Editorials

GP with an extended role in population health

How do we move from supporting sick individuals to creating healthy communities? Allen *et al*[1] recently laid out their vision of:

'... a near future where practices collaborate to share data and work alongside public health teams, patients, and local organisations to proactively engage with communities to make them more health-promoting places to grow, learn, work, and age. GPs would help identify modifiable determinants and support the development of interventions to address them.'

We propose a new workforce role that could help to make this vision a reality.

POPULATION HEALTH

Population health is the improvement of health and wellbeing, and the reduction of health inequalities, across an entire population. The King's Fund outlined four pillars for population health: wider determinants of health; health behaviours and lifestyles; places and communities we live in; and an integrated health and care system.[2]

The shift towards population health is part of a wider global trend. The World Health Organization's *Declaration of Astana*[3] and the unanimously adopted United Nations General Assembly resolution on universal health coverage[4] name the integration of public health and primary care as the main vehicle for delivering better health outcomes. Co-producing population-level interventions to promote health and prevent disease is becoming a central activity of primary care all over the world.

This fits with the social model of health that sees individuals holistically as part of their families, social networks, and communities. It leads us to ask, 'What keeps people healthy?' Rather than just 'What makes them sick?' New collaborations are forming to explore how to create healthy communities, for example, Wigan Council's Deal based on empowering people and engaging communities.[5] This gives a window of opportunity for primary care teams to co-produce health with their local communities.

> *"One GPwER* [GP with an extended role] *would combine clinical and population health roles, working across a population of up to 100 000 ... for half the week ..."*

PRIMARY CARE NETWORKS: A GAME CHANGER?

General practices are now coming together across England into Primary Care Networks (PCNs) serving 30 000 to 50 000 people.[6] This scaling up is new territory for many but builds on models of general practice at scale, in England and in Wales. PCNs have the potential to make impacts on population health through direct local action where they have control; and through advocacy where they have influence.

GPs see the impact that the determinants of health and the effects of poverty have through the narratives of our patients. We understand the human consequences of these. But staff overwhelmed by demand have little space for transformation. True co-production with communities represents a culture shift, requiring skill, time, and energy. Investing in leading these conversations could lead to potential win-wins to boost community assets while reducing demand on general practice, so the establishment of the National Academy of Social Prescribing (http://www.socialprescribingacademy.org.uk) is a welcome development. There is little value in social prescribing without thriving community assets to work with, so the spirit of co-production should develop with third-sector organisations embedded in communities and already delivering social prescribing.

> *"The interest in public health among GPs has increased, with a recognition of the value of public health skills in primary care. However, there are few opportunities to develop or formally use these skills."*

GP WITH AN EXTENDED ROLE (GPwER) IN POPULATION HEALTH

We propose that a dedicated population health lead GP should support PCN lead GPs, who are firefighting at the front line as well as carrying out the 'must-dos' required of the PCN elements of the GMS contract. One GPwER would combine clinical and population health roles, working across a population of up to 100 000 (maximum of three PCNs) for half the week, with a salaried GP post in one of the PCN practices.[7]

The key value of this role would be as a change agent, as interpreter of intelligence for action, engaging with communities on wider determinants and a driver for prevention (for example, programmes on immunisation, early years, and behaviour change). The impact is likely to be greatest in disadvantaged areas, with goals focused on reducing inequities in health.

The interest in public health among GPs has increased, with a recognition of the value of public health skills in primary care. However, there are few opportunities to develop or formally use these skills. Creating portfolio posts with GP and public health components would be attractive to GPs at the beginning of their career or experienced GPs wishing to stay longer in part-time clinical practice by combining with strategic roles. We would expect the PCNs to establish an appropriate relationship with the Director of Public Health, so that these GPs would engage actively with public health colleagues to align strategy and inform need assessments, planning, and commissioning decisions, and facilitate the two-way exchange of information for mutual benefit.

There have been many forays into public health roles in primary care. Notwithstanding the early integration of public health and primary care in the work of celebrated GPs such as William Pickles and Julian Tudor Hart, the King's Fund launched an experiment with 'community-oriented primary care' in the 1990s,[8]

"There would need to be clarity on the competencies required of this new role and the best way of gaining such competencies with accreditation and quality assurance."

Lambeth CCG employed a small number of embedded GP population health fellows in 2016,[9] and many 'Deep End' practices in Scotland and the North of England have created population health roles for GPs, including Glasgow's 'Pioneer scheme'.[10] Health Education England currently offers fellowships.[11] None of these have systematically created a standardised workforce role.

ACCREDITATION AND EVALUATION

GPs have a long history of taking on extended roles, for example, in dermatology and diabetes. These are now known as GPs with an extended role (GPwER). The Royal College of General Practitioners has developed a governance framework for future specialty-specific GPwERs.[12] The knowledge, skills, and competencies of this role could be mapped against the Public Health Skills and Knowledge Framework,[13] including leadership, quality improvement, and change management skills. There would need to be clarity on the competencies required of this new role and the best way of gaining such competencies with accreditation and quality assurance. Perhaps formal supervision arrangements with local public health teams could help to ensure quality and safety. Where GPs have dual registration in general practice and public health a part-time consultant appointment could be appropriate.

CONCLUSION

PCNs allow general practice to take more of a population health approach and evolve into true community-oriented primary care, with residents engaged in co-producing health and wellbeing alongside service providers. A GP with additional skills in population health could speed up progress and help deliver better outcomes. There are limits on what GPs can do about the wider determinants of health but scaling up through PCNs gives great opportunities to do much better than we do now, with the benefit of reducing the demand on healthcare services.

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