



Healthy Lives, Healthy People: Towards a workforce strategy for the public health system

Consultation document

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Healthy Lives, Healthy People: Towards a workforce strategy for the public health system

Consultation document

Prepared by the Public Health England Transition Team

Foreword

There are a wide range of skills throughout the public, voluntary and private sectors that, if coordinated, could make a sizeable difference to our health and wellbeing, and address health inequalities. How can the workforce that has influence on the health of our population help achieve this goal and make the progress we so badly need to address our big health challenges? What roles can and should the workforce play in the new public health system to make public health everyone's business? How can the personal resources of individuals be harnessed to promote wellbeing and enable people to make more informed decisions? At this time of change and challenge there are many opportunities to do things better.

We want your views on the consultation so we can identify and unlock the potential of the workforce that is linked by a commitment to improve population health and wellbeing. The workforce will be known for its professionalism and expertise, underpinned by access to high-quality evidence. The new education and training system will need to ensure that the workforce is skilled and prepared for the exciting roles they will be asked to undertake in the future. Public health will continue to be a rewarding career that will attract the best people who are ambitious to address the major challenges faced by our population now and in the future. These opportunities will be greatly enhanced for many staff by the major new role for local government in delivering public health. This will bring new and exciting responsibilities for many local professionals.

The Local Government Association fully endorses this consultation process and encourages councils to take part.

The subsequent strategy, which we plan to publish in autumn 2012, will be shaped by your views. The document will be updated regularly. Many thanks for your help with this.



Anne Milton
Parliamentary Under Secretary of State
(Public Health)



Sir Merrick Cockell
Chairman
Local Government Association

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Executive summary

The public health workforce is diverse both in the nature of the functions it performs and in the places it works. The current changes to the public health system will have a significant impact on the public health workforce and will lead to a new system of delivery that will need new skills and new ways of working. The changes provide an ideal opportunity to take stock and review what needs to be done to ensure that there are highly qualified and motivated people delivering positive public health outcomes, wherever they work and whatever their background.

This consultation is the first step towards developing a new public health workforce strategy that will help shape the public health workforce of the future. It will be a living document, regularly reviewed and updated. The consultation is aimed at a broad audience, reflecting the Government's view that public health is everyone's business. Each chapter of this document includes key messages, proposals and consultation questions. Case studies are included where appropriate.

This document does not attempt to prescribe a definitive way of shaping the public health workforces. Neither does it address specifically the transition issues that are associated with the transfer of staff from existing bodies to new ones. The detail on organisational structures, human resource (HR) issues (eg terms and conditions) and levels of employment in various locations are addressed elsewhere – some of which have been published, eg the HR Transition Framework¹ and the *Public Health HR Concordat*², with further documents on HR detail expected during 2012.

The aim of this work is to realise the vision of *Healthy Lives, Healthy People* through the contribution of public health workforces and the wider work of councils and communities. This document sets out proposals that aim to make the phrase: "Public health is everyone's business" a reality.

Leaders in the new public health system, such as directors of public health and consultants with specialist knowledge, must be capable and competent to act as independent professionals and understand how to unlock the potential of other workforces across organisational boundaries. There are many healthcare practitioners and others in the wider workforce who have undergone brief public health courses to enhance their skills. The voluntary

¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126234

² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131111

sector can offer skills that complement other workforces and operate from places that other services cannot reach. The role of the public and communities is also important.

Building on existing skills and developing new ones across all sectors is fundamental to an inclusive public health system. Harnessing the personal resources of individuals can enrich public wellbeing and enable individuals to make more informed decisions.

1. Purpose and vision

Key messages:

- the Government is clear that public health is everyone's business and the system reforms provide a real opportunity to shape the future public health workforce
- this vision must be linked to the public health, NHS and social care outcomes frameworks
- the contribution of the voluntary sector and community leaders is important and new ways of including their contributions to population health need to be identified and delivered
- this is an important new role for local authorities that presents a real opportunity for them to build on and use their knowledge of the wider determinants of health
- the right national and local systems must be in place to secure high-quality sourcing and training of the specialised public health workforce – with defined and measurable outcomes
- an agreed common terminology is required for the functions and roles used by various groups
- the first phase, addressed here, is to understand the current workforce, identify future challenges with particular emphasis on the supply and development of key personnel
- there are a number of areas where further work is needed, and any workforce strategy will need to be updated regularly.

Context

- 1.1 The White Paper *Healthy Lives, Healthy People* (November 2010) set out the Government's proposals for changes to the way public health is organised and delivered in England. Subject to Parliament, the new system will come into force in April 2013. This vision was reinforced in the policy update, *Healthy Lives, Healthy People: update and way forward* in July 2011. The update signposted a series of follow-up documents, setting out more detail of these new arrangements for public health, including:
 - the *Operating Model for Public Health England and The Role of Local Government in Public Health*³, published in December 2011
 - the *Public Health Outcomes Framework* published in January 2012⁴
 - the local authority funding allocations for public health
 - this consultation to inform the development of a public health workforce strategy.
- 1.2 Alongside *Healthy Lives, Healthy People*, a number of national policies influence the context for public health. These are referenced throughout the consultation document where appropriate.
- 1.3 This document describes the new arrangements for a training and education system for the healthcare workforce, which will be relevant for those who choose to undertake

³ <http://healthandcare.dh.gov.uk/public-health-system>

⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

specialist training in public health. These new arrangements are outlined in Chapter 5 and further detail can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132076.

The vision

- 1.4 *Healthy Lives, Healthy People* laid out a vision for the public health workforce (see Box 1). The Local Government Workforce Strategy⁵ laid out similar ambitions in its vision for a skilled, motivated, flexible and diverse workforce that makes a difference to the communities they serve. This consultation aims to build on that ambition.

Box 1. The vision for the public health workforce

We envisage that the public health workforce will be known for its:

- expertise – public health staff, whatever their discipline and wherever they work, will be well-trained and expert in their field, committed to developing and maintaining that expertise and using an evidence-based approach to practice
- professionalism – they will demonstrate the highest standards of professional conduct in their work
- commitment to the population's health and wellbeing – in everything they do, they will focus on improving and protecting the health and wellbeing of their populations, taking account of equality and rights, whether it be a director of public health in a local authority, an infection control nurse in an acute trust or a microbiologist within Public Health England
- flexibility – they will work effectively and in partnership across organisational boundaries.

What is the consultation about and who is it for?

- 1.5 This consultation document sets out a strategic vision for a workforce that will contribute to the future public health system. It signals the importance of building on the best but also the need to change and develop the workforce that contributes to public health in order to deliver in the new public health system. It highlights the new national relationships that will be needed to support training, leadership, development and tracking of the future public health specialist workforce.
- 1.6 The consultation document does not specifically cover organisational structures or human resources (HR) issues, as these are being addressed through the various HR frameworks

⁵ LGA Group. Delivering Through People. The Local Government Workforce Strategy 2010. www.local.gov.uk

and the *Public Health HR Concordat* that was published on 17 November 2011. Neither does the consultation prescribe a definitive way of shaping the public health workforce.

- 1.7 Skills requirements may change over time as the new public health system evolves. In the past, public health workforce strategies have been produced, on average, every 10 years. The speed of change in the workforce and wider society means that we must be more agile and look to review the strategy more regularly in order to support and develop the public health workforce.

Proposal: That when established, Public Health England reviews and updates the public health workforce strategy on a regular basis.

Consultation question: Do you agree that a public health workforce strategy should be reviewed regularly? If so, should this be every three years or every five years?

- 1.8 The development of this consultation has been undertaken in an open and transparent way and that will continue over the coming months. The consultation is aimed at:
- the professional workforces who operate fully or partly for and within the public health system in England
 - current and future employers (for instance local government, the NHS, social enterprises, the Ministry of Defence, the voluntary and private sectors) of the public health workforce
 - local policy makers who will help shape the continuing context within which the public health workforce will operate
 - professional regulators
 - educators, trainers and national organisations charged with ensuring the training of the current and future public health workforce
 - commissioners and providers of public health services, specifically groups who can contribute to public health from within health services
 - professional leadership of the groups who operate fully or partly in the public health system in England
 - community leaders whose work complements professional inputs.
- 1.9 This list is not exhaustive, but demonstrates the complex nature of modern professional public health. There will also be important associations with workforces such as social workers and education.
- 1.10 In building capacity and skills in public health, it is crucial that these workforces interlock and work closely with the NHS to achieve the best outcomes for the populations they serve, in a time of stretched resources. A key aim of a public health workforce strategy will be to promote a highly qualified, learning profession that is attractive to the best graduates, regardless of their profession.

The development of this consultation

- 1.11 In early 2011, the Department of Health established a Working Group to support the development of this consultation. The Working Group had input from professional and trade union bodies, national policy leads, local government, public health specialists and representatives of postgraduate training and education. The membership is listed in Annex A. There has also been wider engagement with a range of organisations, individuals and emerging bodies with a stake in developing workforces and making public health everyone's business.
- 1.12 Key workforce references, current and developing workforce strategies⁶, the most recent public health workforce strategy⁷ and other workforce guidance and strategies^{8,9,10,11,12,13,14,15} have also been taken into account.
- 1.13 The consultation document does not prescribe what the public health workforce should look like or who will be employed by which organisation, as these are matters for local determination. It is crucial that future employers should ensure that public health teams have the appropriate skill mix, training and ongoing continued professional development (CPD), with sufficient business support to deliver their functions efficiently and effectively. Ultimately, the aims are to ensure that the right national and local systems and relationships are in place to secure high quality sourcing and training of public health specialists, and that practitioners and the wider workforce have opportunities to develop their skills in public health.
- 1.14 The proposals in this consultation document apply to England, but the Department of Health will work closely with the devolved administrations on areas of shared interest.
- 1.15 A Consultation Impact Assessment has been published alongside this consultation document and the Department of Health welcomes any information or evidence that would help analyse the impact of the proposals contained in this document.

⁶ A national framework to support local workforce strategy development. www.dh.gsi.gov.uk/publications

⁷ Report on the CMO's Project to strengthen the public health function, 2001. www.dh.gsi.gov.uk/publications

⁸ Planning and Developing the NHS Workforce. London: COI, March 2010

⁹ LGA Group. Delivering Through People. The Local Government W Modernising Allied Health Professions Careers. A competence based career framework. London: Department of Health for England, July 2008
Workforce Strategy 2010. www.local.gov.uk

¹⁰ Health Visitor Implementation Plan 2011-15. Department of Health, February 2011

¹¹ Chief Scientists to the UK Departments of Health. Modernising Scientific Careers. London: COI, February 2010

¹² NHS Employers. Shaping a quality nursing workforce. www.nhsemployers.org

¹³ Working to Put People First. A Strategy for the Adult Social Care Workforce in England. London: COI, 2009

¹⁴ Allied Health Professions Federation. Specialist Clinicians at the heart of health. www.ahpf.org.uk

¹⁵ Modernising Allied Health Professions Careers. A competence based career framework. London: Department of Health for England, July 2008

2. The current public health workforce

Key messages:

- this document refers to the public health workforces to reflect the wide range of people who contribute positively to personal and population health outcomes
- public health interventions require better identification and description of the workforces involved at different stages
- it is also essential in a time of change to focus on sustaining the specialist workforce
- there is a real difficulty in understanding the shape of the public health workforce and this needs to be resolved
- public health specialist and practitioner workforce plans should be subject to quality assured enumeration to ensure and sustain the future public health system.

