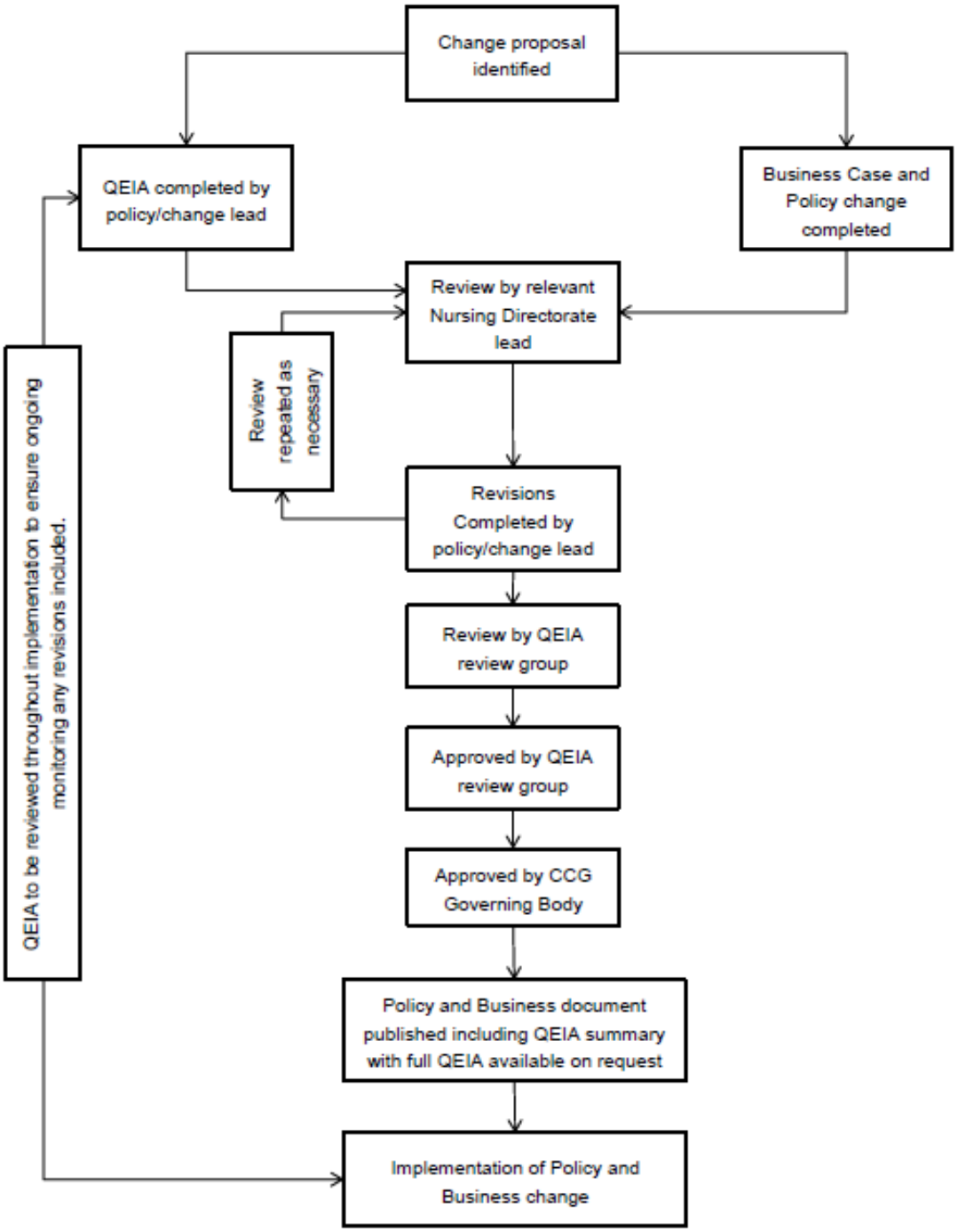
			Publicity & Corporate Finance and/or Claims	Publicity & Locality Finance and/or Claims	Adverse Publicity/reputation	Locality Level % over performance against budget	Finance including claims	Corporate level % over performance against budget
-5	Negative	Catastrophic	**CATASTROPHIC** Adverse Publicity/reputation PLUS Corporate level over performance against budget AND/OR Finance claims	**CATASTROPHIC** Adverse Publicity/reputation PLUS Locality level over performance against budget AND/OR Finance claims	Loss of public confidence Sustained and open external criticism of organisation/individual by (named) staff/GPs on social media Sustained criticism by MPs/ministers leading to resignation of chair/chief officer Sustained external criticism of organisation/individual by staff/GPs on social media leading to resignation of chair/chief officer Sustained criticism of organisation/individual by staff/GPs in media leading to resignation of chair/chief officer Local and national broadcast/print/trade news coverage over more than seven days PMQ discussion with Governmental and shadow parties critical of CCG Political crisis as result of CCG action/inaction Loss of criminal proceedings	>2.1% over performance against budget	Loss of 0.2% or more of budget £2m + Claims over £1million	>1.51% over performance against budget
-4	Negative	Major	**MAJOR** Adverse Publicity/reputation PLUS Corporate level over performance against budget AND/OR Finance claims	**MAJOR** Adverse Publicity/reputation PLUS Locality level over performance against budget AND/OR Finance claims	Long-term reduction of public confidence Sustained criticism by MPs Sustained external criticism of organisation/individual by staff/GPs on social media Sustained criticism of organisation/individual by staff/GPs in media Sustained PALS/complaints contacts National broadcast news coverage over more than two days Local broadcast news coverage over more than three days Front page trade press coverage Front page broadsheet coverage Escalation and public comment at ministerial/PM level with intervention Sustained criticism by Health and Wellbeing Board and intervention National/international recognition of campaigning OSC escalation to ministerial level with intervention Loss of civil court proceedings due wilful act Criminal proceedings	1.51%-2% over performance against budget	Loss of 0.1% to 0.2% – 0.5% of budget £2m - Claim(s) between £100,000 and £1million	1%-1.5% over performance against budget

