Healthcare Management Dictionary

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RADCLIFFE MEDICAL PRESS

Radcliffe Medical Press Ltd
18 Marcham Road
Abingdon
Oxon OX14 1AA
United Kingdom

www.radcliffe-oxford.com
The Radcliffe Medical Press electronic catalogue and online ordering facility.
Direct sales to anywhere in the world

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library.

ISBN 1 85775 802 1

Typeset by Advance Typesetting Ltd, Oxon
Printed and bound by TJ International Ltd, Padstow, Cornwall

Preface

The NHS has its own often bewildering array of management terms, acronyms, jargon and technical phrases. To anyone new to the NHS this can be confusing. Even experienced NHS clinicians or managers may be familiar with the jargon used in their own field, but may find that the terms used in different sectors sound like a foreign language. This dictionary provides plain English definitions of those hundreds of phrases that are commonly used within the NHS, with details of the websites where you can find more information.

This book aims to clarify the terminology and broaden the reader's understanding of healthcare. A mutual understanding of NHS terminology is also invaluable for multi-disciplinary teams, as it can assist communication between disciplines. It is aimed at all NHS workers, especially the new, inexperienced or overworked manager or clinician who has neither the time nor the energy to keep up to date with the new terminology as it emerges.

The main focus is on clinical management terms that are currently in use within primary care. Also included are terms more commonly used in secondary or social care, but which influence or impact on those working in primary care, and general management terms widely used in the private sector that may befuddle or bemuse managers and clinicians as they are imported into the NHS. It is particularly aimed at new or less senior managers who are aiming to take up the mantle of effective leadership and equip themselves with the skills required of them in the new NHS.

No single text can ever be fully comprehensive, and by its very nature some of the material in this book will date very quickly. Because of this, I also recommend the websites www.doh.gov.uk and www.guardiansociety.co.uk, both of which have alphabetical site indexes which are useful to visit in order to obtain information on current Government bodies, new legislation and reports.

I have endeavoured to select the terms that are likely to be most useful in current general practice. If I have not included something which you feel strongly should be included, or I have misinterpreted any material, please let me know so that any amendments can be included in future editions.

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May 2003

About the author

Annie Phillips has written professionally about health and health management since she qualified as a speech and language therapist in 1978. She has over 20 years of NHS experience in primary and secondary care as a clinician and manager.

Her 10 years practising as a speech and language therapist led to research on and publication of an international dysphasia/dementia screening test, presented at the 1986 British Aphasiology Conference. Annie has won various prizes and awards for her subsequent work, and in the 1990s she was a finalist in the Medeconomics Good Management Awards and a regional winner in a national British Institute of Management competition on change management.

She worked as a practice manager and fund manager for a five-partner training practice in central Brighton from 1989 to 1998. Since then she has returned to clinical work as a speech and language therapist and she also works as an independent health adviser, trainer and management consultant to general practice, health authorities, primary care groups and primary care trusts.

Throughout her career she has written extensively for the therapy, GP and management press. She currently writes on contemporary management issues for a range of publications, including *Health Service Journal, Community Care, Doctor, Practice Management* and Croner Publications, with a focus on healthcare politics and human resource management.

As a management consultant, her interest is in organisational analysis and the development of healthy organisations, with a focus on finding ways to manage stress and conflict, understanding and alleviating dysfunctional communication, and developing effective management strategies.

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A

ACAS

The Arbitration, Conciliation and Advisory Services. Founded in 1974, ACAS is considered to be the national employment relations expert. It is a public body funded by taxpayers and run by a council of members from business, unions and the independent sector. ACAS provides information and training for employers and employees on employment legislation, its core role being to prevent and resolve problems in the workplace.

www.acas.org.uk

Access

The extent to which service users are able to receive the care that they require. The issues involved in accessibility include travelling long distances, physical access (e.g. premises suitable for wheelchairs), communication (e.g. interpreters) and the availability of culturally appropriate services.

Access in healthcare is dominated by the focus on improving patient throughput. However, it is also about ensuring that patient care is:[1]

- accessible (no barriers, timely)
- appropriate (evidence based, meets the needs of the population)
- effective and efficient (best use of resources)
- equitable (respectful, provided on the basis of need)
- relevant (responsive and sufficient)
- acceptable (meets user expectations)
- knowledge based (sound information supports any decision making)
- accountable (principally and financially, outcome based)
- integrative (involves other agencies).

An accessible service ensures that all patient groups are catered for, regardless of their age, class or personal circumstances.

The Government introduced access targets in 2000, with the aim of increasing the proportion of patients who see a GP or health professional within 48 hours. Some GP practices improve their patient access by running *open-access* systems (surgeries with no appointments) or *mixed-access* systems (a mixture of booked and non-booked appointments). Although the *advanced-access* system takes more resources to set up, it is considered to be by far the most successful type, both by practices who use it and by the public.

Dr John Oldham's team at the *NHS Modernisation Agency* in Manchester disseminates information on how GPs can best improve their patient access arrangements by using an advanced-access system. This involves auditing consultation rates (telephone consultations, inappropriate follow-ups, etc.) and working out the best methods for resolving appointment problems (e.g. by having one doctor each morning devoted to seeing emergencies only, or using nurse triage).

The principle of advanced access can be summarised as follows.

1 Consultation data are produced by analysing how many patients the practice sees each day.

2 This demand is shaped as appropriate.

3 The demand is then matched to capacity.

4 A contingency plan for busy periods is put in place.

Assessment also takes into account the broader aspects of general practice work, such as the practice nurse/community nurse skill mix, the use of additional support services (e.g. optometry or pharmacy) or the use of NHS Direct, locum and deputising services. *See* **Quality team development**.

www.doh.gov.uk/scg/facs/index.htm

1 Maxwell R (1984) Quality assessment in health. *BMJ.* **288**: 1470.

Accountability

The duty to take responsibility for one's own actions, and to be able to give a full explanation of these actions to those who may request it (e.g. peers, or external agencies such as patients and policy makers).

Accreditation of healthcare

The formal recognition and achievement of a standard of quality attained by a healthcare unit. Accreditation agencies are usually independent of both the providers of care and those purchasing or commissioning it.

Practice accreditation schemes, originally developed by the Royal College of General Practitioners (RCGP), have been piloted and run by several primary care organisations throughout the country. Around 90% of practices in Scotland have now

achieved accreditation. Accreditation requires practices to work within a specified quality framework; the RCGP scheme asks GPs to meet 46 essential criteria, based on what they are currently legally obliged to offer. GPs can then select 20 other 'good' or 'quality' criteria. An example of a 'good' criterion is an average length of booked appointments of not less than 7.5 minutes. An example of a 'quality' criterion is the team having a profile of patients' health needs and a strategy for tackling inequalities. *See* **Certification**.

Action-centred leadership

This approach is associated with the work of John Adair,[1] who noted that the effectiveness of the leader is dependent on meeting three areas of need within the work group, namely the need to achieve the common task, the need for team maintenance and the individual needs of the team members. Adair symbolises these needs by means of three overlapping circles. *See* **Leadership**.

1 Adair J (1979) *Action-Centred Leadership*. Gower, Aldershot.

Acute services

Medical and surgical treatment provided mainly in hospitals, but occasionally in satellite diagnostic and treatment centres. Acute trusts are management units in charge of hospitals that provide these services.

Additional clinical services

A group of services provided by the new GP contract. Most practices would be expected to provide these services, which would include vaccination and immunisation, contraception, child health surveillance, cervical cytology and chronic disease management. In exceptional circumstances it would be possible to opt out of providing one or more additional clinical services. Practices would have to give notice to the primary care organisation of their intention to opt out, so that alternative providers could be found for patients. *See* **GP contract**.

Administrator

Unlike managers, who oversee the planning and development of a piece of work, administrators administrate it. Administrators may plan work activities (e.g. meeting the month's production quotas), but they are rarely required to plan further ahead.

Algorithm

A procedure for problem solving, frequently used by NHS Direct and other computer users. It is a format often used to display clinical guidelines, showing the process of care diagrammatically as a series of branching 'if–then' or 'yes/no'

statements. It usually consists of a series of boxed questions, the answers to which lead down to the next management step. *See* **Protocol**.

Allied health professional (AHP)

A professional healthcare worker who works alongside and supports medical personnel (also called a profession supplementary to medicine). Their training, roles and responsibilities vary widely, with some qualified to honours degree level, working autonomously as diagnosticians (e.g. speech and language therapists), and others working to a medical prescription (e.g. dietitians, radiographers). AHPs include art therapists, chiropodists, clinical scientists, dietitians, medical laboratory technicians, occupational, speech and language therapists, physiotherapists, orthoptists, paramedics, prosthetists, orthotists and radiographers. *See* **Health Professions Council**; **Professions supplementary to medicine**.

APD (Accredited Professional Development Scheme)

An initiative launched by the Royal College of General Practitioners (RCGP) in April 2002 to help doctors to meet revalidation requirements. A voluntary process undertaken over a five-year period, it requires GPs to prove ongoing competence in topics such as keeping up to date, improving care, referrals, prescribing and communication skills. GPs who are undertaking the programme require supervision from an RCGP-accredited facilitator; otherwise they complete the ADP pack alone following participation in an annual study day. *See* **Revalidation**.

www.rcgp.org.uk

Appraisal

The process by which an employee's performance is reviewed periodically against the various requirements of the job. Appraisals developed out of systems of 'merit rating' in the early 1900s. By the mid-1900s this had developed into a *management-by-objectives* approach, advocated by the management guru Peter Drucker, which deliberately excluded any attempt to give personality ratings. Between 1970 and 1990 *performance appraisal* schemes were introduced (which included an overall rating of performance and individual personality characteristics), which were closely linked to *performance-related pay* schemes. From 1990 to the present day, *performance management* has been conceived of as a normal and continuous process of management, rather than an annual ritual. It focuses on agreement and dialogue, and is concerned not only with outputs (results) but also with inputs (competencies).

The needs of the individual and the organisation within which they work do not always coincide, so appraisal is a means of exploring any conflict that exists. Modern appraisals are designed to be peer reviewed, fair, constructive, objective, positive, evidence based, unbiased and supportive, yet challenging. They form part of the *revalidation* system that is being set up for doctors.

There are various appraisal models, which may be one way (rated by the appraiser only), a joint process (self-rated and fed back by the appraiser) or 360 degree (where both appraisee and appraiser make a joint assessment). The *system* may be complex (with multiple-point self-assessment forms, peer reports and/or rating scales) or simple (with samples of notes and conversation). Supporting sources of evidence can be obtained from patients, superiors or peers. The system needs to be regularly evaluated in order to ensure that the process works effectively and efficiently.

The end result of the appraisal process is the individual's performance portfolio, which sits alongside and feeds into a *personal development plan*, which in turn feeds into the revalidation process, thus forming part of the *clinical governance* arrangements of the employing trust. Appraisal processes will differ between organisations, but appraisal should build on the strengths of both the organisation and the individuals who are working within it.

An appraisal is:

- a formal system for examining and building on strengths and minimising weaknesses
- a space for staff to assess their own needs and areas of difficulty
- an opportunity to discuss potential.

It is not

- subjective
- a disciplinary interview
- applied on the basis of insufficient, inadequate or irrelevant information
- presented as fact instead of opinion
- an opportunity to re-emphasise past problems.

During the appraisal interview, the objective is not to tell the individual what is going wrong, but to discuss their potential for development. Whoever appraises should use *assertive, counselling, problem-solving* and *facilitation* skills in order to be fair and unbiased, constructive and positive, objective and supportive, yet also challenging. Appraisals are not hierarchically based, but developmental. They focus on process, not outcomes. The appraisee should be given the opportunity to engage in the discussion, reflect on their own performance, state their needs and expectations and seek clarification. Meaningful (subjective and objective) targets should be set, and all judgements should be evidence based.

www.doh.gov.uk/gpappraisal
www.gmc-uk.org
www.appraisals.nhs.uk

Assertiveness

To be assertive is to communicate clearly, honestly and directly, without avoidance or resorting to manipulative or aggressive behaviour.

Assertiveness is regarded as an important component of cognitive–behavioural approaches to tackling anger, anxiety, depression and low self-esteem. The premise is that changing people's ideas will influence their behaviour, and likewise that changing their behaviour will lead to changes in their ideas.[1–3] Assertive techniques help people to communicate in constructive and satisfying ways and achieve workable results in difficult situations, and they assist in resolving conflicts without aggression. Some of the situations that can be helped with assertive behaviour include the following:

- time management
- identification of obstacles to career or personal development
- overcoming work and people demands
- making and refusing requests
- handling criticism or compliments
- coping with rejection
- building self-esteem
- giving constructive criticism
- staff appraisals and disciplinary procedures
- negotiating
- dealing effectively with conflict and violence
- goal setting.

Behaving assertively helps at both a professional and a personal level, as it can help to prevent aggressive or defensive behaviour. The assertive person takes charge and acts in ways that invite respect, accepting their own limitations and strengths. This in turn leads to clearer communication, as others understand clearly what their needs and desires are, and any potential confusion or discord is alleviated. Assertive skills enable people to cope more readily with feelings of frustration or inadequacy.

One of the first books to be published on assertiveness was written by Anne Dickson, an American psychologist.[4] Dickson's work is the source of much of the material that has subsequently been written on assertiveness in this country. She promoted assertiveness training as a popular method for self-development and for gaining self-confidence and control over one's life.

The assertive speaker:

- is specific
- negotiates

- repeats their message if it is misunderstood
- compromises if it is reasonable to do so
- listens
- self-discloses – expresses their feelings
- innovates – takes chances and risks
- accepts criticism where this is appropriate
- prompts others to express themselves honestly.

Assertive communication usually leaves both the speaker and the listener feeling more comfortable than do avoidance or confrontation. Assertiveness means communicating more honestly and directly. This leaves both parties feeling clearer and more at ease with the interaction. Assertiveness helps most in difficult or problematic situations – when dealing with critical comments or manipulative behaviour, when having to give criticism, or when negotiating.[5] *See* **Transactional analysis.**

www.anniephillips.co.uk

1 Grieger R and Boyd J (1980) *Rational–Emotive Therapy: a skills-based approach.* Van Nostrand Reinhold, New York.

2 Ellis A (1979) *RETR and Assertiveness Training* (audio cassette). Albert Ellis Institute for Rational–Emotive Behavior Therapy, New York.

3 Beck AT, Rush AJ, Shaw BF and Emery G (1979) *Cognitive Therapy of Depression.* Guildford, New York.

4 Dickson A (1982) *A Woman in Your Own Right.* Quartet Books, London.

5 Phillips A (2002) *Assertiveness and the Manager's Job.* Radcliffe Medical Press, Oxford.

Assertive outreach

An approach to working with severely mentally ill adults who do not engage effectively with traditional mental health services. Staff work with service users in their own environment (either at home or in another familiar environment, such as the park or the street), rather than through appointments at an office or hospital.

www.scmh.org.uk/

Assessment

The process of determining or measuring an individual's knowledge, skills or attitudes.[1] In healthcare, it is the term used for measurement of the performance, health or circumstances of an individual, family, group or community against one or more benchmarks in preparation for making a diagnosis or plan of action. *See* **Evaluation; Monitoring.**

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions.* Royal College of General Practitioners, London.

Audit

Medical, clinical and *administrative audit* became popular in the early 1990s, as a risk management tool that was also useful for clinical and managerial purposes. Audit is an objective and systematic way of evaluating the quality of care or service delivery. It is a simple, effective and low-cost way of sifting and analysing data. It aims to promote higher standards of care, effectiveness and efficiency, and it helps to improve standards of care by highlighting discrepancies between perceived standards of practice and measured standards.

Audit is not a research tool. It does use some research methods (e.g. data collection, analysis), but it is not tied to research methodology. Scientific research methods are about proving facts in a way that can be replicated by other people using the same method. Audit is quite different. The aim of internal audit is to examine a particular practice and see whether it can be done better – no one else's practice is relevant. Audit does not require an hypothesis, a control group or a statistically significant sample.

Audit works best when a group of people decide on something to investigate and improve – ownership is important. Any system or method that requires improvement can be audited, whether it is a service, a building design, a way of working, a method of recording or a way of organising. Traditionally, management audit is concerned with two components, namely structure (which can include the environment) and process (which examines service delivery, for example). A classic GP practice audit is the examination and analysis of appointment availability.

- *Medical audit* concerns the performance and professional competence of doctors.
- *Clinical audit* evaluates an aspect of clinical care. Clinical audit is not exclusively medical – it may well involve all members of the healthcare team, patients and other care workers in looking at any aspect of clinical care.
- *Administrative audit* (or *internal audit*) is the audit of activities by non-medical staff, using criteria defined by the organisation itself.
- *External audit* is conducted by outsiders, using criteria defined by authorities outside the organisation.
- *Self-audit* is conducted by individuals or a group within the organisation.
- *Peer audit* is conducted by colleagues who combine resources to compare their audit findings.

Pre-audit involves meeting with all relevant personnel to define the problem, set standards and criteria and establish the required methodology. The audit itself involves collecting the data (*sampling*), analysing the data (comparing the observed practice with the standards set), presenting the findings, evaluating them, and finally implementing new standards, monitoring the change and ultimately reassessment (repeating the survey to test for evidence of effective change).

The audit cycle

Audit involves the following sequence of steps:

- observing the practice
- setting of standards
- gathering of data
- comparison of performance with standards
- implementing appropriate change
- monitoring the effects of the change – the *outcome*
- re-audit, in which the cycle is repeated.

Traditionally these steps are illustrated by a circular diagram, as a sequence that can be started at any point and taken in any order.

The focus in primary care is now moving away from medical audit towards multidisciplinary or whole team audit activities, as it is thought improvement can only take place through changes to systems and organisation of care, rather than by changing individual working practice. The NHS Act 1999 recommends that audit should become a contractual activity for GPs. *See* **Criterion**; **Data**.

www.nice.org.uk
www.radcliffe-oxford.com

For further information on types of audit and how to audit, see the authors' book:

- Phillips A (2002) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.

The National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) have launched a guide to clinical audit, *Principles and Best Practice in Clinical Audit*, which is available from the NICE website www.nice.org.uk or in print from Radcliffe Medical Press (www.radcliffe-oxford.com).

Audit assistant

The title for a member of staff who provides the technical support for medical audit.

Audit Commission

The Government quango responsible for ensuring that public money is well spent. The Audit Commission is in charge of local government's best value inspection regime, and is responsible for auditing the finances of councils and NHS organisations. *See* **Commission for Healthcare Audit and Inspection**.

www.audit-commission.gov.uk/home

Audit facilitator

A professional worker, usually employed by the Medical Audit Advisory Group within a primary care trust, whose role is to assist individual GP practices in implementing audit.

Autocratic leadership

An authoritarian style of management which is regarded as safe and paternalistic, and which carries a clear chain of command and authority. The divisions of work and hierarchy are fully understood by all, as it requires clear, detailed and achievable directives. The autocratic manager is usually an expert in their field, as they receive little or no information from others. This can be dangerous in today's work environment of technological and organisational complexity. Other weaknesses lie in the apparent efficiency of one-way communication – without feedback there are often misunderstandings, communication breakdowns and costly errors. However, the critical weakness of autocratic leadership is its effect on people – it is no longer acceptable for employees to accept and obey orders without question. Most people resent authoritarian rule and respond with resentment, resistance or sabotage. Authoritarian rulers cause low morale. *See* **Leadership**.

B

Balint group

Michael Balint, a Hungarian trained psychotherapist, has described a Balint group as a voluntary, self-selected group of people who meet to learn more about their own behaviour and emotions through reflection upon their work within the group.[1] Balint training for doctors uses group methods to look at the counter-transference process between doctor and patient, and the relationships between the group participants themselves and their leader. The aim is to assist each group member in evaluating his or her responses and recognising useful and difficult personality traits, thereby facilitating useful insight and change. *See* **T-group**.

www.balint.co.uk
www.familymed.musc.edu/balint/

1 Balint M (1964) *The Doctor, his Patient and the Illness*. Churchill Livingstone, Edinburgh.

Beacon services

A scheme that has been set up to identify and spread knowledge of examples of best practice in the NHS, highlighting innovative approaches to reduce health inequalities and improve service provision.

www.ohn.gov.uk
www.modern.nhs.uk/

Bedblocking

The phenomenon whereby older people are forced to stay in hospital beds because other forms of care (such as nursing homes or home care) are not available, thereby 'blocking' beds that could be used by other patients. *See* **Intermediate care**.

Belbin RM

Belbin is best known for the development of a *self-perception inventory* designed to provide members of a group with a simple means of assessing their best team roles.[1] Belbin researched and named the following different personality types found within

groups: the Completer–Finisher, the Implementer, the Monitor–Evaluator, the Teamworker, the Resource Investigator, the Shaper and the Plant. *See* **Group**.

www.belbin.com/

1 Belbin RM (1991) *Management Teams: why they succeed or fail.* Heinemann, London.

Benchmarking

A method used by public sector organisations, charities and private companies for gauging their performance by comparing it with the performance of other similar-sized organisations. The Government encourages public sector bodies to compare their score on various published performance indicators as a way of improving services. Many organisations are now members of 'benchmarking clubs' in which they compare performance information (both published and unpublished).

www.ncvo-vol.org.uk/main/about/does/pdfs/QSTGbenchmarking.pdf

Bias

A predisposition or prejudice towards one particular viewpoint. In statistics, bias is a systematic distortion of a result, arising from a neglected factor.[1] When data are being collected, bias may arise from many causes, including the following:

- inappropriate selection of the population to be studied
- unsuitable measurement methods
- differences in interpretation.

Although attempts are made to avoid bias in research, if they occur they should be formally acknowledged.

1 Damuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions.* Royal College of General Practitioners, London.

Black bag

The doctor's bag. Traditionally a Gladstone bag made of soft black leather with a buckle fastening, it is now more likely to be a briefcase with foam inserts to separate the drugs and equipment inside. Ideally it should be coloured silver, not black, in order to keep the drugs cooler.[1]

- The bag must be lockable.
- It should never be left unattended on home visits (it contains drugs and blank scripts).

- It should be locked and kept out of sight in the boot of a car.
- It should be kept shut when not in use, as bright light may deactivate some of the drugs.
- The origin, expiry date and batch number of all drugs must be recorded.
- Out-of-date drugs should be regularly checked, replaced and disposed of.

It is useful for doctors to keep a second bag, which is more rarely used, for other equipment such as the following:

- peak flow meter
- specimen bottles
- venepuncture equipment, syringes and needles
- venflons and butterflies
- sterile gloves
- sharps box
- swabs
- disposable speculum
- equipment for giving saline infusion
- airways.

1 Rees (2001) The Doctor's Bag. *Doctor*. **27 September**: 63.

Booked admissions

The NHS national booked admissions scheme is an airline-style booking system that was introduced in pilot form in 1999. Originally devised by the National Booked Admissions Advisory Team (part of the Department of Health information technology proposals), it is planned that it will replace waiting-lists by 2005. Under the proposals, patients would be referred by their GPs, who would contact a central agency (NHS Bookings, possibly to be run by NHS Direct) by telephone, letter or email. The patient would then have the responsibility of directing any queries to the centre.

The system will be dependent on computerised links between primary and secondary care, enabling surgeries to book appointments electronically from the surgery as well as via the agency. Patients will be able to arrange outpatient and inpatient admission times at their own convenience, leading to fewer cancelled operations, less bureaucracy and more efficient use of NHS time and resources.

The Government estimates that 17% of GPs' patient contacts are related to referrals or hospital bookings, and the plan is that this telephone booking would free GPs from these patient-related queries.

www.poolehos.org/booked/home.htm
www.society.guardian.co.uk/nhsperformance/

Brainstorming

A method of finding creative solutions to longstanding problems. It starts with a group of people thinking up a list of solutions, including some ridiculous or impossible ones, and then involves sifting through them to see if there are any that, in retrospect, would seem to work.

British Association for Immediate Care (BASICS)

A charity formed in 1977 to foster education and the development of immediate care. Immediate care is defined as the provision of medical help at the scene of an emergency and during transit to definitive care in hospital. It also encompasses the subspecialities of mass-gathering medicine and the medical management of major incidents and disaster.

www.basics.org.uk

British Medical Association (BMA)

An independent, member-only organisation that represents both primary and secondary medical members. The BMA works to represent and develop the careers, education and pay of its members.

www.bma.org.uk

British National Formulary (BNF)

A monthly publication published jointly by the British Medical Association and the Royal Pharmaceutical Society of Great Britain, available free to GPs. It provides information about drugs and their indications, interactions and cost. It is also available online.

www.bnf.org

Brown Bag review

The name given to repeat-prescribing projects which involve a method of reducing prescribing spend and improving clinical care in primary care by implementing

tighter clinical and managerial controls. A full description of this method can be found in the author's book.[1] The steps involved can be summarised as follows:

- an audit of a sample of repeat prescriptions
- identification and analysis of prescribing type and spend (e.g. checking high-cost items and claims)
- a patient compliance check through patient recall or opportunistic consultation to establish use, polypharmacy, compliance, additional self-medication, contra-indications, pharmacokinetics or adverse reactions
- communicating with patients in order to explain, instruct and simplify the regime
- changing the computer recall and flagging system for repeat scripts
- instigating a patient review system for high-risk patient groups
- devising a mechanism for identifying and noting how prescribing is initiated or changed.

Given that two-thirds of all GP prescriptions are repeats, and that they represent 80% of total prescribing costs, such reviews can impact on patient care by considerably reducing risk, wastage and costs.

www.npc.co.uk
www.npc.ppa.nhs.uk

1 Phillips A (2002) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.

Bureaucratic leadership

A leadership and management style that is commonly seen in public sector organisations where there is a demand for uniform treatment, regular procedures and accountability. This brings consistency, dependability and a sense of fairness and impartiality – people understand the rules and feel secure. Regularity of procedures helps to ensure essential values and ethics. However, bureaucracy has led to adherence to specified rules and procedures which can stifle flexibility, creativity and freedom. Although directives, policies and rules are essential in any business, there must be some flexibility. *See* **Leadership**.

Business ethics

This has been defined as the study of moral and ethical matters pertaining to business, institutions, practices and beliefs.[1] The following subjects fall within the domain of business ethics:[2,3]

- workers' rights

- consumer safety
- discrimination
- codes of conduct
- accounting practices
- energy utilisation
- company perks
- contracting
- relationships with trade unions
- whistleblowing
- computer data and privacy
- environmental protection
- research
- corrupt practices.

If dilemmas and disagreements are experienced at work due to a clash of values, this becomes an ethical issue. Some colleagues may be guided more than others by their principles or a sense of duty, their views being influenced by religious beliefs or moral values. Most people can agree on the importance of honesty, truthfulness and integrity, but this process may be assisted if healthcare organisations develop *codes of business ethics* so that individual members and stakeholders can be provided with clear guidance on the business stance. *See* **Sustainable development**.

www.defra.gov.uk/environment/greening/index.htm
www.nhsestates.gov.uk/
www.sustainable-energy.org.uk

1 Donaldson J (1989) *Key Issues in Business Ethics*. Academic Press, London.

2 De George R (1989) *Business Ethics* (3e). Macmillan, Basingstoke.

3 Webly S (1993) *Codes of Business Ethics: why companies should develop them – and how*. Institute of Business Ethics, London.

Business plan

A business plan covers all aspects of an organisation, including the service, finances, premises and team skills. The *process* of business planning enables the business to:[1]

- clarify some of the wider issues facing the business
- evaluate itself, detailing its strengths and weaknesses

- provide a statement of intent for interested stakeholders
- formulate goals and identify the action needed to achieve those goals
- identify resources required in terms of skills, activity and finance
- anticipate and plan for problems.

Business plans are usually issued to the business's professional advisers and sponsors – the bank manager and the accountant. Most practices keep information about practice income and expenditure private to the practice and its own business associates. Sharing the plan helps to firm up proposals so that everyone can ascertain whether or not the practice ideas are going to be viable. It is also useful to establish whether the practice aims and objectives coincide with those of the NHS as a whole.

The business plan provides details of the following:

- business aims and objectives
- staff/partnership structure
- current and future patient services
- the list or population size
- outside commitments
- capital resources – buildings and equipment
- clinical performance
- finance
- overall strengths and weaknesses
- external forces that may impact on the future of the organisation.

See **Planning cycle**.

www.anniephillips.co.uk

1 Phillips A (2002) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.

Business process re-engineering (BPR)

A type of organisational analysis. It is defined as the fundamental and radical redesign of business processes, with the aim of achieving dramatic improvements in performance by critically measuring cost, quality, service and speed.[1] As with total quality management approaches, such exercises challenge the existing framework by questioning attitudes and behaviours, but unlike total quality management, business process re-engineering seeks major advances in performance, takes a strategic

approach and is driven by top management. Total quality management requires a more supportive environment and aims for continuous (as opposed to 'one-off') improvement. *See* **Total quality management**.

1 Hammer M and Champy J (1993) *Re-Engineering the Corporation: a manifesto for business revolution.* Nicholas Brealey, London.

C

Caldicott

The work of Caldicott 'Guardians' within primary care organisations is to ensure that patient confidentiality issues are complied with and manual and IT systems are secure. Caldicott Guardians look at issues such as confidentiality and security, information, clarity, rights of access and documentation accuracy. Primary care organisations work with advice and guidance for protecting and using patient information through a programme of work recommended by Caldicott. *See* **Data Protection Act 1984 and 1998**.

www.doh.gov.uk/

CAMs

The term for therapists who practise *complementary and alternative medicine* (e.g. medical herbalism, aromatherapy, acupuncture). The tension between orthodox, allopathic medicine and the complementary therapies is easing as complementary therapies develop their evidence base and medicine becomes more open to the value of the CAM (complementary and alternative medicine) approach.

The NHS cannot recommend or purchase such care without evidence of the effectiveness of treatments, cost-effectiveness, professional regulation and local health needs assessment, so CAMs are encouraged and supported in research to help build the required evidence base. There are over 91 UK bodies representing 50 000 assorted CAM practitioners, and many more practitioners work without belonging to such a body.

Patients currently make 22 million visits each year to CAM practitioners – 34% to medical herbalists, 21% to aromatherapists, 17% to homeopaths, 14% to acupuncturists and 19% to other practitioners (massage, reflexologists, osteopaths, chiropractors). Osteopaths and chiropractors are now regulated (with aromatherapy, acupuncture and herbalism soon to follow). Around 40% of GPs provide some form of access to CAMs, and 68% refer at least monthly – most commonly to acupuncturists. They usually refer what they fail to manage, especially depression, sleep/eating problems and chronic illness.[1] A common request from GPs is that they need more information about what cases to refer and when. Most of them refer by personal recommendation.

www.ukcollege.com
www.harcourt-international.com

1 Fox M, CEO for the Foundation for Integrated Medicine, speaking at the Conference on Integrated Medicine in Primary Care, 6 October 2001, Brighton.

Capacity

The resources available to an organisation, including people, money, equipment, expertise and information.

www.doh.gov.uk/
www.local-regions.dtlr.gov.uk

Capital spending

Expenditure on new construction, land, improvements to existing property and the purchase of all other equipment and assets (e.g. computer hardware) that have an expected working life of more than one year. *See* **Care package**.

www.hmso.gov.uk/
www.dtlr.gov.uk/

Capitation fees

Part of the system of fees and allowances paid to General Medical Services GPs quarterly, pre the new GP contract. These payments are based on the number and age of people registered with a practice, with elderly patients attracting the highest fees. Additional payments are made each time a patient registers, and each time a doctor takes responsibility for child health surveillance, which includes those children who are on the at-risk register (i.e. at risk of physical, emotional or mental harm). *See* **Fees and allowances**; **New GP contract**.

Care management

This term, introduced in the NHS and Community Care Act 1990, refers to the management of the care of those in receipt of a care package. *See* **Care package**; **Care plan**.

Care package

A group of services brought together to achieve one or more objectives of a *care plan*. *See* **Care management**.

www.doh.gov.uk/

Care pathway

An approach to managing a specific disease or clinical condition that identifies what interventions are required, and which predicts the chronology of care and the expected outcome of the treatment. The approach is designed to ease the passage of the patient by co-ordinating care through the healthcare system from primary to secondary to tertiary care, and vice versa.

www.nelh.nhs.uk/carepathways.asp

Care plan

A plan (sometimes called a *collaborative care plan*) for providing care services to an individual or family. The plan should follow an assessment at a case conference or review and involve service users (patients/clients), carers and their families, as well as all relevant professionals. *See* **Care programme**.

Care programme

A detailed programme of care that contributes to one of the goals of a care plan. *See* **Care plan**.

Carer

A person who provides care on a regular basis, and who is not employed to do so by an agency or organisation. A carer is usually a friend or relative looking after someone who is frail or ill at home. The Government is introducing new legislation with the aim of assisting carers emotionally and financially, in recognition of the physical, emotional and financial savings that carers bring to the State.

Care trust

A local body that is responsible for delivering primary healthcare, community health services and social care for older people. Ministers believe that care trusts will facilitate and integrate joint working between health and social care. The first trusts, which were developed from existing primary care trusts, went live in April 2002.

www.doh.gov.uk/caretrusts/

Case mix

The mixture and severity of clinical conditions that are found in a particular healthcare setting. Healthcare commissioners often use their understanding of case mix to interpret clinical performance. Trusts use case mix crucially to defend their organisation's underperformance. For example, a specialist paediatric department might explain that it has higher than average postoperative disability rates on 'case-mix' grounds, because it has more complex and difficult cases than the norm.

Centralisation

Moving different parts of an organisation together in order to gain economic and administrative advantages. Centralisation makes it easier to implement common policies and develop consistent strategies, it is easier for management control and it leads to greater use of specialisation and improved decision making. It is more common in the public sector, where there is greater demand for accountability, regular procedures and uniform treatments. *See* **Decentralisation**.

Certification

Often used interchangeably with *accreditation*, this may be defined as the formal recognition of competence and performance.[1] The term is commonly used to describe the satisfactory completion of a period of training. Recertification describes the periodic revalidation of a doctor's certification status – a term that has now been superseded by revalidation. *See* **Accreditation of healthcare; Revalidation**.

www.rcgp.org.uk/

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions*. Royal College of General Practitioners, London.

Chair

The person who is given responsibility for controlling a meeting by taking a leadership role and ensuring that the meeting keeps to time. He or she does this by discouraging side talking, allowing space for everyone to contribute, being aware that everyone has a different agenda, and encouraging participants to agree to abide by any decisions that are made.

Good chairing requires excellent interpersonal and communication skills. A chair's role will also be to elicit differing points of view. He or she requires knowledge of the subject under discussion, organisational skills, a broad understanding of group dynamics, and the ability to manage conflict. The chair encourages differing viewpoints while supporting the discussion, and ensures that everyone present sticks to the subject. They will do this by extracting ideas and summarising, thus helping the group to achieve a successful outcome. *See* **Facilitation**.

Change

Change is an inescapable part of working lives, yet most people resist change. There will always be powerful internal and external forces pushing for change, which will be viewed as positive by some in the organisation, and as negative by others. Change involves the whole team, and it is important to involve the whole organisation in any change, so that everyone is clear about the decisions. There is not necessarily ever a best or right way to change things – as this depends on the task and the state of the organisation at the time. *See* **Change management; Forcefield analysis**.

Change management

The process of managing change involves understanding the need to change, understanding the resistance to change, identifying the need for and planning for change. Successful change managers allow for a period of transition, seek commitment and support, problem solve, and use their supporters' energy, enthusiasm and lead. They involve staff and provide facts in order to avoid rumour and uncertainty, and finally they monitor and evaluate change.

Change management is particularly difficult for organisations that lead with an *autocratic* or *task-centred* leadership style, as this style of management is authoritarian and controlling, rather than *people centred*. Nor will change management be successful in organisations with *free-rein* leadership, where it is never clear who leads, and chaotic management results.

Good change management is *proactive* rather than *reactive*. Therefore successful organisations are those which actively prepare for change. Change is unsuccessful when it has been improvised and forced, rather than planned. There is no magic formula for change management, but there are some clear themes, which include the following:[1]

1 a clear sense of direction

2 good communication

3 strong feedback from service users

4 robust performance management systems.

The costs to organisations that resist expected change are dear, but the benefits to those that do not resist are fundamental, both financially (the organisation grows into the role expected of it) and personally (there is less stress and conflict for those working within it). *See* **Change; Forcefield analysis; Stakeholder analysis.**

1 Brindle D (2001) Clear sighted. *Guardian*. **11 July**: 12.

For more information on how to manage change successfully, see the following:

- Phillips A (2001) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.
- Phillips A (2002) *Assertiveness and the Manager's Job*. Radcliffe Medical Press, Oxford.

Charges to patients

NHS GPs are permitted to charge their own patients for non-NHS-approved and private work. This includes certificates given with or without examination (e.g. sick notes, incapacity certificates for employers, insurance companies and sickness medicals), some travel vaccinations, and work done in the surgery on the patient's behalf (e.g. extracting and photocopying medical records for a solicitor's report).

Charismatic organisations

In one of the earliest studies of formal organisations, Weber[1] distinguished three types of authority relating to different types of organisations, namely traditional, bureaucratic and charismatic. Common to single-handed general practice, in charismatic organisations authority is legitimised by a belief in the personal qualities of the leader – the strength of their personality and inspiration. Charismatic organisations flourish only while the leader is established, and if routine procedures, systems and economic support are established in addition.

1 Weber M (1964) *The Theory of Social and Economic Organisation*. Collier Macmillan, London.

Charter mark

An award administered by the Cabinet Office for excellence in delivering a public service. It was launched as part of the Citizen's Charter scheme.

www.cabinet-office.gov.uk/servicefirst/index/markhome.htm

Chief executive bulletins

Circulars that are emailed from the Department of Health weekly to NHS and Council chief executives and directors of social services, and which are then placed on the Department of Health website. They replace the previously used HSC and LAC circulars, listings for which are set out in the bulletins, and are now used only for urgent and priority messages.

www.doh.gov.uk/cebulletin.htm

Child Protection Register

A confidential list, held by social services, of every child in a local authority with regard to whom there is serious concern about abuse or neglect. Registration aims to ensure that children and their families are receiving necessary help, but it does not affect a carer's legal responsibility towards their child. A case conference, usually attended by the family's GP, social worker and health visitor, can decide to place a child on the register. A child protection plan is put in place if there is concern about a child's physical and emotional well-being.

www.adss.org.uk
www.basw.co.uk/

Chi-squared test

A statistical technique that is used to test the frequency of a particular event (the number of times that it occurs). It thus tests the significance of proportions, or associations between categories used in an experiment.[1]

1 Robson C (1975) *Experiment, Design and Statistics in Psychology*. Penguin, Harmondsworth.

Clinical audit

See **Audit**.

Clinical Data Standards Board

The body that will provide the national standards to be used for data collection in any given clinical topic area. Clinical audit data sets developed to support National Service Frameworks, for example, will be scrutinised by the NHS National Information Authority's own data sets and, once ratified, will provide the national standard to be used for other data collection in the same topic area. Over time, this process of standards ratification will provide a library of accredited standards for use throughout the NHS. *See* **National Service Framework**; **NHS National Information Authority**.

www.doh.gov.uk/ipu/strategy/

Clinical governance

An umbrella term covering the implementation of evidence-based practice, supporting and developing the technological and clinical information infrastructure and ensuring that changing practice occurs in the light of *audit*, research and *risk management*.

Clinical governance is at its heart a quality improvement programme for healthcare. It is a concept which aims to bring together all of the components of good clinical practice and quality. It aims to improve patient care by achieving high standards, reflective practice and risk management as well as supporting personal and professional development.

The systems embraced by clinical governance include the following:

- clinical audit
- risk management
- revalidation
- evidence-based clinical practice (National Institute for Clinical Excellence, Commission for Health Improvement, protocols and local guidance)
- development of clinical leadership skills
- continuing education for all staff (personal development plan and practice professional development plan)

- audit of consumer feedback
- accreditation.

It has a strong resemblance to the concept of *total quality management (TQM)*, and involves the following:

1 co-operating and working with others
2 applying the principles locally
3 focusing on improving and maintaining high standards of care
4 helping to ensure good practice
5 setting clear service standards
6 performing clinical audit
7 ensuring that evidence-based practice is carried out
8 collecting records to help review performance and monitor patient care
9 implementing risk management plans
10 reporting adverse healthcare incidents
11 setting clear performance standards for all staff
12 promoting a learning environment
13 valuing openness
14 involving patients.

