

ENABLING THE DEVELOPMENT OF EFFECTIVE PUBLIC HEALTH NETWORKS

Report from National Workshop held at Avonmouth Centre, London, 3 March 2003

Background to the National Workshop.....	2
Key points from the morning: presentations.....	3
Key points from the morning: small group work.....	6
Key points from the afternoon: small group work.....	9
Summary of ideas for future work.....	11
Summary of the main points from the workshop.....	11
Appendix 1: Programme.....	13
Appendix 2: Delegate List.....	14

Background to the National Workshop

Following the organisational changes of “Shifting the Balance of Power”, from April 2002, there has been a policy expectation that effective public health networks would become established to:

- Pool expertise and skills in specialist areas of public health which will be available to all PCTs
- Share good practice and manage public health knowledge
- Act as a source of learning and professional development

Regional Directors of Public Health are charged with “signing off” networks against an agreed criteria. Since April 2002 there have been further changes which will effect networks, the setting up of the Health Protection Agency from April 2003 and proposed changes at Regional level later this year.

The national workshop followed nine one-day regional workshops, held across England in each public health region and supported by each Regional Director of Public Health, between November 2002 and February 2003. These workshops were sponsored by the Department of Health to support development of local public health networks, identify key issues and explore systems and tools to promote local and national sharing and dissemination. The Department of Health commissioned reports from each workshop from the Public Health Resource Unit in Oxford.

The national workshop brought together the key themes from these nine workshops and discussed action needed to take forward identified issues and ensure supporting systems were in place. The Programme is in Appendix 1. The latter would help inform future commissioned work by the Department of Health to support network development.

The national workshop was funded by the Department of Health and jointly sponsored by the Department of Health, Faculty of Public Health Medicine, Health Development Agency and National Electronic Library for Health, Association of Directors of Public Health and the National Public Health and Primary Care Group. The Department of Health commissioned a report from the national workshop from the Public Health Resource Unit in Oxford.

These sponsors had already been involved in the development of a national statement on public health networks in October 2001. This statement defined networks as:

“linked groups of public health professionals working in a co-ordinated manner across organisations and structural boundaries who will have a common agenda to promote health improvement and reduce health inequalities for given populations”.

This statement also recognised that networks will differ in style, geographical area covered and in the range of participants depending upon the network. Invitees to the workshop were principally attendees at the nine regional workshops plus colleagues – public health professionals, colleagues from local government, academia and Workforce Development Confederations - and representatives from

Northern Ireland, Scotland, Wales and the Channel Islands. A list of attendees is attached at Appendix 2.

The objectives for the workshop were:

- To identify the characteristics of an effective public health networks
- To support the development of systems to support networks
- Support and promote dissemination across different networks

The morning session commenced with a series of presentations including feedback from the nine regional workshops, progress with the national evaluation of networks, the role of networks within Local Strategic Partnerships, what our customers want from networks and local examples of good practice in setting up or supporting networks. The rest of the day was spent in group discussion. The morning session was chaired by Professor Sian Griffiths, President of the Faculty of Public Health Medicine and the afternoon session by Dr Muir Gray, Director of the NeLH.

This report will summarise the key points from the presentations and the small group work.

Key points from the morning: presentations

Feedback from the nine regional workshops – Katie Enock (Department of Health)

One model does not fit all

The workshops confirmed that there is no one model of network. There appeared to be two styles of network emerging – those that were about “sharing to survive”, particularly where public health capacity was thin and those that sought to “add value” and undertake work not possible in a single organisation. Networks were also operating at different levels depending upon local need or stage of development:

- “Minimalist”, focussing principally on training and development issues
- “Middle of the road” where there might be a Network Board and agreement on sessional attachments of public health staff
- “Highly organised” with funded administrative support, clear infrastructure, job descriptions for network posts and business plans

Characteristics of an effective network

These could be summarised as the five “C”s:

Coherence: shared vision, clear responsibilities, work plans, programmes, core policies

Control: good management, clear accountabilities and governance

Currency: trust, acceptance of “knock for knock”, value for money

Capacity: infrastructure, clarity on what can be taken on and the resources to do it

Concurrence: stakeholders on board and clear of benefits, whole systems thinking

Information and tools to support sharing

The nine regional workshops were supportive of promoting sharing of knowledge and expertise in specialist areas. There was a particular need to ensure analytical capability was available locally across PCTs. The Public Health Observatories are a valuable route for facilitating knowledge sharing, particularly as they have agreed interoperable systems. There is also a key role locally for knowledge managers.