-3		Moderate	**MODERATE** Adverse Publicity/reputation PLUS **Corporate** level over performance against budget AND/OR Finance claims	**MODERATE** Adverse Publicity/reputation PLUS **Locality** level over performance against budget AND/OR Finance claims	Medium-term reduction in public confidence Moderate external criticism of organisation/individual by staff/GPs on social media Local media coverage with criticism by another statutory organisation Front page negative local media coverage Local negative lead broadcast item National broadsheet coverage limited to inside pages National broadcast news coverage Trade (HSJ etc…) media coverage Heavy increase in PALS/complaints contacts about issue National negative broadsheet coverage of issue Difficult MP enquiries and/or requests to meet to discuss/criticism Escalation internally or externally to ministerial level Difficult Healthwatch presentation with criticism/escalation Difficult Health and Wellbeing Board presentation with criticism/escalation Persistent and effective campaigning OSC escalation to ministerial level Loss of civil court proceedings due negligence or maladministration	1.1%-1.5% over performance against budget	Loss of 0.05% to 0.1%f budget £0.5m - £1m Claim(s) between £10,000 and £100,000	0.5%-1% over performance against budget
-2		Minor	**MINOR** Adverse Publicity/reputation PLUS **Corporate** level over performance against budget AND/OR Finance claims	**MINOR** Adverse Publicity/reputation PLUS **Locality** level over performance against budget AND/OR Finance claims	Short-term reduction in public confidence Internal criticism by staff Local print media coverage limited to inside pages/small articles Moderate social media comment with criticism by patient/s and/or carer/s Increase in PALS/complaints contacts about issue MP enquiry Healthwatch questions/FOI/ request to present Health and wellbeing Board request to meet Overview and scrutiny committee (OSC) presentation request Active social media campaigning Loss of civil court proceedings	0.51%-1% over performance against budget	Small loss (less than 0.05% to 0.01% of budget) <£0.5million Claim less than £10,000	0.26%-0.5% over performance against budget
-1		Negligible	**NEGLIGIBLE** Adverse Publicity/reputation PLUS **Corporate** level over performance against budget AND/OR Finance claims	**NEGLIGIBLE** Adverse Publicity/reputation PLUS **Locality** level over performance against budget AND/OR Finance claims	Public awareness of issue Discussion among staff Questions from staff/other NHS organisation Limited critical social media comment Questions from public/FOI Healthwatch interest or questions Health and Wellbeing board interest or questions Overview and scrutiny committee interest or questions Interest from campaigning organisation Civil court proceedings	0-0.5% over performance against budget	Less than 0.01% or £100k Risk of claim remote	0-0.25% over performance against budget
0		Neutral	**NEUTRAL** Adverse Publicity/reputation PLUS Corporate level over performance against budget AND/OR Finance claims	**NEUTRAL** Adverse Publicity/reputation PLUS Locality level over performance against budget AND/OR Finance claims	No effect either positive or negative	On budget	On budget	On budget

			Publicity & Corporate Finance and/or Claims	Publicity & Locality Finance and/or Claims	Adverse Publicity/reputation	Locality Level % over performance against budget	Finance including claims	Corporate level % over performance against budget
0	Neutral	Neutral	**NEUTRAL** Adverse Publicity/reputation PLUS **Corporate** level over performance against budget AND/OR Finance claims	**NEUTRAL** Adverse Publicity/reputation PLUS **Locality** level over performance against budget AND/OR Finance claims	No effect either positive or negative	On budget	On budget	On budget
1	Positive	Negligible	**NEGLIGIBLE** Positive Publicity/reputation PLUS **Corporate** level under performance against budget AND/OR Finance claims	**NEGLIGIBLE** Positive Publicity/reputation PLUS **Locality** level under performance against budget AND/OR Finance claims	Public awareness of issue Discussion among staff Questions from staff/other NHS organisation Limited supportive social media comment Questions from public/FOI Healthwatch interest or questions Health and Wellbeing board interest or questions Overview and scrutiny committee interest or questions Interest from campaigning organisation	0-0.5% under performance against budget	Saving of 0.01% or £100k Potential claim rewards	0-0.25% under performance against budget
2	Positive	Minor	**MINOR** Positive Publicity/reputation PLUS **Corporate** level under performance against budget AND/OR Finance claims	**MINOR** Positive Publicity/reputation PLUS **Locality** level under performance against budget AND/OR Finance claims	Short-term improvement in public confidence Internal support by staff Local print media coverage limited to inside pages/small articles Moderate social media comment with support by patient/s and/or carer/s Increase in PALS/complaints contacts about issue MP enquiry Healthwatch questions/FOI/ request to present Health and wellbeing Board request to meet Overview and scrutiny committee (OSC) presentation request Active social media campaigning	0.51%-1% under performance against budget	Small saving (less than 0.05% to 0.01% of budget) <£0.5million Claim less than £10,000	0.26%-0.5% under performance against budget
3	Positive	Moderate	**MODERATE** Positive Publicity/reputation PLUS **Corporate** level under performance against budget AND/OR Finance claims	**MODERATE** Positive Publicity/reputation PLUS **Locality** level under performance against budget AND/OR Finance claims	Medium-term improvement in public confidence Moderate external support of organisation/individual by staff/GPs on social media Local media coverage with support by another statutory organisation Front page positive local media coverage Local positive lead broadcast item National broadsheet coverage limited to inside pages National broadcast news coverage Trade (HSJ etc…) media coverage Heavy increase in PALS/complaints contacts about issue National positive broadsheet coverage of issue Positive MP enquiries and/or requests to meet to discuss/support Escalation of positive work internally or externally to ministerial level	1.1%-1.5% over performance against budget	Saving of 0.05% to 0.1%f budget £0.5m - £1m Claim(s) awards between £10,000 and £100,000	0.5%-1% under r performance against budget

