People in UK Public Health

Summary report setting out our recommendations for consideration by the four Health Departments of the UK's four nations

PART 1

Public Health Workforce Development beyond Covid-19: The advisory group's recommendations to the four Health Departments

Foreword

The People in UK Public Health Advisory Group ("the advisory group") has considered the course of the COVID-19 pandemic in the UK to date and the response of the UK's institutions. The advisory group has examined in particular the performance of the UK's public health systems.

We have sought to capture early learning from the various aspects of the public health response. We have discussed what we think has worked well, what has worked less well and where improvements might be made. We have also kept in mind developments in workforce development that were already in progress before the pandemic began.

There have been significant achievements in developing the core public health workforce over the last five years. While there would have been plenty to do over the next five years, the COVID-19 emergency has brought home the urgency of some of the tasks, re-prioritised others and highlighted areas not previously covered adequately.

We appreciate that more formal reviews will take place later but we think it will be helpful to the Health Departments of the four nations to know at the outset the views of the advisory group on matters relating to the public health workforce. We seek to learn lessons and apply the learning to immediate issues of public health workforce planning.

We have also sought to encapsulate our thinking in a set of workforce principles of fairly general application. In this way, we believe that all four Health Departments may find our contribution helpful even accepting that future workforce developments may differ in each of the four nations at more operational levels.

COVID-19 demonstrates that in times of severe threat greater public health capacity is needed. Not every severe threat will be because of a pandemic, it is reasonable to expect threat variety and a higher incidence of threats than in the past. Complex threat situations will require multidisciplinary, multi-level responses. Surge capacity for an effective public health response will require an appropriate mix of skills and personnel.

Below we set out TEN recommendations, our 10-point plan for actions required to deliver agile, effective and responsive public health systems going forward.

David Kidney, Chair, on behalf of People in UK Public Health advisory group

November 2020

Our recommendations

We recommend that:

(1) No-one should expect that all public health capacity will be provided solely through the maintenance of a dedicated or core public health workforce. First, a multidisciplinary response calls for a mix of skills and expertise within and beyond public health. Secondly, the dedicated or core public health resource is finite. Thirdly, additional public health capacity can be drawn in when needed to meet severe threats provided public health education and training can reach into wider workforces to ready this additional capacity.

(2) The Public Health Skills and Knowledge Framework (PHSKF) is a valuable tool for identifying, assessing and developing public health competencies in all relevant workforces. Full digitalisation of the PHSKF as soon as possible is essential to support the drive to maximise public health capacity.

(3) Developing more population health skills in the healthcare workforce is underway and is welcome; it should be accelerated and supported with relevant training materials. Similarly, there are tools for developing these skills in relevant wider workforces (those from which additional capacity will in future be drawn) and these are also to be encouraged. There are excellent online resources in each of the nations and the challenge is to share, network and grow these resources.

(4) The COVID-19 pandemic has laid bare gaps in public health intelligence and data management. The only way in which these gaps can be addressed, at least in the short-to-medium term, is through sharing expertise across disciplines and across organisations, additional training and re-training programmes and enhancing IT capabilities, including machine learning and Artificial Intelligence capabilities.

(5) The true value of delivering public health lies in the inter-relationship between the main pillars of public health practice – health protection, health improvement and healthcare public health. These relationships have been demonstrated time and time again during the COVID-19 pandemic: where the need for test, trace and isolate meets raised vulnerabilities (for example, obesity) and meets healthcare limitations (for example, safe hospital discharge). These inter-related, multidisciplinary, complex challenges require organisational designs that can bring together a workforce of adequate size and appropriately trained and developed, skilled in the three main pillars and supported by the necessary science, research, data and intelligence.

Recommendations (continued)

(6) The dedicated or core public health workforce contributing to this combined effort is not even properly identified, mapped and planned currently. In the Department of Health and Social Care, a project to establish a minimum data set to enable this basic work to be done has been stalled for years. It is urgently necessary to improve workforce intelligence, secure a pipeline of future talent and systemise development of people resources to get the very best out of this workforce. Ensuring diversity in this workforce which serves all communities matters, and providing equality of opportunities for career development matters, too.

