SECTION SEVENTEEN

CLINICAL GOVERNANCE AND THE PCT's PUBLIC HEALTH FUNCTION

This section considers:

- the public health duties and responsibilities that PCTs have inherited from Health Authorities
- the need for sufficient expertise within the Board/PEC to assure appropriate planning and scrutiny of these responsibilities and services
- the extent to which public health considerations inform the clinical governance priorities and actions of the PCT.

Planning for health

It is widely recognised that there are four key determinants of the overall 'health' of any given population. These are:

- population life circumstances (including economic, environmental and 'quality of life' factors)
- population lifestyles (including diet, patterns of exercise, habitual dependence etc)
- population genetic endowment
- the availability and quality of NHS (and other health and social care) provision.

In addition, the complex interplay of life circumstances and of life styles combine to produce a fifth key variable: that is, damagingly high and sustained levels of 'stress'.

'Better population health is the sum of better health of individuals, but needs more than individuals' action to achieve it.'

Donaldson, 2001

Key learning from the pilot programme

Many PCTs have made commendable progress in establishing effective leadership of the public health agenda.

In some PCTs serious attention is now being paid to overall determinants of health as well as to the management of illness and disease. In those that have made the most progress, Public Health perspectives are beginning strongly to influence and (potentially) to shape the scale, the nature and the location of the services that PCTs provide and also those that they commission.

Only in this way will transformation be led by the evidenced needs of local communities.

Despite the fact the PCTs have only recently assumed responsibility for Public Health – and notwithstanding the scope and scale of the other agendas to which they are required to respond - across all the PCTs in the pilot programme the section on Public Health was the second highest scoring at 5.8 on the progress scale (range 3.8 to 7.2).

Interestingly – and perhaps because this was a new responsibility for all PCTs that could be built in rather than bolted on to the functions of the newest – the more recently formed PCTs were likely to find this agenda only slightly more challenging than the more mature PCTs in the cohort. The 25 PCTs that were under a year old when they completed the questions scored an average of 5.7 whilst the remainder scored an average of 5.9 – the smallest variation between the sub-cohorts.

The enthusiasm with which most PCTs have responded to their Public Health duties and responsibilities reflects that close identity between its pre-occupations and those of the communities that PCTs serve. It is also clear that – notwithstanding the stereo-typical assumption that clinicians distrust public perspectives as being academic or remote from day to day realities – most PEC communities strongly welcome and value public health perspectives and contributions.

Where the agenda had not been developed this was most often because a PCT had not been able to recruit into a key Public Health post – or where the calibre of leadership had fallen short of the expectations of (particularly) PEC members.

Where the most progress had been made, Public Health physicians were fully and actively involved in all aspects of the quality agenda – playing an integral role in commissioning and service redesign debates as well as those concerned with health protection (e.g. environmental or immunization actions), health promotion (e.g. promoting action on poverty or diet) or screening programmes.

If PCTs are to lead the transformation of local health economies (in conjunction with their SHAs) it is clearly essential that all PCTs are able to draw upon a breadth as well as a depth of Public Health experience and expertise (with significant implications for the Education and Training agenda of PCTs, an issue discussed more fully in Section 13).

Responsibilities of PCTs

Since the abolition of Regional Health Authorities, PCTs have assumed a wide range of responsibilities in relation to Public Health and have a pivotal role to play in identifying the health needs of their local population, co-ordinating health promotion and disease prevention initiatives and helping to shape the commissioning strategies and plans of the PCT and of the local health economy so that they correspond optimally to current and emergent patterns and volumes of need.

