Summary

Funded by NHS Education South Central (NESC) the Public Health Development Leads (PHDL) group was established, in October 2007 for a period of 18 months, to identify, record and reach local public health practitioners, an organizational need that had been noted by the Public Health Development Team. Invitations to apply were sent to each of the nine Primary Care Trusts within SCSHA and leads had to be nominated and supported by their Director of Public Health to be released for this work for (0.1 wte) per week. Seven Trusts accepted the invitation; one Trust did not have the capacity to release a member of staff, and one declined. Subsequently this Trust has felt its staff have been disadvantaged by not taking part and has now requested to join. It was realized that this group of public health practitioners could, in addition, contribute to addressing key public health issues identified in the Wanless Report (2004) and recently reiterated by Darzi (2008). Namely disseminate public health knowledge, strengthen relationships with Local Authorities and develop education for public health practitioners and the wider workforce. These three areas have provided the overarching framework for all subsequent work undertaken by the Leads.

The Leads have worked both as individuals within their Trusts and as a group to implement and deliver the tasks listed on their work plans. Their work has exceeded that of the original plan and has included development of the Learning Needs Assessment (LNA) to be used as a tool in conjunction with the Public Health Skills and Career Framework and the establishment of practitioner workshops. Both were large projects that might not have been developed, or delivered as quickly, if the PHDLs had not been able to work together as a group. Indicative of the need for this work is the fact that the LNA even in its pre-pilot stage has generated much discussion and the PHDL group has received enquiries from regional and national bodies requesting to take part in its piloting. Work by the Leads has also ensured that SCSHA is in the forefront of the organization and delivery of learning sets in preparation for the anticipated professional registration of public health practitioners. The Leads have worked hard in publicizing their role within their PCTs and other agencies, and gaining recognition as a source of current public health information. They have become known as a point of contact for information on education and training for staff at all levels and in some instances have been pro-active in developing training. All leads have been successful in putting staff forward for career development, including one member who has gained a place on the specialist training course. The Leads have shown great commitment and enthusiasm for this role but would make strong recommendations that if the role is to continue more time is allocated for the work.

The work of the Leads has been valued by their own and other agencies. For the work to continue consideration needs to be given to the issue of sustainability. The Leads, themselves have begun to address this by working to incorporate public health into corporate planning documents, inductions for new staff and job descriptions. However, this does not address the issue of the role of the Leads themselves. The current PHDLs are strongly of the opinion that this role requires a designated lead within the PCT if the work is not to be subsumed by the challenges of day to day service delivery. One suggestion for achieving sustainability has been the incorporation of this role into the job description of existing or new staff within the PCT. However, this alone may not be enough to perpetuate the momentum of the public health development work currently being undertaken. It appears important that for the success of this role those appointed as PHDLs are provided with a forum to come together, share ideas, network, discuss and progress new projects and implement an SHA wide approach to public health.
Background

The Wanless Report Securing Good Health for the Whole Population (2004)\(^1\) cites public health as ‘the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.’ In his report Wanless stresses the role of public health in re-orienting the focus of the NHS from caring for the sick to promoting good health. To achieve this he recognized that ‘...Capacity in the workforce needs to be developed; with appropriately broad skill mixes.’ joint working between PCTs and Local Authorities needs to be strengthened… ‘and responsibilities should be assigned for the educational role, previously played by the Health Education Authority… at a time when full engagement requires the public and the health workforce to have more support.’

Subsequent government papers which include: the NHS Operating Framework (2007)\(^2\), Commissioning Framework for Health and Well-being: Making it Happen: Ministerial Statement (2008)\(^3\), High quality care for all: NHS Next Stage Review, Final Report, (2008)\(^4\) echo and build upon the findings of Wanless (2004). Lord Darzi’s report of 2008 states ‘...this report focuses on what the NHS can do to improve the prevention of ill health.’ ‘...every PCT will commission comprehensive wellbeing and prevention services in partnership with local authorities...’ as part of this there needs to be …a clear focus on improving the quality of NHS education and training.’

The Work plan of the Public Health Development Leads Group (PHDL) in line with the recommendations of Wanless (2004) and Darzi (2008) highlights dissemination of public health knowledge, strengthening of relationships with local authorities, and development of education for public health practitioners and the wider workforce, as key areas of their work.

Funded by NHS Education South Central [NESC]\(^5\), the decision to establish a Public Health Development Leads group arose from the realisation that Public Health Development within NESC needed to identify, record and reach local public health practitioners in the various organisations who undertake public health roles. There is national recognition that the public health workforce is far wider than specialists and consultants. Not only does the PH workforce work across sectors (e.g. in universities, local government, health protection agency etc), but also at practitioner and “wider workforce” levels of both seniority and involvement. In the NHS the public health specialist workforce is mainly employed in PCTs, led by the Director of Public Health, now jointly accountable with local authority.

Data gathered by the PHDLs will be used inform the work of those in the SHA involved in learning and development, education commissioning and workforce planning. Each Director of Public Health (DPH) has a responsibility for workforce development for public health within their own community, the numbers of which, since the introduction of Directors of Public Health as a joint appointment with the Local Authority have expanded, possibly creating a greater need for the

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\(^{5}\)NESC was established in April 2007 to support the development and education of health staff and assist South Central SHA in achieving its long term aspirations to improve the health of its population, reduce health inequalities and enhance patient safety. http://www.southcentral.nhs.uk/page.php?id=182 (date accessed 09.09.2008)
PHDL role. By inviting the DPH from each of the nine Primary Care Trusts (PCTs) within South Central SHA (SCSHA) to nominate a member of their Public Health team it was hoped that this would ensure commitment and support to the work of the leads.

The model had been tried previously in the north of South Central (former Thames Valley SHA area) by the Public Health Resource Unit (PHRU) where it was thought to be a valuable role. Similar models of working exist in NESC and are encouraged in other areas of work, such as the Education Leads group worked with by the Widening Participation Manager.6

Funding

Funding to backfill the PHDL role was provided by NESC for 3.75 hours per week for a period of 18 months from October 2007-March 2009. It was one element of a larger bid to the SHA for practitioner and wider workforce development. Applicants would be released for these (0.1 wte) hours from their current post, or additional hours could be provided for part time members of staff. Time to attend PHDL meetings was also included within the 3.75 hours. It was anticipated that applicants would be experienced members of staff with strong public health backgrounds, probably working at AFC bands 6-8, express an enthusiasm for innovative, developmental work and have the ability to swiftly develop this new role.