Defining the public health workforces

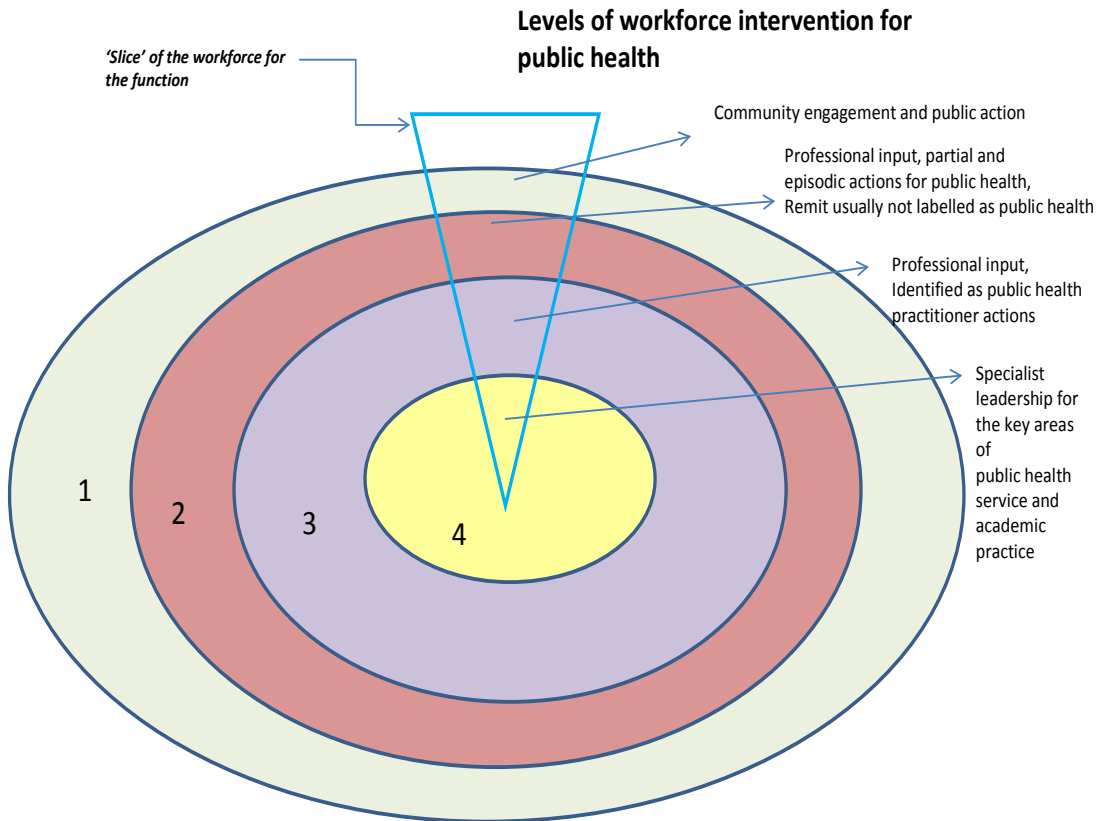
- 2.1 The development of this consultation has highlighted particular difficulties with the use of terminology, definitions and the identification of specialist practitioners and other professionals who may provide key elements of a public health local or national system. Any workforce strategy will need an agreed common terminology for the various functions that make up a public health workforce. This consultation is the start of that discussion.
- 2.2 Many critical roles in public health are carried out by people who are part of a wider professional network contributing at all levels of delivery from strategic leadership to provision of frontline advice. A range of clinicians and other professionals have essential roles to play in improving and protecting population health and reducing health inequalities. Figure 1 shows the varying levels of workforce intervention in public health.
- 2.3 A pragmatic and widely used way of describing the public health workforce was set out in a previous review of public health¹⁶ and has been used to help shape training¹⁷. The three broad workforce categories have been described as:
- Specialists: work as leaders, at a strategic and senior management level or at a senior level of scientific expertise to influence the health of the whole population or of a selected community. This group is usually registered with the Faculty of Public Health or the UK Public Health Register (UKPHR).
 - Public health practitioners: spend a major part, or all, of their time undertaking elements of public health practice. Typically, they may undertake prevention or promotion of health among individuals from selected or vulnerable groups, or from the whole population within a certain geography. Although explicit in their role, these elements may form only part of their overall role.

¹⁶ Department of Health (2001) *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*. London: Department of Health

¹⁷ Sim, F, Lock, K & McKee, M (2007) *Maximizing the contribution of the public health workforce: the English experience*. Bulletin of the World Health Organization, 2007, 85, 12 pp935-940

- Wider workforce: many more people have a role in health improvement and reducing health inequalities although they may not recognise this, including NHS clinicians, many key local government occupations such as teachers, social workers, people working in the criminal justice system, drug action teams, transport engineers, town planners, housing officers, and regeneration managers. This is not an exclusive list and many thousands more contribute to public health through their roles in society.

Figure 1: Levels of workforce intervention in public health



Note: Levels 2-4 can operate within one professional group.

2.4 A consultant in public health is part of a multidisciplinary, recognised European specialty with training standards and competencies set by the Faculty of Public Health. Public health consultants can be from medical or non-medical backgrounds, but all will have completed either an accredited training programme or will have been approved at consultant level via submission of portfolio evidence through the UKPHR. The current consultant workforce is mainly employed by primary care trusts, strategic health authorities, the Department of Health, the Health Protection Agency and in academic departments of public health. Smaller numbers are employed by NHS trusts, public health observatories, the Ministry of Defence, international organisations, businesses and social enterprises.

2.5 The practitioner workforce is not homogeneous and has been developing rapidly in recent years. The Department of Health Working Group concluded that the practitioner workforce could be divided into two possible groups: one that is moving towards a specialist public health role and another that remains within their own professional group (Table 1). This consultation provides an opportunity to reach consensus on a description of the broad groupings of the public health workforce.

Table 1. Four broad groupings of the public health workforces

Group	Description	Example job functions
Public health consultants and those training to be consultants	Consultants in public health medicine and specialists in public health who work at a strategic or senior management level or at a senior level of scientific expertise to influence the health of a whole population or of a selected community. Likely to see public health registration as their primary profession. Includes those seeking registration through portfolio submission (defined specialists) for public health specialists	Public health specialist Consultant in public health medicine Public health consultant Director of public health Specialist registrar in public health Consultants in health protection Professor of public health/academia/research Consultants in dental public health Consultant public health microbiologist Infectious disease consultant Epidemiologists Communicable disease consultant Medical toxicologists
Specialist public health practitioners	Those who spend a major part, or all, of their time in public health practice (and recognise this as core to their own separate professional discipline that is not called public health). Usually have some postgraduate qualifications in public health and may seek to register as public health “practitioners” with the UK Public Health Register.	Environmental specialists Health promotion Health visitors School nurses Occupational nurses Specialist commissioning experts Drugs and alcohol liaison nurses Sexual health nurses Health intelligence and information/analytical support Radiation protection specialists
Practitioners with some public health component to their work	Public health is a key or dominant part of their role, but they would not necessarily recognise public health as their primary professional discipline. Likely to have received elements of public health training through primary professional qualification route.	Smoking cessation and behaviour change practitioners, district nurses, speech and language therapists working in schools or training the early years workforce, obesity/community child health dietitians, occupational health physiotherapists, exercise specialists, radiographer working in screening,

		housing officers, arts therapists in schools, health trainers, podiatrists, paramedics, pre-reg. academics, midwives, drug workers including those working in the criminal justice system, community pharmacists, dentist, GPs, environmental health officers
Wider workforce	Most people, including managers and clinical staff in the NHS, have a role in health improvement and reducing health inequalities although they may not recognise this or have received any training “badged” public health.	Teachers (non-specialist eg PSHE), adult education providers, social workers, business leaders, voluntary sector and community leaders, transport engineers, town planners, housing officers, regeneration managers, leisure centre staff, prison officers, police and fire officers, customs and immigration staff, retailers, pharmacists, healthcare assistants, personal trainers, health professionals in hospitals (private and public) and other settings, pharmacy staff

Consultation question: Are these four groups a useful way of describing the public health workforces?

Public health workforce data

2.6 The most recent Faculty of Public Health workforce census¹⁸ identified just under 1,000 individuals working UK-wide at consultant level in public health and related areas in their primary posts, at a coverage of around 10 per million population. The Faculty of Public Health census drew data from the NHS Information Centre on all public health staff employed under Agenda for Change in the NHS. In 2007, just over half that total workforce was in health promotion roles. This pattern is likely to have changed already with the formation of transformed community services.

2.7 Information on consultants in public health is collated as part of medical specialty planning, collected by the Centre for Workforce Intelligence¹⁹. The Centre for Workforce Intelligence supply forecast is for 575 full time equivalents (719 headcount) of medical consultants in public health by 2018, an average decrease of 3.5%. However, this modelling does not take account of the multidisciplinary nature of public health training, or the additional numbers of consultants and defined specialists that may arise from postgraduates pursuing registration by the portfolio route²⁰. There is a need to improve

¹⁸ Health. Specialist Workforce in the UK. Faculty of Public Health, 2008.

¹⁹ Sharpe P. Recommendations for medical specialty training 2011. Department of Health, Centre for workforce Intelligence, August 2010.

²⁰ The portfolio route is an accredited route to registration in the speciality of public health by the UK Public Health Register.

this modelling to take account of all those who have completed the specialist public health training programme.

- 2.8 There is good data available about the workforces currently in the organisations whose functions will transfer to Public Health England when it is established in April 2013. The major component is from health protection, which consists of a range of different specialties including for example, microbiologists, infectious disease consultants and epidemiologists.
- 2.9 Data is less informative and reliable for most of the practitioner workforce. While NHS data generally provides information about the numbers in various professional groups such as scientists, nurses, allied health professionals and doctors, it cannot distinguish the nature of their work and does not therefore identify those whose main role is in public health.
- 2.10 The proportions of local government pay by pay negotiating group in 2009/10²¹ were: teachers 35%, police and police support staff 15%, firefighters 2% and other local government staff 49%. This “other” group includes professionals who are discharging public health functions, eg environmental health officers and health improvement staff.

Workforce modelling

- 2.11 There has been no modelling of supply and demand for the future consultant and practitioner workforces for the purposes of this consultation and, in the short term, it is not possible to do so. Modelling requires in and out flows, to which data can be applied to understand where the points of pressure are and what options there are to grow or contract a workforce over time – but one also needs a model that indicates what the “right size” is. This information is not available at this point of transition.