A good clinical governance programme would involve the application of good practice principles, such as the following:

1 the detection and investigation of *significant incidents* or adverse events
2 evidence-based clinical practice
3 the integration of clinical audit into the organisation
4 clinical risk reduction
5 the identification of and action against poor clinical performance
6 continuing professional development programmes in place for all staff.

This raises challenges for managers, who will have a role in assisting and encouraging the development of leadership skills and knowledge among clinicians, developing the appropriate accountability structures, and developing mechanisms to ensure that clinical audit is integrated into the organisation. *See* **Accreditation of healthcare;**

Commission for Health Improvement; Competence assessment schemes; National Institute for Clinical Excellence; Performance assessment framework; Performance indicator; Quality; Revalidation.

Clinical Governance Research and Development Unit (CGRDU)

The CGRDU was created in 1999 as a successor to the Eli Lilly National Clinical Audit Centre. Its main aim is research and development within the clinical governance field. The unit aims to support health service staff by providing information, guidance, training and publications on *clinical governance* and *audit* issues.

www.le.ac.uk/cgrdu

Clinical (practice) guidelines

Systematically developed statements (of principle) which assist in decision making about appropriate healthcare for specific conditions.[1] Clinical guidelines can also be used to define quality criteria in contract specifications. Guidelines are made up from collections of *criteria* which describe the nature and reflect the standard of care in precise terms. *See* **Protocol.**

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions.* Royal College of General Practitioners, London.

Clinical supervision

A term used in the NHS to describe the offline management support of clinical staff. It is an opportunity to reflect on practice, to enhance skills and to clarify goals for professional development.[1] Staff who are counsellors, or who have some knowledge of counselling training, are often asked to act as clinical supervisors for other disciplines. *See* **Clinical supervision; Coaching; Mentoring.**

1 Kell C (2002) Can counsellors adequately supervise non-counsellors? *J Counsell Psychother.* **13**: 36–7.

Clinician

A health professional who is directly involved in the care and treatment of patients, for example a nurse, doctor, therapist or midwife.

Closing the loop

The term that is used for completing the audit cycle. It involves adjusting practice in the light of results and repeating the survey to test for evidence of effective change. *See* **Audit.**

Coaching

As part of the facilitation of learning, coaching is a 'process that enables learning and development to occur and thus performance to improve'.[1]

It is a term for bringing out the best in people and improving their skills by giving guidance, insight and encouragement during the learning process. The emphasis is on performance, success and developing one's full potential. A coach is usually someone who is not in their client's profession. MacLennan[2] has identified six main components of successful coaching:

1 first-hand experience and understanding of workplace achievement

2 a conceptual understanding of the process

3 performer-empowering attitudes and assumptions

4 skills in strong rapport creation and maintenance

5 excellent listening skills

6 sophisticated questioning skills.

Coaching is now divided into *executive coaching* and *life coaching*. The latter looks at all of the issues in a person's life, whereas the former is focused on life at work. It is widely accepted that coaching can have an important and revitalising effect on organisations. *Mentoring* requires a set of skills which include the role of a coach. *See* **Clinical supervision; Mentoring.**

1 Parsloe E (1999) The manager as a coach and mentor. *J Counsell Psychother.* **13.**

2 MacLennan N (1995) *Coaching and Mentoring.* Gower, Aldershot.

Code of conduct

See **Management code of conduct.**

Collaborative care

See **Care plan.**

Collaborative care planning

See **Care plan.**

Commission for Health Improvement (CHI)

A Government-sponsored inspection unit that seeks to ensure the quality of clinical practice while driving forward a concept of development, continued improvement, and encouraging and sharing best practice. The CHI aims to provide an accountability

framework for NHS institutions and to improve public confidence in the NHS by addressing dangerous incidents and variations in performance. Like the National Service Frameworks and National Institute for Clinical Excellence guidelines, it aims to co-ordinate risk management, reinforce clinical audit and investigate adverse incidents. Its overall aims is to achieve a reduction in morbidity and mortality in the organisations that it inspects.

The principles of the CHI are:

- patient centred
- independent and fair
- developmental/involving active learning
- evidence-based
- open and approachable
- focused on patient care, not cost.

The CHI sees itself as having four roles, namely to investigate, review, evaluate and implement the following:

- clinical governance reviews
- National Service Framework studies
- National Institute for Clinical Excellence guidelines
- serious failures.

It aims to give advice and information to institutions that it inspects at corporate, patient, team and peer level.

The CHI aspires to provide a framework for NHS institutions to be accountable for their actions. *See* **Commission for Healthcare Audit and Inspection**.

www.nhs.uk
www.doh.gov.uk/
www.modern.nhs.uk/

Commission for Healthcare Audit and Inspection (CHAI)

A new independent body set up to regulate healthcare within the NHS. The Government announced its intention (in March 2003) to establish this new Commission which will bring together the health value-for-money work of the Audit Commission, the work of the Commission for Health Improvement and the private healthcare role of the National Care Standards Commission. This new single Commission

will have responsibility for inspecting both the public and private healthcare sectors. Its principal roles will include:

- inspecting all NHS hospitals, with the ability to recommend special measures where there are persistent problems
- Licensing private healthcare provision
- Assessing the value-for-money of healthcare provision
- publishing reports on the performance of NHS organisations, including 'star ratings'
- publishing an annual report to Parliament on progress on healthcare delivery and the use of resources.

The intention is that CHAI becomes a powerful inspectorate and a force for improvement in the quality and equity of, and access to, NHS services.

www.doh.gov.uk/nhsacc/chai.htm

Commission for Patient and Public Involvement in Health (CPPIH)

An independent body charged with overseeing patient and public involvement in healthcare. This national commission was set up in 2002 as part of the Government plan to get more lay people involved in NHS decision making. Local networks began to be set up in 2003. The commission will oversee the Patient Advocacy and Liaison Service and patient forums that are set up in every acute and primary care trust, and the Independent Complaints Advocacy Service.

The CPPIH will also assist in the development of national patient surveys. *See* **Patient Advocacy and Liaison Service; Patients' forum.**

www.doh.gov.uk/involvingpatients
www.nhs.uk

Commissioning

The process by which the needs of the local population are identified, priorities are set, and appropriate services are then purchased and evaluated. Undertaken by the commissioning bodies such as primary care organisations and care trusts, it involves comparing waiting-list and league-table information provided by service providers such as trusts and special health authorities, and identifying variances in their costs and benefits. The consequences of these variances need to be established – a political and public debate is generated where funding judgements are made between services.

The information needs in commissioning healthcare are wide and complex. Commissioners obtain demographic facts about the numbers and health status of their

population, and they try to identify an understanding of any *health outcomes* (any increased health benefits). Health gains may not always be clearly identifiable as clinical or financial, but may instead be physical, social, mental or emotional. Additional commissioning components include setting targets for health status, using information from existing services, and deciding on possible interventions from audits, research and opinion.

A picture of health is created by means of the following:

- epidemiology
- morbidity data
- mortality data
- locality analysis
- demographics
- auditing and evaluation of current and historical activity
- a review of current medical opinion and evaluation of clinical outcomes.

The *NHS Alliance*, which developed out of locality commissioning, has stated that commissioning should always include needs assessment, prioritisation and impact evaluation. It should be clinically driven, population specific, reflect patient experience rather than organisational boundaries, employ integrated care pathways, be sensitive to local need and have sophisticated service specifications with effective means of evaluating outcome. *See* **Health needs assessment/analysis**.

www.ohn.gov.uk/glossary/c.htm
www.doh.gov.uk/nhsfinancialreforms/
www.doh.gov.uk/finman.htm
www.nhsalliance.org

Communication

Communication may be defined as 'the exchange of information between a sender and receiver with the inference of meaning'. Around 85% of communication content is non-verbal – communicated in gestures, facial expression or tone of voice. Communication is complex, and involves the following:

- a message (statements, questions, commands or warnings)
- a language (words – written or spoken; symbols – music, art, body language and gestures)
- a system (listening, touch, silence, voice, gestures, writing).

The way in which something is communicated (its *delivery*) describes the content. A person's facial expressions, timing and speed, body language, voice tone and

word choice will tell us whether the situation is public or private, doubtful or hopeful, formal or informal, serious or relaxed. These words and symbols have different meanings in different cultures.

Communication is multi-directional. It can be directional or one way, face to face, outward (towards the patient), 'up' from employee to employer, or lateral (when teambuilding, exercising leadership or motivating staff). Different communication styles are adopted for different functions (chairing, facilitating, presenting, instructing, etc.).

Personality, history, motivation and other less visible factors such as organisational structure, interpersonal relationships and the level of information also influence how and what we communicate.

Communication is a central organisational process. The exchange of information between different participants links the various subsystems and hierarchies within the organisation, and builds and reinforces interdependence between them. The larger and more specialised the work groups within the organisation, the greater the potential for misunderstanding. Differences in power, goals and expertise between departments may make communication difficult.

The relationship between the two people who are communicating also affects the accuracy with which messages are given and received – how much trust there is between the two, how much influence the sender has over the receiver, or expected standards of behaviour. All of these factors may limit the amount or type of information that people feel they can legitimately discuss. The amount of information that is held is also significant. If one is relying on only one source of information when judging performance, persistent biases are likely to occur.

Communication enables us to make discoveries about ourselves and others, to solve problems and develop new skills, to manage conflict, emotion and anger, and to question, adapt, change and grow. Some of the barriers to effective communication include the following:

- lack of feedback
- judging, controlling or evaluating behaviour
- internal or external 'noise' (interference)
- the use of language – misunderstandings can arise from the use of unfamiliar, abstract or technical terms
- the quality of listening by the receiver.[1]

The factors that most commonly affect clinical negligence claims are communication breakdown, poor systems and processes and human error.[2] Because of this, it is an important part of the job of any manager in healthcare to develop formal systems to manage administrative and clinical communication systems such as telephone protocols, tracer systems for records, systems for notifying patients of delays and results, and complaints procedures.

Good communication integrates quality through sharing good practice, listening and giving feedback. For communication to be successful, the following criteria have to be met.

- Both sides must be interested and involved.
- Both sides need to be willing to be open and honest.
- Both sides need to feel heard and understood.
- The atmosphere must be comfortable.
- Even if the talking is difficult, the important things need to be said.
- Conversations have to make a difference. Something useful or satisfying must happen as a result.

Good communicators 'read' the situation, engage people's attention, clarify meaning and check understanding. *See* **Listening skills**; **Non-verbal communication**.

1 Phillips A (2002) *Communication and the Manager's Job*. Radcliffe Medical Press, Oxford.

2 Wilson J (1995) General practice risk management. In: *News for Fundholders. Issue 4*. NHS Executive, London.

Community Health Councils

Locally elected bodies which were set up to independently assess local services and help patients to pursue formal complaints. They were replaced by the *Independent Complaints Advocacy Service*, set up as part of the Commission for Patient and Public Involvement in Health, in late 2003. *See* **Commission for Patient and Public Involvement in Health**.

www.btinternet.com/~cornwallchc/chc.htm

Community mental health team

A multidisciplinary team consisting of psychiatrists, social workers, community psychiatric nurses, psychologists and therapists who provide assessment and treatment outside hospitals for patients with severe and enduring mental health problems.

www.psychiatry.ox.ac.uk/
www.scmh.org.uk

Community/compulsory treatment order

Compulsory readmission to hospital of psychiatric patients in the community who fail to take their medication, a proposal introduced by the Government to reform

the 1983 Mental Health Act. Patients discharged from hospital would receive a compulsory care and treatment order specifying where they are permitted to live, as well as a care plan.

www.mind.org.uk/
www.smhc.org.uk

Competence assessment scheme

One of the measuring tools examined by the General Practitioners Council, General Medical Council and Royal College of General Practitioners is a competence assessment scheme, as it is recognised that doctors require not only academic competence but also operational competence.

Research[1] has identified several key competence criteria, which are those qualities most commonly mentioned by other GPs who are seeking medical care for their own family or friends. These criteria include the following:

- empathy and sensitivity
- team involvement
- personal organisation and administrative skills
- mechanisms for coping with stress
- communication skills
- legal, ethical and political awareness
- personal attributes
- professional integrity
- conceptual thinking
- job's relationship to society and family
- personal development
- clinical knowledge
- managing others
- learning and development.

See **Personal development plan.**

1 Ferguson E *et al.* (2000) A competency model for general practice: implications for selection, training and development. *Br J Gen Pract.* **50.**

Complaints

According to a General Medical Service report,[1] the most common complaints requiring resolution in general practice are the following:

- care management (35%)
- complaints associated with grief (20%)
- delayed or failed diagnosis (12.7%).

The recently bereaved are more likely both to attend the doctor for their own recent onset of illness, and to complain following the bereavement of a loved one. It is well documented that feelings such as fear, anxiety and loss of control greatly heighten physical and emotional pain and difficulties.

An effective *complaints procedure* would acknowledge these factors, and would be proactive in preventing complaints initially by supporting good practice. *See* **Complaints procedure**.

www.doh.gov.uk/complaints/index.htm

1 Green (2000) *Pulse*. **15 December**.

Complaints procedure

Primary care trusts require all primary care organisations to have complaints procedures. These procedures must be documented in waiting areas and patient literature, to make it easier for patients to make a complaint if they wish to do so.

Complaints procedures ideally include the auditing of any comments and complaints received, categorise the reason for the failure, are open about naming the person responsible, and encourage collective discussion and problem solving before implementing the solution. *Significant event analysis* can form part of this formal procedure. Here the evidence is presented back to the team so that it can inform future better practice.

If there has been cause for complaint, the complaints policy ideally outlines the best procedures to follow (e.g. a personal apology given over the telephone results in a higher level of complaints being resolved than an apology by letter; putting the problem right immediately causes the least anguish).

All NHS provider units, including GP practices, are required by their commissioning or employing trusts to have complaints procedures in place, so that patients are aware of how to make a complaint and the trust or practice understands the procedure to follow in the event of a complaint made against them. *See* **Complaints**.

Computing in healthcare

Visit www.phcsg.org.uk for the primary healthcare specialist group division of the British Computer Society medical group. Here you will find information on national user groups, discussion topics and *Informatics in Primary Care* (Radcliffe

Medical Press, Oxford, www.radcliffe-oxford.com/journals). *See* **Information technology accreditation.**

www.phcsg.org.uk

Confidentiality

The ethical duty of healthcare professionals to keep private any information which they have learned about their patients. According to the basic principles of confidentiality within the NHS, information may be passed to others if:

- the patient consents to this for a particular purpose, such as an insurance report
- it meets NHS purposes, including the effective management of healthcare
- it is a statutory requirement or in response to a court order
- it is in the public interest.

Healthcare workers must not disclose or use any confidential information obtained in the course of their work, other than for the clinical care of the patient to whom that information relates. The legal and medical exceptions include exceptional circumstances such as disclosure in the patient's own interest, that required by law, any overriding duty to society because of national security or public health concerns, teaching and research or the storage and transmission of records and information. Others may be engaged to handle confidential information, but only to meet management needs.

All health service workers sign up to an ethical obligation to keep information about patients private and confidential. Any staff member who handles patient data has a duty not to disclose learned sensitive information to any third party. In 1993 the General Medical Council allowed that information may be disclosed with the explicit consent of the patient. However, in the case of audit, the general rule is that anonymised data should be used wherever possible. If at any stage a disclosure would enable an individual patient to be identified, that person must be informed and advised of their right to withhold consent to disclosure. In order to ensure patient confidentiality, NHS workers are advised to:

- obtain prior consent from patients
- anonymise patient information
- avoid codes that could identify patients or doctors
- destroy audits when these are complete
- register with the Data Protection Act.

See **Data Protection Act 1984 and 1998.**

Confidential enquiry

An anonymised, often national, survey or data collection of identified adverse events and their related circumstances.[1] *See* **Significant event analysis**.

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meetings and definitions.* Royal College of General Practitioners, London.

Conflict management

Conflict management means to actively seek out the sources of stress within an organisation, either in individuals or in groups, and to devise ways either to accept and manage the difficulties, or to change the situation.[1] *See* **Change management**.

1 Phillips A (2002) *Assertiveness and the Manager's Job.* Radcliffe Medical Press, Oxford.

Constructive criticism

This is criticism given wisely, the only aim being that the person being criticised should learn in a positive manner from the experience. It is specific, avoids attack or blame, and does not give unsolicited or unwanted advice. It is given without judgement, and avoids global or generalised statements about behaviour, as these can be construed as an attack on an individual's personality. Those giving constructive criticism do not assume that they know what motivates other people, for they may be mistaken. Constructive criticism spells out the consequences of changed behaviour, while acknowledging that people may not be able to change. Constructive criticism views others as equals. *See* **Appraisal**; **Assertiveness**; **Disciplinary interview**.

Continuing professional development (CPD)

A process of planned, continuing development of individuals throughout their career. Sometimes termed lifelong learning, it is regarded as the systematic maintenance, improvement and extension of professional knowledge and skills, and the development of the personal qualities necessary to execute the job. An important part of any job is self-development. CPD is designed so that individuals will derive personal satisfaction from their work and contribute fully to the success of their organisation. Management organisations such as the Institute of Health Service Managers (IHSM) are now investigating how to incorporate CPD into the manager's job in healthcare.

CPD was set up by the Government to encompass the entire workforce.[1] It encourages rigorous self-regulation, continued implementation of recertification or revalidation, and acceptance of professional accountability. It requires the development of appraisal systems, learning organisations, revalidation and regulation.

Clinical training is planned for and supported nationally. GPs are now required to keep records of their ongoing clinical development in *personal development plans*.

Nurses have requirements to keep up to date built into their contracts. Other clinical support services (e.g. therapists) have revalidation or registration requirements which ensure that they are kept up to date professionally. It is expected that the Government and primary care trusts will support all NHS professionals (support and ancillary staff), who do not currently have the backing of professional bodies to guide and inform their practice, in CPD.

1 Department of Health (1998) *A First-Class Service: quality in the new NHS*. The Stationery Office, London.

Continuity of care

If a patient or client undergoes a smooth passage through the health and social care system, despite the involvement of many different disciplines in their care, they are said to have received continuity of care. This is often facilitated by the patient being given a named person, or *key worker*, who co-ordinates the episode of care. *See* **Care pathway**.

Contract: GP

Strictly speaking, there is no single GP contract – the term is used in the wider sense, referring to the regulatory framework which governs how GPs work within the NHS (the *Red Book*, terms of service, the legislation and regulations). Negotiations to produce new national (General Medical Service) and local (Personal Medical Service) contracts are currently under way. The Government priorities are for local pay, a fixed budget, quality-driven, quicker and better patient access, skill mix within practices, and developing specialist GP services.

A potted history of general practice shows how this contract has developed.

1 In the nineteenth century, doctors were paid on the basis of the amount that patients paid into sick clubs and friendly societies – this was known as *capitation*.

2 In 1911, the National Insurance Act created a framework of GPs as independent contractors. The 'pool' system of payments was introduced, with the total amount for GPs decided centrally.

3 In 1948, Aneurin Bevin set up the NHS. GPs were persuaded to become employees, but preserved their self-employed status.

4 In 1966, the Government conceded to GP demands for substantial contract changes, including pensions and Government-funded premises and staff.

5 In 1990, health secretary Kenneth Clark imposed a new contract on GPs with higher capitation-based payments, fundholding and an extension of GP services such as health promotion.

6 In 1992, GPs began to express an interest in the salaried option.

7 In 1998, the NHS Primary Care Act introduced the idea of *personal medical service* (PMS) pilots.

8 In 2000, the NHS Plan resolved to expand the local PMS system, and looked to build in national arrangements so that both would operate within a single contractual framework by 2002.

9 GPs voted in early 2003 on whether to accept a new GP contract. *See* **New GP contract**.

www.rcgp.org.uk/

Control

A *control experiment* is an experiment performed to provide a standard of comparison for other experiments. A *control group* is a group of subjects that provides such a standard of comparison.

Managerially, the type and amount of control that is exercised in an organisation has an effect on employee performance.[1] Organisational leaders are aware of the forces in themselves, in the people whom they manage, and in the situation that is being managed.

Control also implies something about the individual's standing within the organisation. It provides either a safe or constraining boundary, and it either restricts or gives freedom of choice. In general, people feel good and powerful when they exercise control, and they may be more willing to conform in these circumstances. Control seems to help individuals to identify with their workplace, but there will always be resistance to control among people with low self-esteem and less belief in authority.

1 Tannenbaum R and Schmidt WH (1973) How to choose a leadership pattern. *Harvard Bus Rev.* **May–June**: 162–75, 178–80.

Controls assurance

A systematic self-assessment procedure for identifying and managing clinical risk. *See* **Clinical governance**; **Health and safety**; **Risk assessment/management**.

Core value system

This represents the key values that are important to people. Common examples of such values include security, respect, money, achievement, health, success, ambition, freedom, integrity, compassion, independence, family, children, travel and trust. When we live in conflict with our own inner values, this can lead to unhappiness, frustration and blocks. Becoming aware of our values, and prioritising them, helps us to reassess our goals. If freedom, independence and achievement are high on our list, we will need to be in a job that can give free rein to these qualities.

Correlation

A statistical term that is used to describe the relationship between one variable and another.[1]

1 Robson C (1975) *Experiment, Design and Statistics in Psychology*. Penguin, Harmondsworth.

Cost rent scheme

A scheme in which GPs pay a notional rent for premises rented from private developers. Primary care organisations are now less likely to use these, preferring *private finance initiative* schemes. *See* **Local Improvement Finance Trusts**; **Premises improvements**.

Council for the Regulation of Healthcare Professionals (CRHP)

Shaped by the Kennedy Report,[1] a body that was established to strengthen the framework of professional self-regulation and to ensure greater consistency between the nine health profession regulatory bodies covering doctors, dentists, nurses, midwives, health visitors, opticians, pharmacists, osteopaths and chiropractors. The Council has now been replaced by the Health Professions Council.

The functions of the CRHP include the following:

- protecting and promoting the interests of service users and the public
- managing a framework for self-regulation
- comparing and reporting on the regulator's performance to promote continuous improvement
- promoting co-operation and the sharing of good practice.

The CRHP was set up as a key part of the Government's drive towards greater co-ordination and accountability in professional self-regulation. Professional regulation in healthcare provides independent standards of training, conduct and competence for each profession in order to protect the public and guide workers and employers. *See* **Health Professions Council**; **Regulation**; **Self-regulation**.

www.hp-uk.org/

1 Kennedy I (2000) *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary*. The Stationery Office, London.

Counselling skills

Interpersonal communication skills developed by counsellors but also used by any good communicators. They include effective listening, active questioning, summarising, problem-solving, diagnosing, evaluating and reflecting skills, and accepting behaviour patterns.

Managers may be required to listen to and give advice on problems that may directly or indirectly affect their staff's work. Here person-centred and first-line counselling skills should ideally be used. They include the following:[1]

- empathy
- non-intrusive support
- listening

- open questions
- reflective questions
- observational skills
- accepting and non-judgemental comments
- summarising.

The interviewer will direct or guide the interviewee, with the aim not of telling them what to do, but rather of helping the interviewee to solve or come to terms with the problems him- or herself. In humanistic counselling practice the counsellor adapts their way of working to suit or 'fit' the individual. The interviewee in this instance acts to provide a sense of:

- choice
- safety
- positive self-regard
- focus of evaluation
- congruence
- open presence
- encouragement
- ongoing commitment to the interviewee.

The interviewee, if given adequate time and space in which to explore their problem, will know when the work begins and ends, but the interviewer provides a safe boundary.

For more information on interviewing and counselling skills, see the author's book.[2] *See* **Interpersonal communication skills**.

1 Rogers C (1967) *On Becoming a Person*. Constable, London.

2 Phillips A (2002) *Communication and the Manager's Job*. Radcliffe Medical Press, Oxford.

Crisis resolution

A service, led by a mental health team of nurses and support workers, designed to provide a 24-hour time-limited service for adults over 18 years of age who have a mental health problem and who have been seen by a GP within the last 24 hours. *See* **Intermediate care**.

Criterion

A standard or benchmark by which something can be judged or decided. Criteria are set as part of the audit cycle. A criterion has been defined by Donabedian as

'a set of discrete, clearly definable and measurable phenomena that are (in some way) relevant to the definition of quality'.[1] A criterion may be defined as an ideal standard that is as clear and specific as possible, and that may be measured both qualitatively and quantitatively. A practice example would be 'a 25% reduction in complaints by X, or X number of telephone calls to be answered within X minutes'.

An *explicit criterion* is one that is declared and written down. An *implicit criterion* is one that uses personal experience and knowledge, that may assess attitudes or subtle variations in care, or that uses values which may be spoken but not written.

Criteria may be *external* (chosen by those outside the audit, e.g. professional colleagues, societies, etc.) or *internal* (external standards that have been readjusted to suit the audit team). Internal criteria are the most successful type, as they meet the particular needs of the individuals in the organisation undertaking the audit. *See* **Audit**; **Standards**.

1 Donabedian A (1982) Explorations in quality assessment and monitoring. In: *The Criteria and Standards of Quality. Volume 2.* Health Administration Press, Ann Arbor, MI.

Critical incident technique

A procedure in which episodes which reflect both good and poor practice are collected in order to develop criteria for rating professional behaviour. Developed by psychologists in the 1950s,[1,2] it is now used extensively in clinical medicine, in hospitals and in other care settings. *See* **Confidential enquiry**; **Significant event analysis**.

1 Flanagan W (1954) The critical incident technique. *Psychol Bull.* **51**: 327–58.

2 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions.* Royal College of General Practitioners, London.

D

Data

A collection of facts, observations or measurements. In *data collection*, particular attention is paid to make certain that the facts are representative, complete and relevant. In *data handling*, the data are stored, protected, manipulated, analysed or presented. In *prospective data collection*, data are collected over a defined period of time or for a predetermined number of cases. Retrospective data collection involves reviewing records in order to gather facts about past performance.[1] *See* **Audit**.

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions*. Royal College of General Practitioners, London.

Data Protection Act (DPA) 1984 and 1998

This was set up in order to protect individuals and organisations from problems relating to confidentiality of data.

The 1984 Act gave individuals extensive rights to examine personal information held on computers, and the 1998 Act strengthens this right by extending the right of access to manual records. The legislation is complex, and some measures may not be in place until as late as 2007.

The Data Protection Acts and the Caldicott Review alert all healthcare providers to the need to improve their computer security and risk management systems, and to be aware of the legal implications of allowing third-party sources access to confidential patient data. The DPA specifies that any individual or organisation that holds third-party information of any kind, either as manual records or on computer, must ensure that they do not disclose this to any third party without the necessary data protection notifications, even if they have the explicit agreement of the individual whose details are being held.

If patient data are made available to external sources such as pharmaceutical companies, in order to improve clinical management, the DPA advises on methods to improve computer security and risk management systems. Data protection notification must cover all of the potential disclosures to third-party organisations. The DPA also makes organisations aware of their responsibilities and liabilities in the event of a complaint.

For further information on patient access to computerised records, or the code of practice on data registration for GPs, contact the Data Protection Registrar, Wycliffe

House, Water Lane, Wilmslow, Cheshire SK9 5AF. Tel: 01625 535777 or 545700. *See* **Confidentiality**.

www.dataprotection.gov.uk/
www.bma.org.uk

Day care

Also known as day services, this is daytime care provided in a centre away from a service user's home. Day care covers a wide range of services, from training, therapy and personal care to social, recreational and educational activities.

www.doh.gov.uk/ncsc/

Day case surgery

Clinical interventions that involve the patient being admitted for planned (*elective*) surgery, treated and discharged all on the same day. It is estimated by the Royal College of Surgeons that almost 50% of all elective surgical interventions can be performed on a day case basis. Both commissioners and the public prefer day case surgery; it is cheaper and more efficient than inpatient care, and the clinical outcomes are just as good.

Day centre

A centre for the provision of day care or day services. *See* **National Care Standards Commission**.

Day rehabilitation

A short-term programme of therapeutic support, provided as one of the intermediate care models at a day hospital or day centre. *See* **Intermediate care**.

Decentralisation

A process of separation of different parts of an organisation, or the extension of activities or services to remote areas once an organisation has become too large to be functional. The advantages are as follows.

- Decisions can be made closer to the actual operating levels of work.
- There is increased responsiveness to local circumstances.
- Support services are more likely to be effective.
- It has an encouraging effect on staff morale and motivation.

However, decentralisation can lead to a loss of control and increased lack of dependence on the main power base, leading to mutual lack of respect and cultural misunderstandings. *See* **Centralisation**.

Delegation

The process by which work is passed on to someone who can do it better, quicker or more cheaply than, or instead of, the delegator, so the latter can concentrate on those tasks that only they are equipped (and paid) to do. It is the process by which someone permits the transfer of authority to another to operate within prescribed limits. Whoever delegates is entrusting responsibility and authority to others (not necessarily subordinates), who then become responsible to the delegator for results. The delegator remains accountable for the performance of the delegatee. What is delegated is essentially the right to make decisions – a person cannot be responsible for a task if authority to act is not given.

In general, the subordinate should tackle predictable tasks, while the more experienced worker should handle exceptional ones. Confidential matters, legally or contractually restricted jobs and ultimate accountability can never be delegated. Delegation is not abdication.

The following factors militate against delegation:

- poor time management
- unclear remits and responsibilities
- underestimatation of a subordinate's competence
- the senior worker feeling insecure with regard to his or her job and work relationships
- fear of criticism.

During the process of delegation the delegator clarifies objectives, agrees the terms of reference, authority and responsibility, gives guidance, support and training, and agrees monitoring and review periods.

Delegation has the advantages that it gives the senior worker more time for thinking and planning, it encourages initiative, and it equips people to solve their own problems.

• Phillips A (2002) *Communication and the Manager's Job*. Radcliffe Medical Press, Oxford.

Department of Health, Social Services and Public Safety (DHSSPS)

The department responsible for promoting and providing integrated health and social care services in Northern Ireland. It sets the overall strategy and is responsible for health and social services policy and legislation.

www.dhsspsni.gov.uk

Deprivation allowance

A series of payments made to General Medical Service GPs, based on an index of deprivation devised by Professor Jarman, and paid on an enumeration per district basis. The payments are banded – one for England and Wales and one for Scotland. *See* **Fees and allowances**.

Desktop review

A form of inspection in which the performance of an organisation is assessed by submitted statistics rather than by a visit from an inspector.

Developmental assessment

An assessment of a child's language, cognitive (intellectual) and physical development that 'screens' for any difficulties. It is usually undertaken by the health visitor, doctor or another paediatric specialist worker (e.g. speech and language therapist or child psychologist). Normal developmental assessments are made as follows:

- developmental assessment at 11–14 days
- developmental assessment at 6–8 weeks
- developmental assessment at 7–9 months
- developmental assessment at 18 months
- developmental assessment at 2½ years
- eye test at 3 years
- developmental assessment at 4 years.

The assessment will provide comprehensive information about the child's development and attainment targets.

www.wellclosesquare.co.uk/protocol/pae/pdevass.htm

Diagnostic and treatment centres

Centres that focus on routine elective operations. *The NHS Plan* announced that more than 20 diagnostic and treatment centres will be developed by 2004, of which eight will be operational. Some of these will be built and managed by the private sector in order to increase the number of elective operations. The Government wishes to support the development of these centres, as they operate at the patient's convenience, away from the interruptions and pressures of general hospital emergency work. *See* **Elective operation**.

Did not attend (DNA)

A term that refers to patients who fail to turn up for their appointments for whatever reason (usually without advance warning), or those who arrive late and cannot be seen. They are recorded in the patient notes as DNAs. A major NHS goal is to improve and simplify its waiting-list procedures so as to minimise the number of DNAs, which cost the health service around £280 million a year.

www.nelh.nhs.uk/management/

Diplomatic leadership

A leadership and management style where the manager has no real line of authority and is dependent on the skills of persuasion for obtaining the co-operation that he or she requires. This approach has advantages in that people work more enthusiastically if they are given reasons for doing a task, and they feel respected. The manager is rewarded by co-operation. However, staff often interpret the attempts to persuade rather than to order as a sign of weakness. The manager has lost out by not having a clear-cut line of authority – and any attempt to revert to a frank autocratic order will have obvious and disastrous effects, while the manager in turn loses the respect of his or her colleagues. *See* **Leadership**.

Directorate of Counter Fraud

An NHS directorate that was established in 1999 to investigate fraudulent activity in every sector of the NHS. *See* **Fraud**.

www.doh.gov.uk/dcfs/index.htm

Disability Discrimination Act 1995 (DDA)

An Act which sets minimum standards demanding that public buildings and private companies which provide a public service make their service accessible to disabled people. It was recently updated to include educational establishments. The DDA requires all organisations to audit their premises and take reasonable measures to ensure that they are accessible to all employees and customers. The DDA also contains legislation to prevent discrimination against job candidates on the basis of their disability. *See* **Employments Rights Act 1996**.

www.disability.gov.uk/

Disability Rights Commission (DRC)

An independent body set up by the Government to help secure civil rights for disabled people. The DRC advises the Government as well as campaigning to encourage good practice, eliminate discrimination and promote equality.

www.drc-gb.org/drc

Disability team

A team consisting of social work managers and occupational therapist care managers who work with older people and those with physical disabilities.

www.dlf.org.uk/

Disciplinary interview

An interview whose aim is to inform an employee of and correct mistakes or unwanted behaviour by helping the employee to improve, thus preventing the situation from arising again. It is not used as a means of imposing sanctions, but with the objective of improving performance in the future. The interview should have a problem-solving style that involves obtaining the facts, exchanging opinions and deciding upon appropriate action. The focus is on performance, not on personalities.

During a disciplinary interview the interviewee does much of the talking, thus allowing the interviewer to obtain the facts. The aim is to reach agreement on the problem and the action decided. Having investigated the facts thoroughly and allowed the employee to put their case, the manager will be expected to clarify expected standards of performance or organisational policy.

Disciplinary interviews may form part of a dismissal procedure, so staff have the right to be accompanied by another individual if they so wish. Each disciplinary interview should be approached according to the stage of the procedure that has been reached. During the initial stages, an informal problem-solving approach may be best, and considerate handling at this stage may prevent the matter from going any further.

Before embarking on a disciplinary procedure, all training options should be taken into consideration before considering dismissal. See **Constructive criticism**.

- Phillips A (2002) *Dealing with Conflict and Criticism. Assertiveness and the manager's job*. Radcliffe Medical Press, Oxford.

Discrimination

Discrimination occurs when individuals or organisations treat other people unequally or unfairly. Discrimination is usually shown against people who are perceived to be in the minority by the more powerful majority (in a patriarchal society, usually white, non-working-class, able-bodied men). People who have made different lifestyle choices (e.g. those who are gay) are frequently discriminated against, as is anyone who is perceived to have less money and therefore less power (e.g. women, the elderly, the working classes).

Discriminatory practice often occurs in organisations or institutions where there are long-held power imbalances, and where these power inequalities are considered to be natural, necessary and beneficial. If there is an hierarchical and patriarchal management style, self-interest prevents any real change.

Anti-discriminatory training recognises the need both to be honest in the face of a natural resistance to losing that power, and to cultivate awareness of cultural

advantages. Training aims to raise awareness of oppressive practices and encourage participants to become aware of their own prejudices and responses. The objective is to raise awareness and thereby change attitudes. *See* **Equal opportunities; Institutional racism.**

• Phillips A (2002) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.

Disease registers

Computerised information systems that are set up as a way of managing patients with chronic, long-term diseases such as asthma, diabetes, hypertension or cardiovascular disease. They include diagnostic and prescribing details as well as consultation and morbidity data, and they incorporate systems for calling and recalling patients.

Dispensing doctors

Doctors who both prescribe and dispense medication to their patients. The General Practitioners Council and the NHS Confederation are currently working on a reform of the mechanism for payments to dispensing doctors under the new GP contract umbrella. The intention is that rural practices should not have to rely on dispensing for their economic viability, and that payment for dispensing should be separate from the allocation formula used to calculate the global sum. The aim is for Government, managers and patients to feel confident that dispensing by doctors is both clinically effective and ethical, and for doctors to feel that the work involved is appropriately rewarded.

District audit

The arm of the Audit Commission that is responsible for ensuring that local government and the health service spend its budget wisely. *See* **Audit Commission.**

www.district-audit.gov.uk

Doctor–patient partnership (DPP)

An organisation that is developing initiatives which empower and involve patients in managing their own chronic, long-term illnesses. The DPP sets up and evaluates projects which seek to involve people other than doctors (e.g. nurses and pharmacists) more in the long-term clinical management of patients with chronic illness.

Research shows that a self-management approach in patients with chronic diseases gives rise to improvements in health outcomes, such as improved psychological adjustment, reduced severity of symptoms, a significant decrease in pain, improved life control and activity and increased life satisfaction, with a consequent reduction in demands on the health service. *See* **Expert Patient Project; Patient empowerment.**

Drug action team (DAT)

A multi-agency partnership that operates the Government's drugs strategy at a local level. The team usually includes police, social services, health authority and voluntary sector groups.

www.drugscope.org.uk/dat/home.asp

Drug companies

Pharmaceutical companies involve themselves in general practice in many ways. Practices will be familiar with their representatives calling for appointments to discuss new products or services. Drug companies support general practice by sponsoring product changes and clinical meetings.

E

Effectiveness

A measure of success in achieving a clearly stated objective.[1] *See* **Audit; Quality.**

1 McCormick JS (1981) Effectiveness and efficiency. *J R Coll Gen Pract.* **31**: 299–302.

Efficacy

The term for the maximum potential benefit that can be expected from the use of an intervention. In medicine, this refers to the ability of a medical or surgical intervention to produce the desired outcome in a defined population under ideal circumstances.[1]

1 Hopkins A and Costain D (1990) *Measuring the Outcomes of Medical Care.* Papers based on a conference held in September 1989, organised by the Royal College of Physicians and the King's Fund Centre for Health Services Development. Royal College of Physicians, London.

Efficiency

The effectiveness of an intervention relative to the resources (one of which may be money) required to achieve it.

Elective operation

Non-emergency operations (also known as routine operations, planned or 'cold' surgery) such as hernias, cataract removal, hysterectomy or hip replacements. *See* **Day case surgery.**

Electronic medical record (EPR)

A record, held on a computer database, which contains a patient's personal details (name, date of birth, etc.), their diagnosis or condition, and details of the treatment/assessments undertaken by a clinician. It typically covers the episodic care provided mainly by one institution, but the aim is to make clinical details available across the full spectrum of care.

Electronic medical records (EPRs) have different characteristics to their paper-based equivalent. For example, they can be accessed simultaneously by different people, audits are easier and alert warnings are improved. However, they do also have

disadvantages. When individual trusts and practices have different electronic interfaces, data transfer is problematic. Systems need to be adapted to accept remote data entry from other sources. There are high training, staff and infrastructure costs. Furthermore, legal and security characteristics have to be considered, such as medical confidentiality, access to records, and coding and linking problems. Accurate codes need to be devised, used and understood by every user of the system. Appropriate links (e.g. between drugs and diagnoses) also need to be devised. There may be problems in retaining coherence in coding over time (e.g. when a diagnosed condition develops or changes).[1]

The Government's IT targets are stringent, but in recognition of the difficulties involved, the NHS National Information Authority in charge of IT within the NHS has set up a funded, centralised programme. Work has begun on the *health records infrastructure (HRI)*, with the aim of achieving full electronic medical records (EPRs) in trusts by 2008. *See* **Electronic record development and implementation programme; NHS National Information Authority; Paperless practice.**

www.doh.gov.uk/ipu/whatnew/itevent/tables/epr.htm

1 NHS Executive (2000) *Electronic Patient Medical Records in Primary Care (changes to the GP terms of service).* Ref: PC – 01/10/00 and Good Practice Guidelines for General Practice Electronic Patient Records. Prepared by the Joint Computing Group of the General Practitioners Committee and the Royal College of General Practitioners, 31 August 2000, version 2.6.

Electronic record development and implementation programme (ERDIP)

A national scheme to promote best practice in electronic record-keeping. *See* **Electronic medical record.**

www.nhsia.nhs.uk/erdip/

Electronic staff record (ESR)

A major initiative of the National Shared Service Authority, this is a national integrated human resources and payroll system. It is planned that it will be delivered across the entire NHS by 2012. *See* **National Shared Service Authority.**

Emergency capacity management system (ECMS)

A system which co-ordinates GP emergency admissions to acute trusts, currently being piloted locally, with national roll-out planned in 2003. The electronic booking system aims to equalise workloads in Accident and Emergency departments.