Selection Process

Of the nine PCTs in SCSHA invited to participate seven put forward applicants. One applicant covered two PCTs and held this role for half a day in each, one PCT declined the invitation and one, despite their strong interest in the project, put forward a member of staff whose participation needed to be on an ad hoc basis as the team did not have the capacity to permit staff release. Consequently this PCT declined to accept the backfill offered for the post. The non-participating PCT subsequently felt their staff to be disadvantaged and are now moving to become involved.7

Nominee applications were required to be signed by both the Director of Public Health and a line manager to ensure official support for the PHDL and their work in this role. To determine their personal level of commitment applicants were asked to detail why they felt they would succeed in this role. Even at this initial stage, some applicants could see the potential for the PHDL project to enhance the work of public health teams within their PCT and noted:

*I believe that we can only be successful in improving health and reducing health inequalities in our community by engaging the wider public health workforce. This will involve identifying key personnel and developing systems and processes to support them and their professional development in public health.*8

*This could really help embed Public Health and Health and Wellbeing 1 in everyone’s work locally*9

Those selected to join the group included one member at AFC band 5, one at band 6, four at band 7 and one at band 8. Five of the group had Masters level qualifications in public health or health related subjects and one is currently studying for a Masters. Only two of the group members were in posts that included public health development as a major part of their work, prior to becoming a PHDL, the remainder, were based in health promotion or health improvement.

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7 Group Chair questionnaire June 2008  
8 Application of group member 4 (July 2007)  
9 Group member 2 baseline form (July 2007)
Applicants provided information listing their knowledge of local, regional and national public health agendas, local public health networks and organizations, numbers of public health staff in their PCT, availability of local public health courses and local training and development agendas. This enabled the Chair to assess the prior knowledge and skills of the group and determine how best, in the first instance, to develop and implement the work plan.

**Terms of Reference**

At the first meeting ways of working were discussed and it was agreed that meetings would be held quarterly, augmented by email communication and, later on, by teleconferences between the meetings. Most meetings were held in Newbury as the central point of SCSHA, and to minimize as far as possible the distances travelled by individual group members. Newbury is a location well served by public transport and car sharing was encouraged. Teleconferences were held between quarterly meetings with the aim of enabling the group to ‘meet’ but lessen their carbon footprint. All correspondence relating to the organization of the group was sent electronically and members were requested to print out documentation only when essential. A data projector and screen were provided for meetings, again, so that documents could be viewed by the group electronically. Administrative and organisational support for the group was provided by the Public Health development team at NESC. The high standard of the administrative support enabled the Leads to focus on their PH development work, something that became increasingly important as the work of the group progressed. All PHDLs agreed to the work plan for the group which was to be monitored as the work progressed and formally reviewed at the end of a year. Membership was not limited to the Leads other colleagues could be invited to join the group on request.

The first agenda for the group was devised by the Chair. Subsequent agendas were arranged in consultation with the group to ensure that the meetings were relevant to their needs in carrying out their public health development work. Evaluation sheets compiled after each quarterly meeting by the Leads also included a space to list suggestions for future work and discussion items for forthcoming agendas. To date four meetings of the group have taken place.

**Accountability**

Activity/Reflective logs were completed monthly and sent by the PHDLs to the Chair recording the tasks they had undertaken against the PHDL work plan. The Leads listed their work under four columns: activity, action points, comments, length of time. Some chose to add a fifth column, reflections on activity. The logs worked to keep both the individuals and the group focused on the PHDL tasks. Guidelines were given to the leads for completion of the sheets to use if they wished. The logs were shared amongst the group who found it helpful to see how others were undertaking the tasks, discuss issues and share advice if requested. The logs enabled the Chair to establish what additional support, information or training would be beneficial to the Leads in assisting with their work either as a group or individually.

A report of the PHDLs work was sent monthly by the Chair to the Head of Innovation, Development and Wider Workforce (IDWW) at NESC, the activity logs of the Leads providing the basis for these reports. Incorporated into larger reports the work of the PHDLs was disseminated across NESC and SCSHA, through monthly management reporting processes. From the inception of the project it was agreed that an evaluation of the PHDL work would be carried out by a NESC Research and Development Manager. At the time of the establishment of the PHDL group a strategic board had not been established in South Central for PH training, education and development. This met for the first time in June 2008 and reporting will now also be to this Board.
Evaluation and Method

For the purposes of evaluation the researcher was invited to attend the group meetings as an observer and was included in all group email correspondence. With consent, copies of completed activity logs were made available to the researcher.

Data from these sources was used to develop a questionnaire sent to the Leads to gather their experiences and views of working as a PHDL during the previous 9 months (see appendix 3). A separate questionnaire was completed by the Chair. Due to the small number of participants in this project it was not possible to carry out a quantitative analysis of the data. Therefore a qualitative approach was considered the most appropriate method for analyses and interpretation of all data sources.10

Ethics

All participants were informed about the purpose of the evaluation, how it would be conducted and reported. All participants gave consent to take part and for documentary material created by them during the course of the project to be used in the evaluation. Participants were assured that their names and other identifiers would not appear in the final evaluation report. Participants were informed that they would be sent a copy of the draft report and given the opportunity to comment.

PHDL work plan

Prior to the first meeting a draft work plan and list of tasks devised by the Chair was sent to the PHDLs. This was further developed by the group and subsequently revised in agreement with each DPH by the PHDL to incorporate their local PCT public health priorities. The work plan involved two sets of tasks, those to be undertaken individually and those together as a group.

Leads were requested to:

- Read the strategy for SC PH Education, Training and Development
- Understand the Public Health Skills and Career Framework
- Discuss with DPH local priorities for workforce development for public health.
- Assess training needs of local providers commissioned by the PCT, e.g. those in health promotion work.
- List public health staff interested in the Defined Specialist portfolio or taking the Faculty of Public Health Part A exam
- Read corporate documents relating to workforce development e.g. workforce strategy, HR Training Plan, LDP, and community plan.
- Understand the structure of their organization
- Identify those in the PCT responsible for training and development.
- Begin to identify and make contact with Local Authority staff with responsibilities for public health.
- Create a database of local public health practitioners and local public health networks.
- Consider the development of a training needs assessment for local public health practitioners.
- List all local health promotion and public health courses, including level of course, location, cost and award details.
- List public health training provided by your PCT or Local Authority.

As a group:

- Develop a database structure to record contacts for use by PHDLs and NESC PHD
- Develop a Learning Needs Assessment for use by PHDLs

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• Develop a CPD programme with PHDL, Specialist Training Programme Directors and the Faculty CPD Co-coordinators.
• Develop and commission the SC Part A support programme
• Develop and distribute information about the academic Bursary Scheme
• Collate list of all relevant local and national health promotion/public health courses and their providers.
• Develop flyer to inform local workforces of all PH opportunities
• Identify, commission and/or provide workshops and seminars as appropriate.
• Invite guest speakers to PHDL group meetings as appropriate
• Regularly review professional body websites to keep updated.

