



# Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

## **Public Health in Hospitals**

**Report from a joint British Association of Medical Managers,  
Faculty of Public Health and Department of Health conference  
May 2004**

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## Foreword

Health improvement and tackling health inequalities, health protection and health and social care quality form the three main domains of specialist public health practice. Acute and mental health work in NHS trusts has largely tended to fall within the latter of these domains – that is, within the sphere of health and social care and quality.

But the NHS agenda for trusts is broadening. The creation of the Health Protection Agency has expanded the remit of health protection and the national focus on health inequalities now, more than ever, recognises the important role NHS activity has to play in narrowing inequalities.

Greater partnership working on the wider determinants of health exists between public health consultants and specialists in primary care trusts and colleagues in local authorities, as reflected in the new local strategic partnerships, to which local trusts and authorities must sign up.

Public health professionals working in acute and other hospital trusts are de facto engaged in and form a core part of the wider NHS agenda as set out in the Planning and Priorities Framework 2003–6. However, the challenge remains to define and support their specific contribution and to ensure public health capacity within trusts across the NHS.

With this challenge in mind, the Faculty of Public Health, in association with the British Association of Medical Managers and the Department of Health, brought together colleagues for a one day conference in October 2003 to discuss the role of public health within hospitals.

This report brings together the presentations and papers from the conference. They present a range of views and experiences of public health professionals working in acute and mental health care sectors. This report signifies a first step and there will be further opportunities for comment and reflection. It is incumbent upon public health leaders at regional and local level to enable and support individuals and public health networks to engage with this agenda.

**Professor Siân Griffiths, OBE**

**President, Faculty of Public Health**

*Please note the views expressed in this report do not necessarily reflect those of the Faculty of Public Health. Reports may have been edited slightly for word length and stylistic consistency.*

## Key points

- KP1: Public health in trusts can incorporate joint working across primary and secondary care, ie. working at the interface to assist in joining up care.
- KP2: Public health in trusts needs to focus on the business end of the trust as well as on its relationship to the wider agenda.
- KP3: There is a need to create a public health network for specialists working in trusts so that they can share their experiences.
- KP4: There is a need to develop public health in medical training to raise skills and awareness of the role. This should also be extended to include other healthcare workers.
- KP5: Procurement constraints are unsupportive of the sustainability agenda.
- KP6: Performance management targets for public health need to be set and taken seriously.
- KP7: There should be a designated public health lead in every hospital.
- KP8: Hospitals need to take responsibility for public health issues, such as reducing smoking, and be actively involved in developing sustainability and implementing evidence-based care.
- KP9: Tariffs should focus hospitals on cost and clinical effectiveness.
- KP10: There is a need to map out the economic arguments for public health in trusts, such as savings resulting from policies public health has helped to implement and deliver.
- KP11: There is a need for a core statement of policy/principles to move this agenda forward.

## Agenda for action

### **Action Point 1: Training opportunities and public health competencies**

Hospitals are an ideal training environment for public health trainees and a model training programme should be developed and promulgated by the Faculty of Public Health (FPH) with support from the Department of Health (DH). The possibility of ensuring that all trainees have some experience of hospital-based training should be explored by training programmes.

### **Action Point 2: Research and development and linking to academic departments**

A network of contacts of public health specialists with experience in particular areas of research and development in trusts should be developed as a resource. This would include experience in utilising research, implementing research and development, and involvement in training or teaching programmes. Contact points should be established and this could become a resource accessible through the Faculty.

### **Action Point 3: Hospital and the public health role – linking with medical directors and clinical directors**

Links between public health specialists and medical and clinical directors should be strengthened through common training and competencies.

A business case should be developed for public health skills interests, based on financial and business benefits, to give some hard examples of how public health can potentially be cost effective. A public health lead should be identified for every trust. This should be taken forward by trusts in conjunction with the British Association of Medical Managers.

### **Action Point 4: Hospitals and the wider public health system**

Appropriate levers need to be used to ensure that trusts play their part in the broader public health agenda, eg. tackling health inequalities. The role of inspection needs to include public health engagement and a scoping exercise should be carried out. In addition hospital trusts could work as partners within public health networks to encourage joint working and integrate services.

### **Action Point 5: Healthy, sustainable hospitals**

Strong cohesive leadership from government is needed, championed by the DH, to make sustainability an important part of hospital agendas and to ensure that it is a core part of hospital performance management.

### **Action Point 6: Role of public health in service redesign and modernisation in hospitals**

Joint appointments between acute trusts and primary care trusts (PCTs) should ensure public health commitment in secondary and tertiary care.

### **Action Point 7: Health protection**

Infection control is a major public health issue through which a more strategic public health view can be developed. Infection control needs to have standards and performance targets which would give a very strong public health message to trusts.

### **Action Point 8: Public health role in mental health trusts**

A strategy is required to identify opportunities for creating more public health posts in mental health trusts, including the training of the mental health workforce in public health skills. There is a need to increase knowledge and awareness within public health of the mental health agenda and the contribution public health can make to it. Opportunities for collaboration between the Royal College of Psychiatrists, public health observatories and the Faculty on the inequalities agenda in mental health should be explored.

## Opening introduction:

**Ms Melanie Johnson, MP**  
**Minister for Public Health**

The title of this conference today is 'Public Health in Hospitals'. I would like to invite you to think about what 'public health *through* hospitals' might mean, with hospitals as part of the wider mission of the whole NHS system to improve public health and to reduce health inequalities.

