Department of Health

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

Summary of responses

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1. Introduction

On 27 March 2012, the Department of Health published a consultation paper, co-branded with the Local Government Association, on the development of a workforce strategy for the new public health system, meeting a commitment in the public health White Paper *Healthy Lives, Healthy People* (Nov 2010).

The development of a public health workforce strategy will support the delivery of the Public Health Outcomes Framework which focuses on two high level outcomes for public health:

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities.

The consultation document explored ways in which to support the specialist public health workforce in the new system and opportunities to embed public health skills and capacity across the wider workforce.

The consultation ran from 27 March to 29 June 2012; this document provides a summary of responses to the consultation. The Department's response to the consultation is set out in Healthy Lives, Healthy People: A public health workforce strategy.

2. Consultation process

The consultation exercise was in accordance with the Government's Code of Practice on Consultation (Annex C). The consultation ran from 27 March 2012 to 29 June 2012, slightly longer than the recommended 12 week period to allow for the Easter period, the long Jubilee Bank Holiday weekend and local government elections.

The consultation document was published on the Department of Health's website, with an option to respond on-line through Citizen Space. The consultation asked 17 questions relating to ways to support and develop the public health workforce including

- Ways to enumerate the public heath workforce
- Recruitment and retention
- The role of public health practitioners
- The role of local education and training boards
- Ways to strengthen academic public health and the public health information and intelligence function

Stakeholder engagement

The consultation was highlighted through official level contacts with stakeholder networks, for example the Public health Engagement Group and the Public Health Workforce Strategy Steering Group. Items were also included in the Public Health Bulletin on [dates]. Attention was also drawn to the consultation on the DH website. In addition, DH officials presented at 16 consultation events across England, attended by approximately 600 people from both the NHS and local authorities.

Number and range of responses

We received 242 responses to the consultation by e-mail and on-line of which 116 were on-line responses and 133 were received by e-mail. Of the responses:

100 were from individuals
17 were from the voluntary and community sector
7 were from representative organisations
2 were from trade unions
5 were from academic institutions
13 were from local authority organisations
4 were from commercial organisations
24 were from professional organisations
69 were from NHS organisations
1 was from a Government Department

A full list of the organisations responding is at Annex B. The Department sought the views of stakeholders and experts in the field during and after the consultation, in order to ensure that a wide range of views was captured.

3. Summary of responses

In this section, we have summarised the key responses to each of the consultation questions. Not all responses answered every question; some answered each question directly while others commented more broadly on the overall content of the consultation document.

Question 1: 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?

The majority of respondents agreed that there was a need to review the strategy on a regular basis.

> *In carrying out regular reviews, the sporadic, revolutionary upheavals of the public health workforce can be avoided and instead be replaced by a more considered and evolutionary approach* (representative organisation).

> *The strategy should be regularly reviewed, particularly for the first few years as public health becomes embedded within its new receiving organisations and in view that the NHS, as well as public health, is going through one of the biggest reorganisations in their history* (representative organisation).

However, there were differing views about the frequency of the review, with suggested timescales from an annual review to every ten years.

> *Due to the changes to the NHS and the overall public health system as a result of the Health and Social Care Act 2012, we recommend an initial review is conducted after 3 years and subsequently 5-7 years thereafter. Having workforce strategies reviewed too regularly can build a certain amount of instability in the system but reviewing the needs of the new system after three years will build in sufficient flexibility to meet the needs of the recently developed organisations such as clinical commissioning groups (CCGs* (NHS organisation).

> *We agree with the proposal to review the strategy on a regular basis. We feel the workforce strategy should be reviewed every three years in the first instance. The timescale for future reviews should be decided after taking into account the degree of change required and the feedback provided by the workforce. 5 years is too long when the system is undergoing rapid change* (NHS organisation).

> *We suggest that the strategy should be reviewed every three years. This would be in line with the policy in local authorities where reviews take place every three years* (joint NHS and local authority organisation).

> *There are merits and drawbacks to both: three years will allow the system to be reviewed, monitored and changes made, with time for impacts to be evaluated and changed; while five years allows system to "bed in". The public health workforce strategy should be reviewed regularly. In order to remain relevant and to enable it to be responsive to all changes, it should be reviewed every five years. This does not mean it has to change dramatically, but this regular review would ensure that it is always up to date and appropriate* (NHS organisation).

Respondents also wanted to ensure that any review would not introduce change for the sake of change or disrupt the system unnecessarily.

> *We agree that it is important to review the workforce strategy, but that this should not be more frequent then every five years. Review of the strategy should not implicitly require a change to the strategy unless the underlying planning assumptions have changed significantly* (NHS organisation).

> *This should clearly be a review of strategy, not necessarily a revision, and there was a theme emerging that flexibility needed to be balanced with stability after a time of immense change, as this would be important to keep morale among the workforce but allow 'tweaks' to the system to be made* (trade union).

Question 2: Are these four groups a useful way of describing the public health workforce?

