



Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

**Public Health Capacity:
the challenges for public health
May 2004**

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Summary and Acknowledgements

This report draws on a series of three workshops organised by the Faculty of Public Health for senior public health professionals held across England in early 2004. The Faculty thanks the Department of Health for England, the Health Protection Agency and the Health Development Agency for their support of the workshops. Thanks also go to PHRU and Allison Thorpe for their hard work.

Workshop objectives

- To develop a clearer understanding of how public health specialists, particularly Directors of Public Health, can be most effective in influencing the health of their populations.
- To explore public health systems and how they can best be structured to meet public health and health inequalities targets.
- To review issues related to specialist public health capacity and suggest ways forward.
- To capture examples of good practice to share with the Department of Health (DH).
- To advise the Faculty of Public Health (FPH) on how it can best support specialist public health practice.

The seminars took place in advance of the publication of the Wanless review and the launch of the White Paper public health consultation. They form one part of a suite of FPH activities, including reviews of the public health workforce[1] and academic public health [2].

Context

In light of the increasingly positive public health policy environment in England there is a need to review specialist capacity in public health. The implementation of changes associated with *Shifting the Balance of Power* and *Getting Ahead of the Curve* had led to a major reorganisation of the public health workforce. As the full impact of these changes become apparent, there is a need to better understand the implication for the future shape of specialist public health practice, particularly with regards to career pathways, working environments and support systems to develop robust specialist public health. A clear understanding of the capacity gap and the measures needed to address this is required if we are to meet the challenges of the increased expectations of public health delivery.

Within this context the workshops were focussed on finding ways to strengthen specialist public health practice and support delivery within existing policies and constraints, whilst at the same time recognising the important and essential contribution of the many different professions in improving health.

Participants

Invitees to the workshops included representatives from:

- directors of public health (DPH) at regional, strategic health authority (SHA) and primary care trust (PCT) levels
- Health Protection Agency (HPA)
- Health Development Agency (HDA)
- Faculty of Public Health board members and advisers
- regional specialist advisers and programme directors
- managed public health network leads
- public health observatories (PHO)

Principles for moving forward agreed at the workshops

The following principles for taking forward work on issues of capacity were agreed at the workshops.

- Use the workshops as an opportunity to look at where we are now and how we can move to where we want to be.
- Learn from recent reorganisations to develop a clear understanding of professional standards and roles which are not reliant on fixed organisational structures for successful delivery of the public health function.
- Apply and take forward, at local level, the learning from the workshops.
- Maximise scarce resources through flexibility and innovative ways of using resources.
- Identify key priorities for public health – both present and future.
- Contribute to the consultation on the White Paper for public health.

Key opinions raised at the workshops

Theme 1: *Working differently*

- public health programmes should cut across different sectors and engage local communities as part of mainstream delivery;
- public health structures need to be simplified and aligned as a public health system;
- there needs to be increased emphasis on public health in performance management in PCTs with both local and national targets;
- the new GP contract has the potential to be a lever for greater focus on prevention and public health;
- new and imaginative ways of working must be developed to liberate time and capacity;
- the role of SHAs should be developed;
- the longer term preventative agenda and increased capacity should be given higher priority;
- The Healthcare Commission has a key role in developing public health.

Theme 2: *Developing public health in primary care by engaging PCTs*

- There is a need to better understand and resolve:
 - tension between corporate and public health agendas for DPHs;
 - difficulty in fulfilling public health engagement role within PCTs and maximising the capacity of the wider public health workforce;
 - challenges to the commissioning role;
- DPHs need adequate support at PCT level to enable them to serve their communities more effectively, so they in turn can support health professionals (particularly local practitioners) in making prevention and health improvement a part of their daily work;
- public health programmes must be fully integrated into performance management;
- Support is needed to develop effective public health teams.

Theme 3: *Health protection*

- greater clarity is needed on levels of autonomy, responsibility and accountability in health protection between PCTs, the HPA, SHAs and local government;
- baseline skills should be developed in all public health staff;
- there is a need to develop roles/competencies/standards of practice;
- availability of robust data is essential to support effective practice.

Theme 4: *Partnership with local government*

- local government has a public health role – its engagement with the broader health agenda is essential;
- co-terminosity with population boundaries facilitates joint-working;
- the public health capacity within local government needs to be more effectively harnessed;
- there is a need to utilise existing powers and opportunities e.g. scrutiny, local strategic partnerships, DPH joint appointments, DPH annual reports;
- common performance measures need to be developed;
- all policy should be assessed for its health impact.

