IMPRESS

Improving and Integrating Respiratory Services

May 2008 Edition

NHS Jargon Buster

Updated online at http://www.impressresp.com

The British Thoracic Society (BTS)+ has over 2,800 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. 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 GPIAG and patient organisations to raise the profile of the speciality and advocate for improvements in standards.

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

The General Practice Airways Group (GPIAG) is an independent charity representing 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 GPIAG see www.gpiag.org

+ The British Thoracic Society is a registered charity (Charity No: 285174) and a private company limited by guarantee (Reg. company no: 1645201). Address for correspondence: 17 Doughty Street. London WC1N 2PL. Tel: +44(0)207 831 8778. Fax: +44(0)207 831 8766. Email: bts@brit-thoracic.org.uk
*The General Practice Airways Group is a registered charity (Charity No: 1098117) and a company in the UK and limited by guarantee (Company No: 4298947) VAT Registration Number: 866 1543 09
Registered offices: 2 Wellington Place, Leeds, LS1 4AP
Address for correspondence: GPIAG, Smithy House, Waterbeck, Lockerbie, DG11 3EY
Tele: +44(0)1461 600639 Fax: + 44(0)1461 207819 Email: info@gpiag.org

IMPRESS NHS JARGON BUSTER

INTRODUCTION TO IMPRESS

Improving and Integrating Respiratory Services in the NHS

A joint initiative by the British Thoracic Society (BTS) and the General Practice Airways Group (GPIAG)

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

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

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

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

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

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

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

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

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

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

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/tabid/63/Default.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.

Dr Tony Davison, Co-chair IMPRESS, BTS
Dr Dermot Ryan, Co-chair IMPRESS, GPIAG

MAY 2008

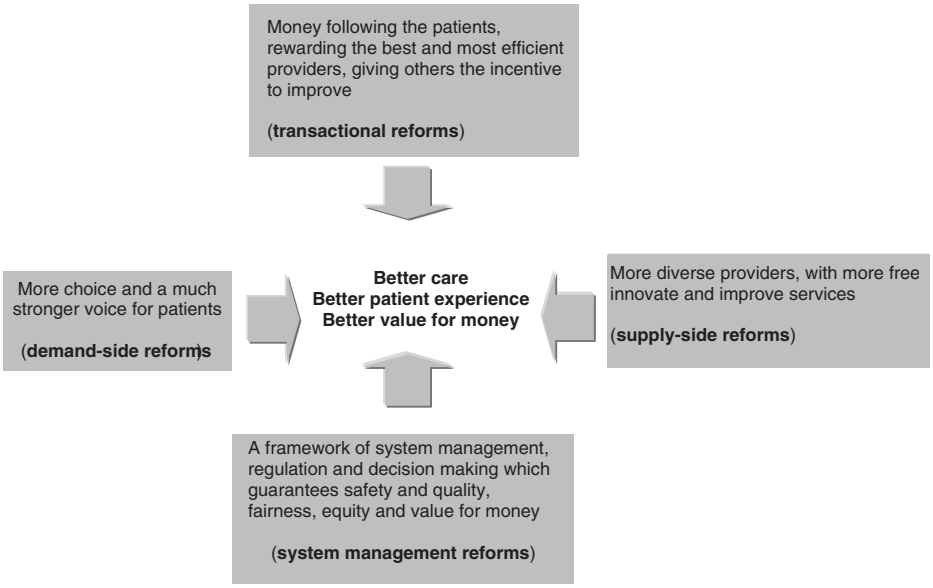
IMPRESS NHS JARGON BUSTER
Also available at http://www.impressresp.com/JargonBuster/tabid/63/Default.aspx

These pages aim to provide a simple guide to the many new 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 contribute 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.

Choice and Health Reform – figure 1



ALPHABETICAL GLOSSARY
Please note that hyperlinks are given to many documents. These were correct at 1 January 2008, but documents do get moved. If you discover an address is no longer correct, we'd be very grateful if you would inform the BTS office <angela.hurlstone@brit-thoracic.org.uk> and we'll correct the on-line version.