(7) Much good work has been done to develop leadership skills and to nurture talent with promise to become future leaders of the public health system. The public health systems of the four nations have introduced support for current leaders and training and preparation for future leaders. The next step must be to build up appropriate developmental support at all levels of the public health workforce if these public health systems are to become agile and fully responsive.

(8) Significant added value is achievable through an approach to systems thinking and leadership at all levels which agitates within and beyond the core public health workforce for integrated, multi-level leadership. Collaboration with scientific, digital and academic communities is essential and this collaboration must be ingrained in relationships between the dedicated or core public health workforce and the wider workforces where the additional public health capacity resides..

(9) A public health workforce organised along these lines can offer attractive careers, both for new entrants (at all levels) and for existing personnel ambitious to develop, progress and reach higher levels of responsibility within the system. In support of these very positive messages, there is a need to develop career maps and careers advice. Routes into careers in public health should be facilitated, and there is value in cross-fertilisation of talent through encouraging movement between organisations and employers. Some work has been done to identify barriers to mobility, but not enough has been done to overcome those barriers yet. Recently, public health apprenticeships have been developed, and acting on these recommendations offers an opportunity to give rocket boosters to the intake of apprentices in public health systems.

(10) It hardly needs saying that under-investment in public health systems prior to COVID-19 played a part in reducing the ability of public health to respond at the scale and speed required at the outset of the emergency. A lesson surely that proper resourcing is essential for public health to be truly effective in its mission to improve health and wellbeing and reduce health inequalities.

People in UK Public Health Nov 2020

People in UK Public Health

Full report and recommendations for consideration by the four Health Departments of the UK's four nations

PART 2

Public Health Workforce Development post-Covid19: The advisory group's report to the four Health Departments

Background

The purpose of this report is to provide the support of the People in UK Public Health Advisory Group ("the advisory group") to the four Health Departments on developing the public health workforce in the wake of COVID-19.

In England, *Fit for the Future*[1] has been the strategic framework for public health workforce development since 2016. It was intended to guide development through to 2021 and is currently under review.

In Northern Ireland there has been no fundamental review of the wider public health function since the establishment of the Public Health Agency in 2009. However, there has been a recognition of the requirement to have a workforce in place which is able to meet the demands of the extant Public Health Strategy "Making Life Better" and the wider "Programme for Government", now known as *New Decade, New Approach*[2].

In Scotland, *Fit for the Future* was used as a starting point to inform the Commission on Leadership for Public Health Workforce Development. This was ahead of the launch of Public Health Scotland and the commitment to provide leadership in ensuring a strong, effective, forward looking public health workforce, in the broadest sense, and across the whole system in Scotland. The Commission was asked to advise on how leadership for the public health workforce should support the ambition for "A resilient, competent and agile workforce that is able to tackle inequalities and enact system change to meet current and future public health challenges and improve and protect the health and wellbeing of the population of Scotland."

In Wales this year, Public Health Wales NHS Trust launched its People Strategy 2020-30: *Our workforce to achieve a healthier future for Wales* [3]. With *Fit for the Future* as one of the sources used to inform its development, the Strategy sets out nine themes under which actions must be realised to deliver strategic priorities, including Attracting and Recruiting Talent, Skills for the Future, Workforce Shape and Planning and Optimising Relationships. Every part of the workforce, including public health practitioners and professionals, will be developed to deliver the Strategy. The next 12 months will see Public Health Wales focus on five key organisational priorities, including the future of work: how the pandemic has shaped purpose, design and ways of working, individually and collectively.

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[1] Fit for the future: public health people https://www.gov.uk/government/publications/fit-for-the-future-public-health-people

[2] A New Decade, a New Approach. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf

[3] A Healthier Wales: our workforce strategy for health and social care https://heiw.nhs.wales/files/workforce-strategy-for-health-and-social-care/workforce-strategy-for-health-and-social-care-final-draft/

Rationale

The UK response to the COVID-19 pandemic has strongly featured the current public health workforce. Some aspects are very positive, for example a greater public and policy recognition of the vital contribution that this workforce makes to protecting and improving the public's health and wellbeing. Some aspects are more challenging, not least historic under-resourcing of public health and a consequent inability to flex and to provide surge capacity at the scale and speed necessary at the start of the emergency.

