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Solutions for Public Health

Healthcare Public Health

Ensuring Sustainability and Capability of Health Care Public Health across the system

Professional workforce development

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1 Background

This report, commissioned by Public Health England (PHE), focusses on the current position of the Healthcare Public Health (HCPH) capability in England; the resources available to support and develop staff delivering this capability; the identification of gaps in development opportunities and potential options for filling those gaps.

The letter from the Government outlining the remit for PHE in 2015/16 stated;

The Government has also commissioned PHE to review and make recommendations on the current operation of the public health system in relation to the future capability, skills & experience of the public health workforce to operate across all the public health functions, including the duty of Local Authorities to provide public health advice to Clinical Commissioning Groups; and to understand the barriers to effective working and freedom of movement between the NHS, local government and national government and its agencies and make recommendations to feed into the planned review of the public health workforce strategy. (Department of Health 2015)

Healthcare public health is defined by the Faculty of Public Health as follows;

Healthcare public health is one of the three core domains of specialist public health practice, alongside health improvement and health protection. Healthcare public health (HCPH) is concerned with maximising the population benefits of healthcare while meeting the needs of individuals and groups, by prioritising available resources, by preventing diseases and by improving health-related outcomes through design, access, utilisation and evaluation of effective and efficient healthcare interventions and pathways of care. (Faculty of Public Health, 2015)

The type of activity the HCPH workforce undertakes is outlined in the 2012 guidance from the Department of Health, 'Healthcare Public Health Advice Service to Clinical Commissioning Groups' and is summarised in Appendix 1. Examples of the HCPH function include:

- Critically appraising the evidence to support development of clinical prioritisation policies for both populations and individuals.
- Interpreting and understanding data on clinical variation in both primary and secondary care and advising providers and making public health recommendations about how to reduce unwarranted variation.
- Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs.
- Applying health economics and a population perspective, including programme budgeting, to provide a context and technical evidence-base for the setting of priorities.
- Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes.

The delivery of Healthcare Public Health following the health and social care service reorganisation in April 2013 as a result of the Health and Social Care Act 2012 (Appendix 2) has led to system wide changes in service delivery and workforce locations in public health.

The Healthcare Public Health function has become organisationally separated from the NHS as public health teams have moved out of the NHS into government agencies, in particular to work in Local Authorities (LAs) and Public Health England. In order to deliver HCPH locally Local Authorities have a duty to provide free public health support to Clinical Commissioning Groups (CCGs) under a memorandum of understanding (Department of Health, 2012). PHE, dental public health staff, based in the NHS area teams support commissioning across LAs and CCGs. Regionally and nationally the HCPH staff based in PHE advise NHS England and the Department of Health.

Across England HCPH resource is operationally delivered to the NHS in a range of ways. These include:

- Local authority funding half and CCG funding half of the HCPH resource, based in the LA (e.g. Sheffield City Council)
- Local authority fund all HCPH resource, based in Local Authority (e.g. Bradford Metropolitan District Council)
- Local authority funds all HCPH resource, based in the CCG.
- Local authority fund all HCPH resource, based in the provider Trust and CCG and LA (e.g. Cheshire East Council)
- CCG directly fund public health post (NHS Leeds CCG, Associate Director post)
- Provider Trust directly fund public health (e.g. Public health team in Oxford University Hospitals NHS Foundation Trust)
- Public Health England funded resource based in NHS England Area Teams (e.g. Screening and Immunisation Teams, Dental Public Health Teams).
- Public Health England funded resource based in PHE Centres (HCPH Consultants) (e.g. supporting Strategic Clinical Networks and LAs)
- Public Health England funded resource embedded in NHS England National Teams and Hubs (Specialised Commissioning Teams).

Beyond the main HCPH operational delivery system are a range of other experienced specialist providers of healthcare public health that are typically contracted to provide a particular service to PHE, Local Authorities, NHS England and CCGs. These groups and individuals may be within the NHS (e.g. Solutions for Public Health, Right Care) small businesses (e.g. Better Value Healthcare, PHAST) or sole traders.

The Faculty of Public Health (FPH) have recently completed a survey of the HCPH workforce which has confirmed anecdotal evidence from FPH Part B examiners, Consultants In Public Health, NHS CCG commissioners, and public health Specialty Registrars of concerns about capacity and capability within English public health teams for discharging sufficient quality and quantity of HCPH functions to meet the need (Faculty of Public Health, 2016).

There is an urgent need to assess the support available to ensure that the HCPH workforce has a good understanding of the core capabilities and the ability to practically apply this knowledge.

1.1 Training, continuing professional development and the HCPH workforce

1.1.1 Specialist training

The formal public health specialty training programme referred to in this report is the training programme, typically for 5 years, regulated by the General Medical Council (GMC) and the UK Public Health Register (UKPHR). The Faculty of Public Health sets the standards for, and maintains quality within the training programme. Entry into specialty training for medical graduates is normally straight from foundation. Entry into training for non-medical graduates can be from a range of relevant qualifications. The latest curriculum for Public Health Specialty Training was approved by the GMC and the UKPHR in July 2015 and outlines the knowledge base and guidance for assessing competency in Health and Care Public Health (as Key Area 7 in the curriculum).

Following the completion of training, those who have qualified can apply for consultant posts. Development to a senior consultant level, such as Director of Public Health, typically requires further training for example through the 'Future Directors' programme'.

Dental Public Health in the UK is a dental specialty registered on the General Dental Council (GDC) Dental Public Health specialist list. Specialist Dental Public Health training, typically for 4 years, has its own curriculum and training scheme, overseen by the GDC.

The award of Certificate of Completion of Specialist Training (CCST) requires evidence of satisfactory completion of training in all aspects of Dental Public Health which are outlined in the curriculum (GDC 2010).

There is continuous assessment of progress and competence through work based assessments following the scheme developed by the FPH, and Annual Reviews of Competence Progression (ARCP). Specialty registrars are required to be successful in the exit Intercollegiate Specialty Training Examination (ISFE) and final ARCP before completion of the programme.

Entry into specialty training for dental graduates can be straight from foundation training but most specialists have had experiences in the various branches of dentistry before entering training and all will have worked within the NHS.

As the FPH recognises the equivalence in training of the dental to the generic public health programme, those who have qualified can apply for consultant posts in both generic and dental public health posts. There may, however, be additional health protection training to cover on-call arrangements.

1.1.2 Practitioner training

Public Health Practitioners referred to in this report are those who are not registered specialists with the GMC or UKPHR, and who may or may not be registered practitioners with the UKPHR.

Registration as a public health practitioner requires the successful submission of a portfolio demonstrating knowledge, skills and experience in public health at a minimum of level 5 of the UK Public Health Skills and Knowledge Framework (PHSKF, 2013) with around 2 years

experience of working in public health. However, practitioners completing their portfolios are often working at levels 5, 6, and 7. Healthcare public health is encompassed in the defined area in the PHSKF 'Health and Social Care Quality', an area of practice focussed on commissioning, clinical governance, quality improvement, patient safety, equity of service provision and prioritisation of health and social care services.

The public health practitioner category covers members of the public health workforce with a wide range of qualifications and experience. Typically, their public health training is ad hoc and varied (Centre for Workforce Intelligence, 2016). Many are highly qualified in areas related to public health and have developed public health careers in a range of public health settings. There has been a move to develop an advanced practitioner level of accreditation for those practitioners who are working at levels 7 or 8 of the Public Health Skills and Knowledge Framework.

1.1.3 Funding of training and continuing professional development

Health Education England (HEE), under its initial mandate, is responsible for the commissioning of education and training of public health and dental public health specialists and other public health staff in PHE and local government, and also has a role in developing public health capacity across the entire health, public health and social care system (HEE, 2014). The work of HEE is supported by a Public Health Advisory Group whose role is to provide an understanding of the supply and demand assumptions for the public health workforce, and its contribution to the wider public health agenda. Its 2014-15 mandate emphasises the role of the Public Health Advisory Group as "the key forum for considering the unique challenges facing the public health workforce by concentrating HEE expertise in one place with a single dialogue between HEE and the public health community to address the training and educational needs of the public health workforce" (HEE 2014).

2 Project Aims

The overall aim of this project is to understand the resources available to the HCPH workforce to support and train them in their role, identify where there might be gaps in this support and propose options to fill those gaps. The national Healthcare Public Health Team in PHE identified three core capability areas to be prioritised by the review with the understanding that other capability areas might emerge out of the report's findings.

The project aimed to:

1. Develop three identified capability areas, Evaluation and Critical Appraisal, Health Economics and Leadership, into defined capability scopes.

2. Map and assess the current availability and suitability of resources available to Public Health staff in meeting these capability needs.

3. Identify gaps in provision and prioritise these according to their current and predicted effect on future workforce capability.

4. Propose options for addressing identified capability gaps (both general and specific) and prioritise these recommendations in terms of future benefits to ensure relevant staff have a good understanding of the core capabilities and ability to practically apply this knowledge.

3 Methodology

SPH has undertaken a mixed methods review of the current position regarding training, competency gaps and resources available for HCPH in order to achieve the aims of the project. The review incorporated the following methodological approaches:

- A desktop document review of the existing definitions and competency frameworks relevant to HCPH to inform the capability scopes.

- Interviews with a range of stakeholders across different organisations involved in different aspects of HCPH including those commissioning HCPH work from public health staff, those involved in the training and supervision of HCPH staff, those providing formal training in specific aspects of HCPH and those in strategic leadership roles within the public health workforce.

- A desktop review of training available to HCPH staff working in PHE including taught Masters in Public Health courses and other ad hoc courses in specific aspects of HCPH.

3.1 Informing the capability scopes

To inform the scopes for the HCPH capabilities the SPH team reviewed the Faculty of Public Health's latest UK Public Health Specialty Training Curriculum (2015), Specialty Training Curriculum for Dental Public Health (2010), the updated version of the Public Health Skills and Careers Framework published by Skills for Health (2013) and the UKPHR standards for practitioner registration.

