Specialists in Public Health
Proceeding to Part II FPHM Membership

Yvonne Cornish,
Centre for Health Services Studies,
University of Kent

Teri Knight,
Health Service Management Centre,
University of Birmingham

July 2002
SPECIALISTS IN PUBLIC HEALTH

Proceeding to
Part II FPHM Membership

Yvonne Cornish
Centre for Health Service Studies
University of Kent

Teri Knight
Health Service Management Centre
University of Birmingham

July 2002
Contents:

1. Acknowledgement

2. Executive Summary

3. Introduction
   3.1 Background to the study
   3.2 The policy context
   3.3 Changes to FPHM Membership by examination

4. Project Approach
   4.1 Purpose of the study
   4.2 Project scope
   4.3 Research questions
   4.4 Review of documentary evidence
   4.5 Method
       4.5.1 Interviews
       4.5.2 Specialists in Public Health
       4.5.3 Programme Directors

5. Overview of Specialist Training Programmes
   5.1 Development of Specialist Training Programmes
   5.2 Programme duration
   5.3 Proposed changes
   5.4 Entry criteria
   5.5 Training experience
   5.6 Monitoring Progress
   5.7 Further integration of Specialist and SpR Training

6. Part II Competencies
   6.1 Relevance of Part II competencies
   6.2 Competency gaps
       6.2.1 Health protection
       6.2.2 Other competency ‘gaps’ identified
   6.3 Competencies not examined by Part II

7. Examinations
   7.1 General comments on Part II examination
       7.1.1 Written submissions
       7.1.2 Oral examination
   7.2 Barriers and facilitators
       7.2.1 Subjects post Part I on training scheme
       7.2.2 Subjects post-Part I not on training scheme

8. Summary of Key Issues

9. References

10. Appendices
1. ACKNOWLEDGEMENT

We would like to thank all those who took part in this study, especially those Public Health Specialist Trainees, Programme Directors, Regional Office Public Health Development leads, and FPHM Part II examiners who agreed to be interviewed. Special thanks are also due to Jane Royle, from the Multidisciplinary Public Health Forum, Sally Dowling from the Association of Public Health Specialist Trainees and Gail Nicholson, from the Faculty of Public Health Medicine, without whose assistance this project would not have been possible.
2. **EXECUTIVE SUMMARY**

Background

This study was jointly commissioned by the Multidisciplinary Public Health Forum and the Honorary Members Committee of the Faculty of Public Health (FPHM) Medicine, to examine how existing Specialist Public Health Training Schemes are responding to changes within and beyond the FPHM, including the opening up of Part II of the Faculty’s membership by examination to all those who have successfully completed the Part I examination, or are otherwise deemed to be exempt.

Scope

The project covered the former English regions of the NHS Executive. Interviews with Public Health Specialist Trainees included those who had passed the FPHM’s Part I examination (therefore able to proceed to Part II) independently of any of the existing training schemes.

Aims

The study set out to address two main questions:

1. What plans are being made for those public health specialist trainees who are either about to take, or have taken, FPHM Part I examinations and who wish to progress to take the Part II examinations?

2. What might be the implications of their taking the Part II examination, for the breadth of competencies which might be assessed through this examination?

Method

The main method of data collection was through telephone interviews with

- Public Health Specialist Trainees
- Other public health specialists drawn from the ‘Independent Part I’ group (see above)
- Programme Directors (of the FPHM Regional Training Programmes)
- Regional Office Public Health leads
- FPHM Part II Examiners

Further information was gained from a review of documentary evidence.

**Summary of Main Findings**

- Specialist Training Schemes had been established in six regions at the time of our study: Eastern; London; North West; South West; Trent and the West Midlands. Schemes were being actively planned in the South East and the North East.

- There were 42 Specialist Trainees in total on existing programmes (source: Association of Public Health Specialist Trainees, November 2001.)
A total of 16 non-medical Public Health Specialist Trainees had been successful in the FPHM Part I examination up to (and including) June 2001. Six of these were on Specialist Public Health Training Schemes.

As Specialist Public Health Training Schemes are being developed, differences between schemes – in terms of programme duration, entry criteria, training opportunities and experiences, and monitoring of progress – are becoming less marked. Entry on to Specialist Training has become highly competitive, and schemes are becoming increasingly integrated with Specialist Registrar Training, especially in relation to the monitoring of trainees progress. Some discrepancies still remain, however, in access to training experience and locations.

The major change to existing training programmes in response to the opening up of the FPHM Part II examination has been the need to extend the duration of training. Whilst gaining agreement for this in principle has been relatively straightforward, securing the necessary funding has proved more challenging.

In terms of existing trainees’ ability to achieve the competencies currently examined in Part II, the main area of concern for Public Health Specialist Trainees and Programme Directors is health protection (communicable disease and environmental hazards). Whilst most of the existing programmes offer theoretical training in this area to all trainees, opportunities for non-clinical Public Health Specialist Trainees to gain ‘hand’s on’ experience through participation in ‘on call’ work is very limited.

There are some concerns that the competencies examined at Part II do not fully reflect the current public health agenda, or encompass the full range of knowledge and skills needed to address this. The current review of the Part II examination offers an opportunity to rethink these competencies in the light of both the wider public health agenda, and a more multidisciplinary professional base.

Consideration also needs to be given to the ways in which public health competencies, once agreed, are assessed. The current plethora of assessment processes, and the lack of congruence between them, needs to be addressed.

The wider public health agenda, together with the organisational changes following implementation of Shifting the Balance of Power in the NHS (Department of Health, 2001) offer an opportunity to broaden the range of training experience for all public health trainees. Training locations need to reflect the full range of public health organisations, including health promotion, local government and academic departments.

Further support is needed for those Public Health Specialist Trainees who have successfully taken the Part I examination independently of existing training schemes, to enable them to proceed with their training and preparation for Part II.
3. INTRODUCTION

This study has been commissioned by the National Co-ordinating Group (NCG) of the Multidisciplinary Public Health Forum (MDPHF) and the Honorary Members Committee of the Faculty of Public Health Medicine (FPHM) and funded by the Faculty.