Emotional intelligence (EQ)

The understanding of emotion; the ability to perceive, integrate, understand and effectively manage one's own and other people's feelings.

The following five domains of EQ have been identified:

- knowing one's emotions
- managing one's emotions
- motivating oneself
- recognising emotions in others
- handling relationships.

The concept of emotional intelligence recognises qualities such as self-control, persistence, resilience, and sensitivity to others' feelings. Clinicians can hone their emotional intelligence by discussing difficult consultations with peers in small groups, or by video analysis, shared surgeries or problem case reviews. Personal and professional success correlates with high IQ and EQ scores.

Employee volunteering

The encouragement and support of their staff by employers in giving their time to volunteer in the local community. The employer supports their employees practically by giving them time off, matching their funding or allowing them to use office equipment.

www.volunteering.org.uk

Employers' liability insurance

Insurance that covers employers against a claim for compensation that is made by a worker injured at work. The certificate of insurance must be displayed in the workplace. If the organisation has not complied with health and safety regulations, the insurer may sue to reclaim any compensation paid out.

Employers' organisation

A body that

- represents local government bosses in national pay negotiations
- supports councils in their human resources role
- provides expert advice and information on people management and development.

www.lg-employers.gov.uk/

Employment law

Employment law is formulated by either statute law (Acts of Parliament), case law (tribunals), European Community directives and court decisions or common law. The legislation covers employment rights for all contracted staff, including bank staff, locum and casual workers. The most relevant acts of employment law to NHS managers are the following:

- Equal Pay Act 1970
- Rehabilitation of Offenders Act 1974
- Race Relations Act 1976
- Employment Rights Act 1993
- Employment Relations Act 1999
- Sex Discrimination Act 1975 and 1986
- Human Rights Act 1998
- Disability Discrimination Act 1995
- National Minimum Wage Act 1988
- Public Interest Disclosure Act 1998
- Working Time Regulations 1998
- Health and Safety at Work Regulations 1992
- Health and Safety at Work Act 1974
- Employment Relations Act 1999.

Careful employers keep within the law by keeping ahead of policy changes and checking that they give all of their employees all of the job opportunities that are offered within the organisation. They keep the necessary paperwork and document all decision making.

Further information on employment regulations for new employers can be obtained from the following sources:

- The Employers Orderline (Inland Revenue). Tel: 0845 764 6646.
- The Inland Revenue helpline. Tel: 0845 607 0143.
- The Department of Trade and Industry (DTI) publications orderline. Tel: 0870 150 2500.
- Arbitration, Conciliation and Advisory Services (ACAS) Reader Ltd. Tel: 01455 852225.

See **Employment Rights Act 1996**.

www.dti.gov.uk
www.acas.org.uk
www.croner.co.uk

Employment Rights Act 1996

The main statutory employment rights are consolidated into this Act and the Industrial Tribunal Act 1996. In addition, there is a considerable amount of anti-discrimination legislation that affects employment, namely the Equal Pay Act 1970 as amended, the Sex Discrimination Act 1975 as amended, the Race Relations Act 1976 and the Disability Discrimination Act 1995. *See* **Employment law.**

www.acas.co.uk

Empowerment

The process of assisting people to enable them to take responsibility for themselves and to make decisions about their own lives.

Enhanced clinical services

See **GP contract; Local enhanced service; National enhanced services.**

Enhanced records

Elaborated clinical records which allow consistent comparison and effective future prospective audit. *See* **Retrospective audit.**

Epidemiology

The branch of medical science that is concerned with the occurrence, distribution and control of diseases in populations. Epidemiologists usually work within public health departments or academia. They collect and examine medical data and identify health trends in order to establish which diseases are on the increase and where, and which treatments are effective and which are not.

www.pho.org.uk/
www.ije.oupjournals.org

Equality awards

The Government, with an eye on the litigation league-tables, recognises the importance of promoting good practice within the NHS, and has therefore set up this award to encourage the NHS to improve equality of provision.

www.doh.gov.uk/nhsequality

Equal opportunities

The Equal Opportunities Commission was set up under the 1975 Sex Discrimination Act to work towards eliminating discrimination in the workplace on the grounds of sex or marital status, while promoting equal opportunities for both men and women. It continues to campaign to close the pay differentials between the sexes, and to eliminate sexual harassment in the workplace.

An equal opportunities employer provides equal opportunities for every individual in their organisation by treating everyone with whom they have contact (patients, staff, representatives of external organisations) equally and fairly. The Human Rights Act 1998, the Sex Discrimination Act 1975 and 1986, the Race Relations Act 1976 and the Employment Relations Act 1999 cover several aspects of increased protection for workers, and demonstrate good models for anti-discriminatory practice. For example, under the Human Rights and Sex Discrimination Acts, the right to equal treatment opens up the risk of employment claims from women who allege discrimination on the grounds of sex.

Equal opportunities employers are aware of the broader issues and barriers that face those who try to access the services to which they are entitled. These may be attitudinal or environmental barriers (e.g. limited transport, poor lighting, cluttered corridors, complicated forms) or institutional/organisational barriers (e.g. queue management systems).

Equal opportunities employers:

- make efforts to understand the complexities and culture of their organisation
- regularly examine any areas of vulnerability
- conform to all relevant employment law
- anticipate the impact of new legislation
- train in disability awareness and equal opportunities
- counsel staff as a first-line management approach to poor performance
- examine reports on complaints, consultation and referral rates
- ask service users what they want
- instigate and develop appraisal systems for clinicians.

Equal opportunities policies outline any necessary disciplinary and grievance procedures. They apply to all procedures and individuals across the organisation, and they aim to offer equity of access, ensuring that services are delivered sensitively and recognising linguistic and cultural barriers. *See* **Discrimination**; **Equality awards**; **Institutional racism**.

• Phillips A (2002) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.

www.eoc.org.uk/

Equal Pay Act 1990

Anti-discrimination legislation to promote equal work. Equal pay law is meant to help ensure women and men in the same employment are treated equally in pay and other contractual terms and conditions of employment. 'Pay' has a wide definition and includes basic salary and other pay benefits, such as occupational pensions, holiday pay, sick pay and shift pay.

Equal pay law in Britain is set out in the Equal Pay Act (EPA) 1970 as amended. European Union law also covers equal pay. Article 141 of the Treaty of Amsterdam requires that women and men should receive equal pay for equal work. Under the EPA employees may claim equal pay with colleagues of the opposite sex where they are in the same employment and are doing:

- work which is the same or broadly similar (known as 'like work')
- work rated as equivalent under an analytical job evaluation scheme
- work which is different but which is of equal value in terms of the demands of the jobs.

Equal pay law covers a broad range of workers regardless of their length of service and whether on full-time, part-time, casual or temporary contracts.

The EOC Code of Practice on Equal Pay recommends that employers should adopt and implement an equal pay policy and carry out a review of the pay system. An equal pay policy should include a statement of commitment to providing equal pay by adopting a transparent and objective pay system. It should also indicate that action in the form of a pay review will be undertaken in order to implement the policy and a system set up to monitor effectiveness. *See* **Discrimination**; **Equal opportunities**; **Pay-and-reward system**; **Pay review**.

www.acas.co.uk
www.eoc.org.uk/

Essential clinical services

The first group of services to be offered within the new GP contract, these are services that will be provided by every practice. They include services initiated by patients who are ill, or who believe themselves to be ill, with conditions from which they are expected to recover. Essential clinical services also cover the general management of terminally ill patients. Other essential clinical services include patients who present with new symptoms such as chest pain, upper respiratory tract infections, fever and other health problems for the first time. *See* **GP contract**.

Evaluation

The gathering of information about an event or process so that judgements may be made about the merit or acceptability of that event or process. *See* **Assessment**; **Monitoring**.

Evidence-based medicine

The systematic analysis of data in order to assess the clinical efficacy and cost-effectiveness of treatments. First described in the *British Medical Journal* in 1996 as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients', it is a discipline that aims to invalidate previously accepted diagnostic tests and therapies and replace them with new ones that are more powerful, accurate, efficacious and safe.

The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.[1] This process underpins, for example, the work of the National Institute for Clinical Excellence (NICE), which decides the technologies and treatments that should be made available on the NHS. The aim of NICE is for the responsibility for decision making to be being taken away from doctors and given instead to multi-disciplinary teams of academics, statisticians, health economists and health practitioners working alongside service users and carers to negotiate the available evidence and disseminate the results to clinicians. The aim is not to dictate or explain, but rather to present clear evidence both to doctors and to the public.

The Department of Health, in their *NHS Psychotherapy Services in England Review of Strategic Policy*,[2] adapted some principles applied to psychotherapy research and produced a four-step model for improved patient care. This model can be used reliably for any service provision:

- to commission systematic research reviews
- to secure professional consensus
- to implement evidence-based practice
- to benchmark service outcomes
- to provide improved patient care.[3]

See **National Institute for Clinical Excellence.**

www.jr2.ox.ac.uk/bandolier
www.nhsdirect.nhs.uk
www.nelh.nhs.uk
www.harcourt-international.com/journals/ebhc
www.sheffield.ac.uk/

1 Sackett DL, Rosenberg WH, Gray J *et al.* (1996) Evidence-based medicine: what it is and what it isn't. *BMJ.* **312:** 71–2.

2 Department of Health (1996) *NHS Psychotherapy Services in England Review of Strategic Policy.* HMSO, London.

3 Roth A and Fonagy P (1996) *What Works for Whom. A critical review of psychotherapy research.* Guildford Press, New York.

Publications on evidence-based practice include the following:

- *Effective Healthcare Bulletins*: available from NHS Centre for Reviews and Dissemination, University of York, York YO1 5DD; subscriptions are available from Royal Society of Medicine Press, PO Box 9002, London W1A 0ZA.
- *Bandolier*: a monthly newsletter on healthcare effectiveness, available from *Bandolier*, Oxford Pain Relief Trust, Oxford, www.jr2.ox.ac.uk/bandolier/
- *Health Updates*: available from the Health Development Agency, www.hda-online.org.uk/

Executive summary

Written by the most senior member of an organisation (the executive partner, chief executive or manager), this is a summary of a document. In a business plan, it identifies the key issues to be considered following a business evaluation. It overviews the organisational strengths and weaknesses, representing the collective view of the whole team, and it summarises the main aims and objectives for the year ahead. Key recommendations are given at the end of the summary.

Experiment

An experiment is a controlled observation in which the relationship between two variables is investigated by deliberately producing a change in one of them and observing the change in the other. It differs from a survey, case study or natural observation in which no outside manipulation occurs. By deliberately manipulating one variable, the experiment aims to control all other variables so that they do not affect the outcome.

Designs for experiments may be complex, and can involve any of the following:

- *independent subjects*, where a sample of people is obtained with individuals allocated randomly to one or other of the experimental conditions
- *matched subjects*, often used in twin studies, where subjects are matched in pairs and each is allocated randomly to each experimental condition
- *repeated-measures design*, where a single subject appears under both of the experimental conditions
- *single-subject design*, where only one subject is used for the experiment.[1]

See **Audit**; **Research**; **Survey**; **Variables**; **Write-up**.

1 Robson C (1975) *Experimental Design and Statistics in Psychology*. Penguin, Harmondsworth.

Expert Patient Project

A pilot project which supports volunteers running groups with the aim of educating, informing and encouraging patients with chronic diseases to self-manage. Research

has demonstrated that this approach can lead to improvements in health outcomes, with a consequent reduction in demand on the health service. It has been demonstrated to be clinically effective in leading to improved psychological adjustment and fewer visits to GPs. Empowering patients with chronic illnesses to undertake increased monitoring of their condition has been shown to lead to reduced severity of symptoms, a significant decrease in pain, improved life control and activity and increased life satisfaction. *See* **Doctor–patient partnership**; **Patient empowerment**.

www.ohn.gov.uk/

F

Facilitation

A facilitator is someone who leads or presents formal or informal group meetings. Their role may be to encourage decision making or to elicit differing points of view, depending on the function of the meeting or training day. A facilitator requires experience, knowledge, organisational skills, a broad understanding of group dynamics, chairing and counselling skills, and the ability to build teams and manage conflict.

The role of the facilitator is to encourage differing viewpoints while supporting the discussion, to keep time and to ensure that everyone present sticks to the subject. They will do this by:

- extracting feelings and ideas from the audience
- summarising the content of the meeting
- helping to pull the ideas of a group together
- enabling the group to move forward
- helping the group to achieve a successful outcome.

A facilitator co-ordinates the group activities, following and accompanying the group rather than leading them. They seek ways of reinforcing positive behaviour and challenging negative behaviour. Facilitators address and balance conflict and are able to tolerate criticism. Overall, their role is to involve everyone, and to allow useful debate while keeping to the agenda and time. Good facilitation requires excellent interpersonal and communication skills. *See* **Group**; **Team**.

- Phillips A (2002) *Communication and the Manager's Job*. Radcliffe Medical Press, Oxford.

Feedback

The reporting of the results of a survey, audit or process.

Fees and allowances

These General Medical Service allowances are the backbone of GP pay. Detailed in the *Red Book*, and updated annually in the medical press, they are paid quarterly in

arrears. They include a set of basic practice allowances (area, initial practice, associate, assistant and seniority allowances), training grants, deprivation payments, capitation fees and payments for reaching certain clinical targets (immunisation, pre-school booster and cytology). Other item-of-service (IOS) payments include those made for immvacs (vaccinations and immunisations), and fees for providing contraceptive and maternity and chronic disease management services. Additional payments cover consultation or telephone treatments for temporary residents, emergency care (including arrest of dental haemorrhage) and miscellaneous allowances for provision of maternity services, health promotion work, minor surgery sessions, night visits and locum/maternity/paternity cover. *See* **General Medical Service allowances.**

Flexible pay enhancements

These may include long service awards, help with childcare, accelerated access to medical services, achievement awards, the availability of job shares, or flexible working schemes such as part-time, term-time only, evening/weekend work, homework or annual hours contracts. Other awards could include the development of profit share/bonus rewards schemes, employee-led roistering, career breaks or flexible retirement.

Flexible pay enhancements work outside the constraints of common pay scales. They are based on identified service needs and reflect the local position. Schemes that do not 'cost' can be developed, such as job enlargements (which increase the scope and range of tasks), job rotations (which decrease boredom and increase variety) and job enrichments (which permit workers greater autonomy and freedom). Such enrichments may involve giving staff more challenging tasks, changing the timing, sequence or pace of the task, or giving them with responsibility for outcomes.

Flexible working has developed across industry as it is recognised that it increases efficiency, meets customer demands, and assists employees in balancing work and personal commitments. *See* **Improving Working Lives standard; Pay-and-reward system.**

Floor targets

Targets that have been set by the Government to cover five areas, namely unemployment, crime, education, health and the environment. They are intended to be minimum standards for improvements in deprived areas, set to test the Government's neighbourhood renewal policy.

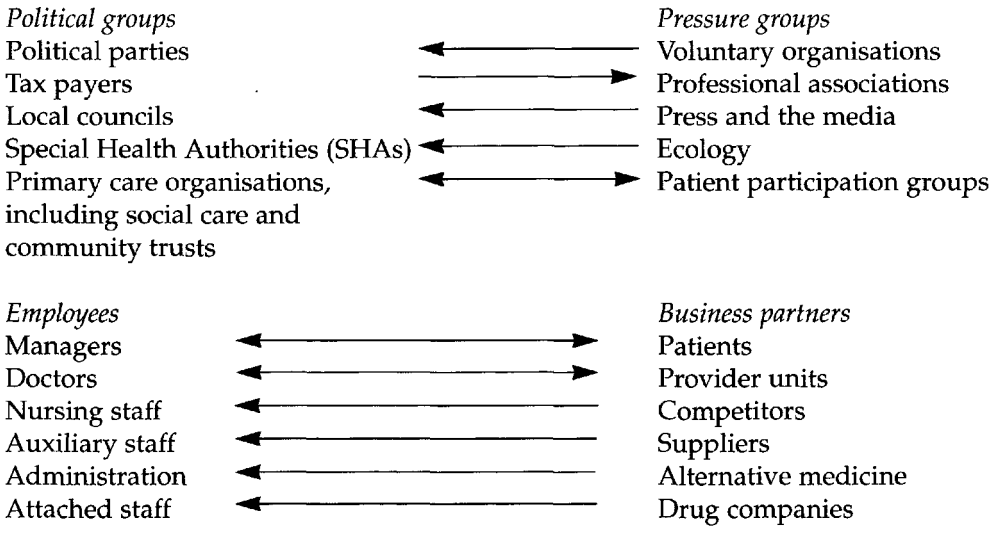
www.neighbourhood.dtlr.gov.uk/

Forcefield analysis

A system for analysing the support for and resistance to change, usually illustrated by drawing arrows between the (opposing) groups that are driving and resisting change. A forcefield analysis can help to ensure that people move beyond the status

quo either by reducing the impact of some of the driving forces (thereby enabling the resisters to move forwards), or by influencing those who are resisting so that they themselves come to realise the need for change.

The following example shows the opposing weights of groups of people (the stakeholders) who stake an interest in general practice:



The analysis will help to identify who drives the change and who has the greatest influence. *See* **Change management**; **Stakeholder analysis**.

Foundation hospitals

From 2003, the Government will permit these high-performing hospitals to run independently, freed from Department of Health controls, as a reward for running high-quality services to audited and regulated standards. The aim is to provide a new model of working with ownership devolved to local communities. Critics, however, see this as one step towards privatisation of the NHS.

Franchising

NHS franchising involves identifying the top NHS managers and appointing them to what are seen as the greatest challenges, which could be either failing trusts, key modernisation initiatives or strategic health authorities. The 'franchise' bid for a top job will involve the management team producing a business plan and operational strategies and appointing its own top team. The bidding team may be from the private, voluntary or public sector.

www.doh.gov.uk/

Fraud

Fraud happens every day across the whole NHS. In primary care, fraudulent activity is commonly found in the areas of false reimbursement claims, false invoices or quotes. Bribery, stealing and corruption are also not uncommon. Good organisation and tight management, including the following, can help to prevent fraud:

- evidence-based practice
- use of policies, especially whistleblowing policies
- double-accounting systems
- risk management
- systematic monitoring
- high-quality healthcare delivery
- teamwork
- scrutiny by an informed public
- Staff training
- Practice performance indicators
- Systems and structures.

See **Directorate of Counter Fraud**.

www.doh.gov.uk/dcfs/index.htm

Free-rein leadership

A particular style of leadership in which the manager uses delegation to optimise full use of time and resources. The freedom given motivates people to make a full effort. However, there is a high degree of risk with very little managerial control. If this style of leadership is used, the manager needs to have a very good knowledge of the competence and integrity of their team and the ability of that team to handle high levels of freedom. Free-reign management is usually only given to senior managers in an organisation. If misused, it can create chaos within the organisation. *See* **Leadership**.

G

Gap funding

A regeneration initiative that was developed in order to attract private investment in potentially risky projects. The idea was to make up the cash difference between the extra cost of developing difficult sites and the possible market values if the project failed. In 1999, the European Commission claimed that the scheme breached its State aid rules. Alternatives have now been approved by the Commission. *See* **Local Improvement Finance Trusts; Private finance initiative**.

General Medical Council (GMC)

A professional regulatory body that licenses doctors to practise medicine in the UK. All working doctors have to be registered with the General Medical Council. The role of the latter includes keeping a register of qualified doctors and disciplining those whose conduct fails to meet professional standards. If a doctor is removed from the register, they may no longer practise medicine in the UK.

The GMC is a charity whose purpose is the protection, promotion and maintenance of the health and safety of the community. It has strong and effective legal powers designed to maintain the standards the public expect of doctors. Their self-declared job is not to protect the medical profession but patients. Hence, if any doctor fails to meet set standards, their right to practise medicine is removed.

The GMC consists of some 104 members: elected doctors, members of the public and doctors appointed by educational bodies – the universities, medical Royal Colleges and faculties.

www.gmc-uk.org

General Medical Service allowances

The services that GPs are currently contracted to provide under national contract standards, for which they are paid a standard set of quarterly fees and allowances. The details and funding of General Medical Services are described in the *Red Book* (Statements of Fees and Allowances), and include a set of basic practice allowances based on practice locality or seniority, as well as training grants, deprivation payments, capitation fees and payments for reaching certain clinical targets. Other payments include those made for vaccinations and immunisations, fees for providing

contraceptive and maternity services, and payments covering treatments for temporary patients, emergency care or out-of-hours visits. Personal Medical Services (PMS) GPs have a different, locally negotiated contract for their work, which will usually include modified GMS services, unless a specialist scheme is run.

www.gmc-org.uk/

General Medical Services cash-limited budget (GMSCL)

Budgets held by primary care organisations which cover most of the cost of GP practice staff, including nurses, premises improvements and information technology.

General Practitioners Council (GPC)

The committee of the British Medical Association that negotiates pay and conditions for GPs.

Glass ceiling

A metaphorical, discriminatory barrier that prevents professionals from reaching senior positions in an organisation, even though no formal barriers to advancement exist. Glass ceilings are usually encountered by women and other oppressed groups.

Goal setting

Goals tell us where we want to go, and *objectives* tell us how to get there. Goals provide the basis for objectives, and they assist in planning and control and help to focus direction.

Goals need to be:

- specific, precise
- measurable (in terms of cost, quality, quantity and timeliness)
- achievable within the available time scale
- realistic (but provide a challenge and stretch the employee)
- jointly established, not imposed
- broken down into objectives
- planned – indicate priorities (must do, could do), subject to a deadline
- continually updated
- checked for success.

A commonly used acronym is SMART: **s**pecific, **m**easurable, **a**chievable, **r**ealistic, **t**argetted.

Goal setting involves planning ahead, addressing the major strategic issues and not simply concentrating on the operational management issues. Goal setting requires clarity, realistic time estimates, patience and the ability to distinguish between 'urgent' and 'important'.

Goal setters map the environment and paint a vision of the future. If personal and organisational goals are met and integrated, a stronger sense of identity and value will result. The art of good management lies in identifying which goals are important, and in achieving them using the minimum possible resources and without unnecessary stress. *See* **Change management; Planning cycle.**

- Phillips A (2002) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.
- Phillips A (2002) *Assertiveness and the Manager's Job*. Radcliffe Medical Press, Oxford.

Golden handcuff

Incentive payment for GPs who continue working past 60 years, payable pro rata for every year that GPs work between 60 and 65 years of age. Eligible GPs have to be working at least 25% of full time, and the scheme only covers principals, not locums. *See* **Incentive payments.**

Golden hello

Government-funded payments to doctors who choose general practice, with additional sums for those doctors who join general practice in an under-doctored area. *See* **Incentive payments.**

Good medical practice

The General Medical Council is seeking to raise the level of GP professionalism. The changes proposed in the 2001 guidance[1] give GPs responsibility for managing themselves and their business more professionally.

1 If doctors have good reason to think that their ability to treat patients is seriously compromised by a lack of resources, they should either put the matter right, or alert their employing/contracting body to their concerns. They should also record these, and the steps taken to resolve them.

2 All doctors are required to make clear, accurate, legible and contemporaneous notes.

3 Doctors must now inform patients, either orally or in writing, why they are being removed from their list. GPs should not end relationships with patients because of a complaint or for financial reasons.

4 GPs are required to encourage and value their teams and to support, monitor and review teamwork. Team leaders will be expected to communicate well and deal openly and supportively with problems concerning the performance, conduct or health of their team members.

5 If there are serious concerns about a colleague's performance, health or conduct, steps must be taken immediately to investigate concerns, protect patients and report concerns to the appropriate body. *See* **Management code of conduct; Professionalism: a code of practice for doctors; Professionalism: a code of practice for managers; Whistleblowing.**

www.gmc-org.uk

1 Lee M (2001) *Pulse*. **13 October**: 29.

GP contract

The Government recognises that GP contracts are outdated and limiting. The way in which family doctors have been rewarded has remained largely unchanged since 1948. The fees and allowances given relate to the number of patients registered and, the Government considers, insufficiently to the services provided and the quality of those services. By 2004, both local Personal Medical Services and national arrangements are set to operate within a single contractual framework, namely the *new GP contract*, which aims to completely amend the current *Red Book* contract. Salaried GPs will become more common, and there will be an inbuilt expectation that GPs will accept and adhere to certain common quality standards.

The new GP contract has been set to meet the objective of allowing GPs to control and manage their workload. It is designed to achieve this by the following means.

- It will make available resources that will take into account the needs of the practice population.
- New work will attract new resources.
- Practices will be allowed to opt out of providing some services.
- Practices will be able to choose the level of quality of service that they provide, by selecting one of five levels to which to adhere.
- Primary care organisations will assume responsibility for the provision of out-of-hours services.
- The current arrangements for patient allocation will be changed.
- Demand management initiatives will be introduced.

The new contract framework delivers a wider range of contractual options, including salaried service. It allows more flexible ways of working, is more family-friendly and encourages career development. It is practice based rather than partner based, which encourages the development of skill mix within the practice.

The aim is to incorporate the best features and the flexibility of the Personal Medical Services contract, but with the security of national negotiation and pricing, and with a greater opportunity to control GP workload. It has been developed as the vehicle for achieving the Government's objective of a single contractual framework for GPs.

The proposed categorisation divides the medical work in general practice into three groups:

1 essential clinical services

2 additional clinical services

3 enhanced clinical services (national and local).

It will be possible for clinical services to move from one group to another.

The new GP contract will be priced ready for the profession to vote on it by April 2003, with implementation planned for 2004. *See* **Access; Salaried GPs; Short-term contracts.**

www.rcgp.org.uk/

GP retainer

A GP who is temporarily absent from work while on leave, usually for pressing or family reasons such as maternity, paternity, adoptive or parental leave, or for sickness, annual or family emergency leave. A retainer fee is paid to the practice while the retainee is absent, to enable them to employ cover for him or her.

Green Paper

A consultation document formed by the Government that sets out their views and invites discussion on a particular policy area, such as planning or the NHS. It is the first step in a policy-making process that usually leads to legislation (White Paper). *See* **White Paper.**

www.explore.parliament.uk/

Grievance procedure and interview

A procedure for staff to object either to an order from a senior, or to any work problem that they believe to be illegal, unethical or counterproductive.

The objective of a grievance interview is to enable an individual to air a complaint, to discover the causes of dissatisfaction and, if possible, to remove them. Organisational policy should clarify the organisation's grievance procedure, which may involve investigating the facts and clarifying possible causes of action. *See* **Counselling skills; Whistleblowing.**

www.pcat.co.uk
www.acas.co.uk

- Phillips A (2002) *Communication and the Manager's Job.* Radcliffe Medical Press, Oxford.

Group

A number of people who share the same task. Combinations of different motivations and personalities within groups can be difficult, but groups usually work to find common ground so that they can work together comfortably. As the group forms, it will unconsciously start to develop shared patterns of perceiving, thinking and communicating to counteract any feelings of individual isolation. Group members

converge towards overt or covert 'norms', and anyone who does not conform to those norms will be under pressure from the rest of the group to do so.

Achieving groups support and reward team members, have a mission, co-operate and work to maintain good interpersonal relationships. They are active, and the individuals within them are clear about their own and others' roles and competencies. They use these different team roles to contribute to the overall aims and to develop the capacity to meet new challenges and demands. The team scans and responds to the environment in order to identify trends, ideas and opportunities and actively promote its mission. If they are to be successful, groups must have autonomy, accountability, authority, responsibility and a remit.

Researchers have shown that groups go through certain processes during their development. Tuckman[1] noted that groups pass through different stages in their development, and classically demonstrate *forming, storming, norming, performing* and *deforming* behaviour. The stages are not linear – a group may regress back to an earlier stage if it is under pressure or stress. In the first stage, known as *dependency*, group members will expect to be told what to do, and they may be defensive and not take any risks. In the second stage, known as *conflict*, the group may begin to feel more confident and therefore become more competitive and challenging. Subgroups and hidden agendas will emerge. In the third stage, known as *togetherness*, individuals begin to feel good about being members of the group, and this leads to a productive phase of group life. As *interdependency* is reached in the fourth stage, groups perform optimally and good interpersonal relationships are evident. The level of commitment to the team is high, and there is flexibility of working practices towards individuals, subgroups or the whole team. During the last stage, known as *loss and grieving*, members may feel threatened or saddened by the ending of the group, and therefore resist the ending.

Some rules of group dynamics can be summarised as follows.[2]

- A group leader will emerge if unelected.
- Working groups should be kept small. In a group of 8 people, there are 8 different agendas but potentially 28 different relationships going on.
- There will be a tendency for men to interrupt women or to dominate the space.
- Oppression will rule – the 'experts' and higher social classes will dominate.

Belbin[3] researched and named the following different personality types that are found within groups: the Completer–Finisher, the Implementer, the Monitor–Evaluator, the Teamworker, the Resource Investigator, the Shaper and the Plant.

1 Tuckman BW (1965) Developmental sequences in small groups. *Psychol Bull.* **63**: 384–99.

2 Middleton J (2000) *The Team Guide to Communication.* Radcliffe Medical Press, Oxford.

3 Belbin RM (1991) *Management Teams: why they succeed or fail.* Heinemann, London.

For more information on teams and groups, see the following:

- Mullins LJ (1999) *Management and Organisational Behaviour* (5e). Financial Times/Pitman Publishing, London.

Guideline

See **Algorithm; Protocol.**

H

Halo effect

The process by which the perception of a person is formulated on the basis of (usually unconscious) impressions, which may be a favourable or unfavourable trait or impression. Interviewers in particular must be aware of their tendency to appoint or not on the basis of the halo effect, as it tends to shut out other relevant characteristics of the person under consideration. The danger is that the perceiver/interviewer may or may not remember or be aware of whom the interviewee reminds him or her. When such quick judgements are made, the interviewer may ignore subsequent stimuli that vary from the original perception, and only (subconsciously) note those characteristics which support the original judgement.

Health Action Zone

A partnership that is set up between the NHS, local authorities, community groups and the voluntary and business sectors in areas of high deprivation. Its aim is to tackle health inequalities and poor health.

www.ohn.gov.uk
www.haznet.org.uk

Health and safety

In 1974 the first Health and Safety at Work Act (HASAWA) created a broad base of duties set up to ensure that employers identified workplace risks and took steps to prevent accidents and ensure the good health of their employees. Subsequent EEC directives have been issued which make employers' requirements more explicit. Employers can be criminally prosecuted for any health and safety breaches. The legal requirements are as follows:

1 to own a written safety policy

2 to have a health and safety law poster or leaflet visible

3 to consult with employees

4 to have employers liability insurance

5 to record and notify accidents

6 to have clear first-aid arrangements

7 to identify those responsible for each procedure.[1]

A health and safety *risk assessment* provides a structured method aimed at protecting individuals, leading to effective action to control the major causes of harm. This involves controlling the risks – that is, identifying and assessing the hazards, establishing whether the existing precautions are adequate, and devising plans to meet any shortcomings. Legislation requires that the assessment must be recorded for employers with five or more employees.

The commonest health and safety risks in general practice relate to people, procedures and the working environment. Health and safety legislation is aimed at protecting patients and staff from dangerous hazards or procedures at work. The clinical and organisational risks inherent in running health services are multiple, covering anything from managing the risks of stress in staff, to the risk of fire, or clinical risk such as infection from spillage, clinical waste or needlestick injury.

Health and safety legislation requires that organisations audit regularly – that is, assess potential hazards, take action to control the situation, and then monitor it.

All employers have a duty of care to their staff under the Health and Safety at Work Act 1974. Further regulations (*The Management of Health and Safety at Work Regulations 1992*) require 'health surveillance', which involves detailed risk assessment for employees. Under the regulations, organisations need to protect their staff from and manage the risks of the impacts of stress at work. Employers are legally bound to provide a safe system of work, and are required to make regular assessments of the potential risk to staff of bullying, harassment or excessive workload. *See* **Controls assurance**.

www.hda-online.org.uk/
www.hse.gov.uk
www.hsebooks.co.uk/

1 *The Management of Health and Safety at Work Regulations 1992. Approved code of practice.* Available from Health & Safety Executive, Tel: 08701 545500 or 01787 881165.

For literature and more information about health and safety, see the following:

- Scriptographic Publications Ltd, Channing House, Butts Road, Alton, Hampshire GU34 1ND. Tel: 01420 541738.
- Moore R and Moore S (1995) *Health and Safety at Work: guidance for general practitioners.* Practice Organisation Series 1. RCGP Publications Unit, London.
- Business and Legal Reports Inc., 6 Redwood, Burnham, Buckinghamshire SL1 8JN. Tel: 01628 666166. Fax: 01628 668522.
- Health and safety: HSE Books, PO Box 1999, Sudbury, Suffolk CO10 2WA. Tel: 01787 881165. HSE Infoline: 0870 154 2200.

For a further discussion of health and safety and risk assessment, see the following:

- Phillips A (2002) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.

Health and social services boards (HSSB)

The Northern Ireland health and social services boards that plan, commission and monitor the health and social services for people in their areas. Four boards cover the country – northern, southern, eastern and western.

www.n-i.nhs.uk

Health and social services councils (HSSC)

In Northern Ireland, each of these councils monitors the operation of the health and personal social services in its board area. It provides advice to the public about services, recommends how services might be improved and advises boards in order to ensure that the whole community's needs are met.

www.nhscc.org

Health and social services trusts (HSST)

In Northern Ireland, the 19 trusts that are responsible for managing hospital and community staff and services under agreements with health and social services boards and GP fundholders. They are managerially independent of health and social services boards and directly accountable to the Department of Health. *See* **Health and social services boards**.

Health authority

Now termed strategic health authorities, these bodies will have strategic responsibilities for healthcare within their regions. They will no longer hold commissioning budgets, as primary care organisations have developed their commissioning role, but will set and oversee standards for the health and social care trusts within their region.

www.nhs.uk/

Healthcare resource group tarrif (HRG)

Developed as a commissioning tool, this classifies healthcare services into different categories based on the type of clinical care offered and the amount of resources being used. The HRG system replaces the 'consultant episode of care' system that commissioners used in the past with one that buys the entire care pathway. Initially there

will be 15 HRGs covering six surgical specialities, and these will expand to encompass all specialities by 2006.

The Government has introduced this new tool as part of their NHS financial reforms[1] which cover payments by result, nationally agreed prices for procedures and episodes of care, and commissioning based on case-mix-specific volumes (i.e. volumes which are adjusted according to the case mix). *See* **Commissioning; Service level agreement.**

www.doh.gov.uk/nhsfinancialreforms/

1 *Reforming NHS Financial Flows. Introducing payment by results: 2002 consultation document.* www.nhs.uk/.

Health Development Agency (HDA)

Established in 2000, this agency is part of the NHS and is funded mainly by the Department of Health. It was set up to tackle inequalities and improve the community's health. The HDA has a public health role and is a national organisation. It also assists primary care trusts in supporting practices with their own health needs assessments.

The HDA has developed policies and guidance for local health planners to access, and it uses examples from health improvement and modernisation plans and Health Action Zones to bring together the theory and practice of reducing health inequalities. The planners whom it is targeting are those agencies which are working to improve the well-being of their population, namely local government, primary care trusts and strategic health authorities.

Evidence and guidance are available from the HDA for all of the following Health of the Nation targets:

- reducing accidents
- teenage pregnancy
- drugs and alcohol
- mental health, diet, nutrition and obesity
- housing and transport
- neighbourhood renewal
- sexually transmitted diseases
- smoking.

To order HDA publications, contact the HDA distributor. Tel: 0870 121 4194. Email: onlinecommunications@HDA-online.org.uk *See* **Health gain; Health needs assessment/analysis.**

www.hawnhs.hda-online.org.uk

Health gain

This is a step beyond health promotion. Improving health gain and reducing health inequalities involve identifying high-risk groups of patients and developing educative approaches to modify risky or unhealthy lifestyle behaviour. Organisations that sign up to health needs analysis are automatically assuming health gain as an outcome. Any primary care organisation that incorporates National Service Frameworks into practice working, and which works to improve access to services for high-risk patients, is supporting the Government plans for overall health gain. The Government health objectives which support health gain are to develop NHS partnerships with social care, to confront the causes of ill health (poverty, deprivation and social exclusion), and to respond more positively to patient need.

The NHS Act 1999 has set standards and targets to improve health and reduce inequality, such as the following:

- the reduction of social exclusion, poverty, discrimination and unemployment
- the reduction of teenage conceptions
- the development of a National Health Poverty Index
- improving service access
- a 10-year programme to reduce heart disease
- 1000 new graduate mental health workers in primary care
- early intervention with regard to psychosis, and assertive outreach
- breast, cervical, colorectal and prostate screening programmes to be set up
- for the elderly, a single assessment process to be shared with social care
- a new sexual health and HIV strategy
- new prescribing regimes.

See **Health needs assessment/analysis; Health promotion.**

www.ohn.gov.uk/
www.modern.nhs.uk/

For further details, see the following:

- Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform.* The Stationery Office, London.

Health Improvement Programme (HimP)

A local plan drawn up by primary care professionals to improve health and healthcare. The primary care organisation works in conjunction with other agencies, such as local authorities and the voluntary sector.

www.doh.gov.uk/himp/

Health inequality

The gap in health status, and in access to health services, between different social classes and ethnic groups, and between populations in different geographical areas.

www.doh.gov.uk/healthinequalities/index.htm

Health needs assessment/analysis

An overview of patient health needs that also summarises recommendations for action. The analysis calculates and compares local/national consultation and morbidity/mortality rates for all targeted clinical areas of concern (e.g. cancer, mental health, teenage pregnancy). A profile is presented showing current service activity and the aims and objectives for the target group stated. The current management and clinical roles and responsibilities and any resource implications would be documented, together with current and future audit activity. The analysis would also review any clinical training needs, assess the skills required, and describe any interventions planned.

Needs assessment is growing increasingly complex, and the aid of public health workers and epidemiologists is becoming essential. However, it is possible for even a small health organisation such as a general practice to make a start in understanding their patient profiles, provided that the problems of data comparison and small sample sizes are addressed.

The following information is needed for health needs analysis:

- demographic data (age/sex/census data)
- birth and death information
- morbidity data on illness and disability
- services used.

Health needs assessment can equip an organisation with working models that may help both to provide the evidence required to re-evaluate their work, and to provide information to enable them to prioritise the service that they provide.

The methods of analysis vary according to the circumstances, and include the following:

- collecting evidence
- defining measurable outcomes
- judging the effectiveness of interventions
- reviewing and comparing data
- keeping abreast of external influences and the local factors that impact on health in the organisation (e.g. socio-psychological forces, legal and political influences, economic trends).

See **Health gain; Health promotion.**

For more information on how to conduct a health needs analysis at GP practice level, see the following:

- Phillips A (2002) *The Business Planning Toolkit.* Radcliffe Medical Press, Oxford.

Health outcomes

One way of measuring the success of clinical or management interventions on patients. Health outcomes can be assessed by using specific tools that measure a process, an outcome or a structure.

- *Measuring the process.* If there are too many variables in your clinical population, a process measurement could look at the success of an intervention by, for example, noting the use of a new service by your client group compared with that by the general population.
- *Measuring the outcome.* If you are looking at changes in mortality rates, this measurement may take many years. It may be more appropriate to look at 'surrogate' indicators such as the reduction of risk (e.g. the number of smokers in the population who have stopped smoking).
- *Measuring the structure.* When attempting to change patterns of behaviour, there are many factors beyond the experiment's control. For example, if one is aiming to reduce the number of teenage pregnancies, it would be essential to record the number of pregnancies. For a more robust indicator, it may be better to measure the number of teenagers who are contacted, counselled and advised. *See* **Health gain; Health promotion.**

Health Professions Council (HPC)

This body came into being on 1 April 2002, replacing the Council for Professions Supplementary to Medicine (CPSM) and all of the 12 uniprofessional boards. Now the sole regulatory body for the 12 allied health professions that were previously covered by the CPSM, it will operate under the Professions Supplementary to Medicines Act 1960 until May 2003.

All allied health professionals working within the NHS must be state registered by the Health Professions Council, so that their qualifications, registration address and professional standing can then be made available for public scrutiny. *See* **Allied health professional; Council for the Regulation of Healthcare Professionals; Professions supplementary to medicine; Regulation.**

www.hpc-uk.org

Health promotion

All NHS agencies can contribute to promoting the nation's health if they have adequate funding, are able to make long-term plans, and are willing to co-ordinate services and recognise the barriers to health promotion. GPs in particular can play a key role in patient education, and are also well positioned to research, evaluate and monitor patient health.

