Royal College of Nursing

RCN Policy Unit

Policy Briefing 03/2005

Glossary of Terms

ABSTRACT
This briefing document is an A to Z of key terms compiled from various organisations with expertise in NHS finances and structures. The aim of the document is to aid understanding during discussions about health and social care reform.

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Introduction

The RCN activist has a key role to play in holding Trusts to account for the management of resources and working with managements to develop effective systems of staff support, engagement and development which deliver high quality and effective health services.

This job is made much more difficult when it comes to understanding how NHS finances work or how the various aspects of NHS reforms fit together. The following glossary contains useful definitions for some of terminology that you may come across when discussing your local Trusts development.

A-B

Asset

This refers to any item which has value in the future such as a building, or a debtor who owes money to the Trust. A building can be an asset in terms of its bricks and mortar or because it houses a service which generates money.

Benchmarks

Benchmarks are sources of information (such as cost, quality outcomes, etc) used as comparators to compare performance between similar organisations or systems.

Best Value

A legal requirement for all local authorities to make sure that they deliver value for money across their services. This is implemented by carrying out reviews, consultations and monitoring of BV performance indicators.

Block Contract

A contract which guarantees a given volume of business with the service provider, usually enabling the contractor to obtain a reduction in the unit cost of service provided.

Break-even duty

At its simplest level this is the requirement for NHS Trusts to balance income and expenditure i.e. make neither a profit nor a loss. For the year 2006/7, Trusts will be asked to return a surplus (profit) to the DH.

Brokerage

This is a form of 'loan' given to Trusts by the SHA or the NHS Bank to deal with sustained deficits. The amount of money available is largely dependent on the money returned from other NHS Trusts to the centre (see *NHS Bank*).

C

Capital

Capital refers to buildings, land and equipment owned by the Trust that has the potential to earn an income for a period greater than 1 year.

Cash

Different from assets or revenue, this is literally the money the Trust has available to 'pay the bills', such as invoices, wage bills and running costs. The cash limits for Trusts are set according to a national formula set by the DH.

Care Management

The process of meeting needs at an individual level, which is sometimes known as micro-commissioning.

Care Pathway

An approach to managing a specific disease or clinical condition that identifies what interventions are required, and sets out the various stages of care through which a patient passes and the expected outcome of treatment.

Care Trusts

A type of NHS body which combines NHS healthcare services and certain delegated functions from local authorities, including personal social services.

Children's Trusts

Children's Trusts are organisational arrangements which bring together strategic planners from relevant sectors to identify where children and young people need outcomes to be improves in a local area and to plan services accordingly.

'Choice'

Giving patients more choice about how, when and where they receive treatment is one cornerstone of the Government's health policy. In the context of NHS reforms, this is the overarching policy term given to range of initiatives within the reform of the NHS designed to act as a driver for efficiency, quality and effectiveness.

'Choose and Book'

Choose and Book is the term given to a national framework which sets out to offer patients fully booked appointments for a range of primarily hospital based interventions.

NHS organisations will be expected to increase the levels of choice available to patients so that by December 2005, patients who require an elective referral will be offered a choice of 4-5 hospitals (or suitable alternative providers) and a choice of time and date for their booked appointment, at the time they are referred by their GP or primary care professional. Ultimately it is intended that patients will have a choice over a range of providers (NHS or private) by 2008.

Commissioning

Commissioning relates to the purchasing and contracting of health care services. It is a broad term that can cover a range of activities but in principle, a distinction can be drawn between two levels of commissioning. At one level, commissioning can involve service planning and design, through identifying population need; assessing the local priorities; understanding the market; and, determining where and how services should be provided and by whom. Secondly, commissioning can involve the daily purchasing of services, through managing contracts and spending budgets.

'Commissioning a Patient Led NHS'

The letter and attachments (entitled Commissioning a Patient led NHS) was sent to NHS Chief Executives and others at the end of July 2005. It builds on the NHS Improvement Plan and Creating a Patient-Led NHS. The details contained in the papers relate to the form and function of

Primary Care Trusts and Strategic Health Authorities and was designed to begin to address the tension between providing services and commissioning services in PCT's.

Amongst other things, it also intended to prompt cost savings of £250m; deliver Practice Based Commissioning (PBC) by December 2006 at the latest; and reconfigure SHA's will be reconfigured to move towards alignment with Government Office boundaries. For a fuller briefing and discussion, please see the Policy Unit briefing on Commissioning a Patient Led NHS.

Consortium (or Buying Consortium)

An arrangement to optimise buying power and make best use of scarce commissioning skills by aggregating the purchasing requirement of more than one public sector organisation.