Conclusion

- 2.12 Although there is some good data on some public health workforces, it is not possible to quantify the whole public health workforce. To ensure the new system is able to deliver against the Public Health Outcomes Framework, it will be essential to have better data and a deeper understanding of the shape of the public health workforce to enable workforce planning and development across the new system.

Consultation question: Do you agree that methods of enumeration of the public health consultant and practitioner workforces should be scoped and piloted at a national level? Or do you think that workforce planning can take place effectively at a more local level, eg LETBs working with local partners?

²¹ <http://www.communities.gov.uk/publications/corporate/statistics/financialstatistics212011>

3. Challenges and opportunities

Key messages:

- the values that bind those who work for population health require greater recognition
- the future offers potential for more multi-disciplinary, cross-professional working and well-defined skills escalators, with the aim of creating a culture of public health in communities and organisations
- progress is needed in intervening appropriately at different times during the life course²² and maximising the opportunities to make “every contact count”
- the NHS must continue to identify and act on its contribution to the health of the populations it serves; and essential public health skills must be retained to deliver the public health agenda throughout transition and into the future
- Public Health England will have a significant workforce function to build capacity in its own workforce and to support sustaining high-quality public health workforces in key sectors
- a good outcome will be to empower communities with skills for health to increase their own resilience and social capital
- the strategy arising from this consultation will promote equality of access to public health careers at every level.

Introduction

- 3.1 Public health prides itself on being at the forefront of current and emerging health and wellbeing issues that are likely to impact on the population. Historically, many public health challenges have been unforeseen such as the advent of human immunodeficiency virus (HIV), severe acute respiratory syndrome (SARS) or the impact of global migrations. These have often required an immediate response using public health skills and knowledge while an evidence base for interventions is developed. Other public health issues have required decades of ongoing championship, such as the battle to reduce tobacco and alcohol related deaths.
- 3.2 The development of the public health workforce must consider not just the immediate needs for the workforce, but also the longer-term issues likely to influence the skills and knowledge necessary for an effective public health function. Structures will be required in order to identify and develop leadership and expertise across the range of public health disciplines. This is discussed further in Chapter 5. A skilled public health workforce operating within a culture that supports and motivates will be essential to ensure the health of the population is maintained and improved both during transition and under the new public health system.

²² an individual's passage through life, analysed as a sequence of significant [life events](#), including birth, marriage, parenthood, divorce and retirement.

3.3 The return of key public health responsibilities to local authorities will provide a range of challenges and opportunities. Local authorities, as democratically accountable stewards of the local place, are ideally placed to shape services to address the needs of the locality and to drive health improvement in their communities. In particular, they will be able to bring to bear their knowledge of the local community to tackle the wider determinants of health.

Values of public health workforces – common goals to improve health of the population

3.4 The features of contemporary public health in the UK are set out in Box 2. This underpins the established definition of public health as “the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society” used since the Acheson Report in 1988²³.

Box 2. The features of contemporary public health

- population based
- emphasises personal and collective responsibility for health, its protection and disease prevention
- recognises the key role of the state, linked to a concern for the underlying socioeconomic and wider determinants of health, as well as disease
- works on an inter-disciplinary basis
- builds partnerships with all those who contribute to the health of the population
- enables equality in access to public health as a career at all levels.

(From Beaglehole, R and Bonita R, Public Health at the Crossroads, Cambridge University Press, 1997)

3.5 The development of the new public health system provides an opportunity to review and redefine the values of the public health workforce. A common culture of expert high performance will be required to support and develop leadership and talent across the workforce.

3.6 In the new system, the public health workforce will work across many organisations, and to different outcome frameworks. Given the challenge of working in this way, the question arises as to whether a common set of values and behaviours based on similar goals can engender a sense of common purpose among diverse workforces.

²³ The Report of the Committee of Inquiry into the Future Development of the Public Health Function, HMSO 1988

3.7 The principles behind ethical public health can be seen in the four principles put forward by Beauchamp and Childress in *Principles of Biomedical Ethics*²⁴.

These can be paraphrased as:

- beneficence – the importance of our actions improving health and wellbeing
- non-maleficence – the importance of our actions not causing harm
- autonomy – respecting the individuals right to make their own choices
- justice – respecting the rights of all individuals to be treated with fairness and equality.

Consultation question: Would these values, combined with the features of public health in Box 2, serve to bind together dispersed public health workforces? How helpful or unhelpful is it to have a single vision and set of values for the public health workforces?

International literature on public health workforces

3.8 In the future, the ability to work across national borders will become increasingly important given the global nature of health. The World Health Organization (WHO) has produced an interim draft *Strengthening Public Health Capacities and Services in Europe: a Framework for Action*²⁵. The draft framework includes several areas for improvement including:

- organisational structures for public health services
- assuring a competent public health workforce
- improving health outcomes through health protection operations and services
- improving health outcomes through disease prevention operations and services
- improving health outcomes through health promotion operations and services
- strengthening regulatory frameworks for protecting and improving health
- developing research and knowledge for policy and practice.

3.9 In England, Public Health England will be in a good position to undertake a capacity building role working closely with Health Education England, key stakeholders in the NHS and local authorities, and with the devolved administrations where appropriate. Public Health England will also need to ensure the development of leadership potential and promote training and standards in the workforce.

3.10 Like many other expert professionals, such as surgeons, lawyers and accountants, public health experts and leaders are rightly expected to exhibit high levels of expertise and professional behaviours. Training and professional development can give the new employing organisations (such as local authorities and Public Health England) confidence that the expert advice and leadership they receive is the best.

²⁴ TL Beauchamp and JF Childress; *Principles of Biomedical Ethics*, OUP, 6th edition 2009

²⁵ Moreno JMM, Kluge H. Strengthening public health capacities in Europe: A Framework for Action. <http://www.euro.who.int/> WHO Office for Europe, September 2011. Last accessed 16 November 2011.

Equity and equality

- 3.11 Over the last 50 years, there have been significant improvements in health; people from every class and region are healthier and living longer than ever before. Unfortunately, not everyone is able to share the benefits equally. It is essential that everyone is empowered and encouraged to do so. The Government has made it clear that tackling health inequalities is a priority, with a determined focus on equity and fairness. Everyone should have the same opportunities to lead a healthy life, no matter where they live or who they are.
- 3.12 The Marmot Review of health inequalities in England²⁶ detailed how a wide range of socio-economic factors help to determine health outcomes of the population. Reducing differences in health and wellbeing outcomes between richest and poorest is one of the greatest public health challenges. Understanding the need to support and, where necessary, intervene at different times during the life course and maximising the opportunities to make “every contact count” is key to addressing these inequalities in health. A workforce that is representative of the community will be better placed to grasp these opportunities.
- 3.13 Equality legislation aims to prevent unfavourable treatment, promote equality of opportunity and foster good relations in relation to certain protected characteristics for both recipients and staff who deliver services. In addition to maximising the impact the public health workforces can have on health inequalities, it will be important to ensure that there is equality in access to training and education for CPD at all levels.
- 3.14 The Equality Act 2010 applies to public bodies and those undertaking (discharging) public functions, to employment, policy making and service delivery. The Act protects everyone from discrimination. It frames these protections by way of a range of “protected characteristics”. These are marriage and civil partnership, pregnancy and maternity, disability, race, religion or belief, sex, age, gender reassignment, sexual orientation and discrimination by association. A new protection of discrimination by association also means the Act has introduced a new protection for carers. Full details of the Act can be found at <http://www.legislation.gov.uk/ukpga/2010/15/contents>. However, the recruitment of a truly representative workforce, with equal access to opportunity does not merely comply with legislation. It has benefits in terms of developing solutions to public health issues through harnessing differing ways of thinking and problem solving.

Consultation question: What further actions would enhance recruitment and retention of truly representative public health workforces?

²⁶ Fair Society, Healthy Lives: The Marmot Review, 2010. www.ucl.ac.uk/marmotreview

Future public health challenges

- 3.15 The ageing population and increased prevalence of long-term conditions will change the health needs of the population. This will require changes to the services commissioned by health and social services. In addition, many traditional areas of public health concern, such as tobacco use, alcohol consumption, drug misuse, cancer, cardiovascular disease and sexually transmitted infection, will continue to require new thinking and innovative approaches. There is an obesity epidemic in the population that is affecting both adults and children and will require action on the individual, community and societal level.
- 3.16 The NHS is currently facing rising demand for services within a challenging financial position. Effective public health interventions can help reduce the level of need in populations, reducing the demand for NHS services as a result of avoidable illness or exacerbation of condition. Helping people remain healthy, and focusing on prevention, will be an important aspect of ensuring the longer-term sustainability of the NHS.
- 3.17 There will be continuing threats from emerging and re-emerging diseases as well as those already known. In a global society, the speed at which these threats can travel is greatly increased. Other issues related to health protection include increasing anti-microbial resistance; health risks arising from climate change; infectious causes of chronic diseases; threats from terrorism; advances in vaccination; chemical, biological, radiological and nuclear hazards (CBRN); and emergency planning, preparation and resilience (EPPR).
- 3.18 Local authorities will need to ensure that the NHS receives the public health advice it needs. This means that the local authority public health workforce at practitioner and specialist levels must continue to have skills and experience across the three domains of public health.
- 3.19 The public health workforce will continue to need specialised knowledge and skills for both commissioning and service delivery. This development will build on the current skill base, which emphasises the importance of, for example:
- academic public health
 - assessing the evidence of effectiveness of health and healthcare interventions, programmes and services
 - health improvement skills
 - health protection skills
 - health information, intelligence and analysis
 - policy and strategy development
 - strategic leadership and collaborative working for health
 - public health commissioning skills.
- 3.20 This is a time of rapid advances in technology, significant environmental and energy challenges requiring technological innovations, an increasingly technologically articulate

and educated population, and increasing societal expectations with regard to quality of health and reduced health risks. These opportunities and challenges require specialist scientific and engineering skills to deliver a balanced public health portfolio that ensures action where technologies pose real health risks, but avoids wasteful allocation of limited resources in over-regulation of very small risks. The information revolution will continue to both facilitate and empower more people to access information on their health, lifestyle and health services. Public health workforces need to keep abreast of technological developments and harness people's engagement with their own health and wellbeing. This will change the nature of interactions with individuals and communities.