Theme 5: *Public health networks*

- networks need a minimum capacity to be effective in providing the critical mass of public health resource for health economies;
- work programmes with clear outcomes and accountability arrangements are essential to ensure delivery;
- closer working between public health networks and academic departments could be beneficial;
- PHOs should have formal links with networks as well as with PCT and SHA public health teams.

Theme 6: *Professional roles, including directors of public health*

- the model of a single-handed DPH is not sustainable;
- the focus of the DPH role should be engaging with the local community and advocating as a local 'champion' for public health;
- there is a recognition of the need for further training for the DPH in leadership, multi-agency working, management, confidence building and media training;
- Joint appointments with local authorities are welcomed.

Theme 7: *Developing capacity*

- public health needs to attract more people through clearly defined career paths, roles and competencies;
- public health should be clearly presented as a career option early on in health education and training;
- SHAs must play a stronger role in performance development of the public health workforce;
- a workforce plan should be developed, with clear guidance on roles and new career pathways should be mapped out.

Theme 8: *Training and research*

- specialist training needs to be reviewed to ensure it is fit for purpose;
- more focus should be given to the public health training of the wider workforce, not only in the NHS but in other sectors;
- academic departments need to work with service departments more effectively to capture good practice and share this widely;
- PHOs should play an active role in disseminating evidence and sharing learning;
- there is a need to make better use of the existing evidence base.

Main themes

1. Working differently

Key opinions:

- public health programmes should cut across different sectors and engage local communities as part of mainstream delivery;
- public health structures need to be simplified and aligned as a public health system;
- there needs to be increased emphasis on public health in performance management in PCTs with both local and national targets;
- the new GP contract has the potential to be a lever for greater focus on prevention and public health;
- new and imaginative ways of working must be developed to liberate time and capacity;
- the role of SHAs should be developed;
- the longer term preventative agenda and increased capacity should be given higher priority;
- The Healthcare Commission has a key role in developing public health.

Rather than working in vertical hierarchies to deliver public health programmes, cross-cutting horizontal approaches which engage communities and other sectors should be promoted. This will entail a move away from the short-term ring-fenced funding for specific projects from central government to allow local decision-making within the mainstream recurrent financial allocations. Greater use of existing initiatives, for example those funded by the Modernisation Agency could be utilised to fund, support and evaluate public health work, such as redesign of sexual health services targeted at areas of greater inequalities to have most impact.

Public health structures in England need to be simplified. Their current organisation needs reviewing to clarify the roles, relationships and accountabilities of the different public health groupings. There are risks in having too many public health structures which are not mainstreamed or have no statutory function, and have an advisory role only to the NHS eg. HPA, HDA and PHOs. At a minimum it can cause confusion and lack of clarity around relationships, as can arise, for example, between PCTs and the HPA over out-of-hours provision (particularly where PCTs have no DPH in post).

Inadequate specialist capacity and loss of an operational tier to new senior management roles is a problem shared by the HPA and PCTs. New and imaginative ways of working (with a dispersed public health workforce) must be developed to liberate time and increase capacity to deliver public health agendas.

Greater emphasis on performance management in public health could help shape the PCT agenda if based on policies supported by evidence. Working with academic public health departments to develop the evidence-base for public health practice would provide a positive contribution to this. The long-term nature of much public health activity is better served by having a national framework of long-term targets with interim milestones. Public health programmes in PCTs should be developed within the framework of performance management and whilst reflecting national priorities should have a high degree of local relevance. The longer term preventative agenda could then be given higher priority with support from increased investment and achievable long-term targets. This approach should be integrated into the mainstream financial and performance management frameworks of PCTs.

Performance targets must focus on those interventions with the greatest impact and these would be monitored by SHAs. Standards for inspection would be set by the Healthcare Commission. But it is important that SHAs are proactive in engaging with and influencing national agendas. It was also recognised that there is a need for more specialist public health capacity within SHAs, and their approach to performance management could become more developmental, for instance by combining qualitative and quantitative data.

