Improving the health of the public by 2040: next steps

Report of an implementation workshop of the Academy of Medical Sciences report
5 January 2017

The Academy of Medical Sciences

The Academy of Medical Sciences
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Opinions expressed in this report do not necessarily represent the views of all participants at the event, the Academy of Medical Sciences, or its Fellows.

All web references were accessed in January 2017.

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Executive summary

On 5 January 2017, the Academy of Medical Sciences held a workshop exploring how to implement the recommendations made in its working group report on 'Improving the health of the public by 2040'. Discussion covered four themes.

Research funding

Attendees were in favour of establishing the UK Strategic Coordinating Body for Health of the Public Research (SCHOPR), as recommended by the Academy. Participants at the workshop argued that, in the first instance, SCHOPR should be situated as a sub-group or under the stewardship of the Office for Strategic Coordination of Health Research (OSCHR). They further agreed that this should take place in the next 12 months. The Academy and the Chair of the project will explore this option further. More specific suggestions regarding the constituency and location of SCHOPR are outlined on pages 5 to 6.

Linking research and delivery

Consensus among attendees was that the 'regional hubs of engagement' recommended by the Academy, as a way of integrating health of the public research with health and social care delivery, should build on existing networks. They agreed that the hubs should include a wide range of sectors, far beyond biomedicine, and that they should be coordinated by a national overarching body while individual hubs maintain freedom to innovate. Although some felt that these hubs could be virtual rather than geographical, it was widely agreed that the first step would be to organise a pilot year. Attendees posited that leadership for these hubs could come from Public Health England, its equivalents in the devolved nations, and the Faculty of Public Health. The Academy and Chair will follow up on these discussions. Further details on participants' views on the constituency and funding of these hubs can be seen on pages 8 to 10.

Undergraduate training

In discussing the Academy's recommendation that relevant stakeholders review undergraduate curricula to develop training in health of the public research, participants stressed the need for wider cultural change to improve the perception of public health. This will be necessary to ensure more clinicians – as well as those outside medicine – are equipped

with the necessary skills and ambition to incorporate a health of the public approach into their work. To change the culture, attendees suggested embedding public health approaches in all clinical specialties during undergraduate training, but acknowledged that this will be dependent on support for educators to change how they approach teaching. Delegates supported the proposal by Medical Schools Council to host a conference within the next six months to facilitate this, and highlight examples of good practice. More on undergraduate training can be found on pages 12 to 14.

Research training

Delegates also explored the Academy's recommendation regarding the development of a credential in health of the public research. Consensus among participants was that accredited training – rather than a credential for clinicians - would be a useful means to bring together and train the wide community of people with interest or expertise in health of the public research. They proposed the development of a future-proofed framework for skills generation, emphasising the need for in-built flexibility. There was agreement among attendees that the Faculty of Public Health, the Health Foundation and other education experts could develop such a framework. It was also agreed that more should be done to help the wider workforce gain awareness of the opportunities available in health of the public research such as National Institute for Health Research (NIHR) fellowship pathways. Pages 16 to 18 outline further discussion on research training.

Introduction

Over the coming decades, the UK population will face a wide range of complex health challenges and opportunities, many of which can only be fully addressed through strategies to secure and improve the health of the public as a whole.

The Academy's report, 'Improving the health of the public by 2040', published in September 2016, makes recommendations as to how the UK's research environment should be arranged to generate and translate the evidence needed to underpin such strategies.[1]

To help ensure these recommendations are taken forward, the Academy hosted a workshop that brought together a diverse mix of stakeholders spanning academia, public health practice, clinical practice, policy, and research funding.

In groups, participants discussed four of the report's recommendations. This meeting report provides a summary of the discussion across these groups. A full list of participants can be seen in Annex 1, an agenda for the event in Annex 2, and the questions posed to attendees in Annex 3.

Research funding

Two groups discussed how to establish the UK Strategic Coordinating Body for Health of the Public Research (SCHOPR) recommended by the Academy.