Sir Donald Acheson's often quoted definition of public health as 'the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society' evokes the knowledge and the skills, and the collective efforts that are required for improving and sustaining the health of the population. In this respect hospitals have an important role to play on a micro and a macro scale in that societal effort for health gain.

When this Government came into power in 1997 it made it clear that improving health and reducing health inequalities were key priorities. This was highlighted in the White Paper *Saving Lives: Our Healthier Nation* which recognised the role played by both 'health settings' and local communities in promoting health.

The White Paper also set challenging targets for reducing deaths from the big killers: cancer and coronary heart disease. The NHS Plan further committed Government to achieving the first ever national inequalities targets on reducing infant mortality and area-based life expectancy gap.

The key question for us is how do we achieve and sustain improvements in public health. How best can we cut heart disease? How best can we improve cancer survival rates? How best can we reduce infant mortality? How best can we prevent infectious diseases? And, indeed, how best to tackle the inequalities in health overall that blight our nation.

Significant strides have already been made – with deaths from cancer falling by over 10% and deaths from coronary heart disease by 23% (from the 1995–1997 baseline). Teenage pregnancy too, although still the highest in Europe, is beginning to fall and the introduction of the meningitis C vaccine has also reduced deaths by 90%. NHS staff can feel proud of their contribution in actually achieving these.

Of course there are new challenges always waiting round the corner to keep us focused on public health: the re-emergence of TB in the developed world, the rise in sexually transmitted infections, especially among young people, and the increase in obesity with its risks of heart disease, diabetes and cancer.

But whether old or new, health problems are often concentrated in the poorest communities. As Sir Donald Acheson reported – poorer people get sick more often and die earlier. Although the average health expectancy and healthy life expectancy is improving, the health gap continues to widen and this is just unacceptable.

Good health is fundamental. It is about life chances and fulfilling potential, and an essential building block of well-being and this is what we should be aiming for and making universal.

*Tackling Health Inequalities – A Programme for Action* launched by John Reid in July 2003, emphasises this Government's determination to tackle health inequalities and to place it at the forefront of its thinking and action.

But Government cannot act alone – it needs the support of a wide range of stakeholders contributing to economic, social and environmental interventions to make a difference. This requires co-operation and a partnership approach to make change happen.

Hospitals have for many years been crucial to the nation's health. They are among the oldest and arguably the most successful of all human institutions. They symbolise our collective social willingness to care for others and their existence holds a symbolic and emotional value independent of their function or their effectiveness.

Our vision for their mission and purpose in the 21st Century needs to move on. Hospitals need to continually change, both to meet our changing expectations and to improve.

Indeed, there are few more significant centres of activity within local communities than the hospital setting – with its patients, outpatients, visitors, professional, administrative and manual staff – and in the environment of many hospitals, a growing commercial sector with shops and catering facilities serving the whole hospital community.

Primary care has captured the attention lately, but secondary and tertiary care – principally through hospitals – still consumes the major part of the healthcare budget.

We will always need hospitals to deliver disease treatment and to care for those who are ill – but we must also seek to maximise the outcomes of this investment in hospitals on health – the real goal of the health system.

NHS Hospital trusts are ideally placed to make an important contribution to tackling health inequalities. All trusts should ensure that service modernisation narrows health inequalities – and does not inadvertently make them worse.

Trusts have a specific role in the achievement of the national Public Service Agreement target for health inequalities which calls on us to narrow the gap in infant mortality across social groups. Trusts can support this by:

- providing high quality midwifery, obstetric and neonatal services;
- reducing smoking in pregnancy, and focusing on paternal smoking;
- promoting increased breast-feeding initiation and duration rates among low income mothers;
- effective education about the ways to promote health, for example immunisation, infant sleeping position etc.

As major providers of healthcare, trusts are perfectly placed to work across care pathways – with the whole of the local health community – to make an impact on the health inequalities agenda.

Health equity auditing is an important tool that trusts can use to make sure that health inequalities are properly reflected in their service delivery. By using postal code, ethnicity data and other means, they can identify areas or groups which have high needs and are suffering poorer health outcomes, and take action to address these – by spotting differential rates of access in areas of high deprivation, or groups who present at the later stages of disease progression, for example. This information can support service improvements, such as improving prevention and screening services in particular areas or for particular groups.

Also, we know that people from disadvantaged groups are more likely to present at Accident & Emergency Units. Trusts' involvement in effective, targeted and innovative action to tackle specific problems or to support those who may have difficulty in accessing services should result in a reduction in demand on A&E Units.

NHS trust hospitals also have to focus on the pressing public health issues within their own walls. Hospitals have to be places where people's health and well-being are paramount – and where the spread of infection is minimal. Effective infection control is essential. This is particularly so for infections acquired as a result of healthcare. Although hospital acquired infections can derive from a number of reasons – the fact that up to 30% could be avoided – that is 30% too many. Infection control has to be an integral part of the public health measures pursued by any hospital. Steps have been taken such as the:

- Controls Assurance Standard requires chief executives of acute trusts to ensure effective control procedures;
- performance indicators on infection control procedures and MRSA improvement score which contributes to the star rating of NHS trusts;
- review visits by the Commission for Health Improvement – which includes assessment of infection control procedures; and
- Hospital Cleanliness and Patient Environment Assessment Team visits – where improvements have been made – but further intense action is required.

