Public health and primary care collaboration – a case study

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Summary
This paper describes the approach of one total purchasing project (TPP) to health needs assessment (HNA) and identifies issues that require consideration when undertaking HNA in primary care. It discusses the advantages of adopting a Health Authority (HA) HNA strategy and the development of a decision-making process for implementing this and other strategies to address possible areas of identified need. The prerequisites, advantages and potential difficulties of this approach are highlighted and related to the needs of primary care groups (PCGs) for addressing health needs and population health.

Keywords: public health, primary care, health needs assessment, strategy

Introduction
Recent changes in the National Health Service (NHS) place increasing responsibility on District Health Authorities (DHAs) to demonstrate that purchasing and provision of health services is related to the health needs of the local population. The development of fundholding allowed some of the purchasing function to be delegated to practice level. With the advent of total purchasing pilot projects (TPPs), this purchasing function expanded and with it, the requirement to undertake health needs assessment (HNA) of the population they serve. The intention of the White Paper The new NHS and the Green Paper Our healthier nation to place more emphasis on primary care, with the development of primary care groups (PCGs), and public health means that HNA must become a core function of primary care.

In this context, and throughout the rest of the paper, HNA is used to encompass not only the various approaches for assessing the health needs of a population but also the concept of a public health approach to improving health, that is, looking at the population as a whole. HNA is taken to include: those patients who do not access health services; the development of strategies for promoting well being; reducing inequalities; making decisions about priorities; providing a quality, evidence-based treatment and referral service for ill patients; and influencing the provision of quality and accessible secondary and tertiary care services.

However, few practices have experience or expertise in approaching the health of their patients or populations in this way. Health visitors, who are trained to consider health in population terms and to undertake HNA in a structured way are not often used for or encouraged in such activities. There may be insufficient public health skills in primary care, therefore, to deliver the Government’s agenda set out in Our healthier nation.

The Government now sees public health as a vital component for improving the health of the population and reducing health inequalities. The Chief Medical Officer’s review of the public health function and The new NHS advocate closer working relationships between public health practitioners and those working in primary care.

This paper discusses some of the practical questions associated with developing HNA and a public health approach within primary care. It describes one TPP’s attempt and identifies the factors critical for success. The potential difficulties are highlighted and related to the requirements of PCGs for developing an approach to HNA and population health.

Setting
Kiveton Park is a semi-rural community to the South West of Rotherham in South Yorkshire. The practice serves a population of about 10,000 people and has five full-time general practitioners (GPs) and a well-developed primary health care team (PHCT). The health profile follows that of Rotherham, though it tends to be slightly better than the Rotherham average.

Method
A commitment to undertake HNA was one of the requirements for achieving TPP status. This was the spur for requesting public health involvement in the practice. Thus, the local Department of Public Health was asked by the Health Authority and the practice to provide advice and support in this endeavour. There is an even greater imperative now for PCGs to develop
a public health perspective to their approach to improving the health of their populations.\(^1,2\) The practice suggested a series of meetings between the author, a member of the Department of Public Health, and one of the GP partners to discuss how the practice might undertake HNA activity. This partner was given time during the working week to devote to TPP business.

The first meeting consisted of a discussion of HNA and the practice’s vision for primary care within Kiveton Park. This vision was to see the practice as a valuable resource for the local community by providing care in a way that went beyond just reacting to presenting illness. Discussion centred on how services provided by the practice could translate into greater health gain for its population.

The ways in which the Department of Public Health might contribute were discussed and included:

1. provision of and guidance in the use of routine data at practice level;
2. assistance in the investigation of health concerns identified through the daily contact between health care professionals and members of the community;
3. provision of information concerning effective interventions and best practice from current literature;
4. provision of the skills and training for the PHCT in the areas of HNA, analysis and interpretation of data, strategic planning, multidisciplinary working and so on.

There was also a frank discussion about the possible ‘hidden’ agendas of public health and the HA in terms of directing and controlling the practice. It was made clear that the HA was fully supportive of the vision of the TPP for primary care in Kiveton Park and the role of the Department of Public Health was to advise and support the PHCT in their endeavour. This cleared the way for developing a trusting partnership between the Department of Public Health and the PHCT.