These responsibilities characteristically cluster under four main headings:

- defining the nature and extent of current and emergent health need within the local community
- promoting local health improvement
- developing local primary care/commissioning secondary care
- developing local public health capacity

If they are to carry out these wide-ranging and demanding functions effectively, Boards and PECs must:

- understand and give a lead to the PCT community concerning the centrality and importance of the public health task
- recognise the impact of inequality upon sections of their patient population and the local community
- provide clear, confident and authoritative leadership of the public health agenda
- ensure that ownership and understanding of and commitment to public health is shared across all of the professional, managerial and support staff of the PCT
- equip the workforce with the requisite competences (values, knowledge and skills) needed to enable them to discharge their public health functions.

The Briefing Report developed by the CHI Knowledge Network (January 2003) provides a comprehensive overview of the interface between Public Health and the duties and responsibilities of PCTs.

Support and accountability

PCTs will be performance managed on the discharge of these functions by the SHA. The Health Development Agency has produced a useful guide that explores how this function is likely to be carried out – and the component elements of performance management of public health (Health Development Agency, 2002.). A comprehensive and clearly-presented public health performance management framework has been developed by the South West London Strategic Health Authority – and the PCT-specific element is included at the end of this section.

REFLECTION
To what extent have the Board and PEC debated their public health duties and responsibilities?

PCTs will be supported in the discharge of their Public Health functions by the Regional Directors of Public Health (RDPH) and by the Health Protection Agency (HPA). Additional significant expertise and support is available from the NHS Public Health Resource Unit (based at the University of Oxford's Institute of Health Science) and from the Faculty of Public Health of the Royal College of Physicians.

Defining the nature and extent of current and emergent health need

Access to a specific and accurate definition of the current and longer term health needs of the local community is an essential prerequisite to the discharge by a Board and PEC of their clinical governance duties in relation to services provided and commissioned by the PCT. It is this definition that enables the Board and PEC to:

- engage in an informed dialogue with the local community
- maintain the appropriate balance between national and local implementation priorities.

In other words, the systematic analysis and identification of local need is the crucial basis of evidence that underpins and justifies the PCT's strategy, priorities and actions.

REFLECTION
What evidence is there to suggest that the Board and PEC been given a specific and accurate analysis of the current and longer term health needs of the local community?

Has this analysis been shared fully with local communities and with partner organisations?

Standards for public health governance

The Faculty of Public Health Medicine of the Royal College of Physicians has defined standards for public health governance in ten key areas. The first of these (Standard 1) sets out the key responsibilities that must be discharged in relation to *Surveillance and Assessment of the Population's Health and Well Being*. Although not specific to PCTs, the standard defines the key issues that must be identified and tasks that an organisation and its partners must perform through the public health function.

First and foremost, a PCT must accurately identify the major health risks and disease patterns in the local community. This must be done while bearing in mind current and emerging disease risks in the UK population, and relating this specifically to the local situation. The PCT will need to be proactive in its approach to collecting and interpreting data, and adopting relevant disease measures at the local level. In defining the overall health needs of its local community, the Board and PEC must ensure that particular attention has been paid to the identification of local examples of health inequalities and to the needs of vulnerable or marginalised sub-groups.

As part of its overall duty to work in partnership, the PCT must openly and fully share information with:

- patients and the local community
- its partner organisations in the health and social care economy
- the SHA.

In this way it can ensure that health improvement and joint investment programmes are shaped and informed by the evidenced needs of local people.

Promoting local health improvement

Public health takes a lead role in addressing health needs, developing strategies and action plans to reduce health inequalities and improve the health of the population. The second standard defined by the Faculty of Public Health Medicine identifies a number of the actions that should proceed from a systematic analysis and definition of need in order to '*Promote and Protect the Population's Health and Well Being*'.

REFLECTION

What evidence is there to suggest that the Board and PEC regularly consider health improvement priorities?

What evidence is there to suggest that health improvement actions and progress are kept under active review?

This means identifying, developing and implementing local evidence-based strategies to

- improve and monitor the health (and threats to health) of the people living in the area
- reduce health inequalities.