Hospitals also have a key role in promoting health, both as a centre of activity, and also as a centre for opportunity, and that is exactly the setting for a 'holistic' approach to health. The World Health Organisation (WHO) has developed a Health Promoting Hospitals Programme and a European network of National Networks for Health Promoting Hospitals now exists. But we need to build on this. Health Promoting Hospitals have to make a planned and systematic commitment to a comprehensive process of organisational development to 'release' their capacity to improve health – as well as to treat disease. The WHO Programme for Health Promoting Hospitals in Europe has also recently developed a set of European WHO Standards for Health Promoting Hospitals with the help of the Health Development Agency. These standards have been 'piloted' by a number of respondents and hospital sites in England and across Europe.

*Key announcement: the Health Development Agency and the Government Office North West are collaborating to establish a post in the National Healthy Settings Development Unit. It will be based at the University of Central Lancashire in Preston to support and develop this work in England.*

Hospital-based NHS expenditure can 'add value' to existing NHS investment in the wider public health through systematic consideration of sustainable, social and economic outcomes. This is a key issue for Government and an important strategy for reducing inequalities in health.

Reducing waste, traffic, pollution, energy consumption, water use and food are all examples of sustainability objectives that have very obvious connections to health improvement. These all function as early interventions to manage the population's exposure to health risk in relation to the primary causes of heart disease, cancer, asthma and many other 'downstream' diseases. It is now time for NHS trusts to ensure that the historically unmanaged and unintended effects of their activities are recognised and addressed in the interest of the wider public health agenda.

Finally, investment in arts is important for promoting health and well-being. Our society is richer for the arts which also provide an important means of cultural expression. It is therefore important that they play a part within the wider health system. The arts in the hospital environment can be used:

- as a component in rehabilitation and for their therapeutic value;
- for improving the physical environment of hospitals;
- directly contributing to health education and promotion work;
- as a learning and training tool;
- for social engagement of staff, patients and visitors and the wider community. For instance: Alder Hey Hospital has set up an arts for health project with an Arts for Health Group which meets regularly. The activities include:
  - a newly formed staff choir which hopes to produce a CD in the new year,
  - play therapists from the children's wards are collaborating with the Tate Gallery Liverpool in a range of creative activities;
  - development of a creative arts strategy for the new oncology unit with funds from the NHS Estates;
  - linking to Liverpool's City of Culture status.

So I hope that hospitals will consider how they can develop this aspect of health enhancement.

This conference has made an excellent first step to draw together the various strands of development underway to ensure that hospitals contribute to the public's health as well as to their disease treatment. I look forward to seeing the continued modernisation of the role and function of hospitals in England and the expansion of their public health role.

## Key points from presentations

### Paper 1: Public health in NHS trusts

**Sir Liam Donaldson**

**Chief Medical Officer, England**

The first senior house officer (SHO) posts in public health [community medicine] were established in Leicestershire in an initiative I began in 1981. In the northern region in the 1990s I created a tranche of posts for medical care epidemiologists in hospitals. Regional funding was provided and bids made by trusts in the region. If there was a weakness, it was that the posts created had an initial job description but the context and content of the work was not properly fleshed out.

In the early days the progress was driven by skills and individuals rather than an agenda or framework. The public health agenda needs to be properly scoped and defined and developed. The challenge for public health is to try to establish it in acute trusts across the country.

#### **What is the scope of the agenda?**

Many of the areas initially addressed by those original posts were to do with enhancing the quality of clinical care. Promoting better outcomes of care was the purpose of the public health input. When teaching epidemiology to medical students the population agenda is strongly promoted, but the contribution of outcomes of care to the health status of the population is also important, particularly with the growing pool of chronic diseases. Public health in acute settings is now perceived as more mainstream public health business than it would have been ten, 20 years ago.

#### **What are the opportunities?**

*Evidence based clinical policy:* the cutting edge of clinical epidemiology is not just to promote and produce guidelines for physicians to use, but to challenge the fundamentals of clinical reasoning in scientific terms. Very few people are doing that in the UK and more of it is needed.

*Development of clinical governance:* a culture of clinical epidemiology promotes rational clinical decision making. The development of clinical governance is a holistic concept about trying to create the culture, system, support and facilitation to improve quality of care, assure quality of care and improve safety. Many of the public health personnel working at hospital level have majored in this important area.

*High quality information systems:* public health training and background give skills in the management and use of information, such as making information systems at provider level more population based, and moving more from lists to registers.

*Appraisal of health technology:* this is largely dealt with at national level, for example, through NICE and the Health Technology Assessment Programme, but the bedding-in of advice and reports at local level – and into local clinical teams – is a public health opportunity. There is a role for those with the right skills.

*Reduction of infection:* is an area in which microbiologists and senior nurses play key roles. Hospital infection and, in particular, anti-microbial resistance in hospital is one of the most important priorities for those monitoring improvements in the NHS. It is high on many people's agendas and public health needs to decide what role it can best play.

*Disease prevention:* thought needs to be given to what effective interventions exist and what is the scope and opportunity for public health approaches, including within the hospital environment.

*Pharmaco-epidemiology:* is a very specialist area of epidemiology and is an important but under-developed field. The national 'yellow cards' system is a start. A lot of information is collected on prescribing in primary care. Information on hospital prescribing is less easily obtainable and very little of this is systematically analysed from an epidemiological viewpoint. This important data needs to be more effectively utilised.

*Research:* the hospital is a laboratory for health services research.