Achieving a good transition

- 3.21 There are challenges in moving from the current to the best possible future scenario for public health. During transition to the new arrangements, the NHS has a significant challenge to make efficiency savings and public health is not exempt. Current local authority budgets are also subject to unprecedented reductions that raise real challenges about the ways in which services are best delivered. It is important that essential skills are retained within the system and transferred to local authorities so that critical public health functions can be commissioned and delivered. There will be much work to do in transition particularly around new structures and relationship building. New relationships and partnerships will need to be developed between, for example, Public Health England, local government, Health Education England, local education and training boards (LETBs), the NHS Commissioning Board, the NHS Leadership Academy, and health and wellbeing boards. There are also changes happening to partner organisations that need to be considered and factored into the transition period – such as police and crime commissioners being elected in November 2012.
- 3.22 It is important that future organisations have the capacity and skills needed to deliver on their new roles. This includes retaining speciality registrars²⁷ in public health that will form the future consultant workforce. The current training arrangements are seen to be valuable, credible and a well-tested means of identifying and selecting high-quality people from multidisciplinary backgrounds. Further development opportunities including cross-boundary working, mentoring, attachments and secondments will be needed to provide the coherent and flexible career paths that will encourage and retain leadership within the public health workforce.
- 3.23 There are a number of detailed issues that will need to be addressed at the local level during the transition to the new public health system. The *Public Health HR Concordat* will complement HR Transition Frameworks²⁸. The Concordat provides guiding principles and standards for the transfer of primary care trust public health commissioning activity

²⁷ People (from medical and non-medical backgrounds) undertaking specialist training in England by Deaneries as part of postgraduate medical and dental training. After five years of study and workplace training they can apply to take up consultant posts as experts and leaders in public health.

²⁸ Public Health Human Resources Concordat. Department of Health for England, November 2011.

and functions (“senders”) to local authorities (“receivers”) and a fair and consistent approach to managing the related detailed HR processes in a local context.

3.24 During transition, the NHS will continue to deliver public health functions. The ongoing interest of the NHS Future Forum in the NHS role in public health²⁹ highlights both the role that NHS health professionals will need to play in achieving public health outcomes, and public health’s continuing role around identifying local health needs, prioritisation, evaluation and evidence based commissioning. During transition and in the future, the NHS must continue to identify and act on its contribution to the health of the populations it serves and in transition must continue to source key public health specialist advice.

Conclusion

3.25 In conclusion, there are exciting opportunities to realise the vision of *Healthy Lives, Healthy People* to build on the strengths of the current system. Under the new public health system there are risks of dispersal of knowledge, professional isolation and lack of skill for new workforce situations. A well-integrated workforce system at local and national level will help to mitigate these risks and ensure a wide and diverse range of professionals can fully contribute to improving the health and wellbeing of the population. However, more restricted budgets will present real challenges that must be addressed. This consultation is the first step towards developing a workforce strategy to help meet these challenges.

Consultation question: Are there workforce challenges and opportunities we have not identified? What support could be put in place to help meet these challenges?

²⁹ www.dh.gov.uk/nhsfutureforum

4. Wider workforces and local communities

Key messages:

- practitioner workforces are an important resource in building capacity for public health
- there is much innovative practice in making public health everyone's business that already deploys workforces across organisational boundaries, the voluntary sector and local communities
- LETBs must be well informed about how an extended workforce with public health skills can complement the consultant workforce and should identify and resource the training needs of this workforce to allow it to do so
- directors of public health and their teams must work with senior local nurse leaders to agree how health visiting and school nursing can best meet local needs
- local health strategies should highlight innovative and evidence based developments to build capacity in children's and workplace public health through the contribution of directors of public health working across local government
- directors of public health should work with clinical commissioning groups to enable local people to develop their own assets and source local solutions to their needs
- Public Health England, Health Education England and the NHS Commissioning Board should work together to promote the role of healthcare professionals in making every contact count.

Introduction

4.1 The Government's approach to improving health and wellbeing in *Healthy Lives, Healthy People* spelt out a commitment at both national and local level to:

- strengthen self-esteem
- positively promote healthier lifestyles and personal responsibility
- adapt the environment to make healthy choices easier.

4.2 The Government is committed to making health everyone's business, using the tools of the new system and a focus on behaviour change at a personal and population level. This is not simple to implement and it has not been achieved to date. The reforms provide a new opportunity for individuals in their communities, through to the leadership of organisations and systems behaving differently. It means that people outside the relatively small specialist workforce for public health, can contribute to the wider public health system as:

- public health practitioners
- professionals from clinical and local government workforces who have contact with individuals and groups experiencing poor health and wellbeing
- leaders of organisations at all levels of the public health system and across the interface between different organisations

- agencies coming into contact with individuals or groups who may not be engaged with traditional health services – such as the police or housing officers
- members of the public taking control of their own health
- all employers respecting their own workforce health
- all schools supporting healthy lifestyles for their staff and pupils.

Looking to the new system – implications for the wider workforce

4.3 In defining the workforce, it is useful to think of people who have a role or an opportunity, however brief, to promote health and prevent illness, irrespective of who employs them. This can include various levels of health and social care staff, working in private, statutory, voluntary and other providers including those providing services under a Right to Provide³⁰. Increasingly, employers, schools, individuals and communities are playing an important role in promoting health and providing care, and as such can be considered a part of the public health workforce.

Case study: Futures Homescape

Futures Homescape provides more than 5,500 homes across Derbyshire delivering a range of supported living services and home for rent or shared ownership. Its Health Trainer programme began in April 2008.

Five neighbourhood support coordinators were given additional skills and training to enhance their role so they could work as a health champion with their clients. This involved providing information/signposting and peer support to people who wanted to improve their health and wellbeing. Health improvement training was provided and relevant additional skills and knowledge-based training.

The service is targeted towards residents aged 60 plus, and one of the primary aims of the service is to reduce the incidence of falls in order to enable residents to remain independent in their own home.

³⁰ The recent White Paper on Open Public Services outlines how modernising public services, ensuring high quality and accessibility, requires increased choice, wherever possible, and public services that are open to a range of providers. It highlights the role that staff-led enterprises have to play in meeting the Government's commitment to improving choice and quality in the delivery of healthcare services. This Right to Provide enables staff to consider a wide range of options, including social enterprise, staff-led mutuals, joint ventures and partnerships. Their freedom to innovate and respond to service user need will put them in a strong position to drive up quality and improve health outcomes.

Case study: Making Every Contact Count – NHS Yorkshire and the Humber

Making Every Contact Count (MECC) is the regional workforce strategy led by directors of public health and their teams to ensure that the Yorkshire and the Humber workforces are confident and competent to make the most of opportunities to help people stay healthy. This systematic evidence-based workforce approach is underpinned with the Prevention and Lifestyle Behaviour Change: a competence framework.

This simple and flexible framework sets out the “function” required of the workforce and then the “form” expected of the workforce, ie the competence. The workforce functions for delivering behaviour change are clearly defined in three of the levels:

Level 1: brief advice and signposting

Level 2: behaviour change intervention eg brief intervention or motivational interviewing

Level 3: behaviour change intervention programme eg weight management programmes.

Based on NICE behaviour change guidance (2007) in terms of both ‘equipping frontline staff’ with skills and developing ‘basic standards’, the framework has had a “viral” impact across and beyond the region and across a significant number of different services and workforces including local authority, acute care, primary care, voluntary sector, pharmacies, leisure services, private industry, fire prevention, probation, mental health and social housing providers. The flexibility of the approach has enabled a localised programme of action bespoke to local populations and services which have been described in case studies. The approach has been supported by Skills for Health and Royal Society of Public Health and there is a growing academic evidence base. We are currently working with NICE and others to evaluate and develop this further.

The resultant change across the NHS and wider systems is evidenced through MECC underpinning commissioning, supporting service provision, informing strategy and planning, assisting workforce planning, driving workforce development and transforming culture. The impact of MECC is being measured in a wide variety of contexts including increased referrals to services, high impact education and training and evidence of the workforce engaging in “public health” especially with the wider and social determinants of health. The framework and resource library are available on the strategic health authority’s website: www.yorksandhumber.nhs.uk

- 4.4 Many critical roles in public health are played by people who are not employed in identifiable “public health” roles. Embedding public health within clinical roles will “make every contact count” for health and wellbeing. Embedding public health across local government will enable joint approaches to be taken with other areas of local

government's work (such as housing, drug workers in police custody suites and courts, the built environment, transport, children's services, social care and leisure) and with key partners (such as the police, business, schools, early years services and voluntary organisations).

- 4.5 The importance of joint work between local workforces to achieve the best outcome for the most vulnerable who frequently suffer multiple disadvantage should not be underestimated. Some outcomes will be shared between public health, social care and NHS outcome frameworks. That these three workforces cooperate remains a clear recommendation from the NHS White Paper³¹ and from the NHS Future Forum³². Health Education England, Public Health England and the NHS Commissioning Board should work together to promote the role of healthcare professionals in making every contact count.

Opportunities for developing communities

- 4.6 A key resource for assessing and improving health is the local community itself. Scenario planning seminars to help develop this consultation document considered what "excellent" would look like in the future. In this context, "excellent" means that all parties play an appropriate role in a fully engaged scenario, including local communities taking control of their own health solutions. This could involve potential new roles to enable communities to identify their own needs and to navigate through the system using local people with an escalating level of national vocational qualifications.

Proposal: directors of public health, working across local government, should work with clinical commissioning groups to enable local people to develop their own community assets and source local solutions to their needs.

- 4.7 It is also essential that the general public is in the driving seat for all aspects of their own health and wellbeing. Utilising existing skills and developing new ones for both public health professionals and the public is fundamental to partnership working. Engaging people as partners can help develop responsibility for personal wellbeing and enable local people to develop their community assets – what makes their communities work. This approach emphasises what people can do rather than what they cannot.

³¹ <http://www.dh.gov.uk/en/healthcare/LiberatingtheNHS/index.htm>

³² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

Case study: Healthy Living Pharmacies

Healthy Living Pharmacies (HLPs), first initiated in Portsmouth and now extending to other parts of the country, are making a real difference to improving the health and wellbeing of the local population. Evaluation in Portsmouth indicates that people walking into an HLP are twice as likely to set a stop smoking quit date and go ahead and quit compared to people who go to a conventional pharmacy. The HLP concept is based on a structured, tiered commissioning framework based on public health need, underpinned by quality criteria, with three enablers in place including workforce development, with staff skilled to proactively engage with the public to improve their lifestyle, premises that are fit for purpose with a dedicated health promotion zone and local engagement. Staff in HLPs use every interaction with the public as an opportunity for a health promoting intervention. Pharmacists working alongside local authority community care services are helping to deliver both improved patient outcomes in reablement and intermediate care at home. They are also helping to deliver measurable benefits in falls reduction.

Ministers announced the establishment of a Pharmacy and Public Health Forum in summer 2011, to be chaired by Professor Richard Parish, chief executive of the Royal Society for Public Health, which includes representation pharmacy and public health interests as well as from the NHS and from a leader of a top-tier local authority. Accelerated roll out of HLPs is one of the priorities that the forum intends to take forward. Everyday millions of people visit pharmacies located in the high street, in supermarkets and in the communities they serve, staffed by trusted professionals and their teams. They are easily accessible to the local population including to people from deprived communities who may not use conventional NHS services but do go to pharmacies. Community pharmacies have over the years been delivering an increasing a range of public health services including stop smoking, sexual health services, weight management and alcohol intervention programmes as well as needle and syringe exchange schemes.

Consultation question: How can local people be encouraged to develop their skills for public health in the new system?

