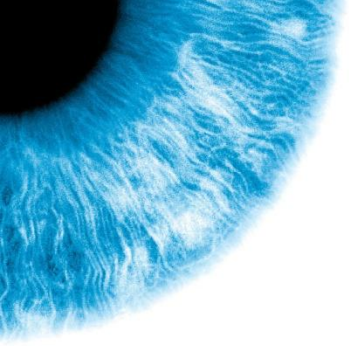

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

NHS EVIDENCE

A user guide for Quality, Innovation, Productivity and Prevention (QIPP) submissions to NHS Evidence

1. Introduction

The Quality, Innovation, Productivity and Prevention (QIPP) Establishing the Evidence project was initiated by the Department of Health (DH) in recognition that there was no current central resource of evidence showing how to improve quality whilst making efficiency savings or central co-ordination of efforts to expand this evidence.

Establishing the Evidence is led by NICE, to collate and expand the evidence of how to improve quality whilst making efficiency savings. It seeks to solve the problem of disparate current evidence and provide a structure for future evidence development. NHS Evidence now provides a central resource of examples of QIPP initiatives (www.evidence.nhs.uk).

Organisations are encouraged to submit examples of initiatives that demonstrate improved savings, quality and / or productivity improvements.

Reasons to get involved:

- The NHS must not lose its focus on quality because of the economic challenges it faces
- Addressing inefficiencies to benefit patient care is the responsibility of all in the NHS
- Trusts will become known as local, regional and national beacons of best practice
- There is an urgent imperative to introduce better ways of doing things

2. Criteria for assessment

NHS Evidence bases its evaluation on the degree to which the submission meets the QIPP criteria of savings, quality, evidence and implementability. The accreditation team assesses the examples and gives each criterion a score which are combined to give an overall score. The overall score is used to identify the best examples, which are indicated on NHS Evidence as ‘recommended’.

A gate process is used to assess how the submission meets the savings, quality, evidence and implementability criteria:

- Gate 1: Amount of resource – savings delivered/anticipated
- Gate 2: Quality outcomes – impact on quality
- Gate 3: Evidence
    - evidence on which the initiative is based
    - evidence of deliverables from implementation
- Gate 4: Implementability – value/effort assessment

3. Document Purpose

This user guide describes how to complete the template.

It is designed to provide information for applicants on submission of appropriate and relevant information required by NHS Evidence to evaluate QIPP submissions.

Private sector organisations should not make submissions independently to the evidence base. Where private sector organisations had been working in/with different NHS trusts and settings, the submission should come directly from them.

Please submit one application for each separate initiative from your organisation to describe how it meets the QIPP challenge.

It is important that the application is complete before it is submitted. Incomplete applications may be returned, resulting in a delay in evaluation of your submission.

4. Instructions

Please complete the template using the instructions below.

Applicants are asked to provide the information for all criteria within the template if possible as this will give the accreditation team a more detailed perspective on the submission and a more accurate assessment. Depending on the size of the initiative and its implementation the template may need to be completed by more than one person.

Explanatory information should be entered in the text box describing your selection for each question. Where explanatory information can be evidenced for example by a business case, please submit the documentation as part of the application.

4.1 Your name and contact details

Please provide a named contact, position in the organisation, contact details (email and telephone number) and organisation details – please identify the most appropriate person to act as liaison with NHS Evidence during the QIPP assessment process. These fields are mandatory.

4.2 Details of your initiative

Add details of your initiative. Briefly describe the issues that the initiative is seeking to address in up to 100 words, in particular what needs to be improved and why.