Recommendation discussed

'We recommend the establishment of the UK Strategic Coordinating Body for Health of the Public Research (SCHOPR) to help meet our aspiration of substantially, continually and sustainably improving health and health equity by identifying research needs and coordinating research activities.'

[Recommendation 1]

Constituency of SCHOPR

There was wide agreement among participants that SCHOPR should be established to ensure a coherent system for health of the public research. The inherent tension in how to constitute the body was discussed. To gather and share information across a wide range of areas affecting health of the public it will need to draw on people from many disciplines and sectors, but to make impactful decisions it will need to be small.

Participants called for SCHOPR to learn from existing bodies such as the UK Clinical Research Collaboration (UKCRC) and the Office for Strategic Co-ordination of Health Research (OSCHR).[23] Delegates thought that OSCHR's success lies in its membership of key players being able to make collective decisions, while UKCRC's success came from its ability to identify and address the broad gaps - from infrastructure gaps to career gaps - for clinical research. Another example given was the Antimicrobial Resistance Funders' Forum, which was thought to operate as an effective network that brings together a range of government departments.[4] Its success was thought to reflect the urgency of the cause: a common purpose leading to the development of a common strategy.

Before deciding what SCHOPR should look like, delegates highlighted the importance of knowing exactly what it will do and who it will aim to influence. SCHOPR must be able to clearly articulate its purpose and demonstrate the value of collaboration to its proposed membership.

It was suggested that SCHOPR could look to the system used by Millennium Development Goals (MDGs) and explored the following four-step model:[5]

- Step 1: Envisage what we want to change – what will need to be different in 20 years.
- Step 2: Set realistic goals with milestones – how much we want to achieve by when.
- Step 3: Identify research questions as well as the methods and workforce needed to answer them.
- Step 4. Establish who is going to fund what.

The group noted that in SCHOPR's case these steps would need to be undertaken by different groups, with the first steps identifying problems and priorities conducted by a larger group involving experts across disciplines as well as policymakers, capacity-builders, and practitioners (especially at the local level). The ultimate funding decisions could then be taken by a smaller group. Some delegates suggested that such a process could address the aforementioned tension in how one sets up SCHOPR. Some noted that this two-group approach may also be articulated as being comprised of a core decision-making group and time-limited engagement with the wider community for more defined challenges.

Delegates highlighted that, upon its establishment, SCOPHR must explore the most effective way of allocating funds and how to use funding as levers in imaginative ways. It needs to be able to catalyse disruptive outputs, supporting a high-risk strategy and funding research that may not work. It was noted that for SCHOPR to support transdisciplinary and intersectoral research the wider environment must facilitate this type of working. SCHOPR will need to work with and stimulate UK Research and Innovation (UKRI) to think about this.[6] For efficiency and coordination, delegates emphasised that SCHOPR should link with similar initiatives currently underway, such as the UK Prevention Research Partnership (which represents the next phase of the National Prevention Research Initiative).[7]

Location of SCHOPR

Both groups identified OSCHR as an appropriate place to situate SCHOPR. It would allow for the immediate, UK-wide establishment of SCHOPR, drawing on existing leadership and providing a line into Treasury through OSCHR. As a possible sub-group of (or under the stewardship of) OSCHR, SCHOPR will be free to have a broad membership that extends beyond the biomedical community. Delegates agreed that SCHOPR could subsequently be made independent of OSCHR or passed onto another suitable body, such as UKRI, as appropriate. The importance of having a strong Chair to lead SCHOPR was highlighted.

Timeline and next steps

If SCHOPR is to be set up within OSCHR, delegates suggested that this should be done within the next 12 months, ensuring time for it to conduct gap analysis and identify strategic priorities ahead of the next comprehensive spending review. SCOPHR will need to make strong economic arguments if it were to make a bid for funding in the spending review. Participants heard that Public Health England (PHE) and the Department of Health are currently undertaking modelling work to obtain such economic data.

