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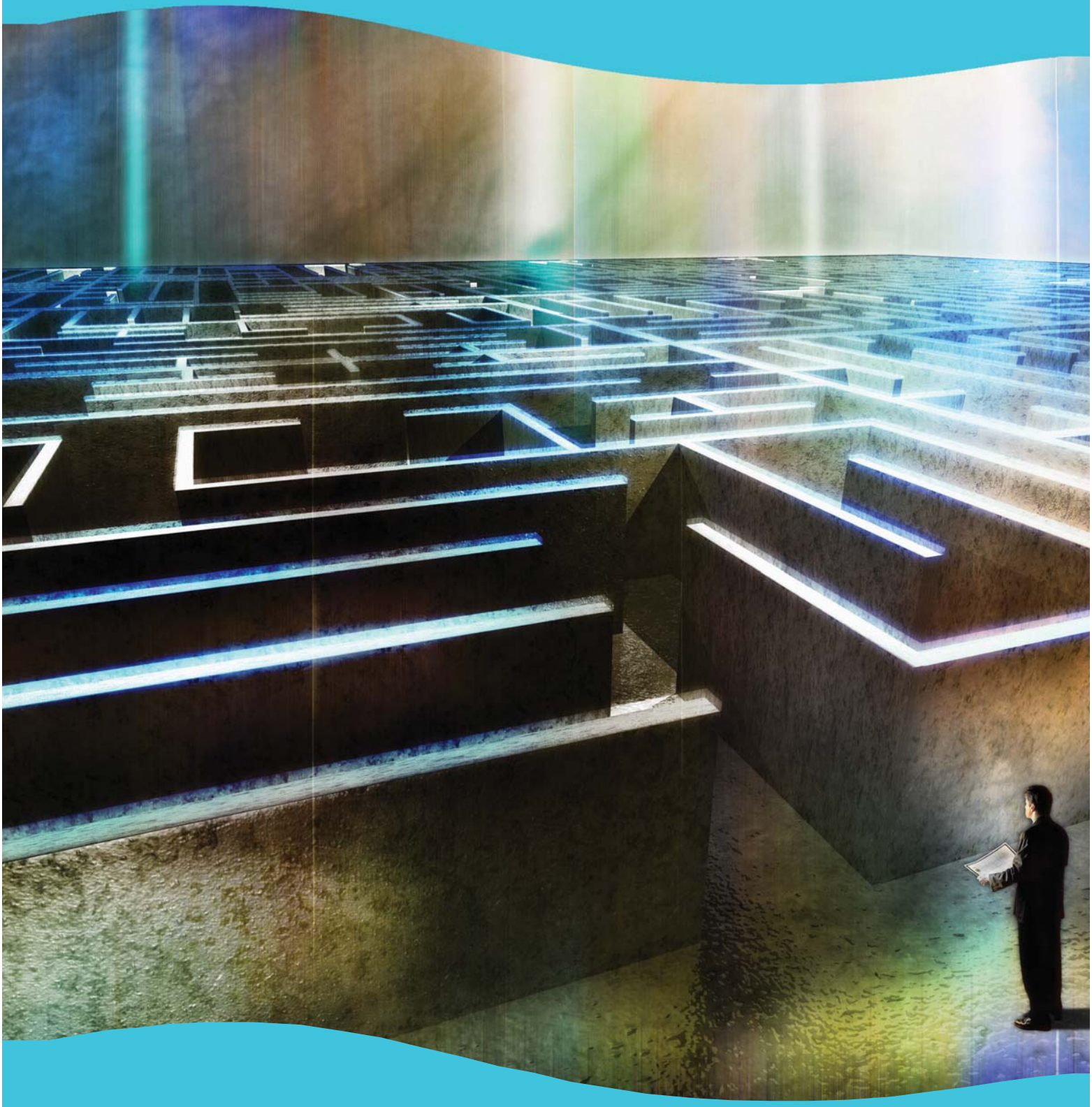
PCRS UK

IMPRESS

Improving and Integrating Respiratory Services



IMPRESS NHS JARGON BUSTER

Third Edition

The British Thoracic Society (BTS) has over 2,600 members who are actively working in a variety of healthcare professions to improve the standards of care for people with lung diseases. Just over half the members are secondary care physicians and doctors in training and the remainder are respiratory nurse specialists, respiratory physiotherapists, respiratory technical and physiological measurement professionals, smoking cessation practitioners and staff working in primary care settings. The Society publishes treatment Guidelines and related educational materials; runs an annual Scientific Meeting and an annual conference and short course programme catering for the multi-professional team; publishes the journal *Thorax*; provides tools to assist individual and team review and performance improvement (including audit and peer review); and works with strategic partners such as PCRS-UK and patient organisations to raise the profile of the speciality and advocate for improvements in standards.

http://www.brit-thoracic.org.uk/

The Primary Care Respiratory Society UK (PCRS-UK) is an independent charity representing over 2,400 primary care health professionals interested in delivering the best standards of respiratory care. It is dedicated to achieving optimal respiratory care for all through:

- Representing primary care respiratory health needs at policy level
- Promoting best practice in primary care respiratory health through education, training and other services
- Supporting the development of primary care health professionals in respiratory medicine
- Facilitating and leading primary care respiratory research

For further information and details of how to join the PCRS-UK see http://www.pcrs-uk.org/

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Jargon Buster

IMPRESS NHS JARGON BUSTER – 3RD EDITION

INTRODUCTION TO IMPRESS

Improving and Integrating Respiratory Services in the NHS

A joint initiative by the British Thoracic Society (BTS) and the Primary Care Respiratory Society UK (PCRS-UK)

The launch

When we launched IMPRESS in 2007, clinicians were experiencing a rapid pace of change in the NHS and it was unsurprising that some clinicians, particularly in England, had a sense of disenfranchisement, disenchantment, and frustration. While there was no shortage of information in the public domain to explain why there was change, and how it would happen, little is directed specifically to clinicians, especially secondary care clinicians.

The need for a national strategy

At the time, many clinicians in the respiratory field felt that their patients were treated as the poor relations, and had lobbied long and hard for a national service framework (NSF) that put an imperative upon decision-makers to invest NHS attention, if not resources, in respiratory care. You will be aware that the Strategy for COPD in England was published for consultation on 23 February 2010. We look forward to its implementation across the country.

BTS and PCRS-UK working together

Taking the initiative, the UK's two leading clinical societies for respiratory care (British Thoracic Society – (BTS) and Primary Care Respiratory Society UK (PCRS-UK) 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 – **IMP**roving and Integrating **RES**piratory **S**ervices. We believed that the lack of clinical engagement in the NHS at the time was regarded by policy makers as one of the rate-limiting factors in achieving progress, and therefore we thought that anything IMPRESS could offer would be well received.

So, what happened?

By 2008 the NHS budget had trebled since 1990: UK healthcare spending (public and private) was 9.2 % of GDP compared with the European average of 8.7% GDP. It was clear the Government expected 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 expected this would require innovation from the NHS and alternative providers. In February 2010 this drive to improve quality and productivity is now enshrined as the QIPP Challenge. The QIPP challenge to the NHS is to improve quality whilst making efficiency savings. David Nicholson, the Chief Executive of the NHS in England, has set the challenge of saving £15–20 billion through efficiency savings from 2011 to 2014. The challenge to the NHS is how to make these savings whilst keeping quality as its "organising principle".

Commissioning and providing – who does what?

The Government set the NHS measurable targets to achieve progress. It also changed the system to facilitate it. This included separating needs assessment, planning and purchasing of services ("commissioning") from their delivery. PCTs would only commission (once they had divested themselves of their community staff into a separate organisation, or, as of December 2009 guidance, supported its merger with another organisation either horizontally to another community health and/or social care provider, or vertically to an acute trust). They would also support practice-based commissioners. Since then, an assurance process has been introduced to monitor how well commissioners are "adding life to years and years to life" through the successful deployment of eleven commissioning competences, known as *World Class Commissioning*. Increasingly, IMPRESS has recognised it has a useful role to guide commissioners about what high quality respiratory care is, and how best to commission it, and has invited health and social commissioners to join the team.

Providers would just provide and 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 remains 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 both commissions and provides. Acute providers would be paid only for work done and coded. And now, in 2010, part of that payment will depend on reaching locally negotiated quality targets, CQUINs. Payment for primary and community provision remains based on a mixture of historic payment, and new investment. However, in 2008 it was understood that too much work had been done and paid for, which put the NHS in financial straits, requiring quick action to bring it back into balance. Now in 2010 there is a different financial challenge brought about by the global financial troubles and the squeeze on public spending. This time the need is not for quick action to bring back into balance, which had been achieved, but rather systematic change to keep productivity at current levels but to reduce spending by £15–£20 billion from 2011 to 2014.

Policy – long term conditions

By 2007 there had already been a policy shift to focus on chronic disease management – now known as long term conditions management, which is where there is most scope to do things differently. Over 30% of all people say that they suffer from a long term condition; that is 17.5 million people in England and Wales. This group accounts for

- 52% of all GP appointments;
- 65% of all outpatient appointments and
- 72% of all inpatient bed days

This analysis by the Department of Health in England which also shows that only about 50% of medicines are taken as prescribed and 5% of inpatients, many with a long term condition, account for 49% of all acute bed days, 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*, required more integrated care, closer to home and out of acute hospitals. The now-familiar long term conditions model describes four levels of care, dependent upon need: health promotion, supported self care, structured, routine disease management 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: change is here to stay. The financial position of many organisations makes these changes more challenging. However, the policy objective remains to give power and control to patients and their proxies, their clinicians. So it is still pertinent to review what contribution clinicians can make, to focus on knowledge and how to improve health and health care and how to be regarded as an expert resource for the system, not just expert case managers. IMPRESS is trying to do this, with your involvement.

Jargon Buster

The first task of IMPRESS was to produce an alphabetical glossary or jargon buster 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 on the following pages and also at http://www.impressresp.com/JargonBuster/JargonBusterAZ.aspx. Feedback so far has been very positive and therefore we will continue to update this, and improve our understanding of regional differences so that we can support all members. This edition does not include all the links to further reading, although it does include a few – but they are all available online.

Dr Tony Davison, Co-chair IMPRESS, BTS
Dr Steve Holmes, Co-chair IMPRESS, PCRS-UK

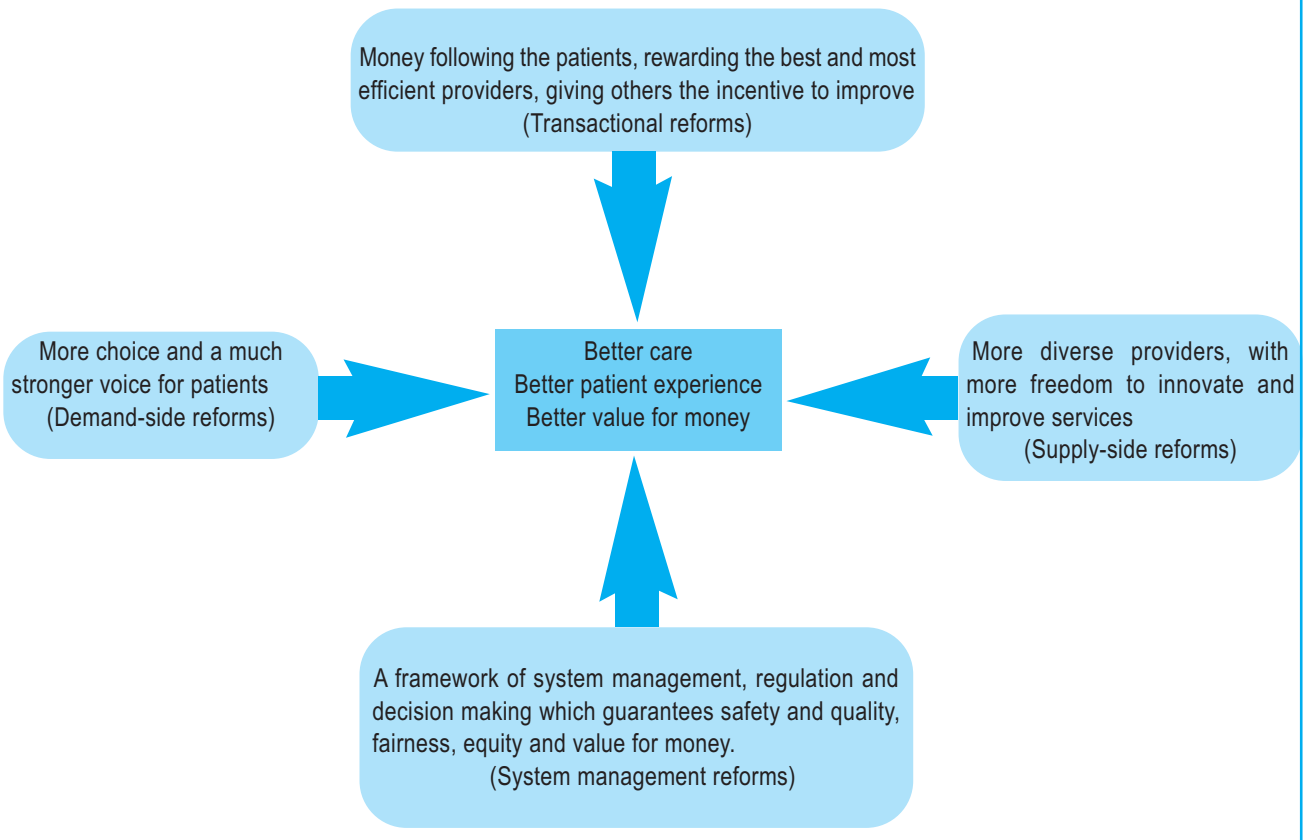
Also available at http://www.impressresp.com/JargonBuster/JargonBusterAZ.aspx

These pages aim to provide a simple guide to the many terms in the NHS in England that describe how healthcare will be planned, measured and paid for. Some of the terms also apply to Wales, Scotland and Northern Ireland. They highlight the relevance for delivering respiratory care.

Before starting the alphabetical glossary you may find it helpful to look at Figure 1 that describes how the various policies have contributed to the three main policy aims to:

- improve patient care, and particularly to reduce inequalities in access to care,
- improve the patient's experience of services
- achieve better value for money.

Figure 1 – Choice and Health Reform



ACADEMIC HEALTH SCIENCE CENTRE (AHSC)

An academic health science centre (AHSC) is a partnership between a healthcare provider and a university first proposed in the English policy **High Quality Care for All**. Five centres were designated by an international panel in 2009:

- Cambridge University Health Partners
- Imperial College
- King's Health Partners
- Manchester AHSC
- UCL Partners

Designation is for 5 years.

ADVANCE CARE PLANS

Advance care planning (ACP) is a voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline. If the individual wishes, their family and friends may be included. It is recommended that, with the individual's agreement, this discussion is documented, regularly reviewed and updated, and communicated to key persons involved in their care. Advance care planning discussions may lead to an advance statement (a statement of wishes and preferences), an **advance decision** to refuse treatment or the appointment of a **Lasting power of Attorney** (LPA).

Further information: **Guide for health and social care staff** and **RCP Advance Care Planning: concise evidence based guidelines**.

Related: *Advance Care Planning website*.

ADVANCE DECISION

The Mental Capacity Act 2005 gives people in England and Wales a statutory right to refuse treatment, through an 'advance decision'. An advance decision allows a person to state what forms of treatment they would or would not like should they become unable to decide for themselves in the future. It is a binding decision. An advance decision *cannot* be used to:

- refuse basic nursing care essential to keep a person comfortable, such as washing, bathing and mouth care
- refuse the offer of food or drink by mouth
- refuse the use of measures solely designed to maintain comfort, for example, painkillers
- demand treatment that a healthcare team considers inappropriate
- ask for anything that is against the law such as euthanasia or assisting someone in taking their own life

Further information: An example from **Alzheimer's Society**.

ALMO (HOUSING)

An ALMO is a company set up to manage and improve council housing stock. It is owned by the local authority but operates under a management agreement between it and the local authority. ALMOs are designed to encourage both the participation of the local community in the management of their homes and the continuous improvement of council housing services. Government funding is provided on the condition that local authorities separate their management and strategic functions. An ALMO must:

- deliver major repairs and improvements to bring homes up to the Decent Homes Standard
- collect rents, deal with arrears and debt counselling
- maintain properties
- manage lettings and deal with empty properties.