Services committed to health promotion define health broadly and holistically as a sense of physical, mental, emotional, social and environmental well-being. They see themselves as instrumental in shaping the future health of their patients, and would ideally demonstrate good, equal relationships with local stakeholders and communicate well with those sections of the community who experience the greatest disadvantage. The services offered would strive to be efficient, economical, effective, appropriate, accessible and equitable. *See* **Health Development Agency; Health gain; Health needs assessment/analysis.**

Health Protection Agency

An independent body established by the Government to improve the provision of health and emergency planning.

Health service ombudsman

There are health service ombudsmen for England, Scotland and Wales. The position of ombudsman was established under the 1973 Health Service Commissioners Act. Accountable directly to Parliament, not to Government, the ombudsman has the power to launch independent investigations into complaints from the public that hardship or injustice has been caused by any of the following:

- the failure of the NHS to provide a service or access to information
- failure of a service
- maladministration (e.g. failure to respond to complaints).

The ombudsman's brief was extended into primary care in the 1990s. A request to have a complaint taken to the ombudsman is the penultimate part of the practice complaints procedure, to be undertaken if a complainant is not happy with the practice, primary care organisation and local independent review panel responses.

The cases that the ombudsman deals with are sensitive and complex, and the majority of those involving GPs focus on service inflexibility, poor complaints handling and badly managed removals from a GP list.

If the ombudsman upholds a complaint, they can demand an apology or seek changes in practice from the offending service provider.

www.health.ombudsman.org.uk/

Health status

In medicine, health status may be measured in many different ways, including the following:

- biomedical control
- symptom level
- functional status
- psychosocial status
- patient satisfaction
- increased knowledge
- behaviour changes.

See **Audit**; **Outcome**.

Healthy living centres

A network of centres set up from 1999 across the UK in areas of rural or urban deprivation. Their aim is to promote health and healthy lifestyles and to tackle social exclusion among the most disadvantaged members of those communities. Each centre may be a physical building, or alternatively a form of outreach. Services that may be provided by healthy living centres include Well Man and Well Woman clinics, sexual health or dietary advice, physical exercise facilities and English language classes.

www.ohn.gov.uk/ohn/partnerships/hlc.htm

Heartsink patient

An anecdotal term used by doctors to refer to one of those patients who induce feelings of mental fatigue, hopelessness, despair and frustration in their doctor. In psychological terms, such counter-transference is the doctor's emotional response to the patient. Any patient who attends frequently, worried that they are ill when no cause can be found, is at risk of being labelled a 'heartsink'. The term can be inappropriate and derogatory, as some of these patients have complex emotional problems which can affect the way that they feel physically, and which may lead to illness (somatisation). Dr James Groves[1] divided heartsink patients into the following four categories:

- dependent clingers
- entitled demanders
- manipulative health-rejectors
- self-destructive deniers.

These features may defeat and stress their carers. Some doctors now consider that their own behaviour and responses may be part of the problem – a failure to come to some shared understanding at the end of a consultation, and a failure of mainstream medicine to recognise adequately the complex psychological, social and emotional aspects of illness.[2] It has been suggested that if clinicians do not deal with patient ideas, concerns and expectations (ICE), patients are more likely to return or complain.[3]

1 Groves J (1978) Heartsink patients. *New Engl J Med.* **298**: 883–7.

2 O'Dowd T (1988) Five years of heartsink patients in general practice. *BMJ.* Mentioned in S Saini (ed.) (2002) Everything you wanted to know about heartsinks. *Doctor (Registrar).* **14 Feb**: 55–7.

3 Jamil T (2003) Coping with patients' unreasonable demands. *Registrar Pulse.* **24 March**: 71.

Hepatitis B vaccine

It is a statutory requirement that anyone working in close contact with body fluids must be vaccinated against hepatitis B. Registered patients and the GP's own employees are exempt from any fee for this, unless it is prescribed as a travel vaccine. A fee for both the vaccine and the administration may be charged to unregistered patients, but it is usual for occupational health departments for NHS or private health and social care organisations to provide this to their own at-risk employees free of charge. If patients require an occupational health service, it is reasonable to refer them to a GP who has no responsibility for them under the terms of service.

Histogram

A pictorial or graphical view of the distribution of a set of scores.

Horizon scanning

A term used in NHS planning for identifying the potential costs of and demands for new clinical developments in the NHS. It describes the identification at an early stage of new drugs, devices and medical procedures that are likely to emerge in the future and have an impact on the NHS in terms of cost and demand.

www.publichealth.bham.ac.uk/horizon/

Hospital-acquired infection (HAI)

Antibiotic-resistant infections or diseases that are on the increase in hospitals. Methicillin-resistant *Staphylococcus aureus* (MRSA) is a common example.

Hospital at home

Intensive support in the patient's own home, including investigations and active treatment of a limited number of conditions that would otherwise require acute hospital

inpatient care, for a limited period. The treatment is above the level of care normally provided by primary care, but does not necessarily require the resources of an acute hospital stay.

Hospital at home can be used as a way of avoiding an acute admission, or to enable earlier discharge from hospital.

This scheme is popular with patients but not with carers. The idea originated in France and has since spread to other countries, where it is undertaken in different ways. In the UK it aims to be a personal, nurse-led service, whereas in the USA the focus is more 'hi-tech'. The primary aims of the scheme are to cut costs and reduce the duration of care, although research suggests that the scheme achieves neither of these objectives for medical patients, nor does it improve health outcomes overall.[1] *See* **Intermediate care**.

1 Shepperd S and Liffe S (2001) *Hospital at Home Versus Inpatient Hospital Care (Cochrane Review)*. The Cochrane Library. Issue 4. Update Software, Oxford.

House officer

A doctor in training who has successfully completed five years at medical school and is learning general medicine in a hospital in preparation for becoming a registrar, and eventually a GP or consultant. House officers are also called junior doctors.

www.bma.org.uk

Hub and spoke

A technical term for concentrating specialists in the centre and having small outreach services for minor forms of the speciality on the outskirts. This approach is considered to be one answer to growing recruitment problems in small specialist services.

Human resource management (HR management)

Human resource managers take personnel management a step further and work with an underlying understanding of the subtext, context and complexities of their organisation. They manage not only operationally but also strategically, and they have in place strategies for managing the risks of staff failing to perform. This understanding embraces the following theories:

- workplace motivation
- organisational communication
- organisational structure and design
- leadership
- group processes

- learning
- personality
- culture, conflict and change
- management control and power.

Human resource management refers to strategic and long-term people management, whereas *Personnel management* deals with the short-term, operational level of people management. Human resource management looks beyond people management, policies and laws to whole system management, where managers work on cultural issues and the organisation moves beyond only directing and controlling people. People management then becomes a key element in the strategic planning of a business.

Where people management policies demonstrate significant concern for employee welfare, and organisations pay more than lip service to investing in their staff, a human resource model is adopted. This ensures that staff are well trained and competent, there is a good skill mix, the working environment is safe and comfortable, and working practices are cost-effective. *See* **Improving Working Lives standard**; **Personnel management**.

Human Rights Act 1998

This European directive was passed in 1998, and it is significant that case law is still being made on the basis of the Act. It primarily gives the right to equal treatment to everyone regardless of age, sex, class, culture or ability. It legislates for personal human rights that can be defended in court, including the right to life, the right to liberty, freedom from inhuman treatment and the right to a family. It has been used by individuals to claim services and benefits that have been denied, and by charities to mount campaigns for changes to Government policies. The Human Rights Act, which was made law in 2001 in the UK, requires public services to respect human rights.

www.hmso.gov.uk

Hypothecated tax

A tax that is raised for spending on a specific purpose (e.g. going to war or improving health services) rather than for general spending by the chancellor. Politicians in the UK rarely rely on this type of taxation.

Hypothesis

A supposition or proposition that is assumed for the sake of argument; a theory to be proved or disproved by reference to facts; a provisional explanation.[1] *See* **Experiment**; **Research**.

1 *Chambers English Dictionary* (1988) Cambridge University Press, Cambridge, p. 702.

I

Iatrogenic
Relating to illness, death or infection caused by doctors. This usually occurs through ignorance, as when drugs prescribed in a good cause interact negatively with each other, or it may be a result of simple random human error. Systems of clinical governance (health and safety, risk management, protocols and clinical guidelines) are put in place to help to reduce this margin of error.

Ideal
The best standard obtained in the best conditions.

Improving Working Lives standard (IWL)
This new standard, set by the NHS Act 1999, means that every member of staff working within the NHS is entitled to belong to an organisation which can prove that it is investing in training and development.

The NHS Plan[1] states that by April 2003 all NHS employers are expected to be accredited as putting IWL standards into practice. These standards, which are part of a set of core performance measurements, will demonstrate that staff are treated well, and this will be linked to the financial resources that the organisation receives. One of the key objectives is for organisations to conduct annual attitude surveys, which involve asking their staff relevant questions and acting on the key messages received.

IWL standards will be conferred on organisations that:

- invest in the training and development of staff
- tackle discrimination and harassment
- improve diversity
- apply an attitude of zero tolerance towards violence against staff
- reduce workplace accidents
- provide occupational health and counselling services
- conduct annual attitude surveys

- ask staff relevant questions and act on the key messages received
- provide access to learning for all NHS staff without a professional qualification
- commit to providing flexible working conditions
- Involve staff in the design and development of better working practices.

Other supporting measures are being developed by the NHS Executive, including a Performance Framework for Human Resources, an Occupational Health Service for all NHS employees, and Employee Accreditation Standards.

www.doh.gov.uk/iwl

1 Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform: investing in NHS staff.* The Stationery Office, London.

Incentive payments

Part of a scheme to improve recruitment and retention, these payments are Government-funded sums of money given to doctors who choose to work in or remain in general practice. *See* **Golden handcuff; Golden hello.**

Independent Complaints Advocacy Service

A service that was set up as part of the Commission for Patient and Public Involvement in Health to help patients to pursue formal complaints through the complaints procedures. It is planned that it will replace Community Health Councils. *See* **Commission for Patient and Public Involvement in Health; Patient Advocacy and Liaison Service.**

Details of the plans are available at www.nhs.uk

Index of deprivation

An official measure used by the Government to target regeneration policies to the most deprived areas.

www.regeneration.dtlr.gov.uk/

Indicator of care

An element of care which is definable, measurable or amenable to change.[1] *See* **Criterion.**

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions.* Royal College of General Practitioners, London.

Industrial tribunal

Industrial tribunals are independent employment tribunals that assess employee claims for unfair dismissal or discrimination using the Sex Discrimination or Disability Discrimination Acts. Staff who are claiming for unfair dismissal can also seek arbitration through the Advisory, Conciliation and Arbitration Service (ACAS). The main statutory employment rights are consolidated into the Employments Rights Act 1996 and the Industrial Tribunal Act 1996.

www.bbc.co.uk/business/work/issues/articles/

Infection control

The process of managing the risk of inadvertently reinfecting oneself or others when working with or handling infectious material. For example, during minor surgery sessions, blood, body fluids, sharps (needles, scalpels, stitch cutters) and laboratory specimens should be handled and disposed of correctly, and needlestick injuries reported correctly and appropriate action taken. The simplest and most important measure is to ensure that hands are washed before and after procedures. *See* **Health and safety**.

www.medical-devices.gov.uk

Information for Health strategy

The NHS Information Strategy introduces information about the use of and plans for IT in the NHS. Strategic health authorities have a duty to implement its recommendations locally. As an example of the type of strategies produced by the NHS Information Strategy, one aim is to develop information strategies to support each National Service Framework, including information for patients and the public:

- to support patient and social care
- to support the quality agenda (clinical audit data and access to evidence)
- to support health improvement (e.g. through disease registers)
- to support management needs.

The strategies are being developed in partnership with all stakeholders, including NHS professions and other care and patient organisations. Related security, confidentiality and data protection issues will be addressed in each case. Each information strategy will cover the following:

- the development of information for patients and the public
- national clinical and clinical audit data sets

- input to the national information infrastructure, such as the National Electronic Library for Health
- input to generic information programmes (e.g. to support, rapid referral).

The contents of the strategies will need to conform to national data standards. Over time, this process of standards ratification will provide a library of accredited standards for use throughout the NHS. *See* **Information technology accreditation; National Electronic Library for Health; National Service Framework; NHS National Information Authority.**

www.doh.gov.uk/ipu/strategy/
www.nhsia.nhs.uk

Information technology accreditation

Accredited IT systems are those that have been approved by the Government and IT industry meeting expected standards. The Government aim is to have compatible systems in place throughout general practice by 2010, so that common data can be easily transferred to central, primary care trust-held servers. The Government recognises the need for the NHS to establish a reliable and coherent information base of patient-related data. This information base, together with the analytical tools required to make use of the data, provides the necessary information to manage the many and various Government-supported schemes, such as Health Improvement Programmes and National Service Frameworks.

At present, accredited systems must:

- be compliant with a nationally recognised coding system
- have data that can be easily extracted and manipulated and easily expanded
- be able to be networked
- be Windows based.

Primary care organisations currently only credit systems that have:

1 user interfaces
2 patient reminder or recall displays
3 appointment books
4 a sound medical diagnostic and drug coding base
5 item-of-service links
6 pathology links modules
7 dispensing modules with drug formularies

8 portable protocol builders

9 anatomical dictionaries

10 NHSnet communications for email, Web browsing and structured messaging

11 bulletin boards to manage emails

12 a facility for collecting immunisation and screening histories.

www.doh.gov.uk/ipu/strategy/

Informed consent

The requirement for patients to understand the care to which they are consenting. In order to prevent adverse patient complaints, patients must consent to their own or their relatives' treatment. This covers all patient groups. Organisational policies must make the route to this explicit, and ensure that everyone understands both the concept and what consent they are giving to the intervention (investigations, research or treatment). Such a policy may include, for example, the way in which patients confirm their agreement to intimate examinations, an explanation of false-negative and false-positive results, or an outline of the limitations of screening. *See* **Data Protection Act 1984 and 1998**.

Inpatient

A patient who has been admitted to hospital for treatment and who is occupying a hospital bed.

www.doh.gov.uk/waitingtimes

Institute of Health Service Management (IHSM)

The largest UK professional body for managers working in healthcare and health services, the IHSM acts as a leading provider of education, training courses, seminars and events, and as a publisher of material on healthcare policy issues. It aims to improve health, medical and healthcare services across the UK by providing information on policy, resources and employment support.

www.ihm.org.uk

Institutional racism

Sir William McPherson first coined the term *institutional racism*, which was used during the Stephen Lawrence Inquiry.[1] The definition refers to 'the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in

processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping which disadvantage minority ethnic people'.

This definition could usefully be broadened to incorporate all dimensions of discrimination on the grounds of gender, age, sexuality, class, disability or lifestyle choice. In most organisations, negative attitudes prevail with regard to diversity and difference; these are often not publicly expressed, but they are frequently expressed internally. *See* **Discrimination; Equal opportunities.**

1 McPherson W, Sir (1999) Institutional racism at work. *The Independent.* **25 February.**

Intelligence

This has been defined as mental agility, *fluid intelligence* being a type of abstract reasoning that is free of cultural influence, and *crystallised intelligence* being dependent on learning and experience. It is now accepted that there are multiple intelligences – verbal, mathematical, special capacity, kinaesthetic, musical and emotional. More questions than answers are raised about the nature of intelligence (e.g. whether it is inherited, constant, dependent on life experience, culture or education, and whether it can be measured or not).[1] Binet and Simon were the first psychologists to measure intelligence in a structured and systematic way. From this work the Stanford Binet test was developed for measuring intelligence quotient (IQ).[2]

1 Binet A and Simon Th (1905) Methodes nouvelles pour le diagnostic du niveau intellectual des anormaux. *Ann Psychologique.* **11**: 191–244.

2 Terman LM (1916) *The Measurement of Intelligence.* Houghton Mifflin, Boston, MA. Cited in LJ Mullins (1999) *Management and Organisational Behaviour* (5e). Pitman Publishing, London.

Intermediate care

Nursing home, rehabilitation or home care services provided to ease the transition of the patient from hospital to home and from medical dependence to functional independence. One of the crucial elements of *The NHS Plan*, intermediate care is an umbrella term used to describe a range of services that incorporate a multi-disciplinary approach, and which are designed to promote independence in line with the 'care closer to home' principle.

The Department of Health has marked intermediate care services with the following standard definitions.

- They are targeted at people who would otherwise face unnecessary or prolonged secondary or long-term residential care.
- They have a planned outcome of maximising independence.
- They are time limited, the average care package running from 1 to 6 weeks.
- They involve cross-professional working, a single assessment framework and records and shared protocols.

There are various models of care services for people with physical, mental and social needs (see above). However, older people are given special focus because of their much higher rate of growth in numbers of acute admissions and use of nursing and residential home care placements.

Intermediate care packages are clinical support packages developed in collaboration with community and secondary care staff, with the aim of supporting patients in need during their transition between hospital and home. Future schemes that are being piloted in some parts of the country train their intermediate care workers as specialised workers who have been taught to take on several health and social care roles, so that patients can be attended by a single care worker rather than the three or four who were previously used.

The current expansion of intermediate care reflects the outcome of the National Beds Inquiry consultation, which demonstrated overwhelming support for 'care closer to home'.

As part of their modernisation agenda, the Government sees GPs as playing a large part in supporting the wider healthcare of their community, and wants them to be more involved with this type of development. It sees general practice as having the necessary technical and interpersonal attributes to provide primary healthcare as well as personal, co-ordinated continuity of care for its patients.

The GP vision of intermediate care is to develop early discharge protocols, and to have nurse-managed beds with GP input and expertise to call upon. It is seen as a transient stage, and not as a cheap alternative to acute or long-term care – although it is more costly than other services, it is patient friendly.

GPs can access support and assistance via the primary care organisation's intermediate care co-ordinator, who has responsibility for securing the development of care pathways and access to service protocols, and for ensuring that intermediate care is integrated across all health and social care communities, including housing and the independent sector.

Government Public Private Partnership (PPP) monies can be used to help to fund these schemes.

See the BMA website www.bma.org.uk/public for more details. Information on intermediate care and specialist GPs can be found on www.bma.org.uk or the Royal College of General Practitioners website at www.rcgp.org.uk. *See* **Crisis resolution**; **Day rehabilitation**; **Hospital at home**; **Rapid response**; **Residential rehabilitation**; **Supported discharge**.

Interpersonal communication skills

Communication skills that are widely based, functional or process orientated. They include such skills as the following:

- motivating
- leading
- listening

- instructing
- organising
- writing
- presenting
- chairing
- counselling
- facilitating
- supervising
- delegating
- interviewing
- appraising.

See **Communication**.

Investors in People (IiP)

IiP was launched in 1991 by the Department of Employment as a standard for training and development of individuals within an organisation. The organisation was taken over by a private company in 1993. It is a Government-sponsored initiative, based on a commitment to the benefits that organisations can gain from a rigorous approach to the development of their human resources. The aim is to develop a more highly skilled and flexible workforce, and to reward organisations that achieve the prescribed training standards with a Kitemark logo.

The IiP initiative provides a national framework for maintaining and increasing the UK's competitive position in world markets. The standard provides a framework for improving business performance and competitiveness through a planned approach to setting and communicating business objectives and developing people to meet those objectives. The standard is held for three years, after which the organisation must apply for reassessment in order to retain it.

The standard is a cyclical process based on four key principles:

1 a public commitment from the top to invest in and develop people in order to achieve business goals

2 planning how individuals and teams are to be developed in order to meet those goals

3 taking the relevant action to achieve this

4 evaluating the outcomes as a basis for continual improvement.

Organisational success is dependent on the effective development of human resources. IiP is recognised as one of the most successful quality awards ever to be introduced. It can be viewed as part of a wider quality management process with natural progression towards total quality management. *See* **Total quality management**.

www.smartman.co.uk
www.artetch.co.uk

Item of service (IOS)

Payment made to GPs following submission of evidence of provision (via an IOS link to the payment section of the primary care organisation). These include payments made for vaccinations and immunisations, and for providing contraceptive, maternity and chronic disease management services. Additional payments cover consultation or telephone treatments for temporary residents, emergency care and miscellaneous allowances for provision of health promotion work, minor surgery sessions and night visits. These payments were phased out for Personal Medical Services GPs, and will also be phased out under the terms of the 2002 New National Contract. *See* **Fees and allowances**.

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J

Job analysis

A managerial task which identifies whether there is a job to be done. This occurs prior to selection and will involve the following steps:

1 reviewing the job description and job specification

2 speaking to the new appointee's manager and subordinate in order to establish what is needed and who would fit in

3 ascertaining whether some of the tasks can be delegated to staff who are already in post

4 listing the pressing reasons for employing a new member of staff

5 looking at the anticipated pros and cons of having the post filled

6 consider the implications for the organisation and related services (e.g. other surgeries, hospitals, health authority) if the post were not filled.

Salary costs are identified, using the mid-point of the incremental scale, to include the following:

1 potential training costs

2 associated capital costs (e.g. new equipment)

3 the overall plans for the organisation in terms of staffing levels and developments (e.g. if you are considering computerising in the near future, you may be able to afford to cut clerical time but increase VDU operation time).

See **Job description; Job specification; Staff profile.**

Job description

The job description should contain the following information:

1 job title

2 grade

3 hours worked

4 Main job purpose (key role(s) and result areas)

5 duties and responsibilities

6 specific limitations of authority

7 areas of responsibility

8 working relationships (reporting and accountability arrangements)

9 any personal competencies required

10 signature of manager

11 date prepared.

Good job descriptions paint an accurate picture of the job. They are clear about any difficulties (any aspects of the job that are particularly demanding or difficult to perform) and tedious or unpleasant aspects.[1] The emphasis should be on purpose and accountability rather than on tasks and responsibility (a cleaner may well vacuum floors, but that is not the purpose of the post – the purpose of such a job is to keep the floors free from dirt). *See* **Job analysis**; **Job specification**; **Staff profile**.

1 Roger A and Cavanagh P (1967) Personnel selection and vocational guidance. In: AT Welford *et al.* (eds) *Society: problems and methods of study*. Routledge, London.

Job enlargement

Increasing the scope of a job and the range of tasks that the worker usually carries out. It is regarded as horizontal job design, as it makes the job structurally larger. However, it may do little to improve staff motivation or performance, as it may simply increase the number and type of tasks that the worker has to complete. *See* **Job enrichment**.

Job enrichment

An extension of the more basic job rotation and enlargement methods, this involves vertical job enlargement. It aims to give the worker more control and greater authority over the planning and execution of their work. It increases the complexity of the work, and should provide a more challenging opportunity for psychological growth. It aims to give workers, especially those higher up in the hierarchy, greater freedom and responsibility. *See* **Job enlargement**.

Job redesign

Restructuring either the nature of a work task or a method of working. *See* **Job enlargement**; **Job enrichment**; **Job rotation**.

Job rotation

The basic form of job redesign, which involves moving staff from one job to another in an attempt to train them, prevent boredom and add variety. Neither the nature of the task nor the method of working is restructured. Job rotation can help to give staff a better understanding of the purpose of the organisation's work. *See* **Job enlargement; Job enrichment; Job redesign.**

Job specification

More detailed description of the skills required of the employee, identifying the task(s), knowledge and specialist skills required for the job that is being advertised. Also known as a *person specification* or *candidate profile*, it looks at the essential and desirable qualifications and personal competencies required for the job. If selection is matched to this, it considerably reduces interviewer bias. A job specification helps to eliminate the contravention of any equal opportunities laws. It determines the primary skills in the job description and stipulates the essential and desirable qualifications and/or experience. For example:

- *skill*: typing medical letters
- *desirable qualification*: Medical Secretary Grade
- *essential minimum*: 50 wpm audio typing, shorthand typing
- *experience*: able to describe a significant period of employment as a medical secretary
- *personal competences*: to set and prioritise work and objectives, to report personal learning and development needs to manager, to be able to influence, build and maintain a network of relevant contacts.

See **Job analysis; Job description; Staff profile.**

Joined up working

The working together of organisations such as councils, hospitals and schools to identify and solve local problems. Joined up working is commonly found in primary care organisations where managers work on issues of joint interest with others in social services, local government or the voluntary sector. The Government has pushed this idea as a means of closing the gaps between public services and improving overall performance. *See* **Joint funding.**

Joint Committee for Postgraduate Training for General Practice (JCPTGP)

The Medical Education Standards Board will shortly take over the role of the JCPTGP and the specialist training authority. *See* **Medical Education Standards Board.**

Joint funding

The agreement of two or more agencies to share the cost of running a project or service. *See* **Joined up working**.

www.doh.gov.uk/jointunit/partnership/htm

Joint investment (and implementation) plan (JIP)

Plans, produced by health authorities and local authorities, that form part of *local action plans (LAPs)* for purchasing care services jointly. JIPs identify workforce plans for the development of intermediate care by identifying key issues (e.g. existing investment, number of beds available and occupied) and detailing the expected benefits of service change for users and carers. JIPs are commonly developed across social care, education and housing sectors, as well as other key agencies such as the voluntary and charity sector and other representatives of service users and carers. *See* **Joint funding**.

K

Key role development

Section 9.5 of the NHS Plan[1] itemises how NHS employers will be required to empower appropriately qualified nurses, midwives and therapists to undertake a wider range of clinical tasks. The expectation is that nurses and the professions supplementary to medicine will be trained to take a broader role in assessment and diagnosis so that they will be able to:

- order pathology and X-rays
- refer directly to allied professionals
- identify areas/specialities where nurses can admit and discharge patients
- manage more chronic disease caseloads
- prescribe limited medicines
- undertake resuscitation training (including defibrillation)
- run minor surgery clinics
- undertake IT triage.

www.modern.nhs.uk

1 Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform.* The Stationery Office, London.

Key workers

Public sector staff, such as nurses, police officers and teachers, who are crucial to the economy and vital for better public services, but who are relatively poorly paid. The term is often used in relation to the lack of affordable housing for such people in areas with high house prices. The definition is now being broadened to include almost all poorly paid workers. Key workers are sometimes referred to as *named workers*.

www.london.gov.uk/

King's Fund

A charitable foundation whose goal is to improve health, especially in London. The King's Fund audits, assesses and makes recommendations to improve healthcare, with a focus on the following:

- tackling health inequalities and social injustice
- enabling health and social care staff and organisations to work in partnership across traditional boundaries
- promoting cultural diversity in healthcare
- encouraging patient and wider public involvement in health and healthcare.

www.kingsfund.org.uk/

Knowledge workers

Employees who apply their theoretical and practical understanding of a specific area of knowledge in order to produce outcomes of commercial, social or personal value. Their performance is very much judged both on their cleverness and creativity and on the commercial value of their applied knowledge. Knowledge workers are increasingly being employed in the consultancy, telecommunications, scientific and technical fields.

L

Laissez-faire leadership

A particular style of leadership in which the manager withdraws leadership if it is observed that team members are working well together – with the proviso that help is on hand if it is required. *See* **Leadership**.

Leadership

Leadership may be hierarchical, top driven, autocratic or bureaucratic. Leadership skills can be learned and developed, but there is no single style of leadership that is appropriate to all situations – different styles are appropriate for different stages of the business.[1]

Common leadership patterns include the following:[2]

- high level of concern for production and low level of concern for people
- low level of concern for production and high level of concern for people
- high level of concern for people and production
- a maternalistic or paternalistic management style in which reward and approval are shown to those who are loyal and obedient to the organisation
- approval of aims to keep people happy
- avoidance of conflict
- risk-taking and innovative behaviour
- high levels of control, with reward and punishment systems
- opportunist behaviour – adapting situations and adapting to people in order to gain the maximum advantage
- a willingness to explore options and alternatives openly and flexibly
- a willingness to change
- manipulation, coercion and changeability
- unfair authority.

Best practice shows us organisations where the decision making is devolved downwards, and ideas are fed upwards. Significant employee involvement is recommended in the 'excellence' literature.[3] People are encouraged by being involved and directing the agenda for change. If the power base is held by expert teams rather than by individuals, people work collectively on clearly defined subject areas. This promotes innovation and creativity, and demonstrates respect for employees.

Leadership styles give a clue to the type of culture within the organisation, and each has its own strengths and weaknesses. Managers have their own individual way of leading. Most adopt a style with which they feel comfortable, that matches the expectations of the people for whom they work and the situation facing them. For example, it is necessary to be autocratic at times of rapid and imposed change or crisis – someone has to make decisions fast. Managers can afford to adopt a more diplomatic stance when there is time to consult and debate.

The leader is not necessarily the manager – the leader visions and the manager controls. A *supportive* style of leadership is related to lower turnover and grievance rates and higher levels of subordinate satisfaction, and results in less inter-group conflict. This is the preferred (and expected) style of leadership in today's work culture.

Directive leadership can increase productivity – but only if the task is routine. Some people prefer a structured style, so that they are being led. This is often the most productive style to use when managing a crisis. *See* **Autocratic leadership; Bureaucratic leadership; Diplomatic leadership; Participative management; Free-rein leadership.**

1 Mintzberg H (1973) *The Nature of Managerial Work.* Harper and Row, New York.

2 Blake RR and Adams McCanse A (1991) *Leadership Dilemmas: grid solutions.* Gulf Publishing Company, Houston, TX.

3 Peters TJ and Waterman RH (1982) *In Search of Excellence.* Harper and Row, London.

Learning difficulty

The condition which affects people who experience more problems than the general population with activities that involve thinking and understanding. *See* **Learning disability.**

www.doh.gov.uk/learningdisabilities

Learning disability

The condition which affects people who need additional help and support with their everyday lives, because they find activities that involve thinking and understanding difficult. Some people with a learning disability may also have an additional impairment, such as a sensory impairment or a physical disability. *See* **Learning difficulty.**

Learning needs

As part of the revalidation and appraisal process, GPs and all NHS staff are required to demonstrate that they understand and can prioritise their own learning or training needs. These can be ascertained formally (e.g. by objective testing, audit or research, peer assessment, educational appraisal or mentoring schemes) or informally (e.g. by self-appraisal, reading and reflection, case review or video-tape consultations). In order to identify their own need to learn, clinical staff (and others, where appropriate) need to:

- be open to new ideas
- undergo continual professional development
- have an intimate knowledge of their role
- learn from experience
- listen actively
- respond fairly to assessments of practice
- learn on the job
- keep up to date
- be willing to make suggestions for improvement in their practice.

The Government is keen to apply personal development plans for all professional workers within the NHS. A range of methods is used to identify learning needs, including the following:

- obtaining feedback from colleagues
- self-appraisal (of individual attitudes, knowledge, awareness of health politics, skills)
- conducting audit or research
- comparing one's performance with that of others
- observing work role and environment
- reading and reflecting
- taking part in educational appraisal or mentoring schemes
- analysing patient/staff contacts by case review
- video-taping consultations
- analysing practice activity data
- undergoing objective testing
- attending educational meetings or training programmes.

See **Learning plan; Patient unmet needs; Personal development plan; Practice professional development plan; Revalidation.**

Learning organisation

An organisation that facilitates learning by all of its members and which continually transforms itself.[1] Learning organisations are said to adapt particularly well to change as they reposition *human resource management* centrally and view employees as key stakeholders. This facilitates an increase in teamwork and employee involvement.

1 Burgoyne J (1995) Feeding minds to grow the business. *People Management*. **21 September**: 22–5.

Learning plan

This documents individual or organisational learning priorities and training needs, and notes where any information that is needed can be obtained. It requires an honest analysis of the present position and how that position was reached, identifies the progress required, and analyses what must be achieved in order to achieve that progress. The contents of a learning plan can be summarised as follows:

- what has been achieved to date
- current knowledge, abilities and opportunities
- future career and life goals
- outcome measurements.

See **Learning needs; Personal development plan.**

Learning sets

A method of *self-managed learning* in which a group of colleagues meet, and each participant is given equal time within the group. The person who is the focus of attention learns and evaluates for him- or herself. There is a shift in his or her ideas in relation to the issue under consideration. The process can be supportive and empowering but challenging, as each person takes personal responsibility for their own learning.

In learning sets:

- more innovative solutions to problems emerge
- learning is disseminated more widely
- the organisation as a whole often develops a learning approach to problem solving
- participants find other people whom they can rely on to continue to support them through change

- participants learn to support and challenge behaviour appropriately, to listen actively and to be honest and open, and they take these skills back to their organisations
- the facilitation skills can be learned and extended to others
- progress may be made in resolving problems to which there may have been no clear solutions before
- effort and resources are not wasted on inappropriate learning
- participants are more open to further self-development
- the focus is on approaching and dealing with practical problems, not on theory
- risk is soon regarded as a developmental and acceptable tool
- individuals adapt the process to suit their own needs
- real issues are addressed, and there is practical, immediate application of the learning
- individuals identify their own needs and arrive at their own solutions.

Learning styles

Researchers have identified several different types of learner:[1]

- the activist who learns by doing
- the pragmatist who learns best when the practical application is obvious
- the theorist who needs to understand the fundamental principles
- the reflector who learns by thinking about things.

Everyone has a different learning style, and these can be recognised along with a broad understanding of group process and behaviour and some of the obstacles to learning (an unwillingness to learn about difference, a fear of change and development). Learning will be more complete, and is more likely to persist, if the learner is empowered to construct their own learning and therefore actively participate in the process. The teacher's role here is to facilitate or mentor, not to impart knowledge.

1 Honey P (1994) Styles of learning. In: A Mumford (ed.) *Handbook of Management Development* (4e). Gower, Aldershot.

Listening skills

Active listening requires the receiver to listen for the total meaning that a person is conveying, in order to try to determine both the content of the message and the feelings underlying it. Active listening also involves noting all of the cues, both verbal and non-verbal, in communication.

We listen and process information faster than we can speak. Good listeners:

- eliminate distractions
- stop talking
- stop interrupting
- relax, and do not rush
- are alert to non-verbal cues
- empathise
- demonstrate understanding – paraphase/summarise frequently
- use open-ended questions to clarify and understand
- use silence
- are not afraid of tension
- allow for reflection.

See **Counselling skills**.

Lloyd George wallets

Buff-coloured A3-sized medical record wallets in use in GP practices which have not yet become paperless. The wallets and their contents are owned by the State.

Local action plan (LAP)

These are used to define healthcare plans developed by primary care trusts in collaboration with local healthcare planning agencies such as social care, housing, education and the independent sector. The plans commonly cover particular groups of people with special care problems, such as services for older people or those with specific physical, mental or social needs. LAPs identify workforce plans for the development of intermediate care covering the NHS, social care and the independent sector. *See* **Joint investment plans**.

Local delivery plan (LDP)

A new system of three-year planning and capital allocations undertaken by trusts. It was set up in response to the Government's *Investment, Expansion and Reform Paper* to replace the Service and Financial Framework.

www.doh.gov.uk/planning2003-2006/index.htm

Local enhanced services

Unlike the other categories of clinical services provided under the GP contract, these will be subject to local discretion and will be locally commissioned. Like national enhanced services, they will be agreed locally between practices wishing to offer them and the primary care organisation, with, if desired, the involvement of the Local Medical Committee. Unlike national enhanced services, they will not be nationally priced. The category could include pilot schemes for innovative services, or provision for a specific local need (e.g. an influx of asylum seekers). *See* **GP contract**.

Local Government Association

A body that represents local authorities in England and Wales, working with central government with the aim of promoting better local government and service working, one approach being to assist joint working with health and social services.

www.lga.gov.uk/

Local implementation strategy (LIS)

A document that has to be produced by special health authorities to describe how they intend to implement *Information for Health* and other local strategies.

Local Improvement Finance Trusts (LIFT)

NHS LIFT is a private limited company set up by the NHS and private sector property developers under the public–private partnership initiative in order to fund, replace and refurbish primary care premises in England. LIFT was developed by the Department of Health and Partnerships UK plc (PUK). Originally a commercial company, it is now a limited company owned by the Department of Health and the private sector. It is regarded as a single corporate entity with a focus on one objective, namely building primary care facilities, and it will take slightly greater risks than other property developers. LIFT will own and lease premises, and it will supplement rather than replace current premises investments. It will build new premises or refurbish old ones for lease. At a local level, a LIFT venture has its funding split 50:50 between the private and public sectors, and its management board consists of NHS managers, GPs and private sector partners, all of whom work together to develop and agree investment locally.

The NHS Plan committed the NHS to entering into a new public–private partnership within a new equity stake company to improve primary care premises in England. This is now being taken forward through Partnerships for Health, a 50:50 joint venture between the Department of Health and Partnerships UK plc (PUK). *See* **Premises improvements**.

www.doh.gov.uk/pfi/nhslift.htm

Local Medical Committee (LMC)

A statutory body consisting of groups of locally elected GPs representing a particular locality who have the power and authority to make comments and recommendations to their local primary care organisations on issues of interest and concern. NHS authorities must consult the Local Medical Committee on issues ranging from GP terms of service to investigations into professional conduct.

www.bma.org.uk/

Local Negotiating Committee (LNC)

Any of the bodies that have been set up in some areas of the country in response to the growing number of GPs contracted for salaried services to primary care trusts. These committees draw up local generic contracts and job descriptions, and also represent other staff-grade doctors and dentists. Representatives from the British Medical Association and Local Medical Committee are included on the committees, which are seen as a particularly effective way of representing GP interests. Contracts are based around a national core service framework with locally negotiated elements, rather like the current Personal Medical Services contract and the proposed new General Medical Services contract. *See* **Salaried GPs**.

www.bma.org.uk/

Locum

A self-employed doctor who is paid to provide cover for absent GP colleagues. Locums are expected to cover surgeries, and also to be proactive and constantly strive to improve their competencies by analysing complaints and compliments, changes in patient care and unexpected outcomes, and requesting feedback from referrals or investigations. Locum workers now have to sign up to clinical governance demands, and also demonstrate reflective learning as part of their continuing professional competence to practise. Thus they may ask practices for feedback on interesting or significant patient outcomes.

Long-stay mental hospital

A hospital that provides long-term care for patients with a mental health problem or a learning disability. Most of these hospitals evolved out of nineteenth-century asylums and were the main form of residential care for these patients until the development of community care in the 1980s.

www.rcpsych.ac.uk/

Looked-after children

Children who are either in care (subject to a care order) or accommodated by a local authority. Children become looked after if, for example, they have been neglected or abused, or their birth parents are temporarily unable to care for them. Social services and voluntary agencies arrange alternative care arrangements either within the children's birth family or in a foster family or a residential children's home. The majority (70%) of looked-after children return to their birth families within one year. The remaining 30% continue to be 'looked after' by the local authority, usually in residential accommodation. The Government has set stringent educational targets to be met by this group.

www.baaf.org.uk

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M

Management code of conduct

A locally managed code of conduct, developed by the NHS Confederation, the Institute of Health Service Management and the Financial Management Association, that requires those who agree to its terms to adhere to strict criteria (e.g. with regard to honesty, openness and probity) while holding senior management positions within the NHS. Other requirements are to be open to continuing professional development, to keep informed of developments both within and external to the profession, to monitor medical and management trends, and to develop a positive relationship with the consumer. The code is regarded as a public affirmation of continued commitment and high values.

The three groups that developed the code hope that it will be incorporated into staff contracts so that managers can be judged by clear and achievable targets, and that breaches of the code will be handled effectively and consistently. Breaking the code could bring serious penalties, including dismissal and a bar on re-employment within the NHS. The code covers the rights as well as the responsibilities of managers. *See* **Professionalism: a code of practice for managers**.

www.doh.gov.uk/managingforexcellence
www.ihm.org.uk

Management role

The manager has a variety of roles within an organisation:

- commercial (buying, selling)
- financial (obtaining capital and making optimal use of funds)
- security
- accounting (stocktaking, balancing accounts, costing, analysis)
- administrative.

The managerial role will include, among other things, planning, problem solving, networking, co-ordinating, organising, supervising, controlling, measuring, motivating, managing conflict, and developing and disciplining staff. *See* **Middle management**.

Manual handling
The Manual Handling Regulations 1992 require employers to make a 'suitable and sufficient' assessment of the risks to health incurred by moving and handling objects at work, taking into account the individual's ability, the load and the working environment. If hazardous handling cannot be avoided, the regulations require the task to be either redesigned ergonomically or automated. *See* **Health and safety**.

Mean
The statistical term for the mathematical average; an intermediate value between two extremes.

Median
The statistical term for the middle value in a series of numerical values arranged in order of magnitude.