Please identify the topic area that your initiative addresses. You can choose more than one topic area. These topic areas are a combination of the eight Darzi pathways and the national workstreams. A brief description of each of the topic areas is shown below:

Topic area	**Area of initiative**
Staying healthy	Focuses on support and advice to stay healthy
Maternity and the newborn	Women should have greater choice and a more personal experience, with care provided by a named midwife
Children	Services need to be more effectively designed around the needs of children and families.
Acute / Urgent care	Focuses on saving lives by creating

	specialised centres for major trauma, heart attack and stroke care. Aim is to maximise the number of instances when right care is given by the right person at the right place and the right time.
Planned care	More care could and should be provided closer to people's homes.
Mental health	Focuses on the challenge to extend services in the community, notably for psychological therapies
Long-term conditions	Personalised partnerships between people with long-term conditions and the professionals and volunteers caring for them
End of life care	Focuses on the necessity for greater dignity and respect at the end of life
Primary Care	Focuses on improving the way in which the NHS commissions and contracts to deliver quality and better value
Right Care	Focuses on eliminating spend on low value activities and focus resources on high value activities, and improving patient care by ensuring they do not undergo inappropriate or unnecessary interventions
Safer Care	Focuses on improving the quality of patient care by focusing on reducing harm and associated expenditure.
Medicines Management	Focuses on improving the efficiency of medicines used in primary care, supporting better commissioning of medicines in primary and secondary care and supporting patients to improve concordance with medicines and reduced waste
Clinical Rationalisation	Focuses on improving the quality and productivity improvements in pathology services
Procurement	Ensures that procurement is coordinated and optimised to get the best value for money in the NHS
Back Office	Focuses on improvement of the efficiency of back office functions to preserve funding for frontline services, by the simplification, standardisation and sharing of back office operations
Productive Care	Focuses on supporting and enabling greater staff productivity in provider organisations in a way that delivers real cash savings
Other	

The purpose of the initiative should be described in this section, including the scope, for example, what is and is not covered by the initiative. Describe the initiative and the changes to clinical practice or service organisation that are involved. Include in which sector of healthcare it is working, (primary, secondary,

tertiary care), the setting in which the initiative operates (for example acute, community, mental health services), the organisations involved for example one acute trust, or a PCT and several GP practices, involvement of any voluntary sector or social care partners. The rationale for the initiative should be explained and information supporting this explanation provided.

If attaching documentation about the initiative, use the text box on the submission form to list the additional documents you are submitting.

Do not embed documents in the submission form.

Sign off by the budget holder (for example, a commissioner or finance director) should be in evidence if possible. It is important that you have approval of your organisation to submit the details of your initiative and to share the information on the submission form. Sign off by the budget holder (for example, a commissioner or finance director) should be in evidence if possible. The reason for this sign off is to ensure the savings and costs have been considered by a financial professional.

4.3 Assessment Criteria

4.3.1 Gate 1: Costs and savings

Gate 1 addresses the level of costs and savings involved type of savings and the costs involved in implementing the initiative. Additional notes on what costs and savings to include are noted in Appendix A, which also describes how to work out which category to select from the drop down list, as does the table below.

Gate 1: Does it generate productivity savings with the potential to save money? - level of costs and savings involved

Category	Very Low	Low	High	Very High
a. Productivity savings delivered / anticipated	*See table below for suggested thresholds, linked to total amount of savings to be achieved. Where it is certain the saving can be delivered (supported by fully costed business case) use the minimum threshold, where savings are theoretical use the maximum threshold.*			
b. Type of savings	No impact on cash, but resources are freed up that can be used for other activity	Minimal impact on cash, but high levels of improved productivity is forecast	A mixture of real cash savings and improved productivity is expected	Real cash savings will be achieved through reduced expenditure

c. Cost of change - likelihood that costs will not be a barrier to implementation	Change requires significant non-recurrent resources such as capital costs for adapting buildings	Change requires additional resources, but resources are non recurrent resources that are less than one year's savings	Change can be achieved with minimal additional resources	No additional resources required

Quantification of savings thresholds:	**Very low -** up to ... 0.01%	**Low -** between v. low value and 0.05%	**High -** between low value and ... 0.10%	**Very high** - above ... 0.10%	
National (population 51,446,200)	£1,500,000	£7,500,000	£15,000,000	£15,000,000	Min
	£2,000,000	£10,000,000	£20,000,000	£20,000,000	Max
Per 100,000 population	£2,900	£14,500	£29,000	£29,000	Min
	£3,900	£19,500	£39,000	£39,000	Max
Per avg. PCT (population 350,000)	£10,200	£51,000	£102,000	£102,000	Min
	£13,600	£68,000	£136,000	£136,000	Max

The assessment team is looking for explicit statements and supporting information that describe the type of savings, if any, and associated costs. For example:

1.1. Level of savings delivered or anticipated – supported by business case costings or other evidence of estimation. After consulting Appendix A to ensure the initiative shows the savings in the correct format, choose from drop down list. See the table above.