The local authority is still responsible for:

- the housing strategy
- housing benefit and rent rebate administration
- the overall policy on rents.

ALTERNATIVE PROVIDER OF MEDICAL SERVICES (APMS) CONTRACT

This is one of the types of contract that **Primary Care Organisations** (PCOs) can have with any provider of primary care to increase capacity and offer more choice. It could be a contract to provide care for a specific population, or a different way of providing care. It can exclude some essential services. For example, a private provider could provide a walk-in centre service.

Related: *GMS, PMS, PTMS* and *SPMS*.

AMBULATORY CARE SENSITIVE CONDITIONS (ACS)

A number of organisations help healthcare commissioners predict who might be at risk of admission, and to find ways to divert or prevent that admission. Work by the **NHS Institute of Innovation and Improvement**, **Imperial College** and **Dr Foster** has identified nineteen ACS conditions for which there is a community-based alternative to admission and which account for 6%–13.2% of total hospital costs. The variation in that proportion gives scope for improvement. COPD, asthma, flu and pneumonia are all in this list of nineteen. See the **Opportunity Locator** for further information.

ANNUAL HEALTH CHECK

This is undertaken in England by the Care Quality Commission, the watchdog for England's healthcare – checking quality and safety provided by the NHS and independent organisations. Performance ratings (excellent – good – fair – weak) for NHS trusts in England are published showing comparative performance in quality of service and managing money. A sample of trusts are inspected, the rest of the ratings are derived from analysis of thousands of data items. To see how your trust has done, visit the Care Quality Commission website: http://www.cqc.org.uk/.

AUTONOMOUS PROVIDER ORGANISATION (APO)

The NHS Operating Framework for 2008/09 required PCTs to 'create an internal separation of their operational provider services and agree service level agreements (SLAs), based on the same business and financial rules as applied to all other providers. The provider side manages services such as health centres, community hospitals, community nursing including district nurses, health visitors and school nurses, continence, contraception and sexual health, dietetics and nutrition, intermediate care, minor injuries, occupational therapy, physiotherapy and speech and language therapy and psychology.

Therefore by April 2009 all PCTs should have divested themselves of service provider functions to focus entirely on commissioning and moved into a contractual relationship with their PCT provider function, using the national model contract for community services in 2009/10.

Transforming Community Services: Enabling new patterns of provision (Jan 2009 DH) suggests that there are several possible organisational models (such as PCT provider services, community foundation trusts and social enterprise companies, and services integrated with other organisations).

However, in the *2010/11 Operating Framework* the guidance changed to ensure the focus was not on organisational structures but on the point of the organisations: "[plans must be] cost effective" and "consistent with implementing a robust approach to quality, innovation, productivity and prevention". SHAs now lead the process. The likely effect of recent guidance is that whilst for many services the preferred service model may be a stand-alone community organisation, some may be vertically integrated with secondary care providers or horizontally integrated with other community services (including, possibly, Social Care).

Related: *Operating Framework; Service level agreement (SLA); Social enterprise.*

BENCHMARKING (SOCIAL CARE)

A method for councils to work out how well they are doing by comparing their performance with other similar councils, and with performance indicators (PIs). It is also used by PCTs, and various information sources such as the NHS Information Centre now enable statutory organisations to select benchmarking groups and national data sets in health and social care to compare performance.

BEST VALUE (SOCIAL CARE)

Best value was a local government performance framework introduced into England and Wales by the Local Government Act 1999. The aim of the framework was to promote continuous improvement in local authorities' performance.

Under the framework, English and Welsh councils were required to monitor a set of best value performance indicators (BVPIs), undertake best value reviews of services and cross-cutting themes, prepare performance improvement plans and report on their performance annually.

Subsequent regulations, including statutory instruments and the Local Government and Public Involvement in Health Act 2007, have removed requirements to publish performance indicators (PIs), undertake best value reviews or publish a best value performance plan (BVPP). However, the general duty to make arrangements to secure continuous improvement in the way in which their functions are exercised, having regard to a combination of economy, efficiency and effectiveness, remains.

BIG CARE DEBATE http://careandsupport.direct.gov.uk/

A national debate about the future provision of care. At Green Paper stage in February 2010. The current proposal is for a National Care Service, the debate is about how it will be funded.
IMPRESS responded to the consultation:
http://www.impressresp.com/LinkClick.aspx?fileticket=3DAMrKtT7Jk%3d&tabid=77

CALDICOTT GUARDIANS

Senior professionals working within the NHS and local authorities to ensure that the confidentiality of patient-identifiable information is maintained and that manual and IT systems are secure. Caldicott Guardians oversee issues such as confidentiality and security, information clarity, rights of access and documentation accuracy.

CARE PATHWAY

To improve the person-centred nature of care, commissioners and service planners now try to understand how patients experience their care from prevention, to diagnosis and assessment, to treatment and where appropriate, to palliative care. This normally involves mapping the journey and the experience using a range of techniques with patients, clinicians, and managers. They describe this journey as a care pathway. Their aim is to improve the flow of patients along this pathway by reducing inefficiencies and improving reliability. Care pathways tend to be disease-specific, and so there also needs to be work done locally to understand and agree how patients with co-morbidities access different care pathways safely and effectively.

CARE PLANNING (SOCIAL CARE/LONG TERM CONDITIONS CARE)

Care planning is a joint process between health and social care professionals and patients and puts patient needs first. Whilst the clinical response must be proportionate to the complexity of a patient's needs, the professional should always ask patients what they want, eg in terms of documentation. A care plan should bring together all the information about the individual's needs, including information needs and aspirations. These are different from an asthma action plan or a COPD plan, which are just one element of a care plan. Some PCTs in England are using care plan templates to capture this information, others are building on existing shared records between health and social care. See **Personalised Care**

CARE QUALITY COMMISSION (CQC)

CQC brings together the independent regulation of health, mental health and adult social care. Before 1 April 2009, this work was carried out by the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection. These organisations no longer exist. CQC's main activities are:

- Registration of health and social care providers to ensure they are meeting essential common quality standards using one common regulatory framework for the first time
- Monitoring and inspection of all health and adult social care
- Using its enforcement powers, such as fines and public warnings or closures, if standards are not being met
- Improving health and social care services by undertaking regular reviews of how well those who arrange and provide services locally are performing and special reviews on particular care services, pathways of care or themes where there are particular concerns about quality
- Reporting the outcomes of its work so that people who use services have information about the quality of their local health and adult social care services. It helps those who arrange and provide services to see where improvement is needed and learn from each other about what works best

CQC website has more information: http://www.cqc.org.uk

Since 1 April 2009, NHS providers have been required to register with the Care Quality Commission and comply with its requirement on

cleanliness and infection control. The new system for registration will be introduced for the NHS in April 2010, and for independent and voluntary healthcare, and adult social care providers from October 2010. Primary dental care providers and private ambulances will be brought into registration in 2011 and primary medical care providers in 2012.

In a speech to the NHS Alliance in October 2009, the then Chair of the CQC, Barbara Young suggested that the Care Quality Commission will focus initially on ensuring that all NHS organisations reach minimum standards, rather than monitoring all organisations or supporting the best to do more. As its work develops over time, it will become clearer how it will approach its role.

CHOICE

Since January 2006 in England, patients are offered the choice of at least four hospitals and a booked appointment when they need a referral for elective care. By 2008, patients should have been able to choose any healthcare provider that meets NHS standards – that is, it may be an independent/private sector provider – and can provide care within the price the NHS is prepared to pay. The extension of the Choice Agenda to the care of people with long term conditions is under review and if it becomes policy, would enable people to choose how certain aspects of their care, along the care pathway, would be delivered to them personally.

CHOOSE AND BOOK

An English NHS initiative that allows people to make their first outpatient appointment, after discussion with their GP, at a time, date and place that suits them with the booking made electronically at the GP practice.

CLINICAL ASSESSMENT SERVICE (CAS) AND CLINICAL ASSESSMENT AND TREATMENT SERVICE (CATS)

Also known as **Referral Management Centres** (RMCs). This is a model of providing the equivalent of outpatients services for identified care pathways in either primary or secondary care. The CAS provides a clinical evaluation of a patient's condition and treatment. Patients are referred to the service by their GP and may be reviewed in person or virtually, using medical records and a phone conversation with the patient. If necessary, they will then be treated or referred on for further investigation or treatment. GPwSIs may staff the service. Referral to the CAS will be part of the Choose and Book programme. Typically it is this assessment service that offers the choice, rather than the initial referrer. The CAS/CATS may be provided by the independent sector.
Further information: **BMA guidance**, **a response from National Clinical Director for Primary Care** suggesting that the set up of RMCs needs to be done in negotiation with practice-based commissioning, and will not be the only model.

CO-CREATION OF HEALTH

This is used to refer to the joint production of health outcomes between patients with long term conditions and clinicians; an innovative approach to self-management.

The Health Foundation is currently funding a Co-creating Health project: www.health.org.uk/current_work/programmes/cocreating_health.html.

There are two COPD pilot sites: NHS Ayrshire and Arran and Cambridge University Hospitals NHS Foundation Trust, Cambridgeshire Primary Care Trust (PCT). The IMPRESS website *Patient and Public Engagement* section has more information.

COMBINED PREDICTIVE RISK MODEL

See **Predictive Risk**. NHS Croydon has piloted this model as part of its **virtual wards** project.

COMMERCIAL OPERATING MODEL

Launched by DH England June 2009 Necessity – not nicety. New regional Commercial Support Units are to be established (CSUs) within SHAs. In addition, there are plans for a Procurement, Investment and Commercial Division (PICD), National Procurement Council, and Strategic Market Development Unit.

Related: *Commercial Support Units (CDUs); National Procurement Council; Procurement, Investment and Commercial and Division (PICD); Strategic Market Development Unit (SMDU)*

COMMERCIAL SUPPORT UNITS (CDUS)

Part of new DH England Commercial Operating Model June 2009; these are SHA-based units "to help commissioners raise their game, focusing on World Class Commissioning competencies 7, 9 and 10 – analysing, stimulating and managing healthcare markets, securing and applying procurement skills, and managing contracts effectively as a 'demanding' customer". Alongside support, a key element of the offer will be skills transfer, creating permanent PCT capability in these key areas.

The CSUs will also provide the third and private sectors wishing to provide NHS funded services a point of commercial contact in each region. The policy document *Necessity – not nicety* emphasises the commitment to maximise the contribution of third and private sector organisations. Governance and funding arrangements will be put in place to guard against any conflict of interest, real or perceived, and to support an appropriate blend of co-operation and competition.

Providers will also be able to draw on CSUs for a wide range of commercial and procurement support.

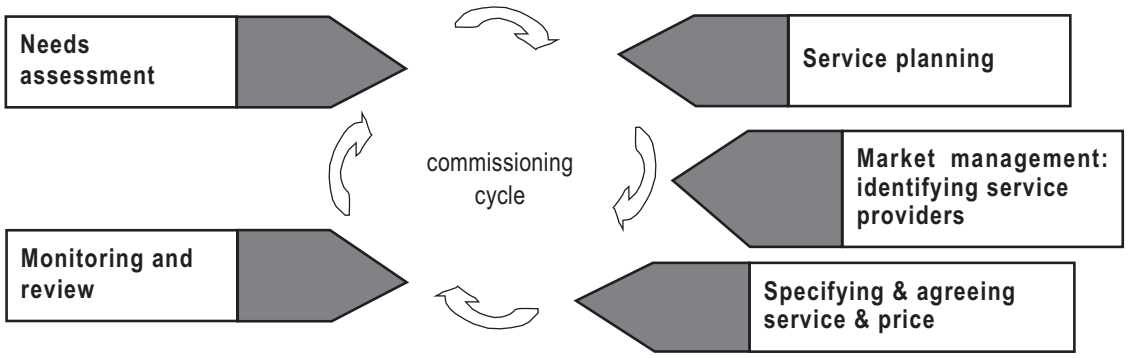
Related: *Commercial Operating Model*

COMMISSIONING

The full set of activities that English PCTs, GPs and local authorities undertake to make sure that health and care services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively. The activities include needs assessment and planning including service design and specification of outcomes; contracting and procurement; performance management, settlement and review. At each stage patients and the public should be involved.

It is a cyclical process, often taking at least a year and involving many people, both clinicians, managers, patients and the public. It is not a single action carried out by one person. There are specific deadlines during the year for production of plans, consultations and monitoring.

Figure 2 – Commissioning cycle



It happens at several levels: at GP level, practice-based commissioning is intended to increase the responsiveness of this cycle to individual and local need, by involving all GP practices either singly or in clusters. A single GP population will range from about 2000 to 12,000 and clusters from about 50,000 to 90,000. It may also involve practices in providing more services in primary care through reinvestment of savings released from managing referrals more effectively. As 80% of a practice workload is managing long term conditions, it is likely that there will be scope for doing things differently.

PCTs and clusters of PCTs will also commission services for populations. A PCT population will range from just over 100,000 in Darlington to over 1 million in Hampshire; whilst Greater Manchester Association of PCTs, a cluster of PCTs represents about 2.5 million people. For some rare or costly interventions, commissioning will continue at regional or national levels.
See http://www.commissioningforthelongterm.org.uk/

The performance of PCTs is managed through a programme called **World Class Commissioning** that requires demonstration of competence in 11 areas. See http://wcc.networks.nhs.uk

COMMISSIONING FRAMEWORK FOR HEALTH AND WELLBEING

This was published in March 2007 by the Department of Health in England as a consultation document as part of the implementation of the White Paper *Our Health Our Care Our Say*. It aims to give health and social care commissioners more "teeth" and to address the "fully engaged" scenario envisaged in the **Wanless Report**. It supports the development of personalised services for people with long term conditions. Most will be "permissive", that is, commissioners will be encouraged rather than forced to implement it. However it also describes the **Joint Strategic Needs Assessment** (JSNA) that has been obligatory from 2008. It lays down an expectation that providers and commissioners of care will actively seek out ways to reduce health inequalities and to support people who are socially excluded. This might include commissioning from alternative providers offering new models of care. Chapter 4 and Pages 81–82 describe the state of play regarding data sharing.

COMMISSIONING INTENTIONS OR PROSPECTUS

English PCTs publish this annually in about November to signal the direction for local services and to get local feedback. They will include a discussion of the key priorities and investment changes. The local authority **Overview and Scrutiny Committee**, public and **Practice Based Commissioners** are all encouraged to respond. This is a very important document that clinicians should look through as soon as it is available. From October 2008 these are also reflected in the PCT's five-year strategic plan.

COMPETITIVE DIALOGUE

Described in EU public procurement directives, it is used in the award of complex contracts (particularly for the **Private Finance Initiative**). It needs expert guidance. See **Office of Government Commerce** briefing.

COMPREHENSIVE AREA ASSESSMENT (CAA)

This is one of three regulation activities for health and social care. In addition to World Class Commissioning and the Care Quality Commission regulation of health and adult social care, the CAA, led by the Audit Commission examines how well councils are working together with other public bodies to meet the needs of the people they serve. It is a joint assessment made by six independent watchdogs:

- the Audit Commission
- Care Quality Commission (CQC)
- HM Inspectorate of Constabulary
- HM Inspectorate of Prisons
- HM Inspectorate of Probation
- Ofsted.

Assessments will be made publicly available every year and will provide an annual snapshot of quality of life in the area. The first results are now available on the new Oneplace website which was launched in December 2009. http://oneplace.direct.gov.uk

Related: *Care Quality Commission* (CQC); *World Class Commissioning*

CONNECTING FOR HEALTH

This is an NHS agency responsible for delivering the NPfIT programme.

CONTRACTS

As part of the procurement process, Primary Care Trusts must set contracts with providers. There are now standard NHS contracts

for acute hospital, mental health, community and ambulance services. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203

CO-PRODUCTION

This is a phrase used differently by different parts of the NHS and social care system. In the **2009/10 Operating Framework** it is described as one of the principles of the **Next Stage Review High Quality Care for All**. The other principles are subsidiarity, clinical ownership and leadership and system alignment. It is defined there as: "all parts of the system need to continue to work together on shaping and implementing change ... it means in essence ... engaging people across the system to work together to make change happen". It is also used to mean the co-production of services, through the partnership of the NHS and patients and the public either at a policy level or at the level of a 1:1 interaction.
Related: *co-creation*.