### Health needs assessment

At the second meeting, a broader discussion took place regarding a public health approach to primary care and the number of different approaches available for assessing the health needs of a population.\(^3\) This discussion raised the following issues:

1. How should needs be identified?
2. How should priorities be decided? Members of the PHCT may identify several issues.
3. Who would be responsible for making priority decisions?
4. Having selected one area for special attention, what happens to those issues not selected?
5. Identification of problems from current workload may exclude those not presenting to the PHCT.
6. For any one PHCT, the number of patients with any specific medical condition is relatively small and the effort required to improve care may be considerable.

7. Data available at the level of Local Authority Ward or Health Authority may not be meaningful when applied to primary care level.
8. The wider perspective of the health of the community may be missed or ignored if HNA concentrates on a specific medical problem.
9. The time, cost and training required for HNA, e.g. rapid appraisal, may be considerable.
10. The danger of raising expectations for improvement within the community which the practice may not be in a position to meet.
11. The problem of sustaining a project over a period of time in terms of staff enthusiasm and commitment, if work is additional to an already heavy workload.
12. The availability of time, personnel, skill, knowledge and financial resources within the practice and access to external help.
13. The need to develop local ownership and multidisciplinary working.

As well as these issues, a number of other criteria were identified for HNA to be meaningful and acceptable to the PHCT. These included: involvement of the whole practice team, integration of HNA into the ‘routine’ work of the practice, provision of early positive gains to maintain enthusiasm and HNA should also lead to worthwhile health gain for the community.

### Adopting a Health Authority strategy

The local Department of Public Health had been instrumental in the development of a number of health strategies for the Health Authority. These covered a wide range of conditions including coronary heart disease, diabetes, maternal and child health, and disabilities. Each of the strategies included estimates of the size and nature of the problems and ways of tackling them from a primary prevention standpoint through to treatment and rehabilitation, as appropriate. The different agencies and personnel required to implement the strategy were also identified. Thus, many of the concerns identified earlier could be satisfied by the simple expedient of adopting one of the HA strategies and adapting it for implementation at the practice level.

The strategy chosen was that for coronary heart disease (CHD) and stroke. This had additional advantages:

1. commitment, involvement and enthusiasm could be expected from the whole PHCT, as they would know they were tackling a major cause of ill health in the community (one GP and practice nurse were already working on improving care for patients with CHD, the standardized mortality ratio (SMR) for CHD in Rotherham was 125 (25 per cent above the national average)\(^9\) and CHD was a priority for Health of the Nation (HoN).\(^{10)}\).
The strategy contained several smaller, well-circumscribed tasks within the main project. Execution of these could give more immediate results indicating improvement in practice (e.g. ensuring all post heart attack patients were given the opportunity to receive aspirin and beta blockers). This would encourage the team, given that many of the intended outcomes may take many years to be evident. Such smaller tasks would be valuable in themselves, even if the total concept failed.

An intervention strategy would not require development from scratch.

As many of the elements of the strategy involved direct patient management, much of the work could be integrated into ‘routine’ practice activity.

However, questions concerning priority setting, workload and resources still remained. This led to the second suggestion for developing a process for decision-making.

Organizational structure

A number of criteria were seen as essential for effective decision-making. These were: that it represented the wide spectrum of views from the PHCT; there was an effective working group to ensure implementation of the strategy; and there was a means of allowing other recognized health needs of the practice to be brought for consideration by the PHCT.

It was evident that implementation of such a decision-making process would require a new organizational structure within the practice. This led to the development of the management structure model set out in Fig. 1.

The ‘steering group’

Composition

The steering group comprises representatives of the PHCT – doctors, practice nurses, midwives, district nurses, health visitors and administrative staff. A project officer for HNA had already been appointed by the practice. Representatives of public health and health promotion were also included. Other people helpful to the project were to be co-opted as necessary. At this stage, lay representation was not considered and Local Authority involvement was seen as being co-opted as necessary within the working groups. (With the advent of PCGs, this may change.)