Medical Abbreviations
A website designed to help patients, medical secretaries and others to understand some of the abbreviations used by medical personnel.

www.rcgp.org.uk/rcgp/corporate/patients/abbreviations.asp

Medical Defence Union (MDU)
The most well-known medical defence organisation in the UK. It acts to support its doctor and dentist members' medico-legal needs and professional reputations. The MDU acts as a mutual organisation and offers its members indemnity services as well as advising on medico-legal matters. In addition, it offers surgery premises insurance and insurance against clinical/medical negligence, and advises on issues such as risk management. It also supports nurses and practice managers.

www.the-mdu.com

Medical Devices Agency (MDA)
An executive agency of the Department of Health. Its role is to safeguard public health by working with users, manufacturers and law makers to ensure that medical devices meet appropriate standards of safety, quality and performance, and that they comply with the relevant Directives of the European Union.

In order to achieve its objectives, the MDA investigates adverse incidents relating to medical devices, offers advice and practical guides for health and social care professionals involved in primary care, and contributes to the establishment of safety standards and protocols.

www.medical-devices.gov.uk/

Medical Education Standards Board (MESB)

The Government is setting this up as a single supervisory body to replace the Joint Committee on Postgraduate Training for General Practice and the Specialist Training Authority (which supervises training for secondary care doctors). Accountable to the Health Secretary, it will ensure that medical training meets UK requirements, it will issue GP certificates, it will control entry to the new GP register, and it has the power to suspend doctors. The 25-strong board will consist of lay representatives and medical members. The registers will be available to the public. The MESB will maintain links with the General Medical Council on issues such as revalidation.

The aim is to provide a coherent, robust and accountable approach to postgraduate medical education.

Medical model

A model or philosophy of health that works on the premise that all illness has a biological/physiological cause, and can therefore be cured by medical/biochemical intervention (drugs, surgery, etc.). *See* **Social model**.

Medical negligence

A legal term used to describe an error or 'a breach in the duty of care' by a clinician who has caused a medical injury, complicated an existing medical problem or caused the death of a patient. It is also known as clinical negligence. The patient or their dependants can sue the clinician for compensation.

www.the-mdu.com

Medical Protection Society

A mutual association of doctors and other professionals that offers its members professional indemnity cover and advice on risk management.

www.mps.org.uk

Medicines Control Agency (MCA)

An executive agency of the Department of Health whose primary objective is to safeguard public health by ensuring that all medicines on the UK market meet appropriate standards of safety, quality and efficacy. Safety aspects cover potential or actual harmful effects, quality relates to development and manufacture, and efficacy is a measure of the beneficial effect of the medicine on patients.

The MCA aims to achieve its objective by means of the following:

- a system of licensing before the marketing of medicines

- monitoring of medicines after they have been placed on the market
- checking standards of pharmaceutical manufacture and wholesaling
- enforcement of requirements
- responsibility for medicines control policy
- representing UK pharmaceutical regulatory interests internationally
- publishing quality standards for drug substances through the *British Pharmacopoeia*.

The MCA works with governing bodies of medical professions to assess the theoretical and practical aspects that underpin prescribing practice. *See* **National Prescribing Centre**.

www.mca.gov.uk/

Meetings

Good meetings are short and constructive, allowing ideas to be presented and actioned with minimal debate. The format for successful meetings is as follows.

- Circulate an agenda.
- Record apologies of the current meeting.
- Approve the minutes of the last meeting.
- Deal with matters arising.
- Identify and discuss regular issues.
- Identify and discuss specific issues.
- Note any other business (AOB).

Mental Health Act Commission

This watchdog is a special health authority that is fully independent of mental health service providers. It consists of more than 170 members from the medical, nursing, psychology, social work and legal professions. Its main function is to review the operation of the Mental Health Act 1983 in relation to detained patients.

www.mhac.trent.nhs.uk/

Mentoring

This has been defined as 'off-line help by one person to another in making significant transitions in knowledge, work or thinking'.[1] Traditionally it is a master–pupil relationship offered by someone more experienced in a profession, who passes on their wisdom and experience in order to give the novice a helping hand. Mentoring usually occurs by means of a series of supportive and educational meetings for a defined period.

Mentoring is one of the principles of ongoing learning. It is based on the relationship with an experienced organisation member who can share, guide and provide feedback to the employee. The mentor should provide a structured opportunity for the employee to review and discuss their career plans. Researchers suggest that organisations need to be fully committed to the idea of mentoring and ensure that individuals are adequately prepared for the programme.[2] Benefits include managerial effectiveness, communication improvements, the promotion of equal opportunities and self-learning. *See* **Clinical supervision; Coaching.**

1 Clutterbuck D and Megginson D (1999) *Mentoring Executives and Directors*. Butterworth-Heinemann, Oxford.

2 Clutterbuck D and Wynne B (1994) Mentoring and coaching. In: A Mumford (ed.) *Handbook of Management Development* (4e). Gower, Aldershot.

Middle management

Management that concentrates on tactics (i.e. how the overall strategies are to be achieved). This often involves devising and operating short-term plans (from 6 months to 2 years ahead). Senior managers operate more strategically than middle managers (i.e. looking ahead by up to 5 years).

MIQUEST (Morbidity Query and Export System)

This software, commissioned by the NHS National Information Authority, allows extracted data to be standardised and pooled from a variety of proprietary GP systems. All GP systems currently need to be MIQUEST compliant in order to achieve official computer accreditation.

The Primary Care Data Quality project provides a mechanism for capturing the quality data that are required to support clinical governance and National Service Frameworks. Using a set of queries written by this system, and following a data collection plan, GP practices build their own disease registers. The MIQUEST package includes support on installation, training, data extraction and interpretation. It interrogates GP systems to look for clinical data, clinical values or measurements (e.g. minimum or maximum, particular records and criteria). MIQUEST is run with the assumption that improved data quality does ultimately lead to improved patient care.

For more information on MIQUEST, contact any of the following:

1 The General Practice Section, St George's Hospital Medical School, London SW17 ORE. Tel: 020 8725 5661. Email: buckwell@Drs.desk.sthames.NHS.uk

2 The Primary Care Data Quality project. Website: www.drsdesk.sghms.ac.uk\pcdq\pcdq.htm

3 NHSnet. Website: http://www.nelh-pc.mhs.uk

See **NHS National Information Authority; PRIMIS.**

www.nhsia.nhs.uk

Mission statement

A statement that encapsulates the vision of the organisation studied – that is, its goals, aims and objectives. It is used to give a flavour of the organisation, by detailing the values and commitments that will be reflected in the organisation's management, policies and organisational literature.

An example of a mission statement is given below.

> **Practice mission statement**
> This practice strives for public accountability. We want to maintain a responsive and better-quality service for our patients, sharpened and more flexible clinical practice, and see an improvement in communications with our stakeholders. We want to continue to achieve the recent clinical improvements in patient care, delivered with sensitivity at a practice level. To this end we will continue to strive for an improved, efficient and cost-effective service.

Mixed health economy (see LIFT)

The type of economy that is said to be developing where the private sector invests in public sector projects.

Mode

The statistical term for the most frequently occurring item or number in a series. It also refers to the peak(s) in a frequency curve. *See* **Mean**; **Median**.

Modernisation Agency (NHS)

A national body created by the Government in 2000 to help local clinicians and managers to redesign services so as to make them more patient friendly, quick and efficient, and to secure continuous service improvements across the entire NHS.

The agency co-ordinates management and leadership development in order to foster leadership talent at all levels within the health service. It thus has responsibility for the NHS Leadership Centre and the NHS Beacon Services Programme.

www.modern.nhs.uk/

Monitoring

Making pre-specified, objective observations about the characteristics of an event or process using standard forms of data collection. Monitoring is usually done by means of checklists or questionnaires. It should be undertaken against known standards. *See* **Assessment**; **Evaluation**.

Motivation

Motivation to work, job satisfaction and performance are determined by a variety of factors, including economic rewards, social relationships, personal attitudes and values, the nature of the work, leadership styles and the satisfaction derived from the work itself. Employees have an interest in work beyond the actual mechanics of the task in hand – people also need recognition, intellectual stimulation and socialisation. Different people are motivated by different things. The employer's role is to ensure that the motivational needs of their staff are met, that these are taken into account when managing pay-and-reward systems, and that the organisation's aims and values are addressed.

Multi-agency

Referring to the working together of differently funded bodies to share funds and projects so as to achieve the best care for a common client group (health working with social care, the voluntary sector, local authorities, etc.). *See* **Care plan**; **Team**.

Multidisciplinary team

A team or group consisting of representatives from several different professional backgrounds who all have different areas of expertise (e.g. a community mental health team). *See* **Care pathway**; **Intermediate care**.

Myers–Briggs Type Indicator (MBTI)

A form of personality testing[1,2] developed by psychologists from Carl Jung's work on personality attitudes and functions. Jung defined the basic extrovert/introvert personality types, and also postulated that personality differences would be manifested by different cognitive functions of feeling, sensation and intuition. The MBTI is based on these theoretical constructs, with some additional dimensions reflecting the particular personality styles of individuals. The MBTI is usually presented as a table showing characteristics frequently associated with particular personality types – for example, shy and sensitive (prefers ideas to people) versus enthusiastic and high-spirited (but may be too quick). Thus each personality 'type' has both positive and negative characteristics.

www.discoveryourpersonality.com
www.opp.co.uk
www.skepdic.com/myersb.html

1 Briggs Myers I (1987) *Introduction to Type*. Oxford Psychologists Press, Oxford.

2 Hirsch SK and Kummerow J (1990) *Introduction to Type in Organisations*. Oxford Psychologists Press, Oxford.

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N

National Association of Primary Care (NAPC)

A professional body open to those who work in primary care. It was set up to represent the interests of all primary care professionals and to negotiate primary care organisations' interests with central government and other political parties.

www.primarycare.co.uk

National Audit Office (NAO)

An independent body that scrutinises public spending on behalf of Parliament. The NAO audits the accounts of all Government departments and agencies as well as a wide range of other public bodies, and it reports to Parliament on the economy, efficiency and effectiveness with which Government bodies have used public money.

www.nao.gov.uk/

National Beds Inquiry (NBI)

Established within the Department of Health in 1998, its roles are:

- to review assumptions about growth in the volume of general and acute hospital services and the implications for services and bed numbers in the future
- to review the service implications of current mental health policies
- to assess the 'appropriate' use of acute beds by older people and to consider scope for alternative care models, including the further development of intermediate care and community services.

See **Intermediate care.**

National Booked Admissions Programme

A programme set up by the Government to achieve the NHS target plan of replacing waiting-lists with booking systems by 2005. The aim is to allow GPs or their patients

to book their own healthcare appointments online. The National Patient Access Team (NPAT) is charged with achieving this target. *See* **National Patient Access Team**.

www.doh.gov.uk/waitingtimes
www.npat.org.uk/

National Care Standards Commission (NCSC)

A non-departmental public body, responsible to the Secretary of State for Health, that sets, monitors and improves standards of care for vulnerable adults and children in the field of health and social care. It is to take on the regulation of social care and private and voluntary healthcare in England. The NCSC is the independent regulatory body that has been responsible for inspecting and regulating almost all forms of residential care and other voluntary and private care services in England from April 2002. It can order the withdrawal of a care home's licence and the exclusion of individuals from the residential care sector.

The NCSC will regulate the following services:

- care homes
- children's homes
- domiciliary care agencies
- residential family centres
- voluntary adoption agencies
- independent fostering agencies
- private and voluntary hospitals and clinics
- nurses' agencies
- day centres.

See **Commission for Healthcare Audit and Inspection**.

www.doh.gov.uk/ncsc/
www.centrepointgroup.co.uk

National Clinical Assessment Authority (NCAA)

A special health authority set up in April 2001 to provide rapid and objective expert assessment of a doctor's performance, where concerns about that doctor have been raised locally. It produces a report to the referring employer recommending a course of action to address those concerns.

The NCAA also offers support and advice to doctors who are directly referred by their employers for irregular behaviour. It has a complementary function to the General Medical Council, which is the first point of referral in situations of more

serious professional misconduct. Primary care organisations, the Commission for Health Improvement and the NCAA have signed a memorandum of understanding to ensure that doctors are not passed between organisations unnecessarily. GPs in difficulty can self-refer. Not all doctors who are referred will be assessed, but those who are can expect assessment to take between five and six months. This assessment may include psychometric tests to investigate the doctor's attitudes and personality traits. The aim is to identify the doctor's areas of strength as well as their deficiencies. The NCAA will draw up a confidential report and action plan, including recommendations, which is sent both to the doctor and to the referring organisation. The NCAA expects around 100 assessments a year to take place. Cases of poor conduct or performance are dealt with by the General Medical Council, so the NCAA should not pose a threat to self-regulation.[1]

www.ncaa.nhs.uk/

1 Comerford C (2001) Irvine dismisses NCAA threat to self-regulation. *Doctor*. **11 October**: 11.

National Council for Voluntary Organisations (NCVO)

An umbrella body for voluntary organisations and charities in England. The NCVO represents more than 1000 organisations. It negotiates with the Government over service levels, charity law and consultation, and it also provides support and services to organisations.

www.ncvo-vol.org.uk/

National Electronic Library for Health (NELH)

An electronic accredited NHS library of health information, which enables clinicians to access information on the latest treatments and best practice. This primary care library aims to:

- rate the information sources to which it has links
- apply strict criteria of evidence base
- be relevant to primary care
- provide the right volume of information
- use accredited sources only.

It is hoped that the NELH will discourage clinicians from accessing unauthorised, unstandardised and poor-quality material now available on the Internet by using only approved (accredited) material. *See* **NHS National Information Authority**.

www.nelh.nhs.uk

National enhanced services

These services, which are provided by GPs under the new contract, will be locally commissioned. Patients should expect to find these national enhanced services in every locality, but they would not be provided by every practice. Examples of this service would include more specialised minor surgery, services to violent patients, or out-of-hours services. Practices wishing to provide them would opt into enhanced clinical services. *See* **GP contract**.

National Health Performance Fund

A discretionary fund, worth £500 million a year by 2003–04, set up to provide an incentive to NHS bodies and to reward them. NHS authorities and trusts will be able to access up to £5 million each from the fund to spend on new equipment, facilities and staff bonuses, depending on the organisation's annual performance and progress relative to agreed plans and targets.

www.doh.gov.uk/nhsperformance/

National Institute for Clinical Excellence (NICE)

Set up in 1999, the National Institute for Clinical Excellence was set up as a special arm of the NHS in England, with a multi-million-pound budget to develop authoritative and reliable guidance on clinical management in controversial areas of medicine, alongside its more high-profile role of assessing the value of new drugs. The equivalent body in Scotland is the Scottish Health Technology Board.

One of the aims of NICE is to eliminate the postcode lottery of care, and the other is to ensure that the public are empowered by gaining access to the same high-quality information as their doctors, so that they are then able to make informed choices about their care. Paternalism within healthcare systems limits this choice, as some doctors aim to 'protect' patients from unsettling information. Some doctors also fear that NICE puts too much emphasis on cost cutting, and that it encourages uniformity of consultations, thus preventing clinical freedom.

NICE appraises what are considered to be the best interventions and treatments, and produces guidelines to ensure a faster, more uniform uptake of treatments which work best for patients. It forms one strand of clinical governance. It offers authoritative guidance on the highest standards of care, and aims to improve the nature and completeness of data held on primary care by:

- appraising technology
- developing clinical care programmes
- promoting monitoring of clinical performance through:
  - audit
  - referral protocols

- procedural manuals
- nursing benchmarks
- disease management protocols
- integrated care pathways
- clinical guidelines that are multi-disciplinary, formally evidenced, clinically effective, cost-effective and applicable to the majority.

The National Institute for Clinical Excellence has a remit to produce and disseminate evidence-based clinical guidelines, and the Commission for Health Improvement will contribute to this. By March 2001, NICE had appraised 22 technologies, 19 of which were eventually approved for NHS use. Of these, clinical benefit was cited in all cases, but cost per quality-adjusted life-year was only cited in 50% of cases, and restrictions on the use of these treatments kept the cost of this adjustment to below £30 000 in the majority of cases. The net cost of NICE decisions was less than 0.5% of annual NHS spending.[1] *See* **Evidence-based medicine**.

www.nice.org.uk
Referral guidelines are available from primary care trusts or www.nice.org.uk/pdf/referraladvice.pdf

1 *See* www.nice.org.uk for general information about clinical guidelines.

National Institute for Mental Health in England (NIMHE)

An institute that was set up to provide research and expertise to help the NHS to implement the National Service Framework on mental health. From spring 2003, the institute will co-ordinate and disseminate research and good practice, facilitate training and improve mental health services.

www.doh.gov.uk/mentalhealthczar/

National Medicines Management Services Collaborative

A pilot scheme, run by the National Prescribing Centre, that aims to tackle medicines waste.

www.npc.co.uk

National minimum wage

The lowest wage an employer can legally pay its staff in the UK (different rates are set for Northern Ireland). Currently set at £4.22 an hour for those over the age of

22 years, and at £3.60 an hour for 18- to 22-year-olds, the national minimum wage is revised annually.

www.inlandrevenue.gov.uk/nmw/

National Patient Access Team (NPAT)

The body that was set up in June 1998 to help the NHS to achieve the Government's waiting-list targets. It identifies and disseminates good practice in the field of waiting-list management, and assists staff in introducing efficient elective care processes, such as booked admissions. The National Patient Access Team is charged with achieving the patient access improvements outlined in the NHS Plan 1999, including those set, for example, by the National Booked Admission Programme. *See* **National Booked Admissions Programme**.

www.npat.org.uk/

National Patient Safety Agency (NPSA)

A Government-sponsored watchdog set up in early 2002 as part of *The NHS Plan* to improve medical accountability and patient confidence in the service. The NPSA manages a reporting system which analyses medical errors and adverse incidents, collecting information from NHS organisations, patients and carers. Where risks are identified, the NPSA will produce solutions to prevent mistakes recurring, and it will specify national goals and establish mechanisms to track progress. It ensures that lessons are learned and fed back into practice, service organisation and delivery.

The NPSA stores reports of patient errors (examples of near misses or significant event analyses sent in by primary or secondary healthcare organisations on a quarterly basis). According to the NPSA, around 10% of patients experience adverse events, and 50% of these are preventable. It has drawn up a memorandum of understanding with related professional bodies, but all material handled by the NPSA is confidential, and there are no plans to identify doctors who are reported to this watchdog. *See* **Significant event analysis**.

www.npsa.org.uk/

National Prescribing Centre

A national Government-funded body that is responsible for modernising prescribing policies and disseminating advice and guidelines on prescription medicines, new drugs and nurse prescribing.

www.npc.co.uk
For NHS web users see www.npc.ppa.nhs.uk

National Primary Care Collaborative

Set up by the National Primary Care Development Team in June 2000, this involves practices from every primary care trust in England, and is considered to be the largest health quality improvement programme in the world. *See* **National Primary Care Development Team; Quality.**

www.npdt.org/

National Primary Care Development Team (NPCDT)

A team that was established in February 2000 primarily to assist primary care organisations (practices and primary care trusts) in developing their ability to deliver rapid, sustainable and systematic improvements in the care that they provide to patients and their communities.

The team, headed up by Dr John Oldham, is perhaps best known for its work on advanced access and the National Primary Care Collaborative. This agency addresses all modernisation requirements of the NHS. It aims to encourage streamlining of services, sharing of skills and developing of best practice, and it supports the development of, for example, specialist GPs, patient directives and National Service Frameworks.

Contact details are as follows:

National Primary Care Development Team
Gateway House
Piccadilly South
Manchester
M60 7LP.
Tel: 0161 236 1566.
Fax: 0161 236 4857.

See **NHS Modernisation Agency.**

www.npdt.org/
www.modern.nhs.uk/

National Primary Care Research and Development Centre (NPCRDC)

A body established in 1995, which is responsible for looking at the following:

- variations in health and healthcare
- primary care organisations
- the quality of primary care.

Its work focuses on quality in primary care, governance, budgets, workforce and partnerships within primary care.

www.npcrdc.man.ac.uk

National Service Framework (NSF)

Introduced in 1998, any of the frameworks that establish a set of national minimum standards of clinical quality and access to services in a series of major care areas and disease groups. The aim is to drive up performance and decrease geographical variations in care standards. The five service frameworks produced during the period 1999–2002 cover between them around 80% of the illnesses in the UK population, which represent half of the total NHS spend, and account for the highest mortality rates. These areas and disease groups are mental health, coronary heart disease, the National Cancer Plan, older people's services and diabetes.

NSFs establish models of treatment and care based on evidence of best practice. They look for uniformity of treatment to a minimum standard, and consistency across major care areas. In providing a treatment framework for a particular disorder or group of diseases, they aim to address the following:

- healthcare improvements
- inequalities of access
- differences in outlook
- differences in outcome
- differences in quality of care
- postcode rationing.

The six components of the NSF performance assessment framework are health improvement, fair access, efficiency, effective delivery of appropriate care, user/carer experience, and health outcomes. NSFs aim to address the programme of care from primary through to tertiary and secondary care, including both prevention and rehabilitation. They advise on setting standards/benchmarks, and also give referral and clinical risk management advice. They are devised after close collaboration with relevant professional bodies and the NHS Research and Development Centre. Clinically, the aim of an NSF would be to address the best ways to assess, diagnose, record, treat and monitor a particular disease group. *See* **Clinical governance**; **Information for Health strategy**.

www.doh.gov.uk/nsf

National Shared Service Authority

A special health authority, managed by but working independently from the Department of Health, that is responsible for developing and delivering the NHS electronic staff record (ESR), a national integrated human resources and payroll system that is planned to be delivered across the entire NHS by 2012.

National Workforce Development Board (NWDB)

This replaced the Medical Practices Committee (MPC) in April 2002, and has taken on the role of monitoring and planning the GP workforce, taking into account the distribution and role of GPs and other primary care workers in the area being examined. GP workforce planning is notoriously complex (the MPC defined 63 elements that could influence workload[1]). There are also local Workforce Development Confederations, which are involved in developing workforce plans at local level. *See* **Skill mix review**.

1 Jarvis S (2001) Death of a distributor. *Primary Care Management*. **November**: 31–2.

Need

In the care sector, this is defined as a person's requirement for a service, which has been accepted by the organisation which provides that service.

Needlestick injury

The term for an accidental injury with a used needle, scalpel or stitch cutter, leading to potential contamination with body fluids. The following clinical procedures are then considered and followed:

- establishing the potential risks of the donor
- vaccination with hepatitis B/immunoglobulin
- use of antiviral prophylactic drugs
- referral to occupational health services
- taking blood samples from the donor and recipient for analysis and long-term storage with their informed consent.

See **Infection control; Medical Devices Agency**.

Networking

Making connections and building visibility with work colleagues both within and outside the organisation for which one works. Networkers deliberately form relationships with others – who are usually more senior or influential – by identifying contacts in a current network and targeting people whom they think can help them to achieve their aims. They behave opportunistically, show others that they share their objectives and are interested in their goals (reciprocity), and demonstrate great resilience. It requires courage to make new connections, and they often risk rejection. Networking can involve any of the following:[1]

- attending meetings outside the organisation

- speaking at conferences or making presentations
- generating new contacts
- self-marketing
- collaborating with others in one's field on a piece of work.

Networking provides employees with additional personal and professional support. It is generally thought to enhance the professional standing of the party who is making the contact.

1 Pabari M and McMahon G (2002) Networking. *Counsel Psychother J.* 13: 38–9.

New Deal for Communities

A Government initiative to tackle deprivation by providing intensive financial and other support to run-down areas of the UK. Its aims are to tackle poor job prospects, crime, educational under-achievement, poor health, poor physical environment and sub-standard housing.

New GP contract

Negotiations on the new GP contract began between the General Medical Council and NHS Confederation members acting on behalf of the Government in 2001. The contract was accepted in principle by the profession in mid-2002, and GPs will be voting on whether or not to implement the contract fully once it is priced and finalised in 2003. The 2002 budget was set by the Government to fund the radical changes to the NHS that it was prescribing.

The national General Medical Services contract is similar in principle to the Personal Medical Services contract. It aims to target patient needs more effectively by expanding the range of primary care offered, developing new arrangements for service delivery, improving service access for patients and introducing better clinical quality. It also aims to streamline contractual arrangements, reduce the bureaucracy involved in administering the *Red Book*, and expand practice capacity without extending the partnership. Set fees will be paid for providing certain core and specialist services, and training grants, target and item-of-service payments will be replaced by an annual payment that reflects the practice population and workload.

Written to reflect Government priorities, the aim of the contract is for general practice to be:

- run on a fixed budget
- rewarded for a quality-driven service and faster and better patient access
- developing skill mix within practices
- developing specialist GP services.

The underlying principle of the new contract is to give GPs the choice of whether to provide only core essential services (directly treating those who are ill, or who believe themselves to be ill), or whether to opt into providing a larger range of additional and enhanced clinical services. Additional services may be defined as health promotion (e.g. cervical cytology or vaccinations and immunisations). Enhanced clinical services would be adopted where practices opt to provide, for example, a specialist GP service or minor surgery.

Start-up and infrastructure costs associated with quality and outcomes will be funded. Quality markers will be tiered in three levels, with confirmation of achievement ranging from accepting level one standards (organisational quality markers) to the types of audits expected of practices that achieve National Service Framework standards at the premium level three.

In asking GPs to adopt the new contract standards, the expectation is that they will accept national clinical standards, accountability and a clinical governance structure, with the overall aim of rewarding quality, not quantity.

www.gmc-org.uk

New Opportunities Fund

The body responsible for distributing National Lottery money to health, education and environment projects in the UK.

www.nof.org.uk

NHS Act 1999

Introduced as part of the Labour Government NHS modernisation plan, this was designed as a plan for investment and reform. Some of its core principles are that the NHS would:

- continue to provide a publicly funded, universal service for all, based on clinical need
- provide comprehensive, clinically appropriate, evidence-based and cost-effective services
- be patient centred – shaped around patient need and preference
- continue to improve quality and reduce errors
- support and value its staff
- work to provide seamless care by developing partnerships with patients, their carers and their families, between health and social care, and between the voluntary sector, public and private organisations
- work with other public sector departments to reduce health inequalities
- provide open access to information about services, treatment and performance.

The Act is supported by a document, *The NHS Plan*,[1] that sets out how these objectives are to be achieved, using ambitious targets. It introduced for the first time the idea of extending Personal Medical Services, the clinical accountability framework, and targets for improving access. It also set out a plan for changing the NHS skill mix, by developing the nurse and therapy roles so that they could take more responsibility for patient care and decision making. *See* **NHS Plan**.

www.modern.nhs.uk

1 Department of Health (1999) *The NHS Plan: a plan for investment, a plan for reform*. The Stationery Office, London.

NHS Alliance

An organisation which sets out to represent primary care, primary care organisations and the staff, professionals and managers working within them. The NHS Alliance aims to be an independent organisation that champions primary care trusts (and their equivalent organisations in Scotland, Wales and Northern Ireland). It advocates local empowerment and equal working relationships, equity, inclusiveness, co-operation, democracy and multi-professional working.

The NHS Alliance plays a major role in supporting and developing primary care trusts, and provides opportunities for its members to network at regular meetings and seminars. It grew out of the locality commissioning movement that set up in opposition to fundholding in the mid-1990s.

www.nhsalliance.org

NHS Appointments Commission

A body that was established in 2001 to make all chair and non-executive appointments to NHS trusts, primary care trusts and health authorities. It was recently delegated the powers to appoint members to the Council for the Regulation of Health Care Professionals.

www.nhsconfed.org/nexus/welcomepack/appointments.htm

NHS Centre for Reviews

A centre that was established in 1994 to provide the NHS with information on the effectiveness of treatment and the delivery and organisation of healthcare. Its role has since been taken over by the more widely publicised National Institute for Clinical Excellence (NICE). *See* **National Institute for Clinical Excellence**.

www.york.ac.uk/inst/crd/welcome.htm

NHS Direct

A telephone helpline and website that gives access to a 24-hour nurse advice and health information service, providing confidential information on the following:

- what to do if you or members of your family are feeling ill
- specific health conditions
- local healthcare services, such as doctors, dentists or late-night-opening pharmacies
- self-help and support organisations.

Devised as one way of improving patient access, it aims to act as the first point of contact for all patient queries, especially out of hours. By 2004, NHS Direct will also be referring people directly to their local pharmacy for help (trials in Scotland are already in progress).

www.nhsdirect.NHS.uk
www.nhsdirectwales.nhs.uk/

NHS Directory

Billed as the gateway to complementary and alternative medicine for the NHS, this directory provides contact details for CAM disciplines that wish to forge closer links with GPs. It is free to all NHS professionals who wish to contact practitioners in the UK. *See* **CAMs**.

www.nhsdirectory.org

NHS History

A website that charts the history and development of the NHS from the 1920s to the 1990s.

www.hsj.co.uk/timeline/index.htm

NHS Leadership Centre

A body that was set up to develop the capabilities of leaders at all levels within the service in order to achieve improvement. Working under the umbrella of the NHS Modernisation Agency, it aims to identify and promote good leadership behaviour and to develop management skills in the NHS. It will work with both clinicians and managers. *See* **NHS University**; **Workforce development confederations**.

www.modern.nhs.uk
www.nhs.uk/modernnhs

NHS Lift

A Government scheme that was established to take up public–private equity–stake companies to overhaul GP premises. Originally set up to cover six areas, in early 2002 it was extended to a further 12 areas, despite criticism from the Commons Health Select Committee for failing to evaluate the existing schemes.

www.doh.gov.uk/pfi/nhslift.htm

NHS Litigation Agency

A special health authority which handles up to 5000 claims annually and indemnifies NHS bodies in the event of clinical negligence and non-clinical risks.

www.nhsla.com

NHS Modernisation Agency

An agency that was set up to address the modernisation requirements of the NHS. It aims to bring together healthcare improvement and leadership development in one place, to meet patient needs, and to help local clinicians and managers to meet that need. This agency encourages streamlining of services, sharing of skills, developing best practice, and national protocols and care pathway plans. The National Primary Care Development arm, whose team is headed up by Dr John Oldham, is best known for its work on advanced access.

The NHS Modernisation Agency works on issues such as clinical governance, changing workforce patterns, Beacon projects, management education and training schemes.

Update reports produced by the modernisation board can be found at www.doh.gov.uk. *See* **National Primary Care Development Team**.

www.modern.nhs.uk/

NHS National Information Authority (NHSNIA) (previously Information Management Group)

Previously known as the Information Management Group, but now renamed, this organisation is responsible for the provision of national products, standards and services to support the sharing and best possible use of information throughout the health service, via local implementation of the *Information for Health* strategy. It is in charge of NHSnet and *Information for Health*. *See* **National Electronic Library for Health**.

The NHSNIA website is www.nhsia.nhs.uk. NHS intranet users can access the site at www.avoca.co.uk

NHSnet

The secure national electronic intranet network for the NHS, enabling all parts of the service to communicate over the Internet. It is run by the NHS, to support the NHS. The aim was to have the network on every desk by December 1999, but due to technological difficulties (the original network used outdated and cumbersome X400 technology) this target was moved back to a time when the latest SMTP/broadband technology could be used. Its services include an NHS message handling service, high-speed Internet access and a national email system and electronic address book. It is hoped that every NHS employee and contractor will have their own named email address that will remain unchanged regardless of where that person works nationally. *See* **NHS National Information Authority**.

www.nhsia.nhs.uk/nhsnet/

NHS Plan

The controversial and radical plan for modernisation, investment and reform that was set out by the Government in July 2000.[1]

This 144-page document sets out new ideas for funding and investment in healthcare, and changes in relationships between clinical staff, the NHS and the private sector and social care. The five key challenges it proposed were across partnership, performance, professions and the wider NHS workforce, patient care and prevention. The aim was to make the NHS more user friendly, to improve the quality of service and minimise errors, to support and value staff, and to build a seamless service for patients. The plan discusses the ways in which this would be achieved, through additional funding and investment in staff, developing national service standards, improving clinical performance and empowering patients. A key factor was the aim of removing old-fashioned demarcations between staff, and barriers between services.

www.nhs.uk/nhsplan

1 Department of Health (1999) *The NHS Plan: a plan for investment, a plan for reform.* The Stationery Office, London.

NHSplus

A network of occupational health services based in NHS hospitals, which provides an occupational health service to NHS staff and sells services to the private sector. Services include pre-employment screening, health checks, immunisation, drug and alcohol screening, and ergonomic advice (advice on manual handling of loads, lifting and VDU operation).

www.nhsplus.nhs.uk/

NHS Purchasing and Supply Agency (PSA)

An agency that was formed in April 2000 alongside its sister organisation, the NHS Logistics Authority, to replace the NHS Supplies Authority. Its role is to act as a centre of expertise and knowledge in all purchasing and supply matters for the NHS. It contracts nationally for products and services critical to the NHS, and it buys in bulk where savings can be found.

www.pasa.doh.gov.uk/

NHS University (NHSU)

This organisation will set up a programme of learning accessible to everyone employed in health, in partnership with social services, the voluntary sector, private bodies and patient organisations, in England. The main focus is to drive forward the modernisation of the NHS, helping to deliver a patient-centred and devolved service with the emphasis on teamwork. NHSU is a national body that aims to influence policy and play a leading role in developing frameworks of national standards. It will provide support and encouragement to adults in the NHS, and will encourage interest in healthcare careers for school and university leavers.

The Government hopes eventually to accredit the NHSU with full university status.

www.doh.gov/uk/nhsuniversity

Non-verbal communication

Non-verbal signals such as gestures, touch, silence, tone of voice and delivery, which represent around 85% of communication context, and help to describe the content of the words. Facial expressions, timing and speed, body language and word choice serve to underline or undermine the verbal message. These signals tell us whether the situation is public or private, formal or informal, and serious or relaxed.

Non-verbal communication can contradict a verbal message or alter its meaning. Dress code, the apparent wealth and status reflected in the surroundings, and the use of time and space all clarify the meaning of verbal communication or increase its impact. Non-verbal signs of dominance and status are demonstrated by those who acquire or hold the largest space. A more equal, less oppressive stance is created by those who listen more than they speak, who use less discriminatory or oppressive language, and who create a less formal environment. *See* **Communication**; **Listening skills**.

Norm

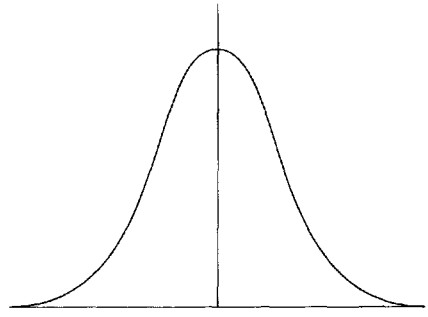
A common or standard value or pattern for a given group or type. In statistics, it refers to the representative value for a group of scores.[1] *See* **Mean**; **Median**; **Mode**.

1 Samuel O, Grant J and Irvine D (1994) *Quality and Audit in General Practice: meanings and definitions*. Royal College of General Practitioners, London.

Normal distribution

The statistical term for a graphical display showing a curve which is bell-shaped and symmetrical around its *mean* (mid-point). If a significantly large number of observations or measurements is made, the distribution naturally approximates to this normal distribution. Mathematically, the distribution of means of samples taken from any population will tend towards the normal distribution as the number of samples taken increases. For example, human heights and IQ are distributed in this way.[1]

1 Robson C (1975) *Experimental Design and Statistics in Psychology*. Penguin, Harmondsworth.



The normal distribution curve.

Normalisation policy

A policy that enables someone with a physical or mental disability to live as full a life as possible and to have access to all public services.

Not-for-profit organisation

A term that originally hailed from the USA, and which refers to a voluntary sector or charity sector organisation.

www.nonprofits.org/

Nurse prescribing

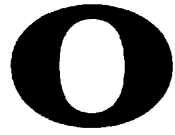
From May 2001, the Government extended independent nurse prescribing to allow more nurses to prescribe medication for a wider range of medical conditions, such as minor injuries and palliative care. Training is available to develop nurses in this way to further extend their role in general practice and the community.

www.doh.gov.uk/nurseprescribing/

Nursing home

A residential home that has qualified nursing staff available to provide nursing care for elderly people. Their work is monitored by local authority registration and inspection units. *See* **Residential home**.

www.rnha.co.uk
www.ncha.gb.com/



Objective

The *goal* is the end point (the final achievement aimed for), the *aims* are the priorities set (what the plan is) and the *objectives* specify how you will achieve those aims (how you will map the outcome).

Ideally, objectives are:

- brief
- realistic and achievable
- verifiable
- time bound (it is known when they are to be achieved)
- quantifiable (the quality can be indicated)
- quantifiable (measurable, the cost of achieving them can be prescribed)
- challenging
- easy to prioritise.

An example of criteria for good objectives is given below.

Goal:	to identify and meet the health needs of our elderly population.
Aim:	for all clinicians to update patient details at consultation.
Objectives:	1 team meeting to agree clinical coding and level of morbidity, mortality and consultation data by X
	2 to run an age/sex/diagnosis review in X
	3 X to conduct a literature review to compare our data with regional and national data held by public health.

Setting objectives involves the following steps:

- identifying priorities, costing them and staging them
- noting how success will be measured once the objective has been achieved
- noting who is responsible for achieving the objective by when: using basic 'who, why, what, where, when' headings.

Note any critical success factors, and build in a system for monitoring whether or not the objectives have been achieved. *See* **Goal setting**.

Organisational analysis and development

An applied behavioural science approach to planned change and development of an organisation.[1] It is concerned with attempts to improve the overall effectiveness and efficiency of the organisation. It looks at how organisational structure and the motivational climate (those within the organisation, their attitudes and their level of morale) can hinder achievement of its goals.[2] Organisational analysis examines how the organisation works and how its aims are defined and communicated. It aims to bring the organisation up to a level where it works optimally, thereby benefiting the employers, staff and other stakeholders (the patients, primary care organisations, trusts and allied Government bodies within the NHS).

The study of organisations is closely associated with the following:

- organisational culture
- organisational climate
- employee commitment
- organisational conflict
- change management
- management development.[3]

In order to bring about change, organisational analysis and development makes use of a number of approaches, including survey research, feedback and teambuilding. *See* **Organisations**.

1 Mumford E (1986) Helping organisations through action research: the socio-technical approach. *Qual Work Life.* **3**: 329–44.

2 Harvey DF and Brown DR (1988) *An Experiential Approach to Organisational Development* (3e). Prentice-Hall, New Jersey.

3 Mullins LJ (1999) *Management and Organisational Behaviour* (5e). Financial Times/Pitman Publishing, London.

Organisational context

The shape and size of an organisation, its position in relation to its stakeholders, and the interactions that it has with its external environment.

Organisations come in all shapes and sizes (consider the differences between a bank, a hospital, a leisure centre, a general practice and an airport). However, there are common factors. There are always two broad categories of resources:

- non-human – physical assets, materials, equipment, facilities
- human – people's abilities and skills, and their influence.

In all organisations we see the efforts and interactions of people working to achieve objectives through a structure which is directed and controlled by management. Formally, organisations operate through organisational charts, policies and procedures. Informally, they operate through personal friendships, grapevines, emotions, power games, informal relationships and leadership. The basic components of an organisation are the *operating component* (consisting of the people who actually do the work or provide the service, such as the clinical and reception team) and the *administrative component* (consisting of the managers and their team of supervisors). *See* **Organisations.**

Organisational culture

As a collection of traditions, values, policies, beliefs and attitudes that constitute a pervasive context[1] (a basic underlying assumption) for everything that is thought of and done in an organisation. All organisations are influenced by external cultural factors (e.g. language, values, religion, education, the law, economics and politics) and by internal value-driven systems (dominated perhaps by religion, conservatism or ecology).[2] In each case, authority is legitimised differently. In traditional organisations, authority is permitted by custom and by a longstanding belief in the natural right to rule. In charismatic organisations, authority is justified by a belief in the personal qualities of the leader. In bureaucratic organisations, authority is based on formal rules and impersonal principles.[3]

Some key influences on NHS culture[4]

- History – when and why the NHS was formed.
- How GPs are seen in relation to their consultant colleagues.
- The primary function of hospitals and general practice.
- The importance of reputation and the range of services provided.
- The primary goals and objectives of the NHS.
- Size and location.

continued overleaf

- Communication difficulties that present.
- Opportunities for development.
- Management influences.
- Response to change.
- Routines and rituals and the stories that are told.
- The symbols that are used.