We hope the findings from this study will be of interest to all those involved in the education and training of Public Health Specialists, within and beyond the Faculty of Public Health Medicine, but it is especially aimed at

- Members of the Tripartite Steering Group (RIPH, MDPHF and FPHM)
- The Royal Institute of Public Health (RIPH)
- The Faculty of Public Health Medicine (FPHM) Education Committee
- The Multidisciplinary Public Health Forum (MDPHF)
- The FPHM Honorary Members Committee
- The Association of Public Health Specialist Trainees (APHST)
- Faculty of Public Health Medicine Part II Examiners
- Programme Directors (of NHS Public Health Training Schemes)
- Faculty Advisers
- Public Health Specialist Trainees currently in training
- All Public Health Specialists intending to take the Part II Membership examination.

In preparing this report, we have tried to assume no previous knowledge of FPHM training structures and processes. We have therefore included a number of appendices containing further information which may be useful to those to for whom some of the issues discussed here may be unfamiliar.

3.1 Background to the study

Until the latter half of the 1990s, formal professional training in public health was almost exclusively confined to training in public health medicine. Plenty of other disciplines contributed to the practice of improving the health of the population, and the public health function within and beyond the NHS was delivered by individuals with a wide range of academic and professional qualifications. Nevertheless, whilst qualified medical practitioners wishing to practice public health could undertake higher specialist training - leading to Membership of the Faculty of Public Health Medicine and (usually) a career as a Consultant in Public Health Medicine, other groups had little formal status, no career pathways, and limited opportunities for further education and professional development. (Somervaille and Griffiths, 1995; Cornish, 1996; Cornish, 1998; Dunkley, 1998; Cornish 2000)

By the middle of the 1990s, however, there began to be considerable pressure for change. Public health practice, particularly in the NHS, became increasingly multidisciplinary - but training and career opportunities for most of these staff remained extremely limited. Furthermore, in spite of early expectations that the Faculty would consider the option of extending membership to non-medical colleagues practising, teaching or conducting research in public health, in practice no action (apart from the admittance of a small
number of Honorary Members) was taken on this front until 1994. (Crown, 1999). Around this time, the Faculty Board began to discuss the training needs of public health practitioners from backgrounds other than medicine, and commissioned a first survey to examine this issue (Somervaille and Griffiths, 1995.) However, when a proposal to extend membership by examination was put to a vote in 1995, this was rejected.

There was considerable concern about this situation, which was not only regarded as inequitable in terms of opportunities for public health professionals, but also unsatisfactory in terms of ensuring effective public health practice. As a result, the Multidisciplinary Public Health Forum (MDPHF) was established, to take forward the development of training opportunities, career structures, accreditation mechanisms and continuing professional development for a multidisciplinary public health workforce.

During the latter half of the 1990s, the MDPHF worked successfully with a number of organisations, including the Royal Institute of Public Health and the Faculty of Public Health Medicine, to bring about further changes and in 1998, the FPHM introduced a new category of Diplomate Membership, open to all professional groups, with a common examination. (Crown, 1999) These changes were welcomed by the Multidisciplinary Public Health Forum, which continued to actively campaign to ensure that the public’s health was being promoted and protected by a profession in which diversity was recognised, and all those with a public health role were appropriately trained for the purpose.

3.2 The policy context

The Government health strategy, *Saving Lives: Our Healthier Nation* (Department of Health, 1999) reinforced this message, with its commitment to “unlock the potential of the entire public health workforce” to deliver its ambitious health improvement agenda. Regional Offices of the NHS Executive responded by providing the funding necessary to develop public health capacity and capability, through mechanisms such as the Public Health Development Fund. This supported the establishment of a growing number of Specialist Training Schemes, usually incorporating and MSc or MPH programme. Following the Faculty decision in 1998, schemes established prior to this date, as well as the newly-established schemes, began to encourage their Public Health Specialist Trainees to regard the Part I FPHM examination as the ‘exit point’ to their training.

More recently, *Shifting the Balance of Power* (Department of Health, 2001) has further enhanced the opportunities for Public Health Specialists. Every Primary Care Trust is now expected to have a Director of Public Health, appointed at Board level, to lead their local health improvement agenda. Many of this ‘new generation’ of public health leaders will be drawn from the ranks of experienced Public Health Specialists. The issue of training, accreditation and professional development for public health specialists will therefore have an added impetus. The balance of power within public health is shifting.
3.3 Changes to the FPHM Membership Examinations

Following a ballot of its members, the FPHM finally opened up full Membership by Examination in June 2001. Any public health professional who has passed the UK Faculty's Diploma and Part I Membership Examination, or has been exempted from it (though reciprocal arrangements in relation to the Part I examination in Ireland), may now apply to take the Part II Examination. However, a number of existing Public Health Specialist Training Schemes, especially those established before this change took place, were not set up to enable this group of trainees to achieve fully trained status as Specialist Practitioners. For this reason, it was felt necessary to review existing training arrangements for this group. This report forms part of that review process.
4. PROJECT APPROACH

4.1 Purpose of the study

The purpose of this study was to explore how existing Public Health Specialist Training Programmes are responding to changes in which:

- Existing sources of funding (i.e. the Public Health Development Fund) are coming to an end.
- New structures and mechanisms are being established to link professional education and training to workforce planning (i.e. the bringing together of Deaneries and Workforce Development Confederations.)
- The FPHM has opened up its Part II membership examination to all those who pass the Part I examination, or are deemed exempt.

4.2 Project scope

Although the Faculty of Public Health Medicine includes the countries of Scotland, Wales and Northern Ireland, we limited our study to the English Regions of the NHIS. The rationale for this approach was not simply pragmatic. Our evidence confirms that Specialist Training in these countries is at an earlier stage of development than in England. Moreover, public health practice within each country is now developing within a slightly different policy context. Further work may be required in these areas, but we felt that this was beyond our current remit.

Within the English Regions, however, we did not confine our study to those people already on organised training programmes. As success at the Part I examination is one of the sole criteria for applying to enter Part II, we felt it would be important to include people who had taken and passed the Part I examination independently of a Public Health Specialist Training Scheme. This was seen as particularly important, as the needs of this group are more difficult to capture through existing arrangements. Whilst all those with Part I can become Diplomate Members of the FPHM, those not on formal training schemes are not currently linked in to any of the Faculty’s Training Groups, or to organisations such as the Association of Public Health Specialist Trainees (APHSTs).

4.3 Research questions

The study set out to address two main questions:

3. What plans are being made for those public health specialist trainees who are either about to take, or have taken, FPHM Part I examinations and who wish to progress to take the Part II examinations?