Academic Health Science Centre (AHSC) This is a partnership between a number of hospitals and universities supported by the Healthcare for London report by Sir Ara Darzi
http://www.healthcareforlondon.nhs.uk/framework_for_action.asp
The purpose is to bring together world-class research, teaching and patient care. One is proposed between St Mary's NHS Trust, the Hammersmith Hospitals NHS Trust and Imperial College London. As Lord Sir Ara Darzi is also heading an England-wide review of services, the term is included here.

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. See also GMS, PMS, PTMS and SPMS

Ambulatory Care Sensitive Conditions (ACS) A number of organizations including the NHS Institute are looking to help commissioners predict who might be at risk of admission, and to find ways to divert that admission. Work by the Institute, Imperial College and Dr Foster's has identified nineteen ACS conditions which account for 6%-13.2% of total hospital costs for which there is a community-based alternative to admission. The variation in that proportion gives scope for improvement. COPD, asthma,

flu and pneumonia are significant in this list of nineteen. See http://www.drfosterintelligence.co.uk/managementInformation/HUM/ for how it can be used. The Kings Fund together with New York University and Health Dialog has also developed the **Patients At Risk of Re-hospitalisation (PARR) Case Finding Tool and a later version called the Combined Model.**

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.

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 will be 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.

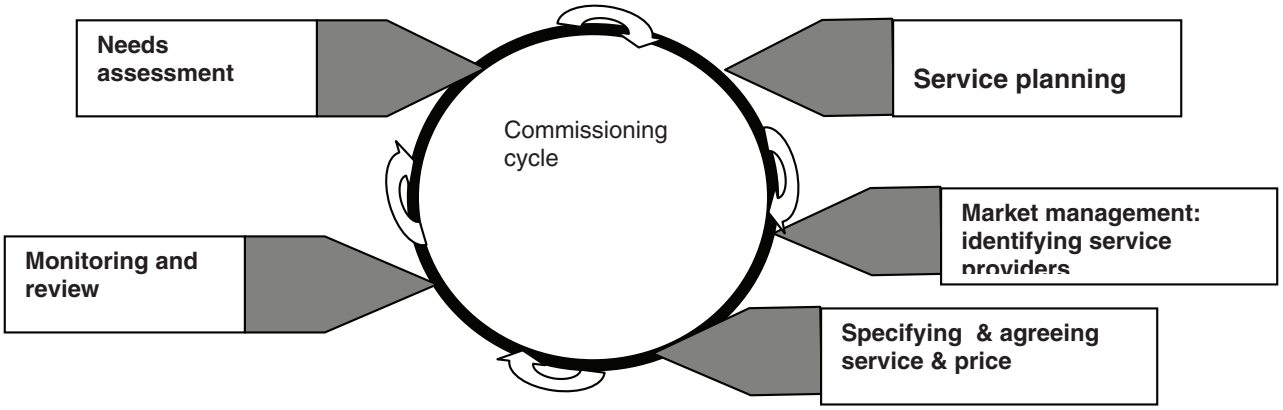
Choose and Book An English NHS initiative that allows people to make their first outpatient appointment, after discussion with their GP, at a time, date and place that suits them with the booking made electronically at the GP practice.

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** (see below) 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. There is recent BMA guidance about RMCs, with a response from David Colin Thome, National Clinical Director for Primary Care and 18 weeks suggesting that the set up of RMCs needs to be done in negotiation with practice-based commissioning, and will not be the only model Access both documents at http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_074531

Combined predictive risk model – a risk stratification process developed by the Kings Fund, New York University and Health Dialog and piloted successfully by Croydon PCT as part of the **virtual wards** programme. See http://www.kingsfund.org.uk/current_projects/predictive_risk/index.html

Commissioning The full set of activities that PCTs and GPs and local authorities undertake to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively see http://www.improvementfoundation.org/documents/Annex_The_Commissioning_Framework.pdf

It is a cyclical process, often taking at least a year and involving many people, both clinicians and managers. 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.



