

BMA



Public Health Specialists Manifesto May 2022



British Medical Association
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Public Health Specialists Manifesto

Introduction

1. The purpose of this manifesto is to give voice to the concerns of public health doctors as expressed through the survey the Public Health Medicine Committee undertook at the end of 2020. The Committee has added some further details where it was felt these were needed.
2. A number of issues have been identified from the survey and confirmed through accounts of members' experiences during the last 18 months. For example, the lack of public health experts in leadership and advisory roles was a concern and a frustration. Many of the issues identified were legacy issues from the 2013 reorganisation which have been highlighted by COVID system pressures and exacerbated by the recent reorganisation of public health in England.
3. The Committee agreed that there should be a time-tabled action plan for each point, including where action had already been taken. In the meantime, the document has already been used to inform the Committee officers' internal lobbying across the BMA, in drafting the Committee's submission to the Doctors and Dentists Review Body and in discussions with the policy and communications teams at the BMA.

Employment arrangements

4. The fragmentation of Public Health must be addressed urgently if the public are to benefit from a system which is fit for purpose. In order to promote and maintain vital networks, data flows and movement of specialists around the system, all public health specialists should be employed by the NHS, as is current BMA policy, regardless of any additional contracts which might be required for specific places of work. As a backstop position, there should be agreement to a standard minimum contract for public health specialists based on the NHS medical and dental contract and recognised for the purposes of progression, occupational benefits, pensions and redundancy by all employers of public health specialist staff. The terms and conditions should include recognition of additional hours worked, including during exceptional circumstances, such as a pandemic, being reimbursed through payment or alternatively, time off in lieu, only where this is feasible and agreed to by the employee, across all public health employers in England.
5. The BMA should have negotiating rights for the terms and conditions of service of local authority employed public health doctors, as well as those employed by the UKHSA, OHID, DHSC more broadly, NHS England/Improvement and the wider NHS in England, Universities, the NHS in the devolved nations and in other settings across the UK.
6. We also assert that public health trainees in England should be employed on the 2016 junior doctor contract during their public health training. The contract should be held by a lead employer with a full understanding of their particular needs and priorities. This should be accompanied by associated

honorary contracts with the host employers that facilitate the implementation of the junior doctor contract in their organisation. There should be a cover-all document for host organisations, for example in the form of a service level agreement or memorandum of understanding between them and the lead employer which recognises their shared responsibility for the trainee and for the effective operation of the contract.

Specific Issues raised by the survey along with proposed policy and recommendations for remedy

Low morale

7. The recovery phase of the pandemic should be used to improve the morale and wellbeing of staff. This should mean that temporarily retired volunteer public health professional staff and other public health professionals are used to relieve pressure on substantive staff.
8. There must be a professional appraisal system which is fit for purpose and functions to support staff at all points in their career, including when the system is under pressure. While we support the decision to simplify the appraisal and revalidation processes during the pandemic, we were disappointed to see from our survey that many respondents did not feel that they could contact their appraiser for support and advice. Appraisal must have explicit supportive as well as development functions.
9. There should be systematic external review of annual job plans by the Faculty of Public Health, similar to that in place for CPD documentation, linked to the vision, values and goals of public health, nationally and locally (as appropriate) informing but separate from a doctor's appraisal.



Action point:

These suggestions should inform the Committee's engagement with the Academy of Medical Royal Colleges' review of appraisal.

Stress, burn out and mental health problems amongst Public Health staff

10. Employers should provide an adequate range of support services for public health staff at all points in their career, including training of managers and occupational health provision, with rapid signposting to appropriate sources of psychological support. There must be access to adequate surge capacity when the system is under pressure. These additional sources of support need to be independent of employer organisations and must maintain the highest standards of professionalism and confidentiality, in order to ensure the trust and confidence of those who need them. For those public health doctors working in local authorities or the civil service (OHID and UKHSA), employers must recognise and address the need for specific support services for doctors and other healthcare practitioners that understand their particular and unique circumstances.

11. It is also vital that managers are trained, and themselves supported, to provide both regular supportive managerial appraisal and first-line support for staff with psychological distress, exhaustion and other signs of burnout, with a flexible approach to working patterns on the part of the employer organisation and individual managers. This training and approach can play a key role, especially in the early stages of PTSD and moral injury, when it can be a helpful part of recovery to be enabled to stay in the workplace, sometimes with reduced working hours and to continue to be in the company of others in and outside work, even when this is not the natural inclination of those affected.

12. In all cases, assurance should be sought that this vital managerial training and psychological services can be accessed in all settings across the UK. Details should be requested about what arrangements are already in place for employees, including flexible working practices, Occupational Health provision and independent confidential psychological support and whether these are equitable across regions, how they are publicised to employees, what evaluations have been carried out and plans for future provision of training and services and the promotion of these to employees.