The Government's view is that the prevailing culture within the NHS is hierarchical and patriarchal and that, in terms of work, self-interest dominates. Clinicians and managers regard power inequalities within the NHS as natural, necessary and beneficial. They attach little value to having a supportive superior, and they support a medical ascendancy model of management,[5] in which a doctor's professional autonomy and attitudes are seldom questioned by those outside the medical profession, and few doctors feel that financial or managerial decisions affect their professional practice in any meaningful way. *See* **Institutional racism; Leadership.**

1 McLean A and Marshall J (1993) *Intervening in Cultures.* Working paper. University of Bath, Bath.

2 Welford R and Prescott K (1994) *European Business: an issue-based approach* (2e). Pitman Publishing, London.

3 Weber M (1964) *The Theory of Social and Economic Organisation.* Collier Macmillan, London.

4 Mullins LJ (1999) *Management and Organisational Behaviour* (5e). Financial Times/Pitman Publishing, London.

5 May A (1998) Streets ahead on quality. *Health Service J.* **10 December.**

For more information about NHS culture and ways to work with it, see the following:

- Phillips A (2002) *The Business Planning Toolkit.* Radcliffe Medical Press, Oxford.

Organisational environment

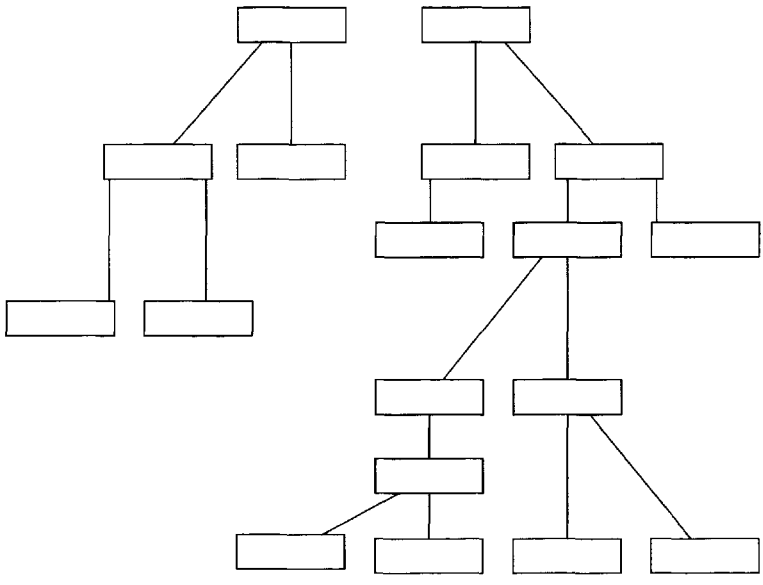
The 'surface' influences on general practice, consisting of external influences (e.g. the Government, economic activity, scientific advances, social and cultural influences) and internal influences (e.g. patients, technology, formal goals, facilities, rules and regulations). The behavioural aspects (e.g. attitudes, personality conflicts and political behaviour) are more covert. It is the manager's role to understand and integrate the influences of their organisational environment – to co-ordinate, encourage and improve systems and individuals and to ensure that people's work needs are satisfied.[1] *See* **Organisations.**

1 Hellriegel D, Slocum JW and Woodman RW (1998) *Organizational Behaviour* (8e). Thomson Learning, London.

Organisational structure

The structure devised by management to create order, to help to establish relationships between people, and to direct the efforts of the organisation towards the goals that they have established.

The ideal organisational structure is usually hierarchical, and may look something like this:



Organisational structure.

Structural problems occur when a sensible hierarchy is not followed. Inconsistent and arbitrary decisions, poor delegation and a lack of policies and procedures will lead to low morale. Poor time management and poor communication then lead to failure to make decisions or re-evaluate past decisions. Conflicting goals, cross-purposes and lack of clarity about objectives and priorities lead to conflict and poor co-ordination.[1]

1 Child J (1988) *Organisation: a guide to problems and practice* (2e). Paul Chapman, London, p. 4.

Organisation

A structure for containing the workplace and the workforce. It functions in context, so a full understanding of what an organisation is requires a broad understanding of the following:

- the organisational context (the interactions with the external environment)
- the organisational structure
- management processes

- people – and why they behave as they do, their motivations, aims and goals, and their position within a group.

Traditionally, organisations can be distinguished in terms of two generic groups, namely private enterprise and the public sector. General practice and private medicine straddle the two uncomfortably as there will always be an inherent tension between the care-taking quality and the need to make money.

Our Healthier Nation

An umbrella term for the work involving a variety of partner agencies in the pursuit of better health for the nation, namely the Department of Health, the Health Development Agency, the Local Government Associations and the National Council for Voluntary Organisations.

The White Paper entitled *Saving Lives: Our Healthier Nation* was a comprehensive Government-wide public health strategy for England, published in July 1999 with twin goals:

- to improve health
- to reduce the health gap (health inequalities).

The strategy is still current, and aims to prevent up to 300 000 untimely and unnecessary deaths by the year 2010. *Our Healthier Nation* brings together information on national priorities, Health Action Zones, NHS Beacons and current associated research. *See* **Health Action Zone**.

www.ohn.gov.uk
www.archive.official-documents.co.uk/

Outcome

The result or visible effect of an event.[1] Donabedian's definition applies more specifically to health: 'A change in the patient's current and future health status that can be attributed to antecedent health care'.[2] Donabedian adds social, psychological and functional domains to his construct of health, broadening it to include patient satisfaction, knowledge and behaviour. This illustrates how health outcome is often difficult to ascertain, as health change may be the result either of healthcare changes or of other changes such as environmental and lifestyle influences.

In clinical audit, the definition of an *outcome measure* has been refined as: 'a set of criteria which can be used to describe a health state which has been influenced by healthcare in terms of change over time'.[3]

This needs to reflect some measurable relationship to a process performed on a patient, but recognises that either a positive or a negative outcome can occur as a result of a whole range of environmental and lifestyle influences, not all of which are under clinical control.

The term *health outcome* is used to describe the result of one or more health interventions. If health change does occur as a result of clinical interventions, the validity and reliability of the change can be enhanced if the change can be duplicated, and standards can be defined.

The complexity of outcome measurements is further illustrated by Lohr, who stated that 'outcomes can be short term, long term or anything in between, and the classifications can be quite arbitrary'.[4]

A *proxy outcome* measure is one that is not definitive, but which has a valid and established (evidence-based) link with an outcome measure, so that it can provide similar information.[3] In medicine, most proxy measures are used to establish a (non-scientific) link with an outcome measure (e.g. a parent stating how much sleep a child has lost due to illness).

1 Brown L (ed.) (1993) *New Shorter Oxford English Dictionary*. Clarendon Press, Oxford.

2 Donabedian A (1980) The definition of quality: a conceptual exploration. In: *Explorations in Quality Assessment and Monitoring*. Health Administration Press, Ann Arbor, MI.

3 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice. Meanings and definitions*. Royal College of General Practitioners, London.

4 Lohr KN (1988) Outcome measurement: concepts and questions. *Inquiry*. **25**: 37–50.

Out-of-area treatment (Oats)

A single episode of care relating to emergency or specialist treatments carried out in an NHS setting that is outside the patient's home health authority and that is not covered by existing service agreements. It often occurs when holidaymakers require urgent treatment. Each recorded 'Oat' results in the financial allocation to the home primary care trust being adjusted downwards, and that of the primary care trust in which the treatment is carried out being adjusted upwards.

Out of hours (OOH)

The term used for GPs providing medical cover outside normal surgery times (e.g. early morning, evening, night and weekend work). GPs will be able to opt out of OOH if they accept the terms of the new contract, and primary care trusts will be responsible for providing OOH cover. These 24-hour responsibilities are now more frequently being taken over by local GP co-operatives, Healthcall or NHS Direct.

Outpatient

A patient who attends hospital for treatment, consultation and advice, but who does not require a stay in hospital.

Outsourcing

Awarding a contract to a private, public or voluntary sector organisation to supply a service previously run by a public sector body such as a council or hospital.

Over-the-counter medicines

Medicines and medical appliances that are bought directly from the pharmacist, and are available to the public without a prescription. The Government is continually looking to extend the range of these medicines as part of their drive to improve patient access. *See* **Prescription-only medicines**.

Ownership

This is obtained once people who are undertaking a project feel that the task is both appropriate and of personal relevance.

P

PACT (Prescribing Analysis and CosTs) data

Practice reports that are sent out regularly by the Prescription Pricing Authority in Newcastle, giving an analysis of all scripts issued by GPs in England and Wales. The scripts are analysed in terms of different clinical indications and cost, and may be requested by individual GP or by type of drug.

www.npc.co.uk
For NHS web users, visit www.npc.ppa.nhs.uk

Palliative care

The physical, psychological, social and spiritual care of patients whose disease is no longer curable (e.g. those with HIV/AIDS, cancer, and some degenerative neurological disorders). Palliative care was developed by and is still largely provided by voluntary hospices, but some hospitals have specialist palliative care teams, which aim to provide the best possible quality of life for these patients.

www.hospice-spc-council.org.uk

Paperless practice

A GP practice that no longer uses paper filing systems for patient records, but which stores patient information on computers. Such practices need to ensure that patient records are available to others who are involved with the care of the same patient, and they have to store paper-based information from other parties (e.g. laboratory results). Electronic medical records (EPRs) have different characteristics to their paper-based equivalent. For example, they can be accessed simultaneously by different people, audits are easier and alert warnings are improved. However, they do also have disadvantages.

Paper records allow for considerable freedom of expression, as computer codes never reflect the breadth of normal written communication. Security is less problematic and easier to maintain. Practices that are seeking to go paperless apply to their primary care trust for approval. They need to consider a slow migration, how to construct and use interim records, and take into account factors such as accessibility, capacity and confidentiality. Simultaneous access to both paper and electronic

systems will be needed for at least two years. *See* **Caldicott; Electronic medical record.**

www.nhsia/nhs.uk/

Paramedic

Ambulance paramedics in the UK are highly experienced ambulance technicians who undertake clinical training in anatomy and physiology, advanced trauma management, life-saving procedures, and the treatment of serious medical emergencies. Paramedics use a range of invasive skills and administer a wide range of drugs.

www.asa.uk.net

Parkinson's law

The maxim that 'work expands so as to fill the time available for its completion.'[1] General recognition of this principle is found in the proverb 'It's the busiest person who has time to spare.' Among other features of organisational practice that Parkinson discusses are the nature of committees and the Law of Triviality, which means that in a committee the time spent on any agenda item will be in inverse proportion to the sum involved.

1 Parkinson CN (1986) *Parkinson's Law*. Penguin, Harmondsworth.

Participative management

A leadership/management style in which people participate in and help to formulate a decision, so that they support decisions instead of fighting them, and they work hard to make it work, because it becomes their idea. The organisation thus benefits from a rich array of good information and ideas. This is now thought to be by far the best way of leading, as group discussion improves decision making, and may actually help to avert disaster. Individuals are encouraged to develop, and they contribute more to the organisation as a result. They also develop a sense of personal achievement and value. People work better and more enthusiastically when they are given a high level of freedom with regard to their contribution.

On the negative side, this style of management requires an enormous amount of time, which is often not available in the NHS. It can be inefficient if it is used inappropriately (if people are not bright or committed enough to take on board the responsibility that it releases). If it is not handled well, it can result in a complete loss of managerial control. *See* **Leadership.**

Partnership

Working with and alongside others. The Government aim, outlined in the 1999 NHS Plan, is for the NHS to work *strategically* in partnership with social care, education,

transport and the voluntary sector to reduce health inequalities, and for GPs to work *operationally* in partnership with other healthcare colleagues in the wider primary care and secondary care team (e.g. social workers, therapists and consultants), in order to achieve a seamless standard of care for patients.

Partnership agreement

A partnership deed which details agreed general practice administrative and financial arrangements, such as holiday entitlement, sick pay allowances, voting arrangements and permitted periods of notice. It is sensible for all non-salaried GPs (both Personal Medical Services and General Medical Services partnerships) to have a partnership deed, which usually also covers the following:

1 financial aspects:
   - partnership assets – including property investments, equipment, sale of goodwill
   - tax – needs to refer to the current tax regime and include reference to reserve accounts and the nominated partner
   - income and expenditure – allocation of allowances, profit shares, including ownership expenses, golden hellos and goodbyes, primary care trust work, out of hours, locums, Medical Defence Union cover, absence from the practice allowances
2 leave – references to maternity, paternity, adoption, sabbatical or compassionate leave
3 retirement issues – flexibility, suspension, notice periods, resignation from medical list
4 Personal Medical Services contract – restrictions and breaches and withdrawal notices
5 any restrictive covenants.

The British Medical Association and the General Medical Council both give detailed guidance on partnership agreements, and supporting advice can be obtained from Local Medical Councils. GPs should also obtain independent legal and accountancy advice. It is important that the agreement or deed is current and valid.

Patient Advocacy and Liaison Service (PALS)

A service designed to help the public to air concerns about their treatment, care and support. It was set up after the dissolution of local Community Health Councils. PALS has direct access to trusts' chief executives, as well as strong negotiating powers. Their aim is for staff to be available to patients, carers and their families to help to

resolve complaints and concerns quickly. *The NHS Plan* announced the commitment to establish PALS in every trust by 2002. The first wave of PALS 'Pathfinder' sites became operational in April 2001.

The aims of PALS will vary in different localities, but include the need:

- for patients to have their concerns dealt with in a conciliatory manner
- to liaise with local primary care trusts with regard to PALs activity, gaps in services and any training needs
- to inform local people about the NHS, and to refer them on to specialist advocacy services if necessary.

PALS is central to the new system of patient and public involvement. It does not replace the existing specialist advocacy services, such as mental health and learning disability advocacy, but will be complementary to these services. *See* **Commission for Patient and Public Involvement in Health; Patient participation.**

www.doh.gov.uk/patientadviceandliasonservice/index.htm

Patient empowerment

A self-management approach for patients with chronic diseases, which research has shown gives rise to improvements in health outcomes with a consequent reduction in demand on the health service. For example, the *Heart Manual*, which was developed by the British Heart Foundation Rehabilitation Research Unit at the University of York, reaches about 5000 patients in the UK each year. It has been proved to be clinically effective in demonstrating improved psychological adjustment, fewer visits to GPs and a significant reduction in rates of readmission to hospital in the first six months following a heart attack. Empowering patients with chronic illnesses to undertake increased monitoring of their condition has been shown to lead to reduced severity of symptoms, a significant decrease in pain, improved life control and activity and increased life satisfaction. *See* **Doctor–patient partnership; Expert Patient Project.**

Patient Group Directives

Documents written to enable certain non-medical professional groups, such as nurses and pharmacists, to prescribe named medicines to particular and identified patient groups. They are used in cases where the presence in the population of a particular illnesses or condition significantly increases the workload of GPs (e.g. an influenza epidemic, increased demand for anti-smoking medication or the morning-after pill). The aim is to improve patient access, assist GPs with workload reduction, and enable allied professionals to take on some of the clinical responsibilities for patients.

Such directives stipulate the following:

- under what circumstances and criteria action will occur

- which staff group it will be applied to
- whether there is a need to apply additional local guidelines
- training requirements
- communication arrangements (e.g. when and how the responsible GP will be informed, and who will be copied in)
- consultation arrangements.

www.npc.co.uk
For NHS web users, visit www.npc.ppa.nhs.uk

Patient participation

An umbrella term for the various methods of involving 'service users' (patients) in discussions about healthcare provision, the aim being that they can constructively contribute to local difficult or unpalatable rationing decisions. Primary care contributes to this process by developing projects such as the following:

- patient voice projects (discussion/focus groups)
- patient participation groups
- informal feedback systems (e.g. suggestions boxes)
- health panels
- citizens' juries
- open meetings
- rapid appraisal (gathering information from key local informants)
- disease support groups
- interviews
- opinion polls
- neighbourhood forums
- public consultation exercises (involving patients in a particular service development)
- practice-based annual surveys
- appraisal systems (e.g. customer panels)
- postal questionnaires.

Patient participation works on the premise that patients know their experience of illness better than anyone else. If patients feel empowered, they will develop more choice and are more likely to take control of their own illnesses. They also learn and

so become better informed and less passively dependent on the NHS. By participating in the discussion, patients become better educated and develop a broader understanding of public health issues and the patterns of health and disease. *See* **Patient Advocacy and Liaison Service; Patient survey; Patients' forum; Survey.**

For some more ideas and a broader understanding of such methods, see the following:

- Lilley R (2000) *The PCG Toolkit*. Radcliffe Medical Press, Oxford.

Patient prospectus

An A4-size fold-out leaflet produced by primary care trusts and sent to every household annually. These prospectuses are designed to provide information on the availability and quality of local health services. They also contain feedback from patients, and set out the top priorities for trusts in response to those views.

www.doh.gov.uk/patientprospectus

Patient survey

A survey that is either locally or nationally constructed, and which measures the following:

- access
- availability
- interpersonal care
- continuity of care
- trust
- referral
- co-ordination of care outside a practice.

The best patient surveys ensure that all questions are relevant, unambiguous, simple, flow in a logical order in a language that the studied population understands, and give simple choices of response. They do not make assumptions, ask leading or biased questions, use complex, inappropriate or offensive language, or assume that all answers will be honest. The sample size is important, as is the relevance of the sample population. It is useful to invest in specialist help when constructing a patient survey. *See* **Patient participation; Survey.**

www.npdt.org/

Patient transport service (PTS)

A service that transports patients with non-urgent conditions to and from a range of treatment settings, including outpatients, disablement service centres, routine discharges and admissions, geriatric and psychogeriatric day care, and non-urgent inter-hospital transfers. It is staffed by ambulance care assistants, who are trained in first aid, driving skills, and lifting and handling techniques.

www.asa.uk.net

Patient's unmet needs (PUNs)

Looking at the patient's unmet needs (PUNs) is one way in which clinicians can identify their own learning needs. If patient needs are not met, this may be due to a deficiency in the clinician's knowledge or skill – thus identifying the doctor's unmet needs (DUNs). PUNs can be identified by transcribing and analysing difficult and unsatisfactory consultations, and identifying where and at what point the communication between doctor and patient broke down. *See* **Learning needs.**

Patients' Forum

Every healthcare trust has a patient forum. Their aim is to monitor and review services and to influence and inform decision making. Forum members elect one of their number as a Non-Executive Director of the Trust Board.

Pay-and-reward system (performance-related pay)

The system by which staff are paid. Pay-and-reward systems may be traditional (salaries with automatic incremental pay rises), or more flexible (with a single spine scale and rewards for job development, responsibilities and initiative, rather than for age and seniority).

Any intrinsic (value-based) non-pay awards are best demonstrated by allowing individuals to use their creativity and control, allowing them to build their own jobs (job enrichment), and recognising each individual's orientation to work. Extrinsic rewards, which are measured more formally, can be demonstrated in additional holiday for long-term service, training, etc. Such flexible pay enhancements develop initiatives outside the constraints of the common pay scales. They are based on identified service needs and reflect the local position.

Pay-and-reward systems should offer terms that recruit, retain and motivate appropriately skilled staff, and which offer reasonable internal pay relativities. They should be seen as long-term pay strategies which take into account the informed view of staff as well as managers.

Pay review

This is a review of all the pay elements of a job and includes:

- a statistical analysis of the workforce

- gathering information on all elements of pay
- determining which jobs involve equal work, i.e. are same work or work of equal value
- a comparison of all elements of pay for the men and women doing equal work
- determining whether any differences identified are based on sex and whether they can be objectively justified.

In small organisations such as general practice it may not be practicable to implement all the detailed provisions of an equal pay review. The Equal Opportunities Commission (EOC) is in the process of producing tailored advice on equal pay reviews for the small business sector which is due to be launched in mid-2003. *See* **Equal Pay Act 1990.**

www.eoc.org.uk/

Pay review body (PRB)

Any of the independent panels that take evidence annually from the Department of Health and staff unions before making a recommendation on remuneration to the Secretary of State for Health, who (usually) accepts and authorises the recommended pay rise. There are two panels – one covering doctors and dentists and the other covering nursing staff, midwives, health visitors and professions allied to medicine. Pay review bodies are currently being phased out.

www.doh.gov.uk/reviewbodies/

Payroll giving

A method of giving to charity through an employee's pay packet. Donations come straight from the employee's gross pay before tax, effectively making the donation cheaper for the person donating. Until April 2003, the Government promised to add 10% to all payroll donations.

www.inlandrevenue.gov.uk/payrollgiving/

Primary Care Data Quality (PCDQ) programme

This project, supported by the NHS National Information Authority, was commissioned in recognition of the problems that GP practices have with data management. Its MIQUEST software allows extracted data to be standardised, anonymised and pooled from a variety of proprietary GP systems.

The PCDQ programme provides a mechanism for capturing the quality data required to support clinical governance and the National Service Frameworks. Using a set of queries written by this system, and following a data collection plan, GP practices are able to build their own disease registers and monitor their patients'

treatment. The programme has been devised to highlight the importance of good-quality data input and management. *See* **MIQUEST; PRIMIS.**

www.nelh-pc.nhs.uk
For those on the NHSnet, visit http://nww.nelh-pc.nhs.uk

Peer appraisal
See **Appraisal.**

Peer review
The consideration or appraisal of performance by colleagues within the same profession, or by another group with comparable skills and experience. Changes in behaviour have been found to be greatest among those who were in most disagreement at the outset of the peer-review process.[1]

1 Grol R (1990) Peer review in primary care. *Qual Assurance Healthcare.* **2**: 119–26.

Performance assessment framework
There are six components of the National Service Framework (NSF) performance assessment framework, namely health improvement, fair access, efficiency, effective delivery of appropriate care, user/carer experience and health outcomes.

National Service Frameworks establish models of treatment and care based on evidence of best practice. They look for uniformity of treatment to a minimum standard, and for consistency across major care areas. They provide a treatment framework for a particular disorder or group of diseases, and aim to address the following:

- healthcare improvements
- inequalities of access
- differences in outlook
- differences in outcome
- differences in quality of care
- postcode rationing.

See **National Service Framework.**

Performance indicator
A predictor of overall performance. In general practice, the term is used interchangeably with 'medical audit standard'. The Government, health authorities and primary care organisations have developed performance indicators:

- as a measuring aid

- to inform the clinical governance agenda
- to support them in dealing with patient complaints as part of their risk management procedure.

There are performance indicators in place as administrative audits (failure to apply for Postgraduate Educational Allowance, comparisons of item-of-service payments, complaints, patient removal requests) and also clinical indicators (e.g. in prescribing, or standards of medical record summaries). *See* **Audit; Standards**.

Performance management

The underlying principle of this style of management is to support and reward well-performing individuals and effective systems by using priority setting, targets, timescales and outcome measurements.

There is an opposing argument that performance and outcomes are notoriously difficult to measure, as the number of variables makes objective measurement impossible, and the review becomes too subjective. *See* **Performance review**.

Performance-related pay

A method of salary enhancement that is related to an individual's performance in the job. It is now rarely used as it is generally thought to be demotivating and unfair. Any intrinsic (value-based, non-pay) rewards are best demonstrated by enabling individuals to use their creativity and control, allowing them to build their own jobs (job enrichment), and recognising each individual's orientation with regard to work. *See* **Pay-and-reward system**.

Performance review

Continuous performance monitoring undertaken as part of the management cycle to ensure that effective practice is maintained. In audit, it refers to activity concerned with data collection and analysis, and applying the information to introduce change. In management, it refers to the appraisal of an employee's work. In both instances the audit cycle is followed, where performance is measured and compared with a pre-ordained standard, the aim being to bring the performance closer to the standard.[1]

1 Horder J, Mourin K, Pendleton D *et al.* (1986) Terminology of performance review. In: D Pendleton, T Schofield and M Marinkar (eds) *In Pursuit of Quality: approaches to performance review in general practice.* Royal College of General Practitioners, London.

Personal development plan (PDP)

A personal, confidential folder that describes a learning plan set out over a short period of time. For clinicians, it should contain descriptions and demonstrations of the following:

- current practice

- chosen fields of work or specialties, and time approportioned to this
- continuing educational and professional development
- good clinical care, good relationships with patients and colleagues
- audit results
- appraisal
- any complaints or plaudits
- any significant events (including critical incidents)
- criminal convictions or disciplinary hearings
- any breaks in registration
- any conditions set, erasure or suspensions.

PDPs aim to address not just academic but also operational competence. They will eventually replace the Postgraduate Educational Allowance mechanism. It is expected that GPs will make any learning and recording integral to their working day. Practices will be expected to provide a multidisciplinary training and development plan as part of the core practice professional development plan (PPDP).

A PDP should reflect the culture of a GP's working environment as well as the skills and knowledge relating to their post. It should:

- identify noted weaknesses in knowledge, skills and attitudes
- identify what has been learned from mistakes, and how
- note changes in role or responsibilities which create new learning opportunities
- prioritise learning needs and set outcomes
- set goals and describe how these will be achieved over a set period of time
- justify the selection of these goals
- describe the plan to evaluate outcomes.

See **Competence assessment scheme; Learning plan; Practice professional development plan; Revalidation.**

Personality

Personality differences can be a source of great strength and creativity, or of conflict. People and organisations each have their own personality. Personalities differ from each other in terms of the following:

- attitudes
- values

- beliefs
- culture.

People also demonstrate a whole range of abilities and talents (musical, interpersonal and communication skills, self-knowledge skills, spatial ability, sports achievements, artistic and creative abilities), all of which combine to make up what we call personality. Personality is influenced by early developmental experiences (social, family and cultural) as well as by adult experiences. *See* **Belbin RM**; **Group**; **Myers–Briggs Type indicator**.

Personnel management

The short-term, operational level of people management, involving the direction and control of people through policies and procedures (induction, disciplinary procedures, interview, etc.).

It is a simplistic model of people management which seeks to direct and control, and unless human resource management principles are applied, it tends to view people as dispensable assets.

Personnel management is concerned with first-line staff management; a more complex system is employed by human resource managers. Personnel managers are responsible for the following:

- human resource planning and employment
- payroll administration, including related rewards (e.g. holiday and maternity pay)
- organisational design
- management of work patterns
- observing current and future employment legislation and legal requirements
- training and development
- staff relations, services, welfare and safety.

This will involve the organisational development of the following:

- job descriptions
- contracts of employment
- disciplinary procedures
- grievance procedures
- annual appraisals
- training and development policies

- additional services (e.g. pensions, occupational health or counselling schemes for staff).

See **Human resource management.**

PEST analysis (political, economic, sociocultural and technological analysis)

A popular technique for analysing the general environment, which looks at the potential (future) impact of political and other variables on an organisation (e.g. legislation, demographic changes, shifts in values and culture, State investment and technological developments).

Peter principle

In the study of occupational incompetence and hierarchies, this refers to the situation where competent employees tend to be promoted until a position of incompetence is reached. The analysis of hundreds of cases of incompetence led to the formulation of the principle that 'in a hierarchy every employee tends to rise to their level of incompetence.'[1]

1 Peter LJ and Hull R (1970) *The Peter Principle.* Pan Books, London.

Planning cycle

A cycle that involves the following steps:

- identifying the problem
- collecting the data to quantify the problem
- analysing the problem
- organising and co-ordinating a plan of action
- implementing the plan
- reviewing
- monitoring.

Planning involves objectivity, realism, flexibility, logical thinking and wide communication. It needs everyone's involvement through delegation and team work. The process of planning enables the individual or organisation to evaluate and clarify some of the wider issues facing it, and it helps to formulate goals and identify the resources and action necessary to achieve those goals. Planners work methodically using a variety of methods, such as audit, mapping or charts (which map the goals graphically on the vertical axis, and show the timescale on the horizontal axis), to set out the plan of action.

PMR

A commonly used abbreviation for a personal medical record.

Personal Medical Services (PMS)

Introduced via the NHS (Primary Care) Act 1997, Personal Medical Services allow primary care providers such as GPs, nurses and community trusts to test different ways of delivering services. For GPs, PMS contracts replace the standard national GP contract, and doctors are paid according to performance against targets based on meeting local health needs. PMS also allow GPs (who have traditionally been self-employed) to work on a salaried basis as employees of the local NHS authority.

The PMS contract was developed following Government surveys in the late 1990s which showed that the traditional model of independent contractor status, with its financial and managerial responsibilities, together with the 24-hour responsibility for patient care, was a major contributor to stress and a significant barrier to GP recruitment. The PMS contract is designed to be more flexible than the GMS contract. It is being sold as suitable for anyone wishing to:

- target more precisely the needs of a particular group of patients
- expand the range of primary care offered
- develop new arrangements/organisations for the delivery of services
- provide more flexible employment options for GPs
- give other primary care professionals greater career scope and opportunities
- expand practice capacity without extending the partnership
- streamline their contractual arrangements
- develop better human resource management systems
- develop enhanced financial management and accountability frameworks
- improve service access for their patients
- reduce the bureaucracy involved in administering the *Red Book*
- address local recruitment and retention problems
- improve the equity of GMS resource allocation.

The Government envisaged GPs benefiting from flexible working patterns, a steady cash flow, a reduction in bureaucracy, and being able to negotiate their own salary and terms of service.

A PMS contract can be formed from the following:

- a single practice
- a group of practices
- a whole primary care group.

PMS contracts may be either:

- *PMS*: provision of those services which patients could normally be expected to receive from any GP (e.g. General Medical Services)
- *PMS-PLUS*: provision of a wider range of services over and above that normally provided as General Medical Services, such as non-core services or elements of hospital and community health services.

The principles of PMS can be summarised as follows.

- they reward quality, not quantity
- they adopt accepted national clinical standards
- they account for local Health Improvement Programmes
- they accept a clinical governance structure
- they aim to empower local services to change
- they should be developed in partnership with all stakeholders
- they should ensure seamless and integrated care.

PMS contracts set minimum standards around accessibility, staffing, clinical governance and accountability. Practices with a large list size may be reluctant to increase partnership size, but PMS flexibility allows practices to receive growth monies not taken up for extra partners to develop salaried doctor and nurse practitioner posts, thus increasing career opportunities and satisfaction. PMS contracts also allow for the development of outreach work with other agencies. Community nurses can be employed directly, giving a return of flexibility for local innovation.

PMS-PLUS schemes will bring further benefits to patients as services transfer from secondary care, and improve the equity of GMS resource usage (e.g. by improving services to deprived areas).[1] *See* **Primary care**.

www.doh.gov.uk/pricare/pca
www.bma.org.uk
www.nhsalliance.org

1 NHS Executive (2000) *Personal Medical Services Pilots Under the NHS (Primary Care) Act 1997: a comprehensive guide* (3e). NHS Executive, Leeds.

Population

In healthcare, this term is often used to describe an entire group of people, objects or events (e.g. all of the asthmatic patients in a practice, or all of the nurse referrals undertaken in a year).

Postcode lottery

The term used to describe the inequalities in care that can be found in different parts of the UK, due to different resource priorities. As with local Government allocation, the Government allocates resources using different measures of deprivation, weighted capitation, etc. These resources are distributed at a local level according to a mix of local and national priorities, which may differ from one county to the next.

Postgraduate Educational Allowance (PGEA)

An annual allowance that is paid to GPs who undertake to attend a certain number of training events each year, to include a range of both clinical and management topics. PGEA approval is sought and obtained from the local GP regional training office prior to such an event being organised. The PGEA scheme will eventually be replaced by another funding source under the terms of the new contract and revalidation. *See* **Fees and allowances; Revalidation.**

Post Registration Education and Practice (PREP)

A continuing education programme for nurses that is an essential element of maintaining registration on the UKCC central register. It became mandatory under law in 1995. The standards are not dissimilar to those of the current *continuing medical education* and the new revalidation proposals. The core aim is to drive up nursing standards, and the programme includes details of registration renewals, breaks in service, standards for professional development and a *personal professional profile (PPP)*, similar to a personal development plan. There is a UKCC recommendation that all nurses in practice should be supported or mentored by colleagues, and that time should be set aside to allow reflection on practice.[1] *See* **Revalidation.**

1 Richardson A (1998) Personal professional profiles. *Nurs Standard.* **12**: 35–40.

Practice activity analysis

The recording and analysis of common data held in general practices, so that doctors and managers can compare individual or group performance and activity with pooled data from other practices. Such analyses are usually undertaken within or between practices.

Practice allowance

An allowance that forms part of the payments made to non-Personal Medical Services GPs for General Medical Services. The allowances are graded according to the number of patients on the list (basic practice allowance), a designated area allowance, seniority payments, and an initial practice allowance for newly qualified doctors. There is also a GP assistant or associate allowance. Other allowances are given for having locums, agreeing to attend postgraduate educational sessions (Postgraduate Educational Allowance) and providing an out-of hours service. *See* **Fees and allowances.**

Practice manager

A manager who is employed by the GPs within a practice, and whose role is to manage the business and the GPs themselves. As general practice is run as a small business, and the main bulk of the income is from contracted NHS work, this may involve all of the following:

- *financial management*: cashflow forecasting, managing debt, partnership tax, simple book-keeping (practice accounts up to trial balance level), budgetary controls, costs and pricing, long-term planning
- *information and technology*: IT and presentation skills, knowledge of spreadsheets and data analysis packages, using IT for audit and research
- *estates and premises management*
- *product management*: stock control, production control, measuring systems
- *selling and marketing*: customer relations, prospecting, promoting the business.

The practice manager's role has changed considerably over the years, and the NHS now demands very highly developed management skills from its managers. The most frequently encountered problem in general practice is that employing doctors in the past often underestimated the level of management skill required. It is still not unusual to find managers appointed from within the business who were previously receptionists with very good organisational and interpersonal skills, but no experience of business planning or organisational analysis and strategy.

A practice manager needs to have excellent interpersonal skills, a high level of self-awareness, and an ability to research and analyse. Increasingly, practice managers are found to be more actively involved in strategic and clinical management (planning, monitoring and advising the partnership on clinical governance, systems management, alternative clinical management paths and business development).

The key tasks of the practice manager are as follows:

- understanding, supporting and maintaining the practice ethos
- representing the practice to all professional and public bodies
- facilitating consensus between partners, enabling decisions and ensuring that they are acted upon
- supporting the interests of all groups within the practice
- communicating effectively by means of writing, reading and presentation
- being responsible for day-to-day decisions
- meetings – preparing, chairing and achieving results
- consultation – using internal and external resources
- negotiation – formal and internal bargaining

- developing people – selection, planning succession, training and developing staff, appraisal, counselling, promotion and managing conflict
- managing teams – understanding psychology, motivation and organisational culture
- managing change
- people management – dealing with stress, planning and using time, investing in and supporting staff
- taking control – managing the bosses, managing problems, decision making
- co-ordinating, implementing and monitoring within the practice.

Practice professional development plan (PPDP)

A business plan that practices are required to produce which includes the individual practice personal development plans (PDPs), and the business, clinical and development aims and objectives for the next few years. Practice professional development plans enable personal development plans and learning needs to be linked to outcomes.

The document that is produced, the exact content of which is defined by the local primary care organisation, feeds into the local workforce planning document (the Health Improvement Programme). PPDPs are normally produced annually, and may also contain the relevant appraisals and revalidation documents for all staff. *See* **Business plan**; **Personal development plan**.

Premises improvements

GP premises can be improved using a variety of funding schemes, including improvement grants, cost rent schemes, personal finance initiatives (PFIs) using independent developers, or Local Improvement Finance Trusts. *See* **Local Improvement Finance Trusts**.

Prescribing formulary

A formulary that sets out the recommended drug type and dose for commonly presenting clinical problems. It may be devised at either practice or locality level, following discussion with its intended users and local pharmaceutical colleagues and prescribing advisers. The discussion will focus on dosage, cost, volume, efficacy, palatability, adverse reactions and side-effects, as well as patient compliance, concordance and convenience. The following issues will also be considered:

- drug licensing
- controlled drugs and drug dependence
- setting sensible targets to achieve change
- areas where patient education can achieve change

- the evidence base
- secondary care initiatives
- circumstances where variations can be explained by repeat prescribing cycles.

A formulary is devised following discussion of current 'best practice', which may include recommendations about doctor compliance, using better tolerated, cheaper or more effective drug dosages or volumes, as well as successful best management systems (e.g. when to review opportunistically, who to alert if exceptionally high spends are expected). Also included in the discussion would be a system of review to accommodate emerging new drugs.

www.npc.co.uk
For NHS web users, visit www.npc.ppa.nhs.uk

Prescribing incentive schemes

Schemes that are run by primary care organisations in order to assist General Medical Service-contracted GPs who are unhappy about spending time and money on what they consider to be initiatives that benefit neither the patient nor themselves. Prescribing incentive schemes aim to give these GPs the financial (and clinical) incentive to effect change in their prescribing habits, the idea being that any money saved through cost-effective and efficient prescribing outweighs that allocated to achieve the target.

Incentives vary across the country, but may include any of the following:

- targeting high-spending practices by using visiting pharmacy advisers, specialist GPs, local community pharmacists or facilitators who can assist with analysis of prescribing patterns
- managed care solutions, where pharmacists link with practices to change select drug groups
- encouraging GPs to use an IT solution – a system which analyses individual and collective prescribing patterns and encourages a formulary approach
- naming and shaming – the use of practice-identifiable league-tables that give information on local and individual prescribing rates and costs
- production of a local formulary
- making Brown Bag reviews one of the qualifying arms of the scheme
- providing regular education events
- increasing the distribution of patient education leaflets to practices
- finding out which drug companies are willing to sponsor product change.

See **Prescribing indicators and targets.**

www.npc.co.uk
For NHS web users, visit www.npc.ppa.nhs.uk

Prescribing indicators and targets

The NHS supports GP practices that wish to reduce prescribing costs, and to further this aim, primary care organisations have set up prescribing indicators using national recommendations. The indicators usually fall into specific, commonly used drug groups (e.g. antibiotics, hypnotics, antifungals, anti-inflammatories), or generic versus brand use. The targets will take into account specific local issues that affect prescribing costs adversely, as well as the effects of new staff or systems destabilising the use of the formulary. For example, the following factors are considered:

- the instigatation of nurse prescribing
- whether the practice population is stable or transient
- high-cost patient groups
- high levels of hospital-initiated prescribing
- an unusual environment that creates additional or associated clinical costs.

See **Prescribing incentive schemes.**

www.npc.co.uk
For NHS web users, visit www.npc.ppa.nhs.uk

Prescribing protocols

Locally agreed protocols that include information about the clinical or management systems needed to reduce prescribing risk. Within this, educational standards are set for clinicians and staff, and agreements are made concerning who prescribes what, where and why, with the aim of achieving consistency. With the aim of reducing clinical and administrative risk, administrative standards may also be set, defining the following:

- patient access
- systems for preventing fraud
- systems for ensuring secure storage
- standards set for the time period between receipt and production of scripts
- time limits for prescription collection, if scripts are available by email or telephone, or if patients can obtain them without being seen
- the use of educational leaflets and posters on reducing drug use

- agreements for signatures, counter-signatures, additions or corrections
- type and frequency of updating of records.

See **Prescribing formulary**.

www.npc.co.uk
For NHS web users, visit www.npc.ppa.nhs.uk

Prescribing strategy

Local health organisations have such strategies, which include the use of prescribing indicators, formularies, protocols, prescribing targets and patient directives. Prescribing strategies are produced after discussion and agreement with local stakeholders. The main issue for GPs is usually target setting – the main hinge for this is the prescribing incentive scheme.

www.npc.co.uk
For NHS web users, visit www.npc.ppa.nhs.uk

Prescription-only medicines (POMs)

Medication that is available by prescription only. *See* **Over-the-counter medicines**.

Prescription Pricing Authority (PPA)

An organisation that sends out monthly, quarterly or annual reports which analyse doctors' prescribing habits. Doctors can request a particular level of analysis, level one being the first, simple level, and level three being the most complex. By means of such analyses, doctors can monitor their own and their partners' prescribing habits and costs, and see whether their particular prescribing pattern matches that of the locality, or whether it deviates from the national norm. The PPA is particularly concerned with highlighting the use of high-cost or high-use drug groups. PACT data shows the doses prescribed as well as the number, type and cost of drugs. Analysis of their PPA reports by a partnership forms part of the wider prescribing formulary discussion.

www.npc.ppa.nhs.uk

Presentation skills

The mainly one-way communication skills that are required for presenting. Presenters need to have a prior understanding of their audience, what they are expecting from the presentation, and their prior knowledge of the subject. They will ascertain the purpose of the presentation (e.g. whether they are aiming to inform or persuade). A good presentation will:

- have a preface outlining its topic, purpose, duration and shape

- introduce the speaker, seeking common ground with the audience
- give a brief outline of the present situation, why there is a need for change, etc.
- look at the main alternatives that the audience will want to consider
- summarise the facts/arguments
- propose a recommended course of action
- admit the limitations of any proposals, and then make persuasive points about them
- invite questions.