3.2 Interviews with stakeholders

We developed a list of people to interview drawn from across the HCPH workforce and those providing training and support to that workforce. The PHE Healthcare Public Health Team reviewed the initial list and provided suggestions for other people to approach. They included public health staff with healthcare public health roles in PHE, those providing training in health economics, critical appraisal and leadership skills and those involved in the wider training of public health staff including the Faculty of Public Health, and the Heads of Public Health Schools. A list of the people interviewed is in Appendix 3.

People were initially approached by e-mail and given some background to the project and asked to provide a convenient time for a telephone interview. Interviews were carried out with a small number of questions as discussion points and typically lasted between 40 and 50 minutes.

Notes were taken of each interview and these were reviewed by the project team and common themes extracted.

3.3 Mapping available resources

We developed a spreadsheet to map details of Masters in Public Health Courses and separate modules available to public health staff working in England. Details about ad hoc training courses focussed on leadership, evaluation and critical appraisal and health economics were also gathered.

The information collected (if readily available) included:

- Name of course
- Institution providing course
- Course duration
- Course format e.g. taught or distance learning
- Compulsory and optional elements
- Cost of course
- Qualification gained
- Access criteria

We used Appendix 4 of the Faculty of Public Health February 2009 report 'Scoping and Mapping Education & Qualifications for Public Health Practitioners' as a starting point for identifying formal Masters in Public Health courses available to public health staff in England. We supplemented this with an internet search to identify other Masters in Public Health (MPH) courses available and also searched listings sites such as findamasters.com to identify any other relevant MPH degree courses in the UK.

For ad hoc courses, we conducted internet searches specifically looking for courses covering the topics associated with the three capabilities.

4 Healthcare public health capability areas identified

The PHE Health Care Public Health team prioritised three capabilities identified as key to the delivery of the HCPH function. The interviews with the HCPH workforce and training organisations included a question about key skills required to undertake HCPH. The skills considered necessary by interviewees for HCPH competence included:

- leadership
- evaluation and critical appraisal
- health economics
- health intelligence
- policy development
- communication skills
- professional and ethical practice

4.1 Leadership

Aim: To use a range of effective strategic leadership, organisational and management skills, in a variety of complex public health situations and contexts, dealing effectively with uncertainty and the unexpected to achieve public health goals (FPH, PH Specialty Curriculum 2015 Key Area 4).

Strong leadership skills were seen by many interviewees to be the most important capability for consultants in HCPH, often over and above technical skills, especially if those technical skills can be accessed from elsewhere in the system. The type of leadership skills required concerned influencing, negotiating and persuading people in both their own and different organisations. HCPH consultants from Local Authorities working with Clinical Commissioning Groups have no 'right' to be part of CCG plans, so they need strong persuasive and negotiating skills. HCPH consultants in PHE Centres who may aim to support Strategic Clinical Networks at a local level will only do so if they can persuade managers and clinical leads of the networks that they have a useful function. With an absence of positional status and power, leadership skills and relationship management are essential to any success in HCPH delivery. Knowledge of and experience working in the NHS was considered an important element of leadership in HCPH delivery (see 4.8).

For practitioners, leadership can often entail leading on discrete pieces of work and persuading people from other organisations, who are outside their direct sphere of influence, to provide information, or spend time and effort collaborating on a project. Leadership training for senior practitioners was seen as important in their development to enable effective support of HCPH consultants and when leading initiatives in their own right.

4.2 Evaluation and critical appraisal skills

Aim: To be able to use a range of resources to generate and communicate appropriately evidenced and informed recommendations for improving population health across operational and strategic health and care settings (FPH, PH Specialty Curriculum 2015 key area 8.4).

Evaluation and critical appraisal skills were seen as a skill all HCPH consultants need to be able to demonstrate. Locally it is important for CCGs to be able to make decisions and develop policy based on evidence of cost and clinical effectiveness. A key skill is being able to frame a question to be answered prior to identifying the strength of the evidence and the limitations of different research methodologies.

PHE consultants based in the specialised commissioning function are most likely to undertake rapid evidence reviews of selected topics whilst PHE Centre colleagues may be asked for a rapid response to a query about a particular intervention.

There was a view that practitioners could be a valuable support to HCPH consultants if they were trained appropriately and experienced in for example critical appraisal, evidence review and commissioning. There are relatively few practitioners currently carrying out these roles.

4.3 Health economics

Aim: Critique and appraise service developments for their costs and impacts on health and health inequalities, using health economic tools to support decision making (FPH, PH Specialty Curriculum 2015 Key Area 7.6).

Different views were held about the level of health economic knowledge HCPH consultants and practitioners needed. An understanding of the principles and applications of the tools was required, but it was thought unlikely that there would be the opportunity to carry out a full health economic analysis unless the specialist/practitioner wanted to move into a role

with a health economic focus. It was suggested that some actual experience of carrying out health economic modelling would give confidence of applying those skills in the future. Where health economics was discussed as a competence in it's own right there was variation in perceived relevance for HCPH however, when discussed as an essential element of NHS **commissioning**, those interviewed were more positive about the benefits of this capability for HCPH delivery.

4.4 Health intelligence

Aim: To be able to synthesise data into information about the surveillance or assessment of a population's health and wellbeing from multiple sources that can be communicated clearly and inform action planning to improve population health outcomes (FPH, PH Specialty Curriculum 2015, key area 1).

Basic technical skills of accessing, manipulating, analysing, interpreting and reporting health information are regarded as key to health care public health. Support in the form of advanced technical skills from health intelligence analysts and ready access to clinical and demographic data were viewed as essential. Access to clinical data for the NHS public health workforce has become problematic since public health teams have moved to Local Authorities. Health information that is analysed and presented by Clinical Commissioning Groups and NHS Trusts is important to be able to plan and monitor demand, capacity and the quality of a service from a population perspective.

Consultants in HCPH need to be able to carry out basic data manipulations, understand the data and interpret it. Some HCPH consultants in PHE were able to call on the technical skills of health intelligence analysts or public health practitioners with strong analytical skills to support them whilst others in Local Authorities did not have that resource and undertook the work themselves.

4.5 Policy development

Aim: To be able to influence and contribute to the development of policy and lead the development and implementation of a strategy (FPH, PH Specialty Curriculum 2015 Key Area 3).

Input to health policy development and implementation to ensure that it is not only feasible, but reflects the outcomes of appraisal of evidence, health intelligence and economic analysis was seen as part of the HCPH role. Evaluating policy and critically analysing whether desired changes have been achieved was seen as a key HCPH task by interviewees.

4.6 Communication skills

Aim: Demonstrate appropriate presentation communication and listening skills, as appropriate for the audience or individual. Communicate in clear written format and in presentations to a range of organisations and audiences (FPH, PH Specialty Curriculum 2015 Key Area 2).

Due to the complexity of the public health system, sophisticated communication skills were felt to be key to success in delivering HCPH. Without these skills, HCPH consultants either in PHE or Local Authorities, were less likely to be able to influence health policy and strategy.

4.7 Professional and ethical practice

Aim: To be able to shape, pursue actively and evaluate your own personal and professional development, using insight into your own behaviours and attitudes and their impact to modify behaviour and to practise within the framework of the GMC's Good Medical Practice (as used for appraisal and revalidation for consultants in public health) and the UKPHR's Code of Conduct (FPH, PH Specialty Curriculum 2015 Key Area 9).

Having insight into one's own behaviour and the positive and negative impact of behaviours on others is a sign of emotional intelligence. Linked with leadership behaviours and communication skills, being reflective about one's own practice maximises the chances of success in the delivery of HCPH in a complex multi-agency environment where an HCPH consultant is unlikely to be in a position of power.

4.8 Experience of the NHS

Whilst skills development was seen as important, experience of working within and understanding the NHS was seen as essential by people interviewed. The move of public health to Local Authorities has enabled familiarity and understanding of local government, but many newer members of the public health workforce have no direct experience of the NHS, the way it functions, and the way money moves around the system. It is possible for a trainee to successfully complete the 5 year training programme without working in any NHS settings.

5 Capability scopes for skills required for Health Care Public Health

A competency in Health and Care Public Health is the capability to apply or use a set of related knowledge, skills, and abilities required to successfully perform "critical work functions" or tasks in a defined work setting.

The competencies in the table below are those that match the key skills identified by the PHE Healthcare Public Health team and the people we interviewed who worked or trained in the HCPH field. The competencies are drawn from:

- Faculty of Public Health curriculum for Public Health specialists (2015)
- General Dental Council Specialty Training Curriculum, Dental Public Health (2010)
- Updated UK Public Health Knowledge and Skills Framework (2013)
- Newly revised UKPHKSF out for consultation between December 2015 and January 2016 (https://www.youtube.com/watch?v=fLvNeX1Vw7M).