4		Major	**MAJOR** Positive Publicity/reputation PLUS **Corporate** level under performance against budget AND/OR Finance claims	**MAJOR** Positive Publicity/reputation PLUS **Locality** level under performance against budget AND/OR Finance claims	Long-term enhancement of public confidence Sustained support by MPs Sustained external support of organisation/individual by staff/GPs on social media Sustained support of organisation/individual by staff/GPs in media Sustained PALS/complaints contacts National broadcast news coverage over more than two days Local broadcast news coverage over more than three days Front page trade press coverage Front page broadsheet coverage Escalation and public comment at ministerial/PM level with intervention Sustained support by Health and Wellbeing Board and intervention National/international recognition of campaigning OSC positive escalation to ministerial level with intervention	1.51%-2% over performance against budget	Saving of 0.1% to 0.2% – 0.5% of budget £2m Claim(s) awards between £100,000 and £1million	0.5%-1% under performance against budget
5		Excellence	**EXCELLENCE** Positive Publicity/reputation PLUS **Corporate** level under performance against budget AND/OR Finance claims	**EXCELLENCE** Positive Publicity/reputation PLUS **Locality** level under performance against budget AND/OR Finance claims	Enhancement of public confidence Sustained and open external support of organisation/individual by (named) staff/GPs on social media Sustained support by MPs/ministers leading to recognition of CCG Chair and Chief Officer Sustained external support of organisation/individual by staff/GPs on social media leading to recognition of CCG Chair and Chief Officer Sustained support of organisation/individual by staff/GPs in media leading to recognition of CCG Chair and Chief Officer Local and national broadcast/print/trade news coverage over more than seven days PMQ discussion with Governmental and shadow parties critical of CCG	>2.1% over performance against budget	Saving of 0.2% or more of budget £2m+ Claims awards of over £1million	>1.51% under performance against budget