The new GP contract also has the potential to be a lever for greater focus on prevention and public health within PCTs. Toolkits, for example, that enable rapid evaluation of PCT programmes (from a public health perspective), could be developed. This could contribute to effective performance management of national service frameworks (NSFs) ensuring PCTs and partners deliver. However, to achieve the greatest impact, PCTs must move beyond simply NHS business and think about their role as partners in the wider health improvement agenda and develop joint local targets within the national frameworks. To support this, national government departments could share common public health targets. This would be made more possible if government has access to public health expertise to inform policy development.

2. Developing public health in primary care by engaging PCTs

Key opinions:

- There is a need to better understand and resolve:
 - tension between corporate and public health agendas for DPHs;
 - difficulty in fulfilling public health engagement role within PCTs and maximising the capacity of the wider public health workforce;
 - challenges to the commissioning role;
- DPHs need adequate support at PCT level to enable them to serve their communities more effectively, so they in turn can support health professionals (particularly local practitioners) in making prevention and health improvement a part of their daily work;
- public health programmes must be fully integrated into performance management;
- Support is needed to develop effective public health teams.

Many examples of PCTs engaged in the public health agenda presented encouraging stories of new and innovative practice [see Appendix1]. However, this was not a uniform picture. PCTs, and the emphasis they give to the public health agenda, vary across the country. Population size, levels of resource, attitudes of chief executives and boards, as well as relationships with local government, can all make a difference.

Common problems identified for public health in primary care fell into three main areas:

Tension between corporate and public health agendas for DPHs

Tension exists between the longer term public health agenda and the pressures of the short term corporate PCT agenda which is primarily concerned with the NHS priorities such as access and choice, meeting financial targets and implementing the GP contract. This leads to difficulties in owning the inequalities agenda in a meaningful way in some PCTs.

Difficulty fulfilling public health engagement role within PCTs and maximising the capacity of the wider public health workforce

Particular problems arise when PCT teams are very small or where there is no DPH to lead the public health work. Small public health teams are too stretched by corporate agendas, leaving little or no time to work with (and through) others to deliver public health goals, particularly on the broader determinants of health. They lack the time to develop the public health skills of primary care, to engage primary care practitioners in prevention and health improvement and to develop a profile and presence within the local community. It is particularly difficult to develop partnership work where capacity is stretched. This is exacerbated if there is a lack of co-terminosity between PCTs and local authorities.

Challenges of the commissioning role

PCT commissioning is still relatively weak. An integrated approach to commissioning public health programmes would be the ideal for public health specialists. However, problems of capacity in PCTs prevent many public health specialists from supporting (and themselves being supported in) adopting this approach. This can lead to professional silos and fragmented services rather than team approaches.

Solutions

More creative and improved ways of working with local public health practitioners are needed to generate capacity. Some PCTs found that developing local public health teams to include health visitors, school nurses and community development workers had strengthened capacity, and helped to develop new models of working. For example, some areas were funding GPs with a special interest in public health (GPSIs).

It is important that all primary care practitioners have public health skills and that public health becomes a valued part of their work. Effective delivery of public health programmes depends on providing learning opportunities for everyone interested in public health issues. Professional Executive Committee (PEC) chairs, where engaged with public health, have a positive influence, supporting the integration of public health practice across the PCT, as well as developing public health capacity through primary care practitioners.

Further solutions to the problems faced within PCTs include:

- linking public health agendas and the evidence base with tangible and meaningful outcomes for PCTs to encourage wide local ownership;
- setting health improvement targets for CEOs on a par with choice, access and financial balance, and including public health indicators as a key part of star ratings;
- encouraging PCTs to move beyond just NHS business and think about their role as partners in the wider health improvement agenda within the local community.

Close working with local government was seen as key, with positive experiences of joint posts with local government, including joint DPH posts. PCT engagement was also enhanced through improved identification of local public health champions, for example appointing a non-executive director as champion.

3. Health protection

Key opinions:

- greater clarity is needed on levels of autonomy, responsibility and accountability in health protection between PCTs, the HPA, SHAs and local government;
- baseline skills should be developed in all public health staff;
- there is a need to develop roles/competencies/standards of practice;
- availability of robust data is essential to support effective practice.

On 1 April 2003 a new organisation – the Health Protection Agency – was created as a result of proposals in *Getting Ahead of the Curve*. The agency has redefined health protection by drawing together expertise and services for control of communicable disease, public protection from radiological hazards, chemical response services and emergency planning (in response to major disasters and threats of bioterrorism). Specialists in this area of public health practice are now employed by the HPA, many of them within the Local and Regional Service [LARS]. This has changed relationships both with PCTs and with professional colleagues in other areas of public health practice. Ways of working and inter relationships within the HPA and with the NHS and other key sectors, such as local authorities, are still 'bedding-down'.