The workshops indicated a number of ways sharing could be promoted ranging from local interoperable websites and learning sets for network managers to sharing of models of good practice as well as “elephant traps”. National funding of licences for accessing key databases was also seen as important, to ensure equity of access.

Feedback on progress with the national evaluation of networks (Amanda Killoran, Health Development Agency)

The evaluation included interviews with Strategic Health Authority Director of Public Health or nominated person and key people in local networks in Eastern, North West and East Midlands health regions.

The majority of networks are still at a formative stage and local configurations will tend to stem from local contexts. Most are still concerned with NHS issues although intend to take on broader agendas working with Local Strategic Partnerships. The more advanced in tackling broader issues tend to be in the HAZ areas. There is a range of types of networks building up from within a PCT, a “nesting” of groups of PCTs, a “meta type” linking to other networks.

Key features of networks emerging from the interviews were the attempt to maintain locally the public health capacity that had been available within the former health authority, to use networks to provide support and professional development and to use networks to deliver PCT agendas. There were tensions about gaining clarity and commitment to a shared network agenda and balancing this with local PCT priorities and also over how structured the network needed to be. What influences network development is the level and awareness of stakeholders, especially PCTs, whether there is a history of collaboration locally and whether there is funding available for infrastructure support. There needed to be a good communications system in place to allow development from a formative stage to a formal and organised way of working.

The role of networks within Local Strategic Partnerships (LSPs) – Julia Taylor (Central Liverpool PCT)

There is potential for public health networks and LSPs to address inequalities and develop joint indicators.

There are, however, challenges, not least the complexity of different geographical boundaries and different foci. Continually mapping who is doing what and where, is possibly less fruitful than looking strategically at issues. Regional Government Offices in particular are charged with accrediting both LSPs and networks and there are therefore opportunities for exerting influence at that level. Networks and LSPs

need to be clear on their guiding principles as well as accountability for who is going to deliver what.

*The use of electronic networks in public health – Linda Wintersgill
(Northumberland, Tyne and Wear Strategic Health Authority)*

Electronic networks can help networks to share best practice, provide discussion fora for problem-solving and provide access to information from a variety of sources. They can provide help rapidly as well as respond flexibly to new programmes and targets. They must add value for participating members. The vision is to have interoperable electronic networks which provide gateways to all information on public health issues whether this is local, regional or national and which provides timely and accurate information via the website.

For effective electronic networks to happen there needs to be, as a minimum, a DsPH network to ensure network members are involved at every stage of development and a network coordinator in post as well as agreements across all the participating PCTs and common policies and protocols. There should be “quick wins” to build up trust as well as continual evaluation. Above all electronic networks must be realistic about what can be achieved.

*What do our customers want from public health networks – Aidan Thomas
(Epping Forest PCT)*

It should not be forgotten that the key customer is the population and the role of public health within a PCT is to influence the health of the population. PCTs are not “rebadged” health authorities. Within PCTs the key committee where decisions are made is the Professional Executive Committee (PEC). Public health networks must be clear about their added value to PECs and avoid duplication or unnecessary additional overheads.

PCTs are developing understanding about how to collaborate, a particularly crucial issue for smaller PCTs. Public health networks can provide support and development for individual professionals and, depending upon the size of the PCT, key specialist services such as health screening, health protection, dental public health, library and audit support. As PCTs move onto the inequalities agenda there is a major opportunity for networks to take on the championing role.

