SECTION TWENTY
ADDITIONAL PCT RESPONSIBILITIES

This section considers:

- the extent to which the PCT's existing clinical governance strategy and procedures appropriately discharge the duty of quality in relation to the additional responsibilities they have inherited from Health Authorities and in relation to community dentistry, pharmacy and optometry
- the need for sufficient expertise within the Board/PEC to assure appropriate planning and scrutiny of these responsibilities and services
- the extent to which the PCT has discharged its 'Emergency Planning' responsibilities and, where relevant, is prepared to assume responsibility for local prison healthcare commissioning
- the need to mainstream all of these activities so that they become fully part of the standard and core business of the PCT.

PCTs' additional responsibilities

Shifting the Balance of Power had major implications for the regulation and management of a broad range of primary care services and functions. Not only have PCTs assumed responsibility for commissioning acute and other medical services on behalf of their patient populations, they have also taken over responsibility for commissioning and quality assuring community services in general dentistry, pharmacy and optometry. As a result, the clinical governance responsibilities of a Board and PEC now extend to these services. They extend also to the provisions PCTs are required to make as a result of the 'Emergency Planning' responsibilities that they have inherited, from October 2002, from Health Authorities.

'PCTs will have responsibility for the management, development and integration of all primary care services (medical, dental, pharmaceutical and optical).'

Department of Health, 2001

Key learning from the pilot programme

The vast majority of PCTs in the pilot sample believe that they have engaged actively with their 'Emergency Planning' responsibilities – either directly or through agreements with other lead PCTs in their local health economies.

The assumption of responsibility for prison-based health provision has been met with pro-active imagination in some cases, though in others it is a cause of considerable and persisting concern.

Most PCTs also struggled to make headway in incorporating pharmacists (and especially) dentists and optometrists into their professional community.

There were, however, a number of notable exceptions where dentists and pharmacists in particular now function as fully integrated members of the PCT professional communities. Examples of this degree of integration of optometrists were, at the time of the pilot activity, harder to identify.

Not least because of the high volume and invasive nature of general dental practice, with all of the attendant risks of communicable infection, most PCTs expressed particular concerns about the management of risks associated with these activities.

While recognising that community pharmacy might pose at least equal risks, most PCTs felt that their existing or newly-formed links were more securely based. However, a number expressed concern about the difficulties associated with verifying the professional credentials of locum pharmacists.

All PCTs would welcome the active support of the respective professional lead bodies in developing strategies to secure engagement and effective collaborative working, though some were still resistant to extending to these groups the opportunity for representation on the PEC and/or CG committees.

Across all of the PCTs in the pilot programme, the section on Additional Responsibilities scored 4.8 on the progress scale (range 3.1 to 7.0). The range reflects in part the very different inheritance of different PCTs from their predecessor organisations and often relates to the particular difficulties experienced in deprived inner city communities, especially where dentistry is concerned.

As in almost all other cases, the more recently formed PCTs were likely to find the it somewhat more challenging to assume these additional responsibilities alongside the broader problems associated with creating a new organisation. The differentiation was, however, one of the smallest recorded, perhaps because these new responsibilities could be built in rather than having to be bolted on to their core business agenda. The 25 PCTs that were under a year old when they completed the questions scored an average of 4.7 whilst the remainder scored an average of 4.9.

The overall figure conceals a significant differentiation between the discrete issues covered within this section. Almost all PCTs were broadly confident that they – or others acting on their behalf – had put in place emergency planning provision.

So far as dentistry in particular was concerned, PCTs demonstrated significantly less confidence that they had in place systems and processes that adequately discharged their duty of quality in relation to either dentistry, pharmacy and optometry. In many cases, they had not even developed a strategy and action plan for appropriate systems and processes.

Discussions within the feedback workshops underlined that the highest level of concern related to dentistry (with a number of notable examples where good practice was firmly embedded). This anxiety was highlighted once it became clear from a number of published CHI reviews that this had become one focus of the activity of a significant number of review teams.

Many PCTs had taken pro-active steps to extend membership of their Clinical Governance Committees or their PECs to professional staff who could represent these discrete professional groups. A minority had, however, been resistant to this and appeared to view the arrival of these new professions as a threat to established patterns of (predominantly GP) hegemony.