Function

The steering group would

1. be a focus for the PHCT to present other identified health needs for assessment; the group would determine whether to pursue these and, if so, identify appropriate resources;
2. use reports from the working groups to identify resource and commissioning issues; it would liaise with the Contract Monitoring Group (this group liaises with the HA over contracting and commissioning issues);
3. deal with any difficulties that may arise in implementing the projects;
4. determine priorities for tasks identified by working groups necessary for implementing their projects;
5. discuss other issues, for example, communication within the practice and with the public;
6. provide an overview of the projects and determine priorities of others identified by the PHCT;
7. manage the workload of the practice and co-ordinate HNA and strategic development of health care for the practice population;
8. monitor, audit and evaluate the projects.

The working groups

Composition

The working groups comprise a GP, a representative of public health and other members of the PHCT as appropriate for each project. Four or five members were seen as optimum for efficient working.

Function

The function of the working group was essentially to be a project group responsible for investigating the problem
identified for HNA. This would entail developing a strategy for addressing the problem and identifying the tasks, personnel and resource implications of doing the work. It would also be responsible for ensuring the project was completed within agreed timescales and for evaluating the activity.

Next steps
The two suggestions – adoption of the HA strategy for CHD and stroke and the development of a new organizational structure – were presented first to the GPs, who readily supported them. This was followed by the first meeting of the proposed ‘steering group’. The process and the thinking to date were shared and the suggested approaches were readily accepted.

The steering group agreed to meet at three monthly intervals. The first working group for CHD and stroke was established and was followed, after the first three months, by the establishment of a group concentrating on improving services for young people.

Factors critical for success
For the Kiveton Park TPP, HNA was seen as an essential tool in informing their commissioning strategy. This strategy is intended to facilitate their vision of both providing high-quality health care locally and developing the primary care centre as an integral part of the wider health resources of the community. This vision allowed the ready acceptance of a public health approach to population health. Other practices may not be so community or population orientated and the development of a public health approach may require much more groundwork before it is accepted.

The high degree of motivation within the PHCT allowed the adoption of a ready-made health strategy based on one of the HoN target areas. This approach overcame many of the problems of either determining priorities of different competing suggestions or undertaking a formal HNA within the practice.

Ownership by the practice was very important. The initial practice-centred approach was fundamental in fostering this and crucial to all that happened subsequently. It allowed the practice to articulate the benefits, as it saw them, of TPP for the Kiveton Park community. It enabled the Department of Public Health to develop an understanding of the relationship of the practice with the community. It also set the context in which both HNA and the relationship between public health and primary care could operate.

The adoption of a ready-made strategy meant that action on the interventions could be started immediately, without waiting for further information gathering. This was important, in that some changes occurred fairly early in the project. These provided encouragement for the PHCT to continue with the longer-term aspects of the project.

The practice identified a number of skills required if the project was to succeed. Some of these were present within the PHCT but others were lacking. These include:

(1) Skills or resources in the practice:
- data collection and collation – with good computer search and retrieving facilities;
- negotiating skills;
- quality monitoring;
- established relationships with providers.

(2) Skills or resources required:
- HA support for data about health problems in the wider context of Rotherham – so that commissioning would not occur in isolation and lead to increased fragmentation of health care provision and more inequity, within Rotherham as a whole;
- communication with the HA concerning problems with service provision, so that evidence can be collected and used to improve the situation;
- increased collaboration with the departments of health promotion and public health;
- training in the use of statistics, use of information and research skills;
- resource allocation so as to develop as a commissioning agency with a strategic approach to health care.

Potential difficulties
Despite the motivation of the TPP for HNA and its contribution to their vision for primary care in Kiveton Park, the immediate concerns were contractual, organizational and financial, as these aspects had deadlines to coincide with the starting date of the TPP scheme. Therefore, discussion of health needs did not begin until these matters had been fairly well concluded. This pattern might easily be replicated during the formation of PCGs.