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 12000 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.
A useful website is http://www.commissioningforthelongterm.org.uk/

Commissioning Framework for Health and Wellbeing was published in March 2007 by the Department of Health as a consultation document as part of the implementation of the White Paper Our Health our care our say.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604 It aims to give 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 will be 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 (see above)** practices are all being encouraged to respond. This is a very important document that clinicians should look through as soon as it is available.

Connecting for Health http://www.connectingforhealth.nhs.uk/about is an NHS agency responsible for delivering the **NPfIT programme**.

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 could 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 that PCOs must provide for their populations, but not all practices are obliged to provide them eg childhood immunizations. 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.

Elective care Planned care for a pre-existing illness or condition.

Elective centre A new term coined by Professor Sir Ara Darzi as part of the review of London's health services published in July 2007 http://www.healthcareforlondon.nhs.uk/framework_for_action.asp 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 Professor Sir Ara Darzi is due to head an England-wide review of services, the term Elective Centre is included here. See also **Urgent Care Centre**s.

EMIS – one of the main GP computer 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 systematize protocols and care as there may be different templates in use. See **Torex**, **TPP** and **VAMP Vision.**

Essential and additional services are what we would expect our GP to provide. All **General Medical Services (GMS see below)** and Personal Medical Services (**PMS** – see below) 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: See **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; See http://www.expertpatients.nhs.uk/public/default.aspx 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.

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 family doctors (GPs) and their staff and a national tariff. It remains the most common way for primary care services to be provided in most areas. See **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 in service development as well as clinical care. In respiratory care there are, as yet, very few and the roles vary. See http://www.gpiag.org/gpwsi/index.php. See **PwSIs**

Grouping related to 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. Steve Connellan of the BTS is leading work to refine the Respiratory HRGs further (v4). For example he hopes there will be the option to code 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 2. 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

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) Treatment centres (TCs) 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. A new book by Player and Leys, with foreward by Dr Wendy Savage, Confuse and Conceal on the story has just been published, see http://www.merlinpress.co.uk/acatalog/CONFUSE_AND_CONCEAL.html

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. file:///See http///www.isip.nhs.uk/

There are nine useful principles to judge your service against, to help make the case for service change: http://www.isip.nhs.uk/guidance/caredelivery

- 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.

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 know more about how they are applied and interpreted locally. See http://www.who.int/classifications/apps/icd/icd10online/ Chapter X is diseases of the respiratory system. Chronic lower respiratory diseases are J40-J47.

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, See also Opportunity Locator
Further information can be found at
http://www.kingsfund.org.uk/current_projects/archive/rehabilitation_and_intermediate_care/index.html;
Care Service Improvement Partnership change agent team: http://www.cat.csip.org.uk/

Invisible Lives - Recent report by the British Lung Foundation that used Mosaic data to identify hot spots for COPD. See http://www.lunguk.org/NR/rdonlyres/E027CA18-B5C6-49AB-96FA-C4AF55E6F484/0/InvisibleLivesreport.pdf

Joint Strategic Needs Assessment (JSNA) was announced in the new **Commissioning Framework for Health and Wellbeing** launched by the Department of Health on 6 March 2007 to take effect in 2008. It is the means by which Primary Care Trusts and local authorities will 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 that is contained in the current Local Government and Public Involvement in Health Bill. JSNAs will 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.

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 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'.

Local authority Democratically elected local body with responsibility for discharging a range of functions as set out in local government legislation. Local authorities have Overview and Scrutiny Committees (**OSC – see below**) that have 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.