So far as the issue of responsibility for prison-based health care services is concerned, the picture presented in the feedback sessions was polarised. By its nature, this is not an issue for all PCTs, though it does affect a significant proportion of them. In a number of cases, significant progress had already been achieved with active dialogue being the precursor to strategies and plans to embed all aspects of clinical governance into prison-based health services. In other cases, there had been no significant dialogue and the PCT regarded with deep concern the assumption of responsibility that did not appear to be matched by appropriate authority or resource.

Given the level of confidence expressed in relation to Emergency Planning, the questions that relate specifically to those responsibilities have been removed. However, the support materials have, for the present, been left in place as a point of reference for Board and PEC members who wish to assure themselves that their own PCT is meeting its statutory responsibilities.

Integrating new responsibilities with existing core PCT functions

PCTs must develop a common strategy and a set of processes and procedures that embrace all the functions for which they are accountable. This will enable them to ensure:

- seamless care
- equity of standards of quality
- patient safety.

The processes and procedures need to be sufficiently flexible to:

- deal appropriately with the particular needs of specialist services
- take account of and incorporate the breadth of the responsibilities they have inherited from Health Authorities.

These responsibilities include:

- Public Health and Health Improvement
- Communicable disease
- Immunisation and Vaccination
- Health Screening:
- Environmental Hazards and decontamination.

They must also ensure that, in both new and existing provision, they incorporate:

- the requirements of the Race Relations Amendment Act
- their responsibilities to members of the community whose first language is not English (themes that CHI will address directly in its reviews).

Particularly in view of these new responsibilities, demands and service innovations, membership of the PCT must contain appropriate professional and non-executive expertise to meet the challenge of these new responsibilities.

REFLECTION

What evidence is there that these new responsibilities and demands have been discussed and debated within the Board/PEC?

There should be a systematic review of the membership of:

- the PEC
- the clinical governance committee
- other regulatory committees within the PCT

'There had been substantial increases in the numbers of schemes to extend the range of services available in primary care, including counselling (74%), specialist nurses (67%), and specialist GPs (62%).'

National Primary Care Resource and Development Centre, 2002

Once any necessary changes in personnel have been made, a formal review of existing clinical governance strategy, implementation and monitoring processes must ensure that these map appropriately against the needs of the patients and users of these new services and against the needs of the contracted staff within them.

General dentistry

Independent contractors working under NHS General Dental Services regulations are already obliged to have a practice quality assurance system in place. These duties are explored and explained in the British Dental Association's *Quality Systems for Dental Practice Guidance.*

The PCT will need to assure itself that there is an appropriate fit between this system and that in place for core PCT services. This analysis should take into account, in a contextually appropriate fashion:

- patient involvement
- the patient experience
- all of the technical components of clinical governance, with particular emphasis upon proactive risk management (given the nature of the clinical tasks performed by dentists).

This analysis should also identify any clinical governance-related training and development needs. Appropriate steps should then be taken, in collaboration with the independent contractors, to ensure that these needs have been addressed.

In carrying out this analysis, the PCT's staff should liaise with professional dental advisors, the OHAG and LDC as well as with the independent contractors themselves.

All of these issues should be reflected in the Clinical Governance Development plan, and progress should be mapped through the Annual Clinical Governance Report.

REFLECTION

How well developed are the PCTs relationships with local dental services?

Is there appropriate dental expertise within your governance structures?

What evidence is there to support your views?

Pharmacy services

A parallel process needs to occur in pharmacy. Particular attention will need to be paid to appropriate channels of two-way information flow, since dispensing pharmacists play a vital role in monitoring the prescribing practice of local GPs.

The Department of Health has set out the ways in which clinical governance maps against the duties and responsibilities of pharmacists in *Clinical Governance Pharmacy Guidelines*.

This guidance contains a very clear checklist and plan of action for implementation of clinical governance. Similarly, the CHI questionnaire to community pharmacists on clinical governance arrangements clearly identifies the areas that CHI are likely to consider during a clinical governance review.

'Pharmacy provides an excellent example of a service area where many opportunities may exist for mutual discussion and debate about additional ways in which pharmacists may be able to monitor and support members of the local community. 53% of PCTs had extended the role of pharmacists.'

National Primary Care Resource and Development Centre, 2002

The Department of Health recently announced key decisions on supplementary prescribing by pharmacists (and nurses), following diagnosis of a patient by a doctor.

Once trained, supplementary prescribers will be able to prescribe all medicines currently prescribed by doctors, with the exception only of unlicensed medicines (unless part of clinical trials) and of controlled drugs. Prescribing of controlled drugs will be included after the necessary legislative changes. There will be no legal limit on the conditions that may be included in supplementary prescribing.