4. What might be the implications of their taking the Part II examination, for the breadth of competencies which might be assessed through this examination?
Following feedback from the Honorary Members Group of the FPHM and the Association of Specialist Public Health Trainees, we included in our study a number of people who had passed the Faculty’s Part I examination, but were not currently on a Public Health Specialist Training Scheme. (See method section, below) For the purpose of this study, we will refer to these as the ‘Independent Part I’ group.

4.4 Review of documentary evidence

4.4.1 ‘Grey literature’

At the time of our study, there appeared to be little up-to-date information to describe the existing Training Schemes for Public Health Specialists. A brief snapshot had been prepared in March 2000, by Dr Viv Spellar (Health Development Agency), for the South East Regional Office. This had identified training programmes in five of the eight English regions of the NHS. Only two of these schemes (in the North West and the West Midlands) had at that time been in existence for long enough to experience more than one cohort of students.

The South West, Trent and London set up their schemes in 1999-2000, and were followed by Eastern Region in 2001. A further summary of these schemes was subsequently produced for the Department of Health Executive, by Janet Baker (West Midlands Regional Office). Information from these two papers has been used to inform this project, together with notes from a meeting on training for public health specialists, held at the London School of Hygiene and Tropical Medicine on 23rd May, 2000.

4.4.2 Other sources of documentary evidence

In order to inform the questionnaire we drew on the above ‘grey literature’. We also examined the following documents:

- Regulations and procedures for the Part II Membership of the Faculty of Public Health Medicine Examination

- Faculty of Public Health Medicine Public Health Training Portfolio (April 2001)

4.5 Method

4.5.1 Interviews

The main method of data collection was through telephone interviews with:

- Public Health Specialist Trainees
- Other public health specialists drawn from the ‘Independent Part I’ group (see above)
- Programme Directors (of the FPHM Regional Training Programmes)
- Regional Office Public Health leads
- FPHM Part II Examiners
Interviews were conducted using a semi-structured interview schedule. One researcher conducted interviews with specialist trainees and the other, with programme directors. The process of identifying and selecting interviewees is given below. All interviews were conducted on a 'non-attributable' basis, and data from different sources has been combined to maintain confidentiality. The data generated were analysed and collated collaboratively.

Interview findings were triangulated where more than one source was available, to ensure that information given was as up-to-date as possible. However, in view of the rapidly-changing organisational environment for public health following implementation of *Shifting the Balance of Power* (DoH, 2001) and the changes taking place as Workforce Confederations and Deaneries begin to work together, we are aware that by the time we began to prepare this report some of the information we have may already be out-of-date.

4.5.2 Specialist in Public Health trainees and non-trainees with Part I

The study attempted to identify and contact all who had passed the Part I examinations between January 1999 and June 2001. (Results of the January 2002 examination had not been published when we began our study.) This amounted to 16 individuals, not all of whom were on a Public Health Specialist training scheme at the time of the interviews (February/March 2002). We also aimed to include a sample of those currently on training schemes who were pre-part I at the time of the study. These were selected to ensure we had representation of all regional training schemes, across the total sample. It did not prove possible to contact all of those selected; the final sample achieved is described in the table below and their background experience is summarised in table 2.

Table 1: The study sample

<table>
<thead>
<tr>
<th>Category</th>
<th>Training scheme</th>
<th>Region</th>
<th>Stage</th>
<th>Intending to take Part II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passed Part I</td>
<td>Yes=9 (one has Dipl.Epid.)</td>
<td>NW=3</td>
<td>2nd year=3</td>
<td>Yes=9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>London=2</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SW=2</td>
<td>3rd year=6</td>
<td>Yes=4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trent=2</td>
<td></td>
<td>Don’t know=1</td>
</tr>
<tr>
<td></td>
<td>No=5</td>
<td>NW=2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>London=1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SW=2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Passed Part I N=5</td>
<td>WM=3</td>
<td>1st year=3</td>
<td>Yes=5</td>
</tr>
<tr>
<td></td>
<td>Yes=5</td>
<td>Eastern=1</td>
<td>2nd year=2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trent=1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Part I</td>
<td>No=0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Summary:

Total interviewed: 19

Regions:
- North West = 5
- London = 3
- South West = 4
- West Midlands = 3
- Eastern = 1
- Trent = 3

Training scheme:
- Yes = 14
- No = 5

Post-Part I:
- 14 (2 out of 16 in total were not traceable)
  One of these had the Diploma in Epidemiology, not Part I

Pre-Part I:
- 5

Table 2: Background experience of interviewees (Public Health Specialist Trainees and Independent Part I group)

<table>
<thead>
<tr>
<th>Pre-part I on training schemes</th>
<th>Background experience and discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS – Primary care/Acute health</td>
<td>Epidemiology</td>
</tr>
<tr>
<td>care/Management/Nursing/Infection control</td>
<td>Information</td>
</tr>
<tr>
<td>Environmental science</td>
<td>Research</td>
</tr>
<tr>
<td>Local government</td>
<td>Dietetics</td>
</tr>
<tr>
<td></td>
<td>Allied Health Professionals</td>
</tr>
<tr>
<td></td>
<td>Overseas medical training</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-part I on training schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS management/health promotion/public health</td>
</tr>
<tr>
<td>Local government environmental health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-part I not on training schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Service management</td>
</tr>
<tr>
<td>Health promotion/public health</td>
</tr>
<tr>
<td>Local government environmental health</td>
</tr>
</tbody>
</table>

4.5.3 Programme directors and Regional Office Leads

All Programme Directors in the nine English Regions of the NHS were contacted and interviewed by telephone, together with four Regional Office leads, and two Part II examiners. Interviews took place during March and April, 2002. Additional information was collected from a review of relevant documentary evidence (see above).

The findings from the documentary review and the interviews are presented in the following sections.
5. OVERVIEW OF SPECIALIST TRAINING PROGRAMMES

5.1 Development of Specialist Training Programmes

As Table 3 shows, the West Midlands was one of the first NHS Regions to formalise public health training for graduates from disciplines other than medicine. In 1994, it established a Public Health Bursary scheme to fund trainees for a period of two years, during which they studied for their MPH on a part-time basis at the University of Birmingham, whilst also working in the Public Health Directorate at the Regional Health Authority. In 1998, this was replaced by the Trainee Public Health Scientist Scheme, which was a three-year programme. (There is currently one trainee still on this programme, who is likely to take the FPHM Part I examination.) The current Public Health Specialist Training Scheme was established in September 2000, following a successful pilot in 1999.