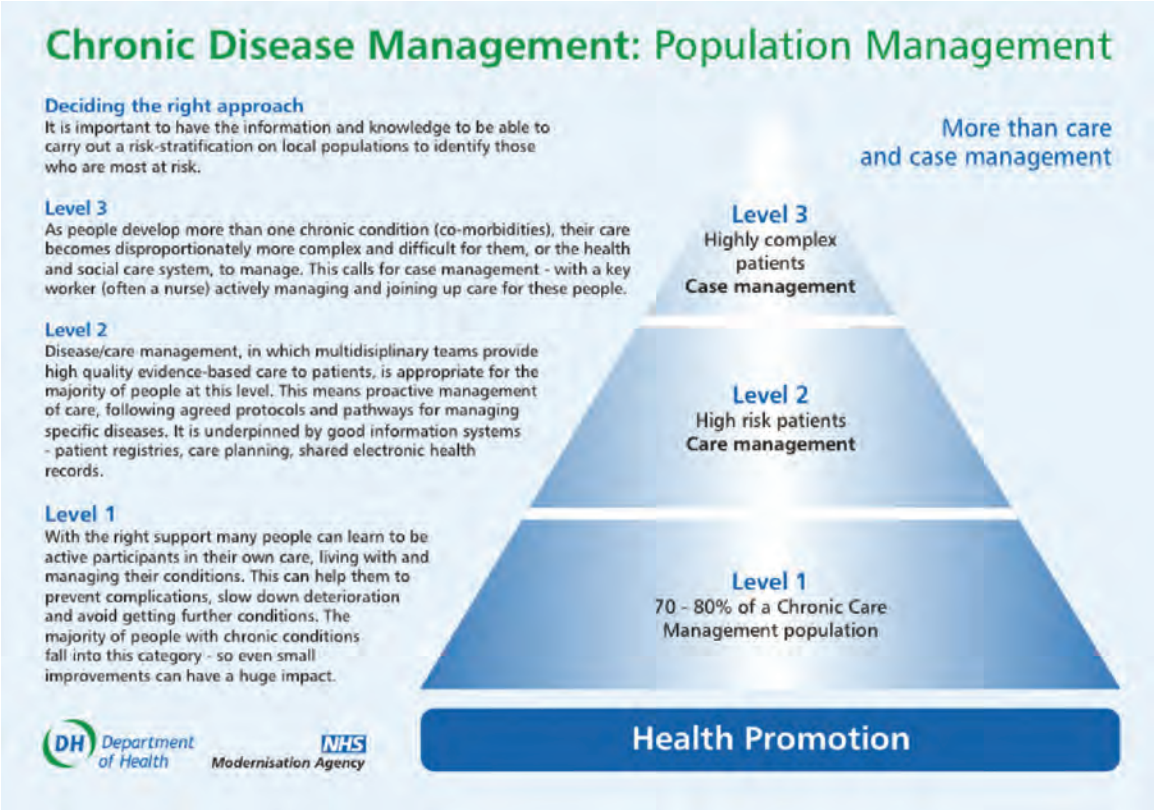
Local Health Boards (LHBs) in Wales there are 21 LHBs and one unified healthcare board, each of which is co-terminous with (has the same boundaries as) local government unitary authorities. The main roles of the LHBs are corporate and clinical governance; securing and providing primary and community 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/sites3/page.cfm?orgid=452&pid=11646

Local Health Boards (Health Boards) in Scotland 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. See http://www.show.scot.nhs.uk/nhsstaff/home.htm

Local Involvement Networks (LINks) previously known as patient forums. LINks will be established for every local authority area and report to their Overview and Scrutiny Committees. No-one yet knows how they will work, but the idea is to gather information from local people about health and social services. The challenge will be to avoid the "usual suspects".

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. It is based on categorizing care according to a **risk stratification**. http://www.natpact.nhs.uk/uploads/Pyramid%20%20Chronic%20Disease%20Management.pdf



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.