Although the new arrangements are working reasonably well, greater clarity is needed about levels of autonomy, responsibility and accountability, particularly at local level. The different cultures of PCTs and the HPA need to be brought together. Given the newness of the HPA and the change in its structure and function it would help PCTs if the health protection role was mapped out for each locality: emergency planning systems are not always clear and the lack of clarity between the roles of PCTs, SHAs and local government with reference to health protection must be addressed.

Having a co-ordinator (not necessarily a doctor) to form a link between the HPA and the PCT was seen as valuable and should be available in each locality. Each patch [SHA] should nominate a lead PCT, a lead DPH and a lead HPA person to form a network which would then link to the national organisation and its strategy. Modelling and supporting each other on delivering out-of-hours cover was also seen as crucial, as was ensuring clarity of roles for emergency planning.

Given the expanding role of public health, the knowledge and skills of the broader public health family need to be developed. Education programmes should also be developed for all staff. People within the broad public health family with complementary skills should be recognised and included in health protection. This would ensure that everyone has baseline skills, and could contribute to creating a flexible workforce able to work together – whatever the employing organisation. To do this requires greater clarity on roles, competencies and standards of practice. Shared learning opportunities would also help avoid silo working and support stronger networks. Consideration should be given to developing increased skills to deal with chemical incidents and attract more microbiologists into health protection.

Improved information and availability of robust data are essential to support effective practice. Easier accessibility of the HPA website as well as a nationally cohesive on-call handbook would also support this.

4. Partnership with local government

Key opinions:

- local government has a public health role – its engagement with the broader health agenda is essential;
- co-terminosity with population boundaries facilitates joint-working;
- the public health capacity within local government needs to be more effectively harnessed;
- there is a need to utilise existing powers and opportunities e.g. scrutiny, local strategic partnerships, DPH joint appointments, DPH annual reports;
- common performance measures should be developed
- all policy should be assessed for its health impact

The essential public health role of local government was consistently highlighted, as were the benefits and positive outcomes of joint working. These were most common in PCTs who shared a common population and common boundaries with their local authorities. If there is to be any organisational change then alignment of boundaries to create co-terminosity would facilitate joint working and would be a positive move, enhancing the delivery of public health.

Local government needs to engage in the broader health agenda. It would be helpful for each local authority to have a director designated to lead on public health (if they did not already have a DPH jointly appointed with a PCT).

The (frequently unrecognised) public health capacity within local government must be harnessed and opportunities to bring a health influence to the local government agenda taken, for example through council performance plans and performance assessments, using local government powers, and utilising the scrutiny process. Opportunities to further develop joint working through common objectives and shared targets would be welcomed. The local strategic partnership (LSP) is a vehicle which can help set a common agenda to improve health and reduce inequalities through the health services and local government for a given population. Use of the comprehensive performance assessment could also be helpful as would linking with local delivery plans. Councils should be asked to routinely assess the impact on the public's health of all their policies and to use their powers and scrutiny functions to bring influence to the health agenda. The DPH Annual Report should be used as an opportunity to influence and be presented annually to full council as well as all health service partners. Making the economic case, as highlighted in the Wanless review, is also important.

To be effective local councils must recognise the need for public health capacity. This includes addressing concerns around the loss of environmental health officer capacity and their status within local government. This has increased pressure on HPA teams with adverse implications for local authorities in fulfilling their statutory requirements. Another obstacle to good joint working is the difficulty in sharing public health information and effective ways to share information are needed.

5. Public health networks

Key opinions:

- networks need a minimum capacity to be effective in providing the critical mass of public health resource for health economies;
- work programmes with clear outcomes and accountability arrangements are essential to ensure delivery;
- closer working between public health networks and academic departments could be beneficial;
- PHOs should have formal links with networks as well as with PCT and SHA public health teams.

Shifting the Balance of Power led to the creation of DsPH within every PCT. This strategic/management role has led to the loss of an operational tier in public health at specialist level. Dispersal of larger public health departments has also led to dilution of skills, for example in health promotion. Developing networks of specialists with the time and skills to carry out detailed work across populations of appropriate size are one way to address this deficit and assist with operational delivery.