Action points:

Write to UKHSA, OHID, DHSC and HEE (with respect to trainees) and to the ADPH for information and collaborative working (including via the PHMCC) and to the LGA for further information and support, to encourage provision of these services and training for local authority employees.

(Devolved nations) Write to the relevant health departments to seek this assurance.

Write to DHSC regarding increasing Occupational Health provision more generally – in line with wider BMA policy.

Lack of coaching, counselling and associated training

13. All employers should provide prompt and easy access to coaching, mentoring, counselling and, as above, other psychological support services and pro-actively provide all employees with directories of these resources and other sources of support, such as for those experiencing abuse or financial difficulties. These must be available for all employees, including managers, who may not be public health trained as well as professional public health and support staff and should be fit for purpose for staff at all points in their career and when the system is under pressure. Managers need to be trained to understand when outside support is required, what type of support is most appropriate and how it can be accessed by employees.



Action points:

(England and devolved nations) – suggested provision and communications as above.

Managers should be trained to provide basic coaching, counselling and mentoring, given the stresses that their staff can be under.

Lack of ability to reduce stress such as though taking holiday or taking exercise

14. Employers should provide services to reduce workforce stress, including in times of increased workload, in line with expert recommendation, through regular rest periods and mandatory leave, provision of nutritious food and exercise facilities and access to psychological support. These must also be available for managers who may not be public health-trained, as well as for professional public health and support staff and be fit for purpose for staff at all points in their career and when the system is under pressure.



Action points:

Include request for information on the provision of these working practices and facilities in the communications detailed above.

Lack of payment for additional hours worked (some employers)

15. All employers should pay for overtime in accordance with TCS and/or natural justice, particularly in circumstances where the workload and/or under-staffing makes the taking of time off in lieu difficult or impossible, or doing so would result in unacceptable delays to training progression.
16. The Committee should emphasise the links back to the earlier statement, regarding a standard minimum contract for employed public health doctors, regardless of hosting organisation and that this must include provision for overtime payments to be made. There needs to be an understanding that public health doctors are unable to shift their hours in the way that many hospital doctors do in order to avoid the need for overtime pay, for example, because of the constraints of their work and the relative lack of a need for overnight cover.



Action points:

Highlight this issue in the submissions to the Doctors and Dentists Review Body.

Raise the concern with the Local Government Association and at meetings of the Public Health Working Group.

Support the raising of the issue at relevant local negotiating committees and equivalents.

Some staff were not indemnified or inadequately indemnified by their employer

17. To reduce liability of individual doctors, all employers of public health professional staff must indemnify their employees in circumstances where NHS indemnity does not already apply. There should be a requirement for full employer indemnity (with minimum levels of "indemnification" as standard) across all organisations. This indemnity should be equivalent to that offered to doctors working in the NHS.

18. The issue of indemnity in public health is so poorly understood that we suggest mandating training on indemnity for trainees, educational supervisors and employers, covering why it is important, what is covered in block vs personal indemnity and why having both is important. This should be a standing item on LNC agendas and in annual appraisals. It would also be helpful to engage representatives of the major medical defence organisations, such as the MDU and MPS, to discuss the particular needs of Independent Public Health doctors working in various settings.



Action points:

Clarify the indemnity arrangements for public health registrars with Health Education England and the lead employers and communicate findings widely in accessible formats

Write to UKSA, OHID and NHSE/I regarding the committee's concerns on indemnity.

Write to all local authorities in England setting out the need to provide indemnity for professional Public Health staff.

Raise at meetings of the Public Health Working Group.

Write to the major medical defence organisations to request a meeting to discuss the needs of independent Public Health Consultants.

Lack of a consistent, authoritative mechanism to assure that across the country all populations receive a high-quality Public Health Service

19. An independent authoritative body should be established to monitor the standard of public health services in England regularly and to publish reports. There should be set public health standards with discretion to add additional requirements according to local need.
20. The independent body would review organisational capacity and capability on an annual or two-yearly basis. It would provide an independent organisational analysis of the fitness for purpose to host a specific public health function or functions. It could either be part of the CQC or an alternative external auditor.
21. All public health posts should require formal and recognised public health qualifications and that these should be "essential" not "desirable" requirements in job descriptions. Consultant and specialist posts should require the completion of specialty training and director of public health posts, a minimum period of time spent in a consultant or specialist post.



Action points:

Work up the proposal for an independent public health monitoring body for England.

