

The organisation and delivery of health improvement in general practice and primary care: a scoping study

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Scientific summary

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Background

This project was developed with an explicit focus on the delivery and organisation of health improvement activities in general practice and the primary health-care team. It was designed to examine who delivers these interventions, where they are located, what approaches are developed in practices, how individual practices organise such public health activities of general practice and how these contribute to health improvement through prevention and health promotion activities.

The aim was to identify the current extent of knowledge about the health improvement activities in general practice and the wider primary health-care team. The key objectives were to provide an overview of the range and type of health improvement activities, identify gaps in knowledge and identify areas for further empirical research. We mapped the range and type of health improvement activity undertaken by general practice staff and the primary health-care team based within general practice and undertook a comprehensive synthesis of the literature to identify effective approaches to the delivery and organisation of health improvement interventions in a general practice setting.

An initial review of the key literature identified two broad areas of concern with the current evidence base. The first was methodological. While there were a substantial number of research papers and reviews on health promotion in general practice, the focus was on the intervention. Very little attention has been paid to the way interventions are delivered or organised. The second was that many reviews draw on international evidence and this raises important questions about their relevance to UK general practice and primary care services. This review therefore focuses on the UK context.

Methods

We undertook a comprehensive search of the literature. We identified 16,791 papers and reviewed titles and abstracts to select potential papers to include in the review. This resulted in a pool of 1140 papers that were included for data extraction. Of these, 658 papers were selected for inclusion in the review, of which 347 were included in the evidence synthesis. We also had data from 45 interviews with practitioners. These included 11 general practitioners (GPs) and 11 practice nurses interviewed within the context of their practice, 16 Clinical Commissioning Group (CCG) board members (15 GPs and one nurse), three lay members and four public health specialists/consultants. In addition, two group sessions with GPs were held.

Findings

Little attention is paid in the literature to examining the impact of the organisational context on the way services are delivered or how this affects the effectiveness of health improvement interventions in general practice.

The focus of attention is mainly on individual prevention approaches for medical conditions related to preventing specific diseases such as diabetes or coronary heart disease, with practices engaging in both primary and secondary prevention. GP activity appears to be driven by specific contractual incentives and conditions. However, practice is affected by other factors such as peer pressure, relationships with public health departments, education and training. While direct incentives such as contract standards or the Quality and Outcomes Framework (QOF) do influence practice, GPs may be simply reacting to maximise their income and do not prioritise activities on those most in need. The use of thresholds can provide perverse incentives and there is some evidence that GPs use exception reporting to maximise their points score and income. While many GPs see health promotion as an integral part of practice, GPs generally do not take a population approach but focus on individual patients. There is little evidence to show that GPs undertake wider public health roles in terms of population surveillance beyond contractually defined screening and monitoring. For example, GPs address eye health for people with diabetes, but less is known about their wider role in screening for eye problems, chronic diseases and mental health or, for example, oral health in young children despite good evidence to support such a role.

Few high-quality studies were identified in key areas of primary prevention, except for smoking cessation services, where services to support quitting were viewed as effective. The evidence to support interventions for increasing exercise or reducing weight was limited, approaches in primary care and in schools have little impact and any benefit is generally only short-term. The cost-effectiveness of primary preventative lifestyle interventions is difficult to determine because of the diverse nature of the interventions (type and organisation, different target groups) and research methodology. Multiple risk factor interventions in primary prevention comprising counselling, education and drug treatments were more likely to be effective in high-risk groups than in the general population.

Advice from the GP is rated highly by patients and may be acted upon. There is some evidence demonstrating increased secondary prevention activity but provision is not as effective as it could be and, while the provision of secondary prevention can be improved by using specific disease management programmes, the optimal mix of their components remains uncertain. There is insufficient evidence to make clear decisions about the balance between universal, opportunistic and targeted health promotion interventions.

There is good evidence that practices have responded in different ways to incentives such as the QOF in terms of how they organise practice. There has been a shift to employing nurses and health-care assistants to do much routine prevention work. The QOF has also led to improved recording of the health status of patients in their practice. However, the focus on single disease risk factors has been widely criticised and can lead to a number of problems or skew practice to the neglect of non-incentivised areas of practice.

Recent reforms to the English NHS pose potential threats to the ability of primary care, and general practice more specifically, to deliver health improvement. Commissioning agencies need to urgently identify how services from primary care-based public health providers (midwives, school nurses, health visitors, etc.) are commissioned and supported. Thought also needs to be given to how health improvement activities funded through local contractual arrangements are continued and how local variations in funding and service delivery can be sustained. Developments in health improvement in general practice benefited from local negotiation and relationships with the public health departments in primary care trusts. Concerns have been raised about the ongoing links between public health and general practice since local authorities (LAs) took on public health responsibilities in April 2013.

Conclusion

We found that the evidence was mixed in terms of detail and methodological quality and that identifying sufficient information about the context and organisation of the delivery of health improvement interventions was very limited. Given this, undertaking any systematic approach to even a narrative evidence synthesis was not possible.

We highlight some key areas where there are strengths and specific shortcomings in the evidence. Further scoping work and specific research are required to understand the public health role of general practice and identify effective approaches to the delivery and organisation of health improvement in general practice and primary care settings.

There is currently insufficient good evidence to strongly support many of the health improvement interventions undertaken in general practice. There is some evidence to support specific interventions being undertaken with some patient groups and in some locations. Further research is needed to strengthen these areas to provide more supportive and clearer evidence.

