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Cornish, Yvonne (2004) Is there a case for establishing a multi-Centre Masters Programme in Public Health across Kent, Surrey and Sussex? A feasibility study. Centre for Health Services Studies, 46 pp.

### DOI

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# **Is there a case for establishing a multi- centre Masters Programme in Public Health across Kent, Surrey and Sussex?**

## **A feasibility study**

**Yvonne Cornish  
Centre for Health Service Studies  
University of Kent**

September 2004

# CONTENTS

<b>1.</b>	<b>INTRODUCTION</b>	<b>p. 4</b>
	Aims Overview of report	
<b>2.</b>	<b>BACKGROUND AND RATIONALE</b>	<b>p. 6</b>
	Early discussions within Kent Exploring the potential for a partnership approach across Kent and Sussex Extending the partnership across Kent, Surrey and Sussex The Masters Planning Group Issues arising from the Masters Planning Group Developing the Feasibility Study	
<b>3.</b>	<b>APPROACH</b>	<b>p. 10</b>
	Aims Methods Comment of methods used	
<b>4.</b>	<b>POLICY AND ORGANISATIONAL CONTEXT</b>	<b>p. 12</b>
	The current public health policy agenda Strengthening the public health function	
<b>5.</b>	<b>THE PUBLIC HEALTH WORKFORCE</b>	<b>p. 14</b>
	Who's in the public health workforce? Assessing capacity in the specialist public health workforce Assessing capacity across the public health workforce	
<b>6.</b>	<b>EDUCATION AND TRAINING NEEDS</b>	<b>p. 17</b>
	Training needs of public health specialists Training needs of public health practitioners Training needs of the wider public health workforce Public health skills audits Comment on training needs	

<b>7.</b>	<b>PROFESSIONAL STANDARDS AND REGISTRATION</b>	<b>p. 23</b>
	Context Standards and competencies for public health practice Professional registration for public health specialists	
<b>8.</b>	<b>CURRENT PPROVISION</b>	<b>p. 26</b>
	Higher Education Institutions within the vicinity of KSS Kent Sussex Surrey London Elsewhere in the South East Region	
<b>9.</b>	<b>BALANCING SUPPLY AND DEMAND</b>	<b>p. 32</b>
	Mapping courses to training needs Mapping courses to competencies Flexibility and diversity Information sharing Guiding principles for public health education and training in KSS	
<b>10.</b>	<b>DISCUSSION</b>	<b>p. 36</b>
	Is there a case for a multi-centred Masters programme in KSS? Size of the potential market How local do programmes need to be? Quality issues Feasibility issues Interim conclusions	
<b>11.</b>	<b>OPTIONS FOR THE FUTURE</b>	<b>p. 39</b>
	No change Single provider Partnership model Multi-versity model Consortium arrangement	
<b>12.</b>	<b>CONCLUSIONS</b>	<b>p. 42</b>
<b>13.</b>	<b>RECOMMENDATIONS</b>	<b>p. 43</b>

**Appendix A Membership of the KSS Masters Planning Group  
and Feasibility Study Sub-group**

**Appendix B References**

## **1. INTRODUCTION**

This study, which was commissioned by the Kent, Surrey and Sussex Workforce Development Confederation, assesses the feasibility of establishing a multi-centred modular masters programme in public health. The purpose of such a programme, would be to support the development of the public health workforce within the South East of the Region, to ensure that it is ‘fit for purpose’ in terms of delivering the current public health agenda.

This study builds on a considerable amount of previous work, some of which has been undertaken at a national level, but a great deal of which has been done locally, within the South East region. This includes work previously undertaken on behalf of the South East Regional Office of the NHS Executive, local NHS Education and Training Consortia in Kent and Sussex, and the Kent, Surrey and Sussex Workforce Development Confederation.

### **Aims**

The study aims to

- (i) Detail and document the need for a broad-based Masters course
- (ii) Identify options for provision
- (iii) Make recommendations

To achieve these aims, the study summarises previous work on the education and training needs of the public health workforce, overviews recent studies on workforce capacity in public health, and explores current provision within reasonable travelling distance of public health staff living and working within the area covered by the Kent, Surrey and Sussex Strategic Health Authorities and their Workforce Development Confederations.

### **Overview of report**

Section 2 of this report outlines the immediate background to the study, documenting the early discussions between education providers and the NHS. It was these early discussions which led to the Masters Planning Group being set up, to explore the possibility of developing a multi-centred Masters in Public Health.

Section 3 describes the approach to the study, and the methods used. Limitations of the project and the methods used are also discussed.

Sections 4, 5, 6 and 7 relate to first study aim (i), by reviewing factors likely to impact on the need for higher education and training in public health. These factors include:

- the current public health policy agenda (section 4)
- current workforce capacity (section 5)
- education and training needs of the public health workforce (section 6) and
- standards and competencies for professional practice and professional registration (section 7).

Sections 8 – 11 address the second project aim (ii), by providing an overview of current provision of post-graduate specialist public health training.

Existing Masters level programmes within travelling distance of the Kent, Surrey and Sussex workforce are described in section 8; whilst the balance of supply and demand is discussed in section 9.

Section 10 assesses the strength of the case for developing a multi-centred Masters in Public Health in Kent, Surrey and Sussex, on the basis of the evidence produced for this report, whilst section 11 identifies – and assesses the strengths and weaknesses of – a number of options for the future delivery of post-graduate training in public health.

Conclusions and recommendations can be found in section 12 and 13.

## **2. BACKGROUND AND RATIONALE**

Prior to the Feasibility Study being commissioned, a number of initiatives had already taken place within Kent, Surrey and Sussex around the development of education and training provision to support public health development. It is important to understand these in terms of the current study, as they illustrate many of the issues that will need to be addressed in relation to assessing the feasibility of developing a multi-centred, flexible Masters Programme across Kent, Surrey and Sussex in the near future.

### **Early discussions within Kent**

Discussions began in March 2001, between the Kent Public Health Development Co-ordinator, and staff at the Centre for Health Services Studies at the University of Kent. At this time, responsibility for non-medical education and training for the NHS in Kent, Surrey and Sussex was spread across three local Education and Training Consortia, each of which had its own Public Health Development Group, working with its own local Higher Education Institutions.

A number of meetings were subsequently held between CHSS staff and local stakeholders (Kent Education and Training Consortium, the South East Regional Office, both East and West Kent Health Authorities, a Primary Care Group from West Kent and a District Council from East Kent) to explore the market for a locally-based Masters programme in Public Health, to support the development of public health capacity and capability within Kent.

Meanwhile, teaching staff within CHSS began work on developing the academic content of the programme, taking account of the National Standards for Specialist Practice in Public Health (Healthworks UK, July 2001) and explored a number of options for flexible delivery of such a programme (eg 'block' teaching, evening sessions and open access to individual modules on the programme for the purposes of Continuing Professional Development.)

Module outlines were developed, and taken through relevant University Committees, in preparation for an early start to the new programme. The University's response was initially supportive of this development, which it saw to be in line with its strategic direction. Within CHSS, the introduction of a Masters in Public Health fitted well with further integration of the Canterbury and Tunbridge Wells groups, both of which were to be involved in this development.

However, some members of the Kent Education and Training Consortia's Public Health Development Group began to express reservations about the speed of this development within the University, and questioned whether supporting this development was an appropriate use of the Education Co-ordinator's time. (See minutes of the Kent Public Health Development Steering Group meeting, 25<sup>th</sup> May 2001.) As a result, the University decided to adopt a more incremental approach, in which, rather than continuing with its plans to establish a new post-graduate programme, it began to explore the possibility of building on its existing MA in Health Studies.

The intension was to add specific modules that would build on the current strengths within CHSS – this would extend the options available to existing MA students, provide a public-health focussed health policy Masters for new students, and enable the local (Kent wide) public health workforce to access individual modules as part of their continuing professional development, or to ‘top up’ their existing public health education.

### **Exploring the potential for a partnership approach across Kent and Sussex**

Meanwhile, informal discussions between the Universities of Kent, Brighton and Greenwich indicated that there was scope for exploring the potential for a partnership approach. This was felt to have the advantage of enabling organisations to maximise their use of scarce resources, whilst minimising what each saw as potentially unproductive competition and duplication of effort. Two possible models were discussed during an internal meeting at the University of Kent:

- A single masters programme, approved by all partners
- Each institution maintaining its own existing masters programmes, but recognising each other’s modules.

The former was felt to be the most technically complex, requiring some kind of formal partnership and mutual accreditation structure; whilst the latter approach might well be able to build upon systems for transferring credits between institutions. Both approaches were felt to require further investigation, to ascertain their feasibility. It was these early discussions, combined with changes to the NHS structures for commissioning education and training (see below) that led the KSS Workforce Development Confederation to commission this feasibility study.