The PCT is likely to need to engage in some or all of the following activities:

- setting up strategies and action plans involving other local partners aimed at
  - tackling the causes of health inequality
  - including action to prevent CHD, diabetes and cancer by supporting smoking cessation
  - reducing obesity through access to healthy food, mental health promotion and opportunities for physical activity
- working with local business representative bodies, key employers and trades unions to promote the overall economic and social well-being of the local; community
- setting up strategies to improve mental health and mental health in the workplace
- local delivery plans including the implementation of NSFs and working in partnership with other stakeholders to ensure maximum joined-up service delivery using an evidence-based approach
- overseeing commissioning arrangements;
- supporting acute trusts in service delivery
- supporting Health Action Zones, Sure Start Programmes, Healthy Schools projects, School Fruit scheme
- encouraging more localised, hands-on, community orientated approach to public health issues
- supporting programmes to reduce domestic violence and increasing community safety (as regards health protection they will be supported by the HPA (see below))
- working with local partners to develop and implement local teenage pregnancy strategies and action plans to achieve under-18 conception rate targets
- reducing infant mortality through identifying and supporting mothers at risk
- ensuring the widest possible participation in the health and health care agenda by;
- assuming the local representative role for health services in the development of Local Strategic Partnerships (Local Government White Paper, 2001)
- providing effective adult sexual health services to meet the needs of the local population, in line with the national Sexual Health Strategy.
- ensuring compliance with regulations and laws to protect and promote health e.g. Ionising Radiation (Medical Exposure) Regulations.
- feeding into wider R&D arrangements (via PH networks or other arrangements) to support research as well as research into practice.

Given the scope and breadth of this potential agenda, the Board and the PEC must ensure that they have developed a clear strategy and identified a prioritised and realistic set of actions to promote local health improvement that can be carried out within an agreed timetable. They have a duty to keep all of these issues under active and periodic review, so that they can respond in a timely fashion to changing or emerging local need.

Developing local primary care and commissioning secondary care

Because of their pivotal role within local health economies, as both providers and commissioners of care for the local population, PCTs have a particular responsibility (in collaboration with the SHA) for shaping the development of local models, patterns and locations of care so that they map optimally against the defined overall health needs of their local population.

The public health function will need, therefore, to:

- support the commissioning process through evidence-based and ethical decision-making so that services are commissioned appropriately and transparently using a common decision-making process that complies with the requirements of the Human Rights Act 1998
- ensure, through the commissioning process, that organisations providing care to the PCT's patient population pay due attention to ensuring effective infection control measures are in place and implemented
- assist the PCT to assume the local leadership role on health inequalities and take the lead for health on partnership working (in particular in Local Strategic Partnerships)
- enable the PCT to play a wider role in engaging with regeneration and renewal strategies, e.g. developing and implementing local programmes to tackle deprivation, such as cross-government Neighbourhood Renewal Strategies.

Members of the PCT community will also need to be equipped with the competences necessary to educate the local community and partner organisations on health and inequalities issues. This might include, for example:

- working with local educational authorities to encourage and support increased take-up of the National Healthy Schools Standard, particularly in deprived areas,
- supporting the provision of sex/relationship and drug education in local youth groups and schools.

Additionally, the public health function should enable the PCT to take coordinated action at local level in line with the National Service Framework for Coronary Heart Disease, the Cancer Plan and *The NHS Plan* (with a particular focus on the targets set out in the Priorities and Planning Framework 2003-2006) to prevent, wherever possible, chronic disease such as CHD, diabetes and cancer.

REFLECTION

What evidence is there to suggest that public health perspectives and understandings inform the commissioning process?

How well developed and monitored are health promotion/illness prevention strategies and actions?

If this coordinated action is to occur, all members of the PCT community – and of the organisations that provide commissioned care, need to recognise that maximum improvement to population health is brought about by effective prevention and other interventions, for example tackling smoking, promoting healthy eating, promoting physical activity, reducing overweight and obesity, tackling hypertension and preventing accidental injury.