CPAP

Continuous positive airway pressure: treatment comprising a portable, electrically powered pump which delivers air through a tight fitting nasal mask or similar device. Used overnight for people with obstructive sleep apnoea syndrome (OSAS). NICE approved. The IMPRESS publication *Service Specification for Investigation and treatment of Obstructive Sleep Apnoea Syndrome* is available to download at:
http://www.impressresp.com/Portals/0/IMPRESS/OSAS4-web.pdf

CQUIN COMMISSIONING FOR HIGHER QUALITY AND INNOVATION

The CQUIN ("sequin") scheme was announced in the *Darzi Review High Quality Care for All* (June 2008). Hospital payment will be linked to quality. It will allocate a proportion of the tariff uplift for rewarding quality. In the first year of operation (from April 2009) hospital providers will trigger payments by simply submitting data – ensuring data flows are in place. However from "no later than 2010" payments will be linked directly to outcomes. The standard NHS contracts for 2010/11 require commissioners to make 1.5% of the contract value available for providers to earn if they achieve locally agreed quality improvement and innovation goals and, for acute providers, two national goals.

Reports from the **Healthcare Financial Management Association** (HFMA) in 2009 suggested that an average district hospital with a turnover of £250m could expect up to £9m through the quality payments system. A range of quality measures covering safety (including cleanliness and infection rate), clinical outcomes and patients' views about the success of their treatment (recorded in patient-reported outcome measures or PROMs) will be used.

Related: *National Quality Board; QIPP; Quality; Quality Accounts; Quality and outcomes framework (QOF); Quality Metrics/Indicators; Quality Standards*

CSC (SYSTMONE)

One of the main GP clinical IT systems. Virtually every practice is computerised in the UK. These rely on Read coding to record activity. The systems have many templates to prompt users to ask certain questions and to ensure data are collected to enable QOF points to be awarded. There may be more than one system in use in a PCT, which can make it hard to systematise protocols and care as there may be different templates in use.

Related: *EMIS, Healthy, InPractice, iSOFT, Microtest*

DEPRIVATION OF LIBERTY

The Mental Capacity Act (2005) amended by the Mental Health Act 2007 introduced new deprivation of liberty safeguards. From 1 April 2009 healthcare professionals and managers working in the NHS, independent hospitals and care homes must have clear procedures in place to comply with the new **Deprivation of Liberty Safeguards** (DoLS) introduced under the Mental Capacity Act (MCA). A code of practice is available from the Department of Health website: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094348

The safeguards provide a framework for approving the deprivation of liberty for people who lack the capacity to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty. There is a written application for authorisation required. The PCT must commission 6 assessments including age, mental health (undertaken by a doctor approved under s12 MHA or has special expertise in mental disorder), mental capacity, and "best interests" assessments (assessor must have specified qualification including social work). The assessment must be carried out within 21 days of the application.

DIGNITY

Ensuring that a person receives the type of care that makes them feel respected as an individual and helps them develop or maintain self-esteem and take pride in themselves. This should take place in every setting whether in the community or in the acute sector.

The Dignity in Care Campaign launched in 2006 across health and social care, aims to stimulate a national debate around dignity in care and create a care system where there is zero tolerance of abuse and disrespect of adults. Key areas are care for older people and people with mental health problems. There are now four thousand dignity champions.
http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/index.htm and http://www.dhcarenetworks.org.uk/dignityincare/index.cfm

DIRECT PAYMENTS (SOCIAL CARE)

Direct Payments are means-tested payments made instead of receiving social care. The money received should be enough to meet your care needs. Direct Payments have been available since 1997 and are made to a wide variety of people, including carers, adult service users and people with short-term needs. Direct Payments should not be confused with direct payment; this is the method by which **Personal Budgets** and **Individual Budgets** are paid.

DIRECTED ENHANCED SERVICES (DES)

Related: *Enhanced*.

DYSPNOEA

Shortness of breath/distressing breathing. May or may not be associated with a low oxygen level in the blood (hypoxia/hypoxaemia).

Related: *Hypoxia/hypoxaemia*

ELECTIVE CARE

Planned care for a pre-existing illness or condition.

ELECTIVE CENTRE

A term coined by Professor Sir Ara Darzi as part of the review of London's health services published in July 2007. It will focus on particular types of high-throughput surgical procedures such as knee replacements, arthroscopies and cataract operations. It will be separate from emergency surgery and will support the achievement of increased day cases and reduced waiting times. Critical care support will be available. The example used is South West London Elective Orthopaedic Centre (SWLEOC) on the Epsom General Hospital site. As the Darzi review was influential, the term is included here.

Related: *Urgent Care Centres*.

EMIS

One of the main GP clinical IT systems. Virtually every practice is computerized in the UK. These rely on *Read* coding to record activity. The systems have many templates to prompt users to ask certain questions and to ensure data are collected to enable QOF points to be awarded. There may be more than one system in use in a PCT, which can make it hard to systematise protocols and care as there may be different templates in use.

Related: *CSC (SystmOne), Healthy, InPractice, iSOFT, Microtest*

END OF LIFE

This term is now used to cover both advanced care and palliative care in different care settings such as care homes, hospitals, primary care and hospices for adults with advanced, progressive illness. There are national generic end of life care strategies in England, Wales and Scotland. In Northern Ireland there is a Respiratory Strategy including a chapter on end of life. The Department of Health in England website has a useful set of resources. In addition, IMPRESS has produced a *Response to DH England Consultation on End of Life Care Quality Metrics* that explores the challenges of achieving for people with advanced chronic respiratory illness the same quality of care as those with malignant disease. IMPRESS has also produced a communications skills education pack including filmed testimonies from patients and carers called *Effective Care – Effective Communication: Living and Dying with COPD*.

ENGAGEMENT

The process of involving others at an individual and collective level. It starts with information, then feedback, then influence. Commissioners are expected to demonstrate competence in clinical and public/patient engagement.

See the **Public and patient engagement** (PPE) section of the IMPRESS website.

ENHANCED SERVICES

Services within the GMS contract that are not essential or additional. Their main role is to help PCOs reduce demand on secondary care by providing more local services responsive to local need and that also provide value for money. Any provider can apply to provide the enhanced service, including an acute trust. It is worth knowing what plans the PCO has for enhanced services. For example, there may be a COPD enhanced service that goes over and above the QOF requirements.

Directed Enhanced Service (DES) Services are negotiated nationally. PCOs must provide them for their populations; practices can choose whether or not to provide them e.g. extended hours. English practices currently receive a DES fee to engage with their PCT in practice-based commissioning.

Local Enhanced Service (LES) A locally developed service that PCOs have determined necessary to meet the needs of their population. For an example from Tower Hamlets aiming to optimise COPD care see:
http://www.impressresp.com/Portals/0/IMPRESS/COPD%20LES%20TowerHamlets2009.doc.

EMIS template can be downloaded from:
http://www.impressresp.com/Portals/0/IMPRESS/COPD%20Template%20Guide%20Jan%2008.doc.

EQUALITY IMPACT ASSESSMENT (EQIA) (SOCIAL CARE)

An Equality Impact Assessment (EqIA) is a tool for identifying the potential impact of a council's policies, services and functions on its residents and staff. It can help staff provide and deliver excellent services to residents by making sure that these reflect the needs of the community. By carrying out EqIAs, a council may also ensure that the services it provides fulfil the requirements of anti-discrimination and equalities legislation.

EQUITABLE ACCESS TO PRIMARY MEDICAL CARE (EAPMC) PROGRAMME

EAPMC was introduced in the Next Stage Review. See the DH webiste:
http://www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/index.htm

There are currently two features, supported by a £250m investment to support English PCTs in establishing:

- at least 100 new general practices in the 25% of PCTs with the poorest provision; and
- one new GP-led health centre in each PCT in easily accessible locations.

Related: *GP-led health centre*.

ESSENTIAL AND ADDITIONAL SERVICES

These are what we would expect our GP to provide. All General Medical Services (GMS) and Personal Medical Services (PMS) practices are expected to provide essential services to their registered patients and include management of patients who are ill, terminally ill or think they are ill, and management of long term conditions. There are also a set of 7 additional services that practices can choose to opt out of: cervical cytology, child health surveillance, maternity medical services, contraceptive services, minor surgery, childhood immunisations and pre-school boosters and vaccinations and immunisations.

Related: *Enhanced services*.

EXPERT PATIENT PROGRAMME (EPP)

An NHS in England programme designed to spread good self-care and self-management skills to a wide range of people with long-term conditions. Based originally on work by Kate Lorig from Stanford University it uses trained non-medical leaders, on a voluntary basis, as educators and equips people with long-term conditions with the skills to manage their own conditions. Most programmes are for groups of people with a variety of conditions who meet on a weekly basis for 6 weeks and skills taught are not disease-specific. There is likely to be an EPP programme running in your PCT.

It is likely to reinforce the benefits of a pulmonary rehabilitation programme rather than to substitute for it, as its strengths are in improving self-efficacy (confidence), energy, and also, an emerging finding, improving social inclusion. The formal evaluation is now published in *J Epidemiol Community Health. 2007 Mar;61(3):254-61*. It does not show reduced use of health services. One of the hypotheses for this is that the health system is insufficiently flexible to cope with more empowered patients – for example if a patient is still offered six-monthly appointments, they will probably attend, even if they no longer believe they need them.

FAIR ACCESS TO CARE

Social care for adults, unlike healthcare, is not free for everyone. Everyone is entitled to a free assessment, including carers, but councils only have a limited amount of money, and cannot provide services direct to everyone. They use the Government's Fair Access to Care Services guidance as part of their assessment, to help decide what level of risk the individual has, and whether to pay for support. There are four levels of risk set out in the guidance:

Low – when there is little risk to the person's independence
Moderate – where there is some risk to the person's independence either now or in the near future
Substantial – where there are significant risks to the person's safety and independence
Critical – where there are immediate risks to the person's safety and independence

Most councils currently fund support for adults with a substantial or critical risk to their safety, independence or wellbeing. There is different guidance for children.

The support offered will be means tested through a financial assessment. A social care team would be able to provide health colleagues with client information categorised by level of risk, but not by diagnosis.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009653

FESC

Framework for procuring External Support for Commissioners launched by the DH in England in 2007. This includes an approved list of 14 commercial providers of support to commissioners. The companies are:

Aetna Health Services (UK) Limited
AXA PPP Healthcare Administration Services Limited
BUPA Membership Commissioning Limited
CHKS Ltd – trading as Partners In Commissioning
Dr Foster Limited, trading as Dr Foster Intelligence
Health Dialog Services Corporation
Humana Europe, Ltd
KPMG LLP
McKesson Information Solutions UK Limited
McKinsey and Company, Inc. United Kingdom
Navigant Consulting, Inc
Tribal Consulting Limited
UnitedHealth Europe Limited
WG Consulting Healthcare Limited, trading as WG

They are approved to offer some, or all of these services: Assessment and planning, contracting and procurement, performance management, settlement and review and patient and public engagement.

GENERAL MEDICAL SERVICES (GMS)

This is one of the main types of contract that PCOs can have with primary care providers. It is a nationally negotiated contract that sets out the core range of services provided by GPs and their staff and a national tariff. It remains the most common way for primary care services to be provided in most areas.

Related: *APMS, PCTMS, PMS*, and *SPMS*.

GENERAL PRACTITIONERS WITH SPECIAL INTEREST IN RESPIRATORY MEDICINE (GPWSIs)

These are practising GPs with a special expertise in respiratory medicine whose role often includes service development as well as clinical care. In respiratory care there are, as yet, very few and the roles vary. See the **Primary Care Respiratory Society UK** website:
http://www.pcrs-uk.org/gpwsi/index.php

Related: *Practitioner with Special Interests (PwSI)*

GP-LED HEALTH CENTRE

The DH requires every PCT in England to develop a GP-led Health Centre in response to concerns expressed nationally about difficulty in accessing primary care (now enshrined as The Equitable Access to Primary Medical Care programme (EAPMC).

It is also partly a policy agenda to increase competition into primary care by opening up the market to new players. For this reason the contract for the GP Led Health Centre has to be let in a specific way, according to a national timetable. The contracts should have been let by April 2009. At September 18 2008, all PCTs had met Milestone 3 (advertised and short-listed bidders), and 1/3 had issued invitations to tender (ITTs) to short listed bidders (milestone 4: 31 October).

GROUPING (DATA)

Inpatient activity can be grouped and reported at 3 different levels:

- High Level: Point of Delivery, e.g. Day Case, Elective or Non Elective
- Medium Level: Specialty, e.g. General Surgery, General Medicine
- Low Level: Healthcare Resource Group (HRG – see below), e.g. D22, D39

HEALTHCARE RESOURCE GROUPS (HRGs)

A way of grouping the hospital treatment of patients by casemix to allow analysis of the appropriateness, efficiency and effectiveness of care. Each group contains cases that are clinically similar and will consume similar quantities of healthcare resources. There are, for example, a number of codes which would naturally map to the HRG 'COPD' e.g.emphysema; chronic obstructive pulmonary disease; unspecified; chronic obstructive pulmonary disease with acute exacerbation etc. These should all represent a similar demand on resources. Currently, the cost of such an admission is derived from an average length of stay in hospital and to define the care in somewhat greater detail, the HRGs are split on the basis of complications and comorbidity. One can almost add on an extra day for every comorbid factor e.g. diabetes, A/F. The national tariff (see below) is calculated at HRG level, but activity is usually reported at specialty level. BTS is leading work to refine the Respiratory HRGs further. For example codes for ambulatory care and for short COPD admissions (eg Hospital at Home), acute exacerbations without or with ventilatory support and whether it is via NIV or intubation. HRGs do not include primary care coding or resource use. See ***Appendix 1*** for HRGv4. For the full respiratory list see letter D in the HRG definitions manual:
http://www.icservices.nhs.uk/casemix/hrg_manuals/Definitions_Manual_A-H.pdf

On behalf of the BTS, Steve Connellan has produced (September 2008) an extremely useful guide to coding respiratory care: http://www.impressresp.com/Portals/0/IMPRESS/Aguidetorespiratorycoding.pdf This can act as a discussion with governance leads about diagnosis and coding ambiguities, the importance of recording complications and comorbidities, greater use of the new OPCS codes including physiology measurement, AHP activity and interventions such a NIV support and oxygen assessment, creation of formal links with commissioners to consult on care packages, activity outside PbR and innovative approaches to integrated care.

HEALTHY

One of the main GP clinical IT systems. See **CSC**

Related: *CSC (SystmOne)*, *EMIS*, *InPractice*, *iSOFT*, *Microtest*

HIGH QUALITY CARE FOR ALL

See **Next Stage Review**

HOSPITAL EPISODE STATISTICS (HES)

This is a national data warehouse for England of care provided by NHS hospitals and NHS hospital patients treated elsewhere. For further information go to: http://www.hesonline.nhs.uk

HYPOXIA/HYPOXAEMIA

Shortage of oxygen/low oxygen level in the blood. Identified using a pulse oximeter, a peg-like probe usually placed on the finger that measures oxygen saturation in the blood. May or may not be associated with breathlessness.

ICD

International classification of diseases Version 10 is currently in use. Every patient admitted to hospital should have an associated ICD code – this contributes to defining the HRG. The reports generated from this data are only as good as the coding and analysis but are often used to analyse demand for services. Local coding and information departments can tell you more about how they are applied and interpreted locally.
See http://apps.who.int/classifications/apps/icd/icd10online/.
Chapter X is diseases of the respiratory system. Chronic lower respiratory diseases are J40-J47.

INDEPENDENT SECTOR (IS)

An umbrella term for all non-NHS bodies delivering healthcare, including a wide range of private companies and voluntary organisations.