Networks need a minimum capacity to be effective in providing the critical mass of public health resource for health economies. Many areas are below this minimum and DsPH, particularly where they are single-handed, have little or no time to develop/participate in network roles/delivery.

Consensus exists that networks have a role in facilitating learning between public health specialists and in providing specific project support as well as training, continuing professional development and as a means of pooling specialist expertise. But it is important that they are appropriately designed to fulfil the function expected of them: they must be managed, adequately resourced and sufficiently flexible to address population needs. Many networks are currently loose and work through informal arrangements with little in the way of infrastructure or ownership by PCT chief executives. Strengthening networks as a key element of the NHS and PCT environment could be achieved by ensuring that each network is appropriately managed, with local lead PCT CEOs and local authority directors playing key roles. Networks will continue to be patchy without stronger direction from the centre eg. in the form of guidance on what should be expected from them, the support and resources needed to make them happen and function effectively, and how they should be directed.

Business plans, work programmes (with outcomes) and clear accountability arrangements should all be part of an effective network. SHAs need to hold networks to account with Board level responsibility for ensuring sufficient capacity to deliver against key public health targets.

Successful networks demonstrate the benefit of engaging the wider community in public health delivery. The academic community should also be included.

Closer working between networks and academic departments could be beneficial. Universities could form intra-university public health alliances and negotiate local service level agreements (SLAs) with PCTs and networks to deliver health needs assessments, health information, training and education, effectiveness reviews etc. This could contribute to improving the difficulties faced in academic training in public health and improve joined-up working between public health professionals. Public health observatories should also have formal links with networks as well as public health departments in PCTs and SHAs.

6. Professional roles, including directors of public health

Key opinions:

- the model of a single-handed DPH is not sustainable;
- focus of the DPH role should be engaging with the local community and advocating as a local 'champion' for public health;
- there is a recognition for the need for further training for the DPH in leadership, multi-agency working, management, confidence building and media training;
- Joint appointments with local authorities are welcomed.

There was a strong steer that the model of single-handed DsPH is not sustainable, particularly as the role is primarily corporate and strategic. A minimum of 2.5 wte specialists in public health were needed for each PCT, including the DPH. Appropriate arrangements are needed at local level to provide public health cover for PCTs where there is no DPH in post and, where public health resources are scarce. Some PCT public health teams may need amalgamating and network support is essential.

The focus of the DPH role should be engaging with the local community and advocating as a local 'champion' for public health. Ideally, the DPH should be visible, known, 'out and about', credible and able to deliver. Co-terminosity between PCTs and local authorities will make this more achievable and enable links with local authorities. Regional offices and SHAs must be proactive in facilitating these developments by encouraging the development of policies and structures to support public health in PCTs and local authorities. Job descriptions should be reviewed to reflect the key elements of the DPH role as it develops to ensure that expectations of DPH function are realistic and manageable.

Many specialists appointed as DPHs recognise the need for leadership training and other skills, including multi-agency working, management, confidence building and media training. This should be extended to public health specialist training. Leadership development opportunities for other health professionals including health visitors, local government staff and nurses should also be facilitated. The NHS Leadership Centre and NHS University (NHSU) have an important role to play in supporting and developing the evolving role of public health specialists.

7. Developing capacity

Key opinions:

- public health needs to attract more people through clearly defined career paths, roles and competencies;
- public health should be clearly presented as a career option early on in health education and training;
- SHAs must play a stronger role in performance development of the public health workforce;
- a workforce plan should be developed, with clear guidance on roles and new career pathways should be mapped out.

In line with the Wanless report, *Securing Good Health for the Whole Population*, a need was identified for a workforce plan that recognised roles and responsibilities of the public health workforce. The plan should also map out potential career pathways as well detail a coherent and integrated approach to specialist training. The need for skills development to enhance the multidisciplinary professional workforce capacity, both in the short term (through top-up schemes) and in the longer term (by taking a strategic, cross-sectoral approach to identify essential skills and available training pathways to meet competencies) was consistently highlighted. The over-riding priority is for more people with public health skills and for clearly defined career progression. This requires explicitly defined roles (such as public health specialists, or public health managers), competencies and consistency in the way jobs are badged. Experience of public health earlier in medical or other healthcare training could attract people into public health as a career. Engaging people early, for example through developing public health as an undergraduate course, and perhaps even extending this to bring public health into the school curriculum to promote an early understanding, could capture interest at an earlier age. An opportunity may exist to test this idea through the new medical schools, as well as working with the NHSU to develop skills escalators and baselines.

