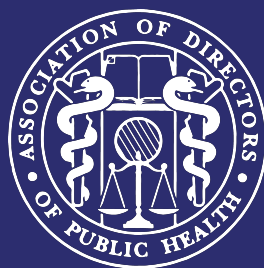


Healthcare Public Health in England

A critical assessment of how the accredited public health workforce is recognised, valued and deployed across the NHS in England



FACULTY OF
PUBLIC HEALTH



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Report commissioned by The Faculty of Public Health and Association of Directors of Public Health.

Policy review	21 core NHS, government, and professional body documents
Interview schedule	17 semi-structured interviews, undertaken January–February 2026
Date	June 2026
Authored by	Joseph Home, Joe Dalloz, Frances Burnett, Julia Weldon, Yvonne Doyle

Note: This report aims to distinguish between verified evidence, interpretation, and inference. All interview quotations are anonymised.

Foreword

Successive Governments have set out ambitions for the NHS to prioritise prevention and improve population health, but the specialist public health workforce which must support these ambitions remains under-deployed across the health and care system.

This report makes the case for the skills, commitment, and leadership that public health professionals bring – and for the better population outcomes the NHS in England could achieve by consistently embedding public health expertise in healthcare decision-making.

It presents the current and future potential of the public health profession to be deployed within healthcare as it has not been for over a decade. Since public health responsibilities moved out of the NHS in England, the majority of the specialist workforce has been based elsewhere – in local government, in national bodies such as the UK Health Security Agency and the Office for Health Improvement and Disparities, and across academia, the civil service and the voluntary sector. Currently a mere 10% of the specialty are employed or defined as working within healthcare, despite completing a demanding training programme which equips them to work within, and lead, these systems to deliver better population-level health outcomes. We consider this a serious misstep that has contributed to the struggles of the wider system to deliver the best for population health from collective investments, including the more than £200bn committed to the health and care system itself. This played out starkly during the recent pandemic and continues to do so in the deteriorating health of the UK's citizens.

It is not a report about professional isolationism or protection. It is clear to everyone we have spoken to in this process that there has been a fracturing of the health and care system in England. Amongst other consequences, this has deepened a deficit in the skills that are necessary to deliver patient and population health outcomes safely and with efficacy. The process followed in producing our recommendations has shone a light on this, but also held a mirror to our own profession and its currently neglected leadership role in health and care settings and the potential for this to change in the future.

The recommendations in this report are focussed on building public health input into the NHS in England for the benefit of the health of the populations we serve. We see the report as a first step towards rebuilding an effective healthcare public health system. The present reorganisation of the NHS makes this moment both urgent and rare: an opportunity to build public health capability into the next phase of the system by design.

Alongside the few qualified colleagues currently working within the NHS in England, public health offers a committed and high-quality group of Specialist Registrars, three of whom have largely led and produced this work. It is their future, and they are committed to joining the people already working within the health and care system and local government to better serve the people of England.

Yvonne Doyle

Chair
Health Services Committee
Faculty of Public Health

Julia Weldon

Former Board Member
Association of Directors of Public Health

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Part 1 — Framing

Section 1: Executive Summary

Commissioned by the Faculty of Public Health and the Association of Directors of Public Health, this report provides a critical assessment of how the accredited public health specialist workforce is recognised, deployed, and valued across the NHS in England. It identifies key gaps in visibility, utilisation, and impact, and sets out a stronger evidence base to inform policy decisions, support system improvement, and maximise the contribution of this workforce to delivering better population health outcomes.

Overall pattern

Across the twenty one-document policy review and seventeen practitioner interviews, a structurally consistent pattern emerges: population health language has expanded dramatically across NHS and government policy and functions, while the accredited public health specialist workforce required to deliver it has been simultaneously dissolved, diffused, or silently assumed.