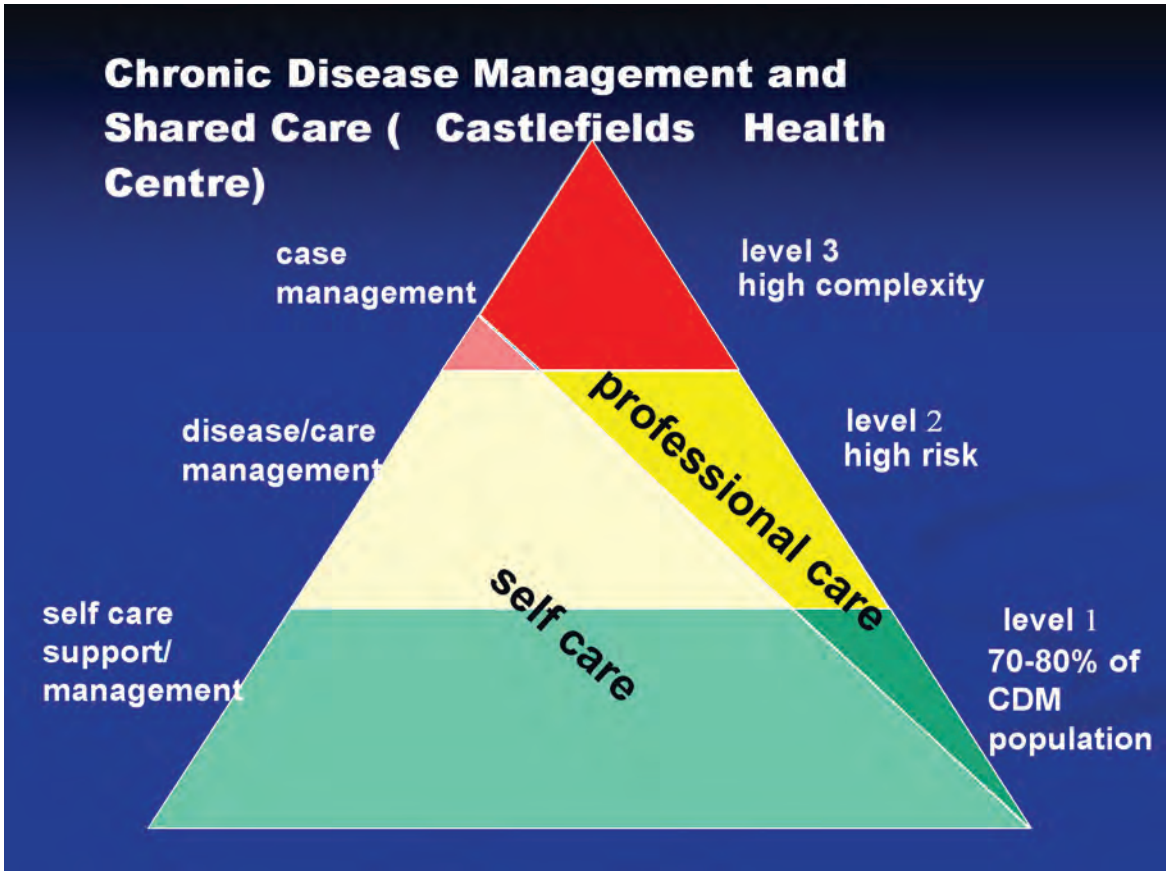
Commissioners will talk about and use these categorizations.

They 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.

A fourth element, **health promotion**, has received little attention or budget up to now, although this has been identified by government as a gap, and will be monitored by the Healthcare Commission more closely in 2007/08.

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 diagram below from Castlefields Health Centre develops the model showing 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.

Needs assessment 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 wellbeing. 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/ giving 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 eg Wyre Forst Public Health Report 2006 http://www.wyreforest-aphr.org.uk/Panel4_1_1_6.aspx?MenuID=Panel4_1_1_6 See also **Mosaic**. See also **JSNA**

Mosaic is an innovative example of new ways of assessing needs using combinations of public databases and mapping software. It was used by the BLF for its **Invisible Lives** document. http://www.business-strategies.co.uk/Products and services/Micromarketing data/Consumer segmentation/Mosaic/Mosaic Public Sector.aspx

NHS Choices at www.nhs.uk is a 50/50 venture between the NHS and Dr Foster and is 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.