Delegates stressed the importance of evaluating the impact of SCHOPR several years after it has been set up. To determine what the body has achieved there needs to be a clear definition of what SCHOPR's success will look like at the outset.

References

1. Academy of Medical Sciences (2016). *Improving the health of the public by 2040*. http://www.acmedsci.ac.uk/download.php?f=file&i=37428

2 House of Lords Science and Technology Committee (2009). Setting priorities for publicly funded research – Memorandum by the Office for Strategic Coordination of Health Research (OSCHR).
http://www.publications.parliament.uk/pa/ld200910/ldselect/ldsctech/104/10011203.htm

3. House of Lords Science and Technology Committee (2009). *Setting priorities for publicly funded research – Memorandum by the Office for Strategic Coordination of Health Research (OSCHR).*
http://www.publications.parliament.uk/pa/ld200910/ldselect/ldsctech/104/10011203.htm

4. http://www.mrc.ac.uk/research/initiatives/antimicrobial-resistance/antimicrobial-resistance-funders-forum/

5. http://www.un.org/millenniumgoals/

6. Department for Business, Innovation and Skills (2016). *Case for the creation of UK Research and Innovation.*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/527803/bis-16-291-ukri-case-for-creation.pdf

7. http://www.mrc.ac.uk/research/initiatives/national-prevention-research-initiative-npri/

Linking research and delivery

Two groups considered the 'regional hubs of engagement' the Academy recommended as a mechanism to integrate health of the public research with health and social care delivery.

Recommendation discussed

'We recommend that Public Health England, Health Education England and their equivalents in Scotland, Wales and Northern Ireland work with the research community to develop **regional hubs of engagement** between practitioners and researchers to integrate health of the public research and health and social care delivery, building on existing national and regional public health structures, which together can form a UK-wide network.'

[Recommendation 6]

Constituency of the hubs

The aim of the regional hubs of engagement is to bring together academics and practitioners. Participants felt it important to define exactly what is meant by 'practitioner'. Traditionally, the term refers to those working directly in the health sector. It is increasingly clear, however, that most of the drivers of population health and the interventions that shape it lie outside of the health sector, with the actors influencing health including, for example, supermarkets and urban planners. Delegates agreed that the hubs need to include a broad range of sectors and that the involvement of local government is crucial as they have a wide reach from universities to the NHS to the third sector. Engaging with local government will be a big challenge, but is especially important given they are in charge of many of the initiatives that the regional hubs should explore.

A few delegates argued that some existing geographical hubs have not been as successful at

linking academia and practice as hoped, and that we ought to explore new topic and outcome based, inter-sectoral, and collaborative approaches; similar to the work of the London School of Hygiene and Tropical Medicine in agriculture. Whilst close proximity between practitioners and academics was thought to facilitate easier collaboration, others argued that geographical and sector-based hubs are not mutually exclusive. Virtual hubs (which at the same time reflect local needs) may also be beneficial, and would widen access to those who are far from research institutions. It was thought that rigid structures will not work and the hubs need freedom to innovate. For instance, rather than having the same sector take the lead in each hub, it would be preferable to have the most appropriate sector – whether academia, local government, the NHS or the third sector – lead in different places. This would be important for preventing duplication of work, determining best practice, and ensuring sustainability of funding. So that knowledge is mobilised for the benefit of the entire UK population, delegates thought that there needs to be a UK-wide body overseeing these hubs.

Consensus among participants was that, rather than starting from scratch, it would be preferable to build on and draw together existing networks. PHE, who have expressed interest in supporting the creation of these hubs, already have nine centres.[8] Other examples of existing centres include the following:

- The Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement (DECIPher, in Wales).[9]
- Centre for Excellence in Public Health (Northern Ireland).[10]
- Fuse Centre for Translational Research in Public Health (a network of universities in North-East England).[11]
- School for Public Health Research.[12]
- Collaborations for Leadership in Applied Health Research and Care (CLAHRCs).[13]

Funding

Some participants suggested that existing hubs could initially provide their own funding, but that they will need sustainable income further down the line. Funding will be required for academic posts, as well as to promote communication, which delegates noted is an essential requirement of network-forming. One participant thought that 10% of the budget for Biomedical Research Centres (BRCs) would be sufficient to fund these hubs.