### **Extending the partnership across Kent, Surrey and Sussex**

Towards the end of 2001, the possibility of developing a multi-professional, flexible and modular Masters level programme in Public Health, which could be delivered across the Kent, Surrey and Sussex area came under active consideration. Although formally initiated by the Kent Education Consortia (see letter from the Public Health Development Co-ordinator, 26<sup>th</sup> October 2001) this idea built on a number of informal discussions which had already taken place between education providers (see above.) Extending the partnership to the discussions also seemed a logical step in view of the anticipated changes to the commissioning of professional education and training within the NHS. (Local Education and Training Consortia were replaced by Workforce Development Confederations in April, 2002 and a single WDC was established for Kent, Surrey and Sussex.)

### **The Masters Planning Group**

In January, 2002, therefore, a Masters Planning Group was established. Its membership included the Public Health Development Co-ordinators from Kent, Surrey and Sussex, and representatives from the following Higher Education Institutions:



- Canterbury Christchurch University College
- London South Bank University
- University of Brighton
- University of Greenwich
- University of Kent<sup>1</sup>
- University of Surrey

This group met on a number of occasions throughout 2002, during which time members undertook a ‘brainstorming’ exercise to identify the issues which would need to be addressed in setting up a collaborative programme, and conducted an initial mapping of existing modules, within their own post-graduate programmes, against the draft *National Standards for Specialist Practice in Public Health* (Healthwork UK, July 2001) Notes from both exercises have been previously circulated.

### **Issues arising from the Masters Planning Group**

Despite some initial progress, however, the group failed to reach a consensus on the most appropriate way forward. Group members did, however, highlight a number of key issues which needed to be resolved before moving forward. These included the need to

- Understand the complexity of putting together this type of programme
- Establish a ‘level playing field’ between providers
- Demonstrate commitment from each of the prospective partner organisations
- Ensure commitment from local employers, and the Workforce Development Confederation, in supporting students attending such a programme
- Demonstrate the added value of a flexible, multi-provider approach
- Consider alternative options.

In response to these issues, and additional concerns of its own (see below) the KSS Workforce Development Confederation agreed to commission a feasibility study, which would also

- Provide evidence of a need amongst the target group
- Map existing provision within participating Universities<sup>2</sup>

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<sup>1</sup> The Centre for Health Services Studies, at the University of Kent, withdrew from the group in October 2002

<sup>2</sup> This mapping had already been started by the Masters Planning Group

- Clarify the mechanisms/systems needed/involved in setting up and maintaining this type of course
- Identify and consult with stakeholders.

(Source: minutes from the meeting of the Masters Planning Group, 4<sup>th</sup> October, 2002)

### **Developing the Feasibility Study**

A small sub-group was established to develop a project brief, and to oversee this work<sup>3</sup>. A draft commissioning brief was circulated to all members of the Masters Planning Group for comment during November 2002, followed by a final version in January 2003. Throughout this time, there was further discussion within the Masters Planning Group about which organisations should be invited to tender<sup>4</sup>, and what the Feasibility Study should include.

Some members felt the scope of the project should be as broad as possible – ie that it needed to include a training needs analysis, a workforce analysis, and an option appraisal, complete with a full costing and quality audit for each option. Others argued that it needed to be very focussed – the Masters Planning Group was proposing a highly innovative educational initiative, but the feasibility of making this work within and between local HEIs needed to be established, prior to further market testing of the proposed programme within the public health community.

In their tender response, therefore, CHSS suggested an approach which would take account of, and build upon, on previous work wherever this was relevant, rather than undertaking further training needs assessment of the local public health workforce. The rationale for this approach was that a number of national and local projects had already explored the capacity and capability of the public health workforce, including assessing the education and training needs of public health specialists and practitioners.

Whilst some of this work had a national focus, much had been undertaken locally, within the South East Region. This included a number of studies commissioned by the South East Regional Office of the NHS Executive, which subsequently informed *Developing Public Health in the South East – a framework for action* (NHS Executive, May 2000). Other studies had been commissioned by the Public Health Development Groups of the former Kent, Surrey and Sussex Education and Training Consortia.

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<sup>3</sup> For a list of participants, see Appendix A

<sup>4</sup> As CHSS had withdrawn from the Masters Planning Group, it was invited to tender for this project.

### **3. APPROACH**

The aims of the study were set out in the commissioning brief as follows:

#### **Aims**

- To detail and document the need for a broad based masters course
- To identify options for provision
- To make recommendations

(Source: Public Health Masters Feasibility study: Commissioning Brief. Kent, Surrey and Sussex Workforce Development Confederation, January 2003)

#### **Methods**

To meet the aims and objectives outlined in the project brief, the following work was undertaken:

- (i) Existing national and local research on the education and training needs of public health specialists and practitioners has been identified and reviewed.
- (ii) Existing national and local research on building capacity and capability of the public health workforce has been identified and reviewed.
- (iii) The initial mapping of existing masters level provision in the relevant (Kent, Surrey and Sussex) Higher Education Institutions has been revisited.
- (iv) In-depth interviews have been undertaken with key stakeholders in local Higher Education Institutions who were party to the earlier discussions, in order to assess:
  - their perception of the need for additional/more flexible provision
  - their views on how this might be provided
  - the procedures and processes necessary to take this forward.

#### **Comment on methods used**

No additional original research has been undertaken in relation to training needs or workforce capacity – conclusions are drawn on the basis of existing research.

Information on current provision was obtained from University web-sites, accessed early in the Spring Term of 2004. Information is assumed to be accurate for the academic year 2003-2004, but readers need to be aware that changes may have been made by education providers since that date.

Interviews with key stakeholders took place during the Summer Vacation 2003. Information from these discussions were used, in combination with other sources, to identify a number of options for the future provision of education and training for public health professional practice.

In line with the project proposal, options were taken back to a full meeting of the Masters Planning Group in October 2003, for further discussion and consideration. Members were asked to discuss the options within their own organisations, and to rank options in order of preference.

Options include:

- no change
- open (competitive) market
- single (preferred) provider
- formal partnership model (two HEIs' establishing a joint programme)
- formal multi-versity model (more than two HEI's establishing a shared programme)
- consortium arrangement (cooperation between an agreed group of HEI's to streamline current inter-University transfers)

The remainder of this report details the factors that need to be taken into account in assessing the feasibility of these options.

#### 4. POLICY AND ORGANISATIONAL CONTEXT

Any discussion of the need (or otherwise) for a Masters Programme in public health needs to be set within the context of a number of recent policy and organisational developments which have had, and will continue to have, a profound impact on the roles and responsibilities of the public health workforce. For the purpose of this report, the starting point will be the current government's national strategy for health, *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999).

More recently, following publication of the Wanless Report (Wanless, 2004) earlier this year, the Department of Health has undertaken widespread consultation on a number of key public health issues, under the title *Choosing Health* and a new White Paper on Public Health is due to be published shortly.

##### **The current public health policy agenda**

Over the last five years, the Government has set out an ambitious public health agenda. The national strategy for health, *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999) identified two main policy goals - improving the overall health status of the population, and reducing inequalities in health. To achieve these goals, the strategy recognises the need to address the wider social, economic and environmental determinants of poor health, and acknowledges that these goals cannot be achieved by the NHS acting alone.

Throughout the strategy, therefore, there is a strong emphasis on the need for 'joined up' approaches to policy development and implementation at all levels, and for the NHS to work in partnership with other local agencies – particularly local government – to improve the health and well-being of local communities. The *NHS Plan* (Secretary of State for Health, 2002) reinforced this message. Improving health, preventing disease and tackling inequalities in the health status of local populations are now key components of the Government's modernisation agenda for the NHS and across the public sector.

There are, however, considerable concerns about the public sector's capacity to deliver this agenda. *Saving Lives* recognised that the quality of public health practice was variable, and made a number of recommendations for increasing the skill-base of the public health workforce, including announcing the new role of Specialist in Public Health (Secretary of State for Health, 2002, para. 11.25) and setting standards for professional practice. "We need to make sure that the public health workforce is skilled, staffed and resourced to deal with the major task of delivering our health strategy." (Secretary of State for Health, 2002, para. 11.8)

The *Second Report* of the Parliamentary Select Committee on Health (House of Lords, 2001) also highlighted many areas where the implementation of the public health agenda needed greater support, including developing the public health capacity of primary care, and strengthening public health leadership at all levels. Developing the public health workforce is clearly central to the delivery of the Government's public health agenda.

## Strengthening the Public Health Function

Development of the public health workforce was the focus of a national project, initiated by the former Chief Medical Officer, Sir Kenneth Calman, in 1997. This project, which produced an interim report in February 1998, identified the need to increase capacity and capability within public health. “Education, training and organisational development are crucial” (DoH, 1998, p.1) the report argued; adding that this needed to be linked to career pathways, accreditation systems, and equal opportunities for specialists and practitioners from a variety of backgrounds.

These interim findings were further reinforced by the current CMO, Professor Sir Liam Donaldson, in *The Report of the Chief Medical Officer’s Project to Strengthen the Public Health Function* (Department of Health, 2001) which set out a framework for strengthening public health within the context of *The NHS Plan* (Secretary of State for Health, 2000)

This report highlighted the need to increase capacity (people) and capability (skills) in public health, across all sectors of the workforce. Overall recommendations include

- Increasing workforce capacity
- Strengthening multi-disciplinary public health
- Strengthening capabilities
- Education, training and organisation development
- Leadership and management development
- Strengthening academic public health

In terms of ‘strengthen capabilities’ in the public health workforce, the report made a distinction between technical and implementation skills.