Continuing Care

Healthcare, provided over a long period of time, to meet physical or mental health needs which have arisen as a result of disability, accident or illness. It can be provided in hospital. Or a person can be supported in their own home, or in residential or nursing homes.

D-E

Decommissioning

The process of planning and managing a reduction in service activity or terminating a contract in line with commissioning objectives.

Direct Payments

Payments giving recipients the means of controlling their own care at home, allowing more choice and flexibility. They are regular monthly payments from social services enabling people to employ their own personal assistants for care, instead of receiving help arranged by social services.

F

Foundation trusts (FTs)

NHS foundation trusts were first set up as a result of the Health and Social Care

(Community Health and Standards) Act 2003. More hospitals have become foundation trusts since then and all Acute NHS Trusts will be required to attain FT status by the end of 2008. Although remaining part of the NHS, foundation trusts are subject to reduced control from central government. They differ from traditional NHS trusts in three main ways;

1. they possess the freedom to decide locally how to meet their obligations (which can also involve borrowing money from private sources);

2. they are accountable, through (mainly elected) governors, to their members, who are drawn from local residents, patients and staff; and

3. they are authorised and monitored by Monitor, the Independent Regulator of NHS Foundation Trusts.

G-K

General Medical Services (GMS)

This is one type of contract Primary Care Trusts (PCTs) 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.

GPsSI (General Practitioners with Special Interests)

General Practitioners with Special Interests supplement their generalist role by delivering a clinical service beyond the normal scope of general practice. They may undertake advanced procedures or develop specific services.

GMS contract

On 20 June 2003, GPs accepted a new General Medical Services (GMS) contract, negotiated by the British Medical Association (BMA) and the NHS Confederation. The terms of this contract mean that payments to GPs are more closely related to the quantity and quality of the services they provide.

Health economy

The term health economy refers to all providers, purchasers, and service users within a given geographical area.

Independent Contractor

In primary care, this normally refers to a self-employed professional. The vast majority of GPs are self employed - unlike hospital doctors who are directly employed by the hospital.

Individual budgets

Individual budgets bring together a variety of income streams from different public care agencies to provide a sum for an individual, who has control over the way it is spent to meet his or her care needs.

L

Legacy costs

Legacy costs may be defined literally as the cost of past decisions in a changing financial environment. Legacy costs can occur when moving from one system of funding where average costs were not central to the process, to another system where activity is paid for at national average costs. In the past, prices paid by PCTs for hospital services were set without any reference to the national average cost. Likewise, capital funding (such as PFI or LIFT) was not allocated by reference to capital productivity – in other words, there was no assessment of the amount of extra patient services which would be delivered per pound of capital investment in the new building.

It should therefore be no surprise that some hospitals have inherited legacy capital costs arising from past capital investments where the annual costs are higher than allowed for in the average cost of PbR tariffs. Hospitals with higher than average costs than the national average will not fully recover those costs out of the PbR tariff revenue even if efficiently managed, unless an explicit uplift is provided to those Trusts.

Local Area Agreement (LAA)

A Local Area Agreement is a three-year agreement that sets out the priorities for a local area in certain policy fields as agreed between central government, the local authority and Local Strategic Partnership (LSP). The agreement is made up of outcomes, indicators and targets aimed at

delivering a better quality for people through improving performance on a range of national and local priorities.

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 delivery of services over a three-year period.

Local Improvement Finance Trusts (LIFT)

Local Improvement Finance Trusts are a new method for funding primary care and community care estates modernisation, similar in some respects to PFI. The contracts involved in a LIFT scheme are for buildings and maintenance. It is an additional procurement route for developing primary care estates that currently includes the use of conventional public capital, premises built and operated under the national contract for general medical services (GMS), PFI and other public-private partnerships.

M

Macro-commissioning

The process of meeting needs at a strategic level for whole groups of service users and/or whole populations.

'Market Forces'

Market forces may be characterised as any system of incentives which rely on market-type mechanisms such as contracts, price or cost to create a desired behaviour from the various participants in that market. For example, competition, fixed or decreasing budget limits, bidding for contracts, and so on may all be seen as market forces.

Market Forces Factor (MFF)

An index used in resource allocation under PbR to adjust for unavoidable variations in costs. It is designed to take account of the differing costs of staff, regional allowances or weightings, land, buildings and equipment.

Micro-commissioning

The process of meeting needs at an individual level.

N

National Service Framework

A National Service Framework details about out how services should be organised to cater for patients with particular conditions; in particular it would detail the standards that services will have to meet to comply with the NSF.

In all parts of the country, the NHS is required to organise its services to ensure the best quality and the fairest access. The National Service Frameworks, for example, may help decide which services are best provided in primary care, in hospitals and in specialist centres.

