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

Final North West Response

Question 1: Do you agree that a public health workforce strategy should be reviewed regularly? If so, should this be every three or every five years?
• Depends on the agreed lifespan of the final strategy but reviewed every 3 years - linked with 3 year funding cycle. • 5 years is too long in a rapidly developing public health system.
Question 2: Are these four groups a useful way of describing the public health workforces?
It is useful to categorise the workforce into different groups, but the current grouping needs to be altered as: • Workforce groupings needs to be meaningful and applicable to LAs and rest of PH system and other workforce strategies • Senior level staff (which are not consultant) are not represented by the categorisation of practitioners • The implications of registration on some workforce. • The list of job function examples does not reflect the wider remit of PH roles, a comprehensive list needs to be included or an example under the 3 domains of PH. • % of time spent undertaking public health functions could be a mechanism for defining roles. WHO is currently consulting on a European Action Plan (EAP) for Strengthening Public Health Capacities and Services to support member states improve health, tackle inequalities and deliver effective services. The EAP has 10 essential public health operations (EPHOs) all of which have workforce implications in terms of numbers, location, skills, training and resources required. The EAP is being submitted to the WHO Regional Committee in September 2012. It's content and implications (including guiding principles) should be considered in relation to this consultation.
Question 3: Do you agree the 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?
• Support the creation of nationally agreed definitions and methods of enumeration of both consultant and practitioner workforces. • Workforce planning should be developed at a local level through the LETBs using nationally agreed framework of methodologies and definitions which have accountability to HEE
Question 4: Would these values, combined with the features of public health in Box 2 (p18), 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?
• Helpful to have a single vision, values and principles. • *Advocacy* might also be included • *Vision must be in language that is meaningful to LA and other i*ndividuals and agencies outside the NHS.
Question 5: What further actions would enhance recruitment and retention of truly representative public health workforces?
• Creation of career development pathways for all levels of staff , e.g. health intelligence staff • Raising the profile of public health and its impact on population health through a celebration of the success of immunisation programmes against meningitis and rubella or measles, smoke free places, screening programmes, • Promotion of evidence on effectiveness of treatments / interventions • Learn from career pathway development in other professions – such as healthcare scientists, physiotherapists, nurses. • Quality leadership to take on the mantle of developing clearly defined career pathways for public health.
Question 6: Are there workforce challenges and opportunities we have not identified? What support could be put in place to help meet these challenges?
• The public health workforce will be fragmented across the system, this brings both challenges and opportunities • Influencing Public Health England and Health Education England to develop the national system on public health training • Influencing Local Education and Training Boards (LETBs) to ensure commitment to developing skills and training in the new public health workforce system. • Potential disinvestment in training • Reducing budgets can create a real commitment to do things differently and work in partnership • Diminishing budgets and reduced capacity to deliver services to local communities
Question 7: How can local people be encouraged to develop their skills for public health in the new system?
Communities already have considerable assets, skills and capacity for health and wellbeing and building and mobilising these using assets approaches should be a key area of competence across the whole public health workforce. Recognise that communities currently contribute significantly but PH contribution not always recognised. Elected members will become advocates for public health within communities and by influencing Health and Wellbeing Boards. They are aware of the impact of (ill) health on their local communities but are not technical experts. They will need the opportunity to develop public health skills and knowledge. Skills development locally needs to link to JSNA in order to address local health & wellbeing priorities.

There are already effective quality assured ways to deliver and build skills, for instance:

- RSPH Level 2, Understanding Health Improvement award to develop health champions and support elected member development
- Apprenticeship programmes within LAs, NHS and other organisations, with opportunities to promote these locally, particularly in areas of high inequalities
- Health at work schemes– engaging organisational and personal commitment to building health in the workplace
- Developing learning platforms to support knowledge transfer and sustainability so best practice is from the out-going system is not lost is the new.

Leadership is needed at all levels.

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

The public health element of GP training needs to be strengthened. This could be delivered in a number of ways::

- Incorporate into the current GP training, an optional 6-month placement to an approved public health training slots in Local Authorities
- Promote a Masters in Public Health or other training for GPs.
- Mandate as a joint responsibility of GP Specialist Training Schemes and Public Health Specialist Training Schools. For example, to produce one trained GP with an additional PH offer, for every 20 GPs trained
- Agree standard Faculty requirements to be a GP specialist with endorsement from Royal College of GPs and Medical Royal Colleges

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

- Developing of Career Pathways in public health are essential at all levels of the public health workforce.
- This will support people in their careers and also people who move in and out of public health roles.
- Some progress has been made already at describing career pathways for entry level to the public health workforce. The most comprehensive information about public health careers for all levels (including case studies) is currently found at www.phorcast.co.uk
- Opportunities need to be explored to produce a fluid workforce across the system.