Findings

Mission Statement and Vision Statement

Created together at an early stage of the project, the group considered these statements to be important and embodied for them the central focus of their work as PHDLs and how they linked to the SCSHA aim of achieving ‘A skilled and competent workforce that prevents disease, protects and promotes health and prolongs healthy life for the population of South Central.’

Mission Statement

To act as the Public Health Development network group across South Central providing information and support for public health career and competence development for the NHS and its health and wellbeing partner organization workforces across South Central.

Vision Statement

As representatives of the group we facilitate and motivate local workforces to increase their public health and health promotion competence through training and development, both to further individual careers and to contribute to the improvement of health and the reduction of health inequalities across South Central.

The group found it hard consigning a large task and role into a concise statement. Each word was seriously considered. For example how as individuals and as a group would they act as facilitators? How would they publicise their role? How could they implement the delivery of key public health aims? The group hoped that by working together they would be able to accomplish a greater number of their objectives through their sharing of intelligence, resources and expertise.

Meetings

The quarterly meetings of the group were conducted over a full day, with lunch usually taken as a working lunch. Ground rules for working together were established at the first meeting and were agreed as:
• confidentiality and anonymising comments
• being open and sharing challenges
• preparedness to share documents and resources.

These were considered important if the members were to be able to learn, make mistakes and move forward in achieving their group goals. As the group became established and the level of discussion and reporting back increased it became necessary to adhere strictly to the timings on the agenda and continue discussions via email or telephone conversations outside the meeting. The group found the telephone meetings useful as a means to communicate simple information and as an adjunct to the quarterly meetings but, would not like them to replace the quarterly meetings. They were not considered a suitable forum for group wide discussion, sharing of documents, discussion of individual issues or networking.
These were all features greatly appreciated as components of the quarterly meetings and viewed by the group as necessary for the progression and faster delivery of their work plan.

Very useful to hear updates from colleagues in other areas – this has really helped me to evaluate what I have been doing and given me direction for where I need to focus my efforts.\(^{11}\)

Feel we are working together well as a team now – becoming productive. I value the feedback for each areas activity.\(^{12}\)

Although very well structured, meetings also allow time to explore difficult issues.\(^{13}\)

…it’s this discussion and reflection with colleagues which helps me most in my PHDL work. I understand better what others are doing and can make links with my own situation in a mutually supportive relaxed environment.\(^{14}\)

…as much as anything it’s the quick chats you can have between the important bits! It’s been very helpful to develop relationships with others in the group – it’s much easier to pick up a phone or respond to an email if you know the face.\(^{15}\)

The PHDL who was not backfilled and attended only one quarterly meeting still valued this opportunity ‘…it was good to put faces to names and was easier to discuss issues’.\(^{16}\)

Support provided by the Chair to members of this group included: dissemination of national and regional information and documentation on public health at the quarterly meetings and via email, provision of individual support to the Leads, if requested, and at the instigation of the Leads locating specialist speakers to attend meetings. As a result of the Chair’s longstanding connections and high esteem in the field of public health\(^{17}\), speakers responded quickly to requests to address the PHDLs.

Speakers have included:

- Simon Bryant, trainee – PH Specialist Training Scheme
- Clare Griffin, PH PTS Manager : The Practitioner Training Scheme’.
- Rhiannon Walters, PH consultant : Developing Local Authorities as Public Health Organisations
- Viv Speller, PH consultant - Leading Improvement and Health and Well Being and South East Teaching PH Network
- Pat Christmas, PH consultant - PH Practitioner Learning Sets’

The speakers were chosen to increase the Leads knowledge and understanding of three key areas of their work plan; developing the workforce, implementing and disseminating knowledge and use of the PHS&CF, and linking with local authorities. Comments from evaluation sheets noted:

\(^{11}\) Quarterly meeting evaluation sheet – these sheets were completely anonymous.
\(^{12}\) Quarterly meeting evaluation sheet
\(^{13}\) Quarterly meeting evaluation sheet
\(^{14}\) Group member 5, questionnaire June 2008.
\(^{15}\) Group member 2, questionnaire June 2008.
\(^{16}\) Group member 7, questionnaire June 2008.
\(^{17}\) During this period the Chair was elected an Honorary Fellow of the Faculty of Public Health in recognition of distinguished services in the field of public health.
Information of Part A and Practitioner Training Scheme very helpful to fill knowledge gaps. I now feel more confident in advising about learning opportunities at a higher level to other colleagues.

The group in return supported the Chair by working jointly on the PHDL mission and vision statements, responding within 48 hours to email requests for information, providing comment on internal draft documents, critiquing national documents and considering their implications for the delivery of local public health initiatives, development of a Learning Needs Analysis (LNA) to be used in conjunction with the PHS&CF, and the development of training for public health practitioners and the wider workforce.

**Work plan progress and targets achieved - July 2008**

<table>
<thead>
<tr>
<th>Targets</th>
<th>Started</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Read the strategy for SC PH Education, Training and Development</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>2  Understand the Public Health Skills and Career Framework</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>3  Discuss with DPH local priorities for workforce development for public health.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>4  Assess training needs of local providers commissioned by the PCT, e.g. those in health promotion work.</td>
<td>✔️</td>
<td>ongoing</td>
</tr>
<tr>
<td>5  List public health staff interested in the Defined Specialist portfolio or taking the Faculty of Public Health Part A exam</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>6  Read corporate documents relating to workforce development e.g. workforce strategy, HR Training Plan, LDP and community plan.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>7  Understand the structure of your organization</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>8  Identify those in the PCT responsible for training and development.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>9  Begin to identify and make contact with Local Authority staff with responsibilities for public health.</td>
<td>✔️</td>
<td>ongoing</td>
</tr>
<tr>
<td>10 Create a database of local public health practitioners and local public health networks.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>11 Consider the development of a training needs assessment for local public health practitioners</td>
<td>✔️</td>
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<tr>
<td>12 List all local health promotion and public health courses, including level of course, location, cost and award details.</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>13 List public health training provided by your PCT or Local Authority</td>
<td>✔️</td>
<td>✔️</td>
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</tbody>
</table>

**Work plan targets**

The Leads began work on all of the targets listed on their individual work plans and had by the end of June completed over 75% of them. They are aware however, that several of these tasks will need to be repeated on a regular basis if they are to continue to be effective in their development role, for example, the updating of databases and reading of corporate documents. Tasks marked with a cross comprise elements of the work plan that will continue for the duration of the project. The group is nearing completion in their development of a learning needs analysis tool which will help assess training needs for public health practitioners, those in health promotion work and the wider workforce and enable them to progress these elements of their work plan.