Technical skills stated to be ‘in short supply’ were

- Epidemiology
- Health Needs assessment
- Analysis and interpretation of clinical and health information and statistics
- Critical appraisal skills
- Dissemination and use of research evidence

Implementation skills which needed strengthening included

- Leadership and advocacy for public health programmes
- Skills at working in partnership and across sectors
- Skills in developing community capacity for health improvement
- Skills in managing change
- Communication and team working

(Department of Health, 2001)

## 5. THE PUBLIC HEALTH WORKFORCE

Developing all those involved in delivery of the public health function is a complex task. The diversity of the public health workforce was acknowledged in both the interim and final reports of the Chief Medical Officer's (Department of Health, 1998, 2001).

### Who's in the public health workforce?

Three broad categories of public health staff were initially identified (DoH, 1998, p. 17), and, whilst these have been subject to minor revisions, this taxonomy has now become the basis for a number of studies into workforce capacity and capability, in addition to being used to inform local public health development plans. The specific wording within each category varies according to the source, but can be briefly summarised into the three broad headings in Box 1, below.

#### **BOX 1: Who's who in the public health workforce**

- *Wider public health workers* – who have the potential to make a positive contribution to public health through policy and decision-making that might influence health and well-being
- *Public health practitioners* – who spend a substantial part of their working practice furthering health by working with communities and individuals.
- *Public health specialists* – from a variety of backgrounds whose role is managing strategic change in public health.

Source: Developing Public Health in the South East: A framework for Action (NHSE, 2000)

Around the time that the CMOs final report was being prepared, a national project to explore and document the breadth of potential career pathways within public health was undertaken for the West Midlands Regional Office of the NHSE (Cornish and Knight, 2000). This (national) research included an initial mapping exercise, which identified people with careers in public health located in a wide range of national and local organisations, within and beyond the health care system, Box 2, below.

#### **BOX 2: Mapping public health practice**

- The NHS Executive (HQ and Regional Offices)
- Health Authorities
- Primary Care Groups and Primary Care Trusts
- Acute NHS Trusts
- Community NHS Trusts
- District, County and Unitary Local Authorities (departments of environmental health, social services, education, housing, cross-directorate policy units etc.)
- Academic departments (epidemiology, social medicine, social science etc.)
- Institutes of Public Health and Public Health Resource Units
- Public Health Laboratory Service
- Communicable Disease Surveillance Centre
- Health Development Agency
- Office for National Statistics

Source: Exploring Public Health Career Paths (Cornish and Knight, 2000)

Related research on developing public health capacity in the South East built on this mapping<sup>5</sup>, and a matrix of job titles and organisational locations for public health within the NHS was developed as part of a series of local projects exploring public health capacity in the South East Region (Cornish, 1999; Cornish, 2000). An updated version of this matrix is now contained in The *Public Health Development Plan* for Kent, Surrey and Sussex. (Kent, Surrey and Sussex Workforce Development Plan, 2003, p.19).

Attempts to assess the size of the public health workforce (nationally and locally) have been fraught with methodological difficulties, mainly because of the sheer diversity of the public health workforce and the wide range of organisations in which public health staff are located. The recent period of organisational change, following *Shifting the Balance of Power* (DoH, 2001) has added to this complexity. Moreover, until very recently, workforce planning for public health was restricted to public health medicine. There had been no attempt at workforce planning for health promotion, or for any of the many other occupational groups which contribute to delivery of the public health function. (Cornish, 1999)

### **Assessing capacity in the specialist public health workforce**

Within the South East Region, a systematic attempt was made to address this issue – at least, in terms of assessing the size of the ‘specialist’ or ‘core’ workforce – through sending detailed postal questionnaires to all health authorities in the region. (Cornish, 2000) This survey, which was commissioned by the former NHS Executive South East, collected data on all specialist public health and health promotion staff working in the NHS across the SE region. The project report provides numbers and WTE’s (whole time equivalents) for various groups of staff, including Consultants in Public Health Medicine, Public Health Specialists, Public Health Nurses, Health Promotion Specialists, Specialist Registrars in Public Health Medicine etc., broken down by Education and Training Consortium.<sup>6</sup>

This study showed that there was a total of 569 specialist public health staff working within the NHS in the South East Region. Of these, 19 were based in the Regional Office (this included 4 Consultants and 2 Specialist Registrars in Public Health Medicine, and 7 Public Health Specialists). The remainder were located in health authorities. (The devolution of public health to primary care trusts, which followed implementation of *Shifting the Balance of Power* had not yet taken place.)

The data reveals some interesting similarities and some differences in the balance of medical/non-medical staffing within the specialist public health workforce across the Kent, Surrey, and Sussex area. For example, whilst all had similar numbers of Health Promotion Specialists (42, 49 and 53 respectively), Sussex had the highest number of Public Health Specialists (47, as opposed to 10 in Kent, and 7 in Surrey). Public

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<sup>5</sup> The South East is not the only region to attempt to map out and quantify the public health workforce. Similar ‘capacity and capability’ projects are known to have been undertaken in London and the West Midlands, and the Department of Health commissioned a national workforce project from the Health Development Agency. This attempted to look across all three categories of the public health workforce, but the final report has never been published.

<sup>6</sup> These predated the current Workforce Development Confederations



health doctors were more equally distributed, with 12 Consultants in Kent, 13 in Surrey and Chichester, and 15 in Sussex. Numbers of Specialist Registrars ('trainees' in public health medicine) on the other hand, were small – there were only 3 in Sussex and 3 in Kent at the time of the survey, and none in Surrey and Chichester<sup>7</sup>.

More recently, the Faculty of Public Health has published its own study, *The Specialist Public Health Workforce in the UK: A report for the Board of the Faculty of Public Health* (Perlman and Gray, 2004). This report, based on data collected via a national survey undertaken in October 2003, focuses on public health consultants and public health specialists working at consultant level. It finds a wide variation across the country, in terms of consultants and specialists, trainees, service public health specialists and academics. The report uses a 'normative' approach to workforce planning, and concludes that, on this basis:

“If each region were to achieve the same as the highest this would require an increase of approximately 20% of trainees, 25% more consultants and specialists, and 50% more public health academics in the UK.” (Pelman and Gray, 2004, p.4)

Normative targets are set by region for all public health consultants and public health specialists and for public health trainees (Specialist Registrars and Public Health Specialist Trainees<sup>8</sup>). For the South East Region, a target of 144 consultants and specialists, and 70 trainees is suggested.<sup>9</sup> According to the survey (which achieved a response rate of 78%) there are currently 77 consultants and specialists, and 56 trainees currently in post – suggesting there is an argument for increasing the 'core' public health workforce within the South East.

### **Assessing capacity across the public health workforce**

The methodological difficulties involved in assessing the capacity of the specialist public health workforce are considerably enhanced when attempting to assess capacity across the three categories identified in the Chief Medical Officer's Report. (Department of Health, 1998). Nevertheless, a team of researchers in the London Region have recently attempted this task, using a tailored classification tool developed specifically for this purpose. Details of the methodology used have been published (Walters et al, 2002), and the classification tool has been piloted in four health in London. Results are being used to inform the city's regional workforce plan, and a further article reporting the findings is expected.

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<sup>7</sup> At the time of the survey, Chichester, which is in West Sussex, was included in the Surrey and Chichester Education and Training Consortia. It is now part of the Surrey and Sussex Workforce Development Confederation.

<sup>8</sup> In other words, specialists accepted onto the 'formal' training scheme, supported by their local Deanery.

<sup>9</sup> This is for the South East Region of the NHS. It is not broken down by Deanery.

## 6. EDUCATION AND TRAINING NEEDS

A great deal of work has been undertaken over the last ten years, nationally and locally, to identify the training needs of different sectors of the public health workforce. These training needs assessments have been undertaken at different points in time, in different parts of the country, and using different methodologies (including postal surveys, in-depth interviews, focus groups, and Delphi consultations.) Most of these studies have been published as ‘grey’ literature, within the NHS, and some may now be difficult to obtain. A number of key studies are therefore reviewed below.

Following a request from the project Steering Group, an attempt has been made to ‘map’ studies (and the needs identified within them) to specific subgroups within the public health workforce. However, this approach needs to be interpreted with some caution. Many of these studies were undertaken before the taxonomy currently in use was developed, so there is considerable variation between studies in terms of who was included within the category ‘public health’. (See Box 1 for the CMOs three categories of public health.)

### Training needs of public health specialists

A number of early studies focussed on the group now commonly included within the group referred to as **public health specialists** (ie those ‘core’ public health professionals from backgrounds other than medicine). These include a national survey undertaken by Somerville and Griffiths (1995); focus group studies undertaken in the South East Thames and West Midlands Regions by Cornish (1996 and 1998); and a survey undertaken in the South West Region by Royle, Speller and Moon (1999.)