This question and the Table 1 in the consultation document generated a great deal of discussion and raised a number of concerns. Generally, there was broad agreement that the practitioner workforce had developed in recent years and support for the inclusion of the wider workforce, but many respondents disagreed with the roles assigned to each grouping and highlighted roles that had not been included such as public health commissioners and health promotion specialists.

> *It is right to take this comprehensive view of the public health workforce, given the potential for integrated working between different areas of care and the improvement in outcomes and care this can produce. Such an approach will truly put 'every contact count' at the heart of the wider health workforce* (professional organisation).

> *We particularly welcome the clear acknowledgement that professionals outside the health sector can and do contribute to health promotion and disease prevention – even if some of them may not be aware of the fact* (voluntary and community sector).

Some respondents highlighted the need for the groupings to be applicable across local authorities, the NHS, Public Health England, the NHS Commissioning Board and others and that there should be recognition that there may be staff working at different levels and in different organisations within each group.

> *.. the proposed workforce group does not reflect the existing public health workforce currently in the local authorities. It is a document that is focused on NHS public heath staff, and hardly mentions the public health workforce working in local authorities* (NHS organisation).

> *Table 1 from the public health consultation setting out the broad groupings of the public health workforce seems sensible in what it is trying to achieve and is a good starting point, however the difficulties come in the issues of defining exactly what the public health workforce is and how much of the role is devoted to public health as referred to in the paper* (NHS organisation).

Responses reflected the complexity of the public health workforce and the difficulty in agreeing common terminology.

Describing the public health workforce has always been difficult but the specialist-practitioner-wider workforce paradigm has stood the test of time. There will never be a definitive list (particularly between practitioners and the wider workforce) as different people my do the same jobs very differently and throughout a career move between roles (eg practitioners may become specialists later on) (NHS organisation).

Some respondents suggested that it may be more helpful to consider the functions that are required to deliver public health outcomes rather than specific professional groups or job titles.

Groups should be defined by skills and functions, focusing n what should be achieved, rather then the 'jobs' people are currently doing. Public health will need a mix of skills and employees need to be flexible, rather than bound by role definition (NHS organisation).

Some respondents suggested that an alternative approach might be to define staff as being either 'strategic' or 'frontline' whilst others suggested that groups could be classified by how they are professionally regulated.

Question 3: Do you agree that the enumeration of the public health consultant and practitioner workforce 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?

There was a general consensus amongst respondents that there was a role at both national and local level in determining the numbers in the public health workforce and in workforce planning.

Accurate enumeration of the specialist and practitioner workforce is critical and while it should be based on local and regional workforce planning, the methods of enumeration should be scoped and piloted at a national level because of the need to have common definitions (NHS organisation).

There were also comments about the purpose of enumerating the workforce:

This is not just about counting but making sure there is the right number of workforce, in the right place, but with the right public health skill and competence to deliver outcomes (NHS organisation)

However, there was recognition from some respondents of the poor quality of public health workforce data:

Workforce modelling and information is currently poor and needs to be done better (representative organisation).

.. to ensure the new system is able to deliver against the Public Health Outcomes , 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 (professional organisation).

Some respondents suggested that the enumeration of staff should be limited to those that work full time in public health – including practitioners.

> …t*he strategy is far too wide and should not aim to enumerate everyone potentially involved in public health …. For adequate enumeration it will be essential to have clearer definitions of the public health workforce and the distinction between those working at a population level and those working at individual one-to-one level delivering public health interventions, could be a useful way of doing this* (NHS organisation).

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

There was a mixed response to this question with some respondents welcoming the idea of a single vision, whilst others felt that a single vision would not be enough to bind together a dispersed workforce.

> *It is important to have a consistent definition, vision and set of values in order to prevent public health from becoming so fragmented or dissipated into other roles* (NHS organisation).

> *While it is helpful to have a vision and set of values underpinning public health, it will not necessarily serve to bind diverse workforces, especially where staff do not recognise that the work they do fits under the public health banner* (academic institution).

> *I think it is essential for the public health workforce to have a vision and core set of values. Public health is in danger of defining itself too broadly and needs to be clear what its core values and remit are* (individual).

> *A clearly articulated set of shared values across public health as proposed is useful both to maintain a public health identity and to support clear communication of public health vision to other sectors in line with the principle that "public health is everybody's business* (academic institution)

Of those respondents who commented on the proposed set of values (Beauchamp and Childress), many were concerned that they were too medical, were not specific to public health and not relevant to local authority settings.

> *They are too individual and don't properly reflect community values eg Nuffield or human rights* (NHS organisation).

> *It is important that plain English is used and to reduce medical/clinical terminology where possible so that the wider audience can understand and relate to the values* (local authority organisation).

> *A more useful common goal can be constructed around the core definition of public health given in the Acheson report (1988): The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society* (professional organisation).

Some respondents referred to the *Good Public Health Practice: general professional expectations of public health physicians and specialists in public health* produced by the Faculty for Public Health. This guidance has recently been revised so it is applicable to those working at practitioner level.