Not one core NHS operational or structural document in the policy review explicitly mandates the employment, governance, or resourcing of accredited public health specialists, to lead population health work. Responsibility for delivering these health outcomes are instead assigned to system leaders, place-based partnerships, neighbourhood teams, or diffuse population health functions without naming, training, governing, or funding a specific professional cadre.

The current arrangements for sourcing accredited public health skills into the NHS are fragmented, confused, and in some locations inadequate. National publications endorse prevention, inequalities reduction, strategic commissioning, and neighbourhood health, yet current NHS arrangements still lack workforce specificity, leaving population health responsibilities inconsistent and diffused.

Interviewees across NHS England, ICBs, provider trusts, local authorities, combined authorities, think tanks, and professional bodies confirmed that accredited specialists are valued where encountered, but inconsistently embedded, frequently substituted by generic workforce categories, and too often positioned as advisory rather than decision-shaping actors.

This report argues for a population public health approach in which accredited public health professionals, both NHS-side specialists and local-authority Directors of Public Health, sit at the helm rather than as one part among many. Such a movement is not exclusionary; it explicitly brings forward and supports the wider population-health workforce, including non-accredited professionals doing valuable work, while ensuring that responsibility for safe, evidence-based leadership rests with the regulated, competency-holding profession.

1. Main finding

The central conclusion of this report is that the NHS increasingly expects population level health outcomes but does not yet consistently specify, secure, or support the accredited public health specialist capacity required to deliver them safely and effectively. This is not principally a problem of policy rhetoric, because prevention, inequalities reduction, neighbourhood health, strategic commissioning, and service redesign all feature prominently in current national policy.

The problem lies in translation. Policy ambition has not been matched by equal clarity on workforce architecture, governance, professional standards, training pathways, or operational influence. The logical step that the current policy environment misses is straightforward. The NHS does not expect surgical outcomes from a generically trained workforce: it requires named, regulated, competency-holding professionals. Population health outcomes warrant the same logic. If the NHS expects measurable improvements in prevention, inequalities reduction, strategic commissioning and value, it must require, not merely encourage the named, accredited, regulated workforce that holds the recognised competencies to deliver them. Anything else is an under-specification that the system bears, and ultimately populations bear.

1.2 Why this matters now

Life expectancy in England is in decline, and inequalities in health outcomes continue to widen despite rising investment in health systems. Recent times have seen profound organisational upheaval across the NHS. The abolition of Public Health England, now followed by that of NHS England, implementation of ICBs followed by ongoing restructuring and consolidation, and broader system turbulence, increases the risk that the already inconsistent public health capability is further diluted during redesign.

At the same time, this period creates an unusual opportunity. Neighbourhood health guidance, place-based reform, and the Faculty of Public Health's March 2026 statement on consistent professional standards together create a timely policy window for embedding stronger public health capability into the next phase of NHS structures.

This is not principally a workforce-protection issue. It is a quality and safety issue. Where the NHS lacks consistent access to accredited public health expertise, the system makes worse decisions about pathway design, prioritisation, equity and resource allocation, and is less able to identify and act on serious health inequalities. The consequences fall on populations and patients, through avoidable harm, widening inequalities and inefficient use of finite NHS resource, and that consequence is the central reason this report should be acted on, not deferred.

1.3 Recommendations

1. Rebuild specialist public health leadership into NHS decision making across ICBs and providers
2. Continue to recognise Directors of Public Health as the leadership anchor at place
3. Strengthen professional standards in senior public health and population health roles
4. Move beyond the Core Offer to a partnership model of healthcare public health
5. Reform training and post-CCT development so that future consultants are best prepared for operational, managerial, and leadership responsibility.
6. Build public health capability into neighbourhood working and emerging Integrated Health Organisation development.
7. Reduce fragmentation and duplication through integrative and system leadership
8. Reframe public health as a broad strategic capability
9. Strengthen communication of the value and identity of accredited public health professionals.
10. Define and share best practice models for how accredited public health advice and leadership can be organised within and around NHS settings.