'Supplementary prescribing training for nurses is expected to be in place by the end of January 2003 with the first nurses acting as supplementary prescribers by the Spring. Supplementary prescribing training for pharmacists should be in place from spring 2003, with the first pharmacists prescribing from late summer 2003.'

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

REFLECTION

How well developed are the PCT's relationships with local pharmacists?

Is there appropriate pharmacy expertise within the PCT's governance structures?

Are plans in hand to maximise the improvements that could flow from greater use of the expertise of local pharmacists?

What evidence exists to support your views?

The Department issued guidelines on the implementation of supplementary prescribing in England early in 2003 and these should now be routinely embedded in PCT policy and procedures.

This forms only one element of the expanding and developing roles of community pharmacy. *Pharmacy in the Future* sets out a number of the significant developments that will drive forward this agenda, including

- a new national contract
- LPS
- the treatment by pharmacists of minor ailments
- repeat dispensing
- medicines management.

A Kings Fund survey (November 2002) *Developing community pharmacy: what pharmacists think is needed* (which can be found at www.kingsfund.org.uk/) explored with 178 pharmacists in North East London the level of services they provide, their views on Government targets, and the support they need to achieve these. The survey showed that community pharmacists are keen to expand the number of services they provide to patients, providing they have the resources to do so. It also showed that many pharmacies are already providing more services than required under their national contract. The report contains a number of key recommendations, including that PCTs need to take on a proactive role in engaging with community pharmacists.

Optometry services

A parallel process needs to occur in optometry.

'As patient services move increasingly out of hospital and are delivered by multi-professional teams, it becomes increasingly important for PCTs to recognise and take on properly their wider responsibilities.'

Stephen Ryan, Association of Optometrists

Optometrists and their professional representative bodies are concerned that PCTs may be reluctant to

- take seriously their responsibilities to the profession
- fund the developmental work necessary at the local level to ensure integration and the development of seamless governance of overall care.

For example, 85% of optometrists are already participating voluntarily in the continuing education programme run by the Royal College of Optometrists, in preparation for mandatory revalidation in 2005. PCTs may need to review what they could do locally to support optometrists in this process?

The Royal College of Optometrists has set out the ways in which clinical governance maps against the duties and responsibilities of optometrists in Clinical Governance Optometry Guidelines.

The Association of Optometrists (AOP) believes that it would be very helpful if the PCT's answers to the rating questions (20.1-20.3) at the end of this section could be formally shared with the Local Optometric Committee. This would help to determine whether the PCT's perception of progress is shared by the LOC. This exchange of views might also form a platform for further work.

As with dentistry, the PCT needs to attend to appropriate channels of two-way information flow, since optometrists can provide early warning of a number of conditions, especially with older people, that do not necessarily present symptomatically. The AOP believe that a number of specific activities could foster and further the process of integration and mainstreaming.

i) Shared care or co-management schemes (which could prove a useful vehicle for the introduction of clinically governed care) existed in 72% of the old health authorities and the AOP are in the process of gathering PCT specific data.

ii) Schemes involving the referral of cataract patients (or those with other eye problems) by optometrists to hospitals would provide PCTs with an opportunity to address clinical governance issues which cross primary-secondary care boundaries.

iii) Optometrists are also well-placed to be involved in multi-disciplinary clinical governance work on topics such as the redesign of diabetes services.

REFLECTION

How well developed are the PCT's relationships with local optometry services?

Is there appropriate optometry expertise within our governance structures?

What evidence is there to support your views?

Emergency planning

In addition to the above on-going service responsibilities, other 'special responsibilities' have also now been transferred to PCTs. Foremost amongst these are the Emergency Planning duties. These are particularly pertinent in the wake of heightened public and political concern over the well-publicised rail disasters and the September 11 after shocks.

'Health Authorities [will] delegate the emergency planning function to PCTs as soon as is practicable during the period up to October 2002.'

Department of Health, 2002

In collaboration with SHAs, local arrangements may be negotiated that will allow designated PCTs to assume a lead responsibility for this function across a specified health community. Nevertheless, each PCT will have to prepare and have approved its own strategy and action plan.

'Although all PCTs are required to prepare major incident plans, the lead PCT model allows for co-ordination of this activity.'

Department of Health, 2002

However, concern has recently been expressed at the unacceptable variation in preparedness that currently exists across England.

REFLECTION

Is the Board clear about which PCT (if any) has lead responsibility for emergency planning?