The UK Faculty of Public Health has contributed a recent publication about the *future structures and standards of the public health system.*[4]

We have summarised what we think are the main areas needing immediate attention and we have formulated a **10-point plan of recommendations** for the four Health Departments. We set out the actions which we believe are required to deliver the required agile, effective and responsive public health workforce needed over the coming few years.

We understand the different positions of the four nations. They currently are in different stages of development of their public health workforces and there are organisational and structural differences. Nevertheless, we believe that the recommendations we make are applicable as general workforce principles across the UK.

We have taken *Fit for the* Future as our starting point in that we gave consideration to all of the five themes in it as we worked towards writing this report.

We have noted, in *Fit for the* Future and in other publications, much use of the concepts of a *core public health workforce* and a *wider public health workforce*. Having regard to the changing demands on our public health systems and the complexity of the challenges we all face, we throw open the question how useful this classification will be going forward.

We also note the wider use of the term *Population Health* (particularly within the NHS) which we treat as synonymous with *Public Health*.

Capacity in public health

More than anything else, COVID-19 has shown just how vital an effective health protection function is – not just in the public health workforce, but in the skills of other workforces, too - in responding to severe threats like pandemics. There needs to be a system for training, verifying and identifying those people in other workforces beyond public health who can be drawn into health protection work in an emergency.

As COVID-19 also demonstrated, the other main pillars of public health practice – health improvement and healthcare public health – are completely complementary to health protection. As we have seen with the added impetus to tackle obesity and the safe discharge of patients from hospitals, there are strong interactions between all these three pillars during an emergency (and the more preventative work that can be carried out in anticipation of future emergencies, the better prepared nations will be to face those emergencies).

However, there are also underpinning, complementary and supporting activities that are equally crucial to successful public health practice. These include systems thinking, science, research and data, intelligence and analysis, academia, and effective public health workforce planning.

[4] Functions and standards of a Public Health System
https://www.fph.org.uk/media/3031/fph_systems_and_function-final-v2.pdf

Data and their analysis (and timely reporting) have been proved to be the very lifeblood of tackling an emergency as severe as COVID-19. The scientists involved at every stage of the process have in the past sometimes felt under-valued. They have certainly proved their worth now. As we consider how to develop a public health workforce fit for the future, it will be necessary to accommodate public health scientists more centrally, with the recognition in terms of status and significance that their roles merit.

Academic public health is a key part of the workforce. As we move forward, there will be a need to develop stronger links between all academic public health departments and the dedicated or core public health workforce and their employers. We argue that there is a pressing need for us to understand this workforce better, as well as the courses, qualifications and continuing professional development that they offer.

In Northern Ireland in the months leading up to the COVID-19 pandemic there was a push to finalise arrangements for the establishment of a multidisciplinary training scheme. The programme for practitioner registration has operated in a limited way for several years but will require a significant boost after the immediate COVID-19 crisis has passed. The COVID-19 pandemic has thrown into sharp and painful relief the significant disadvantages of not fully utilising or developing the public health workforce. In particular, generic training at practitioner level across the three domains of public health. More than ever, in order to maximise capacity, the plan is to repurpose the public health cadre in order to adapt to changing demands as the COVID-19 pandemic progresses. Development of leadership in Public Health across disciplines is also seen as an urgent priority once the immediate crisis has passed.

In Scotland, a need has been identified not to lose sight of population health and the impact of health inequalities including on vulnerable groups and communities and in relation to place-based wellbeing. This is across society not only public health.

The *Public Health Skills and Knowledge Framework*[5] ("PHSKF") has been transformed in recent years. It has been welcomed and put to use in all four nations. There has been some delay in developing its full digitisation (what was originally called a "digital passport") and we argue that digitisation is now an important and pressing next step.