INDEPENDENT SECTOR TREATMENT CENTRE (ISTC) AND TREATMENT CENTRES (TCs)

These are providers of elective surgery and tests for patients. Commercial providers have won a number of tenders from the NHS to expand capacity. The price is normally agreed outside the national tariff. See *Confuse and Conceal* a book by Player and Leys, with foreward by Dr Wendy Savage, for more on the story:
www.merlinpress.co.uk/acatalog/CONFUSE_AND_CONCEAL.html

INDICATIVE ALLOWANCE (SOCIAL CARE)

The Indicative Allowance is also known as the Gross Individual Budget and is the maximum amount of funding made available to meet an individual's social care support needs. It is worked out through the Resource allocation system (RAS).

Related: *RAS - resource allocation system (social care)*

INDICATORS FOR QUALITY IMPROVEMENT (IQI)

In response to High Quality Care for All these indicators have been developed by the NHS Information Centre drawn from national datasets and are primarily intended for use by NHS staff to inform quality improvement activities, supported by appropriate statistical techniques to analyse and interpret the data. There are over 200 available from the Information Centre.

INDIRECT PAYMENTS (SOCIAL CARE)

Indirect Payments are similar to **Direct Payments**, but instead of being paid to the individual who needs the service, payments are made to a nominated individual or into a trust. The trustees or nominated people then pay for services on the individual's behalf.

Related: *Direct Payments (social care)*

INDIVIDUAL BUDGETS (SOCIAL CARE)

Service users/patients receive an individual budget and use this to pay for a variety of services. The individual budget contains funding from several sources, including social services, the Independent Living Fund, Supporting People, Disabled Facilities Grant and Access to Work. It can also be used to purchase equipment if this is needed. Crucially, individual budgets encompass a number of different agencies but are accessed at a single point, making the system easier to navigate for service users compared to the old multi-agency approach.

Related: *Direct Payments (social care); Individual Health Budget (IHB); Personalisation (health and social care)*

INDIVIDUAL HEALTH BUDGET (IHB)

IHBs are being piloted at present (autumn 2009) for participating PCTs. They offer the following budget options to patients

- Notional budget held by commissioner
- Budget managed by a third party on patient's behalf e.g. care provider, independent trust
- Direct Payment to patient for health care

INDIVIDUAL SERVICE FUND (SOCIAL CARE)

An Individual Service Fund is an individual budget that a service provider manages on behalf of a service user. Payments are made with the understanding that the service provider can deliver what is needed and it meets the criteria set out in the service user's support plan.

INFORMATION PRESCRIPTIONS (IP)

http://www.informationprescription.info/index.html

One of five core elements of self care identified in the patient prospectus *Your Health, Your Way 2008*. Published in January 2009, *The NHS Constitution*, makes the provision of patient information a right and is backed up by legislation for the first time. *The NHS Constitution* also states that the NHS "... will help people to access relevant information about their long-term condition." Information prescriptions will contain a series of links or signposts to guide people to sources of information about their health and care – for example information about conditions and treatments, care services, benefits advice and support groups.

For help to set up a system, see the online resource: http://www.informationprescription.info/resource/index.html.

For a final report of the evaluation of pilots see: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086889

INPRACTICE

One of the main GP clinical IT systems. See **CSC**

Related: *CSC (SystmOne)*, *EMIS*, *Healthy*, *iSOFT*, *Microtest*

INTEGRATED CARE ORGANISATIONS (ICOs)

These form part of the *Next Stage Review* and are seen as a means of achieving improved coordination of care, delivering better services between secondary, primary and social care, and providing improved overall care for patients more economically. A national pilot in England started in 2009 including two COPD pilots. Core features include primary care involvement. They may be disease-specific or generic services. Social care is not compulsory. Indeed, the term 'integrated care' can be used, as it was initially for IMPRESS, to mean care crossing primary, community and secondary care boundaries, but it also means integration between health and social care. There is a very good literature review by Naomi Fulop, as well as a prospectus on the integrated care pilots: http://www.impressresp.com/GoodPracticeExamples/tabid/95/Default.aspx

INTEGRATED SERVICE IMPROVEMENT PROGRAMME (ISIP)

An NHS in England approach and set of tools to help health and social care communities work together to plan and make changes that will address current national priorities to achieve financial balance, bring care closer to home and out of hospital and address the 18-week waits target. It looks daunting, but is a systematic and thorough approach to ensure the changes planned will make a positive difference. See http://www.isip.nhs.uk/.

There are nine useful principles to judge your service against, to help make the case for service change:

- Health Equality Across Populations
- Support Individual Wellbeing
- Care Provided in the Right Setting
- Appropriate Access and Choice for All
- Timely, Convenient and Responsive Services
- High Quality Clinical Outcomes
- Optimise Workforce Capacity and Capability
- Efficient and Effective Delivery of Services
- Financial Balance Across the Local Health Economy.

See: http://www.isip.nhs.uk/library/caredelivery

INTEGRATION

IMPRESS, as a joint initiative between two clinical societies, started from the point of wanting to explore how to improve patient care through improvements in the care pathway across primary and secondary care. Therefore, in effect, it was advocating integration between primary and secondary care. As community providers have moved at arms length from primary care trusts, so IMPRESS has also explicitly included community service providers. It is also aware that for many, integration – see **Integrated Care Organisations and Pilots** – means integration with social care providers so that patients get the services they need without the need to understand or negotiate boundaries.

There are many useful resources for the evidence base on integration. Few, as yet, can describe significant benefits, particularly from integration of organisations. See Rebecca Rosen's review. In addition, Naomi Fulop and colleagues produced a review of the literature on integration to support the selection of the DH pilot sites. See the IMPRESS website for further details: http://www.impressresp.com/GoodPracticeExamples/tabid/95/Default.aspx

In terms of making a difference, integration of data seems to be an important step, but so is finding a common vocabulary. This Jargon Buster includes both health and social care vocabulary. The *Practical Guide to Integrated Working from the Integrated Care Network (2008)* offers some further insights into what integration means – between health and local authority services. It also offers a definition: "In its most complete form, integration refers a single system of needs assessment, service commissioning and /or service provision." The end point is improved outcomes.

Related: *Integrated care organisations (ICOs)*

INTERMEDIATE CARE

Also known as step up, step down and transitional care – this is care out of hospital for people who are medically stable but still need temporary care in a community bed or home-care for recovery

and rehabilitation. Commissioners are increasing their investment in such services in order to provide care closer to home, to reduce avoidable admissions and excess lengths of stay. The services are often nurse-led but there needs to be clear agreement about medical responsibility. Further information can be found on The King's Fund website: http://www.kingsfund.org.uk.

Related: *Opportunity Locator*.

INVISIBLE LIVES

Report by the British Lung Foundation that used Mosaic data to identify hot spots for COPD. The pdf file can be download from: http://www.lunguk.org/Resources/British%20Lung%20Foundation/Migrated%20Resources/Documents/I/Invisible%20Lives%20report.pdf

INVITATION TO TENDER (ITT)

Call for bids as part of the procurement process in competitive tendering. Often preceded by a pre-qualification questionnaire (PQQ). See: http://www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/DH_082218

ISOFT

One of the main GP clinical IT systems.
Related: *CSC (SystmOne), EMIS, Healthy, InPractice, Microtest*

JOINED UP WORKING

Joined-up working involves working in partnership with others, whether in the public, private or voluntary sector, in order to identify and solve local problems. The government increasingly regards joined-up working as a means of fostering efficiency, effectiveness and community engagement in the improvement of local government performance.

JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

This was announced in the new DH England Commissioning Framework for Health and Wellbeing that took effect in 2008. It is the means by which Primary Care Trusts and local authorities describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to meet those needs. JSNAs form the basis of a new duty to co-operate for PCTs and local authorities. JSNAs take account of data and information on inequalities between the differing, and overlapping, communities in local areas and support the meeting of statutory requirements in relation to equality audits. For more information from the Department of Health see:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_081097

Also refer to the online IMPRESS information on needs assessment:
http://www.impressresp.com/Commissioning/NeedsAssessment/tabid/83/Default.aspx

KEY LINES OF ENQUIRY (KLOE) (SOCIAL CARE)

Key Lines of Enquiry (KLOE) are detailed questions that help inspectors inform their inspection judgements. They are used by inspection teams, but they are also published to help audited and inspected bodies with their own assessments.

LASTING POWER OF ATTORNEY (LPA)

This is a statutory form of power of attorney created by the Mental Capacity Act (2005). Anyone who has the capacity to do so may choose a person (an 'attorney') to take decisions on their behalf if they subsequently lose capacity. A LPA must be in a prescribed form and be registered with the Office of the Public Guardian: www.publicguardian.gov.uk/index.htm.

More information is available at:
www.dca.gov.uk/menincap/faq.htm.

Related: *Advance Care Plans*

LINks (LOCAL INVOLVEMENT NETWORKS)

Local Involvement Networks are independent networks that exist in every local authority area of England to give people more influence over how their local health and social care services are planned and delivered. They are funded by the local authority, are publicly accountable and must produce an annual report for the Secretary of State. Participants are volunteers, and both individuals and organisations can join. An NHS organisation is excluded from joining, but an individual employee can, as long as they declare their interest. The challenge will be to avoid involving just the "usual suspects". Each LINk sets its own work programme. In addition to surveying the population about its needs, and joining steering groups, they have responsibility for monitoring services. They have the legal power to make visits to health and social care services provided by the NHS, local authority, private and third sector providers. Health and social care commissioners and providers should be working with their LINk to understand the needs of their community and to deliver services in appropriate ways. *Engaging and Responding to Communities, a Brief Guide to Local Involvement Networks Gateway* ref 10443 from DH in England and the NHS Alliance (Jan 2010) is aimed at professionals. It gives a description of what they are, how they can be used, and a few examples of how the NHS has engaged with them. For further information see NHS Centre for Involvement and the LINks Exchange online network.

LOCAL AREA AGREEMENT (LAA)

A three-year agreement setting out the priorities for funding and delivery for a local area in certain policy fields as agreed between central government (represented by the Government Office), and a local area, represented by the local authority and Local Strategic Partnership (LSP – see below) and other partners at the local level. It sets out the 'deal' between central government and local authorities and their partners to improve the quality of life for local people. As such, the LAA is also a shorter-term delivery mechanism for the Sustainable Community Strategy (SCS). It describes how performance will be measured using locally collected data. The LAA aims to improve the quality of life for people through improving performance on a range of national and local priorities such as safer communities, neighbourhood renewal, healthier communities, children and young people. It is worth finding out what your local LAA includes and to see how respiratory care might fit as this is a planning and resourcing process that includes resources other than PCTs'.

In the current Communities and Local Government statutory guidance to 'Creating Strong, Safe and Prosperous Communities' and

from the local government perspective, LAAs are a key feature of a more devolved central and or local settlement. Through these, different localities can channel public resources towards the priorities of their own areas, alongside national outcomes and targets.

LOCAL AUTHORITY

Democratically elected local body with responsibility for discharging a range of functions as set out in local government legislation. Local authorities each have an Overview and Scrutiny Committee (OSC) that has an increasingly important role in calling PCTs to account for their plans.

LOCAL DELIVERY PLAN (LDP)

A plan that every PCT prepares and agrees with its Strategic Health Authority (SHA) on how to invest its funds to meet its local and national targets, and improve services. It allows PCTs to plan and budget for the delivery of services over a three-year period. The LDP gives an overview of what the priorities are for a PCT and how it intends to manage its resources and is a public document.

LOCAL HEALTH BOARDS (HEALTH BOARDS) IN SCOTLAND

These are the health organisations within each region such as Lanarkshire, Grampian and Greater Glasgow Health Boards, that are responsible for health protection, health improvement and health promotion. They focus on needs assessment, service development and resource allocation and utilisation. More information available at: http://www.scot.nhs.uk/index.aspx.

LOCAL HEALTH BOARDS (LHBs) IN WALES

There are seven LHBs. The main roles of the LHBs are corporate and clinical governance; securing and providing primary and community care health services, securing secondary care services through long term agreements with trusts; improving the health of communities; partnership; public engagement and provision of services.

For more information see http://www.wales.nhs.uk/catorgs.cfm#22.

LOCAL STRATEGIC PARTNERSHIPS (LSPs)

LSPs bring together representatives of all the different sectors (public, private, voluntary and community) and thematic partnerships. They have responsibility for developing and delivering the Sustainable Communities strategy and Local Area Agreement (LAA).

LONG TERM CONDITIONS (LTC) MANAGEMENT

Previously known as chronic disease management; into which fits the management of patient with many respiratory diseases including COPD, asthma and pulmonary fibrosis. Informed by the Long Term Conditions policy. The best guide is the *Long Term Conditions Compendium of Information* by Department of Health in England. Long term conditions management is based on categorizing care according to a risk stratification.

Level 1 is for patients who can manage their own care and care for themselves, as long as they receive education and support from primary care.

Level 2 care management is where there is a structured, protocol driven approach to care.

Level 3 case management is where a patient needs help to coordinate their care if they are to avoid a succession of unplanned interventions. This is where community matrons, Evercare pilots and others have been focused but increasingly it is recognised that the bulk of healthcare is used by those at Level 2, and therefore anticipating who needs care to avoid becoming more dependent, particularly on hospital care, is a focus of much work.

Commissioners will talk about and use these categorisations. Commissioners may know through disease registers approximately how many people are in each category. For example, Tower Hamlets PCT with a population of 230,000 has an identified total population with COPD of 3000, split 350 in level 3, 650 in level 2 and 2000 in level 3. This is a relatively high figure, reflecting an inner city population with high smoking prevalence and social deprivation.

Underpinning this should be health promotion, which has received less attention or budget up to now.

The LTC model is not static and varies with disease; patients with COPD gradually move up the levels where as patients with asthma may move up or down. Nor is it purely related to severity of disease, because patients' coping abilities also influence how and when they seek professional help.

The Castlefields Health Centre model (see Figure 3 below) shows how self-care and self management happens at all levels, and how well they are enabled is probably the most important factor in determining how patients use services.

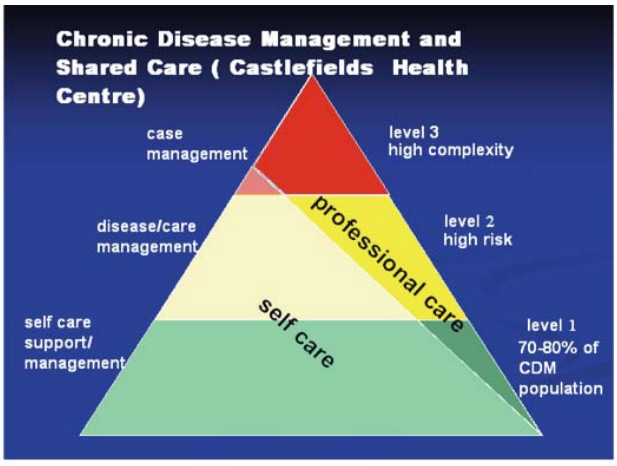
To conclude, who provides the care, and where, is up for negotiation. Currently about 80% of a GP workload is the management of long term conditions and government policy is to promote the role of GPs both as commissioners of care, and as providers.

LONG TERM OXYGEN THERAPY (LTOT)

LTOT is the provision of oxygen for continuous use at home for people with chronic (long-standing) hypoxaemia, most commonly due to COPD.

Related: *Hypoxia/hypoxaemia*

Figure 3 – The Castlefields Health Centre Model



LUNG IMPROVEMENT PROGRAMME

http://www.improvement.nhs.uk/lung/

Set up in 2010 to provide support for the local improvement of respiratory services. This will initially cover COPD, asthma and home oxygen services in England. It is an initiative to support the development of clinical networks and the implementation of the forthcoming National Strategy for COPD.

MENTAL CAPACITY ACT (MCA) 2007

Go to the Direct Government website here:
http://webarchive.nationalarchives.gov.uk/+/www.direct.gov.uk/en/DisabledPeople/HealthAndSupport/YourRightsInHealth/DG_10016888

MICROTEST

One of the main GP clinical IT systems.

Related: *CSC (SystmOne), EMIS, Healthy, InPractice, iSOFT*

NATIONAL PROCUREMENT COUNCIL

Part of June 2009 Commercial Operating Model launched by DH England. Has oversight of the delivery of Comprehensive Spending Review 2007 savings, and includes professional training and development and procurement policy.