Challenges

Evidence

Participants noted that there could be a conflict between the evidence needs of funding bodies and local authorities. Researchers and funders generally want to provide the best evidence, but this is not always possible under the budget and timeframe of local and national government. Resolving the issue requires a culture change and consensus on what evidence would be useful to practitioners and policy makers and exploration of innovative means of obtaining such evidence.

Delegates expressed a strong desire for the hubs to facilitate the evaluation of interventions. They noted that this is not routinely taking place for a variety of reasons, including a lack of funding and a culture in which evidence from evaluation is considered inferior to other forms of evidence.

Data collection

Participants highlighted the need to ensure that various sectors are able to provide researchers with good data. Academics need to advise local authorities on the best data to collect (such as impact of housing upgrade on health) and how these data can be obtained. This could be facilitated by the hubs.

Communication

Researchers need to be aware of the importance of how they frame and communicate their research to policymakers and others outside the health arena. Participants suggested that we need to make it easy for staff and trainees to transfer between local authority offices and universities, as well as enhance opportunities for joint working to help promote mutual understanding and breakdown cultural barriers.

Image

Participants highlighted that promotion of the field of public health research and service is essential to improve funding and recruitment for these hubs. It will also be important to use effective marketing to get a high calibre of people working in public health and make it a feasible career for high preforming medical students (see also the following sections on undergraduate and research training).

Incentivising stakeholders

Delegates discussed how to convince stakeholders to get involved in initiatives such as these hubs and noted the importance of demonstrating economic benefits such as the cost-benefit of good data collection.

One attendee remarked that it is difficult to incentivise government departments to implement preventative health interventions when the benefit will be felt elsewhere. We need to explore new approaches in this area, such as the concept of 'diagonal accounting'. Delegates also discussed the Research Excellence Framework and that one can make a strong local case study for impact, with positive financial consequences for universities.

Timeline and next steps

Some argued that the first year in the development of these hubs should be treated as a pilot year, where innovation is encouraged by allowing networks and centres freedom to explore what works best, gain experience and establish best-practice. Also in the first year, there will be a need to identify a sustainable source of funding with clear goals. Delegates noted that the initiative would benefit from a major donor. Participants suggested establishing measurable goals, noting that the setting up of hubs in itself would be a great success.

An important next step will be to map existing networks, and identify geographical areas in which they do not yet exist. Some participants pointed out that it may be useful to identify and possibly rank the 'most potent actors' (such as supermarkets).

References

8. https://www.gov.uk/guidance/contacts-phe-regions-and-local-centres

9. http://decipher.uk.net/

10. https://www.qub.ac.uk/research-centres/CentreofExcellenceforPublicHealthNorthernIreland/

11. http://www.fuse.ac.uk/

12. http://sphr.nihr.ac.uk/

13. http://www.nihr.ac.uk/about-us/how-we-are-managed/our-structure/infrastructure/collaborations-for-leadership-in-applied-health-research-and-care.htm

Undergraduate training

One group discussed the Academy's recommendation that relevant stakeholders review undergraduate curricula to develop training in health of the public research.

Recommendation discussed

'We recommend that the Medical Schools Council, in collaboration with the General Medical Council and other relevant stakeholders, should undertake a review of competencies within the existing undergraduate medical curricula to identify opportunities to embed, strengthen and develop health of the public training and its broader application in clinical practice.'

