

**PBR, PBC, PCT, CCG, CMHT, CBT, NICE, QUOF:
NHS Alphabeti spaghetti?
A guide for the perplexed: a critical glossary**

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What do the plethora of NHS institutional terms mean? Why are they important to understand? And what is their relationship to one another? Here is a critical glossary.

Our healthcare problems burgeon: these are met by new packages or systems of administration and care. As these multiply, so do the terms and abbreviations. To the outsider, all this can seem as incomprehensible as Morse Code.

Yet the growing dilemmas of the NHS are now reflected, in some form, globally. Understanding our technical responses and then their consequences, has, therefore, interest and relevance far beyond national or professional boundaries.

To aid the interested but confused reader, this Glossary is offered. It combines explanatory definitions with brief critiques of the most common institutional terms.

Some key terms are italicised. Cross-referencing some of these italicised terms should help further comprehension and coherence: space prevents this process being complete.

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Algorithm. A templated and flow-charted system of defined and logical steps prescribed to analyse and manage identified problems. Can be readily diagrammed and computerised. Has rapid appeal due to its standardised reproducibility, apparent clarity, precision and logic. Disadvantages: deals poorly with real-life's ambiguity, variation, meaning and complexity. Can displace individually responsive and intelligent judgement and imagination.

Appraisals for healthcare staff. A formal procedure whose purpose is to monitor and assure quality and safety of professional performance and development. Much effort has been made to standardise and, when possible, quantify such complex evaluations. Guidance has been sought from the newer professions of business management and consultancy. The aspiration is far less controvertible than the results: for the formalistic segues easily to the formulaic. Subsequent attempts to make procedure 'fair and comprehensive' commonly become

burdensome, blind and bureaucratic. Generally professionals have described their experiences of appraisals as elaborate rituals of proffered compliance and verbalised obedience. Far fewer report the kind of intelligent searching dialogue that will helpfully identify or clarify important problems.

Balint. Michael Balint (1896-1970) was a psychoanalyst who, in the 1950s and 1960s, explored the 'subtext' of medical consultations. He started with a small group of London GPs, but his influence expanded to galvanise a generation of doctors to think about inexplicit meaning, encoded actions and attachments, and the possibility of both treatment and illness as kinds of preverbal or paraverbal language. Many GPs experienced their work as enriched and enlightened by such informal and qualitative research. This brief, rich flowering was largely extinguished by the rapid rise of systems that demanded quantification, standardised codes, and mass-reproducibility. *Evidence Based Medicine* has great difficulty accommodating Balint's subtle invitations to explore meaning.

Care Quality Commission (CQC). A governmental network of healthcare inspectors. This is similar in mission to the *Appraisal* of professional individuals, but applied to the healthcare organisation that employs them. As with Appraisals, the task is certainly necessary and important but its sensible and accurate execution very difficult. Again, presentations of formulaic compliance can easily mask deeper lack of integrity. The shocking debacle at *Mid Staffs* exemplifies what can be missed by 'competent' yet routinised methods of inspection.

Clinical Commissioning Group (CCG). A recently mandated executive network for deciding, defining, procuring and purchasing the healthcare needs of an allocated geographical population. The boards are now dominated by local GPs but contain other healthcare professionals and lay members. The CCG has replaced the *Primary Care Trust (PCT)*, which was administered, ultimately, by non-clinical managers. Due to the dominance of GP Practices in the CCGs the activity is now largely implemented as *Practice Based Commissioning (PBC)*.

The aspiration – for democratic healthcare decisions that are locally responsive and responsible, and professionally decided – seems laudable. The unravelling reality is less so: multitasking, overmanaged and weary GPs already have much diminished time for their traditional role as personal physicians and cannot give adequate, good attention to this new and very complex task. The result is an expedient short-circuiting to a hastily assembled (and thus often not competent) network of oligarchies that are themselves likely to be in thrall to a very flawed *Internal Market*.

Cognitive Behaviour Therapy (CBT). An attempt to schematise and standardise therapeutic psychological contact for the mentally or behaviourally troubled. It is largely based on depersonalised diagnostic categories, focused on the symptomatic and explicit, and guided by *algorithms* and *Care Pathways*. It is readily (if speciously) computer-coded and measurable: CBT thus has appeal to planners, economists, managers and the kinds of practitioners who share their mindset. The limitations are similar to all algorithms and Care Pathways: the model has difficulty with complexity, variation, meaning and imagination – and thus can easily impoverish practitioners' personal resources to deal with these.