Related: *Commercial Operating Model; Commercial Support Units*

NATIONAL QUALITY BOARD

In England, as part of *High Quality Care for All*, a new National Quality Board met for the first time on 30 March 2009 to provide strategic oversight and leadership on quality. It oversees 8 dimensions (and these will be underpinned by the clinical revalidation programme):

Quality Standards (led by NICE – 20 per year)
Quality Metrics (led by Information Centre approx 200)
Quality Accounts
CQINs (led by PCTs)
Quality Observatories (1 per SHA)
Clinical Excellence Awards (led by ACCEA)
QOF (led by NICE)
QIPP (quality, innovation, productivity and prevention)

The Quality Board's work programme includes the Mid Staffs Review, clinical prioritisation to influence 2010/11 Operating Framework, NICE quality standards (4 so far: stroke care, specialist neonatal care, VTE prevention and dementia), indicators for quality improvement (IQI), quality accounts, MRSA new target and clinical excellence awards all in the context of QIPP. Its membership, aims and papers are available at:
http://www.dh.gov.uk/en/Healthcare/Highqualitycareforall/NationalQualityBoard/index.htm

Related: *QIPP; Quality; Quality Accounts ; Quality and outcomes framework (QOF); Quality Metrics/Indicators*

NATIONAL STRATEGY

The six week Consultation on a Strategy for Services for Chronic Obstructive Pulmonary Disease (COPD) in England was launched on 23 February 2010. It also includes a section on asthma. The aim of the strategy is to:

- "Ensure that everyone diagnosed with COPD receives equitable, responsive, high quality and effective provision of health and social care services from the right person, at the right time, in the right place, that are cost effective and provide good value for money for taxpayers.
- Advise how local communities can prevent people getting COPD, understand the risks of having poor lung health, secure improvements to the diagnosis and care of people with the disease, and reduce health inequalities.
- Support people with COPD and their carers by offering practical advice and education on managing their disease."

The IMPRESS website has a policy section that includes the relevant respiratory strategies for all four UK nations.

NEEDS ASSESSMENT

This is an activity led by PCTs to inform what services are needed by the local population. It combines population-level data eg the prevalence of COPD by age, sex and GP practice, with an understanding drawn from patients and clinicians about what every individual patient or person at risk of the disease needs. It highlights inequalities in access to healthcare and in health outcomes, which then informs the planning of local services and changes in investment. Need is defined as an ability to benefit from an intervention. The intervention for COPD might be the provision of information, advice and treatment on smoking cessation, a prescription for drugs or any other service that would improve a person's quality of life, independence, and sense of well-being. Given that the best person to judge what makes such a difference is the patient, there is a strong obligation on commissioners to involve patients and the public in both needs assessment and the design of services. An example of public health data that uses QOF (see below) and hospital data can be found at:
http://www.nwpho.org.uk/monthly/nov06a/
This shows prevalence rates and emergency admission rates in the North West. Detail is often found in Public Health Reports that focus on health inequalities, and variation. **Related:** *JSNA*.

NEVER EVENTS

The National Patient Safety Agency has developed a national set of Never Events; serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. PCTs are required to monitor the occurrence of Never Events within the services they commission and publicly report them on an annual basis.

1. Wrong site surgery
2. Retained instrument post-operation
3. Wrong route administration of chemotherapy
4. Misplaced naso or orogastric tube not detected prior to use
5. Inpatient suicide using non-collapsible rails
6. Escape from within the secure perimeter of medium or high secure mental health services by patients who are transferred prisoners
7. In-hospital maternal death from post-partum haemorrhage after elective Caesarean
8. IV administration of mis-selected concentrated potassium chloride

NEXT STAGE (DARZI) REVIEW, HIGH QUALITY CARE FOR ALL

The NHS "once in a generation" review by Lord Darzi: *High Quality Care For All* was published in June 2008. A downloadable copy of the review is available from the DH website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

Further information is available on the IMPRESS policy pages: http://www.impressresp.com/NHSPolicy.aspx

NHS CHOICES http://www.nhs.uk

This is England's biggest health website and the public's gateway to choosing a hospital, booking appointments and gathering validated health information. It is an important development and one in which clinicians should take an interest, including validating the data that is provided to help the public make choices. *The Map of Medicine* is available to patients, and a useful *Behind the Headlines* feature provides a rapid response guide to the science in the news.

NHS COMPARATORS

Provides comparative data to enable commissioners and providers to investigate local activity, costs and outcomes. It includes **SUS** data as well as **QOF** information, GP practice demographic information and prescribing data. It is available to all GP practices, SHAs, PCTs, NHS Trusts, and other "relevant organisations". You first need to request a log-in. http://www.impressresp.com/Commissioning/NeedsAssessment/NHSComparators.aspx

NHS CONSTITUTION (ENGLAND)

This was published on 21 January 2009 and enacted on 19 January 2010. It brings together in one place for the first time in the history of the NHS, what staff, patients and public can expect from the NHS.

As well as capturing the purpose, principles and values of the NHS, the Constitution brings together a number of rights, pledges and responsibilities for staff and patients alike. These rights and responsibilities are the result of extensive discussions and consultations with staff, patients and public and it reflects what matters to them.

All NHS bodies, and private and third- sector providers supplying NHS services in England will be required by law to take account of the Constitution in their decisions and actions. The Government will have a legal duty to renew the Constitution every 10 years. No Government will be able to change the Constitution, without the full involvement of staff, patients and the public.

NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT http://www.institute.nhs.uk/

This has a huge array of tools to support commissioners and clinicians to improve services.

NHS SUPPLY2HEALTH

From 1 October 2008, all NHS commissioners in England were required to post information about tendering opportunities and contract awards at http://www.supply2health.nhs.uk/default.aspx.

NON-INVASIVE VENTILATION (NIV)

NIV is the provision of ventilatory support using an electrically powered portable ventilator and a tight-fitting nasal or face mask or similar device. It is an effective treatment for selected patients with respiratory failure. It may be used acutely for a limited time in hospital and a small number of patients may also have NIV at home, usually for overnight use.

http://www.brit-thoracic.org.uk/ClinicalInformation/NoninvasiveVentilation/NIPPVNIVinAcuteRespiratoryFailureGuideline/tabid/132/Default.aspx.

NPFIT NATIONAL PROGRAMME FOR IT http://www.connectingforhealth.nhs.uk/

This is charged with creating a multi-billion pound infrastructure that aims to improve patient care by enabling clinicians and other NHS staff to increase their efficiency and effectiveness. It is delivered by Connecting for Health. The programme includes the NHS Care Record, the **Choose and Book** scheme, electronic prescriptions, clinical dashboards, and a new IT infrastructure.

OPCS4

Office of Population Censuses and Survey Classification of Surgical Operations and Procedures, 4th revision (OPCS-4) is the classification used of surgical procedures and is used in defining the appropriate HRG. See: http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/index_html

OPEN BOOK

Open book negotiation may be a required part of the tendering or procurement process, by which providers may be expected to fully disclose paperwork, calculations and agreed variations.

OPERATING FRAMEWORK

For the NHS in England is produced annually to give NHS organisations the Department of Health's priorities and planning guidance. See the DH website and the IMPRESS guide: http://www.impressresp.com/NHSPolicy/OperatingFramework.aspx

OPPORTUNITY LOCATOR http://www.institute.nhs.uk/opportunitylocator/

This is analysis commissioned by the NHS Institute to demonstrate the potential for "shift" in services out of hospital either by avoiding an admission, by focusing on the **ambulatory care sensitive conditions** or by facilitating earlier discharge or by reducing outpatient attendances and/or by increasing the number of diagnostic tests. You can select the data by PCT, GP cluster or SHA.

OXYGEN CONCENTRATOR

Is a way of providing oxygen to people at home who need it on a long term basis because they have a low oxygen level (LTOT). It is an electrically powered machine that extracts oxygen from the air and delivers it by plastic tubing to nasal cannulae (plastic prongs that fit into each nostril) or a face mask.

PATIENT REPORTED OUTCOME MEASURES (PROMs)

High Quality Care For All, Lord Darzi's Next Stage Review Final Report June 2008, states that "we will make payments to hospitals

conditional on the quality of care given to patients as well as the volume. A range of quality measures covering safety, clinical outcomes, patient experience and patient's views about the success of their treatment – known as patient reported outcome measures or PROMs – will be used." As yet there is no nationally agreed PROM for respiratory care.

What are they?
PROMs employ short, self-completed questionnaires which measure the patient's health status or health-related quality of life at a single point in time and can be repeated to derive a measure of the impact of health care interventions. A number of PROMs already exist, such as the well-known generic tools EQ5D and the longer SF-36. The criticism of these has been that they were designed for research rather than use in every encounter. Others are now now in development. Some are generic, some disease specific. They can be integrated with clinical outcomes. They can be used at an individual patient level and also at an organisational level.

How is the NHS using them?
The 2008/9 NHS Operating Framework announced that PROMs for these high volume elective procedures in support of the 18-week programme in England will be routinely collected from April 2009 using these national standards as part of the the NHS Contract for Acute Services for:

- Primary Unilateral Hip Replacement: Oxford Hip Score or generic EQ5D
- Primary Unilateral Knee Replacement: Oxford Knee Score or generic EQ5D
- Groin Hernia Repair: no condition specific measure just generic EQ5D
- Varicose Vein Procedures: Aberdeen Varicose Vein Questionnaire or generic EQ5D
  (The LHSTM report also looked at cataract surgery).

The scope will be all patients, not a sample, to ensure sufficient volumes of data are collected (the DH estimates it could generate up to 250,000 reports over a 3 year period). However, it accepts some people will decline to participate, some will only complete the pre-operative questionnaire, and others may not be eligible for a range of reasons including illiteracy.

These will enable comparability across the country, and are based on research with 2,400 patients at 24 sites by the London School of Hygiene and Tropical Medicine. See the report at:
http://www.lshtm.ac.uk/hsru/research/PROMs-Report-12-Dec-07.pdf

Why?
The Next Stage Review describes the several reasons for collecting these PROMs:

1. To assess the relative clinical quality of providers of elective procedures, for clinicians and managers and commissioners benchmarking their own performance, for regulators, clinical audit and for patients and GPs exercising choice.
2. To research what works. Efficacy and cost-effectiveness of different technical approaches to care can be evaluated using PROMs in association with other measures that assess what would have happened to patients in the absence of treatment or with alternative treatment.
3. To assess the appropriateness of referrals to secondary care.

PROMs are included in NHS contracts and linked to payment. In Year 1 (2009-10) the payment rewarded collection of the information, not for the content, but in future years, it will be linked to the content.

PROMs for long term conditions
There is a lot of research looking at this. For example, York University is testing ways of measuring outcomes for different HRGs in circulatory disease. Some systems are already in operation for people who use hospital care, for example, CHKS has input a system across all BUPA hospitals and some NHS trusts that use SF-12 and EQ5D prior to admission and 3 months post-discharge. However, given the low proportion of respiratory patients that would be admitted electively, this will not provide a particularly useful tool in respiratory care. There are several questions: when should the data be collected? Using what tool and by whom? For example, there is currently more potential in primary care as implementation of the Quality and Outcomes Framework means general practices have the computer systems, as well as the contact with most patients. However, if they are to be used to provide feedback to change and improve clinical practice, they will need to engage secondary care as well.

The challenge for PROMs developers is to come up with a simple tool, the use of which becomes habitual, which is validated and available on all computer systems. There is also value, given the issues of comorbidities, of a PROM that is not condition-specific.

The National COPD Resources and Outcomes Project (NCROP) study in COPD by the Royal College of Physicians with the Health Foundation and the latest 2008 National COPD Audit may give a steer as to how PROMs in COPD might be used. The Clinical Strategy for COPD may also produce guidance. The RCP 3 questions is a tool that is used in primary care for asthma.

Further information: DH background Feb 2009 to support the Acute Contract Requirements:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092647

PATIENT-INITIATED PETITION

The public may use such a petition to raise concerns or issues about local services. It is the responsibility of the Overview and Scrutiny Committees and the PCT Board to ensure there are clear mechanisms to petition and for the petition to be considered formally by the two authorities.

PATIENTS AT RISK OF RE-HOSPITALISATION (PARR++)

A case finding tool. This software tool developed by the Kings Fund for the Department of Health links a number of datasets in order to accurately predict the risk of admission and re-admission to hospital. The idea is that patients identified using this tool, and local data will receive case management to avoid admission. A second tool, Combined Predictive Model builds on this work and integrates accident and emergency, inpatient, outpatient and GP data sources to predict risk of emergency admission to hospital across an entire patient population; not just those who have experienced a recent admission. This is important because whilst 0.5% of the population

use around 12% of emergency bed days; the larger volume is used by the broader population. It is worth asking colleagues how they have used the tools.

PATIENT'S PROSPECTUS

See **Your Health Your Way**.

PAYMENT BY RESULTS (PBR)

How acute providers in England are now paid. There is a national fixed tariff for emergency care, elective in-patients, day cases and outpatients bought by NHS commissioners. It does not yet include community services. The important principle is that only work done and recorded using appropriate coding is paid for. A report by the Audit Commission published 14 Feb 2008 analysed progress to date.

It suggests that it has improved the fairness and transparency of the payment system and understanding of costs and the importance of data quality within hospital trusts. It has probably had a positive impact on day case and the efficiency of elective activity (although there are other drivers too such as the 18-week wait target). It also concludes that PCTs have much room for improvement for negotiating and monitoring provider activity. It makes four recommendations:

1. Strengthen diagnosis, procedure and casemix classifications and the timeliness and quality of data available to PCTs
2. Increase the scope for unbundling so that different care pathways can be accommodated more easily – such as hospital at home
3. Introduce some normative tariffs for selected HRGs. These would be based not on average costs but on the costs that high performing efficient providers, offering a good quality service, might expect to incur
4. Consider separate funding streams for capital and quality, for example, as is the case internationally

Further information can be found at the Audit Commission website: http://www.audit-commission.gov.uk/health/audit/paymentbyresults/Pages/Default.aspx

Related: *Tariff*

PERSONAL BUDGETS (SOCIAL CARE)

Personal Budgets are similar to **Individual Budgets**, but are made up solely from social services funding. Personal Budgets are not multi-agency payments, so people would still have to contact other organisations if they receive some level of support from them. People also have a choice as to whether they receive the money as a direct payment, to receive a standard care service, or a mixture of both.

PERSONAL MEDICAL SERVICES (PMS) CONTRACT

This is one of the main types of contract that PCOs can have with primary care providers. It is a locally negotiated contract unlike **GMS** (see above). It allows the option of salaried GPs. More than 40% of GPs in England now work under PMS contracts. PMS practices have often reviewed their skill mix and have enhanced teamworking and extended roles for nurses and other primary care professionals. **Related**: *APMS, GMS*, and *PCTMS*, and *SPMS*.

PERSONALISATION (HEALTH AND SOCIAL CARE)

Personalisation is the all-encompassing term for the Government's agenda to give people more choice about the care they receive. The system places the service user at the centre of the process and allows them to choose the agencies they use and the manner in which they receive support.

PERSONALISED CARE PLANNING

High Quality Care for All, the final report of the NHS Next Stage Review re-affirmed the commitment made by the Department of Health in England that over the two years (2009–2011), every one of the 15 million people with one or more long term conditions should be offered a personalised care plan. Personalised **care planning** addresses all the needs of an individual: not just health, but personal, social, economic, educational, and cultural. A COPD plan or an asthma action plan would fit into this overarching personal care plan. See guide for commissioners here: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093360.pdf

The first report of the Darzi Review in July 2009 claims over 9 million people now have a personal care plan. See *Your Health Your Way* and IMPRESS pages: http://www.impressresp.com/PersonalisingCare.aspx

Related: *Care Planning*

POLYCLINICS

A new term coined by Lord Sir Ara Darzi as part of the review of London's health services published in July 2007 – available at: http://www.healthcareforlondon.nhs.uk/a-framework-for-action-2/.

In the proposed model, polyclinics are community-based facilities for the diagnosis and care of populations of up to 50,000. Some may be located at hospitals, as discrete facilities. They will be open 18–24/7 and house a range of diagnostic equipment, and accommodate a range of specialist clinics and provide urgent care. The model argues for most GP practices to shift premises into the polyclinics so that there would be about 25 FTE GPs in each; to enable access to a wider range of services. Critics argue that this would reduce access for patients and be difficult to achieve in terms of estates planning and negotiation with GPs.