Table 1 Scoping of the capabilities required for delivery of effective healthcare public health

Public Health Specialist Curriculum 2015 and Dental Public Health Curriculum 2010	Key Area	UK Public Health Skills and Knowledge Framework (March 2013)	Revised UK Public health and skills and knowledge framework (consultation document March 2016)
Health information			
Quantitative and qualitative assessment of the population's health, including managing, analysing, interpreting, and communicating information that relates to the determinants and status of health and well-being. *Examples:* *i) Addressing a local issue such as high use of A&E services* *ii) Analysis of perceived high concentration of cancers in a local area* *iii) Undertake a health needs assessment* *iv) Undertake a health inequalities audit* **Dental Public Health** Oral Health Surveillance Dental Public Health Intelligence	1.1 1.2 1.3 1.6 1.8 2.1.1 2.1.8	Core area 1 • Collect and record data on health and wellbeing • Analyse data • Interpret and use data • Summarise and communicate or present analysis of findings • Translate analysis of data into appropriate recommendations for action, policy decisions and commissioning • Facilitate, advise and support others to collect, analyse and use data • Assess and improve the quality of data collection, analysis and dissemination	A1.1 Source, obtain and organise data and information A1.2 Interpret and present data and information A1.3 Manage data and information A1.4 Forecast data needs and develop data capture methods A1.5 Assess and manage risks associated with using and sharing data and information, data security and intellectual property A1.6 Collate and analyse data to produce intelligence that informs decision making, planning, implementation and evaluation

Health and care public health			
To be able to improve the efficiency, effectiveness, safety, reliability, responsiveness and equity of health and care services through applying insights from multiple sources including formal research, health surveillance, needs analysis, service monitoring and evaluation. *Examples:* *i) Develop and implement a plan for improving equity of access to a screening programme* *ii) Contribute to the decision regarding an Individual Funding request* *iii) Evaluate hypertension detection, management and outcomes of care in a local health system* *iv) Participate in a quality monitoring review of a service* **Dental Public Health** Role within the Health Service Developing & Monitoring Quality Dental Services	7.1 7.2 7.3 7.4 7.5 7.7 7.8 2.2.3 2.1.7	Defined area 9 • Apply and implement policies, guidelines, protocols and procedures to deliver quality services • Audit or evaluate services and practices against quality standards using appropriate methods • Identify, assess and communicate risks to service quality • Assess health and social care service needs, utilisation and outcomes • Apply service assessments to planning of services, frameworks and standards • Prepare and present service specifications, service frameworks, models of care and care pathways • Manage and report on governance issues • Commission improvements in health and social care quality • Engage with and advise partners and decision-makers to achieve improvements in quality	A3.3 Target and implement nationwide interventions designed to off-set ill-health (e.g. screening, immunisation) A5.3 Engage in stakeholder co-design and co-production, to develop integrated and equitable person-centred services A5.4 Develop and implement protocols and procedures, integrating national 'best practice' guidance into local delivery systems A5.5 Quality assure, audit, and evaluate services and interventions and contribute to the evidence base B1.3 Develop and implement action plans, with, and for specific groups and communities, to deliver outcomes identified in strategies and policies B3.5 Provide interventions and services, working constructively with the commissioning authority to support monitoring processes and adaptable delivery B3.2 Identify key performance indicators that show improved health outcomes, reduced inequalities and/or the impact on factors that determine health and wellbeing B3.4 Integrate commissioning with other groups and organisations to provide person-centred interventions and services that improve equity of access

Health Economics			
Criticise and appraise service developments for their costs and impacts on health and health inequalities, using health economic tools to support decision making. *Examples:* *i) Lead on the development of a business case and make an economic argument for a new service development* ii) *Appraise the economic analysis of an evidenced based implementation of new drug or intervention for the local population* **Dental Public Health** Knowledge of financial and planning cycles; application of healthcare economics to appropriate dental issues	7.6 2.1.3	Defined area 9 • Appraise business and financial proposals for new service developments or configurations	A5.1 Conduct economic analysis of health services and interventions against health outcomes, inequalities in health, and return on investment. B3.1 Set commissioning priorities, understanding the economic case for investment and securing the best value for money
Effective communication			
To be able to use a range of resources to generate and communicate appropriately evidenced and informed recommendations for improving population health across operational and strategic health and care settings.	2.1 2.2 2.3 2.4 2.6 2.7	Core Area 4 • Communicate effectively about health and wellbeing	C2.2 Communicate sometimes complex information and concepts (including health outcomes, inequalities and life expectancy) to a variety of audiences using different methods

Examples: *i) Written board papers or strategy documents* *ii) Presentations to multiagency groups,* *iii) Briefing elected council members* *iv) Responding to individual members of the public*			
Critical appraisal			
To be able to critically appraise evidence to inform policy and practice, identify evidence gaps with strategies to address these gaps, undertake research activities of a standard that is publishable in peer-reviewed journals, and demonstrate competence in teaching and learning across all areas of public health practice. • 8.4 Advise on the relative strengths and limitations of different research methods to address a specific public health research question. *Example:* *i) Rapid evidence review of a new drug or technology or surgical intervention*	8.4	Core Area 2 • Find and retrieve evidence relating to a specific health topic • Collect and collate evidence • Critically appraise evidence • Synthesize and interpret evidence • Communicate evidence to others • Apply evidence to own area of work • Advise and support others to use evidence in own work • Identify gaps in evidence base and initiate action to fill gaps • Use evidence to influence policies, guidelines, procedures and programmes • Review effectiveness of own area of work	A4.1 Access and appraise evidence gained through systematic methods and through engagement with the wider research community A4.2 Critique published and un-published research, synthesise the evidence and draw appropriate conclusions A4.4 Report and advise on the implications of the evidence base and its implementation for the most effective practice and the delivery of value for money A4.5 Identify gaps in the current evidence base that may be addressed through research A5.2 Appraise new technologies, therapies, procedures and interventions and their implications for health inequalities and service development

Dental Public Health Assessing the Evidence on Oral Health and Dental Interventions, Programmes and Services	2.2		
Leadership			
To use a range of effective strategic leadership, organisational and management skills, in a variety of complex public health situations and contexts, dealing effectively with uncertainty and the unexpected to achieve public health goals. *Example:* *i) Lead development of integration plans across LA and NHS* *ii) Lead development of JSNA* **Dental Public Health** Strategic Leadership & Collaborative Working for Health	4.1, 4.2, 4.3, 4.4, 4.6, 4.7, 4.8, 4.9 2.1.4	Core Area 4 • Work as an effective team member • Collaborate effectively with people and teams to improve population health and wellbeing • Communicate effectively about health and wellbeing • Support, motivate, encourage and facilitate the development of others • Manage programmes or projects to improve health and wellbeing • Lead and influence change • Lead on areas of work • Review and improve collaborative working arrangements and partnerships • Advocate for and promote the value of health and wellbeing and reduction of inequalities • Influence and negotiate to improve health and wellbeing • Constructively reflect on own work and area of practice	C1.2 Work with others, build relationships, encourage contribution and sustain commitment to deliver shared objectives. C1.3 Adapt to change, manage uncertainty, solve problems, and align clear goals and lines of accountability (change) C1.4 Establish a network of leaders and followers engaged in improving health outcomes and reducing inequalities across the system. C1.5 Provide vision, shape thinking, inspire shared purpose, and influence the contributions of others in the system to improve health and address inequalities

Policy development			
To be able to influence and contribute to the development of policy and lead the development and implementation of a strategy. • 3.3 Appraise options for policy and strategy for feasibility of implementation *Example:* *i) Options appraisal of different pathways to cancer diagnosis* • 3.7 Undertake policy or strategy evaluation using an appropriate method, critically analysing whether desired changes have been achieved *Example:* *ii) Evaluate the actions taken to implement a strategy for improving mental health in a population group and the outcome of those actions* **Dental Public Health** Policy & Strategy Development, & Implementation	3.3, 3.7 2.1.3	Core Area 3 • Apply and implement policies in own area of work • Identify and comment on impact of policies on own area of work • Develop specific policies and strategies in own area of work • Support others in implementing policies and strategies • Assess and appraise policies, and recommend changes to improve development and implementation • Assess impact of policy on health and wellbeing • Influence and lead on the development of new policies to improve health and wellbeing	B1.1 Appraise and advise on global, national or local strategies in relation to the public's health and health inequalities B1.2 Assess the impact of health and other policies and strategies on the public's health and health inequalities B1.4 Influence or lead on policy development and strategic planning across organisations, to identify opportunities to promote health, improve access, and reduce inequalities in response to changing health needs and risks B1.5 Monitor the progress and outcomes of strategy and policy implementation

Professional and ethical practice			
To be able to shape, pursue actively and evaluate your own personal and professional development, using insight into your own behaviours and attitudes and their impact to modify behaviour and to practise within the framework of the GMC's Good Medical Practice (as used for appraisal and revalidation for consultants in public health) and the UKPHR's Code of Conduct. *Example* *i) Demonstrate own critical appraisal of performance, assessing what went well and what could have been done better and identifying own strengths and limitations.* *ii)* **Dental Public Health** Appropriate decision making and judgement Appropriate attitudes, ethical understanding and legal responsibilities Personal Development	9.10 2.2.1 2.2.2 2.2.4	Core area 4 • Constructively reflect on own work and area of practice	C1.1 Act with integrity, consistency and purpose, and continue one's own personal development (self

6 Current resources available to Public Health staff delivering HCPH

6.1 Masters courses

Following our search for MSc/MPH/MDPH courses we found a range of courses on offer which are summarised in the table below. For Masters in Public Health programmes, information about modules covering the three capabilities was not always available. Where the information was available there was variation concerning whether the modules covering the three capabilities were mandatory or not. Overall modules covering evaluation and critical appraisal were more likely to be mandatory than those covering leadership or health economics.

Table 2 MSc courses identified covering Public health, leadership, evaluation and critical appraisal and health economics.

Topic of masters course	Number of courses	Modality	Cost range £
Public Health	57	47 taught on site 3 taught on site or distance learning 7 distance learning	4,140-12,525
Health Leadership	6	5 taught on site 1 distance learning	7,348-15,000
Health Economics	10	9 taught on site 1 unknown	6,500-10,500
Health Services research	1	1 taught on site	7,500
Dental Public Health	9	Taught on site	6,500-10,000
Evidence based health care	2	1 distance learning 1 taught	Not available
Health and social care	1	1 taught on site	4,590
Nutrition Physical activity and Public health	1	1 taught on site	6,100

6.2 MSc/MPH Modules separately offered

A small number of universities were explicit about offering separate standalone MPH modules shown in the table below. Many Universities are likely to offer this option if approached.

Table 3 MSc Modules offered separately from a formal accredited certificate, diploma or MSc.