Finally, and in collaboration with the Health Protection Agency and the Regional Director of Public Health, the Board and PEC must ensure that the PCT has the capacity and the expertise to investigate and manage outbreaks of infectious diseases, provide health emergency planning and respond to other threats by detection, diagnosis, prevention and control of infections and communicable diseases, environmental, chemical and (once primary legislation is in place), radiological hazards.

Developing local public health capacity

Within a PCT community, the responsibility for taking forward the multi-faceted public health agenda cannot be the sole responsibility of one or two experts – no matter how eminent. If it is fully to discharge its public health duties and responsibilities, the Board and PEC need to ensure that:

- public health specialists are adequately supported
- health promotional initiatives are appropriately prioritised and resourced
- the entire PCT community has an understanding of and a commitment to the public health agenda – as one expression of their overall commitment to clinical governance.

Working in conjunction with Workforce Development Confederations, PCTs will need to ensure that their education and training strategy explicitly ensures that the public health role and responsibilities of General Practitioners and of the primary care workforce (e.g. health visitors, school nurses, and other community workers), are fully recognised, and that all staff have the requisite competences to discharge these responsibilities. Equally, PCTs must ensure, on an ongoing basis, that newly-appointed staff at all levels possess or develop public health competences.

In their endeavour to develop and maintain a well-educated and trained specialist health protection multidisciplinary public health workforce, the PCT can also draw upon the expertise and support of the Health Protection Agency and upon the educational programmes and processes developed by the NHS Public Health Resource Unit (based at the University of Oxford's Institute of Health Science).

In order to discharge their duty to work in partnership with patients and with local communities, PCTs must have strategies in place to foster informed participation in debate and dialogue concerning public health issues, needs and priorities with:

- a broad cross section of their local community – including vulnerable and marginalised groups
- other key organisations (e.g. commercial and industrial bodies) that may not immediately recognise their impact upon the overall health and well-being of local people.

REFLECTION

What evidence exists of a strategy to secure understanding of and commitment to the Public Health Agenda across the PCT's workforce?

What evidence exists to suggest that the developmental needs of the PCT workforce in relation to public health competence are explicitly addressed in the education and training strategy?

What steps is the PCT taking to foster a wide-ranging debate in and with the local community and with partner organisations in relation to public health needs and priorities?

South West London Strategic Health Authority – PCT-specific excerpt from Overall 'Performance Management Framework for Health'

2 Performance managing the effectiveness of Primary Care Trusts in delivering their core function of health improvement for the PCT populations.

This section is **not** a paper chase. It should be used as an aide-memoir to lead PCT Directors, for their Health Improvement function

DOMAIN OF INTEREST, AND REASON	(STRUCTURE) PROCESS OR OUTCOME?	INDICATOR OR METHOD OF MEASURING	WHO HOLDS THE LEAD RESPONSIBILITY?	COMMENT
Use of health measurement tools in the planning process A fundamental approach to monitoring health at local level and measuring impacts of major programmes on local communities. Profiling is a pre-requisite to setting objective health priorities	Process	Annual public health reports and profiles of the population are produced and are available to key decision makers in the PCT. Surveillance of the population's health occurs regularly via routine, broadly-based data sources Health Impact Assessment (HIA) is employed when reviewing a major new plan or service for its impact on health. Equity audits are conducted to ascertain whether established programmes have addressed their aims and, where relevant, inequalities in health	Director of Public Health and team (with support of PH Network) for production Led by DPH and public health team in PCT. Support for training and implementation by Board of PCT Ditto	The Public Health Network will collaborate to produce supporting data. In-house interpretation needs to follow on from this HIA training is available from the Public Health Observatory in London and elsewhere. Cost implications of conducting an HIA are £15-25K We would expect these tools to be used in the HimP and SaFF process and investment for health. Investment supports key health improvements. The new Census provides information that should be employed on small area monitoring of equity in healthcare