Post-graduate opportunities for those training in other specialties could also be created. The Modernising NHS Careers agenda is being used in some deaneries to bring public health into post-qualification, second year training. Experiences of new career pathways should be shared and developed in all professional groups.

Public health capacity could also be expanded by engaging those groups who do not formally recognise their public health role eg. some PEC Chairs. Work carried out by the Leadership Centre with PEC chairs and DPHs could be built on to develop skills.

Although employed in different organisations and in various roles, the public health workforce must be viewed as a single entity. Training opportunities need to be created and formally recognised for all healthcare professions and include other sectors. Structural changes and the development of public health specialists from a variety of backgrounds has led to a deficit in training opportunities within the NHS. This deficit needs immediate, short term flexible solutions to bridge this gap until more specialists are trained – either through joint training schemes or fast-track top-up and accreditation via the Voluntary Register. New career pathways should be mapped out.

SHAs must play a stronger role in the performance development of public health, including working with workforce development confederations (WDCs) for example, to define key indicators, share good practice and redesign services. SHA public health teams should be able to influence local delivery plans. Greater clarity is needed in roles and relationships between the different public health organisations. In particular the responsibilities and interfaces between local HPA teams and PCTs and between SHAs and Regional teams need to be reviewed. An appropriate organisational model should be devised, one which will envisage the public health system as a 'public health service', and that will include the HPA and the HDA. Regional public health teams have an important and essential role to play, particularly in their ability to influence the wider determinants of health.

A radical rethink on ways to enable public health professionals to work flexibly together, maximise scarce expertise and support critical mass is required. The Welsh model of a national public health system – local teams with access to (and to form part of) specialist resources to support NHS boards – may provide a basis from which to begin this rethink. New ways of delivering public health services and engaging communities in public health issues should be explored to make best use of limited specialist resources and fully engage those with an interest in the public's health.

8. Training and Research

Key opinions:

- specialist training needs to be reviewed to ensure it is fit for purpose;
- more focus should be given to the public health training of the wider workforce, not only in the NHS but in other sectors;
- academic departments need to work with service departments more effectively to capture good practice and share this widely;
- PHOs should play an active role in disseminating evidence and sharing learning;
- there is a need to make better use of the existing evidence base.

A review of the fitness for purpose of existing specialist training and the methods used to assess its impact would be helpful to ensure people entering public health are properly equipped for modern roles. More flexible training packages are needed to ensure specialist training programmes reflect the new public health agendas. Greater focus should be given to public health roles in the education and training of other workers and the public, for example around sexual health issues, and development of the practitioner workforce supported.

Academic departments need to work with service departments to capture good practice and share this widely. They should be strengthened to deliver the research necessary to assess effectiveness of interventions [2]. NHS research tends to be downgraded because university focus has to be on research assessment exercises (RAEs) which limits their ability to respond to service agendas and this should be addressed.

However, public health does not make enough use of the available evidence, with some good research systematically ignored. There is lack of evidence in key prevention areas – but this should not prevent the use and refinement of what already exists. Good denominator data and a recognised authoritative organisation, such as the National Institute of Clinical Excellence (NICE), will add weight to existing evidence. Public health needs to learn from commercial industry, which effectively uses research to gain an understanding of the subtleties in packaging messages. It recognises the underlying psychological issues involved, particularly around children. Social marketing techniques should be explored.

Public health observatories could play an active role in disseminating evidence and sharing learning - possibly on interventions that work and are the most cost-effective. This would be facilitated by PHO interoperability. However, PHOs should be more practically oriented and relevant to PCTs (and avoid being seen as too academic), producing information which is meaningful to a range of partner agencies. Better health intelligence is needed to reprioritise and refocus public health work so that it is proactive rather than reactive. There is a potential role for PHOs in performing risk analyses for PCTs to help them better understand risk versus gain.

References:

1. Perlman F, Gray S, 2004, *The Specialist Public Health Workforce in the UK: A Report for the Board of the Faculty of Public Health*, March 2004
2. The Wellcome Trust, 2004, *Public Health Sciences: Challenges and Opportunities. Report of the Working Group convened by the Wellcome Trust*, March 2004

Appendix 1: Examples of good practice

Smoking

North Somerset PCT:

Engagement in smoking cessation in primary care (24/25 practices have specialist clinics).