Section 2: Introduction and Background

What is public health?

Public health is the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society. It also considers principles of social justice and equity, promoting and protecting better health for all, leaving no-one behind.

Rather than focussing on the health of the individual, public health works to protect and improve the health of communities and populations at local, regional, national, and global level. The shared aim of the diverse range of public health work is to offer populations the best chance to live long lives in good health.

Whilst the work of public health professionals is extremely varied, there are three identifiable domains of public health practice. These three domains are Health Protection, Health Improvement, and Healthcare Public Health. It is this third domain which is the focus of this report.

Healthcare public health is concerned with maximising the population benefits of healthcare and reducing health inequalities while meeting the needs of individuals and groups. It does this by ensuring health services are of consistently high quality and especially that they are evidence-informed and value-based, and address issues of effectiveness, efficiency and equity.

2.1 Rationale

This report investigates the role, recognition, and utilisation of the accredited public health specialist workforce within the NHS in England. It was commissioned by the Faculty of Public Health and the Association of Directors of Public Health to strengthen the evidence base for policy engagement and system improvement and better population health outcomes.

Its purpose is not to argue for professional preservation for its own sake. Rather, it seeks to identify what is missing from current NHS arrangements, what that costs populations, and how the system might better organise itself to improve outcomes, reduce inequalities, and use resources more effectively.

2.2 Definitions and terminology

Accredited public health specialist

For the purposes of this report, an accredited public health specialist is a General Medical Council (GMC) or United Kingdom Public Health Register (UKPHR) registered consultant in public health medicine, those with General Dental Council (GDC) registration in dental public health, or a UKPHR/GMC accredited specialist who has completed recognised training or equivalent portfolio assessment enabling inclusion onto respective specialist registers, and as a result remains subject to professional regulation via the GMC or UKPHR.

Population Health and Public Health

Population health (sometimes referred to as a population health approach) describes the overarching aims of the NHS and UK government to improve health outcomes across whole populations, reduce health inequalities, and prioritise prevention. It defines the goals and outcomes that systems seek to achieve, rather than constituting a distinct professional discipline. As such, the term does not inherently guarantee the involvement of accredited public health specialists.

Public health is the professional specialty that trains and accredits specialists to improve health, protect populations from environmental and infectious risks, and support the effective and equitable use of healthcare services. This latter function, often referred to as healthcare public health, encompasses the skills and competencies needed to translate population health ambitions into practice. These include effective commissioning of healthcare services, population needs assessment, pathway design, service evaluation, addressing inequities in access and outcomes, and allocating resources based on evidence and health economics (including value based care).

The Core Offer

Regulations made under the NHS Act 2006 (as amended by the HSC Act 2012) placed a duty on upper tier and unitary local authorities to “provide or make arrangements to secure provision of a public health advice service to any CCG [and latterly ICB] whose area falls wholly or partly within the authority’s area”. This is known as the Healthcare Public Health Advice Service (Core Offer) and is a prescribed function of the Public Health Grant to local authorities.

System and Place

In this report, 'the system' is used to refer to the wider health and care system, including national bodies, regional structures, providers, commissioners, local government and combined authorities. Where the meaning could be ambiguous, the relevant level is named explicitly.

'Place' is used in this report in the sense common to NHS and integrated-care policy, the geographical and organisational footprint at which place-based partnerships, Health and Wellbeing Boards, and Directors of Public Health operate. We are aware that local government, NHS organisations and combined authorities use the term in distinct ways. Where the meaning shifts, for example to mean a neighbourhood, an ICB footprint, or a combined-authority area, we name the level explicitly. Readers should not assume a uniform definition across all uses in the wider policy literature.

2.3 Structural context

The Health and Social Care Act 2012 transferred public health functions from the NHS to local authorities in 2013, creating a structural separation that has not been reversed. While strengthening the role of public health in local authorities and enabling more direct influence on the wider determinants of health, the NHS no longer had systematic internal access to much of the specialist public health capability it previously relied on.