*Using PHORMS as a knowledge networking tool – Peter Cornelissen and
Julian Flowers (Eastern Region Public Health Observatory)*

“Shifting the Balance of Power” led to a dispersal of public health specialist skills, particularly public health information. The tool was developed to support single-handed public health professionals. It imposes a structure on public health information and improves access to it as well as allowing people to search within the site and, because it is interoperable, search other sites. The site contains reports, spreadsheets, maps, web links and information on people (who add themselves when they want to create on-line CVs). There is a discussion forum. It is also used to post information, minutes and agendas on relevant meetings and events such as Faculty Local Affairs committee (FLAC) meetings.

One key challenge is to encourage people to register and some will need training. Another is to extend the agenda to broader public health issues. Some parts of the web site have restricted access such as the public health compendium, which is restricted to the NHS. There is the facility to operate closed discussion groups.

Each Observatory needs to be linked to its local public health networks. In Eastern Region a network representative sits on the Observatory Board.

Key points from the morning: small group work

The groups were asked in the morning to explore in more depth a number of the issues that had arisen from the nine Regional workshops:

- Identifying and engaging with key stakeholders
- Balancing local PCT and network priorities and ensuring public health remains a priority at PCT level
- The role of the network in supporting public health development
- Sharing intellectual capital across networks
- Processes and skills for undertaking pieces of work on behalf of the network

Each group was also asked to consider whether anything could be developed nationally to support progress.

The afternoon groups looked at practical ways to support network development:

- Providing support in accessing evidence
- Providing public health information
- Public health governance and audit
- The role of Public Health Observatories

Identifying and engaging with key stakeholders

The key stakeholders for networks are PCTs (more than one for each network), local authorities (including social service, housing, transport and education departments), university sectors, voluntary organisations and the community itself.

There is no one approach. Some networks are PCT led and managed, some are clinical networks with public health leads or input and others have a broader approach depending upon the local definition of the network role and the accountabilities.

Securing engagement of key stakeholders required clarity about network objectives and outcomes and how they would be held to account. This would underline for stakeholders the relevance of networks to them.

Nationally, clarity about the role and responsibilities of networks would help as well as being explicit over the minimum criteria for networks.

Balancing local PCT and network priorities and ensuring public health remains a priority at PCT level

Networks must support PCT agendas as a priority. The basic building block for networks is the PCT with the continued emphasis on the Health Improvement Programme (HIMP) principles and reducing health inequalities.

Public health priorities can include medically focussed issues as well as those that are population focussed. The two are not mutually exclusive. Networks can have a particular role in assisting PCTs in engaging with communities.

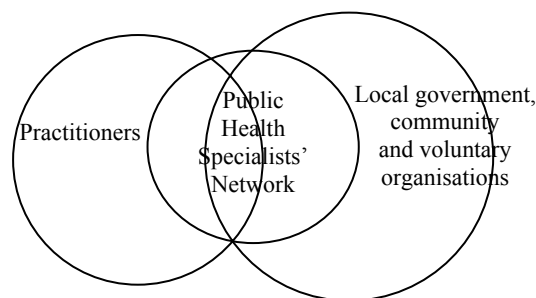
For PCTs to “own” networks there needs to be clear action plans with deliverables that help PCTs meet their agendas. Stakeholders must be involved in shaping network agendas. There is a key role for public health professionals in using public health information to help PCTs achieve their targets, particularly on reducing inequalities and ensuring equity of access to services.

Networks do present opportunities for public health professionals to think beyond this year’s agenda in a PCT and to look at public health issues five and ten years hence.

The role of the network in supporting public health development

Public health networks should be there to add additional value to any existing networks, rather than be seen as a replacement. The network has a key role in supporting public health specialist development and should see itself as being a major player in supporting education, training and development (ETD) and empowerment of public health practitioners locally as well as mapping available local skills. Networks should include local government as well as communities in ETD initiatives to encourage multi-agency approaches.