Commissioning. A currently common term for design, negotiation and procurement of services within the marketised NHS. Like other devices to industrialise and monetarise healthcare it is least problematic when applied to healthcare problems that are generally resolved rapidly and reliably by standardised technical procedure (eg hip replacements). *Pastoral Healthcare* (eg psychiatry) starkly exposes its limitations.

Commodification. The attempt to treat and process all healthcare activities as if they are manufactured objects or geophysical resources. This can work relatively well in tasks that have clear and stable boundaries. *Pastoral Healthcare*, by contrast, needs vocational and holistic attitudes that cannot be processed in this way. Nevertheless, commodification makes welcome sense to planners and managers in conducting many aspects of the *Internal Market*. Experiences from frontline health workers are far less tidy: for many years

there have been mounting, frustrated expressions of clinical and personal meaninglessness and the stymying of good personal care.

Community Mental Health Team (CMHT). Thirty years ago CMHTs were vaunted as a progressive face of the future, consummated by the closure of the old *Mental Hospitals*. Instead mentally distressed patients would be speedily streamed to community-based specialisms. The specialists themselves professionally progress via certified trainings rather than personal qualities or vocation. Recent healthcare management thinking – much derived from 1980s Japanese car manufacturing – promised more efficient, accessible and responsive help. As elsewhere in the NHS, this attempt to industrialise pastoral healthcare produces results that often become inefficient and perverse.

Evidence-based Medicine (EBM). This has been introduced into healthcare to optimise the reliability and efficiency of therapeutic interventions. The idea is to invest in language and procedures that are officially sanctioned by scientific rigour, and then *Governance*. Healthcare economists and planners favour EBM because it is apparently objective, clear and unambiguous – and can then extirpate the errors and obfuscations of the personal and subjective. In this way *Quantification, Standardisation* and *Commodification* are all expedited. EBM thus becomes a key component in the *Internal Market*.

EBM is yet another example from healthcare of how a model's attractive simplicity may be woefully inadequate for complex realities. EBM has mostly operated from evidence restricted to the quantifiable and reproducible. This makes a base that is deemed 'safe', but is also narrow and rigid. It may be necessary, but it often is not sufficient. Problems arise because EBM may be loaded with an authority it cannot bear. Very often the most important aspects of human experience and variation cannot be directly measured or objectified. This is far more than any administrative anomaly: for the unmappable area is the massive – yet vulnerable – human heart of healthcare. EBM, in compatible areas, may be a valuable guiding principle: aggrandised to wider and rigid diktat, it can do real harm.

Increased Access to Psychological Treatment Services (IAPTS). A late parallel, and equivalent, to *CMHTs*. The task focus is therapeutic psychology (not psychiatry). Similar processes are used to identify, stream and manage problems: diagnoses, *Care Pathways* and (especially) the use of *CBT* as a procedural intervention. The system is designed to be easily compatible with electronic informatics, the *Internal Market* and *Payment by Results*. Some also argue that it helps equity and fairness of distribution. The flaws are largely common to those of the *CMHT*.

Internal Market. In the early 1990s this was a seminal and radical idea: to introduce monetarist values and mechanisms to nationalised healthcare. The enormous federal cooperative network would be broken up into economically and occupationally autarkic *NHS Trusts*. Wide and informal affiliations were replaced by a complex system of *Purchaser-Provider Splits*, which need tending by ceaseless negotiations to facilitate 'trade' between the Trusts. Computerised, quantifiable data, *Care Pathways* and *Payment by Results* are all necessary developments to service this Internal Market. The idea is to positively influence motivation and focus attention. After more than twenty years' evolution the results are mixed and highly contentious. Many longer-term observers (myself included) assess the losses as much greater than the gains. Since the recent Health and Social Care Act there is now more possibility of an external market: this amplifies contention.