**Somerville and Griffiths (1995)** identified a workforce of over 1,000 ‘non-medical’ people working within academic and service public health departments. Of these, two thirds were based in the NHS and two-thirds were female. In terms of existing qualifications and training, the survey found that

- Two thirds of respondents were qualified to Masters level or above.
- One third were also professionally qualified.
- Half had received no training in public health or related subjects
- Of those that had, half had received no support for this training
- Over 80% wanted more training

**Cornish (1996 and 1998)** found that public health specialists in the South East Region and the West Midlands region had very similar ideas about their training and development needs. These included identified needs for

- Academic supervision – especially for research design and methodology, and statistical analysis
- Training co-ordinators – a designated individual to support networking, and to enable need and provision to be linked.
- Directory/ mailing lists – to support communication, networking etc.
- Induction programmes – for staff new to public health or the NHS

- Information packs – flexible resource packs with useful information on access to training, courses available etc
- Learning contracts – or personal development plans
- Learning sets – to support professional development
- Mentoring – one to one support and guidance
- Networks – to reduce isolation and share expertise
- Resource centre – linked to co-ordinator, source of advice on training and career development opportunities
- Secondment/shadowing opportunities – to enable staff to broaden their experience
- Short courses – on specific public health topics
- Flexible access to masters modules – to enable individuals to fill in ‘gaps’ in their knowledge and skills, without having to undertake a full Masters programme in public health.

**Royle, Speller and Moon (1999)** asked survey respondents to identify topics for future training events. Those suggested included

- Determinants of health – especially inequalities and poverty
- Public health skills and policy development – including developing public health skills in primary care, health needs assessment and health impact assessment, priority setting and rationing in health care, research methods, and clinical governance
- Partnership working – such as cross-professional and multi-professional working, skills for developing health improvement plans, and working with local authorities
- Personal skills – including management skills and career development
- Research and evaluation skills – especially evaluating health promotion, critical appraisal skills, using statistical packages and preparing research papers.

Results on preferred mode of delivery for these training events were

Workshops – 30%

Presentations – 16%

Learning sets – 21%

Preferred duration for education and training events were

All day – 74%

Half day 17%

Other studies, such as that by Dunkley (1998) take a broader approach, including **public health physicians** and **public health practitioners** as well as **public health specialists**.

In their later review of a number of studies undertaken between 1995 and 2000, **Dunkley and Baird (2000)** list the public health training needs most frequently identified across all levels of the public health workforce, as follows:

- Health needs assessment
- Research methodology
- Finding and interpreting research evidence
- Epidemiology
- Ethics
- Health economics
- Health inequalities
- Determinants of health

They suggest that education and training in these subject areas needs to be available at a wide range of levels, to take account of the diversity of existing knowledge across the workforce, and that teaching should be multi-professional – bringing together people from different organisations. (Dunkley and Baird, 2000)

The review by Dunkley and Baird (2000) shows considerable consistency of findings across studies. So much so, in fact, that the authors conclude that “the key learning and development needs in public health have been identified” and that “action should be taken on the basis of these findings before any further repetition of training needs analysis is carried out.”

Nevertheless, in spite of Dunkley and Baird’s recommendation, further studies have been undertaken, particularly into the education and training needs of public health practitioners, and – though to a lesser extent – the ‘wider’ public health workforce. Some key findings from the most recent, and most local, of these studies are presented below.

### **Training needs of public health practitioners**

A recent survey by **Jenkins et. al (2002a)** focussed on and **practice nurses** working in Kent. Study participants reported limited understanding of many aspects of public health, and said they were ‘least confident’ in the more technical aspects – such as using statistical programmes for interpreting data. They also felt their knowledge was lacking in terms of population health status, health inequalities and clinical governance. (The latter is not specifically a public health issue. This group also reported a number of training needs directly related to clinical practice.) Their main barrier to acquiring the knowledge and skills they felt they needed was lack of time.

More recently, **Vydelingum, et al (2004)** have mapped the needs of the NHS **Public Health Practitioner** Workforce in PCTs in Surrey and Sussex. This multi-method study, undertaken across 6 Primary Care Trusts, included a skills audit, based on a self-assessment by respondents. Specific skills training was needed in the following areas:

- Profiling and health needs assessment
- IT skills to access resources
- Searching for a critically appraising papers
- Epidemiology
- Community development
- Facilitation and team management

- Advocacy skills
- Influencing determinants of health
- Reducing inequalities
- Public health leadership
- Inter-agency working

In addition, a number of broader training needs, to enable practitioners to initiate and manage change, were identified. These included

- Assertiveness and leadership skills
- Committee skills about influencing policy
- IT skills for networking
- Negotiation and facilitation
- Lead and manage change
- Project management
- Monitoring and evaluation
- Partnership and collaborative working

Finally, the report states that any training programme should have the following components:

- Be accessible
- Be modular
- Flexible
- Multi-disciplinary
- Incorporate a broad range of learning styles
- Have work-based training opportunities
- Provide opportunities for shared learning
- Provide 'real life' practice experience

(source: Vydellingum et al. 2004)

### **Training needs of the wider public health workforce**

This group is undoubtedly the least well researched in terms of public health training needs. A recent survey by **Jenkins et al. (2002b)** which was specifically targeted at members of this group, found

- Respondents understanding of public health was quite limited
- Greatest confidence was expressed in leadership skills, communication skills, and the ability to working in partnership
- Least confidence was expressed in use of statistics and presenting data
- Half the respondents identified at least one area in which they wanted training
- Barriers to training included lack of time for almost all respondents
- Access to funding was a barrier for around half of respondents
- Training needs should be relevant to jobs

(source: Jenkins et al 2002b)

## Public health skills audit

The national health strategy, *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999) highlighted the need for a national skills audit. This was subsequently carried out by the Health Development Agency, and published in a series of reports between 2000 and 2001. The *Short Report* (Meyrick et al, 2001) summarises the main findings, by functional role and by occupational groupings. A brief synopsis of some of the main findings, from the functional groups, is given below.

*Wider determinants of health and healthcare provision, strategic roles (1a)* although highly skilled and experienced, this group reported skill deficits in leadership for strategic and partnership aspects of public health work, and lack of knowledge in key implementation areas, such as community development

*Operational and technical roles affecting the wider determinants of health (1b)* this group reported needing skills to support effective partnership working, and wanted to increase their knowledge of public health action

*Public health practitioners in management and leadership roles (2a)* reported large gaps in general management skills, including people, project and change management

*Public health practitioners in operational roles (2b)* this group rated themselves low across all areas of technical and professional skills

*Public health specialists in strategic roles (3a)* reported skill gaps in strategic influence and aspects of multidisciplinary and partnership working, though they felt highly competent technically.

*Public health specialists in technical roles (3b)* reported skill gaps in most areas, though, as this group was reported to be very diverse, with high levels of specialisation, these skill gaps need to be checked against specific role requirements.

(source: adapted from Meyrick et al, 2001)

The skills audit also makes a number of recommendations – two of which are particularly salient to this feasibility study, and are therefore quoted below:

“It should not be assumed that an identified skill gap implies a straightforward training need that can be met through professional training. Participants were explicit in identifying the need for innovative individual, organisational and cross-organisational training and development opportunities....”

“The contribution of public health and health promotion specialists to the public health workforce should be better utilised. Support should be provided for this group of senior and experienced staff to qualify for public health specialist roles, whilst retaining their breadth and quality of public health skills.” (Meyrick et al, 2001)

## **Comment on training needs**

Research into the training needs of public health specialists (Griffiths and Somervaille, 1995; Cornish 1996 and 1998) has shown that staff within this group may be highly competent in some key areas of public health practice (with, for example, a masters level qualification and considerable experience in one or more of the subjects listed above) whilst having had little or no formal education in other key areas. This not only leaves highly able professionals feeling unsure of their skills in key areas of responsibility, it has considerable implications for their future career prospects, including achieving specialist registration (see below).

These studies also found that specialist public health staff may wish to study individual modules in some of the core public health subjects at post-graduate level, but without having to repeat areas of the curriculum in which they already feel well-qualified. The current 'top-up' training programme, which has been established to support appropriately qualified and experienced public health specialists to wishing to apply for the Voluntary Register (see below) is beginning to address many of the needs of this group.

Other public health professionals may be at a stage in their careers where it is difficult for them to undertake a full-time (or even two-year part-time) post-graduate programme, unless they are able to obtain adequate study leave from their employing authority. Ways of building the skills and competencies of this group over time, and in line with their career development needs and aspirations, means that flexibility of access and of provision will be essential if the needs of this group are to be adequately addressed.

Finally, the 'formal' public health training scheme within the London/KSS Deanery, which previously recruited only those applicants with an initial qualification in medicine, is now recruiting public health trainees from a number of other backgrounds. Places on the Training Scheme are limited, however, and entry is highly competitive. This route to gaining public health education and training is not likely to therefore, be available to all those who would might wish to take advantage of it.