This gap was partially addressed through the development of the Core Offer. However, the evidence reviewed here, including during the interview process, suggests that Core Offer arrangements are patchy, variably resourced, and increasingly strained by the workload and financial pressures facing local government public health teams.

Successive NHS leaders have also been recruited and developed without routine exposure to public health specialists as close organisational colleagues. As a result, institutional understanding of the role has weakened over time, even as policy expectations around prevention, inequalities, and population health have expanded.

The structural picture is also being reshaped by the emergence of combined authorities and strategic authorities, including mayoral combined authorities with health duties and place-based partnerships in shaping population health. The expansion of devolved health duties to mayors creates both an opportunity and a risk: an opportunity for stronger place-based and cross-system public health leadership; a risk that under-specification of the accredited workforce inside these new structures repeats the 2013 pattern at a different level of the system. The argument of this report applies to combined authorities and strategic authorities with the same force as to ICBs and providers.

2.4 Urgency context

The report's findings are especially relevant now because the NHS is again being reorganised. In periods of structural turbulence, functions that are not clearly specified in workforce plans or governance models are particularly vulnerable to marginalisation or loss.

At the same time, national neighbourhood health guidance offers a strong policy hook. It aligns closely with this report's argument that prevention, community health improvement, and place-based redesign require clearer and more consistent access to specialist public health capability.

The Faculty of Public Health's March 2026 statement on consistent professional standards in senior public health and population health roles reinforces that point. It highlights the risk of filling senior population health roles without the depth of training, competence, and accountability needed for safe and effective leadership for population health outcomes and addressing serious health inequalities.

A further contextual factor warranting brief acknowledgement is the changing role of technology and artificial intelligence in NHS decision-making, population segmentation, risk stratification and prevention. Accredited public health specialists are well placed to take a leadership role in the responsible use of these technologies, including evidence appraisal, equity auditing, bias detection in population-level algorithms, and translation of data and AI outputs into commissioning, pathway and prevention decisions. The next phase of NHS reform should specify a role for accredited public health expertise in the governance of AI-enabled population health and prevention work.

Section 3: Methods

3.1 Policy review and selection rationale

The policy review examined twenty-one documents selected to provide the most contemporary and operationally relevant account of NHS priorities, structure, workforce planning, and population health policy. The review included national operational guidance, structural specifications, legislation, workforce strategies, professional body publications, think tank analysis, and international guidance.

Selection followed four principles: recency, operational relevance, breadth of perspective, and transparency. Documents were chosen to include both those with formal authority over NHS organisations and those that shape debate, professional standards, and policy interpretation.

The twenty-one documents reviewed were:

1. UK Government. Health and Care Act 2022.
2. Department of Health and Social Care and NHS England. Fit for the future: 10-year health plan for England. 2025
3. NHS England. NHS Long Term Workforce Plan.
4. NHS England. A national framework for NHS action on inclusion health.
5. NHS England. Neighbourhood health guidelines 2025/26.
6. NHS England. NHS Operational Planning Guidance 2025/26.
7. NHS England. Medium term planning framework 2026/27–2028/29.
8. NHS England. Model ICB Blueprint v1.0 2025
9. World Health Organization. Defining essential public health functions. 2024
10. Faculty of Public Health. Healthcare public health definition 2017
11. Faculty of Public Health. The role of the NHS in prevention 2025
12. Faculty of Public Health. Faculty of Public Health strategy 2025–2030.
13. The Association of Directors of Public Health. Embedding Public Health across Integrated Care Systems 2023
14. The Association of Directors of Public Health. The role of public health in the NHS in England 2023
15. Royal College of Physicians. Principles for public health.2025
16. NHS Confederation. Prevention, population health and prosperity: a new era in devolution 2024
17. NHS Confederation. Abolishing NHS England 2025
18. The King's Fund. A vision for population health. 2018
19. The King's Fund. NHS priorities for 2025/26: our insights.
20. British Medical Association. Statement on Public Health 2025
21. British Medical Association. Submission to the NHS 10-year plan 2024

3.2 Interview sample

Seventeen semi-structured interviews were conducted between January and February 2026 under Chatham House rules. Interviewees were drawn from NHS England, Integrated Care

Boards, NHS provider trusts, local authorities, combined authorities, think tanks, policy organisations, and professional bodies.