12. Appendix 3 – Quality & Equality Impact Assessment Flowchart



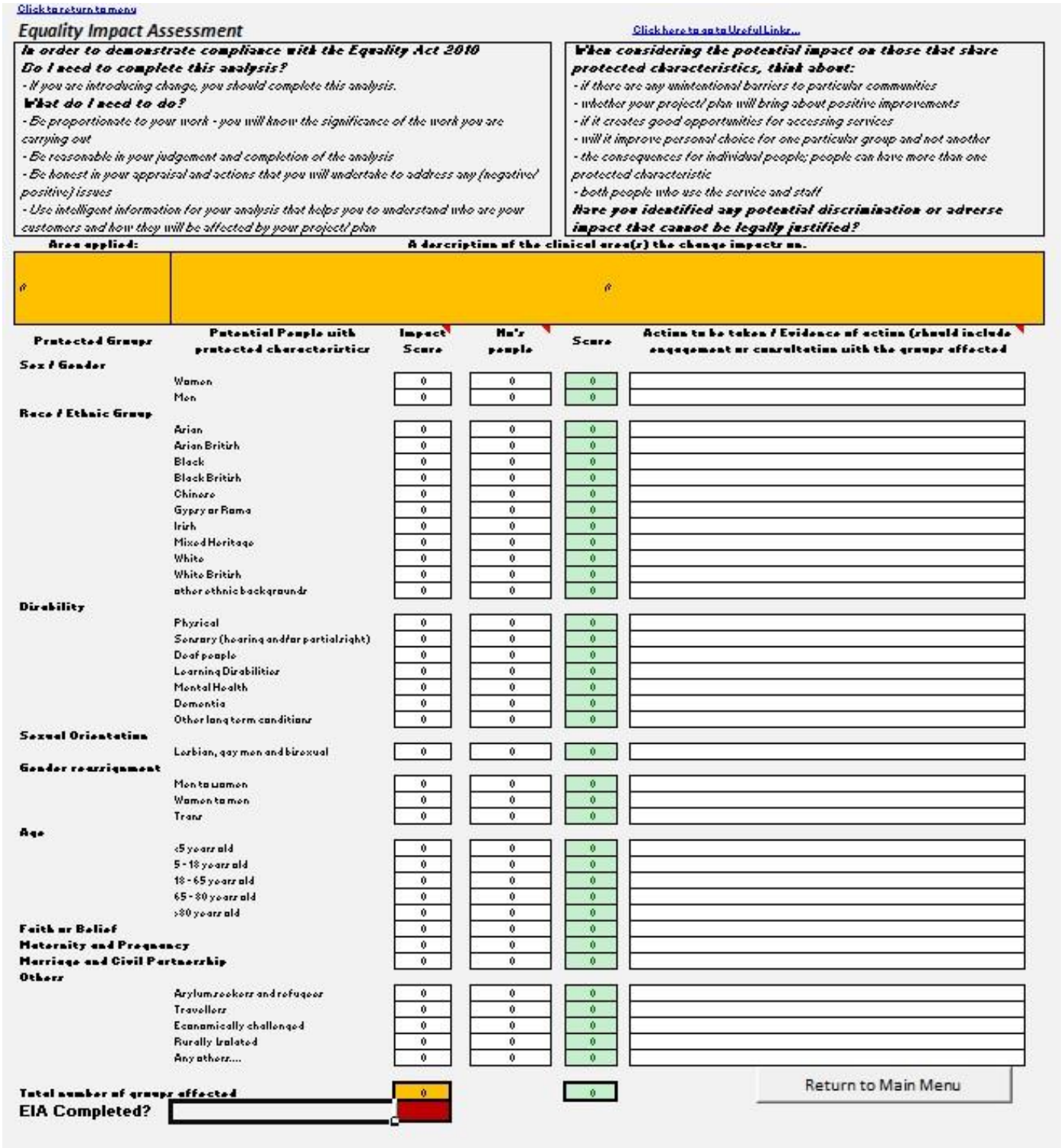
13. Glossary of Terms

The table below provides an overview for some of the specific terms and abbreviations used within this policy. The definitions of each term are specific to the context of the Quality Impact Assessment Policy.

Terminology	Definition
Assessor	The individual completing the QEIA too and making the overall assessment
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
E&D	Equality & Diversity
EIA	Equality Impact Assessment
JSNA	Joint Strategic Needs Assessments are used to provide a broad range of information about health and factors which influence the health of the population and to help inform and shape the planning and commissioning of services.
National Quality Board	The National Quality Board was established to deliver high quality care for patients throughout the NHS and at the interface of health and social care.
NEW Devon	Northern, Eastern and Western Devon
QIA	Quality Impact Assessment
QEIA	Quality & Equality Impact Assessment

Appendix C

Northern, Eastern and Western Devon NHS Clinical Commissioning Group equality impact assessment



Click to return to menu

Equality Impact Assessment

Click here to go to Useful Links...

Is order to demonstrate compliance with the Equality Act 2010
Do I need to complete this analysis?
- If you are introducing change, you should complete this analysis.

What do I need to do?
- Be proportionate to your work - you will know the significance of the work you are carrying out
- Be reasonable in your judgement and completion of the analysis
- Be honest in your appraisal and actions that you will undertake to address any (negative/ positive) issues
- Use intelligent information for your analysis that helps you to understand who are your customers and how they will be affected by your project/ plan

When considering the potential impact on those that share protected characteristics, think about:
- if there are any unintentional barriers to particular communities
- whether your project/ plan will bring about positive improvements
- if it creates good opportunities for accessing services
- will it improve personal choice for one particular group and not another
- the consequences for individual people; people can have more than one protected characteristic
- both people who use the service and staff

Have you identified any potential discrimination or adverse impact that cannot be legally justified?

Area applied:	A description of the clinical area(s) the change impacts on.
#	#

Protected Groups	Potential People with protected characteristics	Impact Score	No's people	Score	Actions to be taken / Evidence of actions (should include engagement or consultations with the groups affected
Sex / Gender					
	Women	0	0	0	
	Men	0	0	0	
Race / Ethnic Group					
	Asian	0	0	0	
	Asian British	0	0	0	
	Black	0	0	0	
	Black British	0	0	0	
	Chinese	0	0	0	
	Gypsy or Roma	0	0	0	
	Irish	0	0	0	
	Mixed Heritage	0	0	0	
	White	0	0	0	
	White British	0	0	0	
	other ethnic backgrounds	0	0	0	
Disability					
	Physical	0	0	0	
	Sensory (hearing and/or partial sight)	0	0	0	
	Deaf people	0	0	0	
	Learning Disabilities	0	0	0	
	Mental Health	0	0	0	
	Dementia	0	0	0	
	Other long term conditions	0	0	0	
Sexual Orientation					
	Lesbian, gay men and bisexual	0	0	0	
Gender reassignment					
	Men to women	0	0	0	
	Women to men	0	0	0	
	Trans	0	0	0	
Age					
	<5 years old	0	0	0	
	5 - 18 years old	0	0	0	
	18 - 65 years old	0	0	0	
	65 - 80 years old	0	0	0	
	>80 years old	0	0	0	
Faith or Belief		0	0	0	
Maternity and Pregnancy		0	0	0	
Marriage and Civil Partnership		0	0	0	
Others					
	Asylum seekers and refugees	0	0	0	
	Travellers	0	0	0	
	Economically challenged	0	0	0	
	Rurally isolated	0	0	0	
	Any others....	0	0	0	
Total number of groups affected		0		0	
EIA Completed?					