The North West region was also in the forefront of developing formal training programmes for what they then termed Public Health ‘Associates.’ Again, the scheme has changed since it was established, reflecting the opening up of first Part I and then Part II of FPHM membership. Whilst initial funding for this was on a ‘one-off’ basis, regular, recurrent funding has now been secured.

Table 3: Development of Specialist Training Programmes

<table>
<thead>
<tr>
<th>NHS Region</th>
<th>Year SPH Training Scheme Established</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Midlands</td>
<td>1994, 1998, 2000</td>
<td>This scheme has gone through 3 distinct phases of development</td>
</tr>
<tr>
<td>North West</td>
<td>1998 - 1999</td>
<td>This scheme has also been updated</td>
</tr>
<tr>
<td>South West</td>
<td>1999 - 2000</td>
<td></td>
</tr>
<tr>
<td>Trent</td>
<td>1999 - 2000</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>1999 – 2000</td>
<td>This has now become the London and KSS scheme (see below)</td>
</tr>
<tr>
<td>Eastern</td>
<td>2000 – 2001</td>
<td></td>
</tr>
<tr>
<td>South East</td>
<td>2001 – 2002</td>
<td>There are 3 ‘patches’ – KSS, Oxford and Wessex. Only Oxford currently has its own scheme (KSS is merged with London; Wessex is awaiting funding)</td>
</tr>
<tr>
<td>Northern and Yorkshire</td>
<td>2002</td>
<td>Scheme planned – funding being sought.</td>
</tr>
</tbody>
</table>

At the time of our study, the South East Region had agreed to set up three schemes, one in each of the three Deanery/Workforce Confederation ‘patches’. At the time of writing this report, trainees were being recruited to two of these (Oxford and the joint London/Kent Surrey and Sussex programmes – Wessex, whilst committed to this development in principle, remains unable to proceed until training funds are identified.) At the other end of the country, in the Northern and Yorkshire Deanery, the establishment of a Public
Health Specialist training scheme had also been agreed in principle, but a decision to take this forward was still subject to further negotiations around funding.

5.2 Programme duration

Almost all the Specialist Training Programmes set up prior to the opening up of the Part II Faculty Membership Examination were of either 2 or 3 years duration. The only exception to this was the London Programme, which was initially established as a 4 year programme in anticipation of the Faculty changes. (There was an expectation that four years would allow sufficient time for trainees to achieve the competencies required for Part II.

However, this scheme has subsequently been extended to five years, to ensure 'equivalence' with Specialist Registrar training requirements.) The earliest programmes (West Midlands and the North West) began with 2 year training programmes which combined experience of working in a public health department with part-time postgraduate study in public health. The anticipated 'exit point' for these early programmes was the MPH (West Midlands) or MSc (North West).

Following the decision to allow public health specialists from academic disciplines or health professions other than medicine to take the Part I examination, well-established programmes such as the West Midlands, which had been operating a 2 year scheme, extended this to 3 years. This would allow their trainees to sit the Part I FPHM examination after completion of the two-year part-time Masters programme. Other regions which were setting up Specialist training around this time, such as the South West and Eastern Programmes, however, established 3 year schemes from the outset – again, using successful completion of Part I FPHM membership as an 'exit criteria' in addition to the Masters programme.

5.3 Proposed changes

The major change to existing training programmes in response to the opening up of the FPHM Part II examination has been the need to extend the duration of training. Gaining agreement in principle for these extensions has generally been straightforward, with Training Committees, Deaneries and many of the Workforce Development Confederations reported as being very supportive. However, securing the necessary funding to implement the proposed changes has been rather more difficult. Some Programme Directors we spoke to were confident that funding would be forthcoming, others were more circumspect. Comments such as “this extension has been agreed professionally, but funding still has to be secured” were typical.

However, interviews with trainees suggest that there is some anxiety about the extension of their training. Whether this is because of the delays in confirmation of funding in some regions, or because of a failure of local communication is not entirely clear. Even where trainees had been told that the programme had been extended, none reported having this confirmed in writing. In some regions trainees were concerned that only limited funding was available and that this might not cover all trainees, let alone those who had passed Part 1, but who were not on training schemes.
The latter group appear not to be followed up in any way by the FPHM since passing Part I and only due to their personal efforts in remaining networked, had they kept up with developments.

Some Programme Directors recognised this, but most didn’t feel they had the capacity to meet the needs of this group. Others felt the solution was to encourage them to apply to join a the existing training scheme, part way in – and one region had specifically encouraged this in its recent recruitment round.

Other proposed changes included further integration between the Specialist and SpR Training Programmes (where these were not already fully integrated.) This often included formalising access to training opportunities previously either unavailable or only available informally, to Specialists.

5.4 Entry Criteria

Entry criteria for the Specialist Training Programmes have changed since these were first established. Whilst the earlier programmes all had graduate entry, they tended to recruit recent graduates, with relatively limited relevant work experience.

As new programmes were established, entry criteria became more stringent. As a result, a perception developed that there was considerable variation in entry criteria across programmes. This in turn led to some anxieties about quality control of programmes, and the potential suitability of some of the earlier trainees to progress to a senior level in public health practice.

On the basis of the evidence from our interviews, we feel that these perceptions are unfounded. Entry criteria for all programmes have become considerably more stringent, with most now requiring a good honours degree (passed at 2.1 or above) or a professional qualification, followed by either 4 or 5 years of relevant, post-graduate work experience. Furthermore, Programme Directors are reporting that recent advertisements are attracting considerable numbers of high calibre applicants. Public Health Specialist recruitment is now therefore highly competitive.

Indeed, many applicants far exceed the minimum requirements. A number of Programme Directors reported recruiting trainees with excellent professional and academic qualifications (sometimes this includes an MPH or the FPHM Diploma or Part I) and considerable public health experience. In such cases, there appears to be sufficient flexibility within some programmes to allow applicants with both an MPH and Part I to enter a shortened scheme, which will then allow them to progress to Part II training immediately. At least one programme (South West) actively recruited Specialist Trainees who already had Part I this year. Such arrangements are likely to be of particular interest to those already working in public health at a senior level, who may have studied independently for public health qualifications.