Topic	Number	Modality	Cost £
Leadership	2	1 distance learning 1 blended learning	Not available
Critical appraisal	2	1 distance learning 1 unknown	Not available
Health economics	8	3 onsite (1 week) 1 web based programme 3 Distance learning	660 +

6.3 MSc/MPH/MDPH (or equivalent) and healthcare public health

Each Masters course, or equivalent, developed by a university department will reflect the expertise and interests of the staff teaching the modules. Courses vary in the modules that are considered mandatory and optional and may have a strong emphasis on particular elements of the field such as global public health or health promotion. For people aiming to build a career in HCPH who are choosing a Masters course with a public health focus (MPH, MSc, MDPH), modules covering the following areas would provide a good foundation on which to build the skills required:

6.3.1 Health services leadership/management

Examples of topics covered include: Principles of leadership and delegation; principles of negotiation and influencing; principles, theories and methods of effective communication (written and oral) in general, and in a management context; structure and management of inter-organisational (network) relationships, including inter-sectoral work, collaborative working practices and partnerships; management models and theories associated with motivation, leadership and change management, and their application to practical situations and problems; complexity of the operating environment for public health.

6.3.2 Evidence based healthcare/ critical appraisal/systematic review

Examples of topics covered include: Hierarchy of research evidence from well conducted meta-analysis down to small case series, critical appraisal and the acquisition of skills necessary to undertake such work; introduction to information systems; principles of systematic literature reviews and critical appraisal; search strategies; computer-assisted search methods; practicalities of writing up the results of a systematic review; introduction to meta-analysis; and dissemination of findings.

6.3.3 Health economic analysis/commissioning/health care financing

Examples of the topics covered: Basic principles of health economics and the role of health economics in decision making; how to critique health economics studies; different methods of economic evaluation and decision modelling; knowledge of health and health care systems; the roles and limitations of markets and incentives in health systems and setting priorities; including the cost effectiveness of public health, and public health interventions; cost-effectiveness analysis; cost-utility analysis, option appraisal and cost-benefit analysis, marginal analysis, the measurement of health benefits in terms of QALYs and related measures.

6.3.4 Epidemiology and statistics

Example of topics covered: The ability to sort and manipulate data, and to draw appropriate conclusions from quantitative and qualitative data; knowledge of the defining clinical features, distribution, causes, behavioural features and determinants of diseases which currently make a significant impact on the health of local population that require the planned provision of health services at individual, community and structural levels.

6.3.5 Health care policy

Example of topics covered: Differences between policy and strategy, and the impact of policies on health; principles underpinning the development of policy options and the strategy for their delivery; implementation and evaluation of policies including the relevant concepts of power, interests and ideology; stakeholder engagement in policy development, including its facilitation and consideration of possible obstacles.

6.3.6 Health information

Example topics covered: The importance of health information; how to identify valid sources of health information; health information systems in the UK; how they are integrated; the governance structure behind health information.

6.3.7 Health care quality

Examples of topics covered: Principles underlying the development of clinical guidelines, clinical effectiveness and quality standards, and their application in health and social care; public and patient involvement in health service planning; professional accountability, clinical governance, performance and appraisal; risk management and patient safety.

6.4 Standalone courses for the three capabilities

A sample of standalone courses covering aspects of the three capabilities is outlined in the table below. This is not an exhaustive list, but rather a snapshot of courses easily identified across England currently. New courses are being developed all the time as the capabilities evolve.

Table 4: Standalone courses covering leadership, evaluation and critical appraisal and health economics as accessed from websites in February 2016.

Course name	Organisation	Purpose	Cost
Leadership			
NHS Leadership Academy	NHS	12 different programmes covering leadership from aspiring leaders to systems leadership for those already leading organisations.	Variable
'Grow' your own' Developing the next generation of health and social care leaders	PHE/NHS(HEE)	5 days over a 3 month period covering, Strategic Influencing, Leading Branding and Personal Resilience and Resourcefulness	£170
Common Purpose Leadership Programme	Common purpose	Programme for emerging and Senior Leaders - not exclusive to Health, and crosses public, private and voluntary sectors, can be customised. UK and International. E.g. Meridian course, 3 day for experienced leaders £4590 plus vat	Variable
The School for Health and Care Radicals	NHS IQ	Free five week virtual learning programme for change activists in health and social care - by webinar	Free
Leadership and Management/ Coaching and Mentoring	National Skills Academy for Health	Institute of Leadership & Management, Level 5 certificate 4 days	£1150
Leadership skills courses	PHE – Civil service learning programmes	To develop generic leadership skills in people within the civil service (PHE employees)	Free within PHE
Leadership skills courses	Local Government Association	Courses aimed at aspiring leaders, high calibre graduates, middle-management and senior leaders. Public sector focus – rather than NHS	Free within the LA
Leadership and Management	PHAST	A range of 28 one and 2 day health leadership and management courses e.g. Influencing without authority	£250
Leadership development programmes; "Leading collaboratively with patients and communities", "Leadership for Consultants	Kings fund	Clinicians, managers, patients and service users will learn together how to build productive relationships, exploring how different roles and perspectives can be a constructive force for change in policy and service development. 5 one day modules over 8 months	£3900

Leadership for Consultants	Kings fund	Health care practitioners need to work together to deliver better patient care: to do that effectively demands new knowledge, different leadership skills and behaviours as a result of all the recent changes to the health and social care system. This programme will help doctors who are considering how best to be influential at the consultant level to make informed decisions and to be more effective leaders. 3 modules over 5 days	£2400
Evaluation and critical appraisal			
Critical Appraisal Skills Programme	CASP UK c/o Better Value Healthcare	Online resources, useful links and able to commission CASP workshops and attend Train the Trainer events (Oxford)	996-1195
Critical appraisal resources	Keele University	Online guides and support (collation of)	
Critical appraisal resources	Healthcare Improvement Scotland/ SIGN	Online/ video resources	
Critical appraisal resources	Birmingham University	Online guides and support (collation of)	
Critical appraisal resources	PHAST	Text and video online courses	
Introduction to systematic reviews	Centre for Evidence Based Medicine	1 day workshop	£155
Critical appraisal course	The Critical Appraisal Company	Online – 6-8 hours CPD accredited	£75
Critical appraisal workshop	The Critical Appraisal Company	2 days – CPD accredited	£360-395
Critical appraisal Masterclass	The Critical Appraisal Company	1 day – CPD accredited Company also offer bespoke courses	£240
Introduction to medical statistics	Centre for Evidence Based Medicine	1 day workshop	£155

Introduction to evidence based medicine	Centre for Evidence Based Medicine	1 day workshop	£155
Introduction to Systematic Reviews and Critical Appraisal Course	University College London	Defining a meaningful research question and the key research factors implicated in answering a research question in an efficient and valid way. Develop skills to design your own research study and/or evaluate existing published material. 1 day workshop	£125
Introduction to Systematic Reviews and Critical Appraisal Course	University of York	Introduction to systematic review methodology and critical appraisal skills. Attention will be restricted to the quantitative evaluation of effectiveness in health related research - 3 day workshop	
Health economics/commissioning			
Adults' services commissioning skills; Children's services commissioning skills	IPC/ Oxford Brookes	Work through each stage of the IPC framework for commissioning and purchasing, and tackle a series of realistic exercises designed to illustrate the techniques and tools available for effective commissioning. - 4 day course	£790
Health Economics – achieving value in hellish times	PHAST	Assessing value for money, cost effectiveness, STAR PBMA outcome ands value based payment and novel models of contracting; 1 day course	£250
Value based healthcare	Better value health care	Bespoke courses about commissioning	
Leading Quality Improvement and Change in Public Care	IPC/ Oxford Brookes	Promoting and Implementing Evidence-based Practice; Monitoring, Review & Analysis; Involving Patients, Service Users and Carers in Improving the Quality of Services; Managing Demand and Capacity – 4 day course	
Leading Strategy and Commissioning Services	Bournemouth University	Critically review the strategy formulation and implementation in your own organisation and produce an improvement plan. You will develop skills and knowledge which will allow you to be effective in leading or contributing to organisational strategy and commissioning services	£800
Executive programme for strategic commissioning	Birmingham University	This 5 day Executive Programme in Strategic Commissioning focuses directly on the current challenge of coping with public service funding cuts at a time of rising service needs and	£975

		expectations and considers issues such as: • Structures and models for strategic commissioning • Shaping more successful communities and improved outcomes • Integration across all public services • Monitoring and evaluating of outcomes • Driving organisational and partnership performance • Improving procurement • Making the most of alternative methods of service delivery • Harnessing user and community co-production	
Evaluating Quality and Understanding the Commissioning Process	Sheffield Hallam University	Critically analyse the nature of quality in your organisation and the relationship between quality and organisational performance; Evaluate tools and techniques for assessing and improving quality in your organisation; Demonstrate a critical understanding of commissioning within the health and social care markets; Critically evaluate the role and contribution of the leader to effective commissioning processes; Critically appraise how learning from the module will be applied in practice 3 day course	£1500
Commissioning workshop: Informatics in health and care service planning	Faculty of Public Health	Understanding the datasets available and the quality behind them; The process of data warehousing, mining and linkage; The legal basis for developing linked datasets; The application of linked datasets and their benefits over Joint Strategic Needs Assessment (JSNA) core datasets; System modelling. 1 day aimed at Public Health consultants	

7 Gaps in the provision of resources available to meet HCPH capability

7.1 Overview

Key Area 7 of the 2015 Public Health Specialist Training Curriculum (Health and Care Public Health) covers the basics of what a consultant working in HCPH should be capable of delivering. The equivalent section for practitioners is defined area 9 in the UK Public Health Skills and Knowledge Framework. Views gathered from the interviews suggested that this area is not so much seen as a combination of generic skills alone, but a combination of skills applied specifically in the NHS setting and an understanding and confidence of working in that setting which is as important as (and sometimes more so) than the technical ability to use the skill.