Return to Main Menu

Appendix D

Reference to risk and total score outcome scales

Removing the references to risk involves changing the "Review body – threshold for authorisation total score table". It is suggested that the ratings be changed to use the word impact instead of risk. The score name has been changed to "Total impact score (using absolute values)". This is a consistent change throughout the tool and will be further highlighted and discussed later in this document. The colours have also been removed to reduce confusion between the colours and association's people hold with those colours. All of these changes can be seen in Figure 5.

Total quality impact score (using absolute values)	<20	20-50	51 - 80	>80
Rating	Low Impact	Medium Impact	High Impact	Very High Impact
Review & Approval Required by	Governing Body			

Figure 5 *Altered QEIA total quality impact score scale*

The actual score not using absolute values and individual assessment scores could also be given an outcome rating scale that might follow the template used in figure 6. This scale uses the same categories as the Total impact score (using absolute values) minimising the use of different categories which could confuse the user. It is on this scale that an indication of risk could more appropriately be given. Figure 7 includes a risk indicator in the negative scoring end of the scale. Such a risk indicator could be appropriately used because a negative impact on quality might pose a risk to patient care.

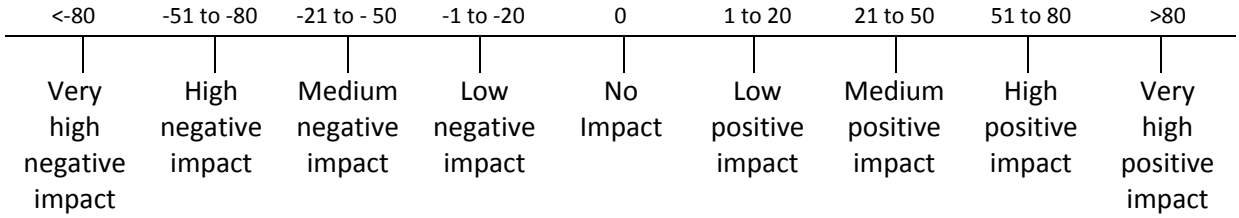


Figure 6 *Suggested actual quality impact score scale for the QEIA*

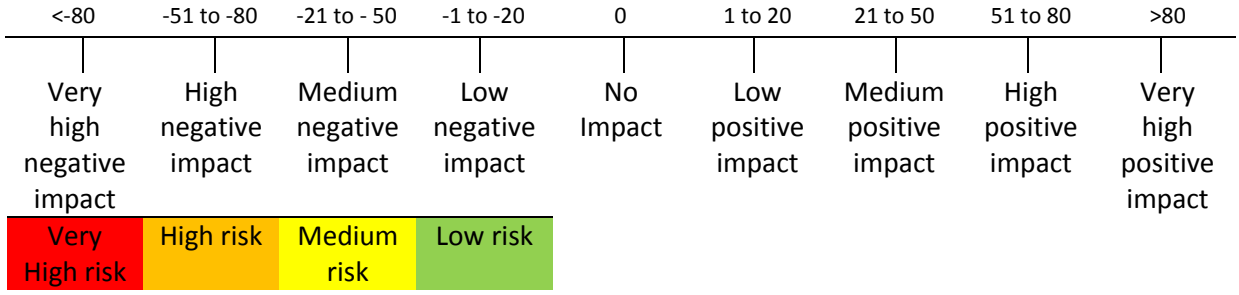


Figure 7 *Suggested actual quality impact score scale inclusive of a risk indicator of negative quality impact for the QEIA.*

Appendix E

Score naming conventions

The names of the scores will be most easily understood when consistent and descriptive naming conventions are used. The name changes suggested below refer to each name change required in the tool and where in the tool it needs to be made.

The format **(Tab name in QEIA tool document) => (Section with the specified tab)** is used to describe the location of the suggested change within the QEIA tool document.

Menu tab => Risk level indicator

This is not a measure of risk, it is suggested that the name be changed to "Impact level". Due to the current setup of the tool the 'risk level' text will change in relation to the summary tab.

Summary tab => Total quality impact scores section

The score name "Total impact of change" should be changed because this phrase does not appear elsewhere in the tool and is inconsistent with the QIA matrix. It is suggested that the name of this score be changed to "Total impact score (using absolute values)". As mentioned in relation to the risk indicator on the menu tab this is not a measure of risk. Using absolute values the impact levels could range from "No impact" to "Very high impact" in line with the revised scoring table outlined in the decision matrix section of this report.

The score name "Overall quality (sum of positive and negative impacts)" could also be changed. A recommended name is "Total impact quality score". This is a fully descriptive name for as it is the true summated score for the quality of the impact that is being measured.

Changing the score name "Other impacts" to "Other impacts score" would ensure it is clear to the user that that this is also a scored value and maintain a naming convention.

The order of the scoring in this section might cause some confusion to the user. They are being asked to score the impact of their proposed change on a scale that uses positive and negative numbers. They will be expecting to see a score that uses both those negative and positive scores as the main output of the tool and the first score. The total impact score (using absolute values) is important but if proffered as the main output score of the tool may cause confusion. It is suggested that the total impact quality score come first followed by the total impact score (using absolute values).