One way to think about the people involved with the network is to start with the core group of public health specialists who might be network members with an obligation to deliver the PCT public health agenda. The links required by the networks to a wider group, who would include practitioners such as health visitors and environmental health officers and lastly linking to an even wider group comprising local government, community and voluntary organisations. As shown in the diagram below.



The Workforce Development Confederations have a key role in funding public health development, although they tend to be NHS focussed training sessions can include multi-agency participants. The Faculty of Public Health Medicine is also a key player in promoting the development of the public health workforce and in mapping pathways to specialist status.

Nationally, it would be helpful to have more clarity about different pathways to accreditation to make the profession more inclusive.

Sharing intellectual capital across networks

There should be promotion of sharing of pieces of work done by individuals for networks beyond the immediate locality. The main barrier however is diffidence about quality of the work i.e. a piece of work done locally might not be considered good enough to be shared with a wider audience. However, all documents need localising and having something to work from for further development means that a “good enough” piece of work is actually what people want. Perhaps the way round this is to refer in some cases to work as “in progress”.

Sharing is essential to help single-handed professionals. Academics could also share work before publication as drafts. Academic departments could work more closely with PCTs. People also need to be allowed time for reflection and writing.

Nationally, having common standards for data structure, data retrieval and presentation would help to assist in searching.

Processes and skills for undertaking pieces of work on behalf of the network

Network work should not be undertaken on an informal basis but within formal agreements. Governance arrangements for all networks should be in place. The network needs to have a process to deal with potential conflicts for individuals between network and PCT priorities. Protocols need to be in place, to support network outputs this should include:

- clarity on who is leading different pieces of work
- defined role with boundaries and explicit sessional time
- who is the person accountable to
- what support is needed
- what is the final product.

One model is to use a lead PCT in the network to hold the agreements for people whilst working on network sessional time.

Individuals involved in network work need to have these sessions and roles agreed on an annual basis within their job plans and form part of their appraisals. This would also help ensure PCTs were in agreement. Those involved should go beyond public health specialists, eg community practitioners, and they should be supported in network work through continuous professional development (CPD).

There are audit tools around to help identify specialist expertise. Development of skills should form part of CPD.

Nationally, it would help if there could be a framework to help networks understand the level of resource that is likely to be needed.

Key points from the afternoon: small group work

Providing support in accessing evidence

It is hard sometimes to access evidence particularly if it is not all published. It would be helpful if the NeLH could get information on what people have worked on.

Evidence can be hard to access on community and broader health determinants work. The H.D.A. publications are an extremely valuable resource for this. Better ways need to be developed to capture local work.

There are issues in accessing evidence particularly in knowing whether the quality of what is there is good enough, handling conflicting evidence and asking the right question in the first place.

It is very hard for a single-handed DPH to have time to access evidence. There is a clear role for an information scientist/knowledge manager per network to help.

Nationally, it would help to have a national casebook of questions and answers.

Providing public health information

Data are not necessarily information. There are issues in particular about the interpretation where numbers are small or the confidence intervals are wide.

There are still major issues about accessing data from different agencies eg the police. It is not always clear what data can be shared or the quality of the data that are shared.

Data also requires substantiation through qualitative research or through direct engagement with communities to ascertain their views.

Nationally, it would help if it were made easier to share data across different agencies, for example using the NHS number as a base.

Public health governance and audit

Governance needs to start with the definition of the network and its purpose. There may be a range of networks under one umbrella some of which will have formal accountabilities through the Strategic Health Authority eg DsPH groups and some through PCTs, managed networks of public health professionals spanning more than one PCT and undertaking specialist roles across the patch.. Some may be professional groupings eg dentists. Others may link with LSPs. At the PCT level they need to be all inclusive, drawing in public health practitioners.

Governance is easier to organise in managed networks based around PCTs where there may be Board and clarity about who is doing what pieces of work. It is more difficult where networks are informal or “virtual”. Governance is a key issue for network boards to address.

Each network will need clear accountability arrangements, a business plan and an education and training plan all measurable against the standards of good public health practice. Arrangements for achieving these standards need to be flexible.