The sample included both registered public health specialists and senior leaders who were not registered public health professionals. The analysis aims to capture multiple vantage points, including critical and challenging perspectives from outside the profession.

3.3 Analytical framework

A structured document review was undertaken to identify the key challenges described in policy, the solutions proposed, how public health was referenced, whether public health was presented as part of the solution, and the extent to which the proposals aligned with recognised public health competencies.

Interview data were analysed thematically and then integrated with the policy review findings. This allowed the authors to identify points of alignment, points of misalignment, and recurring structural patterns across policy and practice.

3.4 Limitations

This was a qualitative study based on purposive and snowball sampling rather than random selection. It cannot claim to represent every perspective across the NHS, and the sample is likely to include a relatively high proportion of individuals with formed views about public health's role.

The policy landscape was also evolving during the period of analysis. Findings should therefore be read as a well-evidenced account of a changing environment rather than as a static snapshot of a settled system.

Anonymisation protects interviewees but reduces the organisational specificity of some quotations. The study is also interpretive rather than quantitative, and it does not attempt to provide definitive estimates of workforce gaps, costs, or return on investment.

3.5 Positionality and declaration of interests

This report was commissioned by the Faculty of Public Health and the Association of Directors of Public Health, and all authors are public health professionals. We wish to make this positionality transparent to readers.

The report has therefore sought to let the evidence speak, to include challenging non-public-health perspectives, and to frame all conclusions in terms of population benefit rather than professional interest.

Part 2 — Policy review

Section 4: What the NHS expects and what it specifies

4.1 Core problem framing

Across the policy review, three challenges recur with notable consistency: operational pressure, financial constraint, and the need to improve outcomes through prevention, equity, and better coordination across organisational boundaries. National policy is therefore not ambiguous about the scale of the problem.

The ambiguity lies in delivery and capability. Policy increasingly expects population health approaches but is much less clear about how this should be optimally achieved, and how accredited public health expertise and leadership should be present in order to deliver them.

4.2 Proposed solutions and workforce demand

The policy review consistently proposes population health, prevention, neighbourhood working, strategic commissioning, and better integration as routes to improved outcomes and better value. However, responsibility is generally assigned to systems, places, neighbourhood teams, or generic leadership functions rather than a consideration of the leadership, accountability and development required. There is a lack of specification of accredited public health roles.

Three patterns are especially visible. First, responsibility is diffused across system leaders and transformation functions. Second, prevention and inequalities work is devolved to local systems without parallel clarity about the professional capability required locally. Third, neighbourhood health is operationalised through plans and teams, but the guidance does not clearly require specialist public health leadership in design, governance, or evaluation.

Population health commissioning deserves particular emphasis. Strategic commissioning is the principal route through which NHS resource is allocated against population need, and is therefore the principal point at which accredited public health expertise translates into population outcome. Commissioning intent, prioritisation frameworks, equity audits, value-based contracting decisions and the use of population segmentation in needs assessment are all areas where accredited public health input is currently inconsistent or absent. The report calls for accredited specialist input to be a stated requirement of NHS strategic commissioning, equity impact assessment and population-health commissioning decisions, at both ICB and provider level.

Section 5: Framework analysis

Theme 1: Problem framing

At strategy level, policy problem framing is often analytically strong. It recognises the interaction of prevention failure, inequality, demand growth, financial pressure, and fragmentation across organisations and sectors.