To what extent is the Board and PEC satisfied that it meets all minimum standards of preparedness?

To what extent has the Board and PEC considered the impact on core provision if the plan should need to be invoked?

'I hope that NHS CEOs and Boards will have looked at the findings of the NAO report on emergency planning in the NHS ... These show a very patchy picture of preparedness around the country. Please review your own position at Board level.'

Crisp, 2002

As one part of ensuring that these statutory functions have been discharged, the Boards and PECs of PCTs must explicitly address and consider:

- the issue of quality in relation to the plan
- the maintenance of the quality of core service provision when and if this plan needs to be invoked.

'PCTs are uniquely positioned to ensure that there is an integrated primary care and community services response to major incidents, as PCTs are both commissioners of healthcare and providers of primary care services.'

Department of Health, 2002

Commissioning care for local prison populations

Over the next five years, where there is a prison located within their geographical catchment area, PCTs will assume full responsibility for the health care of prisoners as responsibility for health provision transfers from the Prison Service to the NHS. This will affect one in three PCTs.

With effect from April 2003, affected PCTs will become responsible for commissioning care from the Prison Service. This care will fall under the general remit of their statutory duty of quality and PCTs will need to take reasonable steps, through the commissioning process, to establish that care is safe and that systems and processes are beginning to be put in place to ensure that care is clinically governed. As a result PCTs, together with their SHAs, will need to support prison staff in the development of systems and processes that assure and improve the quality of care. Developmental work is already underway at HMP Wandsworth with the support of the Modernisation Agency and of the Health Advisory Service. At HMP Long Lartin a baseline measure of clinical governance capacity and capability has been undertaken with the support of staff from South Worcestershire PCT. Details of these pilot activities and useful background information can be found in one of the Prison Newsletters at www.doh.gov.uk/prisonhealth/newsletter9.pdf

Priorities for action

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

1

2

3

References

British Dental Association *Quality Systems for Dental Practice Guidance*, London: BDA at www.bda-dentistry.org.uk

Crisp, N. 2002. *NHS and Social Care Bulletin* No.24

Department of Health 2001. *Shifting the Balance of Power within the NHS: Securing delivery*, London: DH

Department of Health *Clinical Governance Pharmacy Guidelines* at www.doh.gov.uk/clinicalgovernance/pharmacyguidelines or www.doh.gov.uk/clinicalgovernance/communityplanning.htm

Department of Health, 2002. *Planning for major incidents: the NHS Guidance The Primary Care Trust (PCT) Version 10-24*, London: DH

National Primary Care Resource and Development Centre 2002. *National Tracker Survey of Primary Care Groups and Trusts 2001/2002: Taking Responsibility?* Manchester: NPCRDC

The Royal College of Optometrists *Clinical Governance Optometry Guidelines*, London: Royal College of Optometrists at www.college-optometrists./org/professional/clingov

Resources

Dentistry – Dentists' quality-related duties are explored and explained in the British Dental Association: Quality Systems for Dental Practice Guidance. www.bda-dentistry.org.uk

Emergency planning – the National Audit Office report on Emergency Planning preparedness can be found at: www.nao.gov.uk/whatsnes.htm

King's Fund – a range of publications including *Future Directions for Primary Care Trusts* www.kingsfund.org.uk

NHS Alliance – publications including *Clinical Engagement: a national survey* www.nhsalliance.org/docs/Clinician%20disengagement.pdf

The National Primary and Care Trust Development Programme – the NatPaCT team helps PCTs with organisational development. (See also dental clinical governance reference paper on the NatPaCT website) www.natpact.nhs.uk

Optometry – clinical governance Optometry Guidelines can be found at: www.college-optometrists.org/professional/clingov

Association of Optometrists www.assoc-optometrists.org

Pharmacy – the clinical governance framework for pharmacists can be found at: www.doh.gov.uk/clinicalgovernance/pharmacyguidelines

A guide for clinical governance leads in community pharmacy has been developed by the National Pharmaceutical Association *Implementing Clinical Governance in Community Pharmacy (in England): A Local Development Plan* April 2002

Prescribing guidance www.doh.gov.uk/supplementaryprescribing

Public Health – information on relocation of public health laboratories to PCTs can be found at www.doh.gov.uk/cmo/laboratories/appendix-b.htm

Public Health Tackling Health Inequalities –guidance can be found at www.doh.gov.uk/healthinequalities/ccsrsummaryreport.htm

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.