Working in partnership to influence health determinants and reduce health inequalities Part of the AAA	Process	Key stakeholder collaboration in priority setting and planning, using a range of knowledge about local communities Aims and intended outcomes of the Local Strategic Partnerships have a clear health improvement focus Success of the LSP in influencing mainstream funding for inequalities reductions Current good practice (e.g. SureStart, Healthy Schools) is mainstreamed and/or sustained, and systems are in place to monitor progress Local and national research evidence on inequalities taken on board – e.g. age, sex, social class and smoking inequalities in revascularisations and prescribing of statins	Executive Directors of the PCT. NHS leads on the LSP Boards. NHS leads on the LSP Boards Lead PCT Directors and their teams Public health topic leads in PCTs, supported by Public Health Network	Involvement of health services in regeneration activities Effective area based initiatives are integrated into mainstream funding Shared learning, training and working across different, related initiatives
Co-operative commissioning across health, and social care boundaries Integrated care pathways, for better outcomes Achieving *The NHS Plan*	Process	Co-operation rather than competitive tendering is used preferably for public sector services Improvements in intermediate care provision Progressive risk management structures are present within the PCT to enable innovation and the use of Health Act flexibilities to modernise services	Directors of Commissioning and Finance in PCTs Lead PCT Directors Directors of Finance in PCTs	Examples of risk management from Primary Care should start to emerge

Commissioning services which are based on best evidence and achieve OHN targets Fundamental method of achieving consistent and high quality outcomes for all the population	Process	Achievement of the NSF targets Deployment of public health expertise in the components of commissioning related to effectiveness and appraisal of new technologies prior to their deployment in practice	NSF leads and support teams. Directors of Commissioning	Systems are developed that build a knowledge base of evidence for the PCT to draw on, e.g. diabetes management framework
Commissioning equitably Reduction of inequalities in healthcare. Part of AAA	Process	Decision making on deployment of resources employs systems that are explicitly ethical and equitable. A collegiate approach is adopted with other PCTs where populations are particularly mobile, vulnerable or subject to variations in healthcare experience over boundaries	Directors of Public Health, Commissioning and Finance Director of Public Health as advocate	Frameworks exist that can be adapted for local PCTs, e.g. diabetes management framework
Ethnic health monitoring is achieved in primary care London target, way of measuring potential inequalities in health	Process	Ethnic coding method has been agreed	Directors with responsibility for primary care development, and Head of Information in the PCTs	Levels unknown in most PCTs

A proportion of new primary care developments within areas of high need Reduction of inequalities	Structure	Needs related primary care services, i.e. a higher ratio of GPs, practice nurses and other primary care staff per practice population in areas of high need % of other primary care developments in areas of high need Monitoring primary care to ensure that practices are preparing for the new contract Development initiatives for improvement of primary care premises, including Local Improvement Finance Trust (LIFT) Progressive development of IT systems, and training	Directors for primary care development and service modernisation Chairs of the PECs in PCTs. Directors for primary care development and service modernisation	Creative ways of servicing challenging areas will ensure that the inverse care law is minimised. PMS will almost certainly change with the emerging new contract. This is an area of PCT Risk Management policy to be supported and monitored – there are risks that large numbers of GPs will opt out of specific areas of service provision, e.g. out-of-hours. PCTs will need to plan for this.
Clinical risk management in primary care	Process	The PCT has a systematic way of identifying, monitoring and learning from serious clinical incidents in primary care settings.	Medical Directors of the PCTs Nursing lead/Director in the PCTs Other Clinical Profession leads in the PCTs	Piloted schemes for identifying and learning from SUIs have been tested in MSW. Links with NPSA but no national template for primary care
Disease registers and other patient information	Process	Accurate and complete chronic disease registers are in place in GP surgeries. Coding of patient information is accurate and complete (clinical, demographic, and delivery of care)	Medical Directors of the PCTs PEC Chairs of the PCTs	Accurate coding enables patient care pathways to be tracked. Good practice should be shared and developed more fully

A functioning public health network across PCTs	Process	The business plan, workplan and specifications for the components of service are agreed and monitored, with annual reporting on achievements	DsPH Steering Group SHA DPH and Business Manager	The Network has commenced for SW London and plans are in place

Priorities for action

Now that you have finished reading through this section, please identify three priorities in relation to the PCT's public health clinical governance duties and responsibilities.