What weakens between the move from strategy to operational guidance is not the diagnosis but the workforce specification. There is little disagreement about the problems; the silence concerns which workforce (and consequently what implementation plan) is required to solve them.

Theme 2: Solution and workforce demand

The most important structural finding is the gap between ambition and capability design. Population health is repeatedly invoked as a solution, but accredited public health specialists are rarely named as a required part of the delivery model.

This creates an inverse relationship between advocacy clarity and operational authority. The documents that most clearly describe specialist public health capability tend to be professional or advocacy texts, while those with the strongest mandate over NHS organisations tend to use broader and more generic population health language.

Theme 3: Technical value-add recognition

Where specialist public health capability is described clearly, it extends far beyond prevention in the narrow sense. The policy and interview material together support a broader account of healthcare public health that includes epidemiology, health economics, evidence synthesis, equity auditing, strategic commissioning, pathway redesign, resource allocation, operational improvement, and system leadership.

NHS operational documents, by contrast, tend to reduce technical public health capability to data or analytics. This creates conditions for systematic substitution by non-accredited roles and leaves boards, by default or design, substantially missing modern public health.

Theme 4: System architecture

Policy remains largely silent on architecture. The evidence suggests four broad models in practice: embedded NHS roles, reach-in arrangements through local authority teams, hybrid co-funded roles, and fragmented, random substitution.

The Core Offer remains necessary but is no longer sufficient as the whole answer, designed as it was for previous reorganisations. It addresses commissioning more than provider settings and does not fully meet the demands of a system increasingly organised around neighbourhoods, integration, and complex provider-side operational pressures.

Theme 5: Variation in capacity and skillmix

The practical effect of policy silence is geographical variation in provision, influence, and quality. This variation in specialist provision creates unequal access to high-quality population health leadership and advice.

That variation is not merely a professional issue. It has consequences for the quality of decision-making, the equitable use of resources, and the likelihood that populations in different places will benefit equally and equitably from population health approaches.

Part 3 — Interview themes

Section 7: Qualitative interviews — Nine thematic findings

Theme 1: Fragmented architecture and partnership in practice

Interviewees described marked variation in how accredited public health specialists are positioned across NHS organisations. Four broad structural models emerged: embedded roles, reach-in support from local authority teams, hybrid co-funded roles, and fragmented substitution through multiple narrower posts.

The evidence does not support a simple either-or choice between NHS-employed and local-authority-based models. The strongest arrangements were described as complementary, with the Director of Public Health providing leadership at place and NHS-embedded specialists adding operational proximity and internal influence.

“We reach into local authority public health teams when we need analysis or strategic advice. The challenge is we’re not in early conversations about commissioning design — we comment on already-formed plans rather than shaping them from the start.”

“Local authorities are co-funding a public health consultant post inside the ICB. The specialist has a line to the ICB director and dotted lines to three local authority DPHs. This gives them both insider status and system connectivity.”

Theme 2: Blurred role boundaries and external perceptions

A strong theme across the interviews was persistent misunderstanding of what specialist public health contributes. Public health was variously reduced to health promotion, to data and dashboards, or to a late-stage advisory function rather than a shaping role in decisions.

“One of the biggest misinterpretations is that population health data work is the same as population health practice. Data sits separately from strategic interpretation.”

Some non-public-health interviewees described public health as being “in the background,” while others characterised it as the function that “just tells us what we can’t do,” which reflects a reputational and relational challenge as experienced from outside the profession.

Additionally, interviewees who work closely with accredited public health professionals described public health as bringing unique and useful skillset that was essential if we are to achieve the population health improvements we hope to. Reasons for this included that the profession has been systematically sidelined, at the same time as losing confidence over its

core value and professional identity. Something that in turn led to lack of ambition and comfort in risk when trying to initiate change.

“Many people think public health is just smoking cessation and weight management. There’s a much deeper strategic and technical capability that’s not being recognised.”