[Recommendation 5.1]

Revitalising undergraduate training

Changing the culture

Delegates raised concern that the focus of this recommendation as phrased is too narrow and may not lead to the hoped for transformation. They argued that identifying and reviewing measurable competencies that undergraduates should develop is not a priority. Instead, encouraging a wider cultural change to improve the perception of public health is needed to ensure more clinicians are equipped with the necessary skills and desire to incorporate it into their work. Such a cultural shift would require engagement with students and educators.

Participants explored the aspects of the undergraduate curriculum that need to be changed to strengthen and develop health of the public training and its application. They noted that most students enter medical training with a desire to treat and cure sick people. Public health, which emphasises prevention and 'wellness', is therefore not seen as interesting or relevant to their ambitions. It was also noted that locating medical schools in or near tertiary healthcare centres strengthens the perception that treating the already ill – as opposed to preventing illness – is the most important aspect of medicine.

In this context, it was thought that embedding public health training within all clinical specialties during undergraduate training would be a particularly beneficial way of fostering culture change, helping move past the current siloed approach to teaching and leading to a cohort of clinicians with an appreciation of preventative medicine regardless of their speciality. Some delegates raised concern that creating discrete public health modules within undergraduate (or postgraduate) training would act to reinforce the inaccurate perception that public health is a speciality, and is therefore not a relevant consideration for most clinicians.

Participants felt that it would be particularly beneficial to provide a way of highlighting examples of good practice, where public health training has been well integrated and aligned with clinical training.

Retraining the trainers

Participants expressed a desire to see training in public health focus on developing ways of thinking and 'shaping visions' as opposed to simply providing facts to learn. However, as those teaching undergraduates are also largely siloed in their particular specialty, it was noted that this integration might be difficult to achieve as many educators may not consider it a priority or assume responsibility for teaching it. Educators will therefore also need support to change how they approach teaching.

Fostering social responsibility

Participants noted that it might be beneficial for medical schools to better encourage, recognise and reward students who demonstrate social engagement and responsibility during their training. They also suggested that improving the perception of, and interest in, public health should not be limited only to undergraduate medical teaching. Other disciplines should also be encouraged to consider its importance: responsibility for maintaining and improving the health of the public extends far beyond clinical practice. The Academy’s recommendation that higher education institutions incorporate opportunities for learning about health of the public in a wide range of disciplines relevant to health should be pursued.

Timeline and next steps

Delegates felt strongly that highlighting good practice is an important activity. It was suggested that there should be a conference to share examples of good practice and help implement these changes. Such a conference should be attended by disciplines beyond medicine, recognising that encouraging better training in public health, and its ultimate application, requires those from a wide range of disciplines. They noted that it might be beneficial for the conference to be cross-European in nature, and European Institute of Innovation & Technology (EIT) Health could be approached to help support and fund it.[14] The Medical Schools Council agreed to help organise such a conference within the next six months.

Participants pointed out that Higher Education Funding Council for England (HEFCE) wishes to develop 'sustainability' as a key theme within teaching. As public health could be considered to fall under this remit, it might be helpful to contact HEFCE and learn more about their activities in this area.

Creating a culture change, and increasing interest in public health, is difficult to measure and evaluate (unlike other less abstract competencies). However, informing the GMC of the ambition to improve the perception of public health within teaching will be helpful, especially in the context of the Medical Licensing Assessment development.

'The group also suggested the Academy supports the recommendation made by MSC and Health Education England (HEE) in their report 'By choice – not by chance', produced by Professor Val Wass OBE, for medical schools to revise their curricula so that they reflect the patient journey through different health care settings.'

References

14. https://eithealth.eu/

Research training

One group explored the Academy's recommendation regarding the development of a credential in health of the public research.

Recommendation discussed

'We recommend that the Medical Royal Colleges, led by the Royal College of Physicians and the Faculty of Public Health, should establish a special interest group to develop a credential in health of the public research. This credential should encompass qualitative and quantitative research methods including health informatics and bioinformatics, clinical epidemiology and prevention, health economics, qualitative methodology, behaviour change, intervention methodology including the development and evaluation of complex interventions, and the wider determinants of health. Opportunities for credentialing should be provided for all trainees and not just those who wish to pursue a career in public health.'