NHS Institute for Innovation and Improvement http://www.institute.nhs.uk/has a huge array of tools to support commissioners and clinicians to improve services. For example see the sustainability model and 10-point checklist
http://www.institute.nhs.uk/ServiceTransformation/Using+the+NHS+Sustainability+Model+and+Guide.htm

NPfIT is the National Programme for IT that 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 will be delivered by **Connecting for Health**. The programme includes the NHS Care Record, the **Choose and Book scheme**, electronic prescriptions, and developing 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/clinicalcoding

Operating Framework - this Department of Health document outlines the key priorities for commissioners. The most recent framework - for 2008/09 - is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

Opportunity locator See 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, or by facilitating earlier discharge. You can select the data by PCT or SHA.

Patients At Risk of Re-hospitalisation (PARR) Case Finding Tool. See http://www.networks.nhs.uk/62.php 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 re-admission to hospital. The idea is that patients identified using this tool, and local data will receive case management to avoid admission. The latest development of the software is called Combined Predictive Risk Assessment. It is worth asking colleagues how useful they have found this.

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.

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 analyses progress to date (summary found at http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=30321654-7A78-4be6-ADA3-C2FC1AD3B515&SectionID=sect1#

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

PCT Fitness for Purpose Programme There is some concern amongst policy makers that PCTs are not yet commissioning as effectively as they could. So, the Fitness for Purpose exercise assesses how competent PCTs are, and benchmarks them. It has been a time-consuming process for PCTs. Ultimately it will link to a development programme, and also in the future PCTs may be able to ask for expert help such as actuarial skills to support them. In turn, PCTs have a responsibility to develop GP commissioners.

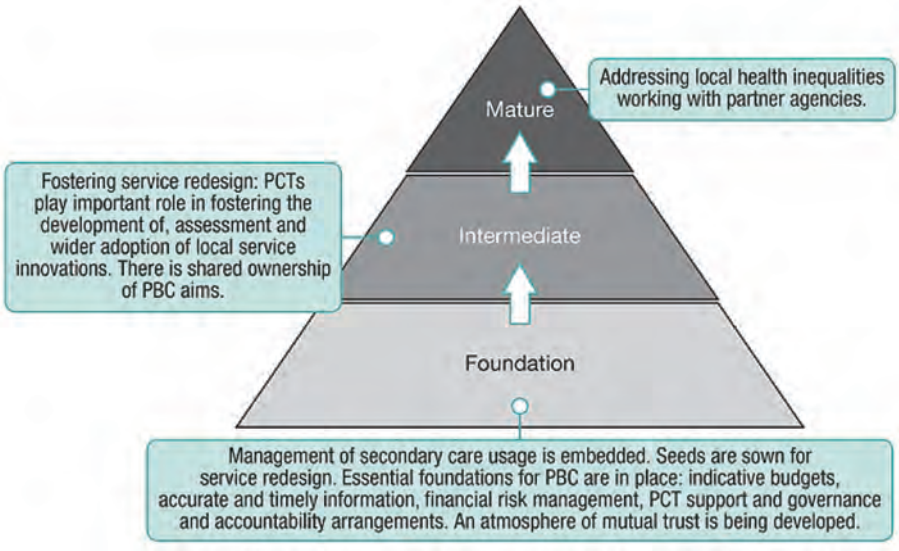
Personal Medical Services (PMS) contract This is one of the main types of contract that PCOs can have with primary care providers. It is a locally negotiated contract unlike GMS (see above). It allows the option of salaried GPs. More than 40% of GPs in England now work under PMS contracts. PMS practices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

Polyclinics A new term coined by Lord Sir Ara Darzi as part of the review of London's health services published in July 2007 http://www.healthcareforlondon.nhs.uk/framework_for_action.asp In the proposed model, polyclinics will be 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. As Professor Sir Ara Darzi is due to head an England-wide review of services, the term polyclinic is included here.

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 (see here) 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 Audit Commission has recently published a review of progress, Putting Commissioning into Practice (November 2007) see http://www.audit-commission.gov.uk/fm/pbc.asp?CategoryID=ENGLISH%5E574%5ESUBJECT%5E1490 where it agrees that there are commissioning groups hampered by lack of information. It has presented a schema for judging the PCT's management of practice-based commissioning as follows;



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**

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

Primary Care Trusts (PCTs) Freestanding statutory NHS bodies in England with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services such as district nursing as part of their functions.