The contribution and development of the healthcare practitioner workforces

4.8 Public health practitioners are key members of the public health workforce. Standards³³ have been developed to support the registration of practitioners who have chosen to develop their public health skills in more depth using the Public Health Skills and Career

³³ UK Public Health Register. Public Health Practitioner Standards. www.publichealthregister.org.uk/practitioner-standard

Framework³⁴ and the National Occupational Standards for Public Health³⁵. Standards do not cover the entire spectrum of specialist public health practice but focus on professional and ethical practice, essential knowledge and skills, application of competencies to practice and underpinning skills and knowledge to achieve improvements in health.

Case study: Suffolk Health Champions Project

The Suffolk Health Champions Project enables volunteers to empower others to make a “healthy” difference to their lifestyles. Through accredited training, health champions learn how they can act on health in their community and how they can break down some of the barriers people face around accessing health information and services. They take health information to people and offer community-led support.

So far, health champions have supported community members to:

- lose weight
- stop smoking
- reduce stress and depression
- act on heart health (cholesterol, diabetes)
- improve health and wellbeing of people with mobility problems
- address language barriers by translating information and instructions.

In addition, the health champions have raised money for charities, organised events to promote health and wellbeing, and been involved in projects to break down cultural barriers.

4.9 In addition, a number of professional bodies offer training programmes³⁶ that enable healthcare practitioners with an interest in public health to achieve qualifications at different levels. They build capacity and awareness of the health impact of various roles and can offer practitioners the opportunity to progress further in their careers in public health.

³⁴ http://www.phorcast.org.uk/document_store/1318857881_bNPm_public_health_skills_and_career_framework.pdf

³⁵ <http://www.skillsforhealth.org.uk/about-us/competences%10national-occupational-standards>

³⁶ Such as the Royal Society for Public Health and the Chartered Institute of Environmental Health (www.rsph.org.uk, www.cieh.org/ www.rcgp.org.uk)

Case study: Stoke Speaks Out

Stoke on Trent is one of the 20 early implementer sites for the Healthy Child Programme (HCP). Children's centre staff support their health colleagues (midwives, health visitors and speech and language therapists) to deliver the HCP. Midwives introduce pregnant mothers to children's centre services and health visitors, so that health visitors can share their key messages.

As part of the "Stoke Speaks Out" initiative a multi-agency team trains all the children's workforce including health visitors and midwives to identify children with speech and language delays. The health visitors then refer them to children's centres that offer quality advice or refer to speech and language therapy services who deliver a package of support for the child/family.

The percentage of children entering nursery with language delay fell from 64% in 2004 to 39.1% in 2010. This reduction is directly attributed to children's centres, health visiting and Stoke Speaks Out. A new child development learning tracker, including Stoke Speaks Out baselines, will be shared across health visiting, speech and language therapy, and children's centres.

- 4.10 These workforces will form important components of extended public health teams and networks. For instance, the 10,500-strong environmental health workforce is an established force for protecting and improving health within local government. Environmental health officers play a vital role during infectious disease outbreaks and work in partnership with the NHS, the Health and Safety Executive and other partners in a range of business and other settings.

Case study: Eat Out, Eat Well

Surrey County Council established its Eat Out, Eat Well scheme in 2009. The scheme aims to recognise with an award those food service businesses that offer healthier options to their customers, and therefore influence consumer food choice to improve public health, in particular a reduction in the incidence of obesity in Surrey.

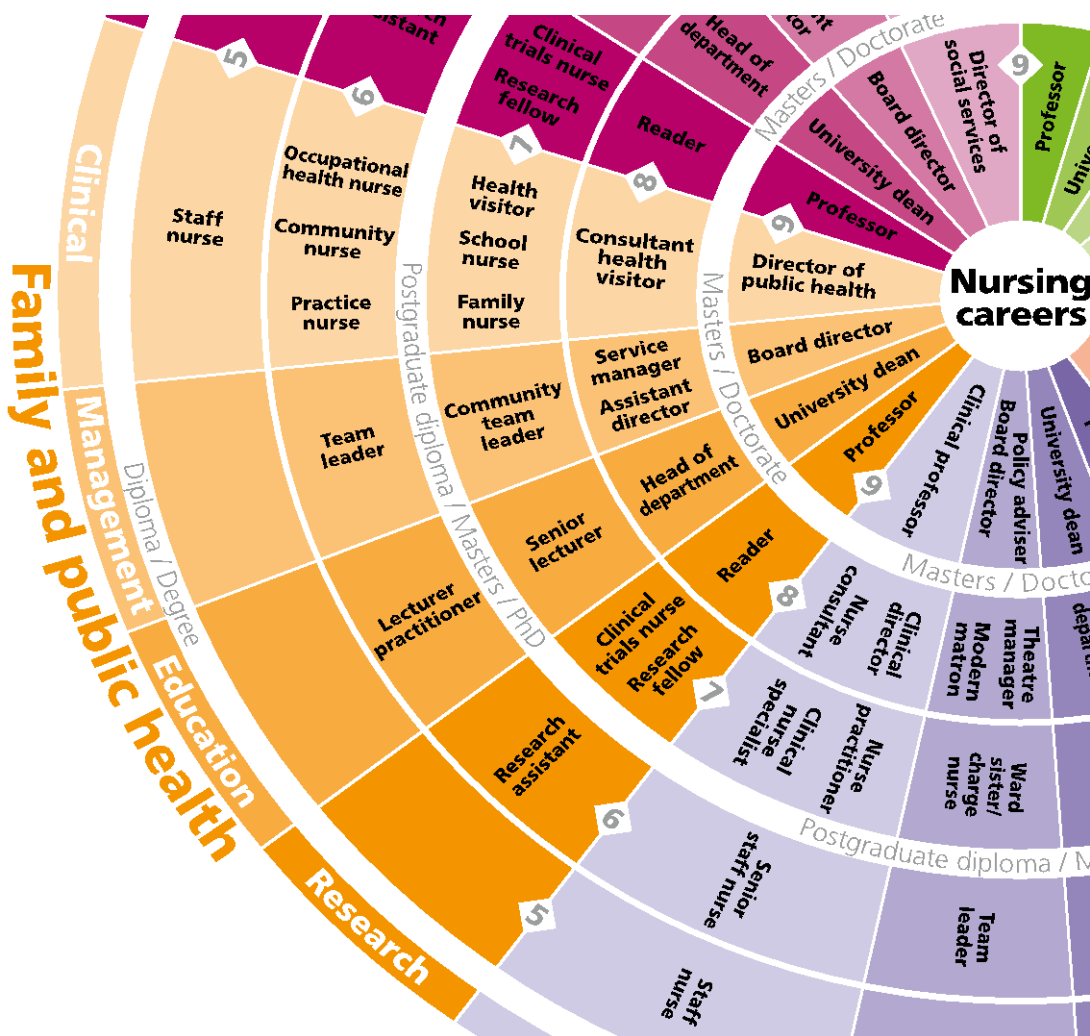
A wide range of businesses can apply for the award including takeaways, sandwich bars, pubs, workplace restaurants, leisure centres, hospital trusts, children's centres, colleges and independent schools. A prerequisite for obtaining the award is compliance with food safety and standards legislation. The scheme is operated by Surrey Trading Standards in partnership with the environmental health services.

4.11 GPs have a critical role in providing advice, brief interventions and referral to targeted services through their daily contact with patients. Some GPs will also play a crucial leadership role in clinical commissioning groups, which will need to work with local authorities and a diverse range of health professionals to commission healthcare services in ways that contribute to improvements in health. *Healthy Lives, Healthy People* identified Public Health England as having a key role in strengthening the focus on public health in the training of GPs.

Consultation question: How can the public health element of GP training and continued professional development be enhanced?

4.12 The nursing profession and specialist community public health nurses (SCPHNs) are essential partners across the three domains of public health, with clinical roles that are important in building resilience in the population. Figure 4 shows the various roles in public health that nursing can offer.

Figure 4: Flexible nursing careers in family and public health³⁷



³⁷ Shaping a quality nursing workforce. www.nhsemployers.org

- 4.13 Health visiting and school nursing services are key to the leadership and delivery of the Healthy Child Programme: pregnancy to 19, the public health programme for children. *Healthy Lives, Healthy People* emphasised some key leadership roles for these practitioners in helping to develop local health approaches to public health, providing links between public health and the NHS and leadership in promoting good health and addressing inequalities.
- 4.14 The Department of Health launched *A call to action for health visiting* in February 2011 and a workforce plan is in place to recruit 4,200 full time equivalents by 2015 and refresh and extend the skills of the current workforce. A service plan is being implemented to deliver a new service model for health visiting services reaching from community health to family and individual health and safeguarding. A new public health to individual health framework is being trialled, and a range of care pathways developed to enable health visitors and school nurses to provide those strong and effective links envisaged in *Healthy Lives, Healthy People*.
- 4.15 School nursing provides public health input for children and young people through the Healthy Child Programme (HCP) 5–15, including a range of health promotion and protection activities in school and sometimes in other “young people’s settings”. They also provide services for children with complex health needs to support them to access education. The national School Nursing Development Programme engages in innovative ways with children, for example via the British Youth Council, and is aiming to train young people to act as health champions.
- 4.16 National programmes are currently addressing the professional needs and mobilisation of health visitors and school nurses. This will coordinate with local services to provide new career and educational opportunities to support current and future SCPHNs. The aim is to ensure they are at the heart of child, young people and family public health.
- 4.17 Initiatives are underway to improve the health of the 27.6m adult working population, including the NHS workforce, and those in higher education³⁸. The Boorman Review³⁹ recommended that staff health and wellbeing services are aligned with wider public health policies. Occupational health nursing has much to offer public health in realising new opportunities to improve health in the workplace. This nursing workforce should be considered part of the extended public health family, building on the future opportunities arising from local economic partnerships.
- 4.18 Practitioner workforces are an important resource, operating in a wide range of settings. Directors of public health and senior leaders in public health need a better understanding of who and where these practitioner workforces are, how they can contribute to behaviour change and better public health outcomes, whether these contributions are part of their

³⁸ Improving Health and Changing Lives; Dame Carol Black 2008

³⁹ Dr Stephen Boorman. NHS Health and Wellbeing. Leeds: Department of Health 2009. www.dh.gov.uk/publications

core role and how they interact with consultants in public health. LETBs⁴⁰ must take account of the need of the public health system for a good range of practitioners to build capacity and add complementary skills.

Consultation question: Would it be helpful to describe the potential career pathways open to public health practitioner workforces?

Conclusion

- 4.19 Healthcare practitioners can play a key role in "making every contact count" from clinicians in hospitals, drug workers in police custody suites and courts, to those working in primary care who have direct contact with patients, such as GPs and A&E staff. Many practitioners already have a significant part to play in helping to support behaviour change and improve public health outcomes, although they may not class themselves as part of the public health workforce.
- 4.20 Throughout England, there are already many examples of innovative initiatives and effective partnership working between primary care trusts, local authorities and the community itself. Not only can this help build resilience in the community, it can have broader benefits through the development of relationships and shared understanding of the problems facing the community and potential solutions. The voluntary sector can also have a significant impact, particularly with hard to reach groups that do not traditionally engage with existing health services.
- 4.21 There are real opportunities for local authorities and other employers to embed public health across the workforce that could bring wider benefits for both staff and the community, equipping them with new skills and providing a more satisfying role.