[Recommendation 5.4]

The value of accredited training

Participants noted that credentialing, as recommended by the Academy, would be helpful but only for a narrow subset of doctors. They agreed that the structure of accredited training (such as a course, programme or module) is useful, as it will allow the whole community of public health specialists and those interested in the health of the public more generally to be brought together and trained. As well as opening up health of the public research to a wider cadre of people, delegates noted that a diploma, certificate or credential will help foster a broader appreciation of population research methodologies, which are often given less regard than traditional lab-based research or randomised controlled trials.

There was strong support for creating and future-proofing a framework for skills generation that can be used in a range of settings, which can then form part of a credential in the future. There was also consensus around the need to build flexibility into the training. Participants highlighted

the need to think about how to support clinicians who work part-time, often for family reasons, as they find it difficult to split that time among research, training, and service; with service delivery usually taking priority. The modular model – of a certificate leading to a diploma leading to a Masters – might be a good way of achieving this flexibility as it will allow people to move in and out of training, and it would allow it to reach out to the wider workforce. Striking the right balance of e-learning and face-to-face training will also help facilitate the necessary flexibility.

Challenges

Delegates noted that it will require significant investment and time to develop accredited training in health of the public research, with 'champions' to drive forward the agenda. They also highlighted the need to clarify what is meant by 'health of the public research', which is a broad term. One participant suggested developing worked examples within specific universities.

Questions were raised about the demand for this training. One delegate noted that there are many clinicians who wish, but are unable, to be dual-trained in public health research. Accredited training or credentialing may help address this but a broader concern amongst clinicians about employment prospects when pursuing this route will need to be addressed. Participants highlighted the difficulties in getting joint funding for posts between academia and public health service or joint university and local authority appointments, particularly in view of large cuts to local authority budgets.

Delegates also highlighted the need to raise awareness among public health professionals and the wider relevant workforce of the existing opportunities available in health of the public research. In England this includes NIHR fellowships for non-medical public health trainees. They heard that NIHR is considering ring-fencing fellowships in areas of national priority, such as obesity, which could be held by people from a range of backgrounds, as well as in areas where workforce and capacity do not match the needs of the health sector. It was highlighted, however, that there is no access to NIHR funding outside England. More generally, there are differences in research training and how it is approached across the four nations which will need to be factored in when developing the proposed accredited training.

It was noted within the competency framework for the Faculty of Public Health (FPH), there are additional 'elective' competencies that public health professionals can undertake, over and above the competencies needed for accreditation, so clarity will be needed on how the proposed certificate/diploma/credential will fit within this framework.

Timeline and next steps

Delegates thought that FPH Academic Research Committee could develop a curriculum for accredited training with help from others, such as the Health Foundation, is moving more into the area of population health and wellbeing, and are considering how to develop multidisciplinary public health fellowships. They heard that HEE and FPH are planning on organising a workshop on academic public health research training, where this could be discussed in more detail.

Participants thought that universities would be best-placed to quality assure the training course, but also expressed desire for a scalable programme that can be quality assured by the General Medical Council (GMC) in the future. There is a need to look at the UK as a whole, recognising areas of strength and weakness, to determine which institution should take up the development of a broad training programme.

In terms of a timeline, participants suggested a plan of action be developed in the next six months, with course enrolment beginning in 2019-2020.