In addition to general comments about a vision and set of values, some respondents suggested other aspects of contemporary public health that should be included such as advocacy, sustainability, innovation, empowerment and excellence, and tackling health inequalities.

Question 5: What action would enhance recruitment and retention of truly representative public health workforces?

A number of respondents commented on the need to improve the diversity of the current workforce and the methods employed to recruit. These comments applied to ethnicity, social class, gender and sexuality. One or two comments disagreed with the suggestion behind the question that PH is less diverse than other professions or that it is necessarily a good thing and may lead to a workforce with 'split values and visions'.

> *…. recruit from diverse communities, go to areas where people are likely to look at opportunities and do not just stick to the NHS Jobs website* (indvidual)

> *Despite employment protections for lesbian, gay and bisexual people, discrimination is still rife in the NHS. This can have a profound impact on career progression and limits the visibility of senior leaders who can act as role models for others* (community and voluntary sector).

A large number of respondents referred to the wider variation in opportunities and privileges for training and career enhancement between medically trained PH specialists and non-medics in the profession. There is a strong view that non medics and other related professional groups (eg nutritionists/dieticians etc) are not as well supported in their professional development as medically qualified colleagues and therefore fail to penetrate more senior management levels in public health. Some called for greater emphasis on the social model of health and away from the current dominant medical model.

> *…. currently medicine dominates. There needs to be clear career pathways and opportunities for other post graduate level professional to enter without being devalued in order to meet future challenges* (individual).

> *A clear career pathway is needed for the whole workforce not just consultants* (individual)

And of the strategy:

> *This strategy has a key contribution to make in setting out the multidisciplinary nature of public health as a strength and unique feature…..It is important to recognise that medically qualified staff are a very small proportion of the overall PH workforce and increasingly a minority of the specialist PH workforce* (NHS organisation).

Some commented on the lack of support for more senior non medical staff and the need for more flexibility in training for those coming in from different professional backgrounds.

> *…the need for PH professionals working at senior levels who are not consultants or trainees needs to be considered in the …strategy. It is currently not clear what the career development opportunities or route to registration is for these professionals, as many will be too experienced to benefit from …the Public Health Training Scheme* (NHS organisation).

There were also comments concerning the lack of equivalence between MPH courses.

> *There is considerable diversity in the content of the many MPH courses now available and this lack of assurance of equivalence is a source of problems and potential inequity* (NHS organisation).

A significant number commented on the need for greater clarity (and communication on) training and development opportunities across all PH groups, and career pathways. Many felt the specialist/practitioner divide was unhelpful and simplistic, others felt the dispersal of PH into different sectors could create different career structures and the widening of roles vs specialist training and careers should be planned more effectively.

> *…. a clear career pathway is needed for the whole of the workforce not just consultants. The pathway needs to take into account the NHS/LA employment separation and how this will impact on professional progression* (individual)

> *There needs to be a clear process for practitioners from a wide variety of areas to access routes for training and development to PH consultant. The portfolio route should have clearer learning and development competencies so staff can build up skills knowledge and expertise to enhance their role and work. This should be regardless of whether they ultimately submit a portfolio* (individual).

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

The majority of respondents identified the reform of the public health system as a significant challenge with concerns focused on transition and human resource issues, the cultural differences between the NHS and local authorities, the risk of an ever more dispersed workforce, and the risk that the profession would become less attractive to doctors.

> *There could be fracturing of the multi-disciplinary workforce as a result, with the potential for non-medics (who are already paid less at Consultant level for the same posts as their medic colleagues) being more likely to be employed by Local Authorities than other organisations as medics may be unwilling to work outside the NHS* (NHS organisation).

> *There is a risk that public health staff are moved from specific into generic roles post transition and that skills will be lost or diluted. There is a role for Public Health England to work with Local Authorities to support the workforce through such challenges and ensure that access to development and accredited training is provided* (local authority organisation).

> *PH transition to LA is a key challenge and some of the current PH workforce will need to develop new skills and knowledge to operate within the new PH structures. Training and development for LA staff and elected members is likely also to be required to support their understanding of public health and its responsibilities* (NHS organisation).

> *There is a balance to be met between these two paradigms of medical public health and the social public health within Las* (NHS organisation).

However, other respondents felt that the move of public health to local authorities provided real opportunities.

Moving public health control/organisation to local authorities where the role of many existing services is primarily to promote and improve public health, presents an opportunity to bring about stronger linkages between those services and a greater emphasis on the public health elements (professional organisation).

Several respondents raised issues around training and education - both for specialty registrars and for the wider workforce. Some were concerned about the availability of training placements in local authorities and the lack of posts for people coming out of the specialty training programme whilst others made suggestions about embedding public health training across the health and social care curricula.

There is a need to embed PH into pre-reg training and the wider workforce so it becomes a core element of every role, thus utilising the extensive network of professionals within health and social care (individual).