The importance of the PHSKF lies in providing the means to assess public health competence of individuals and across organisations. It can help in guiding public health content in Job Descriptions, self-assessment of users' competences, and professional development, including reflection and accumulation of evidence.

The UK Faculty of Public Health has paused a review of the *Public Health Specialty Training Programme Curriculum*[6] (the current version is the 2015 Curriculum) in order to await the outcome of any relevant COVID-19 reviews. There is an opportunity, therefore, to make changes to this Curriculum in line with new thinking about the future needs of the public health workforce.

The UK Public Health Register (UKPHR) completed a first review of the standards for public health practitioner registration in 2016, which led to the publication of amended standards in 2019.

UKPHR registration is open to public health specialists, Specialty Training Registrars and public health practitioners everywhere in the UK. There are UK professional standards for other key workforce professions such as Health Visitors, School Nurses and Environmental Health Practitioners.

[5] https://www.gov.uk/government/publications/public-health-skills-and-knowledge-framework-phskf/public-health-skills-and-knowledge-framework-august-2019-update
[6] https://www.fph.org.uk/media/1131/ph-curriculum-2015.pdf

We recommend that:

- ***No-one should expect that all public health capacity will be provided solely through the maintenance of a dedicated or core public health workforce. First, a multidisciplinary response calls for a mix of skills and expertise within and beyond public health. Secondly, the dedicated or core public health resource is finite. Thirdly, additional public health capacity can be drawn in when needed to meet severe threats provided public health education and training can reach into wider workforces to ready this additional capacity.***
- ***The Public Health Skills and Knowledge Framework (PHSKF) is a valuable tool for identifying, assessing and developing public health competencies in all relevant workforces. Full digitalisation of the PHSKF as soon as possible is essential to support the drive to maximise public health capacity.***
- ***Developing more population health skills in the healthcare workforce is underway and is welcome; it should be accelerated and supported with relevant training materials. Similarly, there are tools for developing these skills in relevant wider workforces (those from which additional capacity will in future be drawn) and these are also to be encouraged. There are excellent online resources in each of the nations and the challenge is to share, network and grow these resources.***
- ***The COVID-19 pandemic has laid bare gaps in public health intelligence and data management. The only way in which these gaps can be addressed, at least in the short-to-medium term, is through sharing expertise across disciplines and across organisations, additional training and re-training programmes and enhancing IT capabilities, including machine learning and Artificial Intelligence capabilities.***
- ***The true value of delivering public health lies in the inter-relationship between the main pillars of public health practice – health protection, health improvement and healthcare public health. These relationships have been demonstrated time and time again during the COVID-19 pandemic: where the need for test, trace and isolate meets raised vulnerabilities (for example, obesity) and meets healthcare limitations (for example, safe hospital discharge). These inter-related, multidisciplinary, complex challenges require organisational designs that can bring together a workforce of adequate size and appropriately trained and developed, skilled in the three main pillars and supported by the necessary science, research, data and intelligence.***

Building a 21st century public health workforce

COVID-19 has shown significant gaps in Workforce Intelligence and this needs to be addressed as a priority. There have been occasional research programmes aimed at identifying the numbers and characteristics of the Public Health Consultant workforce but little else. This has made workforce planning (for example, identifying and addressing career bottlenecks) and redeployment in an emergency difficult. This knowledge deficit needs remedying as soon as possible.

The pervasive significance of public health leadership, not only within the dedicated or core public health workforce but also across systems is widely recognised. There have been a number of initiatives to improve leadership training and preparedness for leadership, which are most welcome. It is imperative that these initiatives become mainstream and appropriately resourced. In Scotland, this has led to greater emphasis on the need for public health leadership – and political astuteness - at every level.

At the height of the COVID-19 emergency, it was perhaps inevitable for there to be some top-down centralised leadership. However, subsequent developments starkly re-emphasised the need for strong local systems leadership as well.

There is a need to explain more clearly what we mean by *systems leadership* and map how different levels of leadership will operate more seamlessly, especially in an emergency.