Lack of discussion re job plans

22. All employers should review their arrangements for job planning and engage with a quality assurance process (as above), potentially using internal or external audit functions.



Action point:

Provide dedicated guidance for public health consultants on job planning appropriate to the nation of the UK in which they work.

Importance of the ability of Public Health staff to change job plan rapidly and become part of surge capacity in health protection

23. There should be formal arrangements between the different public health employers in England, setting out arrangements to produce public health (both specialist and administrative support) surge capacity for both short-term emergencies and the response required for more prolonged exceptional events, such as a pandemic. Such arrangements should include inductions, training and indemnity for public health working outside their usual role and organisation. These arrangements should be a part of emergency plans at local, regional and national level, for all relevant PH employing organisations and agencies. Consideration should also be given to how best additional capacity can be provided across the borders of the UK both at a local level and between the nations of the UK.

24. To improve agility and responsiveness there should be basic minimum training each year for all staff, for example on emerging issues of concern and the details of their potential redeployment roles in a situation where surge capacity is required.



Action points:

Write to all the employers of public health doctors in England with this suggestion.

Lack of pandemic preparedness

25. There should be regular pandemic preparedness exercises both locally and nationally. The recommendations arising from these exercises should be made public.

26. There should be less dependence on overseas suppliers of PPE, vaccines and medications, through investment in innovation and domestic production, to increase national resilience. These proposals should be linked to work that the Health Foundation and others are doing around the NHS becoming an anchor institution – local procurement is a core part of this and so there is great potential in supporting pandemic preparedness as well.



Action point:

These suggestions should inform the BMA's review of the lessons learned from the pandemic, through the Covid Inquiry Steering Group.

Poor utilisation of Public Health staff willing to return to work especially recent retirees

27. There should be a review of the return-to-work volunteers process, in order to learn lessons and make recommendations for the future. This should involve the GMC as well as employers.

28. Some of these retirees should also be utilised to provide the psychological and educational/appraisal support and undertake mentoring roles as suggested above, as well as providing public health services.



Action points:

Write to the GMC requesting a review of the return-to-work volunteer doctor scheme, including recommendations about the future arrangements for the scheme. The review should include a specialty-specific identification of the number of requests to be re-registered, the time taken to process requests, the number successfully returned onto the Register, numbers placed in work and whether this was in their specialist area, the proportion who did not find work and the reasons why they were not utilised, and the measures taken to quality assure these doctors, for example through appraisal.

Write to the employers of public health doctors and to the Local Government Association asking them to comment on the utility of the GMC scheme. Was it successful in increasing the capacity of the system? Do they want the scheme to continue? How would they amend the scheme to improve effectiveness and efficiency?

Carry out a brief survey of public health doctors who have utilised the scheme, possibly jointly with the Retired Members Committee.

Lack of trained Public Health staff and support to Public Health function

29. More substantive public health consultant posts should be created and funded, with a review of normative numbers, informed by both the Acheson and Marmot reports, to take account of both the population need for public health services across the three domains of public health work and the widening gap in health inequalities.

30. There should be a thorough and rapid review of public health workforce current capacity and overarching needs, to inform planning and an increase in the number of specialist training posts in Public Health across the UK with accompanying relevant resources.

31. Trainees rely heavily on their educational supervisors and training programme directors to help them through their specialist training. The significantly increased workload arising from the COVID pandemic has greatly diminished the access that trainees have had to their supervisors and thus their experience of the training programme. There needs to be adequate support and remuneration for educational supervisors and training programme directors so that the system does not rely on their goodwill to function effectively. There should be a commitment to continue funding the MPH/MSc for trainees that do not have this qualification prior to entering training.

32. Higher specialist training in Public Health should continue to equip all consultants and specialists to be competent in all three main domains of Public Health.
33. There should be regular (normally every two years) medical workforce reviews to ensure that the capacity and robustness of public health to meet future demand and probable future emergencies. Reviews should consider attrition in training, staff retention, career progression and equality & diversity within the Public Health workforce. Ideally, given that public health is a relatively small branch of practice and the inter-connectedness of the issues faced by individual public health specialists, these reviews should be undertaken on a UK-wide basis. These should be subject to regular parliamentary scrutiny by the House of Commons Health and Social Care Committee and the relevant committees of the devolved parliaments and assemblies.
34. The workforce review should be acted upon by the Faculty of Public Health and by Health Education England (HEE) and the relevant parts of the devolved administrations in consultation with the BMA and other stakeholders.
35. To improve capacity there should be a single workforce function for each national public health function reflecting their different ways of working with 5-year views of capacity and capability. There should also be specific 2, 5 and 10-year plans that could focus on pressure points such as consultant transitions, wellbeing, retirements and the need for immediate response and surge capacity versus long-term planning.
36. This should be acted upon by the Faculty of Public Health and by Health Education England and by the relevant parts of the devolved administrations in consultation with the BMA and other stakeholders.