Furthermore, worries in some quarters about ability of some of the earlier, more junior, trainees to progress to Part II have also appear to be unsubstantiated. Only one region’s programme has experienced a high drop-out rate, and reasons for this include insecurity over the future of the programme. Across other programmes, almost all current trainees
have been, or are expected to become, able to progress to Part II. Such progress is, of course, subject to rigorous monitoring (usually using the same RITA process as is being used for the Specialist Registrars) and successful completion of the MPH (or MSc in Public Health) and the FPHM Part I examination.

5.5 Training opportunities and experience

The quality and range of training locations is an important factor in public health training, and training programmes are aware of the need to ensure that a full range of training locations are open to Public Health Specialists. Furthermore, opportunities for rotations between locations are being increased as programmes are being extended. However, there are some exceptions. One programme initially appointed each Specialist trainee to a particular health authority, so that "rotations were not part of the plan" when the scheme was initiated. However, the current Programme Director would like to be able to rotate trainees in the future. Others report that, whilst all locations are open "in theory" there have been some local reservations; as one Programme Director observed, "no rotations or training locations are closed to them, though the system hasn't been tested to its limits!"

Particular opposition appears to be occurring within some programmes around communicable disease placements - though other programmes have successfully overcome potential opposition. In the South West, for example, one Specialist Trainee is currently doing a part-time attachment to the Communicable Disease Surveillance Centre, and this is reported to be "working well". However, in another region, there has been strong opposition to specialists doing "on-call" rotations, even though one trainee is very keen gain experience in this area.

Academic placements also seem to be unavailable to Public Health Specialist trainees, and the reasons for this need further exploration. One factor appears to be the reluctance of University departments to employ non-clinical lecturers without a PhD - although this does not appear to be an issue for clinical lecturers. Indeed, some programmes have created either joint posts (usually Honorary Lectureships) to enable Specialist Registrars to gain teaching experience, or to undertake a research degree.

Overall, most of the trainees we interviewed felt that the breadth of training opportunities and experiences available to them were similar to those available to Specialist Registrars. However, experience of communicable disease control was a notable exception (this issue will be discussed further in relation to Part II competencies in the next section.) Some specialist trainees, however, also felt that the were being steered away from more clinical work, for instance around screening, in favour of the specialist registrars and this limited their training opportunities. Communicable disease control training showed regional variation. Some schemes, North West and South West, provide a three month communicable disease control placement for all trainees. In London, extra communicable disease control training with on-call is also offered to all trainees. Public Health Specialist trainees from Trent reported that the level of training around communicable disease control was not the same for them as for Specialist Registrar trainees. The difficulty of inter-regional transfer was also noted.
Table 4: Overview of Regional Training Schemes

<table>
<thead>
<tr>
<th>Region</th>
<th>Yrs #</th>
<th>FT/PT</th>
<th>Taught course</th>
<th>Other components</th>
<th>Assessment Framework</th>
<th>Supervision</th>
<th>Other comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Midland</td>
<td>3 (5)</td>
<td>FT</td>
<td>MPH</td>
<td>Tutorials weekly for Part 1 CPD events Other short courses if needed</td>
<td>RITA</td>
<td>Service trainer &amp; academic tutor</td>
<td>Scheme same as Specialist Registrar Trainees</td>
</tr>
<tr>
<td>Eastern</td>
<td>3</td>
<td>FT</td>
<td>MSc PH</td>
<td>Training days Trainees group</td>
<td>RITA</td>
<td>Service trainer</td>
<td>Scheme same as Specialist Registrar Trainees</td>
</tr>
<tr>
<td>London</td>
<td>4 (5)</td>
<td>FT</td>
<td>MSc PH</td>
<td>2 study days/wk Training days</td>
<td>RITA</td>
<td>Service trainer &amp; academic tutor</td>
<td>Scheme same as Specialist Registrar Trainees</td>
</tr>
<tr>
<td>South West</td>
<td>3 (5)</td>
<td>FT</td>
<td>MSc PH</td>
<td>Tutorials Study days Rotation</td>
<td>RITA or SpPH (have developed their own portfolio)</td>
<td>Service trainer &amp; academic tutor</td>
<td>Scheme same as Specialist Registrar Trainees</td>
</tr>
<tr>
<td>Trent</td>
<td>2 (4)</td>
<td>FT</td>
<td>MPH</td>
<td>Training days monthly Peer-led sessions 1.5 study days/wk</td>
<td>RITA or SpPH (have developed their own version?)</td>
<td>Service trainer</td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td>4</td>
<td>FT</td>
<td>MPH</td>
<td>Study days, tutorials, peer-led sessions,</td>
<td>RITA</td>
<td>Service trainer &amp; academic tutor</td>
<td>Scheme same as Specialist Registrar</td>
</tr>
</tbody>
</table>

# Length of scheme as reported by trainees. Revised length of scheme (in some cases this is still subject to confirmation of funding) is given alongside, in brackets.

NB. RITA = FPHM’s Record of Inservice Training Assessment

5.6 Monitoring Progress

All programmes monitor the progress of their Specialist Trainees rigorously. The most usual way of doing this is to include Specialists in the same annual RITA assessment process used for monitoring progress of Specialist Registrars. Programme Directors using this approach have found no particular problems arising for Specialist Trainees, with both groups using the same log book, and responding in a similar way. One Programme (Trent) which has until recently used a modified form of the RITA assessment process, in which sections dealing with communicable disease have been omitted, reported that it is “now moving towards the same RITA process.”

One Programme Director interviewed emphasised that “everyone is grappling with the new log book,” whilst another reported that there had been some feedback from Specialist Trainees “that they are being developed into ‘genetically-modified’ doctors!” The main difference between Specialists and SpRs in terms of the RITA process seems to be that the Deanery doesn’t need to see the results. At least one programme (London) now has a Specialist on the RITA panel.
Other means of ‘quality control’ of programmes include the FPHM Visit Programme. The inclusion of Specialist Visitors in the visit team has been successfully piloted in a number of regions, and this approach is now being ‘rolled out’ across all programmes.