“Public health is seen as the function that says why you can’t do this rather than how to make this work. It’s seen as a brake rather than an accelerator.”

Interviewees suggested that the widespread use of the term population health across non-accredited roles has made it genuinely unclear to many NHS leaders who is qualified to lead work of such critical importance. This confusion was described as structural rather than incidental.

Theme 3: What accredited public health specialists distinctively offer

Interviewees were clear that accredited public health specialists contribute more than technical analysis. Their distinctive contribution lies in integrating epidemiology, evidence appraisal, health economics, equity analysis, policy interpretation, and leadership into forms that are usable in live NHS decision-making.

This integrative value was linked to practical issues including pathway design, inclusion health, strategic commissioning, equitable access, and the ability to bring population need into rooms otherwise dominated by activity, finance, or organisational imperatives. Interviewees also described public health specialists as a source of institutional memory during repeated system reorganisation.

“The consultant brings data, economics, and evidence, but also the confidence and training to land that in rooms with lots of complexity — boards, clinical leaders, and finance teams.”

“What public health people bring, at their best, is the ability to connect things — convening people around problems and bringing silos together. You don’t get that from narrower roles.”

“A public health consultant brings a trained eye for equity — who does this policy benefit, who does it harm. That’s not automatic in other roles.”

“Public health practice can be best thought of as a lens, rather than a discrete set of competencies, like you might find in a surgeon or GP. This can cause some confusion as to what we can do, but also lends itself to managing uncertainty in complex systems, and the ability to be dynamic and reflexive.”

Some interviewees described the breadth of skills and experiences they bring to the workplace, aligning them well with senior strategic and leadership roles, where system thinking and collaboration is key. However, public health specialists in senior leadership or

board level positions in ICBs and provider trusts are currently the exception rather than the norm.

Theme 4: Absence of a clear spokesperson and blurred professional identity

Interviewees repeatedly pointed to the absence of a single, clearly recognised spokesperson or “public face” for public health in England, something they described as worsening significantly following the dissolution of Public Health England in 2022. Unlike other clinical disciplines with visible royal colleges and defined public identities, public health is often experienced as a loose collection of roles and organisations, which makes the profession, and the role of accredited consultants in particular, relatively unknown to many NHS leaders, politicians and the public.

Participants described a crowded organisational landscape in healthcare, (professional bodies, advocacy organisations, academic centres) with no agreed, clear narrative about what a public health consultant is, what they are accountable for, and how they differ from generic “population health” or analytics roles. This blurred professional identity, combined with the lack of a coherent spokesperson function, was seen as contributing directly to misunderstandings of public health as “health promotion” or “the team that says you cannot do things”, rather than as a distinct profession offering integrated expertise in epidemiology, health economics, pathway redesign, equity and system leadership. Interviewees with specialist accreditation in public health, and those who worked in adjacent roles, argued that until the profession has a clearer, shared identity and visible spokesperson role, it will remain under-recognised in national workforce plans and under-utilised in system-level decision-making.

Interviewees described this having an impact both on the external perception of the profession, but also the internal professional identity. In turn this contributed in part to individuals with less confidence to bring challenge in their organisations and more likely to operate defensively and avoid risk.

Theme 5: Relevance to current NHS operational problems

Interviewees strongly rejected a framing in which public health is relevant only to long-term prevention. They linked public health directly to present-day NHS problems including elective recovery, urgent and emergency care, pathway redesign, strategic commissioning, service access, inclusion health, financial sustainability, and mental health service planning.

This broader framing should be explicit. Public health is not only about preventing future illness; it also contributes to better use of current resources, better pathway design, more effective targeting of services, and more equitable access to care in the present.

“Understanding population need, designing efficient pathways, reducing waste — exactly what’s needed. But it’s not being prioritised because the system is fighting fires day to day.”

“On refugee health and homeless health, the public health consultant has been central to designing the pathway, commissioning the right services, and evaluating whether it’s working. That’s a microcosm of what could happen system-wide.”