*Green hospitals and 'greening' of hospitals:* a major subject of review and policy making in the late 1980s and early 1990s. Although there is a great deal of good work at international level, it needs to be re-energised and moved higher up the UK agenda.

*NHS as a corporate citizen:* the NHS in most localities is a major employer contributing to a high proportion of the domestic product of the local economy. There is opportunity to use the hospital to contribute to influencing the wider determinants of poor health and inequalities. The NHS needs to collaborate more with the wider community at a local level. Opportunities could be promoted for staff to contribute their experience and expertise to community projects so that the hospital genuinely becomes embedded in the community.

No individual public health professional working at hospital level can achieve, single-handedly, all of these things and one can argue for a public health team, with individuals within that team focusing on a particular area. The challenge is to produce a framework for public health in trusts as the basis of further development.

## **Paper 2: Public health in hospitals: a prerequisite for clinical excellence**

**Mr David Jackson**

**Chief Executive, Bradford Royal Infirmary**

To many senior clinicians and managers in the NHS the idea of a public health contribution to the work of an acute hospital is a contradiction in terms. Many professionals in public health may regard the acute hospital's focus on the individual patient as the antithesis of population health, and many professionals in acute hospitals have only a vague idea of what the specialty of public health covers and have no idea at all about what it can contribute to the work of an acute hospital. However, the experience in Bradford highlights the pivotal role of public health in quality improvement.

Public health is important for an effective and successful acute hospital: 25% of the population uses secondary care services every year and hospitals consume 50% of the NHS budget.

The public health role in Bradford Teaching Hospitals arose from a combination of need and opportunity. Like all acute hospitals in the mid 1990s the challenge was to manage clinical activity on a whole-hospital basis within tightening cost and activity envelopes. This required a very close dialogue with the medical staff and recognition on their part that individual clinical decisions have a direct and powerful impact on other specialties and also on the ability of the hospital as a whole to provide good services.

The creation of the public health post in the trust has led to critical appraisal workshops for trust board members to help them understand the evidence for clinical and policy decision making. The public health role is to:

- play 'honest broker' in dialogue between specialties and across primary and secondary care on the development of clinical guidelines and pathways;
- be the driving force behind many aspects of policy development, particularly around clinical governance and research and development;
- prioritise healthcare decisions by, for example, reviewing the cost-effectiveness of new drugs and new services in diabetes, stroke, lithotripsy.

Our aim is that whatever we do should have a significant and beneficial impact on patient care but it must have measurable outcomes. Clinical quality has to be the primary focus and, critically, it has to have this simple and singular purpose that unites all the healthcare professionals – to improve care for patients.

Analysis of the hospital's standardised morbidity ratio (SMR) and the causes of death in Bradford hospitals are now routine, as is the systematic implementation of known good practice and measurement of its impact on our SMR. Projects on reducing medication errors, reducing post-operative infection, reviewing the effectiveness of clinical observations, reviewing the care of the dying, analysing the effect of team working and the impact of aggressive HR policies are all taking place. The quality agenda is being tackled right across Bradford in primary and secondary care. We simply wouldn't have got this far – and we certainly couldn't continue with this ambitious commitment to the local community – without the contribution of public health.

### **Paper 3: Local public health**

**Dr John Wright**

**Consultant in Public Health Medicine, Bradford Royal Infirmary**

There is a very important role in public health in promoting cost effective practice evidence-based practice. A public health physician in a Trust may be teaching critical appraisal skills, promoting access to evidence, trying to challenge decisions that were being made without any evidence-base at all; working in consensus with primary and secondary care; being the 'honest broker'; but also systematically reviewing the evidence. A crucial public health role is reviewing the vast quantity of evidence and doing it on a systematic basis. It is not just about guidelines but also about their implementation. Locally we have developed our 'guideline escalator': we research into identifying the barriers to implementation, devise strategies to encourage implementation, and examine the characteristics of the guidelines and the settings and what health professionals do. Public health practice in hospitals is concerned with change management. This is a very powerful role for public health.

Audit is something that public health professionals feel very comfortable with, both methodologically in being able to undertake robust audit, but also in terms of familiarity with analysis and presentation of data. Audits of clinical interventions may not be seen by many as a public health intervention but they are very cost-effective and clinically effective.

The work which has come under public health in our Trust includes:

- reducing unnecessary deaths using control charts and control charts in quality assurance;
- combining clinical knowledge with that of epidemiology of pharmacology, as well as understanding the epidemiology of error (the human factor) in medication errors;
- reducing unnecessary delays and monitoring demand and supply through referral patterns;
- new service design and redesign of existing services;
- reducing inequality through monitoring access to services;
- developing the health promoting hospital with a real public health agenda;
- assessing health needs and matching services to these needs;
- promoting international health governance – raising awareness of global inequalities.

Public health has a lot of skills and we need to deconstruct these to review what aspects are important for acute trusts. Epidemiology is our science, but the evaluation of services as well as acting as change agents is very powerful. Being an 'honest broker' and providing an independent overview is also essential.

The key question is not about the added value of public health in hospitals – I think this has been established. The real question is how we establish this public health expertise in acute trusts. This can be done through appointing a public health professional in the hospital. Alternatively public health expertise can be promoted by public health professionals in PCTs. The barrier to external support is access, legitimacy, credibility and organisational influence. More fundamentally, the challenge is to promote the public health agenda amongst all secondary care staff so that everybody realises its importance.