⁴⁰ The purpose of these boards will be planning, developing and building capacity in local NHS workforces

5. Getting it right for the public health specialist workforce

Key messages:

- the consultant workforce will be valued for the uniqueness of its knowledge and experience in a wide set of future locations, and its leadership role
- the quality of teamwork in public health will define excellence as much as the skill of the individual specialist
- the collective leadership for public health must promote it as an exciting career to high quality graduates, with potential for impact on the most pressing health challenges of our time
- Public Health England, working with Health Education England, will have a key role in ensuring specialist training is resourced and supported to achieve excellent training and education outcomes,
- training programmes must provide trainees with experience of all three domains of public health practice including new opportunities for training within local government
- to sustain standards and support revalidation, future employers should ensure their public health workforces engage in continuing professional development
- leadership and talent management are needed at all levels of the public health system
- there is a need to strengthen public health academia and public health information and intelligence
- transition during major restructuring historically has led to initial loss of public health specialist capacity in the new systems. The Department of Health and local government in particular have an important role in enabling a well-managed transition.

Introduction

- 5.1 Skills and competence are the bedrock of professional public health training and practice. A substantial proportion of the public health consultant workforce will be facing new working environments from 2013. Local government will become an increasingly important employer and source of explicit public health leadership locally. Public Health England will have national roles including health protection, surveillance, and commissioning of certain health programmes.
- 5.2 The arrangements for workforce planning, education and training in the NHS are changing⁴¹ and it will be crucial to ensure that public health training and education continues to deliver a highly skilled specialist workforce with the right skills to deliver the necessary public health outcomes within the new system.

⁴¹ NHS Futures Forum: Summary report on proposed changes to the NHS. June 2011. London: Department of Health

- 5.3 At national level, there will be an explicit relationship between Public Health England and the NHS on a range of functions. These include the commissioning of certain public health services by the NHS Commissioning Board according to service specifications set by Public Health England, the coordination between Public Health England and NHS of health protection and emergency processes, and the joint relationship on education and training with Health Education England and with LETBs. Being able to take a strategic overview of a "whole system" is a benefit of public health leadership at national and local level that must be retained in the specialty.
- 5.4 While these changes present exciting opportunities, there is a risk of a loss of public health skills and capacity within the system, due to workforce attrition. Data from the Faculty of Public Health (2008)⁴² showed that 47% of the consultant workforce was over 50 years of age; and 10% of the workforce had indicated their intention to leave in the coming five years.

Competencies for specialist public health

- 5.5 There is already a skilled and diverse specialist public health workforce, which provides a good base on which to build for the future. To maintain high standards and levels of workforce excellence to which *Healthy Lives, Healthy People* aspires, the quality of teamwork in public health will be as important to achieving excellence as the skills of the individual specialist. This involves having the right mix of skills within the immediate public health team, and knowing how to source additional capacity in due course – from new working environments and extended networks of practitioners. As part of function mapping in transition, it is important that public health leaders identify the nature of essential skills required for their future teams and that Public Health England, when established, is able to work with local and national partners to identify the core skills necessary for the new system.
- 5.6 Public health consultants use their training in epidemiology, population health, demography and evaluative skills to support the NHS in analysing the health impact of healthcare. They will continue to do so, not least because the provision of such expertise is proposed as a mandated service for local authorities. The new health and wellbeing boards will need public health expertise and it is also expected that clinical senates (which will bring together a range of experts, professionals and others to offer access to independent advice about improvements in quality of care), and clinical commissioning groups will also require public health input. Local health strategies will inform joint commissioning of NHS and other services and this work must be informed by the contribution healthcare makes to the health and wellbeing of local populations. This knowledge base will also be important to support the strategic decisions of the NHS Commissioning Board, supported by Public Health England.

⁴² Health. Specialist Workforce in the UK. Faculty of Public Health, 2008.

- 5.7 Directors of public health will act in support of the NHS and local government during health emergencies. It is essential that public health consultants and leaders retain their competencies in the domain of healthcare public health, and agree with their employers' arrangements for CPD to ensure this happens. This will require structured planning for consultants at every level and across all settings.
- 5.8 To deliver the required change in public health there is a need to consider whether the current skills of the public health workforces are adequate for the task. The new arrangements are likely to require different or additional skills and competencies than those that are currently in place. It will be important for those working in local authorities that their leadership role is clear to others who work in the public health system and to key clinicians, such as general practitioners, who have levers on health and wellbeing.

Proposal: that the Faculty of Public Health, working with relevant stakeholders, reviews whether its specialist competencies need to develop in the light of new working environments, relationships and expectations.

Recruitment to specialist training

- 5.9 Recruitment from a variety of postgraduate backgrounds has added strength and perspective to specialist public health practice over the past 15 years. In the late 2000s, over 85% of the public health consultant workforce was registered on the General Medical Council's register and 9.9% on the voluntary UK Public Health Register (UKPHR).
- 5.10 Recruitment to training is currently highly competitive. One of the key roles of the leadership of the public health specialty is to promote public health as an attractive future career proposition. There needs to be a sustainable workforce system where future employers (for example, local government, Public Health England and the NHS) support a professional environment that attracts medical and other disciplines with an interest in population health.
- 5.11 Medical deaneries are responsible for the management and delivery of postgraduate medical education and the continuing professional development of all doctors and dentists, including public health consultants. These functions, which include monitoring delivery of training within the frameworks and expectations of the regulators, are needed for quality assurance and quality management of public health training in the UK. It is important that these responsibilities are carefully managed through the transition of workforce arrangements and continued in the new system.
- 5.12 Training commissioners will need to be informed by sound workforce planning. Recent research has shown that doctors in public health choose their speciality relatively late

after qualification⁴³. The time lag between educational commissioning and the supply of fully trained consultants is five years, or more if the trainees take sabbatical or maternity leave. Educators and trainers need to review programmes on an annual basis and adjust the style, content and placement opportunities the programme offers as necessary.

5.13 Public Health England will have a substantial provider arm particularly in its health protection service functions including exercises and training and contribution to resilience structures, both for its own staff and external organisations. Public Health England will need to be able to scope the future need for its own specialist workforce and ensure that commissions for planning and recruitment appropriately reflect these needs. Public Health England will work closely with Health Education England and the LETBs to ensure that there is access to high-quality training and education across the three domains of public health.

Proposal: that the roles of Public Health England in relation to training will include:

- **forming effective collaborative arrangements with Health Education England to ensure that Health Education England's strategic framework clearly reflects the need for a recruitment and training programme that meets national professional standards, and to monitor its delivery**
- **ensuring the programme is delivered nationally and locally through Health Education England's accountability relationship with the LETBs**
- **delivering, through appropriate collaboration, certain specialist training for its own workforce, that is not provided via the Faculty of Public Health and LETBS in the future.**

5.14 Given the multidisciplinary nature of the public health workforces, there are untapped opportunities for inter-professional training. Education providers, specialist societies and the Faculty of Public Health could design a variety of these modules, for flexible use. As an example of inter-professional training within public health, the academy model developed by the Health Protection Agency could be adapted towards embedding public health skills in other clinical specialities during formative parts of their training. The academy aims to bring together the dispersed educational activities for health protection into one place and promote further development of educational activities in these areas according to the specified need.

Proposal: that consideration is given to certain modules of postgraduate training for professionals with a public health remit in their future career are undertaken together with those training for specialist public health.

Consultation question: What benefits would new ways of cross-disciplinary training bring to the public health workforces?

⁴³ Goldacre MJ, Laxton L, Lambert TW, Webster P. Career choices for public health: cohort studies of graduates from UK medical schools. *Journal of Public Health*. Advance Access, doi:10.1093/pubmed/fdr067 pp 1-8

Education and training of the future specialist public health workforce

- 5.15 Currently, strategic health authorities determine where to invest the £4.9bn central budget for NHS training and education. The proposed abolition of these (from April 2013) means there is a need to put in place arrangements to ensure that essential functions are maintained and that there is a smooth transition to the new system, Health Education England. Full details of the new system that was subject to a full consultation and subsequent consideration by the NHS Future Forum can be found in *Liberating the NHS: Developing the Healthcare workforce - From Design to Delivery*⁴⁴.
- 5.16 Responses to an earlier consultation on training and education for the NHS workforce⁴⁵ were broadly in favour of a strong mutual relationship between Public Health England and Health Education England. Health Education England's primary focus will be on the education and training of the clinical health workforces, clinicians working in social care, and multidisciplinary public health.

Health Education England functions

- 5.17 The key purpose of Health Education England is: "To ensure that health professionals have the right skills, behaviours and training, and are available in the right numbers, to support the delivery of excellent healthcare and health improvement."
- 5.18 The key functions of Health Education England will be:
- providing national leadership on planning and developing the healthcare workforce
 - authorising and supporting the development of healthcare provider education and training networks
 - promoting high-quality education and training responsive to the changing needs of patients and local communities. This includes responsibility for ensuring effective medical trainee recruitment
 - allocating and accounting for NHS education and training resources and the outcomes achieved.
- 5.19 Work is in progress to design and develop a performance assurance framework that will provide assurance on Health Education England's delivery of its objectives. The Department of Health is developing an education outcomes framework that will set out the outcomes against which Health Education England will be held to account.
- 5.20 Health Education England will be responsible for the efficient allocation of the Multi Professional Education Training (MPET) budget to the LETBs. It will build on the Department of Health's work to develop a financial strategy to ensure appropriate allocation of resources, and ensure that funding is linked with the education outcomes

⁴⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132076

⁴⁵ *Liberating the NHS; developing the healthcare workforce*, DH 2010

framework. Health Education England will ensure strong strategic workforce planning for medium and longer term security of supply, supported by the Centre for Workforce Intelligence.

Authorising the LETBs

- 5.21 Health Education England will be responsible for developing and managing a system of authorisation for local partnerships that provides ongoing assurance based on the outcomes achieved. The LETBs will need to demonstrate their capacity and capability before they are authorised by Health Education England to act independently. Health Education England will design the authorisation process and accountability framework and set the template for local arrangements that strategic health authorities and providers will need to build in to their operating models.
- 5.22 Current planning assumptions suggest between 12 and 15 LETBs will be created, starting as strategic health authority sub-committees and based largely around deanery boundaries. Decisions are yet to be made on the end-state, legal form for LETBs that can work towards establishing in 2012/13.