There is considerable anxiety about terms and conditions, for instance current Specialty Registrars working within the NHS will have no consideration of their current T&Cs when completing training and seeking consultant level positions with in the new system (NHS organisation).

The split of commissioning NHS to NHS commissioning Board, GPP consortia, PH England and the local authority may result in a fragmented training scheme and there is a risk that trainees may not undergo a rounded training programme, or that candidates from medical backgrounds are dissuaded from entering the profession (NHS organisation).

A more general health improvement training for clinicians – and non-clinicians - would be helpful (individual).

A significant number of respondents raised the challenge of ensuring public health remained a multi-disciplinary professional with the splitting the three domains of public health between local authorities and PHE.

It will be difficult for public health consultants and leaders to retain their competencies in the domain of healthcare public health, health protection and health promotion when these functions are being split (individual).

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

Respondents suggested a number of different ways to engage local people including more visible public health workforces at community level, community development programmes, community health champions, volunteering, neighbourhood planning, patient led/peer support models and work via community infrastructure for example schools, Job Centres etc

However there were concerns regarding the safety of practitioners, competitiveness in a provider driven service, and professional resistance.

…. we feel it will be difficult to implement effectively and unrealistic to expect a member of the local community to understand the public health system fully, or to put themselves forward. Resources and infrastructure will be needed to facilitate this. The wider

voluntary workforce will have a key role to play if local people can be encouraged to engage with public health. This again will need resources (NHS organisation).

Local people need to be more aware and responsible for their health. Calling this 'developing their public health skills' is rather overstating the issue and moreover, suggests a simple solution. 'Local people' are not a public health workforce - it takes more than awareness raising to change behaviour. There is lots of evidence about how to improve population well-being, tackle inequalities, use social marketing etc (NHS organisation).

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

There was strong support for the suggestion that GPs training in public health could be enhanced particularly given their new role on Clinical Commissioning Groups.

Developing the role of GPs in CCGs and in primary care is essential – we now have a major opportunity to do so with the primacy of GPs in the new system. WHO has long pioneered PH in primary care and practice elsewhere in the world which is more developed practice than the UK (local authority organisation).

Primary care is part of the public health service and needs to be thought of as such by GPs and all primary care professionals. Strengthening training on every contact counts, improving quality of primary care and integrating primary care and public health is required (NHS organisation).

Respondents identified a number of different ways in which enhanced training could be delivered including integrating public health into the curriculum, mandatory placements in public health departments as part of pre-registration training, job swaps and secondments, joint training and CPD activities with other disciplines, a Masters in Public Health for GPs, and changes to the GP contract to incentivise public health awareness. In some areas, these approaches had already been adopted and had proved successful.

The undergraduate and post grad/CPD curriculum should include explicit competencies In public health, especially for GPs who have commissioning responsibilities in the new CCG system (individual).

Public health education could be delivered in multi-professional sessions with pharmacists and other health professionals as part of CPD to improve understanding and to encourage and facilitate cooperative working (representative organisation).

The Royal Colleges and FPH should work in conjunction to develop training to support GP training at a national level. Inter-professional standards for health improvement need to be rolled out across all medical professions (NHS organisation).

In its response, the RCGP set out plans for enhanced GP training that would see the curriculum extended to four years and include a numbers of outcomes that relate very closely to public health.

However, some respondents expressed caution that GPS should not be expected to become public health experts, as this would detract from their key role.

They should be given a basic understanding of all three domains of public health. They should also be introduced to issues such as the theory of behaviour change; the need for a whole-population perspective in commissioning and health economics (representative organisation).

Other respondents considered that this question could apply more widely with a need to enhance all healthcare professional

While this question specifically addresses GP training because of their critical role as the gatekeepers of advice and services, we believe this question applies to all health professionals and not just GPs. All health professional training needs to encompass public health and health improvement principles as a basic component of the curriculum (professional organisation).

It's hard to see why GPs have been singled out for enhanced health promotion training when more contact is made with practice nurses and reception staff (individual).

It would be helpful if the training of all healthcare professionals included a public health placement, given the criticality of an understanding of public health in initiatives such as 'Making Every Contact Count' (NHS organisation).

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

A significant majority of respondents were in favour of the workforce strategy describing potential career pathways for public health practitioners. Respondents commented that it was important that the career pathways reflected the position post transition, encompass the full range of settings (NHS, PHE, LAs), recognise the diversity of the public health workforce and be based on a framework of common competencies. However, there were also comments that career pathways should be realistic and not raise expectations among practitioners.

Access to a comprehensive and understandable descriptor of potential career pathways across a universal framework would help promote the role and function of public health, and engender interest in the discipline as a career choice (professional organisation).

Yes, we agree that this would be very helpful, and we believe it would support PHE in future rounds of workforce planning. The suggested career pathways should be reviewed alongside the workforce strategy so that any new trends in the way that individuals progress their careers can be assessed, and workforce strategy and planning be adjusted accordingly (professional organisation).