1

2

3

References

Department of Health 2002. *Improvement, Expansion, Reform: the next three years. Priorities and Planning Framework 2003-2006*, London: DoH

Donaldson, L. 2001. *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*, London: DH

Health Development Agency 2002.*Performance Managing Public Health Action in Primary Care Trusts*, London: Health Development Agency

Office of the Deputy Prime Minister 2001. *Strong Leadership – Quality Public Services*, (Local Government White Paper)

South West London Strategic Health Authority 2002. *Performance Management Framework for Health*, South West London Strategic Health Authority

Resources

Chief Medical Officer's website
www.doh.gov.uk/cmo

Chief Nursing Officer's website
www.doh.gov.uk/cno

Delivering Race Equality: a framework for action consultation guide on mental health services for ethnic minorities.
www.doh.gov.uk/deliveringraceequality/index.htm

Department of Health 1999, Saving Lives: our healthier nation, London: The Stationery Office

Donan, S. 1999. Governance of the Public Health Function (draft), Faculty of Public Health Medicine

Faculty of Public Health of the Royal College of Physicians
www.fphm.org.uk

Health Protection Agency
www.npa.org.uk

Getting ahead of the curve. The Government Strategy for Health Protection website
www.doh.gov.uk.cmo/idstrategy

Healthy Schools projects, Young People's Health Network, National Healthy School Standard
On the Wired for health website on
www.wiredforhealth.gov.uk

Health Evidence Bulletins: Wales – cover public health topics
www.hebw.nwcm.ac.uk

Health Development Agency – website features examples of good practice in primary care
www.hda-online.org.uk

National Service Frameworks including for Coronary Heart Disease, the Cancer Plan are available at
www.doh.gov.uk/nsf/nsfhome.htm

Individual NSFs are available as follows:

Mental Health: www.doh.gov.uk/nsf/mentalhealth

Older People: www.doh.gov.uk/nsf/olderpeople

Coronary Heart Disease: www.doh.gov.uk/nsf/coronary

Cancer Plan: www.doh.gov.uk/nsf/cancerplan.htm

Children: www.doh.gov.uk/nsf/children

Diabetes: www.doh.gov.uk/nsf/diabetes

Best practice: a practical aid to implementing NSFs in primary care
www.doh.gov.uk/pricare/nsfbestpractice

The NHS Plan
www.doh.gov.uk/nhsplan

NHS Public Health Resource Unit based at the University of Oxford's Institute of Health Science
www.phru.org.uk

Northern and Yorkshire Regional Office 2001. Organisational competencies for PCTs; Health Inequalities, Partnerships and Health Improvement, Northern and Yorkshire Regional Office

Sexual Health Strategy
Department of Health 2001. National Strategy for Sexual Health and HIV, London: DoH

Sure Start Programmes
www.surestart.gov.uk

Tackling Inequalities: the results of the consultation exercise
www.doh.gov.uk/healthinequalities

Rating the PCT's current stage of development

Please rate the PCT's current stage of development in relation to the following questions.

Remember to use the Response Sheet provided for your answers.

17.1 To what extent do the Board and PEC have a clear and shared understanding of the PCT 's public health duties and responsibilities?

17.2 To what extent is there clear, effective and authoritative leadership within the PCT of the public health agenda?

17.3 To what extent is the nature and location of care provided by the PCT shaped and informed by public health-led understandings of local need?

17.4 To what extent is the commissioning process informed and shaped by public health-led understandings of local need?