## **Paper 4: All acute trusts need public health expertise**

**Dr Jane Collins**

**Chief Executive, Great Ormond Street Hospital for Children**

Public health expertise has been in the trust for about a year. The expertise was brought in because of the creation of a children's health partnership with three other trusts. Great Ormond Street, as a specialist hospital, only provides specialist care to very seriously ill children, and lacked the necessary public health expertise – an expertise that we shouldn't have done without for so long,

The real issue was finding the funding for getting public health into hospitals. Public Health, as defined by Sir Donald Acheson, is the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society. Hospitals have traditionally been part of taking that collective responsibility for health whilst at the same time being focused on illness. The expertise and core activities of public health practitioners are highly relevant to hospital practice as well as the community.

Some of the current issues for acute trusts include:

### **Changing needs and changing services**

Hospitals have not necessarily felt that they were there to meet the actual needs of the patient, in our case the child and family. Rather, that they were there to provide services which they perceived to be needed by the child and family. One of the things which has come out of the NHS Plan is to change this perception.

Hospitals are changing. The average length of stay for a child is now 23 hours. Shorter hospital stays and trying to get children home as soon as possible is as important to us as it is to our colleagues working in district general hospitals. There is more emphasis on community care with better survival rates for many conditions.

The advent of better neonatal intensive care for premature babies is leading to a greater instance of disability. With more children and, indeed, adults having chronic health problems we need to change how we deliver services to meet those needs.

One of the problems is the inequality of resources. Traditionally, the community side has been grossly under-funded. In paediatrics we have perhaps been slightly better off than in adult services in that there is a community paediatric infrastructure, but there are significant problems of resources. There are also inequalities in health between the rich and the poor. Having public health expertise in the trust brings a new perspective. Traditionally, as clinicians, the focus is on the individual patient in front of a clinician as opposed to thinking about the bigger picture. It is helpful to have people who can bring a population-based focus. It is relevant to patient care to place the child in their social context (such as education, ethnicity and religion). These are all important to a child's health and is an area not thought about nearly enough.

Many opportunities for health promotion are missed, especially for children with chronic conditions who attend the hospital. Having public health specialists to bring these issues to the trust's attention is incredibly useful. Particularly for children, but also for older people, the recognition and expertise in bringing cross-sectoral teams together is vitally important. Children don't live in hospitals, they live in a community and in that community they spend time going to school. Linking with education and social care, as well as the justice system (and a whole variety of other systems) is incredibly important.

## **Policy**

There is a great deal of policy which is relevant to acute trusts and public health. Public health brings to these policies the scientific, epidemiological, medical and sociological perspective. We have particularly valued the sociological perspective which we had certainly missed out on before.

Public health also brings expertise to allow analysis and implementation of policy so that when networks and partnership models are being developed, the ability to analyse the data about where children go to hospital, why they go to hospital, what services they need when there, how many need transferring for specialist care etc is expertise that public health can bring. It has been illuminating for the organisation to understand how policy fits within the wider political culture and the population it is serving.

## **Quality and the clinical governance agenda**

There is a rightful emphasis on quality and safety of the services provided, delivered against a background of rising expectations and increasing complexity of care. As a specialist hospital for children, we are sometimes seen as the place of last hope, and expectations are enormously high. Managing these can be extremely difficult. It is a challenge to provide high quality care when it is difficult to get staff with the right expertise, a difficulty throughout the country. We have the added challenge of the European Working Time Directive and the new Consultant Contract as well as meeting the increasing requirements for inspection. Public health specialists help fit all this together

## **Challenging the status quo**

The independent standing and ability of public health specialists to challenge the status quo is extremely important when one is trying to improve quality of services. Public health specialists focus on the needs and wants of those who use services as opposed to the traditional way of organising things around how best to suit the professionals. There is a real opportunity to contribute to quality improvement in developing evidence-based work and also implementing clinical effectiveness. The competencies of public health are of huge benefit to the many staff working at the coal face of hospitals, and presumably outside hospitals as well.

## **Research and development**

Within the organisation there is a need to evaluate the changes being made. Having public health skills in-house allows that to happen but this is an underdeveloped area. With the plethora of policy, how does one evaluate whether it has actually improved outcomes for patients and how do patients feel about it?

Public health professionals have a unique contribution to make in acute trusts across the whole range of services that they deliver. They are essential to effectively delivering the NHS Plan, and to evaluating and improving services, thus supporting us in tackling many of the issues faced by Great Ormond Street. In addition, public health has helped create a greater understanding of the rest of the world which is extremely important for the children who come to access services.

## **Paper 5: INCLEN: a successful international model**

**Professor Dick Heller**

**School of Epidemiology and Health Science, University of Manchester**

There is clinical practice and there is public health. Between these is what used to be known as clinical epidemiology, providing public health skills for clinicians to practice more evidence-based medicine. The International Clinical Epidemiology Network (INCLEN) was designed to help bridge the interface between public health and clinical practice by weaving together equity, efficacy and cost effectiveness in healthcare around the world.

INCLEN was started by the Rockefeller Foundation in the 1980s. Its main aim is to build and sustain institutional capacity, most often through training programmes, around the world. Hundreds of people, in many different countries, have been trained in this way. Now the goal is to increase the public health workforce by giving hospital clinicians research skills with a population orientation. The selling point to the hospital is the skills development in evidence-based medicine but the target is really to increase the public health workforce. The INCLEN model is based on the development of clinical epidemiology units in hospitals. Each unit has clinicians from different specialties trained in clinical epidemiology. These clinicians stay in their own clinical field but are also members of the clinical epidemiology unit. The unit is multidisciplinary and includes a statistician, a health economist, a clinician and a health social scientist. They perform research on common problems within the hospital or in relation to the health needs of the population with the aim of impacting on health policy.