The difficulties of taking a comprehensive strategic approach to health problems in primary care mainly centre on resource issues. Two particular areas of concern are the need for closer collaboration with the local public health and health promotion departments and direct funding.

Although much has been written about the differences between approaches in primary care and that of public health and the suspicion of one with respect to the other11 this has not been the case in Kiveton Park. This may be due to several reasons. The initial approach from the Department of Public Health was to listen to the practice perspective rather than a ‘top-down’ approach.12 The personalities involved in the process developed a mutual respect for each others’ contribution to the process. The fact that the public health physician
involved had been a principal in general practice before moving into public health may have increased his credibility. However, in practical terms, if the same level of support is to be given to all practices, it is unlikely that small Departments of Public Health Medicine or Health Promotion will be able to sustain that within their current resources. Amalgamation of practices into PCGs may allow more efficient use of scarce public health resources. Throughout the paper, reference to the local Department of Public Health Medicine has essentially meant the consultants in public health medicine working in the department. However, there may well be a number of other people such as health promotion specialists, statisticians, epidemiologists and so on within any local department, HA, local authority or local university with public health skills who could be involved in supporting developments in primary care.

Funding is a major concern. Despite the intention to incorporate the project into routine work extra staff time was required. Some of this has been directly funded in terms of locum provision but some has been ‘donated’ by the staff by enthusiastically giving of their own time. However, for any project to be sustainable adequate funding is essential. For PCGs, with the establishment of unified budgets, this is likely to require release of resources by an imaginative approach to commissioning and decisions on the priorities for use of staff and in the allocation of funds for such things as prescribing, referral and other interventions. However, the development of a strategy to improve the care for patients, for example, with CHD or stroke, is likely to increase the need for resources, as ‘best practice’ will inevitably mean more intervention. Thus, there may be a need to discuss issues of dis-investment from other areas of practice activity.

The approach to priority setting, both in terms of what health care needs are to be addressed and what changes in service patterns will be required to fund these will be a major source of concern for PCGs. Primary care has always faced issues of priority setting in respect of time given to patients and in hospital referral. On the whole, these decisions have been ‘fudged’ by the use of waiting lists and waiting times. If a number of areas are suggested for HNA, some have to be chosen and others rejected on the grounds of time available to address them, rather than on grounds of need. How will practices handle this process?\textsuperscript{13,14} The support of public health in developing frameworks for decision-making and involving the public in such decisions will be essential.

Implications for PCGs

PCGs will need to develop a public health approach if they are to improve the health of their populations, rather than continuing to be just reactive to problems as and when they present. As umbrella organizations with greater resources than individual practices, they may well be able to work with the local Department of Public Health to develop effective and efficient use of this public health resource for the benefit of their populations. However, they will also need to develop the skills and knowledge within the PCG to undertake HNA and respond appropriately to the results. Therefore, resources will be required for future training needs. For the Kiveton Park project, acceptance and adoption of the Health Authority strategy on CHD meant that skills pertinent to HNA were not required to begin implementing the project. However, with evolution of this approach, such skills will be required. There will also be a need for access to routine information collected within the district as well as for developing ‘in house’ data collecting systems and access to the relevant national and international literature.

Local Departments of Public Health may be able to advise on the availability and appropriateness of courses but are unlikely to be able to provide the necessary training in house. They will certainly be able and expected to collect and analyse local health and demographic information in a form relevant to PCGs. Such information may include mortality and morbidity statistics, hospital activity and variations in these within the PCG area.

PCGs are also required to consult the public and become multiagency organizations. This should allow them, for example, to broaden the perspective of the ‘steering group’ by including social services and lay representation. This may affect the topics chosen for HNA.

Conclusion

As PCGs develop and become commissioning organizations the assessment of the health needs of their populations will be an essential component of their business. How they approach this task will have resource implications in terms of direct financial support, staff time and access to outside specialist support. It is also likely to raise a number of difficult questions with respect to organizational decision-making and priority setting. This paper describes one practice’s experience in coming to grips with some of these issues.

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