Annex 1: List of attendees

Chair

Professor Dame Anne Johnson DBE FMedSci
Chair of the Population and Lifelong Health Domain, and Vice-Dean for External and International Relations, Faculty of Population Health Sciences, UCL

Participants

Professor Ashley Adamson
Programme Director, HNRC Public Health Nutrition Research, Newcastle University

Dr Rob Aldridge
Academic Clinical Lecturer, Institute of Health Informatics, UCL

Ms Suzanne Ali-Hussan
Business Development Manager, Northern Health Science Alliance

Dr Shona Arora
National Workforce Development Lead, Public Health England

Dr Michael Bannon
Postgraduate Dean, Oxford Deanery

Ms Rhiannon Beaumont-Wood
Executive Director of Quality, Nursing and Allied Health Professionals, Public Health Wales

Dr Jo Bibby
Director of Strategy, Health Foundation

Dr Annette Bramley
Head of Healthcare Technologies, Engineering and Physical Sciences Research Council

Professor Carol Brayne
Director, Cambridge Institute of Public Health, University of Cambridge

Ms Liz Cairncross
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Dr Barbara Camanzi
Futures Health and Cancer Care Theme Leader, Science Technology Facilities Council

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Ms Helen Crisp
Assistant Director of Research and Development, Health Foundation

Professor Jane Dacre
President, Royal College of Physicians

Dr Alan Dangour
Professor in Food and Nutrition for Global Health, London School of Hygiene and Tropical Medicine

Dr Mary De Silva
Head of Population, Environment & Health, Wellcome Trust

Ms Jessica Edwards
Head of Health Research Networks, Universities UK

Ms Janet Flint
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Professor David Ford
Professor of Health Informatics, Swansea University

Professor Deborah Gill
Director, UCL Medical School

Ms Zoë Gray
Director, Involve

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Professor Bernie Hannigan
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Senior Research Portfolio Manager, Health & Human Behaviour Team, Economic and Social Research Council

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Associate Director MRC/CSO Social and Public Health Sciences Unit, University of Glasgow

Professor Stewart Irvine
Director of Medicine, NHS Education Scotland

Professor Susan Jebb OBE
Professor of Diet and Population Health, University of Oxford

Professor David Jones
NIHR Dean for Faculty Trainees; Professor of Liver Immunology, Newcastle University

Professor Frank Kee
Director, UKCRC Centre of Excellence for Public Health Research (NI), Queen's University Belfast

Dr David Kennedy
Deputy Head, School of Medical Education, Newcastle University

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Professor Paul Little FMedSci
Professor of Primary Care Research, University of Southampton

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Dr Joe McNamara
Head of Population and Systems Medicine, Medical Research Council

Dr Colin Melville
Director of Education and Standards, General Medical Council

Professor John Middleton
President, Faculty of Public Health

Professor Andrew Morris FRSE FMedSci
Professor of Medicine, Director of the Usher Institute of Population Health Sciences and Informatics, and Vice-Principal Data Science, Edinburgh

Professor John Newton
Chief Knowledge Officer, Public Health England

Professor Jon Nicholl FMedSci
Dean of the School of Health and Related Research, University of Sheffield

Professor Tim O'Riordan OBE FBA
Emeritus Professor of Environmental Sciences, University of East Anglia

Professor Jeremy Pearson FMedSci
Associate Medical Director (Research), British Heart Foundation

Dr Katie Petty-Saphon
Chief Executive, Medical Schools Council

Dr Elizabeth Robertson
Director of Research, Diabetes UK

Dr Harry Rutter
Senior Clinical Research Fellow, London School of Hygiene and Tropical Medicine

Dr Ewald Schroder
Research Funding Manager, Cancer Research UK

Dr Helen Walters
Consultant in Public Health, National Institute of Health Research