Summary tab => Equality quality impact scores section

The text "Equality Impact Assessment: Groups affected" could be changed to "Number of groups affected". The suggested title states that these are equality impact scores so a simplified score name would be appropriate. It is also recommended that the score name "Sum of +ve and –ve impacts" be changed to "Equality impact score" to aid in simplifying the score names and maintaining naming conventions.

Safety, effectiveness, experience and other impacts tabs => Scoring section

Impact score title could be changed to “Safety/Effectiveness/Experience/Other impact score from -5 (Very high negative impact) to 5 (Very high positive impact).

Safety and other impacts tabs => Scoring section

Patients score title change to “The number of patients per week effected by the proposed change from category 1 (1-50 patients) to 5 (>1000).

Safety tab => Scoring section

Length of change title change to “The number of weeks per year patients are effected by the proposed change 1 (1-4 weeks) to 5 (>40 weeks).

QIA matrix tab => Quality impact table

Suggested changes to the heading and score names for the QIA matrix are displayed in figure 8. These changes are consistent with the previously suggested names for the outcome scores used to be used in the tool.

Assessment	**Impact score (-5 to 5)**	**No. of patients effected (band 1 to 5)**	**No. of weeks per year patients are effected (band 1 to 5)**	**Weighting**	**Outcome Score**
Safety	0	0	0	0	0
Effectiveness	0	0	0	0	0
Experience	0	0	0	0	0
Total quality impact score (using absolute values)					0
Total impact quality score					0
Other impacts	0	0	0	0	0
Total impact quality score (inc. other impacts assessment)					0

Figure 8 *Altered QIA matrix containing altered score and heading names for the QEIA tool*

QIA matrix tab => weighting system

The weighting system is fine as it is but providing predefined categories may simplify the weighting system for the user. An option to turn the weighting system on and off could be used as most users will probably not use the weighting system until they are well acquainted with the tool. Table 3 is an example of what a category weighting system might look like.

Table 3 *An example category weighting system for quality impact assessment scores.*

Category	Percentage	Rating
4	100%	Most important
3	75%	
2	50%	
1	25%	Least important
0	0%	Not included

Using a category weighting system would simplify the process for the user giving them a method by which they could order the importance of the different assessment scores given by the tool.

Appendix F

Title and heading changes

This section describes a series of changes to the wording of some titles and headings within the QEIA tool. These changes have been suggested to help clarify what is being requested of the user and improving the consistency of naming throughout the tool.

The format **(Tab name in QEIA tool document) => (Section with the specified tab)** is used to describe the location of the suggested change within the QEIA tool document.

Menu tab => Proposal summary description

Changing the subtitle of the proposal summary description from "Summary description of the change proposal:" to "Summary description of the proposed change:" might help to clarify that the change has yet to take place by using the explicit future tense.

Summary tab => Proposal summary description title

Should the proposal summary description title on the menu tab be changed to "Summary description of the proposed change:" the text box title should also be changed on in the summary tab.

Summary tab => Total quality impact scores section

It is suggested that the heading "Total Quality Impact" be changed to "Summary of Impact Quality *Scores".* This change would better highlight that these are a group of impact quality scores.

Summary tab => Equality Impact scores section

It is suggested that the heading "Equality impact" be changed to "Summary of Equality Impact Scores". This will maintain consistency of naming conventions.

Safety tab => Area applied section

The heading "Area applied" might be too vague a description for the user to immediately understand. Providing a more descriptive title such as "Department or clinical area name where the change will take place".

Safety, effectiveness, experience and other impacts tabs => Narrative description text box headings

The grammatical tense of the description text boxes in the safety, effectiveness, experience and other impacts assessment tabs is currently slightly ambiguous. Changing the text to better reflect that the change has not taken place but will in the future would be useful for the reader. For example changing the text, "What is the impact on the SAFETY of patients of implementing the change proposed? (Please add a description of evidence)" to "What would be the impact on the SAFETY of patients if the proposed change is implemented? (Please use available evidence and provide references)". The suggested text is more explicitly in the future tense. The request for evidence contained in the parenthesis has also been altered. The suggested text requests references

for the evidence being provided which should prompt the user to include these. The inclusion of an evidence hierarchy is also suggested in Appendix G to aid in this process.

Measurement tab => Narrative description text box heading

Changing the heading “How will the Impact of Safety, Effectiveness and Experience described above be measured?” to “How will the impact of the proposed changes on safety, effectiveness and experience, as previously described, be measured?” removes the need to use the phrase “described above” as the text is not literally above this page.

Safety, effectiveness, experience and other impacts tabs => Assessment page titles

It would be useful to change the title at the top of each assessment page to include the word assessment. For example on the Safety tab to change the Title from “Safety” to “Safety assessment” to better reflect the titles on the menu buttons in the Menu tab.

Appendix G

Other suggested changes

The format **(Tab name in QEIA tool document) => (Section with the specified tab)** is used to describe the location of the suggested change within the QEIA tool document.

Menu tab => Instructions section

It is suggested that some of the text in the instructions section of the menu tab be changed to help clarify the use of the tool. This altered text below has been kept as similar to the original as possible to maintain the message that the author wished to convey.