There needs to be clear lines of accountability and a line manager for network pieces of work as well as mechanisms in place for dealing with poor/underachieving and a quality assurance system for peer review.

Networks are built around trust and relationships. There needs to be transparency over decision-making for this to work.

Networks will need mechanisms for audit, possibly using the Faculty of Public Health Medicine toolkit when produced, which should look not only at pieces of work undertaken but also the network infrastructure.

The development of national standards for areas such as ETD, governance and roles and responsibilities are desirable.

The role of Public Health Observatories

Observatories must add value. As they rely on electronic networking, they could play a key role in providing comparative analyses at PCT and ward level as well as indicating what indicators are reasonable to compare particularly when dealing with small numbers. They can access health as well as local government and other data such as neighbourhood statistics.

They could also help in undertaking modelling work, for example health issues and population growth, which would assist with service planning. Information for DPH annual reports would be particularly helpful as would information to support the work of health scrutiny committees. Information needs to be timely to support funding and planning cycles.

There needs to be clarity about the role of Observatories, however, and where this fits local public health information sources.

Observatories can have a role in helping people at local levels interrogate information sources as well as use local data. They can also be a conduit for sharing of work and have discussion space. It should be borne in mind, however, that not everyone has access to the web.

Observatories cannot do everything and expectations must be realistic in the light of capacity available.

Summary of ideas for future work

Those attending the workshop identified key priorities, which they would like the Department of Health to consider commissioning to support network development

- Clarity in the processes for an individual to undertake the lead on a piece of work for the network.
- Develop Common standards for shared pieces of work.
- Identification of ideal network governance arrangements
- Support the development of interoperable local electronic networks and databases of expertise and knowledge management to share intellectual capital across networks
- Learning sets for network managers
- Develop ways to identify ‘best practice’ networks. This would assist in benchmarking.
- Develop a framework to help networks understand the level of resource that is likely to be needed.
- Develop a national casebook of questions seeking evidence and the answers.
- Look at national purchasing of data and where there are gaps in essential data requirements.

Summary of the main points from the workshop

- The word network embraces a wide range of groupings from the formal to the informal. Clarity is needed when using the term over what is being described
- In the main, networks are still at a formative stage and principally NHS focussed
- No one model will fit all circumstances
- The PCT is the basic building block for networks
- Formal networks will need coordination, clear principles and objectives, accountabilities and governance arrangements and a business plan
- Electronic network support is key to facilitating communicating and sharing across networks and accessing information from a wide range of sources quickly

- Public Health Observatories have a key role in supporting networks
- There is a role for an information scientist/knowledge manager within each managed network
- Networks should be capable of being measured against the standards of good public health practice
- Clear policies, accountabilities and process arrangements need to be in place where individuals undertake work on the part of networks
- Public health capacity building and development is a key function for networks
- Networks are a vital resource for single-handed Directors of Public Health

Appendix 1: Programme
National Workshop on Public Health Networks

Avonmouth House, London
3 March 2003

- 9.30 - 10.00 Arrival, coffee and registration
- 10.00 - 11.30 Chair for morning session, Professor Siân Griffiths
President of the Faculty of Public Health Medicine
- Emerging findings from the 9 “Enabling the Development of Public Health Networks” national workshops – Katie Enock, Department of Health
 - Emerging findings from the H.D.A. project “Mapping the development of public health networks” – Amanda Killoran, Health Development Agency
 - The role of networks within Local Strategic Partnerships – Julia Taylor, Central Liverpool PCT
 - The use of electronic networks in public health - Linda Wintersgill, Northumberland, Tyne and Wear StHA
 - What do our customers want from public health networks – Aidan Thomas, Epping Forest PCT
 - Using PHORMS as a knowledge networking tool – Peter Cornelissen & Julian Flowers, Eastern Region PHO
- 11.30 - 12.00 Coffee
- 12.00 - 1.00 First group work – exploring key themes and identifying issues
- 1.00 - 2.00 Lunch
- Chair for the afternoon session, Dr Muir Gray, Health Development Agency
- 2.00 - 2.20 Feedback from first group work Chairs
- 2.20 - 3.15 Second group work – developing the next stage and action planning
- 3.15 - 4.00 Feedback and panel commentary
- 4.00 Tea and close