Action points:

Write to HEE and the equivalents in the devolved nations requesting a significant recurrent increase in the number of higher specialist training places in public health.

Write to Faculty supporting a review of higher specialist training places in public health. Anticipate that the authoritative review would be sent to HEE. The number of public health consultants should be sufficient to meet expected future demand and have the robustness to meet the demands of a public health emergency.

Inform the development of BMA workforce policy and strategy.

Work with PHMCC members and others to understand how to map current workforce capacity given the complexity of the employing organisations across England

Inadequate Public Health budget

37. Public Health budgets should be increased and at a minimum the reductions since 2013, to the public health budgets of local authorities in England, must be made good and the clinical ring fences maintained. As a minimum, the levels of funding which went to PHE, should be maintained in the financial settlement for the new organisations of UKHSA and OHID, so that appropriate health intelligence, health protection and health improvement services can be established centrally, regionally and locally. Furthermore, the total allocation for health should be reviewed in the light of the Marmot recommendations on reducing inequalities, with a greater proportion of the total health budget allocated to prevention, including both provision for increased public health staff and administrative support services as well as for interventions recommended by public health professionals.

Improper use of Public Health budget

38. To support appropriate setting and use of budgets, there should be an independent audit and review of the use of the Public Health budget in English Local Authorities since 2013 and with ongoing annual review, with the results published, as part of external audit requirement. Explicit public health outcome monitoring must be part of this process. All expenditure from ringfenced public health budgets must be linked to the vision, values and goals of public health, nationally and locally. This requirement should be reflected in the job plans of public health professionals and senior managers in local authorities.

Lack of ability to speak truth to power

39. Public health professionals should be appointed to the Boards and Senior Executive Teams of all public health employer organisations and agencies.
40. To support leadership, an appropriately qualified and registered consultant should be appointed as an independent director of public health (DPH) to both Integrated Care System (ICS) expert advisory boards and commissioning bodies in England. There should also be dedicated public health consultants, specialists and registrars for ICSs, to work alongside the DPH(s), as the local authority and ICS geographies are not coterminous and thus require the extra layer of coordination and consideration of the needs of the whole ICS population, which this would provide.



Action point:

This key requirement should inform the BMA's lobbying of MPs and peers on the Health and Care Bill and of the boards of Integrated Care Systems.

Frustration about lack of employee influence on restructuring of the Public Health system

41. The BMA should identify problems faced by staff and present them to management. The BMA should liaise with others, such as the Faculty of Public Health to represent members' concerns.



Action points:

Inform the local negotiating committees and equivalents of any issues of concern to raise with employers.



Allocation of action points

Academy of Medical Royal Colleges: Appraisal (para 9)

Association of Directors of Public Health: management training (para 12), occupational health (para 12), coaching and counselling (para 13), wellbeing (para 14)

British Medical Association: appraisal (para 9), pandemic preparedness (para 26), training (para 36), Health and Care Bill (para 40)

Department of Health and Social Care: management training (para 12), occupational health (para 12), coaching and counselling (para 13), wellbeing (para 14), surge capacity (para 24), returners scheme (para 28)

Devolved nation health departments: management training (para 12), occupational health (para 12), coaching and counselling (para 13), wellbeing (para 14), surge capacity (para 24), returners scheme (para 28), training (para 36)

Doctors and Dentists Review Body: pay (para 16)

Faculty of Public Health: training (para 36)

General Medical Council: returners scheme (para 28)

Health Education England: management training (para 12), occupational health (para 12), coaching and counselling (para 13), wellbeing (para 14), indemnity (para 18), training (para 36)

Local Government Association: management training (para 12), occupational health (para 12), coaching and counselling (para 13), wellbeing (para 14), pay (para 16), indemnity (para 18), surge capacity (para 24), returners scheme (para 28)

Local Negotiating Committees: pay (para 16), restructuring in England (para 41)

Office of Health Improvement and Disparities: management training (para 12), occupational health (para 12), coaching and counselling (para 13), wellbeing (para 14), indemnity (para 18), surge capacity (para 24), returners scheme (para 28)

Public Health Medicine Committee: proposal for independent monitoring body (para 21), job planning (para 22), returners scheme (para 28)

Public Health Working Group: pay (para 16), indemnity (para 18)

UK Health Security Agency: management training (para 12), occupational health (para 12), coaching and counselling (para 13), wellbeing (para 14), indemnity (para 18), surge capacity (para 24), returners scheme (para 28)

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