5.7 Integration of Public Health Specialist and Specialist Registrar training programmes

A number of trainees interviewed commented on the level of integration of Specialist and Specialist Registrar training. Overall, trainees from the West Midlands, North West and South West, Eastern and London perceived the schemes to be completely integrated/equitable in terms of entry criteria, content and supervision of progress. In Trent this appears to be the aim, though there is still some way to go before this has been achieved. Interviews with Programme Directors confirm the principle of moving towards integrated programmes that are equitable in terms of entry criteria, programme length and content, access to breadth of training opportunities, and supervision of progress.
6. PART II COMPETENCIES

6.1 Relevance of Part II competencies

Interviews with Specialist Trainees and with Programme Directors raised questions about the overall relevance of the current competency framework examined in Part II. Questions fell into two groups – some respondents began by asking whether these competencies were relevant to the current public health agenda, others whether they were appropriate for a wider, more multidisciplinary professional base.

The starting point for some was clearly that we should begin by asking, “are these the right competencies” and then to ask what additional support those coming from other backgrounds might need in order to meet them. (This reflected a concern that the competencies should not be “reduced to a common denominator.”) Others were more critical, feeling that it was difficult for the Part II system to “move with the times” and that the current competencies may not be appropriate for a wider public health workforce. (This often reflected a concern that the competencies were currently biased in favour of public health medicine, rather than public health.)

This led into a discussion about whether a single set of competencies could ever be appropriate to a broader public health workforce. As one Programme Director put it, “the FPHM training is designed for the ‘general specialist’ within public health, but it has no way of assessing the ‘sub-specialist’ or ‘super-specialist.’ This is a very relevant point, which we feel requires further debate. The Multidisciplinary Public Health Forum has been discussing this very issue for some time.

There were also a number of other concerns around the relevance of the Part II competencies, but these tended to focus on the ‘fit’ (or more often, a perceived lack of ‘fit’) between the Part II competencies and other standards, such as the RITA framework and to the 10 key areas of public health practice. Finally, some respondents suggested we needed to ask how well the Part II examination actually measured the competencies identified.

There was a high level of awareness of the Part II competencies among trainees and other post-part I interviewees. Of the 14 subjects interviewed who were on training schemes, only two were unfamiliar with the Part II competencies (4 for written, and 6 for oral examination) at the time of the interview. Nine considered the competencies to be relevant to their public health work, four felt they were only partially relevant and two, not relevant. The lack of relevance mostly related to the issue of communicable and environmental disease control where it was felt that this was a specialist area of public health practice, which should only be a required competency if it was to be part of their job. In addition however, several subjects commented that the competencies felt very ‘theoretical’ and often unrelated to the realities of the job. Also, if Part II examination aimed to demonstrate competence in public health practice then competencies needed to be more practice based.

All five subjects who were not on training schemes were familiar with the Part II competencies and felt they were of partial relevance to their public health roles. Lack of relevance arose mainly to the changing nature of public health work which now extends
beyond the more 'traditional' health authority-based public health roles. Others questioned whether there might be more appropriate ways of assessing competence in the 'new public health world'.

6.2 Competency gaps

6.2.1 Health protection (Communicable disease and environmental health)

A number of Programme Directors and Regional Office leads interviewed felt this was the only area where they anticipated any problems for Specialists Trainees undertaking the Part II examination. The main concern was the one-third of the general oral devoted to communicable disease and environmental hazards. Those specialists with a nursing background were not felt to be at a disadvantage, as many of these had previous experience and training in infection control and were usually able to undertake 'on-call' duties without any problems. There was, however, a feeling that Specialists from a non-clinical background could, at least potentially, be disadvantaged by this part of the examination. This was a particular concern for trainees who had only theoretical training in communicable disease surveillance (i.e. in preparation for the Part I examination), and had no 'hands on' experience of being 'on-call' and actually handling an outbreak.

However, this was not only felt to be a problem for Specialist trainees. At least one Programme Director argued that academics public health colleagues were also regarded to be at a disadvantage in achieving competence in this area, and a number of Programme Directors and Regional Office leads interviewees questioned whether competence in communicable disease control should a requirement for all public health specialists (including those trained in medicine), or whether it should be a 'sub-specialty' for those with a particular interest in this area.

There were also mixed views on the impact of Getting Ahead of the Curve (DoH, 2002?) on this issue. At least one Programme Director thought this "might help" resolve the issues around communicable disease control, as such arrangements would in future need to be team-based, rather than subject to ad hoc arrangements. Other regions, however, anticipated that these arrangements would prove "unworkable" as Directors of Public Health in the new Primary Care Trusts would have to be able to take 'on-call' responsibilities, due to the limited public health capacity within these organisations. Existing Consultants in Communicable Disease Control in at least one region are currently very strongly opposed to Public Health Specialists taking part in the 'on-call' rota.

Overall, there appeared to be a majority view that the issue of communicable disease training – particularly in terms of gaining practical experience of being 'on-call' – for Public Health Specialists would benefit from national guidance, and there was a consensus that the Faculty of Public Health Medicine should be the body to develop this.

However, there were also examples in at least two regions where local arrangements to give Public Health Specialists the necessary training and experience were being piloted without any apparent problems. In these cases, the Programme Directors emphasised the importance of careful preparation – both in terms of the Public Health Specialist trainee and in and in setting up the necessary arrangements. There are clearly some opportunities
for sharing the lessons from these examples, which could be used to inform the development of national guidelines.

The views of trainees had much in common with the views of Programme Directors on this issue. When asked whether there were any areas of the Part II competencies which they felt they lacked, there was consistency of response among trainees and other post-part one interviewees. Of the 19 interviewed, 15 subjects identified communicable disease control and 10, environmental health. As these two competency areas together form one-third of the general oral examination at Part II, it is not surprising that Public Health Specialist trainees feel very concerned about this lack. Furthermore, many clearly feel unsure how they are expected to gain the experience needed to gain these competencies.

6.2.2 Other competency ‘gaps’ identified

Other areas where trainees perceived they had competency gaps included:

- screening
- evaluation (including economic)
- basic human biology
- data analysis
- and literature reviews.

However, none of these areas were identified as being potentially problematic by Programme Directors or Regional Office Public Health leads. It may, therefore, be that these particular concerns are reflecting trainees current levels of competence, rather than the levels they feel they will be expected to have achieved by the end of their training. Certainly, trainees skills in screening, data analysis and literature reviews would be likely to increase as training is extended, and trainees gain practical experience across different locations and a range of public health projects. Basic human biology, however, is not included anywhere in current public health training, as medical students cover this in their initial degree. Whilst none of the programme directors we interviewed suggested that Public Health Specialist Trainees needed any training in biology, several reported that induction arrangements for this group needed to take account that they may not be familiar with clinical settings.