There are currently 27 Public Health Trainees in Kent, Surrey and Sussex. Of these, only 5 are Public Health Specialists. One is a trainee in Dental Public Health; the others are all public health physicians. These trainees in public health used to attend a Masters Programme in Public Health at St George's Medical School. This prepared them for the Part I MFPH examinations, as well as leading to a Masters degree. (The Masters Programme was open to anyone wishing to specialise in public health, but only those on the formal training scheme were funded by the Deanery.) However, following changes to the funding arrangements, this programme has been discontinued. New Trainees in public health are now able to chose where they study for their Masters in Public Health, but are currently being guided towards programmes provided by the London School of Hygiene and Tropical Medicine; Guy's King's and St. Thomas's, or City University/Queen Mary and Westfield College, though they may also be guided towards the University of Brighton in the near future, if this is felt to offer suitable preparation for the MFPH Part I exams.

## 7. PROFESSIONAL STANDARDS AND REGISTRATION

### Context

Education and training needs do not exist in a vacuum. They are closely linked with organisational objectives, as well as to the demands of a specific post. However, for health professionals working in the NHS, there is an additional dimension – that of professional registration. Until recently, public health practice within the NHS was predominantly regarded as a medical speciality, and senior posts (such as Director of Public Health) were restricted to those with a higher specialist qualification, and GMC registration. Formal professional training, leading to a higher specialist qualification in public health, was therefore restricted to doctors. Training standards were therefore set and maintained by the Faculty of Public Health (formerly the Faculty of Public Health Medicine) – which runs its own professional membership examinations. Access to full membership of the FPHM is by examination, and these examinations were also, until recently, only open to qualified medical practitioners.

This situation has now changed dramatically. Following the changes brought about by *Shifting the Balance of Power within the NHS* (Department of Health, 2001) which brought about major changes in the organisation and delivery of public health, the requirement for Directors of Public Health within Primary Care Trusts to be qualified public health physicians has been abolished. Public health is increasingly being led by Primary Care Trusts, working in partnership with other agencies (particularly local government) and local communities. Professionals from backgrounds other than medicine are being actively encouraged to engage in delivery of the public health agenda, and much work is being done locally and nationally to develop public health capacity and capability across the whole public health workforce.

The Faculty of Public Health<sup>10</sup> has responded to these changes by opening up its Part II membership examination to those who have successfully completed Part I, and the Deanery Training Schemes are now recruiting trainees from a wide range of backgrounds. This will enable future public health specialists to train on the same basis as their medical colleagues. Alongside this development, a UK Voluntary Register for Specialists in Public Health is being established, to promote confidence in specialist practice through independent professional registration. Registration will initially be on a voluntary basis – though it is anticipated that statutory registration will become a requirement in the near future. For those who have been working at a senior level in public health for some years, local ‘top-up’ training schemes have been established to ‘fast-track’ their application for membership of this register.

### Standards and competencies for public health practice

Prior to the recent launch of the voluntary register, a considerable amount of work was undertaken to development of national standards for specialist practice in public health (Lessof, Dumelow and McPherson, undated; Healthwork UK, 2001). This has recently been extended to public health practitioners, under the auspices of *Skills for*

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<sup>10</sup> At its Annual General Meeting in 2003, the Faculty of Public Health Medicine voted overwhelmingly to drop the word ‘medicine’ from its title, to reflect the changes in the profession.



*Health*, the Sector Skills Council for the health sector. Work on the development of specialist standards has been overseen by the Tripartite Steering Group,<sup>11</sup> thereby ensuring some common ownership by different professional groups within public health, and the achievement of a broad consensus on the key skills and competencies required for public health practice. The standards and competencies for specialist practice produced by Healthwork UK were used, in conjunction with the RITA competencies (Record of In-service Training Assessment - devised by the Faculty of Public Health for assessing the progress of trainees on formal public health training schemes) as a basis for the assessment framework for specialists wishing to be entered onto the UK Voluntary Register for Specialists in Public Health (see below).

### **Professional registration for public health specialists**

There are currently two routes to professional registration for public health specialists. Trainees on the ‘formal’ (ie Deanery sponsored) public health training scheme now follow the same training route as their medical colleagues (Cornish and Knight, 2002). On successful completion of their training, these public health specialists become eligible to join the new Specialist Register, in the same way that their medical colleagues become eligible for the GMC Specialist Register. For public health specialists not on formal training schemes, there is currently an alternative route. This is via portfolio assessment. The current assessment framework requires submission of an extensive portfolio of evidence to be submitted to a panel of assessors, in which applicants need to demonstrate that they

- have acquired a knowledge base in public health
- know how to apply this knowledge
- can demonstrate application in their public health practice

For ‘generalist’ registration, candidates need to be competent in all ten key areas of public health practice. (see Box 3)

#### **10 Key areas of public health practice**

- Surveillance and assessment of the population’s health and wellbeing
- Promoting and protecting the population’s health and well-being
- Developing quality and risk management within an evaluative culture
- Collaborative working for health
- Developing health programmes and services and reducing inequalities
- Policy and strategy development and implementation
- Working with and for communities
- Strategic leadership for health
- Research and development
- Ethically managing self, people and resources to improve health

(Source: Working paper Tripartite group)

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<sup>11</sup> The Tripartite Steering Group represented the Faculty of Public Health (Medicine), the Royal Institute of Public Health, and the Multidisciplinary Public Health Forum

Whilst there is an expectation that as many public health specialists as possible will be encouraged to apply for general registration, there is also an awareness that some specialists have no immediate interest in becoming fully competent across all ten key areas.

“Public health specialists for ‘specialised’ professional backgrounds (sometimes known as ‘specialist specialists’) have particular areas of expertise, but, like general specialists work (or have the ability to work) at a very senior management or strategic level. The next stage of the register was to test the feasibility of a defined form of registration specific to a particular area of practice”(Griffiths and Sugarman, 2004)

Further consultation is now therefore underway with the following groups

- Health promotion
- Health protection
- Public health pharmacy
- Public health intelligence
- Health economics
- Academic public health
- Environmental health

Outline competency frameworks for defined registration are in place for most of these groups, but the development of detailed competency frameworks is expected to take until 2005.

Note: **Professional registration for public health nurses** is also being considered by the relevant professional bodies for nursing, midwifery and health visiting.

## **8. CURRENT PROVISION**

### **Higher Education Institutions within the vicinity of Kent, Surrey and Sussex**

There are a number of Higher Education Institutions within Kent, Surrey and Sussex, and many located elsewhere in the South East Region, or in central and south-eastern London are also likely to be readily accessible to KSS staff.<sup>12</sup> Staff living and working in the Kent, Surrey and Sussex area should find that at least one of the Higher Education Institutes listed below is within reasonable travelling distance.<sup>13</sup>

#### **Kent**

University of Kent \*  
Canterbury Christ Church University College \*

#### **Sussex**

University of Sussex  
University of Brighton \*  
Chichester University College

#### **Surrey**

University of Surrey

#### **London**

London School of Hygiene and Tropical Medicine \*  
King's College London \*  
University College London \*  
City University \*  
Queen Mary and Westfield College \*  
South Bank University \*  
University of Greenwich \*

#### **Elsewhere in the South East Region**

Oxford Brookes \*  
University of Oxford  
University of Portsmouth  
University of Southampton \*

Many of these educational institutions currently offer post-graduate programmes in public health. Others are known to offer post-graduate programmes which cover some of the key areas of public health practice/competency framework for specialist practice. These are identified with an \* and are discussed further below.

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<sup>12</sup> Note: An interactive map of all UK Universities and Colleges, from which individual university websites can be accessed is available electronically at: <http://scitsc.wlv.ac.uk/ukinfo/ukmap.html>

<sup>13</sup> This list contains a number of HEIs which were not part of this project, so their views on collaborative working have not been sought. Information on the courses has been obtained from publicly-available sources.

However, others may have specific programmes of interest to those with identified training needs in some of the many disciplines which contribute to an understanding of health, and the policies and practices which influence it. Postgraduate programmes in the social sciences - especially psychology, sociology, health economics, social policy, health policy, social or health services research and public sector (including health services) management - are all likely to contain modules that may be relevant to some of the training needs identified in section 6 (above). Further information is available via the relevant websites, either directly or via the link given above.

### **Post graduate programmes in public health**

A brief summary of the main post-graduate programmes public health and public health related subjects known to be currently available in these institutions is given below.<sup>14</sup>

For further details of specific modules offered, of individual module content, and for application procedures, please contact the department concerned.

#### **KENT**

- **University of Kent**

This University does not currently host a Masters Programme in Public Health, but does run an *MA in Health Studies*, which has a strong emphasis on health policy and management, together with research methods. There is also an NHS-funded Research and Development Support Unit (RDSU) located in the Centre for Health Services Studies, which runs short courses in health services research. These are open to anyone working within the NHS in Kent and Surrey. There are plans to introduce a new *Masters in Health Services Research*.