Early in 2008, each PHDL developed their own work plan for the period April-September 2008, based on a template agreed by the group.
1. **Strategy for SC PH Education, Training and Development**

All members of the group read and commented on this document. It provided the starting point for awareness of the scope of NESC’s work in the field of public health and how this would be taken forward. This was important because NESC itself was a new organization, still in the process of disseminating knowledge of its role and function throughout the SHA. One lead noted ‘This was a good context setter for the role’.

2. **Public Health Skills and Career Framework**

All members of the group read and commented on this document and points raised were officially fed back via the Public Health Resource Unit and Skills for Health, the publishers of the document. One lead observed that ‘the PHS&CF needed to become part of nurses and doctors undergraduate courses, public health should be there from the start’, and was writing material to be incorporated into the induction of student nurses.\(^\text{18}\) Another commented:

> The publication of the PHS&CF has been instrumental in providing a necessary direction and a direct set of standards to work with. This has made the task of facilitating development a whole lot easier (easier in a general sense). It has also make it very clear what the underpinning aspects of public health are – which helps with cross organization understanding.\(^\text{19}\)

Recognising the importance of this document, led PHDL members to organize and run two one day workshops, one in the south of the SHA in Winchester and one in the north in Oxford, to introduce the framework to colleagues and members of the wider workforce who have links to public health. The Agenda for the day explained why the framework had been developed, how it could be used as a tool to determine the public health knowledge and skill levels of all staff, not just those employed within PCTs but also non-core public health organizations. The workshops stressed how and why public health was the responsibility of everyone. Leads were successful in achieving strong attendance at both events. Participants for the workshops came from several PCTs, Local Authorities, the police force and universities. The workshops provided an opportunity for participants to give feedback to the speaker (from Skills for Health) and the organizers about the framework and how it might be used or improved. One City Council staff member commented:

> You need to change the language, make it part of the culture. It needs to be done from the top to make it (use of the framework) a priority. For local businesses – sell it to them, e.g. it may help to cut absenteeism.

At this workshop the leads again recognized the need for the Learning Needs Assessment (LNA) to be used as a tool running alongside the PHS&CF. One PHDL observed ‘How can you expect people in non-core public health organizations to know about health models? Could we develop some national self assessment tools to help?’

The workshops provided an opportunity for the PHDLs to introduce themselves and publicise their role as leads. This enabled participants to ‘put a face to a name’ and generated questions immediately. Often the Leads found a willingness amongst organisations to increase public health knowledge but a lack of ideas on how this could be achieved. At one workshop in response to an enquiry about public health training a lead was able to say, ‘You can always come to us as your PHD Leads, we can provide support, workshops and have some access to funding’. The Lead continued by pointing out that training was not always expensive, there were different ways of learning, a training course was not always appropriate, sometimes needs could be met by work shadowing. The PHRU website is to be developed to provide more support and information on the PHS&CF. [www.phru.nhs.uk](http://www.phru.nhs.uk)

\(^{18}\) Group member 3, researcher notes 30 November 2007.

\(^{19}\) Group member 1, questionnaire June 2008.
As a follow up from this workshop the Leads are trying to ensure that knowledge of the PHS&CF is widely known amongst senior members of their PCT staff. The activity sheet of one Lead noted:

Workshop follow up – sent email highlighting the PHS&CF to the team and the need for a strategic view on how this should be taken forward. Head of PCT Human Resources to raise this at the next Directors meeting.20

The Leads repeatedly have found personal contact to be important as a method for progressing many of their work plan targets.

3. Local priorities for workforce development for public health

Discussion with DsPH or line managers to prioritise tasks was completed at an early stage by the Leads and was informed by the initial work plan agreed to by the group. It was recognized by the Leads and their DPH that it would be hard to accomplish all elements listed on the plan in 3.75 hours per week, resulting in the need to focus according to PCT priorities. The priorities of each PCTs differed but included:

- The development of a learning needs assessment tool for school nurses and leisure centre staff.
- Community Pharmacists – better utilization as part of the wider public health workforce
- Development of training and education opportunities for bands 1-4 in public health
- Creation of a database to provide information for public health development and address local CPD needs for PH practitioners.
- Preparation of local primary care staff for undertaking a Cardiovascular Disease Health Inequalities Project.

Throughout the project the leads have regularly reported back to line their managers and DPH. This has ensured that their public health development work continues to fit with PCT priorities, maintained the profile of their work in the PCT, created space for a two way discussion, either in person or via email and enabled the lead to request team support when necessary.

4. Assess training needs of local providers commissioned by the PCT, e.g. those in health promotion work.

As members of the group were variously situated in both the provider and the commissioning arms of their PCTs they were able to share information which enabled greater understanding of how each branch was continuing to evolve and operate. Three of the PHDLs worked closely with Health Trainers, one as a provider of health trainers training, one as a commissioner of health training for trainers and one as an employer of health trainers. All three were examining the development of the Health Trainers and other roles in AFC bands 1-4 at a local and a national level, including the possible development of Assistant Practitioners in public health and a foundation degree in public health. As a member of the National Health Trainers Hub and the Expert Reference Group for Health Trainers City and Guilds award, one PHDL was able to inform the group of this work and the implications it would have for Health Trainers and their training within SCSHA. This information was taken back by the Leads to their individual PCTs. In attempting to assess training need requirements the usefulness of the Learning Needs Assessment tool as a means of providing baseline evidence to inform what training should be provided once again became apparent.

20 Group member 3, activity log 2008
5. List public health staff interested in the Defined Specialist Portfolio or the Faculty of Public Health Part A exam.

All leads made enquiries to find staff interested in the portfolio and the Part A exam, but realized their need for a more detailed understanding of these and other public health qualifications if they were to be able to correctly inform and encourage colleagues. This resulted in the invitation to the speakers listed above to address the group. The PHDLs were all successful in finding staff that were interested in further training and in some cases were able to advise staff to apply for education bursaries funded by NESC. In anticipation that professional registration will become necessary for all public health practitioners for the sake of public protection, work listed under this section grew to include listing staff between bands 5-7 who would be interested in taking part in learning sets designed to advise on the requirements of registration. Several of the PHDLs were themselves interested in the taking part in these learning sets which are going to be organized by the leads and held across the SHA. A highlight for the group was the success one of the PHDLs in gaining a place on the national Public Health Specialist training scheme, having been supported locally to take the Part A exam. The PHDL credited participation in the PHDL work and the support of colleagues as contributing to a successful application.