What was the range and type of health improvement activity undertaken in general practice?

The range and type of activities undertaken in general practice is diverse and is affected by national policies and incentive frameworks. Areas incentivised by the QOF have become increasingly researched in the last few years, stimulating a growth in the number of studies, but these have been mainly focused on clinical, individual risk factors or diseases. The studies also tend to examine only a single parameter, such as the QOF incentive, rather than the broader context of the delivery of interventions, such as who undertakes the work. Research tends to be focused on a limited number of health behaviours and conditions seen as clinically important.

What evidence was there on effective approaches to the delivery and organisation of health improvement interventions in general practice settings?

Overall, we found that the evidence base is very limited. There is insufficient good-quality evidence to draw clear conclusions about many areas of health improvement practice in general practice. There is an urgent need to develop better-quality and more relevant research studies that examine the way interventions are delivered and organised to support continuing developments in health promotion and prevention that are being prioritised in policy and practice.

What gaps were there in the evidence base?

There is not just an absence of research, but also a lack of evidence for effectiveness (e.g. obesity/exercise promotion) and cost-effectiveness from existing research. In addition, much literature has a medicocentric focus and does not examine broader supportive roles or non-medical interventions. While there is a lot of research examining and exploring the views of professionals, few studies examine lack of evidence within the existing literature about issues such as professional roles, and where this is examined it tends to focus on their clinical role.

Similarly there is little research on the effectiveness of different approaches to shared decision-making or costs/benefits in different clinical domains. There is insufficient evidence that compares different ways of organising and delivering health improvement in general practice and primary care. More research is required that examines contextual issues relating to the patient and to local environmental and sociodemographic factors. These may be of particular importance in determining effective interventions with some patients and populations. There is a clear gap in the research related to some neglected population groups including, for example, teenagers, young/middle-aged men, and black and ethnic minority groups.

What are the priority areas for future research?

Research on health improvement in general practice and by the primary health care team needs to move beyond clinical research to include delivery systems. Research needs to be conducted in a primary care context to ensure that it is relevant and more likely to be transferred to practice. One important driver for primary care physician involvement in research is the need to improve quality of care, and more needs to be done to support the development of research within and by primary care.

Currently the major areas of research tend to be driven by clinical interest and there needs to be more discussion about the type and range of disease burdens in primary care – perhaps moving away from areas such as cardiovascular disease where rates are declining – to examining areas with chronic disease burdens: cancer, dementia and other disabilities of old age.

We found substantial numbers of cross-sectional studies examining patient and professional views but less research that examined what was being done and how. Further reviews could be commissioned that examine the whole prevention pathway for health problems that are managed within primary care, drawing together research from general practice, pharmacy, community engagement, etc. Studies are required that examine interventions in a specific condition (e.g. cancer), for a population group (e.g. older people) or an intervention type (e.g. welfare advice).

Implications for policy and practice

Policy

1. If more emphasis is to be placed on the role of general practice in public health, more consideration may need to be given to how to provide support for research within primary care and by primary care practitioners.
2. National policy tends to focus on key clinical issues, and interventions supported by incentives have tended to focus on individuals (e.g. the QOF). This can result in a skewing of activity, and consideration may need to be given to supporting alternative incentive structures.
3. Policy tends to focus on the narrow clinical role of general practice. This may result in a narrow range of activity, and local public health organisations and LAs more generally should consider how they support a wider concept of primary care.
4. Current changes in commissioning and the delivery of public health services may lead to less engagement with general practice on public health issues. Without clear guidelines and processes, gaps in communication and action may develop between LAs and general practice. Local authority public health staff need to be aware of the importance of maintaining close contact with GPs and other primary care staff.
5. Educational providers and commissioners need to consider professional development frameworks for primary care practitioners and consider what aspects of the public health skills framework should be incorporated in core curricula.

Practice

1. Local agencies responsible for public health need to be aware of the risks posed to service provision in primary care-based public health providers (midwives, school nurses, health visitors, etc.) by the new commissioning arrangement. Attention needs to be given to developing appropriate support structures.
2. NHS England, LAs and CCGs may need to consider how existing health improvement activities that have been funded through General Medical Services, Personal Medical Services and other local contractual arrangements can be continued and how local variations in funding and service delivery can be incorporated into the new systems and structures.
3. In the past, developments in health improvement in general practice have benefited from local negotiation and relationships with the public health department in the primary care trust. Concerns have been raised about the ongoing links between public health and general practice following the transfer of public health professionals to LAs, and maintaining and developing these links must be a key priority for public health services and CCGs.

Key recommendations for future research

1. More research needs to be developed that adequately reflects both the context of primary care and other settings where health improvement interventions are undertaken.
2. Research is needed that compares different methods of delivery and organisation; for example, comparing different locations as well as different delivery methods in order to determine the effectiveness of not just the specific intervention but also how it is delivered.
3. More research is required about the specific roles of professionals in primary care.
4. There is an urgent need for cost-effectiveness studies and research on the wider costs and benefits of health improvement activities in general practice and primary care.
5. More comparative research is required that explores whether different models of interventions, different professionals, or different locations are more or less effective than others.
6. Research is needed that examines 'neglected population groups' including, for example, teenagers, young/middle-aged men, and black and ethnic minority groups.
7. Further reviews should be commissioned that examine the whole prevention pathway for health problems that are managed within primary care.
8. Where relevant, consideration should be given to commissioning primary research.

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