**Contact:** [www.kent.ac.uk](http://www.kent.ac.uk)

CHSS

George Allen Wing

University of Kent

Canterbury

Kent CT2 7NF

- **Canterbury Christchurch University College**

This college runs two programmes for public health practitioners. The Advanced Certificate in Public Health Practice, which caters for students new to public health. For more specialist staff, there is the *MSc/PG Diploma/PG Certificate in Health Promotion and Public Health*. This has strong focus on health education and health promotion (it was previously offered as an MSc in Health Education and Health

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<sup>14</sup> Note: current provision may be subject to change, as existing courses and programmes are regularly revised and updated. New programmes currently still in development have not been included here.

Promotion), and is advertised as being particularly suitable for health promotion officers, health visitors, nurses, allied health professionals and teachers.

**Contact:** [www.cant.ac.uk](http://www.cant.ac.uk)

The Centre for Health Education and Research  
Canterbury Christ Church University College  
North Holmes Road  
Canterbury  
Kent CT1 1QU

## SUSSEX

- **University of Brighton**

The University of Brighton *MSc/PGCert/PGDip in Public Health* has been particularly designed to meet the needs of doctors, senior health professionals and environmental scientists working in the areas of public and environmental health. It shares a number of core modules with two closely-related award-bearing programmes, the *MSc Public Health and Management* and the *MSc Public Health and Education*.

**Contact:** [www.bton.ac.uk](http://www.bton.ac.uk)

Faculty of Health  
Postgraduate Medical School  
University of Brighton  
Falmer Campus  
Brighton BN1 9PH

## LONDON

- **London School of Hygiene and Tropical Medicine**

The LSHTM, which is part of the University of London, runs a wide range of postgraduate programmes in public health and related areas, and attracts graduate students and health professionals from all over the world. Many of its Masters Degrees in Public Health therefore have an international focus, and some are available via distance learning. In addition to specific masters programmes in core public health disciplines, such as the *MSc Epidemiology* and the *MSc Demography and Health* there is the generic *MSc in Public Health (General)* which covers the core disciplines in public health. This generic programme also contains a number of more specialist streams, leading to the *MSc in Public Health (Environment and Health)*, the *MSc in Public Health (Health Promotion)*, the *MSc Public Health (Health Services Management)*, and the *MSc Public Health (Health Services/Systems Research)*.

Other Masters Programmes which may be of particular interest to those working in the NHS on the current public health agenda include the *MSc Public Health*

*Nutrition* and the *MSc Reproductive and Sexual Health Research*. Modules can be taken singly as part of the School's Short Course Programme.

**Contact:** [www.lshtm.ac.uk](http://www.lshtm.ac.uk)

London School of Hygiene and Tropical Medicine  
Keppel Street  
London WC1 7HT

- **King's College London**

This programme is made up of three awards, the *Master of Public Health*, the *MSc Public Health* and the *Postgraduate Diploma in Public Health*, offered jointly by the School of Health and Life Sciences and the School of Medicine. Established in 2000, this programme draws on the expertise of a wide range of departments within the college, including Public Health Sciences, Environmental Health, Nutrition and Dietetics, Health Promotion and Management. The programme is specifically aimed at both medical and non-medical public health practitioners, and intended to develop individuals for leadership roles in public health.

**Contact:** [www.kcl.ac.uk](http://www.kcl.ac.uk)

Division of Life Sciences  
Franklin-Wilkins Building  
150 Stamford Street  
London SE1 9NN

- **University College London**

The Department of Social Science and Medicine, located in Imperial College, recently established this *MSc in Social Intervention for Public Health* to provide a cutting edge knowledge and skills base for both non-medical and medical professionals. Established in 2000, this programme offers a multidisciplinary perspective to the theory and practice of public health. There is a strong emphasis on addressing social inequalities through multi-sectoral interventions and community development.

**Contact:** [www.ic.ac.uk](http://www.ic.ac.uk)

Imperial College of Science, Technology and Medicine  
Registry, The Hammersmith Campus  
Commonwealth Building  
Du Cane Road  
London W12 0NN

The Department of Epidemiology and Public Health at University College has recently established a new *MSc in Health and Society*, which is due to start in September 2004. This programme, which has a strong emphasis on social

epidemiology, is aiming to attract doctors, public health professionals, sociologists and other social scientists, biologists and statisticians.

**Contact:** [www.ucl.ac.uk](http://www.ucl.ac.uk)

Department of Epidemiology and Public Health  
UCL, 1-19 Torrington Place  
London WC1E 6BT

- **City University & Queen Mary's, London**

This newly-established *MSc/PG Diploma in Public Health*, which had its first intake of students in September 2003, is the result of collaboration between two universities and their relevant departments: the Institute of Community Health Sciences of Barts and the London, at Queen Mary's School of Medicine and Dentistry, and the St Bartholomew School of Nursing and Midwifery, at City University. The local Workforce Development Confederation supports a number of places for staff based in local PCTs (City and Hackney, Tower Hamlets and Newham) through its contract with City University. Modules can be taken singly to support CPD or 'top-up' training.

**Contact:** [www.ichs.qmw.ac.uk](http://www.ichs.qmw.ac.uk)

Department of General Practice and Primary Care  
Queen Mary  
University of London  
Mile End  
London E1 4NS

Or

Department of Public Health and Primary Care  
St Bartholomew School of Nursing and Midwifery  
City University  
Philpot Street  
London E1 2EA

- **London South Bank University**

This *MSc in Public Health and Health Promotion* builds on South Banks's strong track record in teaching health promotion, though the programme has recently been revised to take account of the new public health agenda. The programme draws primarily from the group best described as public health practitioners – it does not currently have any trainees from the formal London/KSS Deanery Public Health Training Programme. It does, however, attract medically-qualified students, mostly from overseas. UK students travel from across the South East of England to attend this programme.

**Contact:** [www.lsbu.ac.uk](http://www.lsbu.ac.uk)

Institute of Primary Care and Public Health  
Faculty of Health and Social Care  
London South Bank University  
103 Borough Road  
London SE1 0AA

- **University of Greenwich**

This University does not currently have a masters level programme in public health, but does offer a *BSc (Hons) Public Health*. It is one of only three universities in the country currently offering public health education at an undergraduate level.

**Contact:** [www.gre.ac.uk](http://www.gre.ac.uk)

School of Health and Social Care  
University of Greenwich  
Avery Hill Campus  
Southwood Site  
Avery Hill Road  
London SE9 2UG

## **ELSEWHERE IN THE SOUTH EAST REGION**

- **Oxford Brookes University**

The *MSc/PG Diploma in Public Health* is offered by the School of Health and Social Care. It is a flexible programme, in which students study with postgraduates from other disciplines within the University.

Further information is available from the following website:

[www.brookes.ac.uk](http://www.brookes.ac.uk)

- **University of Southampton**

The School of Medicine runs an *MSc in Public Health Nutrition*, made up of a number of core modules (there are no optional modules currently available on this programme) followed by a research project.

Further information is available from the following website:

[www.som.soton.ac.uk](http://www.som.soton.ac.uk)



## **9. BALANCING SUPPLY AND DEMAND**

### **Mapping courses to training needs**

Mapping existing provision onto known demand for each of the CMO's three categories of public health – specialists, practitioners and 'wider' public health is a complex task, for a number of reasons.

Firstly, obtaining a complete, accurate and up-to-date picture of all the existing modules (core and optional) which make up each of the programmes listed above, in the level of detail that would enable current provision to be 'mapped' against identified learning needs, does not seem feasible. Whilst most Education Providers list the modules they offer, and give some information on course content, specific learning objectives and detailed course content are not always in the public domain. Furthermore, optional modules do not run every year. For this reason, any prospective student wishing to find out how well specific programmes and/or modules might meet their learning needs, would be well-advised to talk to the Programme Co-ordinator in the HEI concerned. Alternatively (or in addition) module handbooks, which do contain this information, could be made available via the Public Health Network Education and Training Co-ordinators.

Furthermore, as stated above, training needs have not always been assessed on the basis of the CMO's grouping. Early studies varied considerably in terms of who was included in the category 'public health' – and, whilst the term 'public health specialist' is now commonly agreed, there is less clarity over who falls into the other two categories. Even within the category of 'specialist' public health professionals are not a homogeneous group – their education and training needs vary considerably, depending on their

- academic and professional background
- current roles and responsibilities
- future career aspirations

Previous work suggests that education and training needs for public health should always be assessed on an individual basis, as part of the annual cycle of staff appraisal, and written into Personal Development Plans. All NHS staff are required to have Personal Development Plans, and the Workforce Development Confederation needs to think through how information on education and training needs contained within them can be anonymised, aggregated and shared with Higher Education Institutions to inform future developments.

Finally, with the establishment of the Voluntary Register, public health specialists wishing to apply for registration are likely to be reassessing their training needs in the light of the requirements of the portfolio framework, and will need access to information on how they can best fill any competency gaps identified during this process.