Change of text to – This tool assesses four domains that are related to the quality of patient care: Safety, effectiveness, patient experience, any other impacts on the patient. The tool also includes an equality impact assessment.

Please begin by completing the project information on this page.

Next, please work through the tool to identify the impact of your proposed service change(s) in relation to current practice. You will need to complete the four work sheets, numbered 1 to 4 in the menu below, using text and the drop down boxes. You will also need to complete the equality impact assessment (EIA), button 5, to demonstrate compliance with the equality act 2010. A quality impact score will be automatically generated as you complete the tool; these results are displayed in the summary sheet.

Menu tab => Menu section

To help the user understand the order in which to complete each section of the tool, alternative layouts and the inclusion of a numbering system for each part of the impact assessment are suggested. The numbering system refers to the numbers included in the changed text of the instructions section above.

Suggestion 1

Splitting the menu panel into two sections and ordering the assessment buttons from left to right in order of completion provides a grouping mechanism and is easier for the user because the order of the buttons follows their normal reading direction. The first section contains the assessments numbered and laid out horizontally as shown in Figure 9. Then the “Other views” section enables the user to access the instructions, results, full screen mode etc.

Suggestion 2

Should you want the user to view each screen in a very specific order it is recommended that the menu buttons are numbered and ordered by the order that you wish them to be viewed in.