NHS Bank

The previous and largely informal system of brokerage between NHS organisations in which surpluses were lent to those with deficits has been replaced by the NS Bank. The NHS Bank is responsible for acting as a broker in the distribution of surpluses to other NHS organisations for investment and reform. It does this in the following ways:

1. *Special Assistance Fund* – planned support delivered via SHA's to Trusts with significant structural or transition needs

2. *Public Capital Brokerage* – This aspect of their role ensures that the NHS as a whole makes optimum use of total resources on annual basis

3. *Cash Only Brokerage* – there are nationally set control totals within which the NHS Bank is able to provide additional support to NHS Trusts

The NHS Bank is an arms length body of the DH and provides risk reserves for PCT's and overdraft facilities for NHS Trusts. In future, the NHS Bank will also be responsible for managing all streams of support for capital expenditure from 2005/6.

Non-recurring measures

These are one-off measures which affect the year of account only, e.g. raising capital through the sale of land or via a one-off payment or loan from an external source such as the Strategic Health Authority NHS Bank.

O-Q

Overview and Scrutiny Committees

OSCs are based in Local Government and have a statutory function in consultation through Regulation 4 Local Authority (Overview & Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

This contributes to their wider role in health improvement and reducing health inequalities for their area and its inhabitants. OSCs have to be consulted by the NHS where there are to be major changes to services delivered by the NHS. Consultation is required where there is consideration being given to a proposal for a substantial development of the local health service or a substantial variation of local provision (see RCN briefing on Statutory Consultation for more information).

Payment by Results

Payment by Results is a new funding system for care provided to NHS patients, which pays health care providers on the basis of the work they do. It does this by paying a nationally set price or tariff for similar groups of patients (known as health care resource groups or HRGs) which itself is based on the historic national average cost of providing services to those HRGs.

The fixed tariffs for specified HRGs are set by the Department of Health and are intended to avoid price differentials across providers that could otherwise distort patient choice. Payment is on a 'per spell' basis, where a spell is defined as a continuous period of time spent as a patient within a trust, and may include more than one episode.
The aim of Payment by Results is to provide a transparent, rules-based system for paying NHS trusts. It hopes to reward efficiency, support patient choice and diversity, and encourage strategies for achieving sustainable reductions in waiting times (see RCN Policy Briefing 01/2005 on PbR for a more detailed discussion).

Practice-based commissioning

Practice-based commissioning is the term given to a form of practice level commissioning which enables practices (usually this refers to primary care teams led by GP's although there are some exceptions) to commission care and other services that are directly tailored to the needs of their patients. Practices can keep up to 100 percent of any savings made by agreement with local primary care trust (PCT).

Private Finance Initiative (PFI)

The private finance initiative (PFI) provides a way of funding major capital investments as an alternative to the public procurement route which is funded directly by the Treasury. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects. Contracts typically last for 30 years, during which time the building is leased by a public authority.

It remains a contentious issue with many critics who state that it does not offer value for money and effectively transfers ownership of NHS hospitals out of the NHS. Others point to the relatively large number of new facilities built under the scheme that would not otherwise have been built.

Purchaser

A budget-holding body that buys health or social care services from a provider on behalf of its local population or service users.

Provider Plurality

This term refers to the use of a range of different organisations from NHS and independent, private, and 'not for profit' sectors in the delivery of services. In the context of NHS reforms, 'provider plurality' coupled with competition and patient choice is said to promote efficiency, effectiveness and value for money in the delivery of services.

Provider

An organisation that provides health or social care services under contract arrangements to a purchaser.

Q-R

Quality and Outcomes Framework (QOF)

Part of the contract PCTs have with GPs. It is nationally negotiated and rewards best practice and improving quality.

Resource Accounting and Budgeting regime

RAB is the financial management framework in place across central government. If a trust reports a deficit in one year, its income is reduced by that amount the following year. In addition to affecting the following year's income, the trust's in-year deficit is added to the balance sheet *and* carried forward to future years to give a cumulative position. This

cumulative position is used to assess whether the NHS trust has achieved its statutory duty to 'break even taking one year with another'. The combination of a carried forward cumulative deficit *and* a reduction in income the following year is often known as a 'double deficit'.

S

Service Level Agreement

This is an agreement between two, typically public sector, providers about what services will be provided.

Standards

Standards are a means of describing the level of quality those health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality.

Step-down care

Part of intermediate care facilities that are outside hospitals, enabling people who strongly value their independence to leave acute hospital and get ready to return home.

Step-up care

Part of intermediate care facilities that are outside acute hospitals, enabling people who strongly value their independence to receive more support than is available at home.