See **Facilitation.**

For more information on presentation, including advice on techniques and how to deal with difficult audiences, see the following:

- Phillips A (2002) *Communication and the Manager's Job.* Radcliffe Medical Press, Oxford.

Primary care

Services provided by family doctors, dentists, nurses, midwives, health visitors, pharmacists, optometrists and ophthalmic medical practitioners, as well as other community staff such as community physiotherapists, speech and language therapists, and occupational therapists. *See* **Primary care trust.**

www.doh.gov.uk/pricare/index.htm

Primary Care Division of the National Health Executive (NHE)

The body that works on all the main elements of the Government's modernisation programme for primary and community care.

www.doh.gov.uk/pricare/index.htm

Primary care group (PCG)

Forerunner of the primary care trust, any of the voluntary GP-led groups that have a range of duties, from advising the local health authority on commissioning care for their local population to commissioning care themselves. All primary care groups are expected to become primary care trusts by April 2004. *See* **Primary care**; **Primary care trust.**

Primary care organisation (PCO)

The generic term for primary care groups and primary care trusts. Some primary care groups will be in place until April 2004, when they will become trusts responsible for all of the operational functions of the health authorities that they replace. *See* **Strategic health authority.**

Primary care trust (PCT)

Evolved from primary care groups, PCTs are free-standing statutory bodies that provide primary and community services to their local population. They co-ordinate and manage the work of family doctors and community nursing and therapy services. PCTs will have responsibility for 75% of the entire commissioning budget for healthcare from April 2003, to enable them to commission secondary (hospital) care on behalf of their local population. *See* **Primary care group**.

www.doh.gov.uk/pricare/pcts

Prime service provider (PSP)

Following the publication in 2002 of the Government's IT strategy outlined in the document *Delivering Twenty-First Century IT: support for the NHS*, prime service providers are the companies that will be selected to provide the new NHS computer systems. *See* **Computing in healthcare**; **Electronic medical record**; **Electronic staff record**.

PRIMIS (Primary Care Information Services)

A scheme that aims to help practices to improve patient care by making more effective use of their clinical support systems. PRIMIS is supported by the NHS National Information Authority, and schemes are currently being set up nationwide, with the aid of local facilitators, as part of the NHS modernisation programme.

PRIMIS aims to assist practices and their primary care organisations in making constructive use of their data for audit, governance, and planning and commissioning purposes. PRIMIS facilitators assist with training, data analysis and interpretation, the idea being that consistent and complete recording of clinical data supports:

- improved patient care
- easier prevention and health promotion
- better follow-up
- more effective multidisciplinary care
- better chronic disease management
- improved practice organisation
- easier data extraction and manipulation.

In order to implement PRIMIS, the facilitator supports and trains practices in the following:

- information management skills
- Read codes

- system functionality
- confidentiality and data protection queries
- the use of MIQUEST data extraction tools.

See **NHS Modernisation Programme; NHS National Information Authority.**

www.primis.nhs.uk
www.primis.nottingham.ac.uk

Priority despatch

A system of telephone triage used by ambulance services to ensure that the most urgent emergency calls, such as heart attacks, receive priority treatment. The system enables the call taker in the ambulance service control room to classify the telephone request into one of three categories – A (life-threatening), B (serious but not life-threatening) or C (minor emergencies).

Traditionally, all 999 calls are answered immediately by sending an ambulance with paramedic crew. If they were used to full capability, these despatch criteria would allow the service to delay sending an ambulance to category C calls, or to refer the caller to another agency, such as NHS Direct. *See* **Paramedic.**

www.doh.gov.uk/emergencycare/index.htm

Private finance initiative (PFI)

A public/private initiative whereby primary care premises are developed using independent (private) developers. It is a method of providing new public buildings and projects, such as schools, hospitals, roads and homes, by using private sector money up front that is later repaid with interest by the State. Under rules for the initiative introduced in 1992, a private sector consortium designs, builds, finances and operates the new building or project for a period of at least 25 years. The consortium will be regularly paid from public money depending on its performance throughout that period. *See* **Premises improvements.**

www.centre.public.org.uk/briefings/

Proactive management

The use of planning ahead (being proactive) as a management device to aid clarity and vision in the following:

- time management
- personal organisation
- organisational development.

In contrast, reactive management is crisis ridden. The reactive person responds to influences or a crisis, but does not plan ahead to manage the risk of such an event occurring.

Procurement

The process of buying in goods or services from an external provider. It covers everything from determining the need for new goods to buying, delivering and storing them.

Prodigy (Prescribing Rationally with Decision Support in General Practice)

A computer-guided decision-making tool for GPs. It is a decision support system designed to run alongside a practice clinical computer system, now under the auspices of the National Institute for Clinical Excellence (NICE), that is intended to provide GPs with peer-reviewed, evidenced-based prescribing guidelines for around 200 commonly occurring conditions. It integrates with the patient electronic record, and can thus check for contraindications and drug interactions. It includes patient–doctor shared-decision screens, patient advice leaflets and reference sources for information on the following:

- non-drug treatments
- epidemiology
- definition of the condition
- complications
- references in the literature.

Information is provided for guidance only, and drug choices are made primarily on the basis of efficacy, safety and their side-effect profile.

www.npc.co.uk
For NHS web users, visit www.npc.ppa.nhs.uk

Professions supplementary to medicine (PSM)

See **Allied health professional; Health Professions.**

Provider

A body that provides health or social care under contract arrangements with a purchasing body.

Person specification

See **Job specification.**

Postcode lottery

The term that is applied when each NHS commissioning organisation defines which treatments are available to whom under which circumstances. In order to address this, the Government has funded National Service Frameworks, the National Institute for Clinical Excellence, the Commission for Health Improvement, NHSnet and the National Electronic Library for Health, with the aim of standardising the type and level of care available to the public. When each individual organisation defines its own treatments, the situation leads to a 'postcode lottery' of prescribing and care.

Between them, the above organisations provide a framework that evaluates the levels and types of clinical care available, and they make recommendations on the best outcome-based treatments that are currently available. Supporting management teams within the commissioning organisation involve clinicians in applying the principles set by the Government, assisting them in defining their own commissioning needs and solutions in relation to those set by the Government. *See* **Commissioning.**

Professional Executive Committee (PEC)

The formal means by which GPs and nurses have a say in their primary care trust.

Professionalism: a code of practice for doctors

Working to a common set of standards of good practice that have been set by a professional body. Doctors are being asked to adopt and respect new professional values which encourage professional development, such as the following:

- working well with others, and embracing teamworking
- adopting a certain level of qualification and service quality
- self-regulation
- aspiring to have a standard of behaviour that is based on a complex body of knowledge
- viewing the doctor–patient relationship as more of a partnership
- accepting public accountability
- being business-like – being highly organised and performing well
- constantly reviewing and reflecting on work
- having a clear set of values and beliefs.

An integral part of being a professional is working to a set of standards – the first of which, for doctors, was the Hippocratic oath. The word 'professes' can be interpreted as a public commitment to a set of values, such as this oath.[1] The nature of this professionalism is changing as doctors are being encouraged to become publicly accountable and less paternalistic. In October 2001, the General Medical Council produced guidelines (*Good Medical Practice*) that highlight the importance of putting patients first. Sir Donald Irvine, when he was president of the General Medical Council spoke of the cultural flaws in the profession that hamper this ambition, citing 'excessive paternalism, lack of respect for patients and their right to make decisions about their care, secrecy and complacency about poor practice'.[2]

An important characteristic of a professional is the sharing of ideas and knowledge and a constant desire to keep abreast of new developments. Doctors are being encouraged to build on the concept of professionalism through continuing professional development, more rigorous self-regulation, continued implementation of recertification or revalidation, and accepting accountability for their work.

1 Solotti R (2001) What is it that makes GPs professionals? *Doctor*. **11 October**: 42.

2 Laurance J (2001) The new professionalism. *Doctor*. **11 October**: 65.

Professionalism: a code of practice for managers

The Institute of Health Service Management (IHSM), which represents the majority of practice managers, has published a code of management practice that defines professional management behaviour. Their aim is to promote professional standard setting and good practice, and to encourage professional development. The recently published code builds on the first one, published in November 1992, which stipulates (in addition to giving a guide to management function) that members should uphold the good standing and reputation of the profession of management by:

- having due regard for and compliance with relevant law
- not misusing or abusing their power or position
- providing information on request in order to investigate any alleged breach of practice.

The IHSM definition of a professional is someone who justifiably claims to provide an expert service that is of value to society, by maintaining high standards of education, training and practical judgement and honouring the special trust placed in them by clients, employers, colleagues and the general public. Professionalism in this context also involves the acceptance and habitual exercise of ethical values such as truthfulness, integrity, conscience, openness, transparency, honesty, loyalty and fairness. Other recommendations are that IHSM members should:

- pursue integrity and competence in all managerial activity
- take active steps with regard to continuing professional development

- take responsibility for safeguarding the security of confidential information
- openly declare any personal interest which might be seen to influence managerial decisions
- agree and uphold proper lawful policies and practices within their organisation
- avoid entering into arrangements which unlawfully or improperly affect competitive practice
- never offer or accept any gift, favour or hospitality intended as, or having the effect of, bribery and corruption.

See **Continuing professional development**; **Management code of conduct**.

www.ihm.org.uk

Project brief

A written summary that takes the reader step by step through the process of a project as follows:

- the proposal
- details of the project
- ways of evaluating the performance.

See **Risk assessment/management**.

Prospective audit

The process of gathering data as an event or process happens, usually over a prescribed and defined period of time and using a predetermined number of cases and purpose-designed data-collection forms (recording sheets) or computerised data entry. This has advantages over retrospective audits in that the completeness of the data can be controlled. The disadvantage of prospective audit is that participants may be tempted to alter the data in order to meet a personal agenda, thereby bringing in a research bias. *See* **Audit**; **Sample**.

Protocol

A formal policy or set of guidelines to be followed for a given procedure; an accepted or established procedure that has been developed from broad principles for local (either individual or group) application. Although it is often synonymous with the words 'procedure' or 'guideline', the term 'protocol' is more often used when the procedure is evidence based. *See* **Guideline**.

Public health

Public health concerns itself with examining and monitoring environmental health. Public health experts recognise that health is broadly affected by social and economic factors (e.g. poverty, unemployment, social exclusion), environmental factors (e.g. air and water quality, housing, food and safety) lifestyle choices (e.g. diet, physical activity, use of alcohol and drugs, sexual behaviour) and access to good-quality services (e.g. education, social care, health, local transport and leisure), as well as by fixed factors (e.g. age, sex, genetic make-up).

Those involved in public health consider that responsibility for the population's health exists at many levels – at the individual, practice and community level as well as nationally and globally.

Environmental health officials maintain links with other public and private sector workers who are key to the process of maintaining public health (e.g. social care, the voluntary sector, housing, transport, education, local shops and businesses).

www.pho.org.uk
www.nelph.net/

Public Health Information Scotland (PHIS)

An initiative that aims to increase understanding of the factors that determine health and ill health, helps to formulate public health policy, and increases the effectiveness of the public health endeavour.

www.show.scot.nhs.uk

Public–private partnership

The situation that occurs when an organisation, such as a council or government department, strikes a deal that allows the private sector to deliver a public service. The term can cover anything from the building of a Private Finance Initiative hospital to a contract for a business to collect domestic rubbish. There is some debate as to whether or not the act is one of privatisation, as public bodies are involved in setting standards for the work. *See* **Local Improvement Finance Trusts; Private Finance Initiative.**

www.society.guardian.co.uk
www.4ps.co.uk

Purchaser

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

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Q

Quality

A measure of the degree of technical excellence, but in the context of medicine and healthcare it may also be defined as value for money (effectiveness, efficiency and economy), fitness for purpose (relevant, acceptable) or customer satisfaction (equitable, accessible).[1] Quality means different things to patients, providers and purchasers. For example, human qualities (e.g. kindness) and pain relief may be more important to some than achieving a perfect clinical outcome.

The provision of a *quality service* requires commitment and example from management, an approach which focuses on the customer, and a participative environment and teamwork. *Quality organisations* are those which pursue continuous improvement, with the organisation existing to meet the needs of the patient, not itself.

Some of the steps taken by the present Government to improve the quality of NHS care have the introduction of the following:

- National Service Frameworks
- the National Institute for Clinical Excellence
- the Commission for Health Improvement
- NHSnet
- the National Electronic Library for Health.

Between them, they provide a framework that evaluates the levels and types of clinical care, and makes recommendations on the best outcome-based treatments that are currently available. *See* **Clinical governance**; **Total quality management**.

1 Maxwell R (1984) Quality assessment in health. *BMJ.* **288**: 1470–2.

Quality-adjusted life-year (QALY)

A measure used by health economists to assess the potential health benefits and cost-effectiveness of a particular healthcare intervention (e.g. an operation, or a course of drugs) by taking into account its effect on a patient in terms of subsequent quality and length of life.

QALYs are used by health planners to prioritise treatment (e.g. in the deliberations of the National Institute for Clinical Excellence in determining which procedures should be made available on the NHS). *See* **National Institute for Clinical Excellence.**

Quality assessment

The measurement and comparison of the technical and interpersonal aspects of care against predetermined standards. In healthcare, the National Primary Care Research and Development Centre in Manchester works to assess quality of care in general practice.

www.npcrdc.man.ac.uk

Quality assurance

In healthcare, this was defined by the World Health Organization as follows: 'To assure quality is to ensure that patients receive such care as is most likely to produce the optimal achievable outcome ... consistent with biological circumstances ... concomitant pathology ... compliance with recommended treatment ... minimal expense ... lowest achievable risk to patient ... and maximal satisfaction with process and results'.[1] Ovretveit has an all-encompassing definition, namely 'all activities undertaken to predict and prevent poor quality'.[2]

Quality assurance goes one step further than quality assessment, as it aims to continually monitor and improve standards of care by systematically checking the levels of quality by means of a performance review or audit cycle process. *See* **Quality assessment; Quality control; Total quality management.**

1 World Health Organization (1989) The principles of quality assurance. *Qual Assurance Healthcare.* **1**: 79–95.

2 Ovretveit J (1992) *Health Service Quality: an introduction to quality methods for health services.* Blackwell Scientific Publications, Oxford.

Quality circle

A small, organised group of people who do similar work and who meet together weekly in order to identify, analyse and solve work-related problems. Quality circles have specific methods, and they only flourish when the culture of the work environment has evolved to encourage participation and the admission of mistakes. *See* **Group; Team; Total quality management.**

Quality control

An alternative term for *quality assurance.* It is the process by which quality performance is measured and improved. *See* **Quality assurance; Total quality management.**

Quality improvement
A term that is used interchangeably with medical audit.

Quality Protects
A Government programme, launched in 1998, that aims to transform children's services by 2004. Local authorities must show that they are meeting 11 key objectives which cover children in need, looked after children and children in need of protection. Each council must produce an annual management action plan outlining their strategy for transforming their services in order to receive a share of the children's service grant (worth £885 million over five years) that supports the initiative. Councils must work in partnership with the NHS and the voluntary sector.

www.doh.gov.uk/qualityprotects/

Quality team development (QTD)
A technique devised by the Royal College of General Practitioners. Linking with the Commission for Health Improvement and Health Improvement Programmes requirements, quality team development supports the new culture in addressing performance. It puts patients first, and looks for clinicians and managers to work together. The scheme asks general practice to examine, for example, the ease of obtaining appointments, the quality of premises, the level of confidentiality within the practice and the use of patient surveys. A quality team will have assessed the need for and developed broad health promotion contracts, such as linking with other community agencies (e.g. youth services for sexual health work) or with the council on green issues (e.g. transport, clean air, recycling policies), or they may identify a special client group to which they are to provide a service, and make special access plans to include them.

For example, quality team development might be used to improve primary care access to learning-disabled patients by:

- reviewing screening requirements and including annual screening for mental/visual/thyroid problems
- updating and improving the protocol for determining consent for treatment
- Listing local support groups and specialist services available.

See **Access**.

Quango
A quasi-autonomous, accountable non-Government organisation, sometimes referred to as a non-departmental public body; an organisation that is set up to address specific current issues that would normally be addressed by the (less independent) Civil Service.

Open to public scrutiny, quangos are part of national Government, but they operate at arm's length from Government departments. There are around 1000 such organisations in the UK, which between them spend more than £24 billion. Examples within the NHS include the Audit Commission and the Health and Safety Executive.

www.cabinet-office.gov.uk/central/1997/consult/quchap1/

Quarry House

The seat of the NHS Executive, which arbitrates on applications for Personal Medical Services, trust status, etc.

www.hse.gov.uk

R

Race Relations Act 1976

Part of a whole raft of anti-discrimination legislation, this prevents employers from discriminating against employees on grounds of race. A recent amendment (in 2002) to the act requires GPs to collect data (on ethnic group, country of birth, language spoken and read, religion and interpretation needs) for the ethnic minorities in their practice. The requested target is for practices to have 'ethnically' coded at least 75% of these patients by March 2005.

The 2002 amendment takes steps to deal with racism in the public sector by forcing all public bodies, such as councils, hospitals and schools, to take steps to promote good race relations. *See* **Discrimination**.

www.hmso.gov.uk/

Random case analysis

The statistical term for an on-the-spot audit – that is, a detailed review of the care of a particular patient, such as a review of the care pathway, chosen at random from a list of cases. This review may be a peer group activity or part of the tutorial technique of a clinical teacher. It is often the starting point for identifying a subject to be audited.[1]

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions*. Royal College of General Practitioners, London.

Rapid response

An intermediate care service model designed to prevent avoidable acute admissions by providing rapid assessment and diagnosis for patients referred from GPs, Accident and Emergency, NHS Direct or social care. It provides rapid access to short-term nursing and therapy support on a 24-hour basis. *See* **Intermediate care**.

Re-accreditation

See **Accreditation of healthcare**.

Reactive management

Responding to an effect, influence or crisis without planning ahead to manage the risk of it occurring. It is the opposite of being proactive and planning ahead. *See* **Proactive management**.

Read codes

A numeric coding system, developed by Dr James Read, that is used to develop common terminology and protocols for the electronic communication of patient records and other clinical information. Read codes are also known as clinical terms. The Government plans eventually to replace Read codes with a simple American coding system.

www.nhsia.nhs.uk/

Red Book

The General Medical Service GP 'Bible', which contains information on the fees and allowances available to GPs to resource their practice. It is to be replaced by a less bureaucratic system of payments under the new GP contract proposals. *See* **GP contract**.

www.doh.gov.uk/pricare/

Reference

A statement, theory, result or procedure that is utilised when conducting research or writing, and is credited to its source. The reader is thus enabled either to ascertain what is the author's own opinion, or to find their way to the work that has already been done in the area of research referenced. References are conventionally written in alphabetical or numerical order, in the sequence of author's name, year of publication, title of article, title of journal, volume number and page range (first and last pages) of the article.

Reference costs

A national schedule that itemises the cost of individual treatments across the NHS in areas of major hospital activity (e.g. hip operations), allowing trusts to increase efficiency by comparing costs with similar providers. *See* **Commissioning**.

www.doh.gov.uk/

Referral

A written or spoken request for help for someone in need of an assessment, usually made by a service provider for a service user, although in some services patients can self-refer.

Region

England has nine official Government administrative regions, namely north-east, north-west, Yorkshire and Humberside, East and West Midlands, east of England, south-west, south-east and London.

www.regions.dtlr.gov.uk

Regional co-ordination unit (RCU)

Established in 2000 as the national headquarters for nine regional offices, the RCU was formed to ensure that a range of Government programmes are delivered coherently at a local and regional level. The RCU brings together the English regional services for the following:

- the Home Office
- the Department for Culture, Media and Sport
- the Department for Environment, Food and Rural Affairs
- the Department for Education and Skills
- the Department of Trade and Industry
- the Department for Transport
- the Department for Work and Pensions
- the Department of Health
- the Office of the Deputy Prime Minister.

Together the RCU and local government offices aim to cut through bureaucracy and add value to delivery, bringing together key stakeholders and local partners, using knowledge gained at local level to influence policy design in Whitehall.

www.rcu.gov.uk

Registrar

A qualified doctor who has undergone junior training and is now working towards specialising as either a consultant or a GP. *See* **Vocational Training Scheme**.

Regulation

The establishment by various regulatory bodies of independent standards of training, conduct and professional competence. The aim is to protect the public, guide workers and employees, and ensure personal accountability for maintaining safe and effective practice. Regulation includes effective measures to deal with individuals whose continuing practice presents an unacceptable risk to the public, or who are otherwise unfit to be registered members of the profession. *See* **Council for the Regulation of Healthcare Professionals; Health Professions Council; Self-regulation.**

Reliability

The statistical term for the extent to which a measurement that is made repeatedly in identical circumstances will yield concordant results.[1] The term relates to the consistency of performance of an instrument or method of measurement.[2] The reliability of an individual measure is increased by basing the measure not on a single observation but on a whole series of observations (e.g. using the mean).[3]

1 Brown L (ed.) (1993) *New Shorter Oxford English Dictionary*. Clarendon Press, Oxford.

2 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions*. Royal College of General Practitioners, London.

3 Robson C (1975) *Experimental Design and Statistics in Psychology*. Penguin, Harmondsworth.

Repeat script

A prescription that is reissued in the same or a similar format by a doctor or nurse. In the average large group practice, up to two-thirds of all GP prescriptions may be repeats, which represents around 80% of total prescribing costs.[1]

1 Phillips A (2002) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.

Replication

See **Reproducibility.**

Reproducibility

The statistical term for the likelihood of obtaining the same results when repeating the same measurement (or action) under different circumstances.[1] This reproducibility depends on the variability of findings over time (which is in turn influenced by variables) and on the robustness and consistency of the measuring method. In experiments, the term *replication* may be used instead of reproducibility.

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions*. Royal College of General Practitioners, London.

Research

A rigorous and systematic investigation with the aim of establishing facts or principles or collecting valid information on a subject.[1] It is similar in approach to audit, but the latter uses established knowledge and facts to improve care, whereas research aims to explore new ideas. Furthermore, although audit also uses some research tools (e.g. data collection, analysis), it is not tied to research methodology. Scientific research methods are about proving facts in a way that can be replicated by other people using the same method. Research requires a hypothesis and a control or a statistically significant sample. *See* **Audit**.

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions*. Royal College of General Practitioners, London.

Residential family centre

A centre in which a family lives for a set period. The children remain under their parents' care while living in the centre.

Residential home

A home that provides personal (but not nursing) care and other services and whose work is monitored by local authority registration and inspection units. *See* **Nursing home**.

www.ncha.gb.com/

Residential rehabilitation

A short-term programme of therapy in a residential setting, usually following an acute hospital stay or referral by a GP, rapid response team or social care services. This model of care is suitable for medically stable patients who require a short period of rehabilitation to enable them to regain sufficient confidence and physical functioning to return home safely. It takes place in a unit such as a nursing home, residential care home, community hospital or rehabilitation centre. *See* **Intermediate care**.

Respite care

Care that is provided by a day centre, day hospital, residential centre, hospice or family. It is usually provided by the State to support the carer and give them a break from full-time caring.

Restraint

A controversial means of control, intended to prevent a person from harming him- or herself or other people, commonly used in mental healthcare. It may be physical

(e.g. laying hands on the patient), mechanical (e.g. strapping the patient into a chair) or medical (e.g. sedating or tranquillising the patient).

Restricted funds

Funds that are subject to specific requirements outlined by the giver (e.g. the Government giving a sum of money to a primary care trust to spend on prescribing a particular drug for a particular group of patients). *See* **Ringfencing**.

Retrospective audits

An audit which reviews records in order to gather facts about past activities. This may involve examining existing records whose data may be incomplete, and only making judgements on what is actually recorded.

Any bias can be overcome by planning to collect data prospectively, using specially designed data-collection forms or enhanced records. *See* **Audit**; **Sample**.

Revalidation

Part of the Government's plan to organise additional rapid and robust mechanisms for dealing with poor and under-performing doctors. In the first phase, they concentrated on secondary care, in the second, they concentrated on primary care. The General Medical Council's GP compulsory revalidation programme means that:

- clinical audit will be compulsory
- all contracted doctors will be required to participate in annual appraisal
- non-principals and locums will need to be named on a local register
- all doctors working in primary care will be subject to clinical governance arrangements
- there is agreement to take part in mandatory schemes for reporting significant healthcare events
- GPs must keep personal portfolios that demonstrate their professional and educational development (personal development plans).

GPs will be assessed in a rolling programme. The assessment will be conducted by a local revalidation group consisting of local informed stakeholders such as a locally elected GP, a medical director, a GP educationalist and a lay person. If the group is concerned about failing performance, they will have the authority to refer the individual with a recommendation that he or she should be revalidated.

This system aims to acknowledge and reward clinical progress and achievement, while identifying and supporting those whose performance has deteriorated. It aims to detect and support those doctors who have failed to keep up to date, who are

discourteous to patients, who work poorly with colleagues, or who make poor or dangerous clinical decisions.

The General Medical Council members have also agreed that these revalidation folders could include the following:

- details of criminal convictions
- disciplinary hearings
- any breaks in registration that occurred during the revalidation period
- any conditions placed on the registration by the General Medical Council; any erasure or suspensions.

See **Clinical governance**; **Performance assessment framework**.

www.gmc-org.uk

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995)

Serious injuries in the workplace must be reported under these regulations, where 'serious' is defined by the regulations as fractures (but not to digits), injuries from falling objects, physical assault, loss of sight, electric shock or any injury lasting for more than 3 days. *See* **Health and safety**; **Medical Devices Agency**.

Ringfencing

The practice by the Government of earmarking parts of the funding that it gives to organisations for national priorities, thus effectively instructing those organisations how to spend some of their money. At present, money is ringfenced for spending in areas such as mental healthcare. *See* **Restricted funds**.

Risk assessment/management

Sometimes called *controls assurance*, a systematic approach to evaluating risk, and to reducing loss of life, financial loss, loss of staff availability, loss of safety or loss of reputation.

When applied to a clinical environment, this means looking for hazards, evaluating the risks, and building in mechanisms to avoid mistakes involving people and property. Thus it involves managing the risk of error arising from clinical or organisational mistakes. The main areas include the following:

- *people and risk*: staff need to be protected from the effects of stress, violence, ill health or damage from poor handling procedures

- *healthcare risks*: risk management during clinical procedures is primarily directed at patient outcome, but risks to clinical staff should also be considered
- *the working environment*: this includes equipment, utilities, lighting, flooring, VDU workstations, food hygiene, space, noise and hazardous substances.

When applying risk management principles to a project, goals and objectives are prioritised with specific indicators, namely *must do, could do, high impact* and *low impact*. One of the most reliable ways of measuring risk is through continual audit.

Risk assessment is good (and required) management practice aimed at improving morale, reducing repair bills and insurance premiums, and saving time. Primary care organisations will support such initiatives and assist practices in improving security, both in their cost rent and improvement grant schemes and in GP support schemes. Arrangements are made for GPs who so wish to take on seeing known violent patients for their colleagues locally. *See* **Clinical governance**; **Health and safety**; **Medical Devices Agency**.

www.croner.co.uk
www.medical-devices.gov.uk/

For further information on clinical governance and risk management, see the following:

- Phillips A (2002) *The Business Planning Toolkit*. Radcliffe Medical Press, Oxford.
- Lilley R (1999) *The PCG Tool Kit* (2e). Radcliffe Medical Press, Oxford.
- Lilley R with Lambden P (2000) *Making Sense of Risk Management*. Radcliffe Medical Press, Oxford.

Robust

Within the NHS, the technical term used to describe a scientific, clear and decisive action or measurement. Targets, goal setting and league-tables form robust measurements; evidence-based medicine is also robust. *See* **Performance management**.

Royal College of General Practitioners (RCGP)

An organisation that represents GPs in England, Scotland and Northern Ireland. The RCGP provides its members with information on current relevant research, learning and education opportunities, events, awards, etc. It has a library and publishes its own journal, the *British Journal of General Practice*, which is also available to members online.

www.rcgp.org.uk

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Salaried GPs

The White Paper entitled *The New NHS: modern, dependable* signalled this Government's desire to offer GPs a salaried option. More GPs, especially younger ones, are taking up a salaried option, a choice which brings women in particular more freedom to pursue a life outside work. The salaried option also suits those who wish to avoid the trials and responsibilities of partnership. Where disputes and conflicts occur, it is less important for salaried GPs to evaluate their position and work together as doctors in partnership have to in order to achieve their common core aims and objectives.

Local Negotiating Committees have been set up in some areas of the country in response to the growing number of GPs contracted for salaried services to primary care trusts. These are viewed as a particularly effective way of representing salaried GPs' interests. *See* **GP contract**.

Sample

The process whereby samples of data are taken and analysed during the audit cycle or research. Relevant material has to be selected so that inferences about that group of people, events or objects can be made. For example, if the organisation undertaking the audit has a specific age/sex/ethnic bias to its population, their sample must represent this. If material is selected with a predisposition towards one particular view, this will clearly distort the results.

The method of choosing a sample for any study is of crucial importance, and its size must be sufficient for the purposes of the study. When sampling, material may be selected randomly, sequentially, systematically or as a 'one-off'. Because it is important for samples to be representative, and in order to reduce bias, samples are often taken at random, which reduces the opportunity to select particular examples from memory. The best random samples are generated using random numbers taken from a computer. The size of the sample is immaterial – what is important is that the audit or research team is convinced of the representativeness and relevance of the data presented to them. Samples are expected to be complete, representative, relevant and valid, with confidentiality maintained.

The different types of sampling include the following:

1 *sequential sample*: where cases are taken in their original order

2 *stratified random sample*: where distinct subgroups are identified and random samples are then drawn from each of them

3 *systematic sample*: where one starts at an arbitrary point in a list and chooses cases at regular intervals after that point

4 *random case analysis*: often used as a teaching tool in medical audit, where the case of a particular patient is chosen at random.[1]

See **Audit**; **Sample**.

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions*. Royal College of General Practitioners, London.

Scottish Council for Voluntary Organisations (SCVO)

A membership organisation for Scotland-based charities and voluntary and campaign groups. It provides charity management services and advice, as well as representation to the Scottish Executive and other interested bodies.

www.scvo.org.uk/membership

Scottish Health Care

The Scottish Executive Health Department runs independently from the Health Department in England. This website provides online health information for NHS Scotland. It runs a health management information service for NHS professionals and advises on the latest clinical strategies.

www.show.scot.nhs.uk

Scottish Health Technology Board (SIGN)

The Scottish version of the National Institute for Clinical Excellence, its role is to develop authoritative and reliable guidance on clinical management in controversial areas of medicine, alongside its more high-profile role of assessing the value of new drugs. *See* **National Institute for Clinical Excellence**.

www.htbs.co.uk/

Seamless care

This operates at many levels. Clinically, seamless care results when teams from both acute and community sectors in health, social care and education come together to support the patient in intermediate care schemes. Seamless care results when multi-disciplinary teams work together in collaborative care planning, or from joint

commissioning, joint project or joint funded work at a strategic level. The ultimate aim is to develop partnerships with patients, their carers and their families, between health and social care, and between the voluntary sector, public and private organisations.

Secondary care

Specialist care, typically provided in a hospital setting or following referral from a primary or community health professional. *See* **Primary care.**

www.doh.gov.uk/

Selection interviewing

The process by which a group of interviewers chooses a candidate for a job. Such interviews should be standardised and have a system for evaluation of results in order to avoid the risk of bias. The purpose of selection interviews is to persuade the candidate to do the talking in a controlled way on topics under your direction, to help them to clarify the various options that are open to them, and to ascertain how they may satisfy the job requirements. Selection interviews should be non-directive, diagnostic and reflective, rather than interrogative. They should be non-threatening, and ideally the questions asked should encourage joint problem solving.

The purpose of a selection procedure is to choose a person with the qualifications, skills, experience and personal attributes that would allow him or her to perform a predetermined role. The selection of new members of staff is a crucial decision, as the consequences of a good or bad appointment will remain within the organisation for the duration of the employment of that member of staff.

Selection procedures need to be seen to be fair, consistent and effective – the selection process is an important public relations vehicle. Procedures must be both effective and legal. This involves the following:

- staff profiling and workforce planning
- complying with legal requirements and recommended codes of practice
- job analysis
- job descriptions.

For more information on interviewing skills, see the following:

- Phillips A (2002) *Communication and the Manager's Job.* Radcliffe Medical Press, Oxford.

Self-assessment

A means by which people can set out their own estimation of their needs for support, usually on a standardised form.

Self-help group

A group of people with similar problems who meet together regularly for mutual support and to campaign for improved services.

www.patient.co.uk/selfhelp/

Self-managed learning

A method of learning through reflection. Personal development plans are designed for self-managed learning, where individuals take personal responsibility for their own learning, and evaluate their own learning needs through reflection and observation. By documenting a problem situation, the learner can reflect on what they have learned, how they problem solved, and how they managed the changes required to avoid a recurrence of the problem.

Learning sets are another way in which self-managed learning can occur. Although it is empowering, some people find self-learning difficult, because they feel that others should be responsible for their development, or else they believe that they have nothing to learn about anything. *See* **Continuing professional development**.

Self-regulation

A number of healthcare professionals, including doctors, dentists, nurses, midwives, health visitors, opticians, pharmacists, osteopaths, chiropractors and allied healthcare professionals, such as occupational therapists, physiotherapists and speech and language therapists, currently operate under self-regulation. The various regulatory bodies establish independent standards of training, conduct and professional competence for the protection of the public, to guide workers and employees, and to ensure personal accountability for maintaining safe and effective practice ('fitness to practise'). They include effective measures to deal with individuals (through either exclusion or training recommendations) whose continuing practice presents an unacceptable risk to the public, or who are otherwise unfit to be registered members of their profession. *See* **Council for the Regulation of Healthcare Professionals; Regulation**.

Sensory impairment

Partial or complete loss of the ability to hear or see.

www.sense.org.uk/

Service and Financial Framework (SAFF)

An annual planning round in which new services are developed. It is to be replaced by a three-year Local Delivery Plan.

Health authorities submit annual service and financial frameworks to the NHS Executive, committing them to meeting ministerial targets within the available resources. These frameworks set out agreed activity levels and funding, and are underpinned by a series of service level agreements between commissioning bodies (including health authorities, primary care groups and primary care trusts) and hospital trusts.

www.doh.gov.uk/

Service level agreement

An agreement between organisations and/or agencies setting out how services must be provided, what their standards will be and how monitoring will take place. They were developed as a commissioning tool, and the Government has introduced new service level agreements as part of their NHS financial reforms[1] which cover payments by result, nationally agreed prices for procedures and episodes of care, and commissioning based on case-mix-specific volumes. New service level agreements will define what resources are available, the mix of services provided and the changes of service delivery and quality of service that the provider is agreeing to make. They will ensure payments by result. *See* **Commissioning; Healthcare resource group tarrif.**

www.doh.gov.uk/nhsfinancialreforms/

1 *Reforming NHS Financial Flows. Introducing payment by results: 2002 consultation document.* www.nhs.uk.

Service user

An individual who uses, requests, applies for or benefits from health or local authority services. They may also be referred to as a client (by social services and the voluntary sector) or as a patient or consumer (within the NHS).

Seven-Point Plan

An interview plan[1] which looks at physical make-up, achievements, general intelligence, special aptitudes, interests, disposition and circumstances. It has now been superseded by the equal opportunities interview process.

1 Rodger A (1970) *The Seven-Point Plan* (3e). Originally devised for the National Institute of Industrial Psychology, and now available from the National Foundation for Educational Research. *See also* Mullins LJ (1999) *Management and Organisational Behaviour*. Pitman Publishing, London, pp. 750–1.

Sex Discrimination Act 1975

Part of a raft of employment laws to prevent sexual harassment of or discrimination in the workplace against women (especially pregnant or married women), equal access and contractual rights for all employees. It was recently amended by the Indirect Discrimination and Burden of Proof Regulations 2001. The burden of proof

now lies with the employer, who must show that they did not legally discriminate against the applicant who makes the claim against their employer.

www.acas.co.uk

Shared medical record

A common database of information that is accessible by all healthcare sectors (community, acute and intermediate care). The shared medical record holds common medical information such as main diagnoses, height, weight, immunisation status, screening results, any allergies, prescriptions and at-risk details (e.g. smoking status or social risk factors). Other medical information includes assessment dates, individual care plans, significant results and discharge letters, as well as core administrative data such as referrals. The information is held by and accessible to all of the patient's main carers, thus promoting seamless care. If properly used, it avoids the patient having to duplicate information by giving it to many people on many different occasions.

Shifting the Balance of Power

The programme of change brought about in order to empower frontline staff and patients in the NHS. It is part of the implementation of *The NHS Plan*, and has already led to the establishment of new structures. Its main objective is to foster a new culture in the NHS at all levels which puts the patient first.

The main feature of change has been giving locally based primary care trusts the role of running the NHS and improving health in their areas. This has meant abolishing the previous health authorities and creating new ones (strategic health authorities) that serve larger areas and have a more strategic role. The Department of Health is also refocusing in order to reflect these changes. This includes the abolition of its regional offices.

www.doh.gov.uk/shiftingthebalance/

Short-term contracts

A short-term contract is a time-limited employment contract document, where the employee is contracted to work for a short period – usually between one month and 3 years, but sometimes more. Workers on short-term contracts have full employment rights under current employment legislation, including rights to sick pay, annual leave, pensions, etc.

Short-term contracts and flexible working patterns are becoming more common and desirable throughout the working world, as people no longer feel such a strong need to conform to work values. The social function of work is becoming less important. *See* **GP contract; Salaried GPs.**

Sickness absence

Time away from work due to ill health. Self-certification gives employees some responsibility with regard to deciding the severity of a short-term illness, but the employer has the right to make certain enquiries concerning the length of the illness. It is permissible in law to dismiss an employee should their attendance be unsatisfactory, even if this is due to illness, provided that disciplinary procedures are followed. The length of absence should be balanced against the employer's needs, and advice should be sought from an occupational physician and a human resource manager.

Significance

A statistical term for the level of probability of an occurrence. If an action has caused a change to be induced in an experiment, and the chance of it happening due to chance or random errors is very low, the change is said to be statistically significant.

Significant event

An episode in the care of a patient in which a specific action by a healthcare worker has a particularly beneficial or detrimental outcome.

In medical audit, significant events are used to focus attention on aspects of healthcare which might benefit from review. Significant event audit is a detailed review of the significant events that occur during the care of either a single patient or a group of patients.[1] *See* **Confidential enquiry; Critical incident technique; Significant event analysis.**

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice: meanings and definitions.* Royal College of General Practitioners, London.

Significant event analysis (SEA)

Analysis of important clinical or administrative events (significant healthcare events) that in retrospect proved risky to the patient, doctor or organisation. These are events from which important lessons could have been learned. Significant events may range from a missed diagnosis, missed visit or unexpected death to the theft of a script pad, a staff upset or a patient complaint. Significant event analyses work on the premise that if it is not acknowledged that mistakes can be made, no learning or personal development can occur. Significant events can be examples of when things go right as well as of when they go wrong, and team discussion and analysis enable learning and change to occur.

Significant event analyses ask the following questions.

- What are the facts?
- What went well?
- What went badly?

- How could I improve?
- What action should be taken?
- How should the event be recorded?

Healthcare organisations are required to report significant events, and a single database for analysing and sharing lessons learned from incidents and near misses is being developed. A *confidential enquiry* is a term often used to describe a significant event audit[1] where data are collected with the aim of identifying the circumstances that lead to adverse or unusual events. This is often used in general practice as a review of individual cases. *See* **Significant event**.

1 Bradley CP (1992) Turning anecdotes into data: the critical incident technique. *Fam Pract.* **9**: 98–103.

Single regeneration budget (SRB)

Now discontinued as a national scheme, the single regeneration budget was created in 1994 to narrow the gap between deprived and wealthy areas by funding local regeneration initiatives. Local partnerships of community, voluntary and business groups received money for schemes that aimed to improve employment prospects, address social exclusion and crime, and support economic growth.

www.regeneration.dtlr.gov.uk/

Skill mix review

Following a staff profiling exercise, this procedure maps out the key skills and the hours required to do the job against the available skills and time of the staff. Skill mix review involves noting the following:

- the names of staff
- the whole-time equivalent (wte) hours worked by them
- their job title, grade and pay per hour
- a brief synopsis of their skills
- any training needs.