The Kings Fund report *Under One Roof: Will polyclinics deliver integrated care?*, by Imison *et al* suggests planners should be careful to assess benefits and costs and in particular, recommends the focus for PCTs should be on developing new pathways, not new facilities, which are just a means to an end; that alternative models exists that do not require mass centralisation of family doctor services such as hub-and-spoke and federated models; and that strong clinical and managerial leadership supported by clear governance structures and workforce planners will be necessary.

POWER OF ATTORNEY

Legal document allowing someone else to manage another person's affairs, or specific elements of their affairs, on their behalf. If the individual has a physical illness or an accident resulting in physical injury and they want someone else to look after their affairs, they should create an ordinary power of attorney. However, an ordinary power of attorney should not be used if the individual has been

diagnosed as having, or likely to develop, any mental illness or degenerative disease that can lead to mental incapacity; this is because an ordinary power of attorney automatically comes to an end if you lose your mental capacity.

Related: *Advance Care Plans ; Lasting Power of Attorney (LPA)*

PRACTICE-BASED COMMISSIONING (PBC)

All English GP practices are now responsible for commissioning at least the care covered by the tariff for their practice's population. They are given indicative budgets, based on historical referral and utilization data. Analysis of these data, together with an understanding of the national tariff allows practices to consider alternative ways of providing the services their patients need, including by providing more services in their practice. PbC is structured differently in different places. There may be individual practices, GP practice clusters who commission together, or there may be just one GP cluster to cover the whole area. There is usually a local GP lead for each PBC cluster.

As a provider, it is important to understand how PbC works locally and what the priorities are. For example, a practice-based commissioner might look at the number of respiratory outpatient follow-up appointments and decide it could provide a follow-up service in the practice. It has to submit a PbC business case to the PCT for approval if it wishes to make such a change. The PCT, often via its Professional Executive Committee (PEC), must make a decision within 8 weeks and if it addresses a national or local priority the PCT should approve it. The PCT will include the planned change in the agreements it makes with local acute providers. GPs are incentivised to engage actively in PbC by a promise that 70% of the savings released through the alternative provision can be used by the practice to address national or local priorities.

The findings of a review by The Audit Commission *Putting Commissioning into Practice* (November 2007) found a mixed picture of development. This remains the case. Leading up to the General Election there is political debate about the future importance of this model. One suggestion is Clinical Commissioning by primary and secondary care.

PRACTITIONER WITH SPECIAL INTERESTS (PWSI)

The term covering all primary care professionals working with an extended range of practice. A PwSI in respiratory medicine might be a nurse or physiotherapist running a community respiratory service. See GPwSI.

PREDICTIVE RISK

In order to reduce hospital admissions there needs to be a way of identifying patients with long term conditions before their condition has worsened and whose admissions and readmissions are therefore potentially avoidable. The Kings Fund together with New York University and Health Dialog has developed a number of tools for the NHS: **Patients At Risk of Re-hospitalisation (PARR++)** Case Finding Tool and the **Combined Predictive Model**.
http://www.kingsfund.org.uk/research/projects/predicting_and_reducing_readmission_to_hospital/#resources

PREFERRED PRIORITIES FOR CARE

http://www.endoflifecareforadults.nhs.uk/eolc/CS310.htm is an example of an advance care plan. It is a document that individuals hold themselves and take with them if they receive care in different places. It has space for the individual's thoughts about their care and the choices they would like to make, including saying where, if possible, they would want to be when they die. Information about choices and who might be involved in their care can also be recorded so any care staff can read about what matters to the individual, thereby ensuring continuity of care.

For further information and guidance go to :
http://www.endoflifecareforadults.nhs.uk/eolc/files/F2111-PPC_Staff_Guidance_Dec2007.pdf

An example form:
http://www.endoflifecareforadults.nhs.uk/eolc/files/F2110-Preferred_Priorities_for_Care_V2_Dec2007.pdf

PRIMARY CARE

The collective term for all services which are people's first point of contact with the NHS.

PRIMARY CARE TRUST-LED MEDICAL SERVICES (PCTMS)

One of the main types of contract where general medical services are provided by PCO-employed health care professionals.

Related: *APMS, GMS, PMS,* and *SPMS*.

PRIMARY CARE TRUSTS (PCTs)

Freestanding statutory NHS bodies in England with responsibility for commissioning healthcare and health improvements for their local areas.

PRIOR APPROVAL (PA)

A process to help commissioners ensure that patients receive appropriate care and secure value for money. Prior approval from the PCT/practice is required before the proposed treatment can be provided. It requires clinicians in secondary care to confirm the appropriateness of a treatment with the referring GP (now including consultant-to-consultant referrals).

PROCUREMENT

This is the phase of the commissioning cycle after the service specification when the commissioner decides how to procure the service by competitive process, or through changing an existing service level agreement. Increasingly, Primary Care Trusts will be expected to consider a competitive process, if the investment reaches levels that meet the European Union threshold for an open competitive process. A DH England Guide to procurement May 2008 is due to be revised. Two useful guides to procurement, using case studies of COPD services are available from IMPRESS:
http://www.impressresp.com/Commissioning/Procurement/tabid/86/Default.aspx
In social care terms, procurement is the process of acquiring goods and services from third parties. Various policy drivers encourage local authorities to review procurement services and modernise procurement practices to achieve greater efficiencies. These include:

- Best value
- Implementing Electronic Government (IEG)

- The Office of Government Commerce Gateway programme
- The annual efficiency statement for each local authority, as outlined in the Spending Review 2004, which identified scope for significant efficiencies in the procurement workstream.

PROCUREMENT, INVESTMENT AND COMMERCIAL AND DIVISION (PICD)

Procurement, Investment and Commercial and Division (PICD) of the Department of Health England June 2009 – to strengthen commercial and procurement support for the DH and the system.

Related: *Commercial Operating Model; Commercial Support Units (CDUs)*

PROFESSIONAL EXECUTIVE COMMITTEE (PEC)

These clinical committees of PCTs have, amongst other duties, responsibility for setting practice indicative budgets and to approve proposals for the use of efficiency savings by practices. In some areas PECs are well organized and motivated to take on this role, in other areas PEC membership is under review due to PCT mergers and changes.

PROGRAMME BUDGETING

Programme Budgeting is a well-established technique for assessing investment in programmes of care (e.g. respiratory care) rather than services. All PCTs in England have submitted an annual programme budgeting return since 2003/4. So, for example, the latest figures available show that Estimated England level gross expenditure by respiratory Programme Budget for 2007/08 was £3.85bn out of a total spend of £93.18bn; that is 4%. This compares to problems of circulation of £7.31bn, or 7.8%. Programme budgets can compare relative growth of each programme, year on year. So, for example, nationally (England), respiratory programme budgets grew by 8.86% between 2006/07 and 2007/08 compared to problems of circulation where the comparative figure is 5.97%.

For tools from the Department of Health in England see:
http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743.
These offer atlases that link health outcomes, QOF data and HES activity to programme budgets. A useful tool is the PCT Spend and Outcome Factsheet and Tool (SPOT):
http://www.yhpho.org.uk/resource/view.aspx?RID=49488)

NHS Comparators is another useful tool. See also:
http://www.impressresp.com/Commissioning/NeedsAssessment.aspx

PROMs

See **Patient-reported outcome measures**.

PROPORTIONALITY

One of four principles of procurement which means making procurement processes proportionate to the value, complexity and risk of the services contracted, and critically not excluding potential providers through overly bureaucratic or burdensome procedures.

PROSPECTUS

See **Commissioning intentions**.

PROVIDER

A generic term for an organisation that delivers a healthcare or care service.

PUBLIC AND PATIENT ENGAGEMENT (PPE)

The process of engaging patients and the public at an individual and collective level throughout the commissioning cycle in order to create localised, personalised and effective services. The process moves from information, to feedback, to influence and can be done at each stage of the cycle: needs assessment, decisions about priorities and strategies, service improvement, procurement and contracting and monitoring and performance management. For a guide to PPE from the NHS a powerpoint presentation is available to download from:
http://www.impressresp.com/Portals/0/IMPRESS/Engagement%20cycle.ppt

Related: *Engagement*

PUBLIC SERVICE AGREEMENT (PSA)

This sets out the Government Departments in England's 3 year targets agreed with the Cabinet Office underpinned by a Delivery Agreement. The DH is required to promote better health and well-being for all (PSA delivery agreement 18) and includes reducing mortality rates and smoking prevalence; increasing the proportion of people supported to live independently and increasing access to psychological therapies.

QIPP (ALSO KNOWN AS QUALITY AND PRODUCTIVITY CHALLENGE)

Quality, innovation, productivity and prevention – announced in June 2009 by the Chief Executive of the NHS. This is the next phase of the Darzi Review and is led by the Chief Executive, supported by a new NHS National Director for Improvement and Efficiency (Jim Easton). The challenge, in times of economic downturn, is to improve quality whilst improving productivity (more and different for less). The respiratory community will need to rise to the challenge of finding reliable and sustainable ways to do this. System-wide networks and shared analysis of the data will be a good place to start. There is a new library of evidence:
http://www.library.nhs.uk/qualityandproductivity/
and the NHS Institute has resources such as the Productive Series:
http://www.institute.nhs.uk/cost_and_quality/qipp/cost_and_quality_homepage.html
Examples of good respiratory practice can be found on the IMPRESS website at:
http://www.impressresp.com/GoodPracticeExamples.aspx
and from the Lung Improvement Programme:
http://www.improvement.nhs.uk/lung/

QUALITY

Central to High Quality Care For All is improving quality which it defines in three dimensions: ensuring that care is safe, effective, and provides patients with the most positive experience possible. The principles of how this will be achieved are also listed:

Co-production – implementation should be discussed and decided in partnership with the NHS, Local Authorities and key stakeholders;

Subsidiarity – where necessary, the centre will play an enabling

role, but wherever possible, the details of implementation will be determined locally;

Clinical ownership and leadership – all staff must continue to be active participants and leaders as the work progresses;

System alignment – in doing this work people should ensure that the whole system is aligned around the same vision, allowing them to use their combined leverage at every level to drive up quality.

The National Quality Board is leading on the quality agenda, which is described by a framework pyramid model: at the base are local clinical initiatives to improve services; then provider services will publish quality accounts; then there is the regional activity, to enable benchmarking, using services from the Quality Observatory; and finally, at the top of the pyramid are national priorities and reporting, overseen by the National Quality Board.

Related: *CQUIN Commissioning for higher quality and innovation; National Quality Board; QIPP; Quality Accounts ; Quality and outcomes framework (QOF); Quality Metrics/Indicators; Quality Standards*

QUALITY ACCOUNTS

The Health Act 2009 requires acute, mental health, learning disability and ambulance services to make publicly available from April 2010 a Quality Account just as they publish annual financial accounts. As of February 2010, what will be included, timings and how they will be scrutinised remain a matter for debate but consultation has ended. The duty to publish quality accounts will apply to primary care and community services in 2011. The framework and toolkit was published in February 2010 and is available at www.dh.gov.uk/qualityaccounts

Related: *Operating Framework; Quality; Quality Metrics/Indicators*

QUALITY AND OUTCOMES FRAMEWORK (QOF)

This is part of the GP contract aimed to incentivise practices to provide systematic care for people with long term conditions. Participation is voluntary but most practices participate because it carries significant funds with it for achievement of QOF targets. It has also raised the standard of record-keeping in many places and enabled the development of disease registers for COPD and asthma. However these registers are only as good as the accuracy of the diagnosis. PCOs analyse QMAS (see below) data to determine the level of achievement against the indicators. Practices score points up to a maximum of 1050 points.

From 2009 QOF indicators are developed by NICE.
Particularly relevant to respiratory care are clinical indicators for COPD and asthma and points for annual recording of smoking status. ***Appendix 2*** to this glossary describes these clinical indicators and is worth reading.

The PCRS-UK and BTS contribute to the development of new QOF standards in asthma and COPD.

Related: *National Quality Board; Quality*

QUALITY MANAGEMENT AND ANALYSIS SYSTEM (QMAS)

This is the IT system used to give PCTs/Health Boards and GPs in England and Scotland feedback on practice performance against the QOF (see above) in the GMS contract. It is used to calculate what GPs will be paid under the GMS contract. In Wales MSDs Contract Manager is used, and in Northern Ireland the Payments Calculation and Analysis System (PCAS) is used.

INDICATORS FOR QUALITY IMPROVEMENT (IQI) http://www.ic.nhs.uk/services/measuring-for-quality-improvement

High Quality Care for All, the final report of the NHS Next Stage Review, defined quality in the NHS as safe and effective care of which the patient's whole experience is positive. The NHS Information Centre and the Department of Health have identified an initial, but evolving, set of over 200 indicators to describe the quality of a broad range of services. The long-term vision is to produce an extensive menu of indicators. Some will be used at national level; others will be included as part of local contract negotiations. See also https://mqi.ic.nhs.uk/

QUALITY OBSERVATORY

Part of the English quality agenda, there will be 1 quality observatory per Strategic Health Authority that will be a centre of expertise and play a key role in driving up quality across the region through support and indicator development and assistance with quality accounts. They directly link in with the IQI Measuring for Quality Improvement programme.

Related: *National Quality Board; QIPP; Quality; Quality Accounts; Quality and outcomes framework (QOF); Quality Metrics/Indicators; Quality Standards; Strategic Health Authority (SHA)*

QUALITY STANDARDS

Part of the NHS quality agenda. A NICE quality standard (qualitative statements with quantitative measures) is a set of specific, concise statements that:

- act as markers of high-quality, cost-effective patient care across a pathway or clinical area;
- are derived from the best available evidence; and
- are produced collaboratively with the NHS and social care, along with their partners and service users.

NICE will be producing about 20 per year. Four pilots will be complete by March 2010: stroke care, specialist neonatal care, VTE prevention and dementia. Where possible NICE clinical guidelines will be used as the basis for these pilots.

RAS - RESOURCE ALLOCATION SYSTEM (SOCIAL CARE)

The Resource Allocation System (RAS) is designed to be a fair funding system and to allocate money from adult social services. The RAS works against a set of strict guidelines to ensure it remains fair. It relies on a scoring system based on answers given to a series of questions and then places people within a series of funding bands.

REFERENCE COSTS

These are used in calculating the tariff. They are average costs for

providing a defined service in a given financial year. They cover a broad range of NHS treatments and clinical procedures and have been collected since 1998. Their main purpose is to provide a basis for comparison within (and outside) the NHS between organisations, and down to the level of individual treatments. The 2008/09 costs show how £48 billion was spent. Each Trust has a Reference Cost Index – the lower the score, the higher their relative efficiency. For example, a score of 92 means costs are 8% below the average, a score of 125 means that the costs were 25% higher than the national average. The RCI is adjusted for the same market forces factor as the tariff. See here:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111591

REFERRAL MANAGEMENT CENTRES

See **Clinical Assessment Services** and also BMA guidance at:
http://www.bma.org.uk/

Related: *Clinical Assessment Service (CAS) and Clinical Assessment and Treatment Service (CATS)*

REGIONAL IMPROVEMENT AND EFFICIENCY PARTNERSHIPS (RIEPS – SOCIAL CARE)

RIEPs play a key role in supporting councils. The nine RIEPs were created in April 2008 with a three-year funding package of £185 million from Communities and Local Government. The RIEPs harness the expertise of councils to add new capacity to local government in order to accelerate the drive for greater improvement and efficiency. They build on the successful foundations laid by the former Regional Improvement Partnerships and Regional Centres of Excellence.

Put simply, they help councils deliver the ambitious outcomes, set through local area agreements (LAAs), by supporting them in their efforts to become more efficient, innovative and engaged with citizens.

The report *Leading the Way by Working Together* demonstrates that local government has taken responsibility for its own improvement by working together at a local, regional and national level. It celebrates the achievements of the sector, illustrated with a series of recent case studies and is published July 2009.