Strategic Health Authority

There are now 10 SHAs in England, which originally came into being on the 1st April 2002 but underwent major reorganisation as part of CPLNHS. They determine the strategy and performance manage PCTs and Trusts in their area. In the future, their role will increasingly be concerned with financial management of the health economy and ensuring that the commissioning of services meets the needs of the local population.

T

Targets

Targets refer to a defined level of performance that is being aimed for, often with a numerical and time dimension. The purpose of a target is to

incentivise improvement in the specific area covered by the target over a particular timeframe.

Tariff

Essentially this refers to the list of prices for any given activity. In the case of Payment by Results the tariffs will effectively fix the prices that organisations can charge NHS commissioners in relation to services for NHS patients. Simply put, prices are based on a national average cost with variations allowed for geographical differences in costs called a market forces factor (see above for definition).

Tariff Sharing

Tariff sharing refers to the splitting of the fixed tariff price between one more providers who are providing different elements of the treatment covered by the fixed price.

Terms of authorisation

The terms of authorisation refers to the terms under which the Foundation Trusts may be authorised to provide services under the Health and Social Care Act.

Treatment Centre

Treatment centres are dedicated units that offer pre-booked day and short-stay surgery and diagnostic procedures in specialties such as ophthalmology, orthopaedics, hernia repair and gallbladder and cataract removal, amongst others. Treatment centres can be run by the NHS or the Independent Sector and exit mainly to provide additional capacity (including staff) to address waiting list targets.

U-V

Unbundling and bundling

Under the Payment by Results (PbR) system, trusts are reimbursed per spell, categorised by HRG (See PbR definition above). There are debates as to whether the HRG categories accurately reflect the cost of providing services, and whether they are flexible enough to incorporate varying treatment patterns.

When people refer to ‘unbundling’ the tariff, they mean being able to clearly identify the individual elements which go to make up the cost of each component of the HRG. This would allow different organisations to

carry out different parts of the treatment. For example, unbundling the tariff for an HRG that includes a hospital procedure and after care means that the after care can be administered in the community, with both the hospital and community provider accurately reimbursed for the work that they do.

Conversely, when people talk about 'bundling' the tariff, they mean budgeting for whole patient pathways or treatment programmes, which allows the individual components to be negotiated locally.

Underlying deficit

This is the total amount of one-off measures the health economy has had to find to achieve a break-even position at year end. i.e. the overall position after ignoring in year non-recurrent measures.

W-Z

Weighted Capitation Formula

Funding for primary care trusts (PCTs) is informed by a weighted capitation formula which determines their target shares of available resources to enable them to commission similar levels of healthcare for populations with similar healthcare need.

Four elements are used to set PCTs' actual allocations:

1. Weighted capitation targets are set according to the national weighted capitation formula which calculates PCTs' target shares of available resources by adjusting PCT populations for age (to allow for different levels of health need in different age groups), additional need (highly correlated to social and economic deprivation) and unavoidable geographical differences in the cost of providing healthcare (the market forces factor (MFF));

2. Recurrent baselines which represent the actual current allocation which PCTs receive. For each allocation year the recurrent baseline is the previous year's actual allocation, plus any adjustments made within the financial year;

3. Distance from target (DFT) which is the difference between weighted capitation targets and recurrent baselines above. If the weighted capitation targets are greater than recurrent baselines, a PCT is said to be under target. If the weighted capitation targets are smaller than recurrent baselines, a PCT is said to be over target; and

4. Pace of change policy which determines the level of increase which all PCTs get to deliver on national and local priorities and the level of extra resources to under target PCTs to move them closer to their weighted capitation targets.

There are separate components in the formula for different services: hospital and community health services (HCHS), primary medical services, prescribing and HIV/AIDS. Within each component, each adjustment for age, additional need and unavoidable costs is expressed as an index comparing the PCT score on the adjustment to the national average.

The demands of a rural economy are reflected in both the additional need and unavoidable cost adjustments.

The additional need adjustment recognises that access to services is more difficult in rural areas by including measures of distance to providers in the statistical modelling. The unavoidable cost adjustment includes an adjustment for emergency ambulance services where geographical cost differences are partly accounted for by rurality. (Source: Hansard, 2006)

Sources

All the above definitions have been sourced from a number of credible national bodies with particular expertise in NHS finances or structures. Their contribution is gratefully acknowledged

Department of Health	(www.dh.gov.uk)
Healthcare Commission	(www.healthcare-commission.org.uk)
Kings Fund	(www.kingsfund.org.uk)
NHS Alliance	(www.nhsalliance.org)
Healthcare Financial Management Association	(www.HFMA.org.uk)
Royal College of Nursing	(www.rcn.org.uk)