Describing the potential career pathways would be helpful if it is done from a vision of a dynamic workforce recruiting from a wide skill base, emphasising the added value of training and experience within public health if later returning to a wide range of core disciplines (professional organisation).

Other suggestions included promoting the PHORCaST public health careers website, updating the Public Health Skills and Careers Framework, providing healthcare practitioners with guidance about other senior roles in local authorities where their background knowledge and skills could be useful, ensuring that staff are supported either through time allowed by the employer or/and funding to develop skills and ensure their continued professional

development, or setting up a competency/membership organisation like CIPD that offered information and services to support the development of public health professionals.

> *Work could also be done to build on the work of the Public Health Skills and Career Framework, which looks at knowledge and skills across various levels* (professional organisation)

There were a number of respondents who expressed reservations about the proposal. Some felt that if health was to be everybody's business the workforce involved would be too diverse in terms of the number of disciplines and professions involved for common pathways to be identified. Others valued the current diversity of people working in public health and wouldn't want a career pathway to prevent this.

> *It is important to link any further development in this area with intended workforce planning at national and local levels as is informed discussion with employers. This is to manage practitioner expectations regarding what is available and to ensure that publicised career development pathways are matched with the reality of what roles and training support are made available on the ground* (professional organisation).

> *Perhaps, however i would not want this to become an exclusive list of pathways which could stifle the current diversity within PH that is valuable and has developed due to the dispirit career pathways practitioners have followed to get where they are* (individual).

> *Career pathways are too broad in scope, skill, perspective etc to be described for all the staff considered in the public health workforces categories. If public health is 'everybody's business', the career map will be unhelpfully complex. Also, the underlying premise of this report is that all people can contribute to the public health agenda, directly or indirectly. This suggests the need for a mass change in service culture and staff perspective, particularly those in health and social care roles. A change in perspective is not a new career pathway* (individual).

Question 10: What benefits would new ways of cross-disciplinary training bring to the public health workforces?

Respondents felt that cross-disciplinary training would bring a number of benefits including improved partnership working and collaboration, networking, flexibility and better understanding of the roles of others, reduced duplication and improved co-ordination, reduced silo working, better communication, and an increased focus on population health.

Several respondents however felt that these opportunities already exist:

> *Broader generic skill sets are also being developed through the inclusion of competency standards and frameworks managed in part by Sector Skills Councils. So in summary this is already a rich area, and well under way. It is probably more the case that there needs to be a bringing together of all the key initiatives that are taking place and widespread communication about provision and where this is all leading* (professional organisation)

> *Cross disciplinary training and education already exists. These new ways of working should enhance expertise, information sharing and long-term multidisciplinary working in Public Health* (individual).

A website for "People in Public Health" could help create a sense of identity and act as a supportive resource for students, trainees and all those working in public health (NHS organisation).

Question 11 – how can LETBs best support flexible careers to build extended capacity in public health?

A number of responses stated that there was little awareness within public health and local government about LETBs or what they will do.

We currently do not have knowledge of the LETBs however they can support flexible careers in public health by representing non-medical/clinical personnel and by providing and coordinating suitable training /qualifications to personnel within Local Government (local authority organisation).

We need a better understanding of the function of LETBs to answer this question fully but preliminary thoughts are to ensure there is advocacy for and provision of training for the PH workforce at every level (NHS organisation).

There was strong support from respondents for LETBs to have an appropriate skill mix, including appropriate representation from public health and for LETBs to have effective collaborative working arrangements in place, particularly with higher education institutions to encourage partnership development and encourage innovation.

The make up of the Board should ensure that local public health expertise is best utilised to inform how flexible career structures can be built to meet any planned extension of public health capacity (professional organisation).

…. it will be helpful for the composition of LETBs to be representative of the range of public health participants (professional organisation).

Relationships with a wide range of organisations need to be formalised to facilitate quality assured training across a wider range of sectors than at present (NHS organisation).

Key stakeholders in the new system must work with LETBs so that public health education and training is appropriately resourced and the skills et if maintained and developed (NHS organisation).

Respondents suggested many ways that LETBs could support flexible careers including provision of appropriate CPD and learning and development opportunities across professions, secondments across organisations to allow for learning across sectors, and the development of clear and robust career pathways.

Careers in public health are not linear. To a far greater extent than in other specialities, people come to public health late, and move between roles and organisations, public and private, academic and services as their careers develop (representative organisation).

The development of career pathways in public health would be useful and could support people who may move in and out of public health roles NHS organisation).

LETBs should ensure that public health is embedded within foundation training for a variety of public and voluntary sector professions, as well and, not only, in healthcare role training (NHS organisation).

Q12 Is the healthcare education outcomes framework appropriate for public health? If not, how could it be adapted?

A majority of respondents were positive about the applicability of the EOF to public health, but those who were less positive had significant reservations, which were of two main types. The most frequently cited reservation related to the focus of Domain 4 of the EO, NHS Values and Behaviour. Respondents pointed out that the future arrangements for public health will see most of the workforce working from local authority settings and that the specific reference to the NHS in the title of this domain and to the values outlined in the NHS Constitution would be regarded as inappropriate by these employers.