Clear values linking the savings and associated population. The example should provide a detailed description of what savings could be made, as permitted by the body of evidence.

1.2. Type of savings anticipated, such as reduction in expenditure, or productivity improvements – with reasoning and evidence. Clear values linking the savings and associated population. The example should provide a detailed description of what savings could be made, as permitted by the body of evidence.

1.3. Any reduction in expenditure, is this revenue expenditure or capital expenditure

1.4. Costs relating to making the change - assessment of what costs may be associated with any changes required to implement the example

1.5. Any information which shows how the responses to Gate 1 were arrived at should be added to the text box.

4.3.2 Gate 2: Quality

Gate 2 assesses the outcomes of the initiative on quality, safety, and patient experience.

Gate 2: Does it improve quality of care? - level of quality improvement

Category	Very Low	Low	High	Very High
a. Impact on clinical quality	Potential reduction in clinical quality	Not anticipated to have any impact (favourable or adverse) on quality of care delivered to patients	Clinical quality will be improved to a slight extent resulting in better outcomes anticipated for patients	Significant improvement in clinical quality, such as improved outcomes
b. Impact on patient safety	Potential increased risk to patient safety	Not anticipated to have any impact on patient safety	Improved patient safety, such as reducing the risk of adverse events is anticipated	Significant improvement in patient safety, such as reducing significant adverse events
c. Impact on patient and carer experience	Potential reduction in patient and carer experience	Not anticipated to have any impact on patient and carer experience	Improved patient and carer experience anticipated	Significant improvements in patient and carer experience is anticipated, such as reconfiguration to provide care closer to home

The assessment team is looking for information that describes the examples impact on quality, safety and patient experiences. Please include where the information has been collected from and how this satisfies the criteria in this gate. Issues to consider include:

2.1. Does the initiative show a significant improvement in clinical quality, for example better management of a long term condition to reduce unscheduled hospital admission, or a new approach to rehabilitation to enable quicker recovery.

2.2. What is the impact on patient safety, for example reducing the risk of adverse outcomes.

2.3. Is there any known / expected impact on patient and carer experiences? For example greater involvement in treatment decisions

2.4. Add any information which shows how the responses to Gate 2 were arrived at should be added to the text box.

4.3.3 Gate 3: Evidence of effectiveness

Gate 3 addresses information that describes the evidence base for the initiative and evidence of the outcome or deliverable from implementing the initiative.

Gate 3: Is there underpinning evidence – evidence supporting the initiative (basis and deliverables)

Category	Very Low	Low	High	Very High
a. Evidence for clinical improvement on which the initiative is based	Informed by local experience or opinion	Informed by documented experience at other organisations	Informed by published research evidence such as systematic review or non-accredited guidance	Under-pinned by accredited guidance such as NICE or SIGN guidance or policy of DH or other national body
b. Evidence of practical implementation at a local level	Example is theoretical improvement that has yet to be tested in an organisation	Example is from one team or organisation, and has not been tested in other teams or organisations	Example is based on experience in one or more organisations that has had systematic follow up and reporting of results	More than one documented example of implementation in more than one organisation.

You may want to consider:

3.1. The source of evidence on which the initiative is based (evidence base), for example, is the initiative underpinned by accredited guidance, such as NICE or SIGN or is the initiative informed by local experience or opinion.

3.2. Has the initiative been implemented? Please only select yes if the initiative has been implemented.

3.3. Give details of where the initiative has been implemented, for example in the UK, the type of organisation and whether for example this was a partial implementation, for example one ward, or across a directorate, the whole organisation, or a network of healthcare providers. The details of the implementation will be addressed in criterion 4.1.