Mid-Staffs. Refers to the Mid Staffordshire NHS Trust. In recent years perplexed and appalled attention has focused on the clear and massive failures and abuses of care uncovered in this NHS hospital. The widespread institutional human disengagement has been shocking enough. Further grotesquerie is provided by the attractive and respectable public persona of the Trust: it had received very favourable reports from routine official inspections, eg by the *CQC*. Mid Staffs is one of many egregious examples of concealed inhumanities in current NHS healthcare, though the most notorious. Many see Mid Staffs as being a kind of diabolic iconic: a harsh signal of the consequences of abandoning healthcare's primal task of human recognition and connection. Such abandonment, it is argued, is due largely to the rise of the *Internal Market's* 3Cs (Competition, Commissioning and

Commodification) and a culture cowed by managed demands for numerous, rigid and narrow *targets* and *PBR*. Subsequent statements from Mid Staffs' employees have described a bullied and intimidated work culture redolent of factory workers a century earlier.

National Institute for Health and Care Excellence (NICE). A governmentally appointed network of experts tasked with evaluating and applying *EBM* in specified areas of healthcare. As its operational nucleus is *EBM*, it has the same assets, limitations and liabilities. Thus NICE makes its most competent contributions to healthcare problems that are clearly physically defined, and which can then be reliably resolved or contained by standardised physical procedures.

So, NICE-prescribed frameworks usually make good and useful (though not infallible) contributions to the care of, say, Diabetes or Hypertension. Yet this kind of *algorithmic* management fares far less well with the vast human variations of pastoral healthcare (eg mood disturbance or alcoholism) where individual practitioners' wisdom, experience and subtle hues of judgement are central and indispensable.

Pastoral Healthcare. A term little used, but increasingly needed. It refers to our guiding human matrix of care: all those personal influences that comfort, heal, guide, contain, encourage, vitalise and illuminate. Pastoral healthcare thus extends far beyond any procedure or formula. Although certainly including such activities as personally attuned 'mental healthcare' or 'psychotherapy', it is not confined to these. Good Pastoral Healthcare is synonymous with the heart, soul and broader intellect involved throughout our encounters with others' distress. Like so many holistic activities, its subtler enactments cannot be readily measured, coded or proceduralised: Pastoral Healthcare thus tends to be neglected, displaced or destroyed by a culture dominated by the *Internal Market* and such satellite procedures as *Payment by Results*, *Evidence Based Medicine*, *Quality Outcome Frameworks* etc.

Payment by Results (PBR). The intention and thinking behind this kind of infusion of commercial motivation is relatively clear. It often galvanises

manufacturing industries. Yet the consequences – when applied to complex human welfare – become frequently obscure, tangled and perverse. Results of complex activities are often difficult to define, measure or predict. Motivation in welfare is – and should be – much broader and more complex than that of commerce. Unbridled PBR in healthcare provides specious statistics, bad science and egregiously perverse incentives.

Practice Based Commissioning (PBC). The prevalent form of *Clinical Commissioning Group (CCG)*; this reflects the directive role within the NHS now conferred on GPs.

Primary Care Trust (PCT). For several years this body preceded the CCG in managing the trade and conduct of Community Practitioners (GPs, Dentists, Pharmacists, District Nurses, Health Visitors, Chiropodists etc). It was managed largely by non-clinicians: the transition to CCGs brings doubtful benefits as few GPs can maintain the long-term personal resources necessary for the complexity and size of the task.

QUOF (Quality Outcomes Framework). A complex system of remuneration for GPs, constituting a kind of ‘performance related pay’. This is based on electronically guided and recorded *Specific Performance Indicators*, themselves based on *algorithms* and *Care Pathways* designed by governmental think-tanks and committees. The resultant computerised systems monitor and signal how each practitioner is managing each encounter with a patient with a chronic disease or risk. QUOF has thus brought the government and the computer into the centre of the consulting room in an unprecedented way. The results are mixed. The gains are most clear in bringing more vigilant and systematic management to high risk conditions where therapeutics are clearly effective (eg Hypertension and Coronary Heart Disease), and detection of some other areas of significant risk/poor engagement. The losses are from displacement. Computer informatics and governmentally dictated tasks replace subtle, personally nuanced exchanges that are essential for comfort, understanding and healing influences. Such undesignated ‘softer’ activities are also essential to NHS staff morale. The QUOF-directed GP has become more of a public

health commissar than a personal physician: patients are increasingly 'efficiently' treated, but poorly understood.

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This glossary is part of the book *If You Want Good Personal Healthcare See a Vet. Industrialised Humanity: Why and how should we care for one another?* Published by New Gnosis Press, 2015.

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