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. See also **APMS, GMS, PMS** and **SPMS**

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).

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.

Prospectus See **commissioning intentions**. Also known as Patient Prospectus.

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

Public Service Agreement (PSA) This sets out the Department of Health in England's 3 year targets. There are four objectives and eight targets. The targets that affect people with respiratory disease are:

3. Tackle the underlying determinants of health and health inequalities by reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less

4. To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.

5. To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.

7. Secure sustained national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.

8. Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by:

    increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and

    increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

http://www.dh.gov.uk/AboutUs/HowDHWorks/ServiceStandardsAndCommitments/DHPublicServiceAgreement/PublicServiceAgreementArticle/fs/en?CONTENT_ID=4106188&chk=zYiEVM

Quality and outcomes framework (QOF) is part of the revised GP contract to incentivise practices to provide systematic care for people with long term conditions. Participation is voluntary but most practices are participating 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. Particularly relevant to respiratory care are clinical indicators for COPD and asthma and points for annual recording of smoking status. Appendix 1 to this glossary describes these clinical indicators and is worth reading. In April 2008 a change was made to the indicators. COPD 9 has been substituted by COPD 12, to bring it in line with NICE guidance, and the points reduced by 5 as part of the redistribution of points to reward patient satisfaction with access. COPD 12: the percentage of patients with COPD diagnosed after 1.4.08 in whom the diagnosis has a been confirmed by post bronchodilator spirometry (5 points). Effective integrated care would require these QOF data and data held by secondary care to be pooled, compared and shared on an ongoing basis. However, the Department of Health is still trying to deal with a number of real and imaginary Data Protection problems. The Commissioning Framework for Health and Wellbeing describes the current state of play on this. Some of these issues will be resolved by the electronic patient record, but this is still a long way off. For further information on QOF see the BMA information. The link for asthma is http://www.bma.org.uk/ap.nsf/Content/qof06~clinincalind~asthma; COPD (but see above for change) and smoking indicators are available from the same page.

The GPIAG has a commentary on the previous changes at
http://www.gpiag.org/news/qof_april_2006.php

Quality Management and Analysis System (QMAS) is the English IT system used to give PCTs and GPs 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.

Reference costs were used in calculating the **tariff (see below**). 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 2005/06 costs show how £39 billion was spent.. Each Trust has a Reference Cost Index – the lower the score, the higher their relative efficiency. Eg 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
http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSReferenceCosts/fs/en

Referral management Centres see Clinical Assessment Services and also BMA guidance
http://www.bma.org.uk/ap.nsf/Content/Referralmanagement

Risk stratification – see **Combined Predictive Risk, PARR**

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).

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 specification This is part of the **SLA (see above)** 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 is developing a generic service specification for COPD.

Social enterprise Businesses with primarily social objectives. Their surpluses are reinvested principally in the business or the community rather than 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. See http://www.networks.nhs.uk/180.php

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. See **APMS, GMS, PCTPMS** and **PMS**.

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. They are the link between the Department of Health and the NHS.

Tariff 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 (see above)** created from a large retrospective analysis of average costs incurred by NHS hospital providers, plus an annual increase for inflation. See 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 applies to NHS providers at the moment, although ultimately would be the price paid by NHS commissioners to any provider, and 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.

Below is the 2007 and 2008 tariffs for asthma and COPD (2008 figures in orange). Note that when the market forces factor is applied there will be minor differences, so that the local tariff may not be exactly as listed below.