## **Mapping courses to competencies**

The Masters Planning Group have already mapped their existing courses to the public health competencies provided in the document *National Standards for Public Health Practice* (Healthwork UK, July 2001). This showed that all competency areas appeared to be covered within modules currently offered by the HEIs which formed part of the group – however, coverage varied considerably between Programmes, with some appearing to cover the full range of key areas of public health practice, whilst others are more focussed on specific aspects .

To establish the depth of coverage of specific competencies within specific modules would require more detailed information on specific learning objectives within modules, and individual teaching plans to see how these learning objectives are met within specific teaching session. Whilst this information is usually available to students as part of course and module outlines, full documentation has not been shared as part of this study, and information available on publicly-accessible websites varies considerably in the level of detail given. This has made revisiting the initial mapping exercise rather difficult.

However, practical difficulties in terms of access to teaching materials is not the only issue here. Even some of those who have been involved in the Steering Group have expressed reservations about the mapping of courses to competencies. There appear to be two main reasons for this. Firstly, sharing detailed course outlines in a competitive educational market can feel uncomfortable to some providers. (It is interesting to observe the difference in the level of detail provided on different providers' websites.)

Secondly, whilst some members of the Steering Group have begun to undertake this 'mapping' exercise within their own organisations, others are concerned that the University itself would not support too strong a focus on 'competency-based' training. Many academics and educational experts maintain that there is a difference between education and training, and that Masters Programmes are designed to educate students, not to train them for specific roles in the labour market.

This ongoing debate is reflected in the 'formal' public health training programmes, where the academic and professional aspects of training are provided in different settings, and assessed by different bodies. It is also reflected in the recently-developed Portfolio Framework for those wishing to be accepted on the Voluntary Register. Many of the public health competencies need to be either wholly or partly demonstrated through evidence of job-related activity, rather than attendance at academic courses.

## **Flexibility and diversity**

In addition, the diversity of entry points into the current public health profession – in terms of 'original' academic discipline/professional training and overall level of education and training – as well as the diversity in public health roles and responsibilities, combined with the dual pathway to registration (the 'general' specialist and the 'designated' specialist routes) strongly suggests that there needs to be considerable flexibility in how individual public health specialists/practitioners

achieve the competency levels expected in professional practice. Mapping courses to competencies will, at best, only make a partial contribution to this process.

Previous studies which have explored the training needs of public health professionals from backgrounds other than medicine (Somerville and Griffiths, 1995; Cornish, 1996; Cornish 1998) have shown that many public health specialists entering the profession already hold at least a Master's qualification. Furthermore, there is anecdotal evidence that, due to the fierce competition for the limited number of training places on the formal training programme, many Specialist Trainees who are successful in their applications already hold PhDs. Therefore any single programme aiming to cover all the required competencies (however well it may achieved this) would be unlikely to appeal to this group.

### **Information sharing**

Nevertheless, evidence from previous work which has analysed the training needs of public health professionals (see above) has highlighted the need for more accessible information on what is available in terms of formal educational opportunities. Individuals who have identified an education or training need, either in terms of their current role or their future career development, require accurate and timely information which will enable them to assess the relevance of programmes/modules in meeting those needs. This information needs to be provided by HEIs offering postgraduate public health education, just as information on the education and training needs of specific groups of staff should be made available to HEIs to inform their market analysis.

### **Guiding principles for public health education and training in KSS**

Earlier work on the education and training needs for public health (Cornish, 1996; Cornish, 1998) informed the development of a number of 'guiding principles' which have subsequently been incorporated into local policy (NHS Executive South East, 2000; KSS Workforce Development Confederation et al, 2003). These need to be fully reflected in decisions about future provision.

In considering the options available to them, therefore, the Steering Group and the Workforce Development Confederation need to ensure that education and training for public health within Kent, Surrey and Sussex is:

- Consistent with national policies and priorities
- Employer-led, and in line with organisational objectives
- Sensitive to the needs and career aspirations of employees
- Flexible and equitable in terms of access, content and mode of delivery
- Responsive to the diversity of public health practice, and able to build on and enhance this strength

The diversity of background education, training and experience within the newly-emerging multi-disciplinary profession of public health, whether at a specialist (general or defined) or practitioner level, means that education and training provision to equip individuals for senior posts will need to be based on the notion of a 'skills escalator' (similar to those being developed, for example, in R&D training) in which

people can enter or leave at different points. This will require a wide range of provision, with a diversity of routes – not necessarily (or only) within Institutions, but also between them. An ability to move between programmes, as well as within them, would enable this to be achieved.

## **10. DISCUSSION**

### **Is there a case for a multi-centred Masters programme in KSS?**

Two key questions appear to emerge from this feasibility study. These are:

- Would a flexible, multi-centred Masters Programme meet people's training needs more effectively than existing provision?
- Is such a solution feasible? (ie what procedures or processes would be needed to take it forward?)

A detailed answer to the first question would need further market testing. However, before undertaking this, there are some issues which have been highlighted during discussion with providers, which require consideration.

### **Size of the potential market for Masters in Public Health**

Some concerns have been expressed among providers that the market for Masters Programmes in Public Health may be reaching saturation point. The public health policy agenda has been expanding for a number of years, and the profession has broadened its base in response to this demand. Many Higher Education Institutes in London and the South East have responded to this expansion – in a number of cases by setting up new post-graduate programmes. However, there are no guarantees that this expansion will continue. In the case of Specialists in Public Health, once the current cohort of senior specialists requiring 'top-up' provision to achieved voluntary registration has passed through this process, it is at least possible that numbers requiring formal academic education in public health may in fact decline over time.<sup>15</sup>

### **How local do programmes need to be?**

It is not certain that there are enough people working in either the NHS or its partner organisations who need to access to local educational provision to justify the establishment of an additional local provider. For most people working in either Surrey or Sussex, it is possible to travel to either central/south London, or to Brighton, on a daily basis. Travel arrangements are more difficult for those based in Kent – especially East Kent, where journey times are longer. However, the experience of those departments visited as part of this study suggests that students are willing to travel to courses and programmes which they perceive to be of high quality, and which meet their specific training needs. Specialist trainees on the formal training programme are in any case expected to move around the Deanery in order to gain breadth of training experience; others are known to move in order to gain more experience and/or career advancement.

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<sup>15</sup> This scenario may change in the light of (a) the Wanless report (HM Treasury, 2004) and the forthcoming White Paper on public health and (b) the recent FPH workforce report (Pelman and Gray, 2004)

## **Quality issues**

There are concerns about the ‘student experience’ on a multi-centre programme. Although all Higher Education Institutions are subject to rigorous quality assessment, and do their best to identify problems at an early stage, this is likely to become much more difficult where students are distributed across a number of organisations. Even if one HEI was to be the ‘host’ for such a programme, there are concerns that there would still be no mechanism for sorting out possible problems in a partner institution.

## **Feasibility issues**

In answer to the second question, regarding the feasibility of such a programme, feelings from the provider interviews suggest that, overall, there is some support for the concept of HEIs working cooperatively, in ways that permit each to build on its strengths. However, maintaining student numbers for programmes is essential to keep them running, and from an HEI’s perspective, contributing to a flexible programme, in which students may take only a small number of modules in each institution, would result in considerable effort for a small increase in student numbers. This solution may well not be cost-effective for the Universities concerned.

There are, however, also enormous practical difficulties in considering such a solution. Mutual validation and/or accreditation of each others modules is a lengthy process, complicated by the different regulations and requirements within HEIs. Although there are precedents for this, they have to date (as far as we are aware) only involved two institutions (examples include a joint City/Queen Mary and Westfield MPH Programme in East London, or, more locally, the joint initiative between the Universities of Sussex and Brighton to establish the new Medical School.) Students from the new medical school in Brighton belong to both Universities, but they also have to graduate from both, as there is no legal provision for a single (joint) award.

## **Interim conclusions**

All the HEI involved in the KSS Masters Planning Group, and who took part in this feasibility study, are – in principle – very much in favour of building on their strengths, and working co-operatively with other local providers to address any gaps in local provision. However, pressures within their own organisations, together with the potential difficulties highlighted above, suggest that there is currently little support for taking this option forward. If such a solution is not feasible from the providers point of view, there is little point in undertaking further market testing.

In view of the reservations expressed by stakeholders in the local HEIs, a number of alternatives to a new, flexible, multi-centred Masters Programme have been suggested. These include

- Improving the current system for recognising each other’s modules. All existing programmes have a mechanism by which students can ‘import’ relevant modules studied elsewhere, but the regulations surrounding this do vary between institutions, and the content of each ‘imported’ module usually has to be assessed on a case-by-case basis. This can be time

consuming for academic staff, and frustrating for students. Some kind of prior 'cross-accreditation' would make this process more robust, and more transparent to academic staff and students alike.

