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| **Quality Impact Assessment (QIA)** | | | | | | | | |
| **1. DETAILS** | | | | | | | | |
| **CIP No.** *(ref. CIP tracker)* | | |  | | | | | |
| **Scheme Title:** | | |  | | | | | |
| **Month of Delivery:**  *NB: QIA sign-off* ***must*** *precede this date.* | | |  | | | | | |
| **Project Lead:** | | |  | | | | | |
| **Directorate:** | | |  | | | | | |
| **Project Overview and Objectives:** *The overview should provide sufficient information without the need to refer to other documentation* | | |  | | | | | |
| **Financial Benefits** *(savings in £000s) Recurring/Non-recurring*: | | | **FYE:** | | **PYE:** | | | |
|  | | | | | | | | |
| **2. RAPID ASSESSMENT (*to be completed for all CIPs*):** | | | | | | | | |
| ***If you answer YES to any of these questions a full impact assessment is required – please complete section 3 below*** | **Is the scheme going to impact on workforce?** | | | | | | | |
| **Is the scheme going to impact on service delivery?** | | | | | | | |
| **Is the financial benefit over £50k?** | | | | | | | |
| **Does the initial risk review for the overall project score 4 or above ?(*circle matrix below*)** | | | | | | | |
| **Is a full QIA required?**  *(If NO, please send a signed copy of this report to the PMO – if YES please complete section 3)*  ***NB: both rapid assessments and full QIAs require Head of Nursing and CD/Exec lead and Head of Department signatures*** | | | | | | | | |
| **Print Name and Title: Signature:** | | | | | | | | |
|  | | | | | | | | |
| **3. FULL IMPACT ASSESSMENT:** | | | | | | | | |
| **All sections must be complete** | | | | **Impact Details** (include mitigation / control – *do these measures address the risk*?) **SCORE EACH RISK LISTED** | | **Consequence** | **Likelihood** | **Score** |
| **Risk to Patient Safety**  *Does the project have the potential to impact on the safety of patients, staff or any other person?* | | | | **Risk:** | |  |  |  |
| **Mitigation:** | |
| **Risk to Clinical Effectiveness**  *Have clinicians been involved in developing the project? Is there evidence to support the project (case studies, best practice, NICE guidelines etc.)?* | | | | **Risk:** | |  |  |  |
| **Mitigation:** | |
| **Risk to Patient Experience** – *Consider healthcare environment, dignity and respect of patients, families and carers etc. waiting times, access to services, equality and diversity* | | | | **Risk:** | |  |  |  |
| **Mitigation:** | |
| **Overall risk score:** | | | | | | | | |
| **Scores over 12 must be added to the Directorate Risk Register** | | | | | | **Datix reference:** | | |
| **Benefit for patients:** | |  | | | | | | |
| **Key Quality Indicators (KQIs):** | | *(detail any performance measures or KPIs that will be used to monitor the impact of this scheme)* | | | | | | |
| **Interdependencies with/support required from other departments:**  *Eg. Other directorates/IT/HR etc.* | | *(Provide overview and discussion with other areas)* | | | | | | |
| **Discussed at DMT meeting:** | | | | | | | Date: | |
| **Date of meeting at which QIA will be formally reviewed** : | | | | | | | Date: | |
| **SIGNATURES:** | | | | | | | | |
| **NON-PAY ONLY**  **Approved by Clinical Sponsor:**  Name & Designation:  Date: | | | | | | | Signature: | |
| **Approved by CLINICAL DIRECTOR *or* EXECUTIVE LEAD for Facilities/Corporate Directorates:**  Name:  Date: | | | | | | | Signature: | |
| **Approved by HEAD OF NURSING *or* HEAD OF DEPARTMENT for Facilities/Corporate Directorates:**  Name:  Date: | | | | | | | Signature: | |
| **PLEASE SEND TO PMO FOR FURTHER SIGNATURES** | | | | | | | | |
| **FOR COMPLETION BY THE MEDICAL DIRECTOR AND DIRECTOR OR NURSING** | | | | | | | | |
| **Does the QIA require escalation to the Transformation Board?** *(please circle)* **Y N**  *(If NO, please sign below and return to the PMO – if YES please return to the PMO who will ask for the document to be added to the Transformation Board agenda)* | | | | | | | | |
| **IF ESCALATION IS NOT REQUIRED:**  **Approved by Medical Director:** Signature: Date:  **Approved by Director of Nursing:** Signature: Date: | | | | | | | | |
| **PLEASE RETURN TO PMO** | | | | | | | | |
| **IF ESCALATION TO TRANSFORMATION BOARD IS REQUIRED**  **Date of Transformation Board meeting at which QIA was discussed:** | | | | | | | | |
| **QIA approved by the Chair of Transformation Board:**  Signature: Date: | | | | | | | | |
| **PLEASE RETURN TO PMO** | | | | | | | | |

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| **6 MONTH POST IMPLEMENTATION REVIEW** | | |
| **CIP No. (ref. CIP tracker)** |  | |
| **QIA was reviewed formally at the following meeting/s:**  *The purpose of the subsequent reviews is to ensure that proposed mitigating actions or other measures are put in place and are effective in managing risks to quality.* |  | |
| **Have the risks identified in the QIA been mitigated? Provide evidence against each KQI (key quality indicator).**  *Reference the KQIs from the original quality impact assessment and describe the impact this scheme has had on them.* |  | |
| **Have you identified any further risks or unintended adverse consequences of the implementation of this scheme? How will these be/were these managed?**  *What scheme amendments or other measures will you implement to mitigate this risk?* | **New Risk:** | |
| **New Mitigation:** | |
| **A) What impact is this scheme having on the quality of service delivery?** (i.e. Reducing, Improving or Maintaining Quality)  *Please specify which aspect of your service has been affected.*  **B) Do you consider this to be acceptable and sustainable?** *(Please give your reasoning).* |  | |
| **DMT Recommendations:** *(eg. continue/cease change etc)* | |
| **Approved by CLINICAL DIRECTOR or EXECUTIVE LEAD for Facilities/Corporate Directorates:**  Name:  Date: | | Signature: |
| **Approved by HEAD OF NURSING or HEAD OF DEPARTMENT for Facilities/Corporate Directorates:** Name:  Date: | | Signature: |
| **PLEASE SEND TO PMO FOR FURTHER SIGNATURES** | | |
| **FOR COMPLETION BY THE MEDICAL DIRECTOR AND DIRECTOR OR NURSING** | | |
| **Does the QIA review require escalation to the Transformation Board?***(please circle)* **Y N**  *(If NO, please sign below and return to the PMO – if YES please return to the PMO who will ask for the document to be added to the Transformation Board agenda)* | | |
| **IF ESCALATION IS NOT REQUIRED:**  **Approved by Medical Director:** Signature: Date:  **Approved by Director of Nursing:** Signature: Date: | | |
| **PLEASE RETURN TO PMO** | | |
| **IF ESCALATION TO TRANSFORMATION BOARD IS REQUIRED - Date of Transformation Board meeting at which QIA was discussed:** | | |
| **QIA approved by the Chair of Transformation Board:** Signature: Date: | | |
| **PLEASE RETURN TO PMO** | | |