Evidence-based medicine has thrived, research has led to policy change and teaching has been given to students and healthcare workers.

The question arises of whether a UK counterpart, a 'Public Health in Hospitals Programme', needs to be established, with the aim of training key clinicians and establishing units which link with the NHS and academic public health groups, in order to identify a research agenda and influence health policy. The clinical workforce needs more public health skills. What I hope is that the Public Health in Hospitals Programme will emerge with leadership from the Faculty, that it will establish and develop this middle ground between clinical practice and public health, helping to build evidence for both healthcare and population health.

## **Paper 6: Delivering acute service objectives: practical support from public health practitioners (focus on the Wirral)**

**Mr Frank Burns**

**Chief Executive, Arrowe Park Hospital, The Wirral**

### **Background**

The Wirral is a little finger of land that juts into the Irish Sea just south of Liverpool. It has a population of 350,000 people and includes some of the poorest and most unhealthy (as well as some of the richest and healthiest) people in the country. Difference in male life expectancy between the richest and the poorest parts of the Wirral is currently 10 years and rising. There are relatively high numbers of hospital beds and a generally high standard of general practice. There is also a very high number of emergency admissions.

There are 1,300 hospital beds and most clinical specialties are covered. There are 120 consultants and 5,000 staff. The budget is £170m annually in health resources and there are now two consultants in public health – one that has been appointed for some years and the other recruited recently as a joint appointment between ourselves and the local primary care trust.

Prior to the 1980s, clinical processes were a no go area for managers and administrators. Following this came the era of general management which saw increased tensions between managers and clinicians in the acute sector that lasted until the early 1990s when the notion of resource management (or clinical management) was developed. Clinical directors, and clinicians with management responsibilities, including financial and budgetary, were appointed. But the focus for managers remained on organisational effectiveness, with little attention paid to the question of healthcare delivery.

Shifting the organisation's focus to answering questions about healthcare delivery became the challenge.

Practicing clinicians are driven to distraction with targets and volumes of cases and it is difficult for them to analyse their practice in a detailed and sophisticated way. Resources need to be made available to undertake this analysis and to engage with the clinical community in the evaluative work. But the trust had never been concerned about the issue of resourcing the investment made in supporting financial management processes in the organisation. If you go to your friendly neighbourhood local hospital and ask them how much money they spend on monitoring, supporting, analysing and investigating their financial health you will get something like 1% of their spend. If you stand back as a chief executive of a hospital and think "well, I am spending 1% of my out-turn on supporting managers in understanding financial processes in making financial analyses and understanding efficiency on all those things", and at the same time compare that with the resources made available to the clinical community to understand the outcomes of their work, it is pretty embarrassing.

### **Clinical Practice Research Unit**

To address this issue, the Clinical Practice Research Unit (CPRU) was established in 1995, and a consultant in public health was recruited to lead it in 1997. More recently we have recruited a second consultant in public health to act as a joint director of the Emergency Care Network for the whole of the Wirral health economy. Our current investment in the resources deployed in the clinical governance processes for the trust is about £1m recurring. What do we do with this resource and how does this resource support the work of the hospital?

Clinical governance is vital for an acute hospital. It assures the trust that the resources are producing the best outcomes and that clinical management processes are focused on the clinical governance agenda as a mainstreamed activity.

The elements include:

- national confidential inquiries, including the national confidential inquiry into perioperative deaths;
- national service frameworks;
- improving outcomes guidance associated with the cancer plan;
- conclusions of the Commission for Health Improvement surveys of the quality of our clinical governance processes;
- learning points from serious complaints;
- a battery of clinical indicators that are generated in relation to the work of hospitals;
- outcome from audit;
- outcome from research;
- NICE guidance;
- national surveys;
- independent surveys of patient opinions;
- learning points from adverse incident reporting;
- conceded cases in litigation.

We have a commercial bench-marking company, CHKS and the information from that generates a lot of issues. This is the raw material for clinical governance.

There is an overwhelming number of issues to tackle and a process is needed. The CPRU keeps all this under review, assesses the implications of all of the inputs, and assesses the implications in terms of action required. It is very easy in a big organisation, where one is subject to overwhelming advice and guidance, to simply get buried by it. Creating the intellectual capacity in the organisation to put into practice the actions that some of this material requires is essential. This is the role of the CPRU who then feeds issues through to the Clinical Governance Executive (CGE). The CGE meets fortnightly and includes the chief executive, the chief nursing officer, the medical director and the director of clinical effectiveness. There is a director of clinical risk management (a recently retired surgeon), a director of information (a currently practicing colorectal surgeon) and the chief pharmacist is also involved. It is the role of the CGE to decide priorities for corporate action and performance manage this and to produce policies for monthly clinical governance meetings of clinical directors. The monthly meetings are where we mandate the organisation to adopt change in practice or change in policy or standards. In other words, mainstreaming clinical governance and mandating change of practice or change of policy.

CPRU is extensively involved in benchmarking and comparative outcomes. One very interesting piece of work they have recently undertaken is a qualitative research on re-admissions. This qualitative research showed the difference between statistics and the human stories behind those re-admitted – the vulnerable frightened people who don't feel safe at home.