We also need to ensure that all parts of the public health workforce can access leadership development, beyond strengthening the pipeline for future Directors of Public Health.

In Scotland, there is interest in reworking the definition of the public health workforce, both to recognise the need for greater diversity and to stress the linkages with colleagues in the NHS, in communities and in the third sector. The demands on the NHS, especially in terms of COVID-19 rehabilitation and recovery, highlights workforce development opportunities and scope to frame the contribution of others, for example Allied Health Professionals.

We recommend:

- ***The dedicated or core public health workforce at the heart of the four nations' public health systems is not even properly identified, mapped and planned currently. In the Department of Health and Social Care, a project to establish a minimum data set to enable this basic work to be done has been stalled for years. It is urgently necessary to improve workforce intelligence, secure a pipeline of future talent and systemise development of people resources to get the very best out of this workforce. Ensuring diversity in this workforce which serves all communities matters, and providing equality of opportunities for career development matters, too.***
- ***Much good work has been done to develop leadership skills and to nurture talent with promise to become future leaders of the public health system. The public health systems of the four nations have introduced support for current leaders and training and preparation for future leaders. The next step must be to build up appreciation and support at all levels of the public health workforce if these public health systems are to become agile and fully responsive.***
- ***Significant added value is achievable through an approach to systems thinking and leadership at all levels which agitates within and beyond the core public health workforce for integrated, multi-level leadership. Collaboration with scientific, digital and academic communities is essential and this collaboration must be ingrained in relationships between the dedicated or core public health workforce and other workforces where the additional public health capacity resides.***

Attracting talent into public health systems

An obvious starting point for new entry into the public health workforce is a public health apprenticeships. The first public health degree (Level 6) apprenticeship has been approved by the Institute for Apprenticeships and Technical Education (IfA) and, *in England*, public funding is available to support it. There are some technical rules around the apprenticeship outside of England. Universities in Wales, Scotland or Northern Ireland may deliver the training for an English apprenticeship standard. *In Wales*, perhaps the nearest current equivalent is the Level 7 Health & Care Intelligence Specialist apprenticeship. *In Scotland*, the Level 6 standard may be recreated for approval under the Scottish scheme.

A new Level 3 Community Health and Wellbeing Worker Apprenticeship is in development for approval by the IfA.

There are more and wider opportunities for public health careers bubbling up. Examples include *Advanced Public Health Practitioner* and *Advanced Clinical Practitioner in Public Health*. Work has started to develop more population health skills in the healthcare workforce, but this needs to be accelerated.

There will be opportunities for rethinking medical and other health professional training.

Past work to develop public health (population health) qualifications by way of credentialing for those wanting to practise more in public health or to make progress in public health careers was not universally welcomed. A variant of this approach, however, may be helpful to help augment the public health workforce with extra capacity and skills, for example in health protection and/or Advanced Clinical Practice.

Equally, there are opportunities to upskill the workforce without educational qualifications. There is much to build on, including Population Health Fellowships and e-Learning resources such as *Making Every Contact Count* [7] ("MECC") and *All our Health* [8].

We acknowledge work led by all four nations in developing and making resources available to a wide range of audiences.

In England, joint work by Health Education England and Public Health England led to the creation of a *population wellbeing portal* [9], where e-learning content to support public health has been curated and can be accessed from a single portal. *In Wales*, this portal is signposted for the health and social care workforce by Public Health Wales.

In Scotland, Public Health Scotland has drawn together e-learning modules, event information, resources and forums in a *Virtual Learning Environment* [10].

These resources should allow for the promotion of existing resources and platforms. To aid easy navigation, where new content is identified as requiring development, it will be helpful to ensure stronger collaboration in this space to avoid duplication of content and resources.

There is further work to be done on e-learning resources, particularly in terms of directory, signposting, improving navigation, addressing gaps, collaborating and sharing. The risk of not collaborating is a flooded marketplace leading to potential confusion amongst learners trying to access good quality public health e-learning resources.