The Framework needs a greater public health focus, rather than an NHS focus (for example, it currently refers to NHS values and behaviours which will have less relevance for all public health workers) (professional organisation).

The second most common source of reservation about the applicability to the EOF to public health related to its generic nature. Some of the consultees were looking for specific, competency based, professional standards; indeed a number of consultees referenced such frameworks that have already been developed.

The Outcomes Framework does not say anything you could argue against but provides no blueprint for how you are going to achieve the main aim (local authority organisation).

Whilst the framework would seem appropriate, it does not appear to have sufficient detail to be of practical value (and does not appear to state anything that would be regarded as inappropriate or new with regards to traditional healthcare education) (NHS organisation).

It is noted that the EOF is very high level and further details are needed for it to be able to be applied locally and personally eg in addition to the core domains in the Framework, specific public health outcomes and standards need to be developed and documented (NHS organisation).

Question 13: How can flexible careers for public health specialists best be achieved?

Several respondents mentioned the risk of fragmentation of the workforce either on the lines of the medic versus non medic, or variation in employment status and employers (NHS versus local authority versus PHE). Staff need to be able to move easily between different employers.

‘ it would be very beneficial if they can move between employers and retain a specialist status. One of the potential barriers created by the new reforms is that movement between local, regional and national areas with the new system will result in loss of employment benefits (e.g. long service awards) if they have to change contracts, which is likely to make people more hesitant to move posts’ (NHS organisation).

Some suggested national standards should be set but local flexibility maintained, skills 'passports' could help with transfers. However, job security is important to ensure commitment.

> *Public health specialists should be able to move freely between employing organisations. From practical viewpoint, this means paying attention to details such as who pays their salary, pension arrangements, travel expenses, leave entitlement etc. These are often barriers to flexibility. They should be able to access NHS library and knowledge services and the same resources as their colleagues employed by the health service. The Public Health workforce should be defined by profession rather than organisation which might help to facilitate flexible working* (NHS organisation).

Some saw restrictiveness created between specialist and non specialist training and 'clinical' vs non clinical roles (e.g. health visitors). Analysts and some of the defined groups expressed concern about being drawn away from PH.

> *By taking away the emphasis on the old clinical approach to PH. This includes the latter's influence on the UK Public Health Register which is the very antithesis of 'flexible'* (local authority organisation).

Clear and robust career pathways recognised by both NHS and local government could hep to overcome these barriers. Joint posts, job shares, part time, secondments, honorary positions etc. could also help increase flexibility but must not create disadvantage.

> *How well the new infrastructure works will be dependent on working out the role and place of public health specialists and the opportunities that are presented for working with different employers across the revised system. There are inherent risks and dangers that there will be a loss of specialists who may move back into clinical roles with their existing employer* (professional organisation).

Question 14: what actions would support the development of strong leadership in public health?

Respondents submitted a range of views about the role and status of consultants:

> *Diversity of leadership will also come with a system that progresses people and not a system wholly reliant on medical consultants. The skills and experience of practical hands on knowledge should be recognized and valued. Both medical and non-medical experience should be recognized as complementary and provide a unique skill base for an occupation. Focus on experience, knowledge of people, rather than qualifications obtained – so provide leadership opportunities for a wider PH workforce Strong direction, clear info to leaders and from leaders, a need for a strong and active PH faculty* (NHS organisation).

> *Recognising the good work already being carried out by leaders in PH outside of the medical arena* (individual).

> *Make PH consultants responsible and accountable for a budget* (individual).

> *Increase the self esteem of the work force generally - people feel demoralised when they have no control or are not listened to and this is a common feeling of those working*

within PH currently. No change for a while would be helpful once this very extensive one is complete i(individual)*.*

There were comments about national level leadership

We would like to see greater clarity on the different national public health leadership roles of the Secretary of State for Public Health, Chief Medical Officer and Chief Executive of PHE and how they will work together to improve and protect the health of the nation (NHS organisation)

And….

Unfortunately, there is no recognised PH leadership currently. We have a CMO without a PH mindset, a CEO with no expertise or experience in PH and a reporting system which means that PHE will report to ministers thru career civil servants (individual)*.*

The specialty training programme is the major route to a career as a consultant in public health, taking four to five years of intensive training. Such training represents a significant investment and produces highly skilled public health leaders. It is essential that such individuals are not 'lost' during this transition period as a result of shrinking prospects for employment at an appropriate level within the public health workforce (NHS organisation)*.*

….However there is potentially a lack of joined up leadership and voice for public health as a profession. There is therefore an opportunity for more joined up leadership to be shared between bodies such as the CIEH, RSPH, Faculty of Public Health and the UKPHR (professional organisation)*.*

Question 15: What actions can be taken and by whom, to attract high quality graduates into academic public health careers?