Related: *Local Area Agreement (LAA)*

RIGHT TO REQUEST

This is a commitment in the *Next Stage Review* of the NHS, published in June 2008. It enables NHS staff, specifically nurses and allied health professionals, who may be interested in establishing a social enterprise to put their proposals to their PCT board, and if approved, have their proposal supported. For a series of 'webinars' see the following website:
http://www.entreprenurses.net/righttorequest/

RISK STRATIFICATION

See **Predictive Risk**

Related: *Combined predictive risk model; Patients At Risk of Rehospitalisation (PARR)*

RSL REGISTERED SOCIAL LANDLORD (HOUSING)

Registered Social Landlords are government-funded not-for-profit organisations that provide affordable housing. They include housing associations, trusts and cooperatives. They work with local authorities to provide homes for people meeting the affordable homes criteria. As well as developing land and building homes, RSLs undertake a landlord function by maintaining properties and collecting rent.

SECONDARY CARE

The collective term for services to which a person is referred after the first point of contact. Usually this refers to hospitals in the NHS offering specialised medical services and care (outpatient and inpatient services).

SELF CARE

Individuals taking responsibility for their own health and wellbeing and to care for themselves. This includes taking exercise, eating well, taking action to prevent illness and accidents, the better use of medicines, treatment of minor ailments, and better care of long term conditions.

SELF-DIRECTED SUPPORT (SOCIAL CARE)

Self-directed support is the term used for when people choose their services, organise their care and arrange for payments to be made. This is because the individual who requires the service is directing their own care and has choice when it comes to their support.

SERVICE LEVEL AGREEMENT (SLA)

The agreement between the commissioner and provider is in two parts. The SLA, or contract, and the service specification (see below). The SLA is a formal written agreement and is a standard document written by the Department of Health.

SERVICE LINE MANAGEMENT AND REPORTING

Trusts are moving to service line management as a way of engaging clinicians more in the management of services. It identifies specialist clinical areas and manages them as distinct operational units, supported by service line reporting on financial and quality performance to support decision-making. Monitor has produced a toolkit for trusts to use available at:
www.monitor–nhsft.gov.uk/sites/default/files/publications/Toolkit_for_presenting_SLR_data_Final.pdf

SERVICE SPECIFICATION

This is part of the SLA and specifies in detail how and what services will be provided, including the quality standards that the service should maintain. It is useful to read the service specification because it also explains how the services will be monitored. IMPRESS has produced a generic service specification with an example for COPD:
http://www.impressresp.com/Portals/0/IMPRESS/BPG%20Final.pdf

SOCIAL ENTERPRISE

Businesses with primarily social objectives. Their surpluses are reinvested principally in the business or the community rather than distributed to shareholders. A number of provider services from PCTs are exploring the social enterprise model as a way of setting themselves up apart from the PCT, supported by the Department of Health. The Big Issue, the Eden Project, and John Lewis Partners are good examples, but there are increasing numbers of health

examples. For the Chartered Society of Physiotherapy briefing see: http://www.csp.org.uk/director/members/newsandanalysis/briefings/socialenterprises.cfm
For the NHS briefing see:
http://old.networks.nhs.uk/news.php?180

SPECIALIST PROVIDER OF MEDICAL SERVICES (SPMS) CONTRACT

This is a sub-type of one of the main types of contract, PMS, that PCOs can have with primary care providers. This type of contract is where patients do not have to be registered with the provider to receive care. The agreement sets out which services are to be provided – it does not require the full range of essential services. For example, it might be an appropriate contract for providing primary care for homeless people, travellers or refugees. It is being tested now as a vehicle for providing integrated primary and secondary care services where colleagues work together across an integrated care pathway, retaining their existing employment. For example, there is a musculoskeletal service in Oldham, and could be used for an integrated respiratory service.

Related: *Alternative Provider of Medical Services (APMS) contract; General Medical Services (GMS); Primary Care Trust – led Medical Services (PCTMS)*

SPELL

The continuous period from a patient's admission to discharge from a hospital, even if they are under the care of several consultants during that time hence different from the previously used Finished Consultant Episode (FCE). So, if a patient with acute coronary syndrome and COPD is admitted through the emergency department with breathlessness, and is under a cardiologist but then transferred to a respiratory physician, that might count as two FCEs but just one spell.

STRATEGIC HEALTH AUTHORITY (SHA)

The local headquarters of the NHS in England, responsible for ensuring that national priorities are integrated into local plans and for ensuring that Primary Care Trusts (PCTs) are performing well. SHAs are the link between the Department of Health and the NHS.

STRATEGIC MARKET DEVELOPMENT UNIT (SMDU)

Part of the Commercial Operating Model, SMDUs are due to take responsibility for leadership and support to commissioners in market analysis and market-making.

Related: *Commercial Operating Model; Commercial Support Units (CDUs); Procurement, Investment and Commercial and Division (PICD)*

STRATEGIC PLAN

The World Class Commissioning assurance system requires every PCT to have a strategic plan (October 2008 was the first year of operation). The governance of the PCT will be assessed against this plan. It is the core PCT plan for commissioning over a five-year period. Therefore it is an important document and you should find it available from your PCT's website or by asking for a copy. According to the assurance system it must tell the story about how the PCT will move over a five-year period from assessing the needs of its population to delivering services that will drive improvements in health outcomes. These outcomes will be locally chosen to reflect local priorities and have been agreed with the local population and partners such as healthcare providers and local authority. It will reflect the PCTs commissioning intentions and be informed by the clinical visions that are developed as part of the *Next Stage Review* and the Local Area Agreement with local authorities. As it will be affected by changes in health needs, priorities and resources, it is expected to be refreshed every year and rewritten every three years. It will be accompanied by 3 more detailed plans:

1. A five-year financial plan
2. An organisational development plan
3. An annual operating plan

SUBSIDIARITY

Described in the 2009/10 Operating Plan for NHS in England as one of the guiding principles of the NHS. It means "ensuring that decisions are taken at the right level of the system, which means as close to the patient as possible. It means an enabling role for the NHS centrally, with more power and responsibility residing with patients and clinicians. And it means looking 'out, not up' wherever possible, rather than patrolling the boundaries of their own organisations."

SUPPORT BROKERS (SOCIAL CARE)

Support brokers provide help to people looking for care services. They are at the behest of the service user and provide the technical assistance to put the support package in place. Often they will be work independently from the local authority and will mediate between their client and the authority. Support brokers can be anybody from close friends and family to members of a local charity or voluntary organisation or a social worker.

SUPPORTED SELF CARE/SELF MANAGEMENT

You will find the terms self care and self management used interchangeably in many documents. However, the term self management or supported self care also recognises the role of health and social care providers. The implication of "management" is that the individual needs others to deliver some of their care, but they are in charge of the process. Supporting people to self care is a major part of *Your Health, Your Way*:
http://www.nhs.uk/yourhealth/Pages/Homepage.aspx

The development of direct payments and individual budgets for social care can be seen as important developments in the area of self management and is now being extended to health care.

See also:
http://www.impressresp.com/ServiceDelivery/Supportingselfmanagement/tabid/106/Default.aspx

SECONDARY USES SERVICE (SUS)

The primary use of data in the NHS is to support patient care. Its use for planning and commissioning is a secondary use, hence the name. SUS is the single data warehouse and analysis centre created by the NHS Information Centre pooling Hospital Episode Statistics (HES), and other data collected by providers of NHS care to meet the dataset requirements of NHS commissioners.

Every secondary care provider in England has to send a set of standard data files (Commissioning Data Sets) to the SUS system. These files contain details of all the care they have provided,

including that covered by PbR. SUS data is then used to provide a range of services including NHS Comparators. The Operating Framework for 2008/09 stated that SUS should be the standard repository for performance monitoring, reconciliation and payments by April 2009. For further information go to the Information Centre: http://www.ic.nhs.uk/nhscomparators

TARIFF

This is the amount that a commissioner will pay for a particular package of care including out-patient appointments, spells and procedures. Commissioners now only pay for work that has been done, according to the nationally set tariff with minor local differences when a market forces factor is applied. The tariff is based on a reference cost created from a large retrospective analysis of average costs incurred by NHS hospital providers, plus an annual increase for inflation. See the DH website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081096

The tariff is defined using an HRG; a currency –a spell rather than an FCE; and a cash amount. The tariff has a different rate for children and adults, emergency and elective care, and first outpatient and follow-up outpatient appointment. The tariff for admissions has trimpoints; that is the length of stay up to which the tariff will be paid, and over which an excess bed day charge can be claimed but at a much lower rate. It does not yet cover community interventions. There is also work underway to "unbundle" care such as stroke rehabilitation from acute care so that it is easier to compare costs of elements that might be provided in the community.

29 August 2009: two papers in the BMJ describe the impact of the tariff: Has payment by results affected the way that English hospitals provide care (compared to Scottish hospitals studied at the same time)? *doi:10.1136/bmj.b3047* and editorial *doi:10.1136/bmj.b3081* The main paper concludes that there has been a reduced length of stay/increased throughput and no increased risk to patients. However, there are limitations of the study. Although the authors do look at readmissions, this is limited to patients discharged following orthopoedic procedures and it would have been interesting to see whether medical readmission rates went up (by choosing a high volume casemix e.g. COPD). They did look at 30 day mortality which is better than inpatient mortality although neither are particularly good at indicating whether Payment by Results has been beneficial for patients. As such studies are very difficult to do, this has acted as a baseline and further studies might be able to reduce some of the limitations identified.

In 2010/11 best practice pathway tariffs will be introduced: cataracts,

A Summary of COPD Tariffs

HRG code	HRG name	Combined Daycase / Elective tariff (£)	Elective long stay trimpoint (days)	Non-elective spell tariff (£)	Non-elective long stay trimpoint (days)	Per day long stay payment (for days exceeding trimpoint) (£)	Eligible for Specialist Top-up
DZ21A	Chronic Obstructive Pulmonary Disease or Bronchitis with length of stay 1 day or less discharged home	475	1	475	1	0	Yes
DZ21B	Chronic Obstructive Pulmonary Disease or Bronchitis with Intubation with Major CC	3,718	48	3,718	48	158	Yes
DZ21C	Chronic Obstructive Pulmonary Disease or Bronchitis with Intubation with CC	2,621	25	2,621	25	184	Yes
DZ21E	Chronic Obstructive Pulmonary Disease or Bronchitis with NIV without Intubation with Major CC	3,684	40	3,684	40	210	Yes
DZ21F	Chronic Obstructive Pulmonary Disease or Bronchitis with NIV without Intubation with CC	2,678	25	2,678	25	195	Yes
DZ21G	Chronic Obstructive Pulmonary Disease or Bronchitis with NIV without Intubation without CC	2,168	19	2,168	19	147	Yes
DZ21H	Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with Major CC	3,819	39	3,819	39	185	Yes
DZ21J	Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with CC	2,475	21	2,475	21	184	Yes
DZ21K	Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation without CC	1,849	13	1,849	13	180	Yes

cholecystectomy, fragility hip fracture and the medical condition chosen is stroke. This has been road-tested. Guidance for 2009/10 is now available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110106

THIRD SECTOR

The full range of not-for-profit organisations that are non-governmental and 'value driven'; that is, motivated by the desire to further social, environmental or cultural objectives rather than to make a profit.

TRIMPOINTS

These are the length of stay up to which an individual tariff applies. They are **spell** not FCE-based and, like the tariff itself, are calculated from a large retrospective analysis of average length of stays for particular HRGs. There are separate trimpoints for elective and non-elective activity and some non-elective activity is divided into subgroups according to complexity but this is not very sophisticated at present.

Trimpoints can provide a perverse incentive for PCTs to reduce the efforts they have previously been making to reduce lengths of stay because they pay the same tariff if a person with COPD without complications stays in hospital 3 days or 16 days. However, from an acute provider's perspective, their costs relative to the price paid increase each day the patient stays unnecessarily.

TUPE

Transfer of Undertakings (Protection of Employment) Regulations (2006). Designed to protect the rights of employees in a transfer situation (when a new employer takes over). See the IMPRESS case study 2 on tendering COPD services for an example of the implications of TUPE. Further information in this complex area: Chartered Institute of Professional Development (CIPD) website:
http://www.cipd.co.uk/subjects/emplaw/tupe/tupe.htm
and The Statutory Instrument:
http://www.opsi.gov.uk/si/si2006/20060246.htm

VARIATION

An increasing focus for many commissioners. Two broad definitions of variation are usually considered: avoidable or unwarranted variation caused by healthcare professionals' decisions and actions and warranted variation due to differences between patients that need to be considered by professionals when offering personalised care. There is much work in the NHS looking at both sides – how to reduce variation applying reliability science as well as how to empower patients to achieve shared decisions with their healthcare professionals. See the Institute of Healthcare Improvement website:
http://www.ihi.org/ihi

VIRTUAL WARDS

These were initiated by NHS Croydon as part of their approach to reducing admissions using the **Combined Predictive Risk Model** to identify people at risk of admission and to provide a team approach to managing their care in the community. See the Croydon Virtual Wards case study document at:
http://old.networks.nhs.uk/uploads/06/12/croydon_virtual_wards_case_study.pdf

VITAL SIGNS

This is the new performance management framework for PCTs described in the 2009/10 Operating Plan for NHS in England.

Tier one or "must do" indicators apply to all PCTs and provide national standards and performance measurement. The most important tier one targets are for access to primary care and capacity. Each PCT must produce a plan to be signed off by the SHA.

Tier two national priority must do's for local delivery but with more flexibility about how it is done locally. Each PCT must produce a plan to be signed off by the SHA.

Tier three is a range of indicators which PCTs can use in consultation with partners and local communities to set targets for improvement. Performance management is left to the PCT.

See IMPRESS online **Operating Framework guides**.

VOLUNTARY AND COMMUNITY SECTOR

An umbrella term referring to registered charities as well as non-charitable non-profit organisations, associations, self-help groups and community groups, for public or community benefit.

WANLESS REPORT

Entitled *Securing Good Health for the Whole Population* this report for the Treasury forecast that the only way health service provision will be affordable in the UK in the future is if the "fully engaged" scenario is achieved, where people take a greater responsibility for their health, and services transform themselves through efficient use of resources and a high rate of uptake of technology.

WELFARE TO WORK

In England the white paper *Raising Expectations and Increasing Support: Reforming Welfare for the Future*
http://www.dwp.gov.uk/welfarereform/raisingexpectations/
and the Welfare Reform Act 2009.

In these is provision for giving disabled people the right to control provision of services to them, in some cases through having the money to procure services themselves. The Green Paper was called *No-one Written Off*, and remains the title used by some to describe the reforms.
http://www.dwp.gov.uk/welfarereform/noonewrittenoff/

WORKING IN PARTNERSHIP PROGRAMME (WIPP)
http://www.wipp.nhs.uk/

This is a very useful resource aimed at general practice to improve capacity and includes information and toolkits on HCAs, general practice nurses (GPN), self-care, workload analysis, practice management, sickness absence, repeat medication, and database of good practice. The project closed in August 2008 but the site is still currently available.

WORLD CLASS COMMISSIONING
http://wcc.networks.nhs.uk/

This is the Department of Health's programme to transform commissioning. Eleven world class commissioning competencies are described that PCTs will be expected to develop and perform:

1. Locally lead the NHS
2. Work with community partners
3. Engage with public and patients
4. Collaborate with clinicians
5. Manage knowledge and assess needs
6. Prioritise investment
7. Stimulate the market
8. Promote improvement and innovation
9. Secure procurement skills
10. Manage the local health system
11. Make sound financial investments

YOUR HEALTH YOUR WAY

Previously known as the *Patients' Prospectus*. Launched in England by the DH in November 2008, it aims to inform the public about how their local NHS will discuss with them the choices that are available to help them self-care as part of the supporting people with long term conditions programme.

Five areas of self care have been identified as being key to achieving these aims:

1. Information prescriptions: not tested in COPD yet, but written asthma action plans have well-documented effectiveness.
2. Skills and knowledge training e.g. **EPP** or condition specific: Pulmonary rehabilitation is an effective intervention and needs to be made available to all those for whom it would be impactful. Also Expert Patient programmes for asthma. COPD self-management plans have a cautious endorsement from the most recent Cochrane review.
3. Tools and monitoring devices including assistive technology.
4. Healthy lifestyle eg smoking cessation: The most important risk factor for COPD is smoking, followed by other aspects of social deprivation, diet and occupational exposure to dust, indoor pollution such as smoke from wood and coal fires, and, in a small number of cases, inherited faulty genes. So, prioritise smoking cessation and dietetic advice for those with low and high BMIs. Smoking stops certain asthma medications working and smoke can trigger asthma symptoms so smoking cessation programmes are a priority. These should include strategies to reduce maternal smoking
5. Support networks eg Breathe Easy Groups and Asthma UK helpline.