20.1 To what extent does the PCT have a strategy for integrating dentists, pharmacists and optometrists into the PCT community?

20.2 To what extent is there a strategy to explain to the local community the fact that the PCT now has responsibility for the quality of these services?

20.3 To what extent is there clear and effective professional leadership for all of these groups?

20.4 How adequately are these groups represented within the existing PEC and Board structures?

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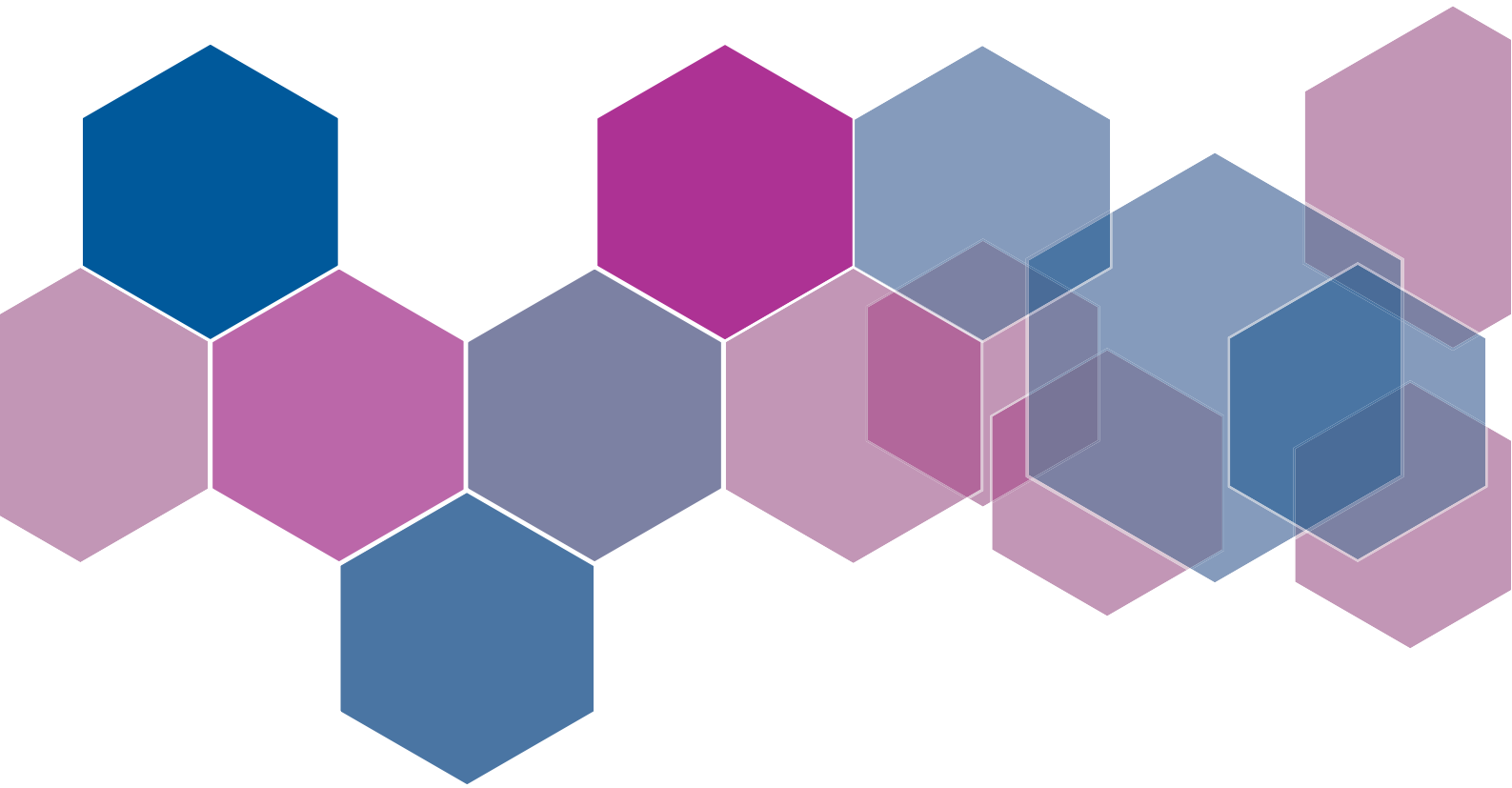

The Strategic Leadership of Clinical Governance in PCTs

A learning resource for the members of PCT Boards and PECs