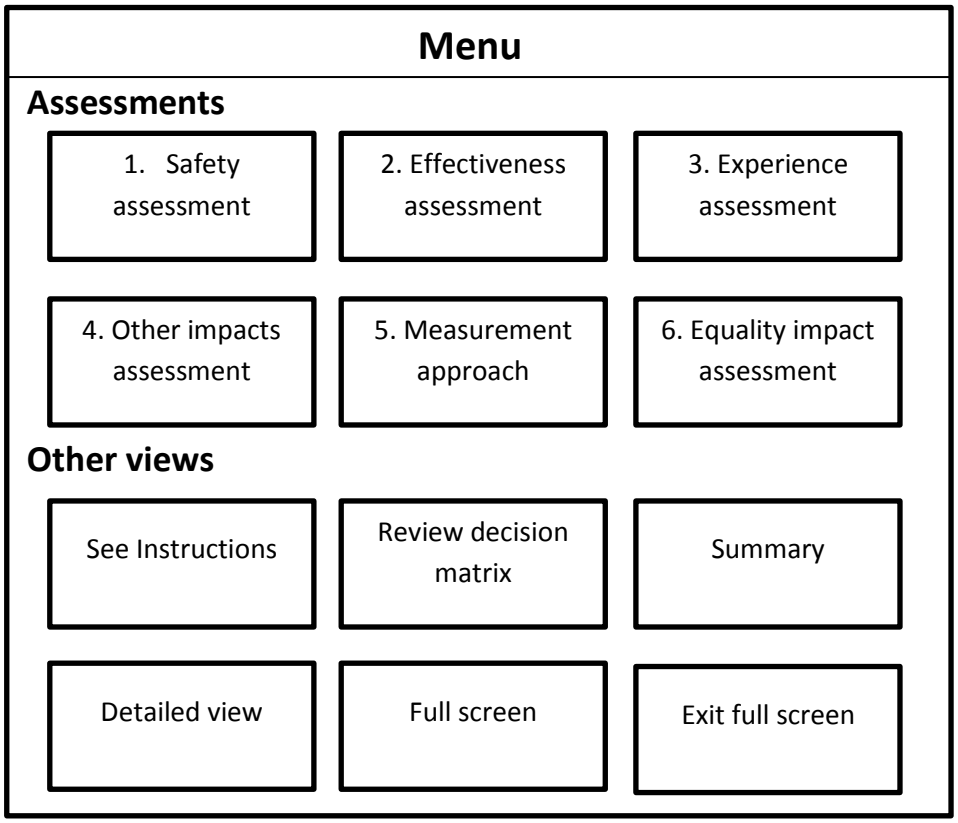


Figure 9 *Menu button panel suggestion 1 – numbered split panel*

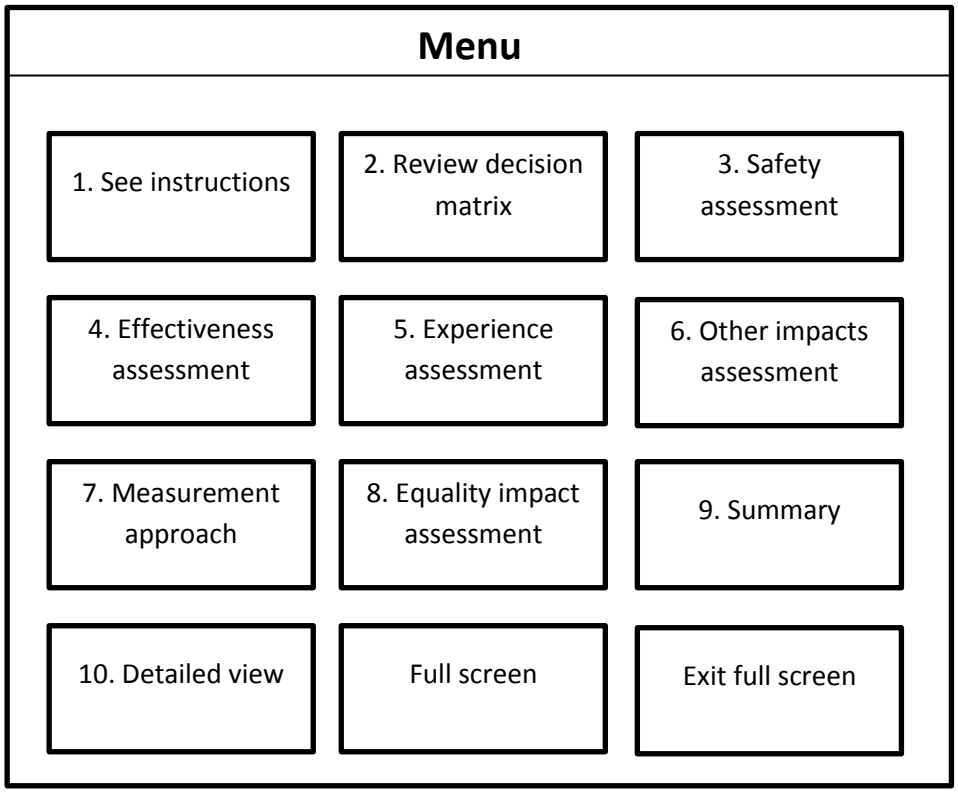


Figure 10 *Menu button panel suggestion 2 – Numbered and ordered single panel*

Not all of the buttons have to be numbered, for example in Figure 10 the full screen buttons have been left without numbers. Leaving buttons unnumbered can help indicate to the user that these buttons are of a different type of function to the other buttons and are best used whenever it is appropriate.

Suggestion 3

The changes to the menu section proposed in suggestions 1 and 2 use a similar layout of the buttons to those currently employed in the QEIA tool and would only require minor changes to the layout of the menu tab to incorporate them.

To fully illustrate the linear order in which the various assessments should be completed the buttons could be laid out in a line as in Figure 11. The line could be orientated vertically or horizontally and the assessments and other views kept separate or amalgamated as in suggestions 1 and 2. Using a more linear layout of the buttons would also make the use of a completion indicator more effective. The completion indicator can be easily linked to a specific button due to there being less rows reducing the ambiguity about which completion check is attached to which button. The completion checks could be a shape, colour or word. An example of this is given in Figure 12

It is suggested that the buttons in the menu be reordered to either reflect the order in which the user should view each page or to separate the assessments and other buttons. The buttons would also be more easily understood if they were ordered from right to left horizontally as this reflects the way the user likely reads information. Figures… show several suggested layout changes all of which would be suitable depending on preference.

Menu tab => Project details section

The “Reviewed by:” section is currently using an incorrect input value as there is not space in the tool for the reviewer to enter their name.

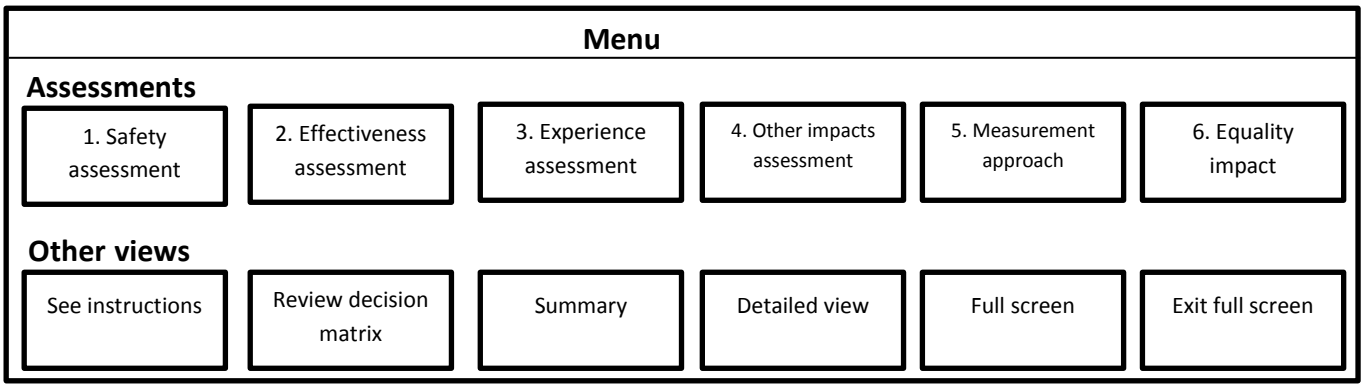


Figure 11 *Menu button panel suggestion 3 – Fully linear horizontal numbered split panel*

Figure 12 *Menu button panel suggestion 4 – Fully linear vertical split panel with completion idicators*

Instructions tab => Guide to completion of the tool

An evidence hierarchy could be useful to guide the user in understanding what types of evidence to include in the narrative description boxes. There are a number of evidence hierarchies available online. For health research they tend to use the general format of:

Level 1: Systematic reviews

Level 2: Randomised controlled trials

Level 3: Quasi-experimental studies

Level 4: Non-experimental studies

Level 5: Case studies/narrative evaluation or review

Level 6: Expert opinion

[Level 1 represents the strongest evidence and level 6 the weakest evidence.]