3.4. Give details of where the initiative has been implemented, for example in the UK. Private sector organisations should not make submissions independently. Where private sector organisations had been working in/with different NHS trusts and settings, the submission should come directly from them.

3.5. If the initiative has been implemented please select the option from the list as to the degree to which the actual benefits matched the assumed benefits before implementation occurred.

3.6. Has the initiative been replicated? Only select yes if the initiative has been taken up by other teams/wards/practices/organisations that were not involved in the development and piloting

3.7. If the initiative has been replicated please provide details which explain where and the results of that replication. Does the replication confirm the original initiative?

3.8. Please provide information relevant to the responses in Gate 3.

4.3.4 Gate 4: Ease of implementation

Gate 4 describes the ease and timescales to implement the initiative.

Gate 4: Is it easy to implement? - likelihood that example will be easy to implement

Category	Very Low	Low	High	Very High
a. Likely speed of implementation	Will take longer than 3 years	Can be achieved between 1 - 3 years	Can be achieved in the medium term: 3 months - 1 year	Can be achieved quickly: 0-3 months
b. Ease of organising the change	Affects multiple organisations, involving multi-agency working	Affects multiple organisations within the NHS, such as working across a health economy	Affects a whole organisation across a number of teams or departments	Affects one department or team
c. Degree and complexity of support and commitment required	Likely to be resistance from most stakeholders	Likely to get a mixed reception	Likely to achieve good buy-in from key influencers	Evidence that all stakeholders fully committed and will be engaged in delivery

The assessment team will be looking for examples that demonstrate:

4.1. Please describe the implementation of the initiative. Describe how the initiative has been implemented.

4.2. The specific timescales associated with the implementation of the initiative should be described and how long it is estimated until the benefits of the implementation are realised

4.3. The size of the change and the ease of organising the change should be included in the response to this criterion. How easy / difficult was it to implement this initiative.

4.4. The level of support required to implement the change should be addressed. For example is there a good buy in from all stakeholders or is there resistance to the implementation.

4.5. Please describe any organisational and financial barriers to implementation which required address

4.6. For implementation of the initiative were any risks considered and how were those risks managed. Please include any possible risks to patient safety, risks to access while service changes are introduced, risks to other DH requirements (targets)

4.7. During implementation did you identify any dependencies? If so what were they and how are they addressed. For example what were the essential pre-requisites without which the initiative could not start to be implemented? Where could there be flexibility in the order in which components were implemented? Or, where were the stages dependent, for example having staff training completed before a new approach was used to manage patient care?

4.8. Please provide information relevant to the responses in Gate 4.

5. Relevant resources.

Please complete the text box with any further relevant information regarding any contacts, resources and publications which would help the end user in implementing the initiative. For example, this might include the published research which underpins your initiative, any information and training materials that were used with staff or patients to explain the initiative, any articles written about your initiative.

6. Submit the template

When you have completed the template, checked your answers and are ready to submit the template please send it to NHSEvidenceAccreditation@nice.org.uk

7. Next steps

Following the submission of the QIPP example, the assessment team will take the following next steps of the QIPP process:

- The assessment team and external advisers assess and validate the submission and prepare a submission report for feedback to the applicant containing information on the assessment..
- The example is categorised and is published on the NHS Evidence website.

Appendix A – notes on estimating costs and savings

When estimating costs an ideal source of evidence is any costed business case that was produced prior to undertaking the change. Ideally, there should also be a review of the initial business case following the change to validate that the costs and savings predicted were delivered in practice.

For changes that were not supported by a business case then please submit details of how costs and savings were estimated. You might find it helpful to talk with your local finance contact and get their input into this section.

Savings thresholds and population served

The thresholds have been linked to the widely quoted savings that the NHS has to make of £15 – £20 billion. These have been scaled down to what it might mean for a typical PCT or per 100,000 population. For providers please consider the population that live within your catchment area, and not the treated population. For example, if the ophthalmology department sees 20,000 people with eye disease from a local population of 600,000 (possibly across a number of PCT areas) then it is the 600,000 that is relevant.