There were, however, three further areas where some Programme Directors expressed particular concern regarding training experience. These are discussed below:

- **Training in local government**: The issue of training opportunities in local government was felt to be “particularly important for this group” reported one interviewee, “as I suspect this is likely to be an area many of them will wish to work in.” This led into discussion of the need for broadening the training opportunities of all public health trainees, as many Specialist Registrars would also welcome the opportunity to gain training experience outside of the NHS.

- **Training in health promotion**: One Programme Director was particularly concerned that opportunities for training in health promotion were being lost, as health promotion departments were becoming “unhitched from their public health departments.” Whilst this process had begun some time ago (many health promotion units moved from their local health authority to the community trust in the early days
of the ‘internal market’) the position did not being made any easier by *Shifting the Balance*.

- **Training in academic departments**: Whilst anecdotal evidence that an academic placement during training improves the success rate at Part II does not seem to be supported by recent evidence (Holland et al, 2002), Programme Directors reported that a number of their Specialist Trainees had expressed a wish to spend some of their training in an academic location. These options are normally available to Specialist Registrars, who often gain valuable teaching or research experience. On some training schemes, Specialist Registrars may also undertake a research degree, and have their training extended to include this. Such placements do not, however, appear to be open to Public Health Specialists. Reasons for this seem to be linked to the way in which those with clinical training can be given an Honorary Lectureship to enable them to teach and/or undertake research leading to an MPhil/PhD or MD, whilst for non-clinical academic staff, a PhD is seen as the ‘entry point’ for an academic post. One Programme Directors is exploring this further with the local academic department, but had not resolved the issue at the time of the interview.

### 6.3 Competencies not examined by Part II

We also asked whether specialist trainees possessed competencies relevant to public health practice, which were not included in the Part II competencies. Again, there was some consistency of response with the most frequently mentioned areas being: management (especially change management and strategy), leadership, communication, community development, partnership working, whole systems working, health promotion and advocacy, also mentioned were political awareness, health (as opposed to *healthcare*) needs assessment, qualitative research, education, international health.

When we then asked about competencies they felt they lacked, which were not included in the Part II competencies but which they thought should be, subjects identified many of the above, especially those relating to management an in addition, organisation development, project management and statistical analysis.

There were no differences in response on the above between those who were, or were not, on training schemes.

A general point which was made by a number of subjects that the list of topics areas given for the oral examination was just that, a list of areas of public health practice, rather than descriptions of ‘competencies’ *per se*. 

22
7. EXAMINATION

7.1 General comments on the Part II examination

The comments listed below are drawn from interviews with trainees. Some of the points raised are picked up in the discussion which follows from this.

- There are too many sets of competencies: RITA, Part II, Healthwork UK
- It’s not just the specialist trainees who feel like this – specialist registrars share our opinions in many cases
- Part II is rumoured to be a bit of a lottery – depends on who you get as examiner
- Part II needs to focus more on how to improve health
- Why bother with more exams to become a member of the FPHM – you can make a difference elsewhere and get more pay!
- The same elitist model is being applied – we need to widen access and not restrict it
- It’s unclear what we are being trained for – is Part II relevant to modern public health practice?
- Sometimes projects are done just for passing Part II and are not part of meaningful work within the organisation
- Part II is too prescriptive – should be more flexible to fit in with work – CDC reports for example, are not acceptable as Part II projects
- A portfolio approach would be a better way to assess competence in practice
- Overseas training places are not open to specialist trainees
- Regional variation in what is offered

Written/oral examinations

None of the Programme Directors anticipated problems regarding Specialist's competence in written submissions. Some even suggested that they were likely to do rather better in this regard than some of their medically-trained colleagues.

However, there was some feeling that this group may need additional preparation for the General Oral examination. One programme director had picked up that the people now proceeding to Part II were already panicking about this - but didn't really understand why. The view expressed was that everyone worried about the orals - but that Public Health Specialists might be particularly worried because they'd only recently been told they could proceed to Part II, so had only just begun the think about it. This particular Programme Director was responding to these concerns by planning a seminar specifically for the Specialists to identify their concerns, and to enable the training programme to respond appropriately. Another thought Specialists might need more preparation for the oral, because the viva "can be very intimidating." This rather implied that Public Health Specialists might be more likely to find the viva more of a problem than the Specialist Registrars.

Further discussion in interviews where Programme Directors raised the Viva process as an issue led to a tentative conclusion that those with medical training might be more used to the viva process, as they experience it throughout their training. Public Health Specialists, however, who are often from backgrounds in the human or social sciences, are more used to writing extended essays, dissertations and research reports as part of their degrees.
Many graduates from such disciplines may never have experienced a viva. Those who have, will usually only have done so if their degree classification was borderline (e.g. between a 2:1 and 2:2) or a potential First, or if they have a PhD.

However, a few of those interviewed (both Programme Directors and Regional Office leads) were concerned that the Viva might be biased – probably unintentionally they felt towards the doctors. Further discussion of “hidden bias” raised questions around how much medical knowledge, or knowledge of things such as prescribing (especially for communicable diseases) or direct patient care (for service evaluations) was assumed by examiners. This was very much linked to other issues raised in the interviews with Programme Directors, particularly a perceived lack of clarity over what is actually being tested in the General Oral.

Interviews with Trainees, and those with Part I but not on a training programme, also asked about barriers and facilitators to the Part II examination. Their answers are summarised below:

**Barriers and facilitators to taking Part II examination:** We asked subjects about the intention to take the Part II examination and explored with them, possible barriers to this and factors which might facilitate them doing so. These are listed below.

**Subjects post-Part I on training schemes:**

Of the nine subjects interviewed, all were intending to go on and take the Part II examination.

**Barriers**
- Assumption of medical knowledge in oral examination
- Finding appropriate projects within the required timescale
- Lack of clarity around what examiners want
- Organisational turbulence (in place of work)
- Lack of support of specialist trainees compared with specialist registrar trainees
- Variability in Part II examiners
- Lack of clarity about what is/is not suitable project material

**Facilitators**
- Having a good trainer
- Access to some-one nominated to support people with Part II
- Peer support group
- More local study days
- Access to Part II examiners
- More guidance from FPHM – have a study day for all trainees and a ‘Beginner’s Guide’
- More co-ordination in finding projects
- Greater fit between what is acceptable for a project and service work
- More support in preparing for the oral examination
- Tutorial support for Part II projects
Subjects post-Part I not on training schemes:

Of the five subjects interviewed, only one was not intending to go on and take the Part II examination.