From the interviews, the focus of responses related to newly trained specialists and consultants and experienced consultants. There was less feedback about practitioners and senior practitioner's experiences. We were informed that practitioners in Local Authorities reported that their public health skills were being diluted as they are drawn more into generic commissioning functions. It was noted that there were very few HCPH practitioners and it was not easy to replace someone with the requisite skills when they left. Often a HCPH consultant has no support team in Local Authorities or in PHE Centres, so there is no one to develop.

The gaps identified in resources available to meet the HCPH capability skills are reported for newly trained specialists/consultants, experienced consultants and practitioners. There was too little information from our interviews to distinguish differences between practitioners and senior practitioners.

7.2 Leadership

7.2.1 Newly trained specialists / consultants

There were some comments that it has become more difficult since 2013 to give PH Specialty Registrars (StRs) experience in leading projects as the potential impact of something going wrong with projects had increased. However, it is arguable, and suggested by some interviewees, that with appropriate supervision, StRs are able to gain significant experience in leading work in a range of settings. As with other capabilities, it is now harder for StRs to gain experience of leadership whilst working directly in an NHS setting. At later stages in their training StRs have variable access to sustained leadership training, versus the full day workshops that are available to most. Access to leadership training is variable and often very expensive.

7.2.2 Experienced consultants

Experienced consultants working in local authorities are accessing systems leadership training via the NHS Leadership Academy. The aspiring Directors of Public Health programme continues to exist as 'The Future Directors Programme'. The review found that leads in HCPH need to have particular leadership skills that are strong in influencing and

engaging in addition to skills in change management and organisational development. These are rare individuals who can combine public health technical skills with charismatic leadership and it may be that careful selection for such roles is as important as ongoing training. What is clearly needed is ready access to mentoring and coaching for all senior public health leads.

7.2.3 Practitioners

It is difficult for practitioners to develop skills in HCPH, but well skilled senior practitioners are needed to support HCPH consultants. Leadership training for practitioners is variable and often not available.

Many senior public health practitioners have had significant training in, and experience of leadership. The lack of formal training programmes for senior practitioners means that many enter public health after achieving senior roles in related professions, including management. Many of these leadership skills are unrecognised and arguably under utilised in public health settings. A structured training programme for senior public health practitioners would have the potential to increase public health technical skills and resource, and enable the full utilisation of other skills in this varied and diverse workforce.

7.3 Evaluation and Critical Appraisal

7.3.1 Newly trained specialists / consultants

There is a perception among those with responsibility for training that evaluation and critical appraisal is an area of technical skill that is well covered in the training programme, and that Specialty Registrars have experience throughout their training of applying these skills in a range of settings. There is agreement amongst programme training directors and Heads of Public Health Schools that it can be difficult for current StRs to gain experience of working directly within, and applying technical skills in, NHS settings. Although the revised faculty curriculum states in Key Area 7 'that by the end of training registrars will be expected to have been involved in work in developing, evaluating, improving and commissioning health and care services. Work must include at least two of the following: an acute health service setting (including clinical networks), a primary care setting, a mental health care setting, a health protection context.' There was broad agreement by those responsible for training that placements in these settings can now be difficult to achieve. However placements in local authorities and other non NHS organisations do still offer the opportunity to carry out of evaluations and critical appraisal of evidence relating to health care services.

7.3.2 Experienced consultants

Consultants will typically have had ongoing experience of applying evaluation and critical appraisal skills. What the review identified was that there is a need for a consistent approach for carrying out rapid appraisals of evidence with accepted limitations on the rigour of the appraisal as a result of time and resource limitations. Interpretation of, for example, NICE guidelines for local application, is an important capability for the HCPH workforce. The capability gap identified is the confidence and willingness to carry out rapid and limited appraisals using consistent tools.

7.3.3 Practitioners

The diversity of training of public health practitioners, and the range of professional backgrounds, means that evaluation and critical appraisal are a significant skills gap for many practitioners. The UKPHR standards for practitioner registration include a standard relating to evidence of effectiveness; 'Standard 7 'Assess the evidence of effective interventions and services to improve health and wellbeing – demonstrating: a. knowledge of the different types, sources and levels of evidence in own area of practice and how to access and use them the appraisal of published evidence and the identification of implications for own area of work.' A minority of senior practitioners have been through the UKPHR registration process and many practitioners will not have had any formal training in this public health technical area.

7.4 Health economics

7.4.1 Newly trained specialists / consultants

There was a perception that an understanding of health economics was important, but that how it was used within the wider practice of the commissioning cycle was a key skill. HCPH consultants will rarely have the opportunity to carry out a full health economic analysis, but they will need to understand cost effectiveness when planning population based service developments. Health Economics is not a standalone key area of the PH Specialty Training Curriculum and there is one sub section under Section 7 (Health and Care Public Health) for the knowledge base required listed as 'Medical sociology, social policy, and health economics' and one requirement to meet that competency 'Criticise and appraise service developments for their costs and impacts on health and health inequalities, using health economic tools to support decision making.' There is no reference to understanding commissioning per se and this was seen as a gap with newly trained specialists who had less access to placements in NHS settings. It was also reported that there was a need to understand the philosophy of commissioning rather than just the commissioning cycle i.e. governance issues and accountability.

7.4.2 Experienced consultants

No gaps were identified for experienced consultants possibly because they would have had experience with NHS commissioning cycles and the attendant health economic principles prior to the April 2013 reorganisation. It was noted however, that although there is currently a group of senior people in public health with experience in the NHS, in the future this is going to be difficult to maintain.

7.4.3 Practitioners

The UK Public Health Skills and Knowledge Framework refers to health economics at senior levels (7, 8 and 9) as part of defined area 9 'Health and Social Care Quality':

- *Understand the principles of health economics and its application to developing service quality*

- *Understand the nature and uses of financial modelling and its application to developing service quality*
- *Understand standard financial instructions and their application to health and wellbeing and the costs of ill-health'*

There was a view that there was little in place around health economics and commissioning for HCPH practitioners. One area reported that half day workshops about commissioning skills were being delivered predominantly for practitioners. Feedback from some participants in 'Better Value Health Care' courses which were delivered to a mix of practitioners and specialists was that it was difficult to see the link between the course content and what they were currently doing in Local Authorities. This may be because few of the practitioners were providing HCPH support for CCGs and they were commissioning services solely from within the Local Authority. There are a number of courses around commissioning aimed at practitioners such as the 5 day course on Strategic Commissioning run by Birmingham University.

8 Options for addressing identified capability gaps

For each capability area three levels of skill were identified depending on the HCPH role:

- Knowledge and understanding of the capability to the extent that principles were understood and could be communicated to other people
- Thorough and pragmatic application of the skills on a frequent basis either as part of a team or leading a piece of work
- Expert leader in the field

8.1 Leadership

From talking to staff across HCPH their perception is that there are adequate leadership courses available at all levels, although they can be expensive. The key issue is that courses and funding are not obviously available for practitioners who have been identified as in need of development. Leadership courses for consultants and expert leaders in the field of HCPH are much more easily identified and funded. For example, PHE have funded the 'Grow your own leaders' and the 'Future Directors' leadership programmes. The Leadership Academy provides courses for staff working in the NHS and public health from the most basic course suitable for practitioners through to systems leadership. For practitioners, access to courses is more varied and in order to develop an HCPH practitioner base leadership courses should be made available to people who want to progress public health careers.

8.2 Evaluation and critical appraisal skills

There is the perception that access to training in the **knowledge and understanding** of the capability via Masters course modules or Critical Appraisal Skills Programme workshops is readily available. At the other end of the spectrum, the expert in critical appraisal is someone who is likely to have trained to undertake systematic reviews or who spends the majority of their time undertaking critical appraisal.

It is much harder to find courses that will help people to undertake pragmatic critical appraisal such as rapid evidence reviews (RERs) (also known as rapid evidence

assessments). Team members can undertake aspects of RERs or one person can lead and undertake the appraisal of a particular topic. There are some placements where PH StR are supervised to undertake RERs, but these are not widely available.

The development of a programme to train and supervise people whose role contains a significant element of critical appraisal is recommended. These may be newly trained specialists/consultants or senior practitioners who would undertake rapid evidence reviews as part of the programme. For consultants this may be in the form of credentialing as defined by the General Medical Council.

8.3 Health Economics

It was clear that all levels of HCPH staff should understand and be able to communicate the principles of health economics. Courses at this level are available and the information will be covered in masters modules. The pragmatic application of health economics as a team member or team leader is as part of commissioning cycle and it is here that training running alongside the NHS commissioning process for HCPH staff would be valuable. To become an expert in health economics, masters courses and doctoral studies are available, leading to work carrying out health economic evaluations and a role as an advisor.

8.4 Development of the HCPH workforce

The element of workforce development most commented on by people interviewed was the lack of opportunity for HCPH staff to have experience of working within the NHS. This was thought to be the most important gap in training and development. More experienced consultants and senior practitioners would have experience in the NHS prior to April 2013, but since then it has become much more difficult for PH StRs to access placements within the NHS and it was understood that training could be accomplished without experience of placements in an NHS setting. For PH StRs and practitioners without an NHS background this was seen as a major gap leading to a lack of confidence in working in HCPH, even if the technical skills were in place.

Overall it was felt that the role of a consultant specialist or practitioner working in HCPH was isolating and pulling together those individuals into an effective network for support was considered important. In order to develop a robust HCPH service UKPHR registration must be supported and developed with a clear structured HCPH element. Structured Practitioner development programmes should also be explicitly funded.