The following steps are then undertaken:

- mapping out the required tasks
- noting any discrepancies
- matching those staff members who are best suited and graded for the job required
- identifying who the job would best be done by, and when.

This techniques requires ruthless honesty and objectivity, and a realistic appraisal of the job needs, followed by further discussion with all of the interested parties. If jobs are to be changed, the usual changes involve any of the following:

- making job changes when staff leave and need to be replaced
- reformulating the job to the hours and tasks that best suit the staff
- upgrading roles and pay to a smaller number of more highly skilled staff
- downgrading roles and pay to a larger number of less skilled staff.

Nurse triage is one example of a common change that is implemented following a larger skill mix review after a national workforce planning exercise.

Skill mix reviews work in organisations that are trying to save money or to overcome persistent recruitment and retention difficulties.

Smart-card

Lifetime patient records that are held on a credit-card-sized card, which is retained by the patient, allowing personal medical information to be accessed by NHS institutions electronically.

Social exclusion

The situation where either individuals or a geographical area suffer from poverty caused by a combination of adverse factors such as unemployment, high crime rates, low incomes and poor housing.

The Government's approach to regeneration is based on tackling the problems posed by social exclusion as a whole, rather than simply focusing on its individual elements. The Social Exclusion Unit (SEU) was set up in December 1997 to help to reduce social exclusion. It works with Government departments to research, implement and promote policies that tackle social exclusion and poverty.

www.cabinet-office.gov.uk/seu/index

Social model

A model or philosophy of health that works on the premise that illness has sociological and psychological causes, and can therefore be cured either by structural changes within society or by psychological intervention (e.g. tackling poverty and social exclusion and/or providing help through the talking therapies to those who need it). *See* **Medical model**.

Social regeneration

The process of tackling the social problems that lead to deprivation, such as crime and drugs. The process is different to physical regeneration, which tackles run-down buildings and communal areas, and economic regeneration, which is aimed at creating jobs and wealth.

www.regeneration-uk.com

Social services departments

Established under the Local Authority Social Services Act 1970 in England and Wales, these local authority departments are responsible for the provision of personal social services. They combined the former children's, health and welfare departments. The services that they provide include social work, home care and community care. *See* **Social work**.

www.adss.org.uk

Social work

The provision of personal help to resolve a range of social and economic difficulties. The term was first adopted by social theorists in the early 1900s, and began to be used more widely in the 1970s following the establishment of social services departments and the British Association of Social Workers. Social workers work across the range of age groups, from infants and children to the very elderly. Their work is increasingly linked with health, education and the criminal justice system. *See* **Social services departments**.

www.basw.co.uk/

Span of control

In line management, the number of subordinates who report directly to a manager or supervisor. It does not refer to the total number of subordinate operating staff. For this reason the terms 'span of responsibility' or 'span of supervision' are sometimes deemed more appropriate. At lower levels in the organisation, where responsibility is more concerned with operational performance, the span can be larger. If the span is too wide, it becomes difficult to supervise adequately and there is a slowness to adapt to change. If it is too narrow, there may be a problem of consistency in decision making and co-ordination. Staff morale may suffer if there is too close a level of supervision, and administrative costs may increase. The ideal span depends on the nature of the organisation, the complexity of work and the personal qualities of the manager.

Special health authorities

Health authorities with unique national supra-regional functions which cannot be effectively undertaken by other types of NHS bodies, such as the NHS National Information Authority or the National Institute for Clinical Excellence.

www.doh.gov.uk/

Specialist GPs

The Government plan is to devolve specialist care down to local levels, which is cheaper, improves access for patients and reduces waiting times. It is facilitating the introduction of specialist GPs who are able and willing to take on some of the more complicated work that is usually undertaken in hospitals (e.g. colposcopies, ECGs and vasectomies). GPs with special interests in areas such as diabetes care, elderly and palliative care, dermatology, mental and sexual health, ENT, cardiology, orthopaedics and rheumatology are also expected to be in demand.

The Royal College of General Practitioners has specified that GPs may work for their own practice population, or provide a wider service to surrounding practices within their primary care trust. Draft specialist accreditation frameworks for GP specialists ask that primary care trusts check GPs for the following:

- evidence of training and/or acquisition of competencies
- arrangements for induction, support and continuing professional development
- appropriate facilities and service delivery
- monitoring and clinical audit arrangements.

Primary care trusts must be satisfied that any appointment fulfils local community and clinical governance needs. GPs with special interests are expected to assist in the commissioning and development of services as part of a generalist or specialist team.[1] *See* **Intermediate care.**

www.nhsalliance.org
www.bma.org.uk
www.rcgp.org.uk

1 Solotti R (2001) RCGP drafts framework for specialist GP service. *Doctor*. **27 September**: 26.

Specialist library

Under the umbrella of the National Electronic Library for Health network, specialist libraries are to be set up within three years. Specialist library teams will be established that are broadly based, to include a network of information specialists, patient organisations and professional bodies from the healthcare community. *See* **National Electronic Library for Health.**

www.nhsia.nhs.uk/nelh/

Specialist registrar

A junior doctor who has finished their basic specialist training as a house officer, and who has embarked upon higher specialist training in the area of medicine in which they wish to specialise in the future. Specialist registrars can become consultants after at least six or seven years. GP registrars are junior doctors who are training to become GPs. *See* **House officer**.

www.bma.org.uk/

Springboard Development Programme

Originally developed by two UK consultants, and used extensively throughout the NHS, this programme is designed to develop female employees by providing an opportunity for women to acknowledge and value their skills and qualities, develop their confidence and set themselves goals for the future.

The programme consists of a structured workbook with a series of exercises, case studies and activities centred on ten topics, including goals and objectives, the world about you, knowing yourself, finding support, the assertive you, more energy – less anxiety, managing your image, blowing your own trumpet and making it happen.

The programme is very popular and successful, and has been adopted by public sector organisations throughout the UK.

www.brazentraining.co.nz

Staff charter

A charter that is produced in consultation with staff and which describes some of the fundamental rights frequently sought by employees. Such a charter could be developed as part of an Improving Working Lives standard initiative, as it shows that staff are both informed and consulted about matters which are likely to affect their employment. Thus staff should have the following rights:

- to be treated fairly, with courtesy and understanding, to ensure equity for all and respect for individual differences
- to be fully and properly trained to do the job that they are employed to do
- to be rewarded fairly for the contribution that they make to the organisation, taking into account effort, skill and achievement
- to comment or complain to their employers without fear or prejudice
- to be able to feed their ideas and views back to a management structure that will listen to and act upon them
- to be informed and consulted about matters that are likely to affect their employment.

Staff profile

A prerequisite for completing a skill mix review, this profile documents the following:

- the names of staff

- their whole-time equivalent (wte) hours worked
- their job title, grade and pay per hour
- a brief synopsis of their skills
- any training needs.

Stakeholder

Any person who has an interest in an organisation, its activities and its achievements, including customers, partners, employees, shareholders, owners, Government and regulators. Stakeholders influence the direction and culture of an organisation, and they have an interest in and/or are affected by the goals or activities of the organisation. Stakeholders within the NHS may belong to Government groups (local councils, primary care trusts), pressure groups (the press, patient voices, professional associations), employees (managers, trust staff) or business partners (patients, provider units, allied professionals, drug companies).

Any consultation or analysis of an organisation is usually 'stakeholder focused'. *See* **Stakeholder analysis**.

Stakeholder analysis

An investigation of the concerns and interests of stakeholders, with the aim of finding out whether there are any conflicts of interest, so that the organisation can work to minimise them.

There are ethical concerns that NHS stakeholders are interested in workers' rights, patient safety, whistleblowing, research, doctors' remuneration, discrimination, privacy and security of data. An example is shown below.

GP stakeholders and their concerns

- Employees (who have joint needs with their employers)
- Providers of finance, both public and private (who expect a fair service for bearing the risk of investment)
- Consumers – customers and patients (who want value for money, good care, efficiency, full service access)
- Community and environment (which are concerned with the siting of buildings, pollution, transport, waste, research)
- Government (which both assists and limits through money and directives)

Healthcare strategy is still partly governed by profit (in general practice in particular), and partly by broader public policy issues such as politics, monopoly supply, bureaucracy and finite resources. The power and influence exercised within the NHS

should also be tempered by responsible and ethical management. NHS organisations by default accept and assume responsibility for the public good.[1] *See* **Forcefield analysis**; **Stakeholder**.

1 Mullins LJ (1999) *Management and Organisational Behaviour* (5e). Financial Times/Pitman Publishing, London.

Stakeholder pension

A low-cost, flexible pension aimed at low or middle earners, often in charities and campaign organisations. It was launched in April 2001. All organisations that employ five or more people must offer a pension facility, either internally or externally.

http://www.stakeholder.opra.gov.uk/

Standards

In audit, an accepted or approved example of something against which others are judged or measured. During audit, standards are set using a specific, measurable criterion as a benchmark. In this context, standards must be precise and measurable, and must specify 'an adequate, acceptable or optional level of quality'.[1] Standards do not have to be a measure of excellence or quality, but of acceptability. If the present standard of care provided for patients is satisfactory, this may be acceptable to the audit team, and the standard may not need to be changed. However, standards are usually raised or altered (reset) in order to achieve better results. The best audits define both minimum and optimum standards. Ownership of standards is a vital stage in accepting the validity of an audit.

In medicine, the term 'standard procedures' is often used interchangeably with 'criterion', 'guideline' and 'protocol'. Here it describes a professionally considered range of acceptable variation from the norm. A *minimum standard* would be considered to be a standard of performance below which performance is unacceptable. An *optimum standard* would be the best standard obtainable with the available resources and conditions. During *standard setting*, standards of care are negotiated and developed within partnership of a group of local clinicians, or from the work of a national standard-setting body such as the National Institute for Clinical Excellence, or set by an external body (e.g. practice performance targets for cytology screening or immunisation rates). If developed nationally, the standards are often adjusted to the local situation. Again ownership is vital, as they are more likely to be accepted if they are defined by those who will use them.[2]

Statistically, a *standard deviation* describes a widely used measure of variability,[3] namely how far a subject is placed from the mean or average scores. The larger the standard deviation, the further the subject score is placed from the average. *See* **Audit**; **Criterion**.

1 Donabedian A (1982) Explorations in quality assessment and monitoring. In: *The Criteria and Standards of Quality. Volume 2.* Health Administration Press, Ann Arbor, MI.

2 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice.* Royal College of General Practitioners, London.

3 Robson C (1975) *Experimental Design and Statistics in Psychology.* Penguin, Harmondsworth.

Star ratings

The annual grading system (from zero to three stars) by which NHS acute trusts are measured against a range of performance indicators (e.g. waiting times, ward cleanliness). The system is designed to give an illustration of their clinical and managerial effectiveness. Three-star trusts are allowed more managerial freedom. Zero-star trusts are placed on 'probation' and given between 3 and 12 months to improve or face the threat of being taken over by alternative management.

Statutory authority

An organisation that is required by law to provide public services and which receives central or local government funding (e.g. trusts, health authorities, local authorities). *See* **Statutory services**.

Statutory maternity leave

All pregnant women, regardless of the amount of hours worked or length of service, are entitled to a period of maternity leave of at least 14 weeks. Of this, 6 weeks is paid at 90% of full salary. *See* **Statutory maternity pay**.

www.acas.co.uk

Statutory maternity pay (SMP)

The pay that is given to pregnant women, the amount and period (currently just under £50 per week for 18 weeks) of which is defined by law. During this time the pregnant woman retains all of her contractual rights, and she cannot be dismissed because of any pregnancy-related illnesses.

Statutory services

Services provided by the local authority as a matter of course (e.g. benefits, social services, hospital treatment on the NHS, schools). *See* **Statutory authority**.

www.dss.dov.uk/lifeevent/benefits

Strategic health authority (SHA)

Set up in April 2002, with the abolition of health authorities and the creation of primary care trusts under NHS *Shifting the Balance* proposals, their working boundaries mirror those of the regional health authorities that they replace.

Strategic health authorities are responsible for performance managing primary care trusts and NHS trusts, a job that was previously done by eight regional and around 95 district offices. Now 28 strategic health authorities will report to four Directorates of Health and Social Care and will be expected to provide feedback to ministers.

Their old role of commissioning health services for their local communities has been passed to primary care trusts. From April 2002, strategic health authorities have provided strategic management support for primary care trusts and hospitals in improving NHS performance. *See* **Health authority**.

www.doh.gov.uk/shiftingthebalance/index.htm

Strategy

A three- to ten-year look ahead at an organisation. There are three different levels of strategy that organisations use for planning ahead:

- operational level (meetings, etc.)
- tactical level (a look at next month, a review of the quarterly returns)
- strategic level (a 3- to 10-year plan).

When forward planning, health organisations consider the forces that currently impact on their performance, and they assess the future effect of these (the economic and demographic trends, the sociological forces, and the legal and governmental developments). Strategic planners consider the overall impact on healthcare of an exponential increase in, for example, the elderly population, or poverty, or the development of new drugs that could completely cure cancer. A good strategic planner will have the ability to look ahead and see the whole picture, not just the detail.

Strategic management concentrates on overall strategies and long-term plans – that is, what the organisation goals should be between 3 and 10 years from now.

Stress management

A term used in workplaces to describe the action human resource departments take to manage stress in their workforce. Various strategies are used by employers, from providing a good occupational health service to ensuring a healthy organisational culture. Stress is most common when there is a mismatch between the worker and the work that they do. It is more likely to occur where there is a poor work culture (poor communication, irregular meetings, absence of training and development) and lack of positive feedback to the employee. Stress thrives in situations of conflict, low pay, constant insecurity, repetitive tasks and continuous change.

Structural funds

Money from the European Union aimed at regenerating the most deprived parts of the European Union. These funds can be used for a wide range of projects, including new businesses, infrastructure, training and job creation. Governments have to match the European Union's investment in order to take full advantage of the money.

www.dti.gov.uk/europe/

Structure
In management, the term for the factors that constitute the context of the organisation, such as the buildings, administrative arrangements, etc.

Substance abuse/misuse
The use of a mood-altering substance in such a way that it is either socially unacceptable or impairs social, medical and/or occupational functioning. Substance misuse is the term often used in the same context as substance abuse, which strictly means use of substances in a manner for which they were not intended.

www.drugscope.org.uk

Superannuation
The amount of money that is deducted regularly from the employee's payslip in a contributory pension scheme, or for the pension that is actually paid out to such employees. Not all NHS work is considered to be pensionable, and some independent contractors, such as GPs, argue that all work which contributes to the overall function of the NHS (e.g. education, training, project and committee work), not just clinical work, should be superannuable.

Supported discharge
A service that provides a short-term period of nursing and/or therapeutic support in a patient's home, typically with an individually tailored package of home care. *See* **Intermediate care**.

Supported housing
Accommodation for vulnerable people with care needs, such as sheltered housing for older people, hostels for the homeless, and accommodation for people with learning difficulties and mental health problems.

Sure Start
An initiative that aims to improve children's life opportunities by working with parents and parents-to-be in deprived areas and providing better access to family support, advice on nurturing, health services and early learning. It forms a cornerstone of the Government's drive to eradicate child poverty. There are already more than 150 local Sure Start programmes across England and Wales, with the number set to rise to at least 500 by 2004. Ministers are investing £580 million in the scheme for the three years from April 2001. *See* **Social exclusion**; **Social regeneration**.

www.surestart.gov.uk/home

Survey

Statistically, the systematic collection and analysis of data from a particular population at any one time. Surveys may be either *descriptive* (seeking to describe issues of concern) or *analytical* (where patterns, differences and correlations are sought from the material).[1] *See* **Patient participation**; **Patient survey**.

1 Samuel O, Grant J and Irvine D (eds) (1994) *Quality and Audit in General Practice*. Royal College of General Practitioners, London.

Sustainable development

An approach to world development that aims to allow economic growth without damaging the environment or natural resources. The Government has produced a strategy for ensuring sustainable development in the UK, and this is expected to be adhered to across the whole of the public sector as well as industry. For primary care, ethical sustainable development has to be considered within the domain of health and safety. It includes the following:

- waste production and disposal
- recycling
- use of ecologically sound materials
- water conservation
- green contracting
- use of local resources
- green transport (discouraging car use, encouraging walking, use of public transport and cycling).

See **Business ethics**; **Health and safety**.

www.sustainable-development.gov.uk
www.defra.gov.uk/environment/greening/index.htm
www.nhsestates.gov.uk/
www.sustainable-energy.org.uk

SWOT analysis

A form of business analysis, developed by Ansoff,[1] that focuses on the strengths and weaknesses, opportunities and threats of an organisation. It is commonly used when studying an organisation, as it provides a basis for problem solving and decision making.

Strengths refer to positive or distinctive attributes that provide a significant market advantage. Weaknesses are any negative aspects or deficiencies in the organisation,

its image or reputation which need to be corrected. Opportunities are considered to be favourable conditions which usually arise from changes in the external environment, technological advances, improved economic conditions, etc. Threats are the opposite of opportunities, and refer to unfavourable situations or developments that are likely to endanger the operations or effectiveness of the organisation (competitors, changing social conditions, legislation, etc.).

1 Ansoff HI (1987) *Corporate Strategy*. Penguin, Harmondsworth. *See also* Ansoff HI (ed.) (1969) *Business Strategy*. Penguin, Harmondsworth.

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T

Target payments

Payments made to General Medical Service GPs who manage to reach the targets set for them nationally to meet a given percentage standard of patient recall for childhood immunisations and cervical cytology (smear tests). Two rates are set (higher and lower) for each patient group. Personal Medical Service GPs are able to negotiate more realistic local targets for their practices, taking into account the local population of defaulters or non-attenders (those who will not or do not attend for their treatment). *See* **Fees and allowances**.

Team

A group of people who are working together to achieve common goals. Teamworking is used to help:

- improve communication
- learning
- develop a sense of belonging
- build co-operation
- develop mutual support
- motivate staff
- achieve more.

The management advantages of teamworking are that each person has the opportunity to contribute their unique knowledge. Individuals achieve more when working in teams than they could alone, and management can ensure that everyone agrees on the objectives and nature of the working relationship.

The way in which clinicians, managers and interrelated services are working together with specific and shared responsibilities for healthcare provision is a new approach for the NHS. The Government vision of healthcare delivery is centred on teamwork, with more integrated/seamless care, multidisciplinary teamworking and disappearing boundaries between primary, secondary and social care.

In integrated and effective teamworking, visions are shared and involvement and co-operation are obtained from everyone. Teamworking is not always easy. The team needs to find a balance between the needs of the following:

- the task – do the task objectives fit with organisational objectives?
- the team – what are the group objectives as a whole?
- the individual – who will want to contribute and challenge, and who may need authority to carry out delegated tasks?

Teams have their own growth process, like groups – they explore, experiment, and then mature, co-operate and perform. Teams progress through various stages of development, rarely in a linear or consistent fashion. As teams struggle to cope with rapidly changing internal or external events, or variations in team membership, they will progress or regress through the levels. Progress is most likely when teams consciously acknowledge or address the need to develop or tackle the reforming issues that are raised by change. Teams that do not take this into account will probably regress to earlier stages of development, despite the length of time that they have been working together, and this will inevitably affect their performance.

Teenage pregnancy unit (TPU)

A national co-ordinating body that was set up to address the growing rate of teenage pregnancy in the UK.

Telemedicine

The use of communication systems, such as video links and computers, to provide remote diagnosis and healthcare, allowing more care to be provided in the community or at home.

www.tis.bl.uk/
www.nelh.nhs.uk/

Temporary resident

A patient who is not registered with a GP practice who signs on for a temporary course of treatment (e.g. while on holiday in the area). Different fees are paid to the GP taking them on for treatment depending on the length of stay and the type of consultation. *See* **Fees and allowances**.

Termination interview (exit interview)

An interview for an individual who is leaving an organisation. The objective of this is for the manager to:

- discover the real reason for the person wanting to resign
- use what they have learned to prevent others from leaving.

T-group

A method of communication/sensitivity training,[1] which became popular in the 1960s, which provides participants with the opportunity to learn more about themselves and their impact on others, and in particular how to improve their interpersonal communication skills.

Training aims to concentrate on the process (feeling) level of communication rather than on content (informational value). Groups are usually leaderless and structureless, although trainers may guide the group, and the dynamic that is created causes individuals to act in characteristic ways. It is these responses that are examined. Feedback received by individuals from other group members forms the main mechanism for learning.

Taking part in T-groups can be a very tense and anxious experience, but it has been shown to lead to an increase in interpersonal skills, to induce change and to encourage more open and flexible behaviour, although whether this behaviour transfers outside the group is not always clear, unless additional therapy work occurs.

1 Cooper CL and Mangham IL (eds) (1971) *T-Groups: a survey of research.* John Wiley & Sons, Chichester.

Thinktank

A colloquial term which has now fallen into official use to denote a research organisation that does pieces of work on specific issues in order to promote specific aims and interests. Thinktanks inform Government and other organisational policy.

www.policylibrary.com/

Third sector

The generic collective name for charity, voluntary, non-government and campaigning organisations.

Time management

The management of limited time in the most effective and efficient way, by the following means:

- having clear objectives

- careful forward planning
- effective organisation
- defining priorities and action
- ability to delegate successfully.

Effective time managers record, conserve and cost the time, as well as managing it.[1]

1 Mullins LJ (1999) *Management and Organisational Behaviour* (5e). Financial Times/Pitman Publishing, London.

Total quality management (TQM)

A particular approach to improved organisational performance and effectiveness. The concept was inspired by Japanese management, and definitions are generally expressed in terms of the following:

- a way of life for the organisation as a whole
- a commitment to total customer satisfaction through a continuous process of improvement
- the contribution and involvement of people.[1]

The principles of total quality management can be summarised as follows:

- management through shared vision
- designing systems to liberate people
- seeking appropriate involvement and co-operation from employees
- making services customer led
- emphasis on quality
- focusing on long-term results
- becoming biased to action.[2]

In TQM, systems are made to fit people. Quick responses are aimed for, and the highest quality equates to the lowest cost. Management empowers rather than controls as people are seen to be key to quality. Human resource management and quality management converge to give total quality. TQM organisations never consider people to be dispensable, but rather they regard them as an asset.

Total quality management applied to healthcare

TQM can provide a strategic focus in the search for a culture of total quality service, which is of particular significance in the public sector. The concept of TQM in healthcare

was broadened by Maxwell and McCormick,[3,4] whose premise was that TQM aimed to improve patient care by achieving high standards, reflective practice and risk management, to ensure that healthcare was:

- accessible (no physical, cultural or linguistic barriers, timely)
- appropriate (conforming to legislation, research based, meeting the needs of the population)
- effective (promoting health and recovery, research based, following good practice guidelines)
- efficient (making best use of resources, skills, money, people, buildings and equipment)
- equitable (respectful to all, providing service on the basis of need, not personal characteristics)
- relevant (responsive to the population served, adequate, balanced)
- acceptable (meeting the cultural and religious expectations of users)
- knowledge based (sound and accurate information supporting decision making)
- accountable (principally and financially, outcome based)
- integrative (involving other agencies).

Total quality management does not supplant traditional approaches, but it provides the tools with which traditional medical knowledge can be made to work better. It is concerned with achieving value for money and using resources effectively, and it aims to give workers more opportunity to contribute to the development of services. It harnesses conflict and focuses on improving processes, and it seeks to reduce interprofessional wrangling.

TQM improves not just numbers but also services. It is involved with improvement, not punishment. For example, if patients require more expensive care because they are older and more fragile, this is considered to be a defensible position for clinicians to take.

TQM changes the culture of an organisation in order to achieve tangible benefits for everyone, and it therefore fails if the leaders are uncommitted or suppress their desire for improvement. It aims not just to satisfy the needs of the patient, but to delight them. *See* **Improving Working Lives standard**; **Quality assurance**.

www.smartman.co.uk
www.qmuk.co.uk

1 Mullins LJ (1999) *Management and Organisational Behaviour* (5e). Financial Times/Pitman Publishing, London.

2 Carlisle J and Parker R (1990) *Beyond Negotiation: redeeming customer–supplier relationships*. John Wiley & Sons, Chichester.

3 Maxwell R (1984) Quality Assessment in health. *BMJ.* **288**: 1470–2.

4 McCormick JS (1981) Effectivenesss and efficiency. *J R Coll Gen Pract.* **31**: 299–302.

Training and Enterprise Council (TEC)

A body that is intended to develop close partnerships between local employers and educational establishments in providing vocational education and training to meet local economic needs.

www.tec.co.uk

Training policy

A policy that demonstrates the organisational attitude to training. Modern policies would ensure that everyone in the organisation was included, and budgets for continuing education would be built into the overall budget. A training policy demonstrates one route to managing the risk of staff failing to perform, adequately as staff training prompts higher standards of care, effectiveness and efficiency, reduces organisational and clinical error, increases staff motivation and reduces costs.

Once written, a training policy would be circulated widely throughout the organisation, and it would address the following:

- ongoing training as a contractual obligation
- widening training options to include wider, non-operational issues (discriminatory practice, quality issues, assertiveness training, time management, teambuilding, etc.)
- the need for an ongoing funding obligation
- the need for requests for training to be taken seriously.

Transactional analysis (TA)

One of the more popular ways of explaining the dynamics of interpersonal communication. Originally developed by Eric Berne,[1] it is now a theory which encompasses personality, perception and communication. Although Berne used it as a psychotherapy method, it has been convincingly used as a training and development tool by organisations.

Transactional analysis has three basic underlying assumptions.

- Personality consists of three ego states which are revealed in distinct ways of behaving – as child, adult and parent. We have preferred ego states.
- All of the events and feelings that we have ever experienced are stored within us and can be replayed.

- A dialogue can be analysed not only in terms of ego state but also in terms of whether the 'transaction' produces a 'complimentary' or 'crossed' reaction.

In the majority of cases at work, transactions are from adult to adult, which encourages rational, logical responses. However, if the child or parent ego states dominate, we can have over-emotional (childlike), critical (critical parent) or over-nurturing (nurturing parent) behaviour re-stimulating unwanted behaviour and leading to resentment. Transactional analysis can be regarded as a useful tool in aiding our understanding of social or difficult work situations and the games that people play both within and outside work organisations.

1 Berne E (1966) *Games People Play*. Penguin, Harmondsworth.

Triage

A process that is used in emergency departments for assessing the relative needs of patients when deciding which of them should be given priority for treatment. It is increasingly being used in GP surgeries to improve access.

www.doh.gov.uk/epcu/

Tuckman BW

Tuckman[1] is best known for his theory that groups pass through different stages in their development, classically demonstrating *forming, storming, norming, performing* and *deforming* behaviour. *See* **Group**.

Task	*Activity*	*Features*
Forming dependence	Define the nature and boundaries of task	• Group members concerned with why they are there • Interpersonal relationships and boundaries are tested • Dependency on leader develops • Uncertainty and anxiety are felt • Commitment to group is low • Grumbling about task • Behaviour meandering and ineffective • Suspicion of task and each other • Testing and confronting behaviour • Hesitating or avoiding task
Storming	Questioning the value of exercise	• Conflict occurs • Members resist task and group influences • Arguments about what the purpose of the group is

(*continued overleaf*)

Task	*Activity*	*Features*
		• Members may undermine each other and the leader • Authority is questioned • People jockey for position within the group • Challenging behaviour • Experimenting with hostility, aggression, frustration, rivalry, resentment, opposition • Defensive behaviour
Norming	Opening up and inviting	• New roles adopted by group members • Resistance to group overcome • Expression of intimate, personal opinions around the goal are expressed • Feelings of belonging to the group and identification with the group as a unit emerge • Commitment goes up • Defining tasks • Evaluating • Mutually supportive • Showing unity and consensus • Liking each other
Performing/ interdependence	Effectively pursuing the task	• Group energy directed towards completion of task • Creative problem solving • Roles become flexible and functional • Frequent and mutual contributions • Interpersonal issues now disregarded, or sorted, or used as a tool to achieve group goals • Feel safe and confident • Achieving
Ending/mourning	Facing the loss of the group experience	• Denial of ending • Termination phase • Group dissolves because task is completed • Group resists disintegration through social contact • Fantasising about the 'good old days' may begin, idealising the past history of the group – this may occur when interpersonal issues prevent the group from accomplishing its task • Bargaining, anger or depression may occur • Group may perform rituals

1 Tuckman BW (1965) Developmental sequences in small groups. *Psychol Bull.* **63**: 384–99.

Two-tier workforce

The situation that is created when a private company takes over the running of a public service (e.g. as has happened in the case of laundry workers and cleaners in hospitals). Workers who were previously employed in the public sector have their terms and conditions protected by law, but usually those newly joining currently have no such defence.

www.unison.org.uk/

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U

Unison

One of the largest public sector unions, that represents many millions of healthcare workers, from administrative, clerical, ambulance, nursing and midwifery, pathology and senior management workers through to scientific, technical, dental and allied health professional staff. Some sectors, such as doctors, speech and language therapists and psychologists, have their own representation elsewhere.

www.unison.org.uk/

User involvement

Involving patients in service developments or their own treatment. The NHS requires that healthcare organisations seek to identify and meet the health needs of the population that they serve. Not all doctors are committed to this. User involvement saves the NHS money in the long term, as it helps patients to take responsibility for their own health through patient education. People who take an active interest in developing healthcare develop a broader understanding of health and disease, and they begin to understand that health is affected by the following factors:

- social and economic factors – poverty, unemployment, social exclusion
- environmental factors – air and water quality, housing, food and safety
- lifestyle choices – diet, physical activity, use of alcohol and drugs, sexual behaviour
- access to good-quality services – education, social care, health, local transport, leisure facilities
- fixed factors – age, sex, genes.

Through being involved in discussions about healthcare provision, the hope is that service users will begin to develop responsibility for their health, and will become less dependent on healthcare providers to meet their needs. Their involvement is particularly useful and welcome when making difficult or unpalatable rationing decisions.

Most healthcare providers need to develop further ways of working in partnership with patients. They could achieve this by the following means:

- patient participation groups
- informal feedback systems (e.g. suggestions boxes)
- health panels
- open meetings
- discussion/focus groups
- rapid appraisal (gathering information from key local informants)
- disease support groups
- interviews
- opinion polls
- neighbourhood forums
- practice-based annual surveys
- appraisal systems (e.g. customer panels)
- postal questionnaires.

See **Patient participation**.

For some more ideas and a broader understanding of patient participation, see the following:

- Lilley R (1999) *The PCG Toolkit* (2e). Radcliffe Medical Press, Oxford.

V

Validity

The extent to which research, experiments or audit measure what they purport to measure.

Variable

In an experiment, the experimenter investigates the relationship between two things or *quantities* by deliberately producing a change in one of them and observing the change in the other. These quantities in which changes take place are known as variables.

The variable which the experimenter deliberately manipulates is called the *independent variable*. The variable in which we are looking for consequent changes is called the *dependent variable*. It is important that the experimenter is aware of and controls as many of the variables as possible during the course of their observation.

The difficulty with much clinical research is that there are inevitably too many variables involved when studying change over time in human subjects. The experimenter may change one variable (e.g. the amount of medicine administered), and make inferences about the relationship between cause and effect. Although attempts are made to match subjects by for example, age and sex, each subject differs physiologically, psychologically and with regard to social class, what they have just eaten or what they ate yesterday, their unique genetic make-up, previous illness or predisposition to illness, etc. It is virtually impossible to control all of these variables, or to control any interaction that may occur between the variables.

Thus the type and extent of the variables are considered in experimental design, and the statistical significance is calculated once any change occurs. *See* **Experiment**.

VDU assessment

A health and safety assessment that employers are obliged to undertake using the 1992 Management of Health and Safety at Work regulations. This includes assessing computer equipment used by employees, to ensure that its use does not cause illness or injury such as repetitive strain injury (RSI) or eye strain.

The 'EC Six-Pack' gives a set of assessments which include investigating the health and safety of display screen equipment. This advises staff on ways to avoid health problems associated with VDUs (e.g. eyestrain, neck and back pain, hand,

wrist and elbow pain, tension headaches, dizziness, nausea, tension and irritability). It also recommends that managers advise or pay staff who spend a significant amount of time working 'on screen' to:

- have regular eye examinations
- arrange their work area so as to provide good lighting and minimise glare
- arrange and adjust their office furniture so as to minimise strain on their eyes, neck and back
- take frequent breaks from using the equipment.

See **Health and safety**.

www.hawnhs.hda-online.org.uk/

Violence at work

The most common forms of violence at work are against people and property. They include attacks and assaults, thefts of equipment or personal possessions, and vandalism.

Various methods have been recommended for reducing violence at work and for improving security, beginning with a risk assessment. This involves identifying the risks, and then creating a plan outlining what to do in order to minimise further such events and ensure the health and safety of everyone and everything in the organisation.

Primary care organisations and local crime prevention officers provide advice on ways to improve external and internal security by introducing sophisticated locking and alarm systems and ensuring that staff have adequate business and security awareness and are trained in customer awareness. Primary care organisations will also give financial support to GP practices that wish to improve their security, and they support retainer schemes for GPs who are willing to take on seeing violent patients for their colleagues locally. *See* **Zero tolerance**.

Vocational Training Scheme (VTS)

The training that GP registrars have to undertake before they enter general practice. *See* **Registrar**.

Voluntary Training Scheme

The training that doctors undertake during their registration period in preparation for becoming a GP. *See* **Registrar**.

Volunteer

A person who gives a portion of their time, or a period of time in a year, without payment to an organisation as a worker or helper. National Government organisations and charities sometimes reimburse volunteers' travel and related expenses.

www.volunteering.org.uk/

Vulnerable children

Disadvantaged children who would benefit from extra help from public agencies to allow them to make the most of their opportunities in life.

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W

Waiting-list
The number of patients who are waiting for treatment on the NHS. *See* **Waiting-time**.

www.doh.gov.uk/waitingtimes/booklist

Waiting-time
The length of time for which patients wait for treatment on the NHS. It normally refers to the period between a GP referral and an outpatient attendance, or the time that elapses between being put on the waiting-list and the date of admission to hospital. *See* **Waiting-list**.

www.doh.gov.uk/nhsplan/

Walk-in centres
Nurse-led drop-in centres managed by the NHS that provide minor treatments, self-help advice and information on the NHS, social services and other local healthcare organisations. Set up in response to the 1999 NHS Plan, they were designed to improve patient access and reduce the GP workload. Staffed by nurses and GPs, they deal mainly with minor illnesses and are particularly popular with commuters and shoppers, as they are often based within easy access of public transport terminals and shops. Continuity of care will remain a problem until patient records are all electronically held. Preliminary research shows that the majority (68%) of patients who use walk-in centres are non-registered patients living in a different area, possibly those who cannot access their own GP easily due to work or other commitments. The vast majority (98%) of patients need either advice or treatment that can be prescribed by a nurse.

www.doh.gov.uk/nhswalkincentres/

Weighted capitation
The resource allocation formula that distributes NHS funds and aims to target resources at the most needy areas. Using basic indicators of need, the formula sets a target

allocation for each region. Ministers decide annually how quickly authorities should be moved towards this target.

www.doh.gov.uk/

Whistleblowing

The disclosure by an employee or professional of genuine concerns about crimes, illegality, negligence, miscarriages of justice, or danger to health and safety or the environment, and the cover-up of any of these, whether committed by the employer or by a fellow employee.

If anyone has serious concerns about clinical malpractice, health and safety breaches or misuse of public funds, the procedure for raising these concerns is termed whistleblowing. The Public Interest Disclosure Act 1998 aims to promote accountability and openness within organisations. Whistleblowers have legal protection under this act. It provides a framework that enables anyone who has suspicions that serious malpractice is occurring to report their concerns in a considered and responsible way. As it is particularly difficult for anyone within a small organisation to raise such concerns, any policy that is written should reflect the dynamics of the employer–employee relationship, so that anyone should feel able to address legitimate concerns without fear of censure or of appearing disloyal. All employees, including agency staff, staff under contract for services and general practitioners, should be covered by such a policy. The latter will cover when to use a whistleblowing procedure, which procedure to use for which issue, what to do, how to protect staff from victimisation and how the organisation will deal with any concerns that are raised.

For further information, contact any of the following:

- Health and Safety Executive. Tel: 020 7717 6000.
- National Audit Office. Tel: 020 7798 7000.
- Serious Fraud Office. Tel: 020 7239 7272.
- NHS fraud reporting number: 08702 400100.

See **Fraud**.

www.hmso.gov.uk/

White Paper

A statement of policy issued by the Government. White Papers are usually preceded by a consultative Green Paper, and often form the foundation of new legislation.

www.explore.parliament.uk/search/

Workforce Development Confederations

Local bodies that work under the national umbrella organisation, the National Workforce Development Board, which have taken on the role of monitoring and planning the local primary healthcare workforce. They develop workforce plans at local level by looking at local skill mix in detail, and they promote and assist individuals who wish to start or return (after a gap) to work within the NHS. *See* **National Workforce Development Board**.

www.wdconfeds.org/
www.nhs.careers.nhs.uk/

Workforce planning

The NHS Plan (Human Resource Strategy 'Working Together') makes it a requirement for employing health organisations to consider how they are going to meet changing clinical demands. Workforce planning requires the organisation to think through the key issues that need to be considered in planning ahead to meet the needs of a given population. This involves analysing existing staff resources by keeping a staff inventory, considering the impact of losses and changes/developments among the staff, forecasting the future needs of and demands on the practice, and reconciling the supply of and demand for staff.

The workforce issues that require broader consideration include local economic and labour market analyses and looking at current trends across the local health economy (e.g. the creation of primary care trusts). The focus on staff addresses any recruitment difficulties, skills shortages, high turnover rates and staff retention problems, as well as professional aspirations and jealousies and any new professional regulations.

Workforce planning:

- is linked to the local Health Improvement Programme
- is directly related to service developments
- supports plans to develop local services
- covers all staff groups
- is focused on changes in service levels and delivery patterns.

The main benefits for forward planning in this way lie in being able to apply tighter, more credible criteria to funding applications, and to be better prepared if staff shortages arise. Planners would consider the following:

- the treatments that occur in the sector under scrutiny
- the skills required
- the evidence base

- the predicted delivery models
- any foreseen impacts of new technology/treatments
- the way in which these new models affect staffing numbers/roles/working arrangements
- the staff groups involved in the patient pathways
- which of these staff groups may now, or in the future, be employed
- whether anyone else could provide the same service
- if so, the training and supervision that they would require.

A workforce plan would review the current staff and service provision and then present a chart specifying current workforce numbers and costs, grades, skills, training needs and age profiles. *See* **Skill mix review**; **Staff profile**; **Workforce Development Confederations**.

Working rights

Formal recognition and respect for people's needs and expectations at work by an organisation. These rights may be written as a code of good practice, and would include the following:

- full observance of all legal matters relating to employment
- just treatment
- fair reward for work done
- job security
- opportunities for training and development
- opportunities for career development
- a pleasant and safe working environment.

See **Staff charter**.

World Health Organization

An international non-governmental organisation, created in June 1946, which aims to promote health and healthcare worldwide. It co-ordinates international health initiatives and work on the prevention and control of disease, advises governments on strengthening health services, and also promotes the following:

- biomedical and health services research

- improved hygiene, housing, nutrition, sanitation and working conditions.

www.who.int/

Write-up

Applying the methodology used when writing up experiments to the presentation of reports. The following sections are included:

- *title*
- *introduction* – a general statement of the problem or subject under discussion, continuing with a review of any other work in the area and any associated explanations or theories. It concludes with the hypothesis (what may be anticipated as an outcome)
- *method* – in this section the reader is told exactly what was done, what information was collected and who was involved (e.g. the experimental design, subjects, apparatus or material and procedure)
- *results* – the presentation and description of results, displayed simply and clearly, preferably using titled and cross-referenced tables and graphs
- *discussion* – the results of any analysis, a description of their bearing on the original hypotheses, the relevance of the results in theoretical and practical terms, and suggestions for further work that is needed. A description of the limitations of the usefulness of the results should be included
- *references.*

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Z

Zero tolerance

A Government-sponsored campaign that promotes the message to NHS employees and their patients that violence towards NHS staff will not be tolerated. The Zero Tolerance campaign was set up to address the growing problem of patient violence in Accident and Emergency and primary care services, especially GP surgeries.

Every primary care trust is working towards having in place systems and structures to ensure that all of their contracted employees, GPs and their staff are protected from violent patients. *See* **Violence at work**.