There was a mixed response to this question – clearer information, more equitable opportunities for all entering public health and in employment, better links with Higher Education Institutes and more attractive packages in terms of funding and support come through the comments.

There needs to be a clear structure with appropriate salary. Led by Public Health department and the Department of Health. More training schemes like the one – SHA linked with local academic institution to provide fully funded academic course (PG Dip in PH Analysis) with salaried job placement in NHS as Trainee PH analyst (individual)*.*

Building links between HEI's and public health departments to identify areas for research and use the expertise of both would be beneficial. Research degrees that do not take the public health practitioners completely out of the workplace would assist in this. This would also help to reduce the disconnect that can be apparent between those that work in academia and those that work in the health service e.g. a focus on getting grants and getting published versus apply best evidence to practice to improve target orientated outcomes (professional organisation)*.*

The market can be stimulated by investment in recruitment drives and there are good examples of how other subject disciplines attract talented graduates in areas as diverse as engineering and the social sciences. It clearly involves discussion with Universities and their partners as well as involving LETBs and Public Health England – particularly if

there is going to be a shortfall in academic public health skills in future. However without information about the demand and supply issues it is difficult to analyse and suggest the most appropriate actions to be taken (professional organisation).

There is a significant disparity between the availability of funding for higher-level research projects for medical and non-medical public health specialty registrars which needs to be addressed. Academic Clinical Fellowships (ACFs) are an important pathway for talented medical registrars to qualify as public health specialists with developed academic skills and interests. These fellowships include protected time to work up a research proposal for NIHR funding and out-of-programme experience to undertake the research. At present there is no national equivalent scheme for non-medical registrars although some locally lectureship posts may be available without protected time (NHS organisation).

One or two people felt that academic qualifications are not the only attribute of successful public health specialists and quote nursing as an example of how an over emphasis on academic qualifications can erode practical skills.

Whilst qualifications are good, they are not enough on their own. I've known many graduates who are well endowed with bits of paper but lack the ability to interact with people and motivate them. A balance of skills necessary but don't let's focus solely on bits of paper! I would also suggest a rounded PH workforce - clinical and non-clinical. Our team works well because we have people with psychological backgrounds, social backgrounds etc. It's about the right mix of people and skills (individual).

I don't necessarily think high quality graduates are always the right people to attract to public health roles; many of the core skills of nursing have been lost since the introduction of graduate training and this has been reflected in the media with our "uncaring nurses". Traditionally nurses with good skills were able to train as the course was less academic however degree level has meant bright people with no/minimal nursing skills are doing the degrees. I understand that nurse education needed to be improved but there are good potential nurses missing out (NHS organisation).

…. training strengths and offers from these departments should not just be restricted to 'trainees' but also made available to public health employees (NHS organisation).

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

Several responses reaffirmed the importance of a strong intelligence function in the delivery of public health services and, related to this, there was concern that the I&I workforce warrants only a short mention in the consultation document despite the assertion that PHI&I is "…mission critical to effective delivery of public health". Respondents felt that the strategy should relate to the I&I system in England as a whole and not just the Public Health England I&I workforce.

The actions specified for PHE in terms of its own I&I function should be widened to the whole I&I function for public health ie the career pathways for I&I should include PHE, local government, CCGs, NCB and social enterprises (individual).

> *Public Health England will have a hugely important role for I&I, but so will local authorities and there is a real opportunity for public health in local authorities to be responsible for much of their I&I function* (NHS organisation).

A majority of respondents agreed that the actions proposed in the consultation (defining career pathways, traineeship schemes, accredited training courses, enabling pathways to registration as a public health "defined" practitioner or specialist) were appropriate but some felt that there were additional actions that could also support the I&I function including reviewing the scope and definition of public health I&I work and the competencies needed, developing practice through sharing case studies and linking more closely with academic public health

> *The suggestions of strengthening the public health information and intelligence function … are all valid* (NHS organisation).

> *The actions proposed are not sufficient. High quality analysts and people able to translate data into information and applied intelligence are in demand throughout the public sector and private sector workforce. We must strengthen our training opportunities, and later career opportunities for people in Public Health Information and Intelligence. We also need to differentiate between specialist public health intelligence skills and general local authority analytical capacity. This specialism will include epidemiology, insight, evidence, research and evaluation* (NHS organisation).

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

A small number of respondents commented on this question. Of those that did respond, most provided general comments but there was no specific evidence offered to help assess the impact of the proposals in the consultation document.

4. Conclusions and next steps

We are grateful to all those who responded to our consultation about the development of a public health workforce strategy. We particularly welcome, and are encouraged by, the level of constructive engagement and the broad mix of individuals and organisations that responded.

The wide range of perspectives in consultation responses have been extremely helpful in identifying the challenges in developing a workforce strategy for the new public health system. Responses have also equipped us with a number of valuable ideas and suggestions as to how we might approach and overcome these challenges.

Next steps: This document has been published alongside Healht Lives, Healthy People: a public health workforce strategy, the strategy that has been informed by this consultation process.

Annex A: 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?