6. Read corporate documents relating to workforce development e.g. workforce strategy, HR Training Plan, LDP, and community plan.

The PHDLs found reading these documents helpful in enabling them to understand ways in which public health knowledge and training could be expanded to build public health capacity in the workforce especially among non-core public health staff. All PHDLs rapidly recognized the importance of ensuring public health was written into strategy and planning documents for progressing public health development and implementing change. Writing documents or liaising with teams responsible for strategy/planning documents increasingly became a key focus of their work. To date PHDL work is now incorporated into one PCT corporate plan, another will include mention of public health knowledge and skills development. A third PHDL is developing a public health development plan for the PCT which will encompass the Public Health Team and the wider workforce. Others reported:

The role has enabled influence on the local HIS Delivery Plan 2008-11. Also it has led to an invite to be part of the PCT Education Forum where the potential to influence/input to policy/strategy is quite high. I believe the focus of the work may lead to wider influence than this in time.

‘B’ to now include Public Health Skills and Career Framework in general workforce development strategy.

I have been asked to write the Public Health Workforce Development Strategy. Have linked with the Associate Director for Workforce Development in the PCT. Also, this work has lead to School Nurses job descriptions being re-written.

Work with the Public Health Commissioning Team to identify ways health promotion and public health can be included in the new organizational development plan and other strategic plans.

Whilst there have been many successes the PHDLs feel that there is still work to be done in ensuring that public health development remains on the agenda. For example, one lead is conscious that in the corporate plan for their PCT

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21 Group member 5, questionnaire June 2008.
22 Group member 1, questionnaire June 2008.
23 Group member 4, activity log 2008.
24 Group member 4, questionnaire June 2008.
‘The objectives of the provider arm of the PCT do not mention public health. This Directorate contains the majority of PH practitioners such as health visitors, school nurses etc., However, PHDL work will continue to try and engage meaningfully with these groups’

7. Understand the structure of your organization

This task was not straightforward for the Leads and required them to think deeply about how they could deliver their work plan. Each of the seven PCTs were different in size, structure and the location of public health staff within the PCT. Five of the Seven PCTs in the project have recently completed, or are continuing to undergo restructuring. Changes created by the reordering of strategic health authorities into alignment with local authority boundaries has resulted in one lead now working in the largest PCT in the country.

The PCT is the largest in the country, employing 3500 staff, and was formed from 7 smaller PCTs. It covers the same area as …(the) County Council, the boundary of which includes 11 boroughs, and district councils. There are 5 acute hospital trusts, 2 ambulance trusts, 2 mental health trusts and a prison is also based in the area.26

For this lead, advertising the role and becoming known as the contact point for information regarding training and education opportunities for public health staff has been an immense task. This lead felt that despite having worked in the role for nine months ‘…given the size of the area I am still not very visible!’ Another member is working in an organisation that has been undergoing a provider/commissioner split, which, has resulted in a splitting of the public health team itself into providers and commissioners. The two groups continue to hold joint meetings but are now physically located in different buildings in the city. Consequently maintenance of good relationships and dissemination of information continues but requires more organised effort than previously. For a third PHDL senior members of staff leaving and a delay in reappointments left the PHDL temporarily unsure of reporting lines for this work. Due to the provider/commissioner split within this PCT the lead found someone they previously reported to no longer had a remit for public health development, the PCT had a period without a Director of Public Health and no clear priorities. The lead identified others to help take the work forward, for example the OD project lead but this took time.27

8. Identify those in the PCT responsible for training and development.

The leads as a group identified ways in which public health could be incorporated at low cost to include greater numbers of staff, in addition to identifying those in the PCT responsible for training and development. Ideas included adding public health to corporate inductions and statutory and mandatory training. The leads ensured that staff responsible for training had knowledge of all the specialist and practitioner public health training available in the SHA, the education bursary scheme and that this information was added to PCT websites. Ongoing reorganization sometimes made it hard for the leads to engage with those responsible for learning and development

‘The size of the PCT, a recent massive restructuring, ongoing reorganization when I started this role and still now, the L&D team are undergoing a further restructuring. These factors make it quite difficult to get the right people on board.’28

One lead discovered those responsible for learning and development when making a funding bid to NESC for training purposes. The lead shared with the group that it was not possible for them as leads to submit an application direct to NESC. The bid must be submitted via the PCT and this necessitated linking with the education leads.29

26 Group member 3, questionnaire June 2008
27 Group member 5, activity log June 2008.
28 Group member 3, questionnaire June 2008
29 Application for funding for public health foundation certificate. Group member 4, researcher notes 30 November 2007.
9. **Begin to identify and make contact with Local Authority staff with responsibilities for public health.**

All leads have begun work in this area and located staff with responsibilities for public health in their Local Authorities. In conjunction with this, the leads have identified other staff for whom they consider public health development is, or could or should be, a part of their work. These include environmental health officers, leisure centre staff, local authority planners and voluntary youth workers. The leads questionnaires revealed that working with local authorities and other linked agencies, were the areas in which they still had the most work to accomplish. Wanless 2004 noted that:

*The role of community pharmacists will also need to be developed to expand overall capacity in the increasingly important management of chronic conditions and take pressure off traditionally skilled people*.

In light of this two of the leads have begun to make links with community pharmacists and the medicines management team. Another lead felt that with additional training pharmacy counter staff could contribute to public health promotion and was seeking ways to take this forward.30

Two PHDLS worked in organizations that had established formal links with the local authority in their area and joint meetings of PCT staff and Local Authority staff took place regularly. One was working with the local authority to develop joint Knowledge and Skills Frameworks (KSF)31 this lead felt that local authorities were lagging behind the NHS in workforce development. With DPH posts now having joint accountability across the local authority and the PCT, work in this area is important for creating greater understanding between the two organizations and developing the opportunities for shared training and workforce development. The second PHDL had mixed success in taking forward PHDL work. When presenting the PHS&CF to a health team within a local authority the lead had a challenging reception as some staff could not see the relevance to their work and resented the ‘imposition from health’. Following further discussion outside of the meeting, the Lead worked hard with this committee and was able to note in the activity log that one of the key individuals "now seems to better understand the purpose of the PHS&CF and understands that this is about health activity rather than applying it across the board to the whole service." This incident highlighted to the group the need to be clear when presenting information and ensuring that it has been correctly understood. Not all working with local authorities has been problematic one lead has achieved great success in providing Health Impact Assessment training to various departments in a local authority, including the planning and transport departments, economic regeneration and the strategy unit.32

10. **Create a database of local public health practitioners and local public health networks**

This was done by the leads individually. Although databases were not shared, information to be sent out was shared amongst the leads. The databases were used by the leads to disseminate: knowledge of the local existing and forthcoming training opportunities and education bursary details, cascade national documents and initiatives related to public health, share public health newsletters, advertise workshops – PHS&CF and the forthcoming learning set workshops in preparation for practitioner registration and to advertise themselves as a point of contact for enquiries and information related to public health training and work within the PCT. This was a very effective way to quickly advertise their work within the PCT but needed to be done in conjunction with attendance at PCT meetings and personal contact.