Local links between training and future workforce needs

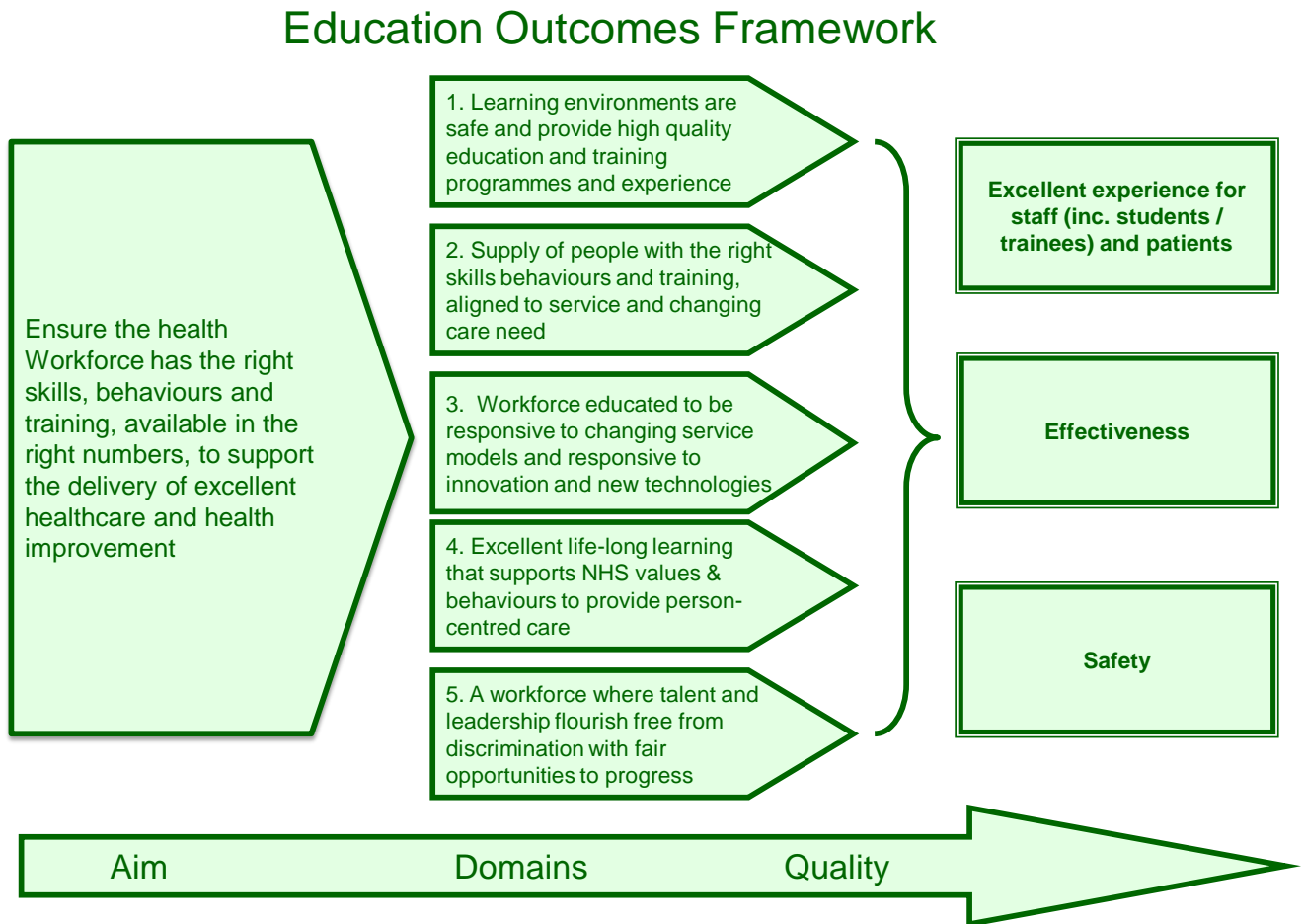
- 5.23 At local level, LETBs will need an understanding of the needs of public health. Important local links will include health and wellbeing boards that have a role in identifying population need for public health services and the skills required to meet those needs. This information must be available to and used by Public Health England to enable it to commission future training programmes.
- 5.24 LETBs will have the ability to engage a number of stakeholders. The majority of responses to an earlier consultation on the arrangements for training and education of the NHS workforce were broadly in favour of local government being members of the local training and provider boards.

Consultation question: How can local education and training boards best support flexible careers to build extended capacity in public health?

Quality and outcomes from training

5.25 An Education Outcomes Framework has been developed as part of the development of new education and training arrangements for the healthcare system. Figure 6 presents this draft framework.

Figure 6: A possible outcomes framework for education and training in public health



Consultation question: is the healthcare Education Outcomes Framework appropriate for public health education and training? If not, how could it be adapted?

Health protection

5.26 There are currently nearly 500 consultant microbiologists and virologists in the UK but only a small fraction are actively engaged in public health microbiology. This is an area of

shortage that may affect public health in future⁴⁶. Those who are actively engaged, provide clinical services to host trusts in support of public health doctors and nurses during incidents, outbreaks and infection control. Within the specialist public health microbiology laboratories, there is also a requirement for clinical scientists, healthcare scientists, biomedical scientists and medical laboratory assistants and information analysts and nurses. There is a range of support staff including laboratory safety officers. Public health laboratories are recognised as training centres for these grades of staff and this should continue. In addition, there are other training sites at the Health Protection Agency that hold national treasure status as well as accredited training activities in academic settings.

5.27 Specialist health protection includes not only public health consultants, nurses and practitioners but also consultants from other medical disciplines and a large variety of other experts and senior scientists. The training and development of this broad specialist health protection workforce will need to include a range of royal colleges (eg Royal College of Pathologists) and other professional bodies. There is a need for enhanced understanding of the future development and shape of the complex workforce that comprises the health protection function in England. Further work is required to feed into the strategy and to support the wider analysis of the future shape of the specialist public health workforce.

Continuing professional development of the specialist workforce

5.28 Professional development is required of the entire specialist public health workforce and will be supported through comprehensive appraisal and performance management systems linked to individual and organisational development needs. *Healthy Lives, Healthy People* states that the future specialist workforce will be recognised for its expertise and professionalism. This involves maintaining high professional standards through CPD, a requirement for ongoing professional registration and demonstrating continued competence. Ad hoc and local opportunities need to be combined with more a coordinated and structured approach to CPD. Future employers can support their professional workforces in expecting the maintenance of high professional standards. This will be essential to ensure that the consultant public health workforce is in a position to be appropriately revalidated.

5.29 It is particularly important that local government plays an active role in expecting maintenance of high professional standards in its public health workforce. This means material support for CPD and in any location, for those who are medically qualified, links to the relevant responsible officer⁴⁷ network for medical and dental revalidation. Local

⁴⁶ Specialty Advisory Committee (SAC) on Medical Microbiology. Independent review of NHS Pathology Services, Call for evidence. London: Royal College of Pathologists, 2006.

⁴⁷ Responsible officers are senior doctors with local responsibility for overseeing the evaluation of fitness to practise, and monitoring the conduct and performance of doctors. The Department of Health is preparing to consult on options for how the responsible officer function will be delivered in local authorities.

government can also support high professional standards by encouraging networking of public health staff to their colleagues, particularly those with specialist knowledge, to avoid professional isolation. Such networks may also provide opportunities for joint learning when working to a common purpose to achieve improved outcomes in a particular population. The use of attachments, secondments and mentoring can play an important part in developing and retaining future workforces across the public health system.

Flexible careers in the specialist workforce

5.30 In this context, flexible careers means the opening of new opportunities to enhance the attractiveness of a career in public health, to broaden the reach and influence of public health and to add value to employers by improving health outcomes. There are a number of ways in which flexibility can be achieved:

- the facility to move within the organisation to new roles, enhancing core competencies
- encouragement to take on new responsibilities within the organisation to broaden the reach of public health within the organisation
- the ability to move between employers and retain specialist status
- the facility to take secondments to enrich experience and to offer enhanced knowledge to the employer
- the design of joint or honorary appointments to cement local relationships and broaden networks.

5.31 Several of these exist now. As employment moves from the NHS to local government, it will be desirable to retain flexibility to move within and between organisations.

Consultation question: How can flexible careers for public health specialists best be achieved?

Leadership at the specialist level

5.32 The Chief Medical Officer will continue to have a leadership role for public health professionals following the establishment of Public Health England. The Chief Medical Officer is the professional lead for the public health profession and doctors employed by the Department of Health. As part of the Chief Medical Officer providing professional leadership for the newly appointed directors of public health⁴⁸, appropriate professional links to the Chief Medical Officer will be developed. As with other professions, this model will take into account the role and responsibilities of other public health leaders within the new system.

⁴⁸ Who will be jointly appointed by local authorities and Public Health England on behalf of the Secretary of State for Health

5.33 Outstanding leadership is strongly associated with high performing organisations⁴⁹ good health outcomes and a culture of safety and quality. With the economic and other challenges that will impact on population health and the ability to deliver high demand services, it is imperative that the whole workforce has the leadership knowledge, skills and behaviours to drive improvements in health services. The most senior leadership in the specialist public health workforce is vested in a number of roles including at various geographical levels: directors of public health, regional directors; heads of academic departments, senior consultants in the Department of Health and directors of national organisations with a public health remit.

5.34 The changes to the public health system will bring a challenge for continued and stronger leadership. For those moving to local government, there will be a need for new skills in working with elected members, and possibly managing new services aligned to public health in that environment. Many senior directors in public health are participating in the NHS Top Leaders Programme. However, there are likely to be bespoke needs for the new environment that are not currently addressed.

Box 3: The Hubbub model – cross-disciplinary leadership development

- Participants from six organisations including the Human Fertilisation and Embryology Authority, the Health Protection Agency, General Social Care Council and South West Directors of Public Health
- The programme is flexible, involving assessment, action learning sets, 360 degree reviews, coaching and mentoring and a world café
- Various levels of leadership included
- Both personalised and structured networking offered
- Organisations pay a flat rate and then a "per candidate" fee, with options to buy more support
- Develops future leaders and manages talent.

5.35 Senior staff working in health protection require a thorough grasp of their contribution to implementing national policy, effective interventions and collaborative working with the other public health professionals. People in these roles require a combination of vision and intellect, as well as analysis and leadership.

5.36 Ensuring that senior public health consultants operate as effective leaders in the system is essential for both trainee and existing consultants. Consultants will also form the basis of recruitment to directors of public health roles as they become vacant. Those at the consultant, specialist and senior lecturer level need structured and purposeful talent management to bring on their development as leaders in their field. The availability of a range of development activities including secondments, attachments, and cross-boundary project working will be required.

⁴⁹ National Leadership Council

- 5.37 Both Public Health England and academic departments will continue to need exceptional leaders in specialist disciplines who can innovate and inspire their frontline colleagues and national government to act on the new knowledge they provide. Many senior public health leaders have already undergone leadership development within the NHS Leadership Framework. This provides a consistent approach irrespective of discipline and is based on the concept that leadership is frequently a shared responsibility.
- 5.38 The NHS Leadership Academy, announced by the Secretary of State for Health in July 2011, will provide a national focus on leadership across the NHS, public health and social care. Public Health England will work closely with the Academy to ensure that the appropriate leadership development is available for the public workforce and that the public health workforce is aware of and takes advantage of these opportunities.