- The scope for distance learning could be investigated. Current programmes rely heavily on face-to-face delivery, but there are examples of programmes which use a combination of face-to-face and distance learning. However, most HEIs are now making course material available to their own students via the internet, so the problem of access may be overcome in this way. (Though, again, regulations around attendance vary between institutions – for some, attendance at a module is compulsory, for others, submission of the assignment is sufficient.)
- Awareness of what is available, and how this relates to the competencies required, needs to be increased. There is a strong suspicion among HEIs (based on anecdotal evidence from their own students) that potential students have to work quite hard to find out what is available to them, and how to access this (including how arrange study leave and to access the funding to cover their fees.) There is a perception that students may be being 'directed' to some HEIs rather than others, but it is not clear on what basis this is happening. Greater transparency needs to be achieved, together with improved communication between the health service and academic departments.

## 11. OPTIONS FOR THE FUTURE

Discussions with key stakeholders within local HEIs has led to identification of the following options, which were subject to further discussion within the Project Group:

- **No change**

*Advantages*

No action required

*Disadvantages*

Current perceptions (not necessarily accurate!) that provision is variable in quality, and not sufficiently flexible to meet the diversity of needs within the service

- **Single provider** (ie one of the existing HEI's becoming the 'preferred provider' and either core funded in some way to run the programme, to provide an agreed number of funded places, or given some assurance that any KSS public health staff being accepted on the programme (or modules for this programme) will have their fees paid. (**Note:** effectively the same as no change, until St George's stops its intake)

*Advantages*

For the HEI concerned, this has considerable advantages, in that it knows it has a market; for the WDC, in that they can work with the provider to ensure they get what they want (and are willing to pay for).

For students, in that they know they will get funded if they secure a place, and that the course has been specifically tailored to their needs.

*Disadvantages*

For the other HEIs - who have no good reason to enter the market. Also, existing providers who do offer relevant modules or programmes will be undermined. Won't offer a level playing field in the education market (and we've recently moved away from the single provider model, in the ending of the St George's contract, even though we still use it, to some extent, for nurses and allied health professionals)

For students - inflexibility of provision. Even if there are choices of modules, students can't 'vote with their feet' if they aren't satisfied with the quality or relevance of the courses to their needs.

Real concerns about a 'one-size-fits-all' approach, which was the main disadvantage of the approach used to train public health doctors in the past. This is



particularly unsuited to multidisciplinary public health, where flexibility is essential because of the wide range of entry points.

- **Partnership model** (ie two - or at most three - providers going for a formal partnership, along the lines of the City/QMW model, or the Sussex & Brighton Medical School. This could be forward by the organisations concerned, if there are two (or possibly three) who are sufficiently committed to doing this.

#### *Advantages*

Makes maximum use of scarce resources, enable each dept or organisation to play to its strengths etc.

#### *Disadvantages*

Complex and time consuming to develop; will require memorandum of agreement and joint structures to be set up by HEI's taking part, but will still need to be approved and accredited by both organisations. Time scale likely to be at least 2 years. Likely that both organisations will have to award degrees (as in Brighton and Sussex med school)

For students - offers potentially more flexibility than single provider, students also gain from specific expertise within contributing departments. However, some concerns about student experience - may feel alienated from both organisations (especially as these will mostly be part-time students). May 'fall between' student monitoring mechanisms of both etc. (wait and see how this works out at City/QMW?)

- **Multi-versity model** - this could take a number of forms, ranging from the same as no. 2, but with more players, in which case it will be more complex to establish and more complex to manage; or it could have the model the VC at Kent talked of (ie not all equal partners! - different HEIs take on different levels of programme, or act as 'feeder' programmes, etc.)

#### *Advantages*

For students, this (latter) could provide a wide range of entry points and flexible routes through the programme - which would be a real advantage. However, the former sound a bit of a nightmare in terms of student experience, as students would be forced to go to different HEI's for different stages of their education and training.

#### *Disadvantage*

For HEI's; former version (like no. 2 only with more players) would be highly complex to establish and to manage in a coherent way; time consuming to set up; high risk if the market contracts.

Latter model (more hierarchical) easier to manage, but is this likely to achieve widespread support? Would need tactful handling – to demonstrate that different levels were available in different places, but quality not being compromised (or some HEI's being seen as 'higher status' than others.)

- **Some kind of APL (Accreditation of Prior Learning) consortium arrangement** - in which there is a more formalised agreement between HEI's around the transferral of credits between programmes. Once the ground rules were established, and the organisations in the partnership signed up to these, there would be mutual recognition of each others modules and CAT points; mutual agreement on issues such as how many modules can be transferred in etc. This would need to be much more robust and transparent than current arrangements, which are seen as arbitrary, often 'ad hoc' and not very transparent to staff or students.

#### *Advantage*

Students would be able to identify their own training needs in relation to their current employment and their future career aspirations, and then 'shop around' to find the provision that best fits their needs and circumstances. If money was linked to acceptance on approved courses/programmes/modules at approved HEI (ie those forming part of the consortia) then students would have a great deal of freedom of choice, and HEIs would have the advantage of knowing that, if they ran programmes (and modules within programmes) that people wanted to come on, the money would follow the student.

With open, transparent processes for 'importing' credits through the credit transfer programme, the workload for staff would be reduced, and quality could be maintained. This appears in any case to be along the lines in which Universities are being encouraged to work.

#### *Disadvantage*

Some work involved, but not as much as would be involved in a developing single, multi-provider Masters Programme. If this were the preferred option, HEIs would welcome support from the WDC in terms of time for joint working, the production of a joint prospectus etc.

## 12. CONCLUSIONS

Following a final meeting of the Masters Planning Group (August, 2004) it was agreed that the introduction of a multi-centre Masters Programme in Public Health does not appear to be a feasible option to pursue within Kent, Surrey and Sussex at the present time.

Education providers who took part in this project, however, would welcome the opportunity to continue to work more closely together, and to work in partnership with the Workforce Development Confederation, to ensure that they are able to provide high-quality public health programmes that are relevant to the needs of the public health workforce.

All parties to this study also felt there was room for improving communication between the NHS (employers and staff) and HEIs, to ensure that potential students are aware of the full range of educational provision available to them, and supported in making choices appropriate to their identified training needs and preferred learning styles.

Education and training co-ordinators attached to local public health networks may wish to obtain structured feedback from those currently on the 'top-up' training scheme, to ensure that they have been able to access the specific modules they need to enable them to meet the requirements for professional registration as either a specialist or generalist on the Voluntary Register.

Education providers may wish to undertake further research into the factors which influence students choice of public health programme. They may also find it helpful to evaluate the quality and relevance of their provision by collecting data on student's current job, prior qualifications, professional experience, learning needs and how these were identified at the time of entry onto the programmes. Further information could be obtained shortly after graduation, to measure outcomes, such as how well students felt the programme met their needs, whether this had any impact on their public health role, and so on.

The Workforce Development Confederation/Strategic Health Authority needs to keep public health education and training needs and provision under review, to ensure that the developing workforce is fully equipped to deliver the public health agenda. In particular, the workforce implications of the forthcoming Government White Paper on Public Health will need to be considered by local

- Public Health Networks
- Primary Care Trusts
- Strategic Health Authorities
- Workforce Development Confederations
- Post-graduate Deaneries
- Higher Education Institutions

## **14. RECOMMENDATIONS**

- (i) The establishment of a multi-centred masters-level post-graduate programme in public health, jointly provided by the higher education institutions which took part in the project, does not appear to be feasible at this time.**
- (ii) Nevertheless, there are a number of potential opportunities for further developing joint working between these higher education institutions – for example:**
  - Joint production of some kind of a public health prospectus (building on the information already provided by the Education and Training Co-ordinators) which enables the public health workforce to rapidly identify modules and programmes which are particularly suited to meeting their individual, identified training needs**
  - Mutual recognition of each others modules (subject to individual University requirements) or at least, greater transparency around the mechanisms for transferring credits between programmes and institutions**

**Even this level of co-operation is likely to take time, and will require a continued commitment to joint working.**

- (iii) The Workforce Development Confederations (or Workforce Development Directorates of Strategic Health Authorities) need to consider their role in shaping the market for education and training in public health, in order to ensure that the needs of the public health staff are being appropriately met across the across the various professional groups which deliver the public health agenda, as well as across the geographical area of Kent, Surrey and Sussex.**

## 15. Appendix A

### **Membership of the KSS Masters Planning Group**

1. Veronica Habgood, University of Greenwich
2. Lee Bennett, University of Greenwich
3. Jane Wills, London South Bank University
4. George Ellison, London South Bank University
5. Ross Lawrenson, University of Surrey
6. Vasu Validingum, University of Surrey
7. Andy Alaszewski, University of Kent
8. Yvonne Cornish, University of Kent
9. Stephen Clift, Canterbury Christchurch University College
10. Peter Main, Canterbury Christchurch University College
11. Brendan O'Connor, University of Brighton
12. John Davis, University of Brighton
13. Sylvia Beacham, KSS WDC
14. Jo Barnes, KSS WDC

### **Membership of the Feasibility Study Steering Group**

Veronica Habgood  
Jane Wills  
Sylvia Beacham  
Yvonne Cornish

### **Researcher/author of this report**

Yvonne Cornish BA (Hons) MSc PhD HonMFPHM

## Appendix B

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