Table 6: Specific options for support of the HCPH workforce

Role	To support development
Practitioner	• Secondments, placements, or other work experience within a relevant NHS setting • Linked to HCPH consultant or senior practitioner to support their HCPH development • Structured development programmes linked to PHSKF
Senior Practitioner (level 7 upwards)	• Secondments, placements, or other work experience within a relevant NHS setting • Support sub-specialisation development, as exists with health intelligence analysts for evaluation and critical appraisal and NHS commissioning/ health economics • Consider learning from advanced practitioner pilots
PH Specialty registrars(StR)	• PH Speciality Registrars with no NHS experience should be required to work in the NHS for a minimum amount of time before they start training • All StRs should have a placement within the NHS
Post-qualification	• Develop long term supervised placements in a variety of settings (compared to civil service practise of long term rotations of 2 years) to develop skills and confidence in delivery of HCPH across profession (NHS, PHE,LA) • Develop credentialing post-qualification for HCPH (and Health and Well being and Health protection) • Mentoring and coaching should be made available
Experienced consultant	• Careful selection of leaders with appropriate understanding /confidence in NHS HCPH practice • Automatic mentors with HCPH expertise should be assigned to senior leaders who are accountable for HCPH delivery • Systems leadership programmes should be offered

9 Recommendations: HCPH workforce development priorities

From the views gathered from interviews and the availability of courses for leadership, evaluation and critical appraisal and health economics there are a set of recommendations set out below.

9.1 Masters courses and modules

Providers of Masters courses aiming to offer modules to people focussed on a career in HCPH should take into account the capabilities identified as essential to deliver HCPH and ensure this content is covered.

9.2 Placements in the NHS for practitioners and specialty registrars during training

Health Education England through Heads of Schools/Training Programme Directors should ensure there are strong portfolios of HCPH training placements in NHS health care settings for PH Specialty Registrars and practitioners. The Faculty of Public Health should consider making NHS placements mandatory in the training scheme

9.3 Support for the practitioners scheme in all settings and across the UK

The PH practitioner registration scheme should be accessible and explicitly funded for practitioners working in all settings, including local authorities, clinical commissioning groups, service providers, NHS England and Public Health England. In order to develop a robust HCPH service UKPHR registration must be supported and developed with a clear structured HCPH element.

9.4 Continuing professional development for HCPH

Health Education England through Heads of Schools/Training Programme Directors should take account of the key HCPH competencies identified in planning continuing professional development for existing PH specialists working in HCPH. There needs to be opportunity for application of HCPH skills across NHS, PHE and LA settings as part of CPD.

9.5 Leadership courses

The capability most commonly mentioned as essential to deliver HCPH is leadership. It is important that Public Health England and Health Education England jointly identify how to ensure equitable funding of continuing professional development for leadership development for post qualification for specialists, consultants and senior PH practitioners. Mentoring and coaching should be made available as part of leadership development.

9.6 Sub-specialisation in HCPH

Health Education England should ensure that opportunities exist for PH practitioners to sub-specialise in one of the technical aspects of HCPH (pre- or post registration). For example, senior PH practitioners skilled in rapid evidence reviews or health economics (in a similar way to health intelligence analysts are skilled in health information) could be key in

supporting the effective delivery of HCPH. Consultant resource dedicated to HCPH is scarce and their impact could be much increased if they had the support of senior public health practitioners with advanced technical skills.

9.7 Work in a clinical setting prior to training

All PH Specialty Registrars aiming for a career in HCPH should have some experience of working in an NHS setting, and if they have not had this prior to the start of the training scheme, must gain this experience during training. For those entering the scheme via the medical route and from other clinical disciplines no additional work experience would be required but for those coming from a non-clinical, non-medical background the FPH might want to consider requiring work experience within an NHS setting to be a mandatory part of training.

10 Discussion and Conclusion

During this review whilst talking to Directors of Public Health and HCPH consultants in local authorities and PHE it was clear there was a strong will to be able to carry out their role effectively and to the best of their ability. This was hampered by some of the organisational issues that the FPH have highlighted in their recent review (FPH 2016) and the written evidence submitted to the House of Commons Select Committee (Public Health post-2013 – structures, organisation, funding and delivery).

Excerpts from our interviews below also show how it is hard to overcome these barriers;

"*LAs are continually cutting the service and an HCPH consultant is an easy target unless they are only focussed on the integration agenda. Other more CCG focussed work much further down agenda and not supported.''*

"There is cognitive and cultural dissonance with LAs supporting CCGs view that using LA resource to support CCGs will result in more demand for social care (e.g. reduce bed blocking and increase intermediate care)"

"HCPH consultants at centres in PHE are not carrying out HCPH as there is no clearly defined role and advice is not always welcome by LAs and SCNs in many areas. Where it works is where there are historical links between colleagues and strong HCPH understanding and support."

From the CCG perspective the NHS Clinical Commissioners produced a members report on a survey of working with public health teams post-2013 (NHS Clinical Commissioners 2015). There were some serious concerns about capacity of public health support, especially in larger areas where multiple CCGs were covered. There was also the assumption that with the tightening of council budgets the public health capacity available to CCGs would lessen.

The NHS and wider public sector are undergoing major changes in the way the system is organised. Commissioning of both health and social care is increasingly being done in larger groups of authorities and CCGs – often collectively. The NHS has introduced Sustainability and Transformation Plans (STPs) organised on 44 footprints based around clinical networks.

The NHS Planning Guidance (NHS England 2015) estimated that the specialised services funding would rise by 7% in 2016/17 (compared to 4% for primary care). Commissioning of specialised services typically requires a population view from a health care public health perspective where high cost, low volume treatments need to be carefully planned across a wide geographical area or in this case an STP. How that advice will be delivered across the STP footprint is not yet clear.

At the same time Combined Authorities and Devolution Agreements are changing local government collaborations. The existing boundary between commissioning and provision is becoming increasingly blurred. New models of provision including the 'Vanguards' may lead to very different structures such as Accountable Care Organisations. There needs to be a re-think as to how HCPH can be flexible enough to input to new structures, where many of the key decisions on population healthcare will be taken in the future.

The HCPH workforce to a greater or lesser extent can be found in all parts of the health system including providers, CCGs, LAs, NHSE and PHE. Identifying the HCPH resource fully at all levels and ensuring a clear training structure pre and post registration combined with high quality funded CPD will ensure the population healthcare input available where ever the consultant or practitioner works will be of a high quality. Practitioners especially are not visible in the HCPH workforce and yet this is the one area where if this group is developed they can form a robust set of skills to support HCPH consultants who in order to deliver HCPH effectively need to focus on deploying considerable leadership skills across culturally dissonant organisations. This will be important for the future workforce, if they are to continue to want to work in this domain and have the confidence to apply their skills effectively.

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12 Appendices

12.1 Appendix 1: Healthcare Public Health Advice Service to Clinical Commissioning Groups

The DH HCPH guidance (*Healthcare Public Health Advice Service to Clinical Commissioning Groups*, June 2012) includes an estimate of the capacity required, proposing that about 40% of the specialist public health capacity in a LA might be devoted to the Healthcare public health advice function (or c1 WTE specialist per 270,000 population). There is an emphasis on the importance of strategic leadership of the LA's Director of Public Health (DPH) and the development of collaborative relationships across the commissioning landscape. A suggested service specification covering defined stages of the commissioning cycle and a clear statement that the money transferred from the NHS to the LAs at transition was intended to cover the CCGs' needs in respect of the advice service.

Within the guidance a set of quality criteria for the service proposes that the service should:

- Include input from specialists in public health as defined by the Faculty of Public Health (FPH)
- Meet CCG needs
- Offer a timely response
- Provide advice that demonstrably contributes to achieving the priorities of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy

The guidance recommends that there be a written local agreement or Memorandum of Understanding between the CCG and the LA and an annual work plan agreed by the CCG and the DPH for particular deliverables. It also recommends that there be an annual presentation to the Health and Wellbeing Board about how the service has been provided.

The table below outlines healthcare public health functions delivered by PH Consultants and practitioners in a HCPH role.

Stages in the Commissioning Cycle	Healthcare Public Health function	Examples of Outputs
Strategic planning - Assessing Needs	Supporting CCGs to make inputs to the Joint Strategic Needs Assessment and to use it in their commissioning plans	Using and interpreting data to assess the population's health, this may include
	Development and interpretation of neighbourhood/locality/practice health profiles, in collaboration with CCGs and local authorities	JSNA and joint health and wellbeing strategy with clear links to CCG commissioning plans
	Providing specialist public health input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality	Neighbourhood/locality /practice health profiles, with commissioning recommendations Clinical commissioners supported to use health

		related datasets to inform commissioning HNA for condition/disease group with intervention / commissioning recommendations
	Health needs assessments (HNA) for particular conditions/disease groups – including use of epidemiological skills to assess the range of interventions from primary/secondary prevention through to specialised clinical procedures	
Reviewing Service Provision	Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population	Vulnerable and target populations clearly identified; PH recommendations on commissioning to meet health needs and address inequalities
	Support to CCGs on interpreting and understanding data on clinical variation in both primary and secondary care. Includes PH support to discussions with primary and secondary care clinicians if requested	PH recommendations on reducing inappropriate variation
	PH support and advice to CCGs on appropriate service review methodology groups, including the protected population characteristics covered by the equality duty	
Deciding Priorities	Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence-base for the setting of priorities	Review of programme budget data
	Advising CCGs on prioritisation processes - governance and best practice	Review of local spend / outcome profile Agreed CCG prioritisation process
	Work with CCGs to identify areas for disinvestment and enable the	

	relative value of competing demands to be assessed	
	Critically appraising the evidence to support development of clinical prioritisation policies for both populations and individuals	PH advice as appropriate Clear outputs from CCG prioritisation Clinical prioritisation policies based on appraised evidence for both populations and individuals
	Horizon scanning: identifying likely impact of new NICE guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation	PH advice to clinical commissioners on likely impacts of new technologies and innovations
Procuring Services	Taking into account the particular characteristics of a specified population	
Designing shape and structure of supply -	Providing PH specialist advice on the effectiveness of interventions, including clinical and cost-effectiveness (for both commissioning and de-commissioning	PH Advice on focussing commissioning on effective/cost effective services
	Providing PH specialist advice on appropriate service review methodology	
	Providing PH specialist advice on medicines management	PH advice to medicines management e.g. ensuring appropriate prescribing policies
Planning capacity and managing demand	Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes	PH advice on development of care pathways/ specifications/ quality indicators
	PH advice on modelling of the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs	PH advice on relevant aspects of modelling/capacity planning
Monitoring and Evaluation Supporting patient choice	PH advice on the design of monitoring and evaluation frameworks, and establishing and evaluating indicators and	Clear monitoring and evaluation framework for new intervention/ service PH recommendations to