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31 Group member 6, researcher meeting notes 19.10.07
32 Group member 4, Chair questionnaire June 2008
11. **Consider the development of a training needs assessment for local public health practitioners.**

The development of a training needs assessment, later renamed the learning needs assessment, became a central focus for the work of the PHDLs. They realized that much of their work plan could be executed more quickly if they could develop a tool that was simple to use for both public health and non-core public health staff for example, staff in local authorities, leisure centre staff, or school nurses. This has been a major task for the group which increased in significance with the publication of the draft PHS&CF. As previously stated the group viewed the framework as good in that it provided a direct set of standards to work with and made clear what were the underpinning aspects of public health. In their opinion the framework needed an additional tool that could be used by specialist and non specialist staff to determine the public health training needs of their staff. This information could then be used to inform the work of learning and development leads or workforce planners and education commissioners. One lead as part of their contribution to the work of the group undertook to map the job descriptions of school nurses against the PHS&CF and was surprised to find that qualified school nurses AFC band 5 were mainly level 2 in the core areas and level 3 in health improvement, whilst AFC band 6s were mainly 2 and 3 on the core areas and level 5 in health improvement.33 This lead was looking forward to using the LNA with the school nurses to compare with the mapping of their job descriptions. The Head of Nursing and the Public Health Development Lead for this area were surprised that the public health elements and levels in the job descriptions were so low. They were very keen to pilot the LNA when it was ready. Already as a result of the work of this lead the PCT are rewriting all school nurse job descriptions to ensure PHS&CF competencies are included. The Chair has received enquiries about the LNA to asking if this was being developed as a national piece of work for the Public Health Resource Unit or Skills for Health, and could it be shared with the SE Teaching public health network.34 The lead was asked if the LNA could be used for mapping the levels of public health competencies in degree and masters courses? The enquirer was interested to see that the PHDL taking the lead for this work ‘had not only interpreted the language of the competence but the language to describe the knowledge/knows how and competency shows how, i.e. The I can, I can explain to another statements’ This function of the LNA was intentionally designed to meet the needs of those who are not so familiar with public health terminology.

12. **List all local health promotion and public health courses, including level of course, location, cost and award details.**

The leads listed the courses they knew and at group meetings shared knowledge of these courses. As a result of this work one lead opened discussions with two local universities about Health Promotion courses and the development of a Public Health Foundation Degree. One lead focused on collating information about all courses available at undergraduate and postgraduate level which was then circulated to all in the group.

In addition to this, NESC commissioned the South East Teaching Public Health Network to undertake a formal “mapping” exercise to relate the content of PH postgraduate modules and courses provided in the area against levels 5-7 of the PH Skills & Career Framework. This data was circulated to the leads in the summer 2008 and is to be created as an internet based, searchable website.

13. **List public health training provided by your PCT or Local Authority.**

Again the leads listed the training available and moved the meeting on to discuss how there was a need for basic health promotion training for the entire NHS workforce.

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33 Group member 4, email correspondence to PHDL group 20 May 2008.
34 Email to Chair from public health consultant 10 April 2008.
Job descriptions and corporate induction again considered as a low cost option for the initial implementation of these ideas.

As the findings listed against the individual work plan items show, in many cases the work undertaken by the leads exceeded their original remit. In addition to identifying those responsible for training and development the leads developed ideas to show how public health knowledge and skills and the capacity of the public health workforce could be extended within existing resources. The PHDLs awareness that for public health knowledge and workforce capacity to grow public health needs to be a component of corporate documents and this has led them to be proactive in either joining committees or feeding information into meetings where decisions on corporate strategy and planning are made. Some PHDLs have been successful in incorporating public health into job descriptions and corporate staff inductions. These are important steps in changing perceptions of public health and ensuring that public health becomes a fundamental part of the work culture and is viewed as ‘the norm’ and not as an ‘add on’.

**Group tasks**

<table>
<thead>
<tr>
<th>Targets</th>
<th>Started</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a database structure to record contacts for use by PHDLs and NESC PHD</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Develop a Learning Needs Assessment for use by PHDLs</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Develop a CPD programme with PHDL, Specialist Training Programme Directors and the Faculty CPD Co-coordinators.</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Develop and commission the SC Part A support programme</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Develop and distribute information about the academic Bursary Scheme</td>
<td>✓ ✓</td>
<td></td>
</tr>
<tr>
<td>Collate list of all relevant local and national health promotion/public health courses and their providers.</td>
<td>✓ ✓</td>
<td></td>
</tr>
<tr>
<td>Develop flyer to inform local workforces of all PH opportunities</td>
<td>✓ ✓</td>
<td></td>
</tr>
<tr>
<td>Identify, commission and/or provide workshops and seminars as appropriate.</td>
<td>✓ x</td>
<td></td>
</tr>
<tr>
<td>Invite guest speakers to PHDL group meetings as appropriate</td>
<td>✓ x</td>
<td></td>
</tr>
<tr>
<td>Regularly review professional body websites to keep updated.</td>
<td>✓ x</td>
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</tr>
</tbody>
</table>

All group tasks have been started but by their nature most require that they are ongoing for the lifetime of the PHDL role. In addition to flyers much information about public health opportunities are now placed by the PHDLs on individual PCT and NESC websites. The LNA is nearing completion and will then be piloted by the leads in their PCTs shortly. It will also be used by the Practitioner Learning Sets.

Questionnaires for the PHDLs were designed to collect information about work not always covered by the activity logs. The questionnaire covered five main categories:

- How PHDL work fitted with that of their employing organization
- Development and implementation of the PHDL work plan
- Running and organization of the PHDL group
- Personal development – benefits from belonging to the group
- Benefits of the PHDL role
  - Locally
  - Regionally
  - Nationally
Questionnaire Results

All PHDLs have found that there is space for this work and role within their home organizations, including leads employed in their primary role as public health development managers. The leads are agreed that the elements of the work plan achieved to date have been beneficial for both their mainstream role and their PCT. Whilst some elements of the leads work plan may have been covered in their home organization prior to the advent of the PHDL role, the creation of this role has given a greater visibility to this work, allowed for a more coordinated approach and protected time has given official sanction to the work. One lead found that it provided an opportunity to formalize the support/information role to other colleagues that she was already carrying out already on an informal basis.35

None of the PHDLs have received feedback from either line managers or their DsPH to indicate that this role is not considered of value to their organization. In fact the success of the leads in incorporating public health into corporate documentation would indicate that there is largely strong support at a senior level, for the work that they have been undertaking.