Professor Helen Ward
Professor of Public Health, Imperial College London

Professor Nick Wareham
Director, MRC Epidemiology Unit, University of Cambridge

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Annex 2: Agenda

Arrival	
13.00	**Registration, coffee and sandwiches**
Welcome	
13.30	**Chair's introduction: overview of the project and recommendations** Professor Dame Anne Johnson DBE FMedSci
13.50	**Comments and questions from the room**
Breakout sessions: taking the recommendations forward	
14.00	**Developing next steps** In groups, develop plans for the steps that need to be taken – including by whom and by when – to ensure the report's recommendations are implemented. ***Groups 1a and 1b: Research funding*** With a particular focus on establishing the UK Strategic Coordinating Body for Health of the Public Research (SCHOPR) *[Recommendation 1]* ***Groups 2a and 2b: Linking research and delivery*** With a particular focus on developing regional hubs of engagement *[Recommendation 6]* ***Group 3a: Undergraduate training*** With a particular focus on undertaking a review of undergraduate training *[Recommendation 5.1]* ***Group 3b: Research training*** With a particular focus on developing a credential in health of the public research *[Recommendation 5.4]*
15.45	**Tea/coffee break**
Feedback	
16.00	**Feedback** Summary and discussion of each group's conclusions [8-10 minutes per group]
16.50	**Closing remarks** Professor Dame Anne Johnson DBE FMedSci

Annex 3: Questions posed

Delegates were offered the following questions to direct their discussions.

Research funding [Recommendation 1]

1. Where should SCHOPR be situated? The Academy has heard recommendations that it would be well-placed as a sub-group of UKRI (when it is established), particularly as this will ensure SCHOPR is seen as transdisciplinary. Others have suggested that SCHOPR could be situated as a sub-group of OSCHR or UKCRC, for example.
2. What are the challenges and benefits to setting up SCHOPR in these (or in other) locations?
3. How should we go about setting up SCHOPR in its preferred location? Who should be tasked with setting it up? How, and by whom, should they be approached?
4. What are the challenges to setting up SCHOPR, and how can they be overcome?
5. What should be the timeline for SCHOPR's establishment? What are the key milestones?
6. How should SCHOPR interact with other initiatives in this area?

Linking research and delivery [Recommendation 6]

1. The report is not prescriptive on how these hubs might be constituted. On the practitioner side, this could be one of PHE's regional structures or local centres, or local health and care systems that have come together to develop and deliver NHS England's Sustainability and Transformation Plans. The academic asset, on the other hand, could be geographical clusters of universities, AHSNs, AHSCs, CLAHRCs or NIHR School of Public Health Research (SPHR). With that in mind, where should the regional hubs of engagement be situated? How should they interface with or build on existing national and regional public health structures?
2. How should we go about setting up these hubs in the preferred locations? Should we begin with a handful of pilots? If so, where? Who should be tasked with setting them up? How, and by whom, should they be approached?
3. What are the challenges to setting up the regional hubs of engagement, and how can they be overcome?
4. What should be the timeline for the establishment of these regional hubs of engagement? What are the key milestones?

Undergraduate training [Recommendation 5.1]

1. One way to realise this could be by feeding into the development of the 'UK Medical Licensing Agreement'. Another longer-term goal would be an amendment to GMC's 'Tomorrow's Doctors'. Or to link this as an allocation criteria to be used by HEFCE for the medical schools expansion. Are these reasonable goals? If so, how can they be accomplished.
2. In the more immediate term, could we engage a number of medical schools to update their curricula in line with our recommendations? If so, how can this be accomplished?
3. More generally, who should be tasked with organising a review of competencies within the existing undergraduate medical curricula? How, and by whom, should they be approached? When?
4. What are the challenges to undertaking such a review, and how can they be overcome?
5. What should be the timeline for the review to be undertaken? What are the key milestones?
6. How can we ensure that training in non-medical disciplines reflects the health of the public, where appropriate?

Research training [Recommendation 5.4]

1. Since developing this recommendation, the Academy has been informed of several challenges associated with developing credentials, including a lack of resource for their design and assessment, uncertainty about the demand for credentials, and an upcoming GMC review on future curricula. In view of these challenges, is a credential the best way to go? It has been suggested that we set up a programme, module or diploma in health of the public research, and to transfer this as a credential at a later stage when they are established.
2. Who should be tasked with setting up this programme, module, diploma or credential? How, and by whom, should they be approached?
3. What are the challenges to setting up the programme, module, diploma or credential, and how can they be overcome?
4. What should be the timeline for the establishment of this programme, module, diploma or credential? What are the key milestones

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