The function of our public health consultant working in our CPRU is to encourage and inspire our clinical community to take data about their work seriously. For example, the clinical team profiles for consultant appraisal through the CPRU is being used to build organisational confidence in data quality, building up an organisational interest in the importance of data quality and the potential power of good quality data.

The CPRU also looks at service model redesign, including examining care pathways:

- the care pathway in myocardial infarction we developed has increased on a sustainable basis the referrals for cardiac rehab from 40% to 90%;
- high profile targets include door-to-needle thrombolysis times and core-to-needle thrombolysis times;
- like most other hospitals in this country our management of stroke patients was historically very poor. They were scattered over the hospital amongst a whole range of specialties depending on who was on take when they came in. We developed through the CPRU, a pathway that resulted in the establishment of an acute stroke unit, employment of stroke co-ordinators, specific rehabilitation services for stroke patients;
- implemented a deep vein thrombosis (DVT) protocol. We have moved DVT from being an in-patient model to an outpatient model of care and are now in the process of moving it into a primary care model of care;
- the pathway we have developed with the support of the CPRU on fracture neck of femur has produced strikingly low mortality rates and this has led to collaborative work with another community;
- care system redesign: as a chief executive it is good to be able to rely on solid pieces of evidential analysis to make proposals for service change that might be contentious. Certainly in terms of children's beds, which began as a properly managed pilot scheme for hospital at home service, but which is now rolled out following evaluation. On the back of that we were able to make proposals to reduce the number of children's beds, which is not a popular thing to propose as far as the local community is concerned but we were able to propose it because we had the evidence-base of a properly evaluated pilot to demonstrate that we didn't need them anymore;
- the emergency care network: huge resources devoted to unplanned treatment in both primary and secondary care, with scope for service redesign and service integration to reduce the number of doors through which people pass on their way to their ultimate form of care. We are looking to this exercise to deliver substantial improvements in patient experience.

CPRU provides a solid organisational hold on research and audit and ensures that these are commissioned and delivered. It is responsible for the proper management of research portfolios; providing practical help and support for individual research projects; developing research skills in the organisation, and ensuring compliance with research governance frameworks, especially in important areas such as proper consenting, documentation, presentation of protocols for ethical approval and approvals for the resources that research consumes.

### **The importance of public health specialists**

The acute sector change agenda is about winning hearts and minds of the clinical community and especially the consultant community. Hospital clinical staff may well be resistant to change but, irrespective of this, they are entitled to expect that the case for changing the service model, or changing their practice is supported by credible evidence presented to them by credible and competent professionals. Evidence from my organisation and from public health specialists working in my organisation shows that our clinical community sees public health specialists as objective, analytically competent and reliable, who will produce analyses and proposals that they can rely on and trust. Our clinical community find that public health specialists don't simply tell them what they need to do and then leave them to do it, but actually work with them and provide practical, credible support.

Public health consultants are driven by evidence and data rather than by conventional wisdom. They are clinicians themselves, knowledgeable across systems. They have a role in the big agendas of acute organisations working with the rest of the health and social welfare economy. We need to use our economic and commercial leverage to support the inequalities agenda. But whilst this is important, we also have an agenda to see that the care we give our patients is the best possible given current knowledge and available resources. We find that we are immensely assisted by the input of our public health consultants.

## Discussion paper:

### **A review of MFPHM Part II competencies and RITA portfolio practice areas in relation to public health training in secondary/tertiary care NHS trusts**

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#### **Context of this document**

This paper is produced in response to a Faculty of Public Health initiative to explore the RITA competencies that can be met from training placement or attachments to NHS (secondary/tertiary) trusts or in respect of work with the secondary/tertiary healthcare sector. The paper's aim is to help inform relevant discussions on public health in trusts. The paper draws on experience in public health training from several sites in the Northwest, Midlands and the Northern regions. The paper partially refers to a previous paper produced by several public health practitioners and trainees working in secondary/tertiary care NHS trusts, produced in the summer of 2002 in response to a consultation by the Chief Medical Officer's office.

#### **Background**

##### *The relative importance of healthcare for population health*

While the provision of effective and efficient healthcare is only one of the many determinants of population health, it ought not to be overlooked. Although healthcare has had little influence in the dramatic improvements in longevity observed between 1900 and 1950, it has been argued that it can be credited with nearly half of the improvement in mean life expectancy observed since then [1]. The relevance of healthcare for population health is likely to further increase due to developments in health technology, and the emphasis on quality and effectiveness in contemporary healthcare provision.

##### *Previous and ongoing initiatives*

Two consultations by the Chief Medical Officer on the development of the public health function in the acute healthcare sector were conducted previously, one in 1998, co-ordinated by Dr Jenny Carpenter, and another co-ordinated by Dr Fiona Sim in 2002. Recently, and independently of the present consultation, the Faculty of Public Health expressed a renewed interest on the subject. This is reflected in recent publications in the Faculty's newsletter [1,2] and journal [3,4]

#### **MFPHM Part II competencies and training in public health in secondary/tertiary care trusts**

Although preparation for any exam does not constitute the 'essence' of any training programme, the importance of 'compatibility' of public health training in secondary/tertiary care NHS trusts with project work suitable for Part II ought not to be overlooked.