Barriers:

- Workload – fitting it in with a demanding job
- Lack of clarity around public health in Primary Care Trusts
- Lack of information on what it would involve
- Lack of fit between Part II requirements and job, especially in relation to projects
- Organisational turbulence
- Isolation (this person said that the interview had been their first contact since passing Part I)

Facilitators:

- Having a trainer
- FPHM study/information day on Part II
- Follow-up of those who have passed Part I by FPHM
- Part II support group and study days
- Time off work to do it

Pre-Part I on training schemes:

Of the five subjects interviewed, all were intending to go on to take the Part II examination.

Barriers:

- Funding may not materialise
- Amount of work involved
- Still very medically dominated
- Resistance to evolution of Part II examination to make it more relevant to multidisciplinary public health

Facilitators:

- Peer support
- Having access to projects which passed
- Supportive employer
- Support on the training scheme
- More information on Part II at the start of the training scheme
- Mentoring scheme

It should be noted that by inclusion in the lists above, it is not implied that the factors relate to all regions.
SUMMARY OF KEY ISSUES

Below is a summary of some of the key issues raised in relation to the existing Part II competencies examined by the Faculty of Public Health Medicine:

- **What competencies are needed to deliver the current public health agenda?**

This is clearly a key issue. There are concerns that the current competencies do not necessarily fully reflect either the current public health agenda, or encompass the full range of competencies required to address it.

We are aware that the FPHM has commissioned a review of its examination process, which has highlighted the Part II competencies as a major issue. There is a working party looking at the Part II examination. This project will feed into and help to inform this review process.

- **Is the assessment process appropriate to measure these competencies?**

Consideration needs to be given to the ways in which public health competencies, once they are agreed, are being assessed. Our respondents frequently commented on the plethora of assessment processes, and the lack of congruence between them, as well as the potential medical bias within the oral examination.

The current review is a offers an opportunity to re-think the Part II examination, to ensure that it is an appropriate, as well as a robust, form of assessment.

- **Is the range of training opportunities appropriate, comprehensive and equitable?**

The wider public health agenda, together with organisational changes following *Shifting the Balance* offer an opportunity to rethink the range of training experience open to public health trainees. Training placements should reflect the full range of public health organisations, and include health promotion departments, local government and academic placements. The issue of training in communicable disease also needs to be resolved.

- **Are all candidates given adequate support in preparing for the examination?**

Whilst Programme Directors are in general taking the needs of Public Health Specialist Trainees on their training schemes very seriously, and working to ensure equitable training opportunities for Public Health Specialist Trainees and Specialist Registrars, those who have taken and passed Part I independently of such schemes feel they do not have adequate support. Whilst most of the Programme Directors interviewed expressed some concern about this group, few felt they had the capacity to address their training needs. Those that did, were either encouraging people with Part I to apply to their (sometimes shortened) training scheme, or were opening Part II seminars to them. None reported access to more formal support, such as a designated trainer and/or academic supervisor.
References


Cornish Y (1996) *Professional Development in Public Health for Public Health Practitioners from Non-medical Disciplines – towards a strategic framework for South Thames.* (South East Institute of Public Health: Tunbridge Wells)

Cornish Y (1998) *Professional Development in Public Health: developing a strategic framework for the West Midlands.* (South East Institute of Public Health: Tunbridge Wells)

Cornish Y (2000) *Developing the Public Health Workforce – a study of the public health and health promotion workforce in the South East Region of the NHS* (Centre for Health Services Studies: Tunbridge Wells)


Department of Health (2001) *Shifting the Balance of Power within the NHS* (Department of Health Publications: London)
APPENDIX A

PUBLIC HEALTH COMPETENCIES

The Part II Examination

1. The written submission - 2000 Guidance

From January 2002, candidates for the Part II examination will be required to address the following competencies in their written submissions:

- To assemble, review critically and interpret the published literature (and, where appropriate other sources) on a particular topic;
- To use epidemiological and/or other approaches to describe the health status or health care needs of a defined population and, where appropriate, to identify environmental or personal factors which either threaten or enhance health
- To identify and obtain relevant information and show how it can be used to plan health services or other activities aimed at improving health
- To assess the effectiveness and efficiency (resource requirements) of health services or other activities aimed at improving health.

2. Competencies required in the General Oral Examination

At the General Oral examination, each candidate will be expected to demonstrate competency in the practice of public health in the following areas, all of which will be covered:

- The promotion of health and the prevention of disease
- The investigation and control of communicable disease
- Environmental health and the investigation and control of environmental diseases
- Using health information and evaluating activities aimed at influencing health
- Screening programmes
- The provision of health care

Source: FPHM
APPENDIX B

The Faculty of Public Health Medicine's 10 Key Areas

The Faculty of Public Health Medicine has agreed the following ten key areas for public health practice which form the basis for developing standards:

- Surveillance and assessment of the health of the population's health and wellbeing (including managing, analysing and interpreting information, knowledge and statistics)

- Protecting and promoting health and well-being, including communicable disease control and environmental health

- Developing quality and risk management within an evaluative culture

- Collaborative working for health

- Developing health programmes and services and reducing inequalities in health

- Policy and strategy development and implementation

- Working with and for communities

- Strategic leadership for health across all sectors

- Research and development

- Ethically managing self, people, and resources (including education and continuing professional development)

Source: FPHM
APPENDIX C

Source: FPHM (Ballot to change Standing Orders, 3rd May 2001)

TRAINING PATHS IN PUBLIC HEALTH

CURRENT ROUTE FOR DOCTORS

Year 1
Medical training & experience
Registered with GMC

Entry to PH training

Training programme

RITA

DIPLOMA

Part I

PROFESSIONAL DEVELOPMENT

PROJECTS

Part II

MPhD awarded

Year 5

CST
GMC Specialist Register

New Specialist in Public Health Register

Senior post with
- Job description asking for relevant experience
- Appraisal using Faculty specialist standards (currently in development)

Import to revalidation & staying on GMC Specialist Register

PROPOSED ROUTE FOR SPECIALISTS

Year 1

Appropriate level of experience & degree

RITA

DIPLOMA