Appendix 2: Delegate List
National Workshop on Public Health Networks

Avonmouth House, London
3 March 2003

Stephen Abbott	Research Fellow, School of Nursing and Midwifery, London
Pat Adams	Conference Organiser, Public Health Resource Unit, Oxford
Mahmood Adil	Head of Clinical Support & Health Protection North West, Directorate of Health and Social Care, Manchester
Helen Alexander	Research Associate, Public Health & Health Policy, Glasgow
Mike Arowobusoye	
Chris Bentley	Director of Public Health & Clinical Engagement, South Yorkshire Strategic Health Authority, Sheffield
Graham Bickler	Director of Public Health, Brighton & Hove City PCT, Brighton
Laura Bowers	Senior Public Health Researcher, Lothian NHS Board, Edinburgh
Sally Brodhurst	HAZ Co-ordinator, Government Office for South East, c/o Oxford City PCT, Oxford
Carina Browne	Senior Lecturer, Department of Applied Social Sciences, London
Paul Butcher	Public Health Specialist, Calderdale PCT, West Yorkshire
Jane Cass	Public Health Development Specialist, Chorley & South Ribble PCT, Leyland, Lancs
Sue Cavanagh	Development Adviser: Primary Care, Primary Care Development Team, London
Amy Cawthorne	Associate Director Essex PHN, WBH Care Trust, Essex
Jim Connelly	Senior Lecturer and Honorary Consultant in PHM, Nuffield Institute for Health, Leeds
Brian Cooke	Consultant in Public Health, South West Peninsula Health Authority, Cornwall
Peter Cornelissen	Information Management & Technology Specialist, Eastern Region Public Health Observatory, Cambridge
Cathy Dorrian	Northern Public Health Network Co-ordinator, Summerfield House, Aberdeen
Glynis Double	CCDC, Public Health, Barking & Dagenham PCT, Barking
Celia Duff	Deputy Regional Director of Public Health, East of England Public Health Group, Cambridge
Ray Earwicker	Health Inequalities Unit, Department of Health, London
Victoria Eaton	Head of Health Promotion, Leeds West PCT, Leeds
Deborah Elliott	Norfolk Public Health Co-ordinator, Norwich
Katie Enock	Public Health Specialist, Department of Health
Stewart Evans	Acting Senior Public Health Manager, Eastern Wakefield PCT, Castleford
Henrietta Ewart	Director of Public Health, Rugby PCT, Rugby
Brid Farrell	Consultant in Public Health Medicine, SHSSB, N Ireland
Lorna Farr	Sure Start Health Development Co-ordinator, Newcastle upon Tyne
Patrick Ffitch	Web Developer, West Midlands Public Health Observatory, Birmingham
Julian Flowers	Technical Director, Eastern Region Public Health Observatory, Cambridge
Sylvia Godden	Epidemiologist, Public Health, Sutton & Merton PCT, London
Ann Goodwin	Senior Public Health Manager, Public Health Group, Nottingham
Trudi Grant	Head of Public Health, Dorset and Somerset Strategic Health Authority, Somerset
Muir Gray	National electronic Library for Health, Oxford
Ian Gray	Policy Officer, Health Development, Chartered Institute of Environmental Health, London
Siân Griffiths	President, Faculty of Public Health Medicine
Steve Hams	Acting Health of Health Improvement, Avon, Gloucester and Wiltshire Strategic Health Authority, Wiltshire
Lyn Harris	Consultant in Public Health Medicine, Dyfed Powys Health Authority, Carmarthen
Steve Harvey	Assistant Director Public Health Services (Health Improvement), Public Health Services, Jersey
Karen Hetherington	South East London Public Health Network Manager, Lewisham PCT, London