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

- Public health is multi-disciplinary and Cross-disciplinary education and training already occurs
- This bring a diversity of complementary knowledge and skills sets
- A longer term vision is needed to support and fit the new system. Current changes present a potential risk of losing diversity, in particular workforces from clinical backgrounds, who wish to remain closer to the NHS.
- Importantly, multi – disciplinary training should be co – located in order to

secure joined agendas and really achieve a flexible workforce working towards same goals.
- Requires effective partnership working arrangements with academic PH colleagues to secure good cross disciplinary working.

Local Authorities will be mandated to provide public health support to NHS commissioners and to do this effectively will need to retain public health specialists with clinical backgrounds. Under-graduate and post-graduate medical training needs to provide exposure to local government and promote the contribution that public health specialists can make within local authorities.

Question 11: How can LETBs (Local Education Training Boards) best support flexible careers to build extended capacity in public health?

1. The education and training needs of the new public health system need to be recognised by LETBs and NLGs.
2. Key stakeholders in the new system must work with LETBs so that public health education and training is appropriately resourced and the skills set is maintained and developed.
3. Greater clarification is needed about Registration for the public health workforce – both specialists and practitioners. Some regions have already invested in Practitioner Registration programmes working through UKPHR.
4. Questions need to be resolved about how clinical staff can maintain registration whilst working in an LA commissioned role.
5. LETBs need to develop flexible careers for health care – that recognises the benefits that diversity in the workforce brings to public health.
6. Needs to be a strong interface between LETBs and other funding organisations responsible for workforce development in order to secure effective cross boundary PH workforce skills development.
7. Need to maintain variety of routes into public health.
8. Strong advocacy required to secure PH workforce development.

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

Partly - Healthcare Education Framework has 5 broad outcomes- excellent education, competent and capable staff, adaptable and flexible workforce, widening participation and NHS Values & behaviours. These outcomes are a set of expectations across the whole healthcare education and training system.

- PH education and training should be aligned to first 4 outcomes
- Regarding the NHS values and behaviours outcome –the system needs to have commitment to CPD and Professional development
- As most of the PH workforce will be outside the NHS, having an outcome specific to NHS values and behaviours does not fit. Values and behaviour will be derived from the workforce's employing organisation.

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

- The training programme needs to have some flexibility built in to allow for caring and other commitments
- Provide a range of pathways for "specialist" workforce.
- Utilise prior accreditation models – so as not to limit entry and maximise

existing expertise in the system.

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

- Leadership development should be part of training and professional development at all levels of public health, from the practitioner and wider workforce. From the workforce working with groups and volunteers to the very senior director.

- Public health principles and values need be included within mainstream leadership programmes to support the development of integrated (and health-aware) systems.

- Public Health England should have the opportunity to establish a world class system for public health leadership development, including succession planning.

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

The development of the new public health system creates an opportunity to increase robust and meaningful engagement between academic public health and service delivery (both in LAs and the NHS). This could include, for instance:

- Academics sitting on transition/Health and Wellbeing Boards
- Public health service managers working with universities to support the development of new curricula
- Closer collaboration on the development of research and implementation of findings.
- Greater marketing of academic PH and its value
- Better links between NHS /LA/ academic public health – there are significant examples of good practice – for instance, the collaboration in the North East between the universities and service providers (www.FUSE.ac.uk) led by Professor David Hunter

All parts of the system will need to work together to achieve this.

Public Health England has an opportunity to demonstrate the value of academic input in developing the new system and career pathways.

Raising the profile of public health careers could help attract a greater number of high quality graduates: The creation of secondments with public health services and academic institutes, building on the models of Harkness Fellowships and NICE trainee placements.

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?

- PHI&I staff are not a homogeneous, easily-defined group. The historical lack of career pathways and academic training provision means that professional qualifications specific to this field of work are largely non-existent. PHI&I organisations have developed ad hoc in-house training and CPD for their own staff

• A large part of the PH intelligence workforce will be moving to local authorities, often as part of a corporate intelligence function. The system needs to ensure analysts get opportunities in public health, skills development and access to educations and training. • This arrangement provides the potential for developing and strengthening the PH information and intelligence function by training other, non-PH analysts in PH competencies. • The new system provides an opportunity to review current activity around PHI&I workforce development and to make improvements for the future. This could include the development of: • PHI&I career pathways. • Traineeship schemes • Training and CPD provision relevant to "real-life" PHI&I practice informed by PHI&I-specific competency frameworks. • Accredited training courses with recognised professional qualifications. • Pathways to registration as a PHI&I "defined" practitioner or specialist
Question 17: Do you have any evidence or information that would help analyse the impact of these proposals?
To be explored in the consultation workshops

The use of the term 'specialist' has been used in 2 contexts throughout the document. One to describe a consultant in public health and the other to describes the whole team. This has led to confusion. The term specialist should be defined to ensure clarity.

Complied following a 'straw man' exercise led by the task & finish group outlined below and supported by a series of four wider workforce consultation events held in Cheshire & Merseyside, Cumbria, Lancashire and Greater Manchester. **http://healthandcare.dh.gov.uk/consult-workforce**

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