	Adult	Child
Thoracic medicine first outpatient appointment	£201 £217	£210 £249
Thoracic medicine follow-up outpatient appointment	£101 104	£123 £167

HRG code	HRG name	Elective spell 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) (£)	Reduced short stay emergency tariff applicable?	% applied in calculation of Reduced short stay emergency tariff	Reduced short stay emergency tariff (£)
D21	Asthma w cc	2,280 1642	21 15	1,875 1836	19 17	188 199	Yes	20	375 367
D22	Asthma w/o cc	1,108 761	7	1,166 1136	11 8	201 192	Yes	35	408 398
D39	Chronic Obstructive Pulmonary Disease or Bronchitis w cc	1,546 1459	15	2,360 2337	25	165 185	Yes	20	472 467
D40	Chronic Obstructive Pulmonary Disease or Bronchitis w/o cc	609 485	2	1,752 1718	17	171 189	Yes	20	350 344

Third sector The full range of non-public, 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.

TPP - The Phoenix Partnership, is a computer systems company working with **Connecting for Health** in the Midlands to test Systmone (sic) software that shares records across primary and community care teams. See **EMIS, Torex, VAMP Vision**

Torex another GP computer system. See **EMIS, TPP, VAMP Vision**

Trimpoints 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. See http://www.ic.nhs.uk/casemix/faq/subtrim/trim_2

Urgent Care See
http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Primarycare/Urgentcare/DH_4123661
The Department of Health describes this as primary care for people who would otherwise attend A&E departments or who want a drop-in service. Urgent care centres tend to be either services adjacent to A&E departments that provide an option for patients without an appointment who have a minor injury or illness, or services that expand the range of services currently provided by walk-in centres, minor injury units or community hospitals. In the future they may also be provided in **polyclinics**.

VAMP Vision another GP computer system. See **EMIS, Torex, TPP**

Variation in practice is the focus for many commissioners. Two broad definitions of variation are usually considered: avoidable variation ("unwarranted") by healthcare professionals and variation ("warranted") 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 www.ihi.org and http://www.fimdm.org/ for more information

Virtual wards are part of Croydon PCT's award-winning 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
http://www.croydon.nhs.uk/sections/frame.html?sec=182 Information for Healthcare Staff

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 see http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm Entitled Securing Good Health for the Whole Population this report for the Treasury forecasts 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.

World Class Commissioning see
http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Commissioning/Worldclasscommissioning/index.htm This is the Department of Health's programme to transform commissioning. 11 world class commissioning competences are described that PCTs' will be expected to develop and perform:

- lead the NHS at a local level
- work collaboratively with partners
- engage with the community
- work closely with clinicians
- manage knowledge and assess needs
- prioritise for improved outcomes
- influence and shape the market
- promote innovation and improvement
- procure robust contracts
- support and manage providers
- demonstrate sound financial management.

Working in Partnership Programme (WIPP) http://www.wipp.nhs.uk/ 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.

For more information about data, please go to the Information Centre website (previously the NHS Information Authority) which is a rich source of data, advice, definitions and further help. http://www.ic.nhs.uk/

IMPRESS Working Party
May 2007
Revised May 2008

APPENDIX 1 – QUALITY AND OUTCOMES FRAMEWORK
For updates, if you are a BMA member, see http://www.bma.org.uk/ap.nsf/Content/Hubthenewgmscontract Note that this is the 2008 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 11. The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the previous 15 months	7	40-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	40-85%

APPENDIX 1 – QUALITY AND OUTCOMES FRAMEWORK

For updates, if you are a BMA member, see http://www.bma.org.uk/ap.nsf/Content/Hubthenewgmscontract Note that this is the 2008 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.

SMOKING INDICATORS

Indicator	Points	Payment Stages
Ongoing management		
Smoking 1: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma whose notes record smoking status in the previous 15 months. Except those who have never smoked where smoking status need only be recorded once since diagnosis	33	40-90%
Smoking 2: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma 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	35	40-90%

APPENDIX 2
HRG Version 4 Reference Costs 2006/07 and PbR National Tariffs 2008/09

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 Major CC
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
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

Specialty	Code	Label
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
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

Specialty	Code	Label
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

The printing of the IMPRESS NHS Jargon Buster has been supported by the provision of unrestricted educational grants from AstraZeneca, Boehringer Ingelheim, GlaxoSmithKline and Pfizer

AstraZeneca

Boehringer Ingelheim

gsk GlaxoSmithKline

Pfizer