

IMPRESS

Improving and Integrating Respiratory Services in the NHS

A BTS GPIAG Initiative

NARRATIVE

There is a rapid pace of change in the NHS and it is unsurprising that some clinicians, particularly in England, have a sense of disenfranchisement, disenchantment, and frustration. While there is no shortage of information in the public domain to explain why there is change, and how it will happen, little is directed specifically to clinicians, especially secondary care clinicians.

The NSF – not the whole story

Many clinicians in the respiratory field have long felt their patients are treated as the poor relations, and have lobbied long and hard for a national service framework (NSF) that puts an imperative upon decision-makers to invest NHS resources in respiratory care. An NSF has now been agreed but this will not be an effective lever until that framework is published, which is not likely until the end of 2008 or beginning of 2009.

BTS and GPIAG working together

Taking the initiative, the UK's two leading clinical societies for respiratory care (BTS and GPIAG) have joined forces to provide leadership, advice and support to their members, to help them navigate the system to provide high quality, integrated care for people with respiratory disease. The joint work is called IMPRESS – IMProving and Integrating RESpiratory Services. The current endemic lack of clinical engagement in the NHS is regarded by policy makers as one of the rate-limiting factors in achieving progress, and therefore any understanding IMPRESS can offer will be well received.

So, what is happening?

By 2008 the NHS budget will have trebled since 1990: UK healthcare spending (public and private) will be 9.2 % of GDP compared with the current European average of 8.7% GDP. So, the Government expects visible progress in terms of improved patient satisfaction, improved public satisfaction, reduced use of expensive acute services, more services closer to people's homes, and a reduction in the health gap between those with a good and a poor quality of life. It expects this will require innovation from the NHS and alternative providers.

Commissioning and providing – who does what?

The Government has set the NHS measurable targets to achieve this progress. It has also changed the system to facilitate it. This includes separating needs assessment, planning and purchasing of services ("commissioning") from their delivery. PCTs will only commission (once they have divested themselves of their community staff into a virtual or real separate organisation) and will support GP commissioners. Providers will just provide and will compete in a market place for payment with other NHS organisations, the private sector and the third sector (not NHS and not for-profit) However, there is a significant exception to this rule. Primary care is regarded as best placed to assess need, and to deliver the majority of care, particularly long term care. Therefore it will both commission and provide. Acute providers will be paid only for work done and coded. Payment for primary and community provision is based on a mixture of historic payment, and new investment. However, too much work has been done and paid for, and now the NHS is in financial straits, and managers have to bring it back into balance, and quickly.

Policy – long term conditions

Current policy assumes there is most scope to do things differently in chronic disease management - now known as long term conditions management.

- 17.5m people in England and Wales report a long term condition.
- Just 5% of inpatients, many with a long term condition, account for 42% of all acute bed days
- Around 80 per cent of GP consultations relate to long-term conditions
- Only about 50% of medicines are taken as prescribed

This analysis by the Department of Health in England has led to several policies that are driving change.

The public health strategy for England **Choosing Health** aims for the public to understand more about the impact of their lifestyle on their health and to take responsibility for it, supported by the NHS. Primary and community care is seen as the right place to deliver care for most people, and the white paper in England **Our Health, Our Care, Our Say**, requires more integrated care, closer to home and out of acute hospitals. The **long term conditions model** describes 4 levels of care, dependent upon need: health promotion, supported self care, disease management (such as prescribed by a national service framework) and case management of complex need. Noticeable at each level is an increased commitment to self management and self care, and a requirement from clinicians to support this.

Change is here to stay

One thing is certain. The sense of a shift of power and control away from hospitals is likely to be permanent. The shift is made all the more unsettling by the financial position of many organizations. However, the policy objective is to give power and control to patients and their proxies, their clinicians. So it is time to review what contribution clinicians can make, and how to improve health and health care; how to be regarded as an expert resource for the system, not just expert case managers. IMPRESS sets out to do this, with your involvement.

Glossary

The first task of IMPRESS was to produce an alphabetical glossary for clinicians and managers working in respiratory care to help them understand the terminology and processes used in the new NHS. It can be found at <http://www.brit-thoracic.org.uk/IMPRESS>. We will continue to update this, and improve our understanding of regional differences so that we can support all members.

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