Editorial

Putting public health practice into primary care practice: practical implications of implementing the changes in Shifting the balance of power in England

Background

Over recent years the advantages of closer working between general practice and public health have been increasingly obvious. A series of reports have highlighted the need to create better and closer ways of working as well as the key contribution of practice members to important public health goals. For example, the Acheson report cited the contribution of health visitors to improving the health of mothers in the postnatal period. Public health specialists, general practitioners (GPs) and primary care teams all have a role to play in improving health, implementing National Service Frameworks and reducing health inequalities. The recent structural changes in the National Health Service (NHS), which place public health in Primary Care Trusts (PCTs), provide an opportunity to develop this relationship and to work with local communities to improve health.

New arrangements

The significant reference in Shifting the balance of power was that: ‘PCTs will be responsible for assessing the health needs of their local community and preparing plans for health improvement, which recognise the diversity of health needs. A strengthened public health function will be needed in PCTs to support this needs assessment and to ensure public health surveillance and population screening are carried out across local communities. In practice some of these functions may be delivered by PCTs co-operating through public health networks to pool resources and talent.’

Implementation of the changes was more fully described in a seminal speech by the acting public health minister, Lord Hunt. In the speech he spelt out the key elements of a public health service: each Director of Public Health (DPH) will be expected to ‘focus their activity on local neighbourhoods and communities leading and driving programmes to improve health and reduce inequalities – they will not be a remote, strategic figure – he or she will be well known, respected and credible with local people – particularly those in the most deprived communities, local authorities, general practitioners and other local clinicians’.

Public health teams will include amongst others health visitors, school nurses, interested GPs and practice nurses, and community development workers. The complexity of the agenda and the scarcity of specialist skills will need strong managed public health networks, the purpose of which will be to pool expertise and skills in specialist areas of public health which can then be available to all PCTs, to share good practice and manage public health knowledge and act as a source of learning and professional development that is locally owned and supported. The work of teams and networks will be structured as public health programmes.

These are significant cultural changes – but this shift applies equally to primary care professionals such as GPs ... the location of public health into primary care will change the way primary care currently thinks and works. For example, population-based approaches to health may be a new departure for some colleagues in general practice. The Appendices to the Shifting the balance of power documents spelt out more specifically the key elements of the public health functions PCTs and primary care staff within them would be expected to deliver.

Implications of the changes for practice

Our previous paper highlighted in general terms the possible implications for practice of activity in the areas described in Shifting the balance of power. This is further developed by considering six key areas in more detail, as described below.

Health surveillance, monitoring and analysis

One of the traditional areas of public health practice has been the production of an annual report on the state of the health of the population at whatever level a DPH or equivalent has worked. With the increasing availability of data public health specialists will be able to work with members of the primary care teams to produce reports on health and disease at practice and PCT level. Such data help us to understand the health needs of the practice population as well as signpost the priorities for action or resources. They will allow audit of practice and comparison with others in a systematic way, supported by the Public Health Observatories at regional level. Although general practices have produced annual reports of varying complexity for some years, there has been considerable variability in the use to which the data have subsequently been put. Increasing use of computerization, and improved clarity regarding the reason for the collection of data, will greatly facilitate the generation of valuable anonymized data. Public health reports will reflect local data on factors that have an impact on health – such as housing, crime and educational attainment. By working together in practices and PCTs GPs can help shape the community response to addressing inequalities, influencing local government and supporting the voluntary sector, as well as being aware of their Local Strategic Partnerships.
Investigation of disease outbreaks, epidemics and risks to health

Control of communicable disease is a key element of both general practice and public health practice. For example, primary care teams are responsible for delivering immunization programmes whereas the public health specialists monitor their uptake, highlight areas of concern and respond to outbreaks of infection. GPs rely on public health support in outbreaks of acute infection but also in treatment of disease such as tuberculosis. Although action in times of crisis, such as meningitis outbreaks, has often been exemplary, communication between public health and general practice has often been poor on a day-to-day basis. There are many mutual educational opportunities – each specialty needs to understand the other’s concerns and priorities, and this can only be to the benefit of the public’s health.