Alison Hill	Director, Public Health Resource Unit, Oxford
Paul Hooper	Manager of Coventry & Warwickshire PHN, South Warwickshire PCT, Warwick
Mike Hughes	Public Health Development Specialist, Huddersfield PCTs, Huddersfield
Julie Istead	Business Manager, Public Health Network, Cambridgeshire and Peterborough Public Health Network, Huntingdon
David Jeffs	Director of Public Health & Strategy, Princess Elizabeth Hospital, Guernsey
Christine Jenkins	Health Strategy Manager, Families and Communities, Cardiff
Paul Kalinda	Public Health Network Manager, Dorset and Somerset Strategic Health Authority, Somerset
Brian Keeble	Director of Public Health, Ipswich PCT, Ipswich
Amanda Killoran	Health Development Agency
John Langley	Public Health Information Specialist, Derwent Shared Services, Derby
Andy Liggins	Director of Public Health, Greater Peterborough PCTs, Peterborough
Christine Mann	Essex PHN Manager, WBH Care Trust, Essex
Tracy Marshall	County LSP Support/Public Health Network Support Manager, Cheltenham & Tewksbury PCT, Cheltenham
Dhana Mathur	Public Health Network Co-ordinator, Eastern Leicester Primary Care Trust, Leicester
Jonathan McInerney	Project Officer, Local Government House, London
Maggie McNab	Assistant Director of Health Improvement, Curie Centre, Hounslow
Jane Meyrick	Head of Capacity and Capability, Health Development Agency, London
Janette Munton	Health Promotion Specialist, Leeds South PCT, Leeds
Duncan Nicholson	
Ugo Okoli	Consultant in Public Health Medicine, Harrow PCT, Middx
Alison Patey	Health Strategy Manager, Government Office for Yorkshire & Humber, Leeds
Meradin Peachey	Director of Public Health, Dartford, Gravesham & Swanley PCT, Kent
Sarah Price	Assistant Director of Public Health, North East London Strategic Health Authority, London
Maggie Rae	Regional Associate Director of Public Health for South West, GOSW, Bristol
Mala Rao	PHN Lead for Essex, WBH Care Trust, Essex
Naomi Rees	Assistant County Consumer Services Officer, Staffordshire County Council
Devinder Reeve	Public Health/Infection Control Nurse, Islington PCT, London
Jane Royle	Public Health Development Manager, Wessex Institute, Southampton
Carol Ryley	Public Health Manager, Essex Strategic Health Authority, Essex
Linda Semple	Health Intelligence Unit Manager, Edinburgh
Peter Sheridan	
Celia Shohet	Associate Director, Health Improvement & Partnership, Bedfordshire Heartlands PCT, Bedfordshire
David Sloan	Director of Health Improvement, Health Improvement, City & Hackney PCT, London
Kaet Karni-Gee Smith	Director of Public Health, Havering PCT, Essex
Chris Stannard	Berkshire Public Health Network Administrator, Centre for Primary Care & Public Health, Reading
Hazel Stuteley OBE	Community Development Manager, West Cornwall PCT, Cornwall
Julia Taylor	Cheshire & Merseyside Public Health Network Co-ordinator, Central Liverpool PCT, Liverpool
Soon-Hoe Teh.	Councillor, Barnet Council, London
Aidan Thomas	Chief Executive, Epping Forest PCT, Essex
Anh Tran	Policy Research Officer, South East Public Health Group, Guildford
Chloe Underwood	Head of Policy & Communications, Faculty of Public Health Medicine, London
Mary Wallis	SW London Public Health Network Business Manager, SW London StHA, London
Julia Weldon	Head of Public Health Nursing and Health Improvement, Eastern Wakefield PCT, Castleford
Linda Wintersgill	Manager for Public Health Programmes, Northumberland, Tyne & Wear Health Authority, Newcastle upon Tyne
Jenny Wright	Deputy Director, Public Health Resource Unit, Oxford