Savings delivered / anticipated

This should be the annual recurrent savings that are anticipated, after deducting any annual recurrent changes in costs. Please specify if the savings or reductions affect capital expenditure or revenue expenditure.

Any costs arising from putting the change into practice should be noted separately. Examples of costs to include are noted overleaf.

The following list is of changes in costs that may be considered – this is not an exhaustive list, other costs and savings may arise that have not been included. (It is intended to update this list based on examples submitted.)

Revenue costs:

- Pay and staff related costs – grade and number of staff (could expressed as whole time equivalents at annual cost or change in hours at hourly rate). This

should be the full cost to employ staff including employer contributions to National Insurance and pensions

- Travel and subsistence expenses – particularly for community services
- Prescribing costs – clearly state which drugs and doses are involved
- Medical and surgical equipment costs (revenue items, or lease costs for more expensive items)
- Costs of devices
- Protective equipment and protective clothing
- Laundry costs or linen costs – is it disposable or recyclable?
- Costs of diagnostic tests
- Premises and establishment expenses such as printing, stationery and postage, telephone costs, clearning costs, rents for space or equipment

Capital costs:

- Changes to land and buildings – building works, architects fees, and associated costs, or non-recurrent income from selling off surplus estate
- Purchase of equipment – medical, diagnostic or other large items that are a capital purchase. Where equipment is leased, this is normally considered to be revenue and part of the running costs, so should be included in the recurrent costs
- Expensive IT systems that are capitalised

Often the detailed changes in costs may not be available, and savings arise from changing levels of activity. Potential ways of estimating the costs are provided for the following examples. It should be noted that in practice, reference costs and tariff are based on ‘full costs’ which includes fixed costs that cannot easily be saved, unless a whole building becomes redundant and can be disposed of. However, it provides a method to quantify the space freed up that may enable an anticipated increase in activity (due to growing and ageing population) to be absorbed and not require additional investment therefore contributing to improved productivity.

Type of activity	Potential costing method
Admissions to hospital	For acute activity use the PbR tariff for the HRGs that are most likely to be affected, this represents the costs avoided by the PCT and loss of income to the Trust. For other activity that is outside of tariff use the national schedule of reference costs (RC)– either the local RC for the organisation or the national average RC could be used. Please state clearly assumptions regarding admission type and HRGs that are affected.
Reductions in lengths of stay	Based on the assumption that utilisation of costs is greater at the start of an admission then using the RC for excess length of stay may be the most appropriate type of cost to use. In the absence of any other data the average costs across all activity (from RC 2008/09) has been calculated as: Elective £884 (includes theatre costs) Elective excess stay £287 Non-elective short stay (< 1 day) £514 Non-elective £375 Non-elective excess stay £233
Changes in day cases	Use the PbR tariff or RC.
Changes in outpatient attendances	Use the PbR tariff or RC if outside of tariff. Where possible use the specific specialty, or an average across all specialties. Different costs apply for first attendances and follow up attendances.
Changes in community visits / workload	Use the RC local or average cost. Please specify which RC currency type has been used
Changes in visits to a GP	There are no RC produced for GP visits, however, the Personal Social Services Research Unit (PSSRU) produce unit costs. In the 2009 edition table 8.8b indicates a surgery consultation lasting 11.7 minutes costs £31. (for more information see http://www.pssru.ac.uk/uc/uc2009contents.htm)
Changes in visits to a Practice Nurse	The PSSRU 2009 unit costs indicate that a typical Practice Nurse consultation costs £9.
Impact on social services	The PSSRU 2009 also includes unit costs for services provided by social services. These include average fees for nursing and residential homes and community care packages.

Cost of change

Changing the way services are delivered to generate savings or improve quality may require some non-recurrent costs (or savings). Examples are noted above in the capital costs section. Additionally, staff costs associated with the change – such as time limited project management staff, or if less starr are required and this can't be achieved through natural wastage or redeployment then redundancy costs may be incurred.