Guidance for the social care workforce is being taken forward through the adult social care workforce strategy. DH will monitor uptake of care planning routinely through the quarterly GP Patient Survey.

APPENDIX 1 – HRG Version 4 2009/2010

Specialty	Code	Label
Cardiac	DZ01Z	Lung Transplant
Cardiac	DZ02A	Complex Thoracic Procedures with Major CC
Cardiac	DZ02B	Complex Thoracic Procedures with CC
Cardiac	DZ02C	Complex Thoracic Procedures without CC
Cardiac	DZ03A	Major Thoracic Procedures with CC
Cardiac	DZ03B	Major Thoracic Procedures without CC
Cardiac	DZ04A	Intermediate Thoracic Procedures with CC
Cardiac	DZ04B	Intermediate Thoracic Procedures without CC
Cardiac	DZ05Z	Other Thoracic Procedures
Cardiac	DZ06Z	Minor Thoracic Procedures
Cardiac	DZ07Z	Fibreoptic Bronchoscopy
Cardiac	DZ08Z	Rigid Bronchoscopy
Respiratory	DZ09A	Pulmonary Embolus with Major CC
Respiratory	DZ09B	Pulmonary Embolus with CC
Respiratory	DZ09C	Pulmonary Embolus without CC
Respiratory	DZ10A	Lung Abscess-Empyema with Major CC
Respiratory	DZ10B	Lung Abscess-Empyema with CC
Respiratory	DZ10C	Lung Abscess-Empyema without CC
Respiratory	DZ11A	Lobar, Atypical or Viral Pneumonia with
Respiratory	DZ11B	Lobar, Atypical or Viral Pneumonia with CC
Respiratory	DZ11C	Lobar, Atypical or Viral Pneumonia without CC
Respiratory	DZ12A	Bronchiectasis with CC
Respiratory	DZ12B	Bronchiectasis without CC
Respiratory	DZ13A	Cystic Fibrosis with CC
Respiratory	DZ13B	Cystic Fibrosis without CC
Respiratory	DZ14A	Pulmonary, Pleural or Other Tuberculosis with CC
Respiratory	DZ14B	Pulmonary, Pleural or Other Tuberculosis without CC
Respiratory	DZ15A	Asthma with Major CC with Intubation
Respiratory	DZ15B	Asthma with CC with Intubation
Respiratory	DZ15C	Asthma without CC with Intubation
Respiratory	DZ15D	Asthma with Major CC without Intubation
Respiratory	DZ15E	Asthma with CC without Intubation
Respiratory	DZ15F	Asthma without CC without Intubation
Respiratory	DZ16A	Pleural Effusion with Major CC
Respiratory	DZ16B	Pleural Effusion with CC
Respiratory	DZ16C	Pleural Effusion without CC
Respiratory	DZ17A	Respiratory Neoplasms with Major CC
Respiratory	DZ17B	Respiratory Neoplasms with CC
Respiratory	DZ17C	Respiratory Neoplasms without CC
Respiratory	DZ18Z	Sleeping Disorders Affecting Breathing
Respiratory	DZ19A	Other Respiratory Diagnoses with Major CC
Respiratory	DZ19B	Other Respiratory Diagnoses with CC
Respiratory	DZ19C	Other Respiratory Diagnoses without CC
Respiratory	DZ20Z	Pulmonary Oedema
Respiratory	DZ21A	Chronic Obstructive Pulmonary Disease or Bronchitis with length of stay 1 day or less discharged home
Respiratory	DZ21B	Chronic Obstructive Pulmonary Disease or Bronchitis with Intubation with Major CC

Specialty	Code	Label
Respiratory	DZ21C	Chronic Obstructive Pulmonary Disease or Bronchitis with Intubation with CC
Respiratory	DZ21D	Chronic Obstructive Pulmonary Disease or Bronchitis with Intubation without CC
Respiratory	DZ21E	Chronic Obstructive Pulmonary Disease or Bronchitis with NIV without Intubation with Major CC
Respiratory	DZ21F	Chronic Obstructive Pulmonary Disease or Bronchitis with NIV without Intubation with CC
Respiratory	DZ21G	Chronic Obstructive Pulmonary Disease or Bronchitis with NIV without Intubation without CC
Respiratory	DZ21H	Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with Major CC
Respiratory	DZ21J	Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with CC
Respiratory	DZ21K	Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation without CC
Respiratory	DZ22A	Unspecified Acute Lower Respiratory Infection with Major CC
Respiratory	DZ22B	Unspecified Acute Lower Respiratory Infection with CC
Respiratory	DZ22C	Unspecified Acute Lower Respiratory Infection without CC
Respiratory	DZ23A	Bronchopneumonia with Major CC
Respiratory	DZ23B	Bronchopneumonia with CC
Respiratory	DZ23C	Bronchopneumonia without CC
Respiratory	DZ24A	Inhalation Lung Injury or Foreign Body with Major CC
Respiratory	DZ24B	Inhalation Lung Injury or Foreign Body with CC
Respiratory	DZ24C	Inhalation Lung Injury or Foreign Body without CC
Respiratory	DZ25A	Fibrosis or Pneumoconiosis with CC
Respiratory	DZ25B	Fibrosis or Pneumoconiosis without CC
Respiratory	DZ26A	Pneumothorax with CC
Respiratory	DZ26B	Pneumothorax without CC
Respiratory	DZ27A	Respiratory Failure with Intubation with Major CC
Respiratory	DZ27B	Respiratory Failure with Intubation with CC
Respiratory	DZ27C	Respiratory Failure with Intubation without CC
Respiratory	DZ27D	Respiratory Failure without Intubation with Major CC
Respiratory	DZ27E	Respiratory Failure without Intubation with CC
Respiratory	DZ27F	Respiratory Failure without Intubation without CC
Respiratory	DZ28Z	Pleurisy
Respiratory	DZ29A	Granulomatous, Allergic Alveolitis or Autoimmune Lung Disease with CC
Respiratory	DZ29B	Granulomatous, Allergic Alveolitis or Autoimmune Lung Disease without CC
Respiratory	DZ30Z	Chest Physiotherapy
Respiratory	DZ31Z	Complex Lung Function Exercise Testing
Respiratory	DZ32Z	Simple Lung Function Exercise Testing
Respiratory	DZ33Z	Hyperbaric oxygen treatment
Respiratory	DZ34Z	Complex Bronchodilator Studies
Respiratory	DZ35Z	Simple Bronchodilator Studies
Respiratory	DZ36Z	Bronchial Reactivity Studies
Respiratory	DZ37Z	Non-invasive Ventilation (NIV) Support Assessment
Respiratory	DZ38Z	Oxygen Assessment and Monitoring
Respiratory	DZ39Z	Complex Gas Exchange Studies
Respiratory	DZ40Z	Simple Gas Exchange Studies
Respiratory	DZ41Z	Smoking Cessation Support
Respiratory	DZ42Z	TB Nurse Support
Respiratory	DZ43Z	Complex Airflow Studies
Respiratory	DZ44Z	Simple Airflow Studies
Respiratory	DZ45Z	Lung Volume Studies
Respiratory	DZ46Z	Respiratory Muscle Strength Studies
Respiratory	DZ48Z	Respiratory Drive Studies
Respiratory	DZ49Z	Respiratory Nurse education/support
Cardiac	EA01Z	Heart & Lung Transplant
Cardiac	EA02Z	Heart Transplant
Cardiac	EA03Z	Pace 1 – Single chamber or Implantable Diagnostic Device
Cardiac	EA04Z	Pace 1 – Single chamber or Implantable Diagnostic Device + other (cath; EP; Ablation; PCI)
Cardiac	EA05Z	Pace 2 Dual Chamber
Cardiac	EA06Z	Pace 2 – Dual Chamber + other (cath; EP; Ablation; PCI)
Cardiac	EA07Z	Pace 3 – Biventricular and all congenital pacemaker Procedures - resynchronisation therapy
Cardiac	EA08Z	Pace 3 – Biventricular and all congenital pacemaker Procedures - resynchronisation therapy and other (cath; EP; Ablation; PCI)
Cardiac	EA09Z	Congenital Interventions: Percutaneous transluminal ASD/VSD/PFO closure and valve insertion
Cardiac	EA10Z	Congenital Interventions: Balloon valve intermediate interventions and arterial duct closure
Cardiac	EA11Z	Congenital Interventions: Other including septostomy, embolisations, non-coronary stents and Energy Moderated Perforation
Cardiac	EA12Z	Implantation cardioverter - defibrillator only
Cardiac	EA13Z	Implantation of cardioverter - defibrillator with other Procedures
Cardiac	EA14Z	Coronary Artery Bypass Graft (First Time)
Cardiac	EA15Z	Coronary Artery Bypass Graft (First Time) with Cardiac Catheterisation
Cardiac	EA16Z	Coronary Artery Bypass Graft (First Time) with PCI, Pacing, EP or RFA +/- Catheterisation
Cardiac	EA17Z	Single Cardiac Valve Procedures
Cardiac	EA18Z	Single Cardiac Valve Procedures with Catheterisation
Cardiac	EA19Z	Single Valve Procedures with PCI, Pacing, EP or RFA +/- Catheterisation

Specialty	Code	Label
Cardiac	EA20Z	Other Complex Cardiac Surgery and Re-do's
Cardiac	EA21Z	Other Complex Cardiac Surgery with Catheterisation
Cardiac	EA22Z	Other Complex Cardiac Surgery with PCI, Pacing, EP or RFA +/- Catheterisation
Cardiac	EA23Z	Major Complex Congenital Surgery
Cardiac	EA24Z	Complex Congenital Surgery
Cardiac	EA25Z	Intermediate Congenital Surgery
Cardiac	EA26Z	Standard Congenital Surgery
Cardiac	EA27Z	Standard EP or Ablation
Cardiac	EA28Z	Standard EP or Ablation with Catheterisation or PCI
Cardiac	EA29Z	Complex Ablation (includes Atrial Fibrillation or VT)
Cardiac	EA30Z	Complex Ablation (includes Atrial Fibrillation or VT) with Catheterisation or PCI
Cardiac	EA31Z	Percutaneous Coronary Intervention (0-2 stents)
Cardiac	EA32Z	Percutaneous Coronary Intervention (0-2 stents) + cath
Cardiac	EA33Z	Percutaneous Coronary Intervention 3+ stents
Cardiac	EA34Z	Percutaneous Coronary Intervention 3+ stents + cath
Cardiac	EA35Z	Other Transluminal Percutaneous Interventions
Cardiac	EA36B	Cath 18 years and under
Cardiac	EA36Z	Cath 19 years and over
Cardiac	EA39Z	Pacemaker Procedure without Generator Implant (includes resiting and removal of cardiac pacemaker system)
Cardiac	EA40Z	Other Non-Complex Cardiac Surgery
Cardiac	EA41Z	Other Non-Complex Cardiac Surgery + cath
Cardiac	EA42Z	Other Non-Complex Cardiac Surgery + other (includes PCI; Pacing; EP; RFA +/- cath not ICD)
Cardiac	EA43Z	Implantation of Prosthetic Heart or Ventricular Assist Device
Cardiac	EA44Z	Minor Cardiac Procedures
Cardiac	EA45Z	Complex echocardiogram (include congenital, transoesophageal and fetal echocardiography)
Cardiac	EA46Z	Simple echocardiogram
Cardiac	EA47Z	ECG Monitoring and stress testing
Cardiac	EB01B	Non-Interventional acquired cardiac conditions 18 years and under
Cardiac	EB01Z	Non Interventional acquired cardiac conditions 19 years and over
Cardiac	EB02Z	Endocarditis
Cardiac	EB03H	Heart Failure or Shock with CC
Cardiac	EB03I	Heart Failure or Shock without CC
Cardiac	EB04H	Hypertension with CC
Cardiac	EB04I	Hypertension without CC
Cardiac	EB05Z	Cardiac Arrest
Cardiac	EB06Z	Cardiac Valve Disorders
Cardiac	EB07H	Arrhythmia or Conduction Disorders with CC
Cardiac	EB07I	Arrhythmia or Conduction Disorders without CC
Cardiac	EB08H	Syncope or Collapse with CC
Cardiac	EB08I	Syncope or Collapse without CC
Cardiac	EB09Z	Non-Interventional Congenital Cardiac Conditions
Cardiac	EB10Z	Actual or suspected myocardial infarction
Cardiac	EB11Z	Deep Vein Thrombosis
Respiratory	PA09A	Major Upper Respiratory Tract Disorders with CC
Respiratory	PA09B	Major Upper Respiratory Tract Disorders without CC
Respiratory	PA10A	Minor Upper Respiratory Tract Disorders with CC
Respiratory	PA10B	Minor Upper Respiratory Tract Disorders without CC
Respiratory	PA11Z	Acute Upper Respiratory Tract Infection and Common Cold
Respiratory	PA12Z	Asthma or Wheezing
Respiratory	PA13A	Cystic Fibrosis with CC
Respiratory	PA13B	Cystic Fibrosis without CC
Respiratory	PA14A	Lower Respiratory Tract Disorders without Acute Bronchiolitis with CC
Respiratory	PA14B	Lower Respiratory Tract Disorders without Acute Bronchiolitis without CC
Respiratory	PA15A	Acute Bronchiolitis with CC
Respiratory	PA15B	Acute Bronchiolitis without CC
Respiratory	PA16A	Major Infections with CC
Respiratory	PA16B	Major Infections without CC
Respiratory	PA17A	Intermediate Infections with CC
Respiratory	PA17B	Intermediate Infections without CC
Respiratory	PA18A	Minor Infections with CC
Respiratory	PA18B	Minor Infections without CC
Respiratory	PA19Z	Viral Infections
Respiratory	PA20Z	Pyrexia of Unknown Origin
Respiratory	PA21A	Infectious and Non-Infectious Gastroenteritis with CC
Respiratory	PA21B	Infectious and Non-Infectious Gastroenteritis without CC
Respiratory	PA22Z	Chest Pain
Respiratory	PA23A	Cardiac Conditions with CC
Respiratory	PA23B	Cardiac Conditions without CC
Respiratory	PA24Z	Arrhythmia or Conduction Disorders
Respiratory	PA33A	Intermediate Upper Respiratory Tract Disorders with CC
Respiratory	PA33B	Intermediate Upper Respiratory Tract Disorders without CC

APPENDIX 2 – GMS QUALITY AND OUTCOME FRAMEWORK INDICATORS 2009/10

For updates, if you are a BMA member, see www.bma.org.uk/ap.nsf/Content/Hubthenewgmscontract or see:
http://www.nhsemployers.org/Aboutus/Publications/Documents/QOF_Guidance_2009_final.pdf

From 2010, NICE is responsible for reviewing and amending QOF indicators.

Note that this is the 2009/10 version, which updates the original contract and therefore the numbers are not sequential and there are some missing to reflect changes and to ensure that any comparative studies are clear what is being compared.

Asthma

Indicator	Points	Payment Stages
Records		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months	4	
Initial Management		
ASTHMA 8. The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility	15	40-80%
Ongoing management		
ASTHMA 3. The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months	6	40-80%
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the previous 15 months	20	40-70%

Chronic Obstructive Pulmonary Disease

Indicator	Points	Payment Stages
Records		
COPD 1. The practice can produce a register of patients with COPD	3	
Initial diagnosis		
COPD 12. The percentage of all patients with COPD diagnosed after 1.4.08 in whom the diagnosis has been confirmed by post bronchodilator spirometry.	5	40-80%
Ongoing Management		
COPD 10. The percentage of patients with COPD with a record of FeV1 in the previous 15 months	7	40-70%
COPD 13. Replaces COPD 11 The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the previous 15 months	9	50-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	40-85%

Smoking

Indicator	Points	Payment Stages
Ongoing management		
Smoking 3. The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months.	30	40-90%
Smoking 4. The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months	30	40-90%

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