Consultation question: What actions would support the development of strong leadership for public health?

Academic public health and public health information and intelligence

- 5.39 Underpinning the delivery of the three domains of public health are two critical functions – those of academic public health and public health information and intelligence. High quality research and intelligence that can be readily applied is critical for public health practice. Even though small in number, public health academics in the UK contribute significantly to international epidemiological studies, clinical trials, health service research and in the evaluation of complex public health interventions using innovative, robust techniques, often in collaboration with frontline specialists.
- 5.40 The Medical Schools Council represents the interests and ambitions of UK medical schools as they relate to the generation of national health, wealth and knowledge through biomedical research and the profession of medicine. The council has been undertaking an annual survey of the clinical academic workforce within UK medical schools since 2003⁵⁰. The survey in May 2010 indicated a 21.7% decline in public health full time equivalents between 2000 and 2009, with a further 1.8% decline to 2010. The number of clinical academic full time equivalents in infection/microbiology saw an 18.7% increase from 2009 to 2010. Of 3,175 full time equivalent clinical academics in substantive academic employment, 162.75 (5%) were in public health. The number of public health academics identified in the Faculty of Public Health census in 2007 at 186 was higher than that identified in the Clinical Academic Staffing Levels survey. This is to be expected, as a number of public health academics will be from backgrounds other than medicine, or based in universities without medical schools.

⁵⁰ A survey of staffing levels of clinical academics in UK medical schools as at 31 July 2009. London: Medical School Council, 2010.

- 5.42 Although current academic clinical fellowships and lectureships are highly competitive and have attracted the highest calibre medical graduates, any move away from flexible and supported academic career pathways will reduce the attractiveness of academic public health to promising researchers.
- 5.43 Potential solutions are to embrace junior doctors from a wider range of clinical specialities, in addition to the highest calibre non-medical graduates who wish to train in defined areas of academic public health (eg clinical epidemiology or evaluation). There is a need to develop multiple, flexible research training pathways, tailored to trainees' interests. The development of academic careers is an area that needs further work during the development of a public health workforce strategy.

Consultation question: What actions can be taken, and by whom, to attract high quality graduates in to academic public health careers?

- 5.44 Discussions with stakeholders suggest that the separation of academic departments and frontline specialist public health functions has been problematic for both groups. There are exemplars of joint funding, working and even co-location, for example in health protection at national level. Academics are not often exposed to the application of their work – and the challenge of designing interventions in less controlled situations than suggested by the theory. Those working in frontline delivery do not always benefit from intellectual challenge and the opportunity to test the evidence base when making important decisions about the value of certain interventions or allocation of resources.
- 5.45 Periods of academic training are of value not only for those pursuing an academic career but also for those in many other roles, in particular those who will become national experts in specific aspects of public health working in senior posts in Public Health England, the Department of Health, the NHS Commissioning Board, and elsewhere. Academic trainees can work closely with public health colleagues in a diverse range of working environments (including local government, Public Health England and the NHS).
- 5.46 Given the competitive nature of contemporary academic environments, it is preferable that academic Departments of Public Health should ideally provide academic training pathways in those areas that reflect their internationally recognised strengths. This will provide public health academic trainees the best quality training in their chosen field.

Proposal: That Public Health England and Health Education England hold a database of academic departments and the training strengths and “offers” from these departments to specialist trainees in public health.

- 5.47 The primary aim of the National Institute for Health Research (NIHR) School for Public Health Research is to increase the evidence base for effective public health practice by

conducting research, including evaluations. At the heart of the NIHR school is collaboration between the leading academic centres of applied public research in England. Building a close relationship with local partners, including public health workforces, the NIHR school will place an emphasis on what works in practice, providing the evidence to support the adoption of healthy lifestyles by individuals and informing decision making by public health professionals.

- 5.48 The NIHR school will increase opportunities by funding more research and hence more researchers. The school also has the potential to enhance academic careers by dovetailing with specific training offered in academic departments of public health.
- 5.49 There are around 1,000 people currently employed in public health information and intelligence (I&I) roles or in posts with a significant I&I function in England. This includes both local public health I&I staff and staff in organisations transferring to Public Health England such as those in public health observatories. This is not a homogenous, easily defined group. The historic lack of career pathways and academic training provision means that professional qualifications specific to this field of work are largely non-existent; training tends to be ad hoc. Public health I&I is likely to be a function spread over different geographical locations and will be seen as mission critical to effective delivery of public health. Public Health England can enable a more effective public health function by identifying its own specialist I&I workforce, and how this could dovetail with pre-existing competencies that other, local workforces will already have to hand from their various roles and training.
- 5.50 Public Health England will have an internal development role for its own I&I function. This can be supported via, for example: defining career pathways in Public Health England; traineeship schemes with accredited training courses; and enabling pathways to registration as a public health “defined” practitioner or specialist.

Consultation question: Are these the right actions to develop and strengthen the public health information and intelligence function? Who should be responsible for delivering these actions?

Conclusion

- 5.51 To support the transition of a complex workforce to new environments, there are a number of areas requiring further work, including:
- an in-depth look before 2013 at the current and future nature of this workforce
 - a position paper on the training and development needs of Public Health England to support the wider analysis of the future shape of the specialist public health workforce
 - the relationship between public health consultants and practitioners and how they will need to work together in the new public health system.

6. Next steps

- 6.1 The Department of Health will consult on the proposals set out in this paper. However, more than that, the Department of Health aims to co-produce the workforce strategy with key stakeholders, and sees the consultation period as a continuation of the engagement and involvement we have already begun. This will help in shaping the strategy further.
- 6.2 Engagement with key stakeholders will be maintained during the consultation period that will run from 27 March to 29 June 2012. The responses received and outputs from consultation events will contribute to the evolving workforce strategy. Following this consultation period the Department of Health will collate and analyse the responses and publish a public health workforce strategy in autumn 2012. That strategy will be a 'live' document and consequently will need to be reviewed regularly in the light of transition in 2013 and onwards.
- 6.3 This consultation document is accompanied by a consultation Impact Assessment. The Department of Health welcomes any information or evidence that would help analyse the impact of the proposals contained in this document.

Consultation question: Do you have any evidence or information that would help analyse the impact of these proposals?

How to respond to this consultation

- 6.4 Annex B includes all the questions from each chapter within this consultation document that we hope you will find helpful in shaping your response. We will also be arranging a number of consultation events around England.
- 6.5 This consultation closes on 29 June 2012. You can contribute to the consultation by providing written comments to:

By email: publichealthworkforceconsultation@dh.gsi.gov.uk

By post:
Public Health Workforce Consultation
Department of Health
Room 102
Richmond House
79 Whitehall
London SW1A 2NS

Online: www.consultations.dh.gov.uk

The consultation process

Criteria for consultation

- 6.6 The consultation on the questions set out in Annex B follows the Government Code of Practice on consultation. In particular, we aim to:
- formally consult at a stage where there is scope to influence the policy outcome
 - consult for at least 12 weeks and consider longer timescales where feasible and sensible
 - be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals
 - ensure that the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach
 - keep the burden of consultation to a minimum to ensure that consultations are effective and to obtain consultees' buy-in to the process
 - analyse responses carefully and give clear feedback to participants following the consultation
 - ensure that officials running the consultation are guided in how to run an effective consultation exercise and share what they learn from the experience.
- 6.7 The full text of the code of practice is on the Better Regulation website at: www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

- 6.8 If you have concerns or comments that you would like to make relating specifically to the consultation process itself, please contact:
- Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds LS2 7UE
Email: consultations.co-ordinator@dh.gsi.gov.uk
Please do not send consultation responses to this address.

Confidentiality of information

- 6.9 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.
- 6.10 Information we receive, including personal information, may be published or disclosed in accordance with access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1988 (DPA) and the Environment Information Regulations 2004).

- 6.11 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory code of practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality will be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.
- 6.12 The Department of Health will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

- 6.13 A summary of the responses to the consultation questions in this document will be made available before or alongside any further action (such as the publication of a public health workforce strategy) and will be placed on the consultations website at: www.dh.gov.uk/Consultations/Responsestoconsultations/index.htm

Annex A: Membership of the Public Health Workforce Strategy Working Group

Chair

Yvonne Doyle, Regional Director of Public Health, South East Coast

External Members

Keith Reid, British Medical Association

Will Frost, British Medical Association

Suzanne Clarke, Department for Communities and Local Government

Kate Arden, Director of Public Health, Ashton, Leigh and Wigan PCT

Jeremy Hawker, Faculty of Public Health

Russell Ampofo, Faculty of Public Health

Tony Vickers-Byrne, Health Protection Agency

Anthony Kessel, Health Protection Agency

Jon Sutcliffe, Local Government Association

Dan Seddon, Mersey Deanery

Sara Corben, Consultant in Public Health / UNITE

Tom Fowler, Speciality Registrar in Public Health

Jan Maw, Royal College of Nursing

Department of Health policy teams

Allied Health Professions

Chief Scientific Officer

Nursing Directorate

Public Health Development Unit

Public Health Workforce

Workforce Directorate

Secretariat

Public Health England Transition Team

Annex B: Summary of consultation questions

Question 1 (Para 1.7): Do you agree that a public health workforce strategy should be reviewed regularly? If so, should this be every three years or every five years?

Question 2 (Para 2.5): Are these four groups a useful way of describing the public health workforces?

Question 3 (Para 2.12): Do you agree that methods of enumeration of the public health consultant and practitioner workforces should be scoped and piloted at a national level? Or do you think that workforce planning can take place effectively at a more local level eg LETBs working with local partners?

Question 4 (Para 3.7): Would these values, combined with the features of public health in Box 2, serve to bind together dispersed public health workforces?

Question 5 (Para 3.14): What further actions would enhance recruitment and retention of truly representative public health workforces?

Question 6 (Para 3.25): Are there workforce challenges and opportunities we have not identified? What support could be put in place to help meet these challenges?

Question 7 (Para 4.7): How can local people be encouraged to develop their skills for public health in the new system?

Question 8 (Para 4.11): How can the public health element of GP training and continued professional development be enhanced?

Question 9 (Para 4.18): Would it be helpful to describe the potential career pathways open to public health practitioner workforces?

Question 10 (Para 5.14): What benefits would multi-disciplinary training bring to the public health workforces?

Question 11 (Para 5.24): How can LETBs best support flexible careers to build extended capacity in public health?

Question 12 (Para 5.25): Is the healthcare Education Outcomes Framework appropriate for public health education and training? If not, how could it be adapted?

Question 13 (Para 5.31): How can flexible careers for public health specialists best be achieved?

Question 14 (Para 5.38): What actions would support the development of strong leadership for public health?

Question 15 (Para 5.43): What actions can be taken, and by whom, to attract high-quality graduates into academic public health?

Question 16 (Para 5.50): Are these the right actions to develop and strengthen the public health information and intelligence function? Who should be responsible for delivering these actions?

Question 17 (para 6.3): Do you have any evidence or information that would help analyse the impact of these proposals?