The four Part II competencies are:

- to assemble, review critically and interpret the published literature (and, where appropriate, other sources) on a particular topic;
- to use epidemiological and/or other approaches to describe the health status or healthcare needs of a defined population and, where appropriate, to identify environmental or personal factors which either threaten or enhance health;
- to identify and obtain relevant information and show how it can be used to plan health services or other activities aimed at improving health;
- to assess the effectiveness and efficiency (resource requirements) of health services or other activities aimed at improving health.

We believe that it is eminently possible for a public health trainee to address any of the above competencies through project work relating to a secondary/tertiary care NHS trust. In relation to the literature review, possible themes may include health technology assessment, clinical and/or cost-effectiveness of novel or proposed interventions or services, and facets of healthcare not fully covered by national service frameworks (but in relation to them).

In relation to the description of health status of a population or health needs assessment (HNA), this may easily lend itself to HNA projects for services that are of population relevance (and, often, population basis) but are by their very nature concentrated in secondary/tertiary care. Such projects may, for example, include HNA for critical care facilities for adults and children, emergency services (trauma or medical) and specialist commissioning interventions (eg. from cochlear implants to cardiac surgery).

Secondary/tertiary care NHS trusts are organisations rich in clinical information through hospital episode statistics (HES) data, and also data collected routinely for clinical purposes (eg. laboratory data) and performance management (eg. Department of Health performance indicators, national and local quality audits). Similarly, secondary/tertiary care NHS trusts are under constant pressure to develop (or re-develop) services. The above make addressing the 'information for planning' in this environment easy.

Lastly, secondary/tertiary care NHS trusts are, in general, very active in assessment of effectiveness and efficiency, through audit and other activities, and again addressing this competency does not pose a problem.

### **RITA portfolio competencies**

It has been argued that training in all ten core elements of public health practice can be addressed through working in a secondary/tertiary care NHS trust [3]. The table below, adopted with modifications from the previous reference, summarily presents the potential for public health work in secondary/tertiary care NHS trusts.

### **Need and potential for public health training in secondary/tertiary care trusts, by core competency**

	Degree of need and potential
Surveillance-assessment of the population health	++
Promotion-protection of population health	++
Quality and risk management within an evaluative culture	+++
Collaborative working for health	++ / +++
Developing health programmes and services for reducing inequalities	++/ +++
Policy and strategy development and implementation	+ / +++
Working with and for communities	+ / +++
Strategic leadership for health*	+ / +++
Research and development	+++
Ethically managing self, people and resources	+++
+ some need/potential for public health training	
++ considerable need/potential for public health training	
+++ great need/potential for public health training.	

*\*Including 'change management'*

It has to be borne in mind that there is no 'ideal' setting for public health training and even at a given primary care trust, the potential for public health training may be limited for some of the ten core competencies. Similarly, training in public health in more 'specialist' settings (such as communicable disease surveillance units, health promotion units, community development units, academic organisations etc) may equally be unable to address the breadth of all the core competencies during a short period (eg. one year). These issues are best addressed with 'complementary' experience through appropriate rotation planning during the five-year (full-time) duration of a training scheme. There is positive experience by public health trainees in secondary/tertiary care NHS trusts successfully completing competencies through RITA reviews.

## Conclusion

There is high compatibility of public health training in secondary/tertiary care trusts with both the MFPHM Part II exam competencies and the ten core (RITA) competencies of public health. Developing the public health function and training in secondary/tertiary care should concentrate on the general organisational, support and career prospects aspects of public health practice and training in this environment, as previously covered in response to the Chief Medical Officer's consultation[6].

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6 The response of a group of Public Health Practitioners in relation to the Chief Medical Officer's consultation process on the public health function in acute and mental health trusts. August 2002. Unpublished document, August 2002.

## **Appendix: The common features of current NHS trust public health roles as agreed at the conference**

There is no single public health function within an NHS trust or confirmed place in the trust structure. Most posts have been developed on an individual basis and postholders have developed their roles once in position. Public health professionals are, therefore, located in different directorates and with a range of titles. The key to success in the role is having corporate credibility with managers and clinicians alike and to be supporting the trust in delivering its key functions and/or targets.

The key roles of public health were summarised as follows:

### **Clinical governance**

- Clinical audit strategies
- Performance management
- Clinical governance, CHI and accreditation visits
- Risk management
- Appraisal

### **Development of strategies**

- Service development and implementation of strategies, such as national service frameworks

### **Clinical effectiveness**

- Evidence-based approaches eg. before introduction of new therapies
- Evaluation

### **Research and Development**

- Mapping research output
- Interpreting results
- Facilitating and conducting research
- Facilitating collaborative links with academic departments and other organisations

### **Leadership role with trust clinicians**

- Acting as a bridge between clinicians and managers including utilising understanding of how the organisation/NHS works as well as the financial system
- Facilitating change management/being prepared to challenge
- Supporting the medical/clinical director functions

### **Using technical public health skills**

- Analysis and interpretation of information to inform decision-making and determine priorities

### **Training and teaching**

- Contributing to undergraduate and postgraduate training of students and doctors
- Contributing to multidisciplinary development of a range of health professionals
- Providing training and project opportunities for SpRs/trainees and specialists in public health

### **Independent role**

- Perceived lack of bias by managers and clinicians

**Patient and public involvement**

- Advocacy and empowerment role
- Techniques of engagement

**External role**

- Interfaces with PCTs
- Links with commissioning

Published by:

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Email: [enquiries@fph.org.uk](mailto:enquiries@fph.org.uk) • Website: [www.fph.org.uk](http://www.fph.org.uk)

Registered Charity No: 263894

ISBN: 1-900273-10-1