- Managing performance - Seeking public and patient views	benchmarks to map service performance	improve quality, outcomes and best use of resources
	Working with clinicians and drawing on comparative clinical information to understand the relationship between patient needs, clinical performance and wider quality and financial outcomes	
	Providing the necessary skills and knowledge, and population relevant health service intelligence to carry out Health Equity Audits and to advise on Health Impact Assessment and meeting the public sector equality duty	Health equity audits. PH advice on Health Impact Assessments and meeting the public sector equality duty
	Interpreting service data outputs, including clinical outputs	PH advice on use of service data outputs

12.2 Appendix 2: Extract from Health and Social Care Act 2012 on HCPH

1.1.1 Regulation 7: Public health advice to CCGs

The Health and Social Care Act and associated regulations place a statutory duty on Upper Tier and Unitary Local Authorities (LAs) to give NHS commissioning a population focus to make maximum impact on population health. This is described in regulations as:

- "Each LA shall provide or shall make arrangements to secure provision of a public health advice service to any CCG whose area falls wholly or partly within the authority's area and further that the service: consists of provision of such information and advice to a CCG as the LA considers necessary or appropriate with a view to protecting or improving the health of people in the LA's area".

In addition the Act gives each Clinical Commissioning Group (CCG) a duty to "obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in the prevention, diagnosis and treatment of illness and the protection or improvement of public health".

The LA HCPH advice service is intended to support CCGs in carrying out this duty and it is specified that this service should be free of charge. The regulations make it clear that the provision of the public health advice service should have regard to the CCG's needs be agreed between the LA and the CCG; and be kept under review.

12.3 Appendix 3: People interviewed for the review.

The SPH team are very grateful for the time and thought given to answering our questions during and after being interviewed for this project.

Name	Organisation	Role
Ms Val Barker	Yorkshire & the Humber Postgraduate Deanery	Head of School of Public Health
Sue Baughan	Public Health England	Lead for health economics competency development
Judith Bell	Public Health England	Lead for critical appraisal competency development
David Chappel	Public Health England	Associate Director, Department: Knowledge and Intelligence Team (Northern and Yorkshire)
Atiya Chaudrhy-Green	East Midlands Strategic Clinical Network	Senior Quality Improvement Lead – Cancer
Rob Cooper	School of Public Health (West Midlands)	Associate Postgraduate Dean & Head of School of Public Health (West Midlands)
Judy Curzon	Public Health England	Public Health Consultant - Workforce at Public Health England
Jeanelle De Gruchy	ADPH	Vice President ADPH Director of Public Health Haringey Council
Greg Fell	Bradford Metropolitan City Council	Consultant in Public Health
Janet Flint	Health Education England	Programme Lead National Programmes
Heather Grimbaldeston	Cheshire East Council	Director of Public Health East Cheshire Council.
James Harvey	Economic Insight	Director
Alison Hill	Better Value Healthcare	CASP trainer
Caroline Hird	Health Education East Midlands	Training Programme Director
Louise Holden	Public Health England, London	Public Health Workforce Development Manager Formerly practitioner registration programme lead KSS
Sally James	Health Education England (West Midlands)	Public Health Workforce Specialist, (West Midlands).and West midlands programme director for UKPHR practitioner registration
Rachel Johns	Public Health England	Deputy Regional Director - PHE North
Bruce Martin	Centre for Workforce Intelligence	Head of Public Health

Ruth Milton	Former chair ADPH.	Consultant in Public Health Medicine
Neil Squires	Public Health England	Lead for leadership competency development
Mohit Sharma	Public Health England	Consultant in HCPH
Mary O'Brien	Public Health England	Consultant in HCPH
Vicky Owen Smith	Stockport Council	Clinical Director of Public Health
Dr Ayoola Oyinloye	South West PH Training Programme	Training Programme Co-ordinator
Chris Packham	Faculty of Public Health	Chairman of Examiners, Part B
Julie Sin	Cheshire East Council	Consultant in HCPH
Kevin Smith	Public Health England	Head of Healthcare Public Health, PHE Centre Yorks & Humber
Allison Streetly	Public Health England	Deputy Director Healthcare Public Health
Claire Sullivan	Public Health England	Public Health Consultant in Health Improvement, PHE Centre North East
Rebecca Wagstaff	Public Health England	Consultant in Health Improvement, Cumbria and Lancashire PHE Centre
Premila Webster	Oxford School of Public Health	Training Director Oxford School of Public Health
Jane Wells	PH Provider Network	Consultant in Public Health Medicine
Claire Winslade	London Training Scheme	SpR London 4th year of training

12.4 Appendix 4: Case study A: Cheshire East Council

The DPH strongly supports HCPH consultants and, with the support of the Portfolio holder and Chief Executive, has affirmed the importance of a comprehensive population based public health function with resources allocated appropriately to HCPH (~40% and 1 WTE per 270,000 population is recommended in the DH publication on this matter, gateway reference 17804).

A population approach is integral to the commissioning cycle of NHS services and the term HCPH is just a shorthand way of saying that. As CCGs are the main commissioners of health care locally, the HCPH work has primarily been with the CCG layer of NHS commissioning. There isn't much direct HCPH input to providers although one colleague is exploring the opportunities for PH support to the two main local providers. That may well uncover inputs needed that are not strictly speaking HCPH but more aligned to other local PH roles (such as advocacy for wider partnership work on the health inequalities agenda, or advice about the health protection system, or just explaining that local PH have a role as a commissioner of some local health services).

The HCPH time available is finite so a CCG has to prioritise how it wishes to make use of the HCPH time available to them. The diagram below shows where the CCG may want support as the HCPH function is an integral part of CCG/NHS commissioning. HCPH can support at strategic level, the CCG business cycle (i.e. the 'tactical' and 'operational' aspects in the diagram), or a combination of both. Any local health intelligence function supports all pillars of local PH function and support for HCPH is no exception.

On a general note, the local team have reflected that HCPH staff (and indeed PH staff more widely) are employed by various different organisations locally, regionally and nationally e.g. by LAs, PHE outposts and the NHS, with different terms and conditions as a result of the 2012 changes to the health service. Whilst teams up and down the country have sought to make this workable, in the longer term a more coherent approach (led nationally perhaps) would be more likely to encourage professional movement across all relevant parts of the HCPH function and may make it easier to develop the workforce and exchange expertise across the system.

Examples: Strategic & governance level inputs:

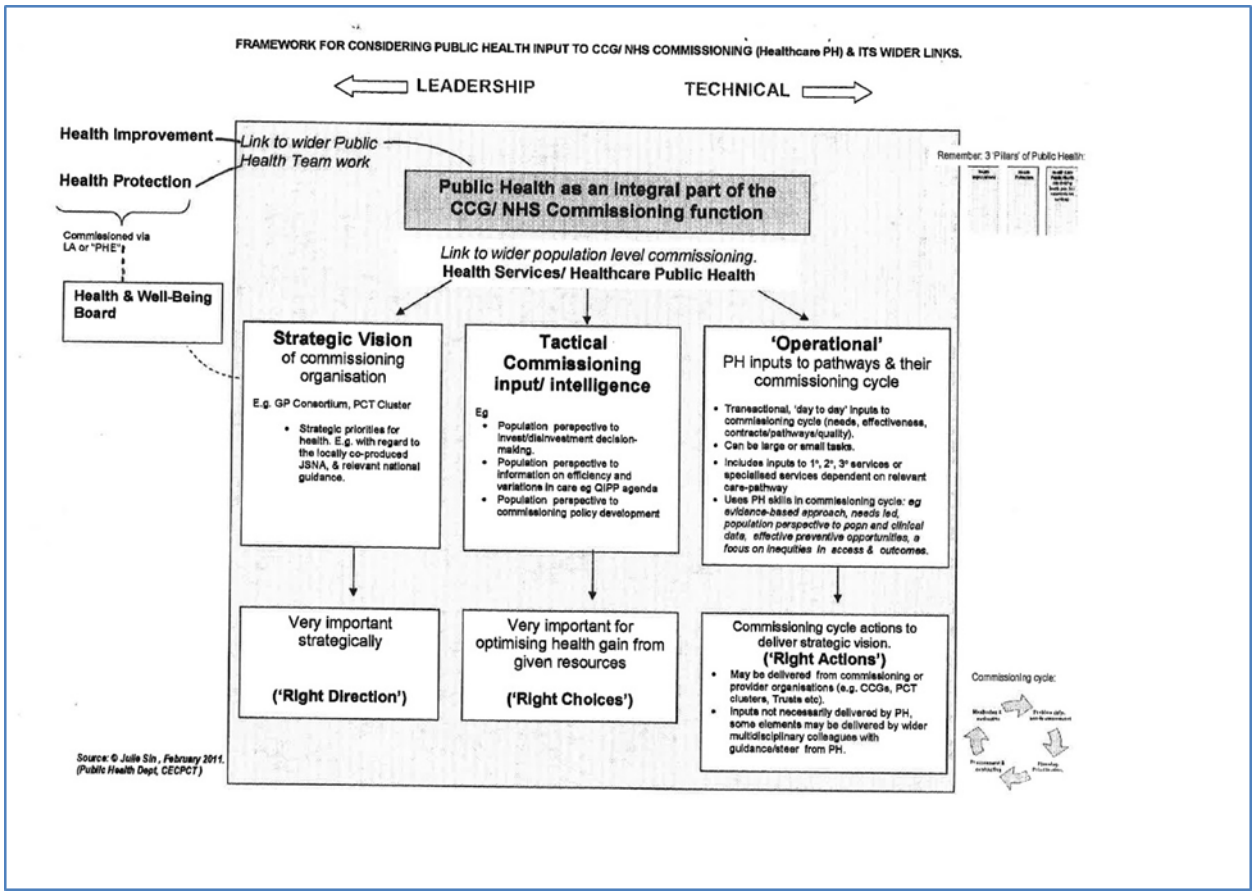
- Provision of PH input to the Governing Body of CCG(s) to ensure specific challenge to CCG commissioning strategy so that it has due regard to health gain, evidence based approaches and population outcomes. Senior public health representative is in the CCG constitutions of both local CCGs with voting rights.
- Key partner to the local JSNA co-production and development (LA host the JSNA programme manager). In turn the JSNA supports the commissioning work of the CCGs.
- Establishment, facilitation and lead review of the Memorandum of Understanding between the CCG and local PH department for healthcare public health support to the CCG and reciprocal arrangements.
- Provision of senior PH input to the development of local integration plans.