Health promotion and disease prevention programmes

The National Service Frameworks highlight the care pathway approach – starting with health promotion and disease prevention. For example, the National Service Frameworks for both cancer and heart disease are committed to reducing the harm created by smoking tobacco, diets low in fruit and vegetables, lack of physical activity and abuse of alcohol. Public health expertise can and does assist in providing evidence of effective interventions, organizing and supporting programmes delivered in practices; for example, the existing smoking cessation programme. GPs are typically very keen to help patients in improving their diet and exercise, and to encourage them to stop smoking – but are likely to lack time, even when they have the expertise. PCT-based initiatives can be of real value – whereas a single practice may be unable to provide expert help, a group of practices in a PCT may be able to provide an exemplary service. Providing data and analysis on uptake of screening programmes such as cervical and breast cancer is another illustration of public health support to general practice and the delivery of patient care.

Working with local communities to improve health and reduce health inequalities

Health is not just the product of health services nor does health care exist in isolation from other services.

Addressing inequalities in health may seem not to be relevant at a local practice level where the focus is on individual patient care. However, GPs and their teams have a key role in addressing inequalities. The NHS plan describes some key areas for activity. For example, smoking rates are higher in social class 5 than in social class 1. The rule of halves first described by Tudor Hart still applies. General practice teams who have targeted preventive activities on high-risk areas have found that this results in great benefit.

GPs and their practice teams can play a role in addressing inequalities through awareness of the health status of their population, targeting disadvantaged individuals with effective interventions but also engaging in the wider community; for example, as advocates for better housing and opportunities for employment. Public health specialists can assist GPs and their practices in developing working relationships with local government and voluntary sector colleagues.

Ensuring effective performance of health services

One of the key competencies of public health specialists is the ability to plan and support delivery of services. To do this effectively they need to work closely with clinicians in primary and secondary care, to provide an understanding of evidence of effective practice and support in making difficult resource decisions. In addition, their competency with data will support monitoring and audit. All doctors also need to recognize and understand the different priorities of those who work with individuals and those who work with populations, as the optimum outcome for both groups comes from close working. Without regular face-to-face discussion these different priorities are likely to be seen as insurmountable barriers, rather than as the source of doubly effective approaches to health problems.

Working with PCT clinical governance leads and PEC chairs, public health specialists can, through their competency with data, support monitoring and audit.

Putting the theory into practice

The examples described in these six areas demonstrate that there is already a public health element to general practice. Often what is needed is a clearer understanding that this is so, who else is involved and how public health specialists can support practice teams to deliver improved health. This will be a challenge to the new DsPH of PCTs and to the PCT public health teams. One way of approaching this would be to identify public health programmes to which all members of the health care team can contribute, and which all see as valuable. Options would be immunization, screening, preventing teenage pregnancy, promoting healthier diets and increasing physical activity. Each programme needs to be set in a context of needs assessment, evidence of effective interventions, service organization to deliver these interventions and ways of auditing or monitoring (performance monitoring) progress. If this explicit approach is agreed, including a clear understanding of who is doing what within what time scale, it will be possible to decide whether this is a practice task, a PCT task or a task for groups of PCTs. This networking concept is one which the Faculty of Public Health Medicine is actively promoting, and which the Royal College of General Practitioners would strongly support. Public health approaches involve close working with other sectors of the community – particularly local government and voluntary groups.

Public health teams will be closely linked to local councils, have a key role in local strategic partnerships and be able to ‘signpost’ for general practice colleagues how their patients can be referred to a broader range of services; for example, by working together to commission more services directly in practices such as debt.
advice or by signposting where to seek help on housing problems or access to local gyms. There are already many examples of this work in practice – but it needs to become the norm not the exception.

**Conclusion**

The purpose of this paper has been to highlight, through examples of these six areas of public health practice, the shared agenda that exists for GPs and public health specialists. Times of organizational change always have threats and opportunities. The structural changes can mean the loss of past relationships and ways of working together. However, by having public health based in PCTs there is an opportunity to work together in new ways, to work with communities to improve health of the practice and PCT populations.

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**References**