West of Cornwall PCT:

Funded no smoking leads in each practice.

GP identified all smokers on his list by putting large black marker on their notes. This reminded him to be proactive and offer smoking advice at every contact with those patients.

Use of pharmacists (community) to support tobacco central programme – smoking cessation funded.

East Devon PCT:

Tobacco control on agenda of local authority staff. EHOs, trading standards, housing, leisure staff who will help deliver the programme.

Kennet and North Wiltshire PCT:

Exceeded smoking target through engagement with primary care.

South Birmingham PCT:

Smoking cessation service work with employers to reduce smoking in manual workers. Promoting breastfeeding using 'Breast Buddies' across most of Birmingham.

CHD Bristol:

Trained Asian men as smoking cessation advisers – increases compliance in ethnic minority groups.

Slough PCT:

Volunteers are being skilled-up to deliver messages to the people within their communities. The project has had a high degree of success because the PCT has a good perception of its community.

Other:

Using Midwives/Health School – Health Visitors to continue the work of smoking cessation

Teenage Pregnancy

Swindon PCT:

Housing mediation for teenage parents to prevent homelessness.

Other:

The emergency of sexual health networks is adding strength to function

The Teenage Pregnancy Unit Review is an example of good practice

Workforce Development

West Midlands:

Public health included foundation year of SHO training – pilot.

Cheltenham and Tewkesbury PCT:

Public health input encouraged and given to all care group planning – mental health, older people's NSF, career planning etc, to ensure public health perspectives can be fully considered.

Bath and NE Somerset PCT:

Multi-agency public health development and implementation group: LA, Housing Association, Regeneration Company, Sure Start, Share tasks of designing single work programme for health improvement.

Berkshire:

Network with full-time administrator and half-time specialist in public health, and public health information underwritten by 6 PCT CES ; chaired by a PCT CE; work of the network is based on an analysis of CHI reviews, HIMPs etc; major problem is vacant DPH posts.

Primary Care Facilitator – support practices on audit, etc of cardiac NSF.

Milton Keynes:

Linking into the Unitary Authority has enormous potential for opportunity and development.

Coronary Heart Disease

South and East Nottingham:

Under 65s twice as likely to die from CHD, 0.5 x likely to receive aspirin and statins. Practice based learning to whole of practices. Ensured populations own through community plan – New approach to follow up after MI. Community Nurse.

Health Protection

Gloucestershire:

Increasing MMR uptake through local action plan. Multi-agency working for the management of white powder incidents.

Devon and Cornwall:

White powder incidents – good multi-agency response – fired production of joint chemical and biological incident plan – good multi-agency document produced and owned.

Response to Foot and Mouth in Devon:

SW region. Mapping of regulated industries. Chemical incident surveillance, memorandum of understanding between HPA and PHOs.

Obesity

South Birmingham:

HOMER project – reviewing diet and exercise in South Birmingham Schools. Linked with joint survey with University of Birmingham dept Sports Sciences. Questionnaires and exercise tolerance validation.

Newark PCT:

Using WHO techniques of managing groups. Newark PCT have also been using the Carnegie concept. A local high school in a deprived area of Newark is now providing its own food due to PCT funding to improve its kitchen.

Cambridge:

A systematic approach for improving working in schools is proving very successful.

Southend PCT:

Local government and PCT are looking at obesity as an overarching theme. Nutrition and physical activity have been identified as keys to success. They are beginning to get away from thinking 'sport' to thinking 'physical activity'. This has proved especially successful in engaging young girls. They are now concentrating on finding ways to make walking and cycling easier and safer and to take that forward into building it into daily routines.

Rugby PCT:

A multi-disciplinary task force is trying to tackle the obesity issue and identify priorities to feed into the local delivery plan. Current thinking focuses on drug treatments, but efforts are being made to try to develop more community approaches.

Accidents

Lincolnshire:

There has been good quantification on years of life lost and disability due to accidents/injury.

Other:

Numerous good examples around falls prevention, osteoporosis, fuel poverty and 'flu vaccinations were identified by the Older Persons' Group. 'Flu vaccinations through GP surgeries can act as funnels to link initiatives and increase joint working. There is a general increase in awareness of the issues.

Smart Risk Programme and Safety Camera Partnership are examples of good practice.

Work has gone ahead around identifying cause or pathways, eg. falls in the elderly, road trauma, education, enforcement and engineering.

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