CCG business cycle & health intelligence inputs

- HCPH work resulted in the development of the local CCG prioritisation process and 'tool' to help consider various options for investment/disinvestment in a more consistent way. Initially used by the CCG in its annual commissioning cycle several years ago, it continues to be used to this day. It's a 'do, learn, refine process' used over the years.
- Provision of inputs to annual commissioning intentions process- to ensure evidence-based and population health gain approach.
- Provision of health needs assessments to support the commissioning cycle of the CCGs, For example for children's health needs (see Public Health Annual Report 2015) and for mental health in children (PHAR 2016 due out). HNAs are very time consuming so a forward work programme needs to identify the priorities for HNA for the year ahead.
- PH is a key partner in the local JSNA development (we host the JSNA programme manager). In turn the JSNA supports the commissioning work of the CCGs.

Day to day support

- Day to day inputs include advice, support and interpretation of routine available statistics, evidence, signposting to relevant colleagues on other enquiries about aspects of local PH function.
- Links to wider footprint HCPH networks for example the CHAMPs Public Health Collaborative, led by the nine Directors of Public Health. The network ensures the nine local authority public health teams across Cheshire and Merseyside work together with the aim of shifting local outcomes, enabling whole system leadership and maximizing public health capacity. The outcome focused collaborative delivers a number of priorities agreed by the Cheshire & Merseyside Directors of Public Health in partnership with Public Health England and NHS England (http://www.champspublichealth.com/about-us).


FRAMEWORK FOR CONSIDERING PUBLIC HEALTH INPUT TO CCG/ NHS COMMISSIONING (Healthcare PH) & ITS WIDER LINKS.
LEADERSHIP
TECHNICAL
Health Improvement
Health Protection
Commissioned via LA or "PHE"
Health & Well-Being Board
Link to wider Public Health Team work
Public Health as an integral part of the CCG/ NHS Commissioning function
Link to wider population level commissioning.
Health Services/ Healthcare Public Health
Strategic Vision of commissioning organisation
E.g. GP Consortium, PCT Cluster
Strategic priorities for health. E.g. with regard to the locally co-produced JSNA, & relevant national guidance.
Tactical Commissioning input/ intelligence
Eg
Population perspective to invest/disinvestment decision-making.
Population perspective to information on efficiency and variations in care eg QIPP agenda
Population perspective to commissioning policy development
'Operational' PH inputs to pathways & their commissioning cycle
Transactional, 'day to day' inputs to commissioning cycle (needs, effectiveness, contracts/pathways/quality).
Can be large or small tasks.
Includes inputs to 1°, 2°, 3° services or specialised services dependent on relevant care-pathway
Uses PH skills in commissioning cycle: eg evidence-based approach, needs led, population perspective to popn and clinical data, effective preventive opportunities, a focus on inequities in access & outcomes.
Very important strategically
('Right Direction')
Very important for optimising health gain from given resources
('Right Choices')
Commissioning cycle actions to deliver strategic vision.
('Right Actions')
May be delivered from commissioning or provider organisations (e.g. CCGs, PCT clusters, Trusts etc).
Inputs not necessarily delivered by PH, some elements may be delivered by wider multidisciplinary colleagues with guidance/steer from PH.
Remember: 3 'Pillars' of Public Health
Commissioning cycle:
Source: © Julie Sin, February 2011, (Public Health Dept, CECPCT)

12.5 Appendix 5: Case study B: Stockport Local Authority

From 1st April 2015 the HCPH consultant was also Deputy PH Director within LA and it was understood that 40% of workforce should be allocated to HCPH delivery. The consultant calls on all the PH team in the LA for support when necessary. CCGs joint fund the HCPH consultant post.

The following elements are necessary to be able to deliver an effective HCPH service to CCGs:

- CCGs recognise and welcome PH input
- At senior level (CEO and DPH) LAs recognise and support HCPH resource going into CCG
- DPH very strong and provides support and required resource despite other parts of LA not understanding need for HCPH resource into CCGs
- Peer support available from a PH network

HCPH Strategic role examples include:

- Strategic input through CCG as Clinical Director of the CCG and a CCG position on the Health and wellbeing board, deputy chair of CCG finance and performance committee, PH input into CCG level 3 co-commissioning committee
- Strategic leadership to the individual funding request panels
- Advocacy role to prioritise areas for planning/ prioritisation

HCPH tactical and operational role, examples include:

- Service redesign - public health input into key areas for service improvement, identified from NHS planning guidance, JSNA or CfV data e.g. atrial fibrillation, diabetes, hypertension - increased detection and optimising treatment/ care
- PH contribution to staff health and well being across NHS and LA organisations
- Prioritisation and implementation lead for new NICE guidance e.g. fracture prevention, falls, dementia
- Clinical lead for 'Stockport Together' prevention and empowerment programme - embedding prevention in every pathway, finding the missing 1000s, Stopbeforetheopstockport.com and #stockportstring
- Drafted and refined a set of public health standards for hospitals in Greater Manchester (under Healthier Together)
- Investigation into why Stockport appears to have lower numbers of breast cancer diagnosed at stage 1/2
- Investigated an increase in winter mortality within one local area of Stockport

12.6 Appendix 6: HCPH workforce development options emerging from interviews

HCPH role	Setting	Barriers to delivering HCPH	Development to meet role in post	External support (HEE, ADPH, FPH, UKPHR)
Practitioner				
	NHS	• HCPH practitioners not visible in NHS but might exist under different titles.	• Secondments into NHS settings should be supported and developed if not already in NHS setting • Linked to HCPH consultant or senior practitioner to support their HCPH role • Ensure appropriate level of training in CASP, Commissioning and project management available.	• UKPHR registration supported and developed with clear structured HCPH element • Practitioner development should be explicitly funded with a defined HCPH element • Practitioner network should be developed
	LA	• Very few practitioners identified		
	PHE	• Very few HCPH practitioners – mostly Health and Wellbeing and Health Protection • Unclear career progression		
Senior practitioner				
	NHS	• HCPH senior practitioners are not visible but exist under different titles (e.g. Right care staff, SPH staff))	• Secondments into NHS settings should be supported and developed if not already in NHS setting • Leadership development should be offered • Training in commissioning made available. • Support sub-specialisation development e.g.: evidence review, population based condition specific pathway review	• UKPHR registration supported and developed with clear structured HCPH element at senior level • Practitioners identified for development to senior practitioner role • Practitioner network should be developed • Sub-specialisations should be defined
	LA	• HCPH practitioners few and far between and difficult to recruit when they leave		
	PHE	• Very few directly supporting HCPH consultants. Unclear career progression.		
Consultant				
	NHS	• MOU between CCGs and LAs variable in interpretation • Can carry out all training without being in NHS environment • No 'right' for HCPH consultant from LA to sit in CCG • CCGs need to want HCPH input and LAs need to want to offer it • Funding of HCPH resource variable models can be all LA, all CCG or combination. • Isolated from peers	• Develop long term supervised placements in a variety of settings (cf civil service practise of long term rotations of 2 years) to develop skills and confidence in delivery of HCPH across profession (NHS, PHE,LA) • Develop credentialing post-qualification for HCPH (and Health and Well being and Health protection) • Mentoring and coaching should be made available.	• PH networks across organisations should be supported and developed. • All PH Specialty Registrars should include a placement in an NHS setting as part of training. • Training should be tailored to the future public health function • All PH Specialty Registrars from a non-clinical background should have some mandatory experience working in the NHS. • PHE should ensure it is accredited as a

	LA	• Focus on integration agenda within LA • HCPH consultant may be vulnerable to cuts as seen as supporting external body. • Tension between visibility in LA to show usefulness and sitting in CCG to deliver HCPH		setting for HCPH placements
	PHE	• Centre HCPH consultants struggling to determine the most useful offer to LA/CCG • LA and CCGs not clear about value of Centre HCPHs		
Senior consultant				
	NHS	• May be isolated with no HCPH team with them in Trust/CCG.	• Careful selection of leaders with appropriate understanding /confidence in NHS HCPH practise. • Automatic mentors with HCPH expertise should be assigned to senior leaders who are accountable for HCPH delivery. • Systems leadership programmes should be offered.	• FPH and ADPH hold strong leadership position on HCPH.
	LA	• DPH tension about how to utilise HCPH resource within LA or sitting with CCG – dependant on relationship with LA CEO • LA CEO view and understanding of HCPH crucial to how and what is delivered		
	PHE	• Understanding of operational HCPH limited		

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