The PHDL role is accepted as a relevant and useful part of the department function. Therefore I have received all the support I have needed and when it has been requested. The type of support that has been most helpful is the willingness of managers to talk issues through and facilitate actions required within the teams.36

The whole L&D team and Head of School Nursing have been extremely supportive. It has been really good being a member of the Clinical Education Network. Strategically my manager is very supportive…37

In one area the PCT has accepted the vision that ‘health promotion’ is part of everyone’s role.38 In another the PCT is putting a health promotion objective into everyone’s job description.39 However one lead found it important to sound a note of caution observing that whilst there was strong support for the role ‘…it is unclear if support for this role would continue if funding were not forthcoming (yet to be tested)’.40 Another lead found that whilst senior management valued the PHDL post they had differing priorities for the role. The DPH wanted a concentration on the development of commissioning whilst the SHA lead wanted to focus on the wider workforce, these competing priorities had to be reconciled and the lead found this difficult given the small number of hours per week allocated to this role.41

Whilst the leads have achieved success in a number of areas their work, contributed to staff and organizational development, evidenced for example, by the increased numbers of staff coming forward for CPD and the greater links between public health staff and local planners in one PCT, it must be acknowledged that they have had to work hard at networking and developing the relationships that have enabled these results to be achieved. This has not always been easy. The size of some PCTs and the continuing changes in structure has made it difficult for them to know who to contact in promoting this work. One lead felt that her contribution to the PCT could have been achieved more quickly had senior staff done more to publicise the role.

I don’t feel that there has been much support in publicizing the role. The key contacts that I have built up (learning and development, heads of nursing, therapies and clinical standards) have been through my own enquiries and suggestions from others in the PHDL group.42

35 Group member 1, questionnaire June 2008
36 Group member 1, questionnaire June 2008
37 Group member 4, questionnaire June 2008
38 Group member 2, Chair’s questionnaire June 2008
39 Group member 4, Chair’s questionnaire June 2008
40 Group member 1, questionnaire June 2008
41 Group member 6, questionnaire June 2008
42 Group member 3, questionnaire June 2008
Another, whilst in receipt of verbal support for publicizing the role, felt that in future she ought to find a way to do this more systematically but had not yet decided how this should be achieved. As cited above one lead found that irrespective of the fact that they sat on an established joint committee of public health and local authority staff there was a continued need to strengthen relationships and build trust. The relationships between the two organisations were fragile and at times could easily break. This necessitated hard work on the part of the lead to regain that trust when breakdown occurred. All agreed that having an official title, being part of a larger group and having senior support for the role enabled them to network and gain entrée into forums that would not always have been within their normal sphere of work.

At employment in 2007 my role was solely as Health Trainer Lead. Once nominated and accepted for the PHDL role this expanded my role formally into one where staff development and the processes involved in this became an additional priority for me. This in turn led to exploration and network linking with sections of the wider PCT (staff and services) that would not have been required with my existing role. It also created a useful regional network of contacts with other PH Depts/Staff members that would have been more difficult to cultivate without this role. Particularly important have been networks forged with the local Education, Training and Development Department and the Associate Director of Organisational Development. I feel currently that a broader understanding of the PHDL role in the wider PCT still needs to be developed but within the time constraints of the role I have had to focus in the identified areas of priority only.

Now also sit on Clinical Education Network and Children’s Workforce Development Group, regularly meet with L&D Leads, the Head of School Nursing re: PHS&CF, regularly meet with people to talk about courses, career progression, development opportunities etc..

In response to the question of how the leads previous experience in public health and health promotion had either helped, or hindered, in enabling them to carry out their PHDL role, all were firm in their opinion that experience was important for the implementation of this role. These views provide justification for the detailed application process and the level of staff aimed at in the original project proposal.

I think the PHD role would have been more difficult if I didn’t have the experience in my main role and also experience of participating in PHD in the past.

It helped as I already had a wide range of contacts locally.

My existing role was helpful in undertaking the PHDL role as I had already become known in the team and established some credibility.

One lead found that whilst their mainstream post provided contacts that assisted with the PHDL role it also ‘hindered in that my main role is huge, far more than I can managed in 22.5 hours per week. The new role is also far more than 3.75 hours per week, therefore I have felt overwhelmed with competing priorities… new work requires time for relationship building and nurturing’. This did not prevent the lead from achieving tasks listed on the work plan however; it must be ensured that commitment to the project does not lead to the PHDLs becoming overworked. All leads mentioned that fitting the work into the number of hours allocated was very difficult and the Chair was aware that the PHDLs were being asked to deliver ‘on a huge agenda’.

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43 Group member 2 questionnaire June 2008
44 Group member 4, questionnaire June 2008
45 Group member 1, questionnaire June 2008
46 Group member 4, questionnaire June 2008
47 Group member 3, questionnaire June 2008
48 Group member 3, questionnaire June 2008
49 Group member 1, questionnaire June 2008
50 Group member 4, questionnaire June 2008
Future work of this nature might need to reconsider either the number of tasks listed on the work plan or extending the number of hours allocated to this role.

Benefits of the PHDL role

Initially the leads found it easy to separate the PHDL role from their mainstream posts. Increasingly the role boundaries have become blurred, but it was felt that the PHDL work enhanced rather than detracted from their mainstream work.

… (the PHDL role) has helped as the roles are closely aligned and mutually supportive. I suppose one slight disadvantage is that it is difficult to draw a line around the PHDL work, but overall I would say that I have used this to the best advantage to ensure that both areas of work are carried out effectively.51

It’s helped a lot – there are clear links between PHDL work and what I would be doing anyway, but the SHA and national perspective (gained from working in the group) has helped me to do this in a more informed way.52

All leads indicated that there have been evident gains both to themselves and their PCTs from adopting the PHDL role and in belonging to the group. The activity logs of the PHDLs show that PTC staff are now more informed about what public health training and development is available and have a named contact point for further information. Through the work of the group, each lead is fully aware of what levels of training and provision are available in each local area and what needs to be developed, for example, the forthcoming practitioner learning sets to be run for staff across the SHA. Through the cascading of information via emails and personal contact from the PHDLs, staff have access to current information about public health. The PCT committees and planning teams that have extended an invitation to the Leads to join are benefitting from current professional public health advice and input into their planning. They are given clear ideas by the PHDLs of how national public health objectives can be met, practical ideas on how the public health workforce capacity can begin to be expanded and in what ways this will bring greater benefits to the wider public.

