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Editorial

Public health networks and primary care trusts

Across England, a new type of public health organization is emerging: the managed public health network. These networks form a diverse spectrum of services, with only one clear thing in common – they are rooted in primary health care. Where have they come from, what are they for, and where could they go?

Background to the networks

Because public health expertise is dispersed across many sites and organizations, it is not surprising that the European Public Health Alliance has found 'opportunities for networking' are a priority. In England, Health Authorities handed over most of their responsibilities to the new, more numerous Primary Care Trusts (PCTs) in April 2002, including their local public health functions. Just before this transfer *Shifting The Balance Of Power*, the Department of Health (2002a) required that within the 28 areas of each future Strategic Health Authority (StHA) its local PCTs should share some public health activities across new systems accountable and responsive to these PCTs: 'Public Health networks will be designed "bottom up"'. Jessop (2002) suggests that a 'strong' network has: 'routine reports, regular meetings and rapid responses to queries'. Based on our collective experience in South East London, Essex and North East London, Watts, Rao and Caan (2002) made specific suggestions about public health networks, using the Football analogy of: 'a system of good leagues to build up its wider public health capacity'.

Lawlor *et al*. (2002) summarized public health activities in the old Health Authorities as: population health, planning and communicable disease control. Some continuity of functions will be needed in the new system. However, since *Saving Lives: Our Healthier Nation* in 1999 it has been clear that public health must become an integral part of primary care organizations. Professionals with specialist expertise have now begun 'working from a new organizational base' (Sim and Mackie, 2002). Most PCTs have not made robust arrangements for dealing with inequalities and public health and the recent consultation on tackling health inequalities (Department of Health, 2002b) revealed 'uncertainty about the future structure and capacity of the public health system'.

Across primary care, good inter-professional developments have been observed but these are very patchy. Unfortunately for the PCT frontline of the NHS, both traditional consultants in public health medicine and new public health specialists show 'a clear indication of development needs in areas of managing complex interpersonal relationships' (Health Development Agency, 2001), in other words, they lack skills in networking.

Public health networks abroad have arisen for a single function, such as the National Public Health Leadership Development Network in America and the common European masters degree project. One of the most remarkable networks (actively engaging over 2000 members since 11 September 2001) was set up by the US Centres for disease control and prevention (CDC) and the Office of Emergency Response (OER) to prepare for bioterrorism.

Prior to April 2002, UK networks were also set up in response to single issues, such as public health training. Issues like continuity of CDC or Population Screening became immediate concerns for our Essex Public Health Network, operating across 13 new PCTs.

What do we know about other types of network ?

Primary care was at the forefront of inter-professional research networks such as our East

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Anglia Research Network (EARNet) which operated between 1995–98. One of our early members, Nigel Starey, coined the term 'Primary Care Trust' for a King's Fund initiative that led eventually to ubiquitous PCTs. The democratic and egalitarian style of EARNet proved especially helpful in supporting Rural Health partnerships (Caan, 1997).

Rehabilitation services share some problems with public health, in that professionals become isolated and training and clinical governance systems are difficult to sustain. In an interagency, multidisciplinary, peripatetic training network, our Eastern Rehab Group aimed for a sustained impact on continuing professional development. In particular, it was event–driven, gradually creating a shared learning environment over the period 1997–99.

The wider social impact of specific health innovations (like networks) is poorly understood, especially in relation to the inequalities agenda (Caan, 2002). One promising model is the London Drug and Alcohol Network (Caan, 2001) involving about 350 agencies. Combining the public health activities of different professions and academic disciplines, in creative and innovative ways, is one of the key challenges for public health networks.

Within community care disciplines, there is a wealth of analysis of social networks. Given the growing importance in public health theories of social capital it is surprising that development of social capital for mutual aid, trust and esteem has not been described in relation to public health networks. However, given the top down organizational models described so far it may not really be surprising that features of social capital like reciprocity have not been prominent. One of the key weaknesses Elston and Fulop (2002) described in Health Improvement Programme collaborations was: 'HImPs appear to have focused on creating stuctures rather than developing aspects of partnership process.' Public health networks as professional organizations are likely to be highly sensitive to context, changing with time and space. The implementation and evolution of these networks is about to be evaluated nationally by the Health Development Agency.

Needs for knowledge

The plans for public health networks need to be signed off by regional directors of public health and their implementation monitored by StHAs. The knowledge base to assess networks' planning and performance has yet to be established. Some preliminary work for public health networks has been done (Royle, 2002), but this drew heavily on experience of clinical cancer networks. Across different StHAs, very different environments and public health resources may be present, and the rate of change may be constrained by different capacities in the evolving PCTs. The realist's question becomes 'What works for whom in what circumstances'?

Scope for innovative research

The NHS R&D programme for Service Delivery and Organisation (SDO) has made a priority of understanding change in primary care organizations. In 2001, the SDO review of the current evidence on managing organizational change identified alternative models of managed clinical networks as offering a future opportunity for naturally occurring experiments. The very diversity of fledgling public health networks in 28 StHAs enables a natural experiment to be evaluated.

For our new but struggling (nonmedical) profession of public health specialist to survive, it is vital that we are actively involved in shaping and sustaining these networks. PCTs employ health promotion specialists and health visitors, and many other crucial public health practitioners like school nurses and midwives. Will they find a welcoming and worthwhile home within these networks ? In the new and rigidly 'performance managed' system for public health, the networks provide the only potential for the emergence of democratic participation. How will the voice of local citizens be heard in the hubbub of building these new organizations ?

In several parts of the country involvement in Health Action Zone or Sure Start initiatives has led to spontaneous collaborative networks, generating *local* public health champions and also holistic models of case study evaluation. At a *national* level, can we draw on existing primary care knowledge of health champions and of interprofessional group learning, to plan for exciting and fruitful collaborative public health research ?

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