Public Health remains very popular as a career choice, as evidenced by competition for job and training places. The COVID-19 emergency has provided a boost to visibility and has stimulated greater interest in public health careers. Many people come into public health mid-career driven by a desire to address 'the bigger picture'.

However, understanding and joining the public health workforce is still very complex and entry points are not clear. Career maps and careers advice need developing. We believe that these shortcomings need to be addressed as soon as possible by the four Health Departments, with added emphasis in the anticipated post-COVID workforce reviews.

In Scotland, specific issues that are being addressed include:

- career options for public health and skills mix required for public health work
- a balance of generic and specialised roles in public health
- equitable access to roles in public health
- the value to be placed on voluntary registration and what support there should be for those preparing portfolios for assessment
- consistency in describing public health skills in job descriptions and adverts.

[7] https://www.makingeverycontactcount.co.uk/
[8] All Our Health: personalised care and population health
https://www.gov.uk/government/collections/all-our-health-personalised-care-and-population-health
[9] https://populationwellbeingportal.e-lfh.org.uk/
[10] https://elearning.healthscotland.com/

We recommend:

- ***A public health workforce organised along these lines can offer attractive careers, both for new entrants (at all levels) and for existing personnel ambitious to develop, progress and reach higher levels of responsibility within the system. In support of these very positive messages, there is a need to develop career maps and careers advice. Routes into careers in public health should be facilitated, and there is value in cross-fertilisation of talent through encouraging movement between organisations and employers. Some work has been done to identify barriers to mobility, but not enough has been done to overcome those barriers yet. Recently, public health apprenticeships have been developed, and acting on these recommendations offers an opportunity to give rocket boosters to the intake of apprentices in public health systems.***

Ensuring resilience, flexibility and mobility

COVID-19 has shown we still have significant work to do to ensure the required levels of resilience, flexibility and mobility. The weakness of workforce intelligence has made it difficult to know how best to find and redeploy people at speed and at scale. Capacity issues added to the difficulty.

Previously, there were some attempts to improve mobility around the system for members of the core public health workforce. An example of this from 2018 was *Public Health England's consensus statement on placements* [11]. Similarly, *in England*, the Standing Group on Local Public Health Teams developed guidance for employers [12] of public health workforces. The advisory group commends both these publications to employers.

There is a need to re-double efforts to ensure movement between employers is possible without detriment, as well as increase secondment, internship and shadowing opportunities.

The elephant in the room is of course the levels of funding for public health. The long-run austerity programme, for example, led to reductions rather than growth in public health resourcing. It has taken a tragic pandemic to bring home how very damaging this under-resourcing has been. The advisory group very much looks forward to an alternative approach to funding whereby past cuts are restored and funding going forward is targeted on implementation of these recommendations wherever possible.

We recommend:

- ***It hardly needs saying that under-investment in public health systems prior to COVID-19 played a part in reducing the ability of public health to respond at the scale and speed required at the outset of the emergency. A lesson surely that proper resourcing is essential for public health to be truly effective in its mission to improve health and wellbeing and reduce health inequalities.***

[11] *Public Health England's Placements in the public health system: consensus statement https://www.gov.uk/government/publications/placements-in-the-public-health-system-consensus-statement*

[12] The Standards for employers of public health teams in England https://www.local.gov.uk/standards-employers-public-health-teams-england

Conclusions

We intend this report to be one of doubtless many contributions to forthcoming debates and discussions about the UK's future public health workforces.

We commend our recommendations – our 10-point plan of action – to policy-makers, employers, education and training providers and to all the individuals who have worked tirelessly and with the utmost determination during the COVID-19 emergency.

We trust in reading out report you can see that it is possible to build back better when it comes to developing our public health systems to better serve the populations of the UK.

We all share the desire for a united public health effort to improve the public's health and wellbeing and to reduce health inequalities – an important element of future "levelling up".

After changes are made, there will be an ongoing need for monitoring, evaluating and revisiting the public health structure and function to ensure that what we do is effective (and stop doing anything found to be ineffective) and when the challenges change, the public health response can adapt to address the change.

David Kidney, Chair
On behalf of People in UK Public Health
Nov 2020