Annex B: List of those who responded

Adfam
African Health Policy Network
Alcohol Concern
Alzheimer's Society
Association of Directors of Public Health
Association of District Nurse Lecturers
Association for Nutrition
Bath and North East Somerset Council
Bayer
Body and Soul
British Association for the Study of Community Dentistry
British Dental Association
British Dietetic Association
British Medical Association
British Psychological Society
British Society of Gastroenterology
British Toilet Association
Chartered Institute of Environmental Health
Chartered Institute of Library and Information Professionals
Cheshire and Merseyside Public Health
Child Accident Prevention Trust
Children and Young People Mental Health Coalition
College of Occupational Therapists
College of Optometrists
Core Cities Group
Council of University Heads of Pharmacy Schools
Darlington Borough Council
East of England Public Health
East Midlands Public Health Forum
FPA/Brooks
Faculty of Occupational Medicine
Faculty of Public Health
General Medical Council
Greater Manchester Directors of Public Health
Hampshire Public Health
Health and Social Care Information Centre
Health Protection Agency
Health Protection Agency East Midlands North
Health Statistics Users Group
Hertford and Bedfordshire Environmental Heads of Service Group
Institute of Health and Society
Institute of Occupational Health and Safety
Islington Council
Islington Public Health
Kirklees Public Health
Knowsley Public Health
Lancashire Directors of Public Health
Lancashire Public Health
Leeds NHS Public Health Directorate

Lesbian and Gay Foundation
Lundbeck
Medical Schools Council
Ministry of Defence
National Children's Bureau
NAVCA
National Lesbian, Bisexual and Gay Partnership
North East Lincolnshire Public Health
North East Regional Employers
Newcastle City Council
NHS Ashton, Leigh and Wigan Public Health Directorate
NHS Bolton
NHS Bradford and Airedale
NHS Cambridgeshire
NHS Central Lancashire Public Health Directorate
NHS Confederation
NHS County Durham and Darlington
NHS Coventry Public Health Department
NHS Cumbria and Cumbria County Council
NHS Doncaster Directorate of Public Health
NHS East of England Public Health
NHS Gloucestershire
NHS Leicester City Directorate of Public Health and Health Improvement
NHS London
NHS Medway
NHS North Lincolnshire
NHS North Yorkshire, North Yorkshire County Council, City of York Council
NHS Redbridge
NHS S/SCC
NHS South West
NHS Stockport Public Health Directorate
NHS Sustainable Development Unit
NHS Tameside and Glossop
NHS Tees Directorate of Public Health
NHS Wiltshire
NHS Wirral Department of Public Health
NHS Yorkshire and Humber Directors of Public Health
North West Public Health
North West Public Health Workforce Transition Group
Northern Deanery Specialty Registrars Group
Oldham PCT Directorate of Public Health
Pharmacy Voice
Public Health Manchester
Public Health NHS South Gloucestershire
Public Health Observatories
Public Health Specialty Registrars, SW England
Public Health Teams for Dorset, Bournemouth and Poole PCTs
Public Health Wales
Public Health Workforce Advisory Group (Sub-group on regulation)
Queen's Nursing Institute
Right Management
Royal College of General Practitioners

Royal College of Midwives
Royal College of Nursing
Royal College of Psychiatry
Royal Pharmaceutical Society
Royal Society for the Prevention of Accidents
Royal Society for Public Health
Sandwell PCT Public Health Department
School of Public Health North East
School of Public Health Wessex Deanery
Skills for Care
Solutions for Public Health
South West London Public Health Analysts Consultation Team
Specialty Registrars, Wessex Deanery
Specialty Registrars Committee, Faculty of Public Health
Staffordshire County Council
Staffordshire Public Health
Stockton Council
Stonewall
Strategic Health Authority Library Leads
Substance Misuse Skills Consortium
Sustrans
Tameside Metropolitan Borough Council
Telford and Wrekin Council
Telford and Wrekin Public Health
Total Improvement Processes Ltd
Tower Hamlets Public Health Directorate
Turning Point
University College London
UK Healthy Cities Network
UK Public Health Register
UK Public Health Register National Practitioners Coordination Group
UNISON
Unite
University of Nottingham
University of Portsmouth
Wakefield MDC
Wellcome Trust
West Midlands SHA
Yorkshire and Humber Public Health
Yorkshire and Humber Public Health Observatory
Yorkshire and Humber social marketing network

In addition, we received responses from 100 members of the public

Annex C: Code of Practice on Consultation

Criterion 1: When to consult

Formal consultation should take place at a stage when there is scope to influence the policy outcome

Criterion 2: Duration of consultation exercises

Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

Criterion 3: Clarity of scope and impact

Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

Criterion 4: Accessibility of consultation exercises

Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

Criterion 5: The burden of consultation

Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

Criterion 6: responsiveness of consultation exercises

Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

Criterion 7: Capacity to consult

Officials running consultation exercises should seek guidance in how to run an effective consultation exercise and share what they have learnt from the experience.