The establishment of the PHDL group brought together public health staff, including the Chair, in a new way. SCSHA is a large area and the creation of this role and the formation of this group provided a forum for a cohesive, SHA wide, approach to the development of and capacity building amongst public health staff and the wider workforce. Leads working in the north of the SHA were quick to note that the group had given ‘An insight that we are not supporting our PH workforce as much as the South of the patch!’53 This might not have come to light so quickly without the Leads membership of the group and is now being beginning to be addressed through the provision of practitioner learning sets and support for one member of staff to undertake the specialist training course. A lead from the South mentioned how membership of the group had increased their motivation for the work ‘It’s been great to have support and ideas from other areas, and there’s sometimes also an element of “If they can do it why can’t we?”’. Whilst unable to attend many of the group meetings one lead reported how important information sent electronically and email correspondence had been ‘…this information flow of opportunities has been invaluable’, 54 without it my PCT would not have known about the new framework or training available. One lead was very clear in the benefits of belonging to the group ‘(It) has given support and guidance and given me a better or clearer work plan to achieve more. If I didn’t belong to the group none of the work would have been done55..

51 Group member 5, questionnaire June 2008
52 Group member 2, questionnaire June 2008
53 Group member 6 question  June 2008
54 Group member 7 questionnaire June 2008
55 Group member 6 questionnaire June 2008
It was felt by the group that they would not have come up with the LNA if they had been working individually, a piece of work that is rapidly gaining recognition outside the confines of the group. The Chair observed that the quality of the work being produced by the group working together already extended beyond the boundaries of the SHA:

> What is being provided in South Central in such a comprehensive, integrated way for anyone to become engaged with developing public health competence within their role, or to become a public health practitioner is quite unique we believe. People from elsewhere are looking to us for guidance, information, tools and techniques in a way which was not the case in the past. Examples such as the LNA being requested by both the Teaching public Health Networks and others working on PH Development in South East Coast SHA come to mind…

Individual benefits were reported as ‘The role has broadened my horizons’, ‘It has made me realize I do like to be part of a team, do like to have my ideas heard and do like feedback – all provided within the group but not in my substantive role,’ ‘The ideas and experiences of others in the group have informed and inspired me.’ It has increased my confidence, made me realize how many different directions that my career could take’.

When asked what would be lost if the PHDL role were not continued elicited a mixed response. There was agreement that elements of the work would continue but some of the momentum would be lost. By having a visible named person ‘banging the drum’ the work has developed at a faster and more focused rate. One lead felt that in her PCT staff may miss opportunities to develop their careers and may not be motivated into thinking about them. Also public health development within the wider workforce would not happen. The lead progressed to considering the impact upon the wider population:

> As public health has such wide ranging impacts in terms of keeping people healthy, saving the NHS money, improving people’s mental health and wellbeing, it follows that the development of many staff groups is crucial to deliver PH objectives. Without a PHD role to drive this, it’s easy for it to slip down the priority list in the daily pressures of keeping a service going.

A second lead saw several consequences if either the role or the support from the SHA was lost. If just the role – then I believe that would entail the loss of mutual support and a certain amount of professional legitimacy for the work. It would also demonstrate that perhaps South Central did not value the work as much as it does at the moment. This might provide PCTs with an “excuse” to put PHD on the backburner again. The loss of easy access to the most relevant and up to date information on PH development provided by the Chair and the PHDL group, supported by funding possibilities from SCSHA for training and development would undoubtedly weaken PHD work across the patch.

Each lead was personally committed to continuing the work to the best of their ability and has already begun addressing the issue of sustainability. For example, ensuring that this work is written into the job description of future public health staff. Currently the group feels that there is still much work to be done, particularly in the final development and dissemination of the LNA, personal development in working towards practitioner registration and in the building and maintenance of interagency working.

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56 Group Chair questionnaire June 2008
57 Group members 2 4 and 5, questionnaire June 2008
58 Group member 2 questionnaire June 2008.
59 Group member 3 questionnaire June 2008
60 Group member 5 questionnaire June 2008
Conclusion

The Leads have worked both as individuals within their Trusts and as a group to implement and deliver the tasks listed on their work plans. Their work has exceeded that of the original plan and has included development of the LNA and the establishment of practitioner workshops. Both were large projects that might not have been developed, or delivered as quickly, if the PHDLs had not been able to work together as a group. Indicative of the need for this work is the fact that the LNA even in its pre-pilot stage has generated much discussion and the PHDL group has received enquiries from regional and national bodies requesting to take part in its piloting. Work by the Leads has also ensured that SCSHA is in the forefront of the organization and delivery of learning sets in preparation for the anticipated professional registration of public health practitioner. The Leads have shown great commitment and enthusiasm for this role but would make strong recommendation that if the role is to continue more time is allocated for the work.

The work of the Leads has been valued by their own and other agencies. For the work to continue consideration needs to be given to the issue of sustainability. The Leads, themselves have begun to address this by working to incorporate public health into corporate planning documents, inductions for new staff and job descriptions. However, this does not address the issue of the role of the Leads themselves.

The current PHDLs are strongly of the opinion that this role requires a designated lead within the PCT if the work is not to be subsumed by the challenges of day to day service delivery. It appears important that for the success of this role those appointed as PHDLs are provided with a forum to come together, share ideas, network, discuss and progress new projects and implement an SHA wide approach to public health development.

Recommendations

1. Issues of sustainability need to be addressed if the role and the work are to continue and be extended

2. The achievements of the PHDLs group should be disseminated through publications and presentations at both national and local events

3. Acknowledgement of the development and delivery of the LNA should be claimed by the PHDL group, and the primary lead for this work named and acknowledged.

4. Knowledge of the formation and work of the PHDLs group should be presented nationally possibly at the UKPHA conference in March 2009.

5. Time allocated for the delivery of this work needs to be extended if Leads are not to become overstretched

6. It is important that the Leads group continue to physically meet together to aid the successful delivery of this work. Benefits include:
   a. networking
   b. a forum for the exchange of ideas and sharing of experiences
c. the development of a cohesive approach to public health development across SCSHA
d. the development of projects that would be difficult to achieve as an individual

7. The group continues to have a designated Chair and administrative support to provide coordination for the work of the group.

8. Activity logs and work plans continue to be used as a means of retaining a focus on the work.

9. Continued building and maintenance of interagency work.

10. Continue to find ways to deliver training and build public health capacity in the wider workforce.

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