Theme 6: Duplication, fragmentation, and unwarranted variation

Interviewees described settings in which multiple teams were independently producing overlapping needs assessments, strategy papers, health inequalities analyses, and planning products with limited coordination.

In some places this extended to duplication around health needs assessment, Joint Strategic Needs Assessment-related work, and parallel analytical exercises produced by different NHS, local authority, or transformation teams. The problem was not only inefficiency but the loss of integrative judgement that occurs when analysis, strategy, equity, and delivery are split across disconnected functions.

“We ended up with three separate teams doing what could have been done by two accredited consultants. Because the capability is fragmented, no one is doing the integrative work.”

“Some systems have relatively advanced embedding. Others are patchy, dependent on local personalities, or lacking embedded capacity in the most deprived areas.”

Theme 7: Influence, professional independence, and development

A recurring concern was the gap between nominal responsibility and real influence. Interviewees described formal population health roles that were advisory in practice, entering decision-making after the major financial, contractual, or operational parameters had already been set.

“On paper, I’m responsible for population health and inequalities. In practice, I arrive at strategic commissioning meetings after the major financial and operational constraints have already been set.”

“If you’re in a portacabin away from the rest of the hospital HQ, you’re going to be quite limited in your influence.”

“The training programme is rotational and supernumerary. You’re not line-managing people or developing operational experience. But when you finish, suddenly you’re expected to manage teams and drive change.”

Theme 8: The training and development gap

A major theme in the interviews was that the central training issue is not a lack of theory, epidemiology, or analytical method. Rather, the gap lies between formal public health training and the operational, managerial, and leadership realities consultants face once they qualify.

Interviewees consistently noted the supernumerary nature of trainees and being incentivised to take on multiple short rotations, meaning many complete training without sustained line management experience, operational accountability, budget responsibility, or enough exposure to delivering change in live services.

Additionally, the lack of current public health leadership in healthcare was acknowledged by interviewees to have led to a gap in training opportunities, limiting the development of public health skills in healthcare contexts since 2013.

As a result, new consultants may enter senior roles with strong analytical and population health capability, but weaker preparation for leading teams, managing risk, navigating politics, influencing executive decisions, translating policy into delivery, and the practical skills needed to work effectively inside complex NHS systems.

“The training programme is rotational and supernumerary. You’re not line-managing people or developing operational experience. But when you finish, suddenly you’re expected to manage teams and drive change.”

This was described as a broader capability gap in operational management, people management, financial management, change management, legal/policy analytical skills and the practical skills needed to work effectively inside complex NHS systems. Several interviewees suggested that short placements and a strong focus on evidencing learning outcomes can also encourage caution, discourage ownership, and make trainees less likely to take on ambitious, high-impact work with real delivery responsibility.

A key distinction in the interviews was between learning about leadership and actually doing leadership. Interviewees did acknowledge that leadership development opportunities already exist across the system, including new consultant programmes, board-preparation routes, regional development offers, consultant networks, and leadership pathways linked to aspiring DPH or other senior roles. However, these opportunities were described as patchy, inconsistent, and often more educational than experiential, and were seen as helpful but insufficient if they do not give trainees and early consultants real accountability, real visibility, and real exposure to operational decision-making.

Interviewees proposed giving trainees more embedded responsibility during training, with placements that offer greater operational depth and closer involvement in delivery, particularly in provider settings, urgent care, elective recovery, mental health, and other areas where current NHS pressure is greatest.

There was also support for learning from adjacent fields such as policy, strategy, legal analysis, business schools, and management disciplines. This reflected a view that senior public health roles now require a wider blend of technical credibility and executive capability

than training has always provided consistently. As such, it was thought that current focus in assessments on epidemiology and statistics, while important, is not representative of the day-to-day work of the public health consultant body.

Finally, interviewees emphasised that development should not stop at CCT. They described a need for clearer post-training pathways, stronger mentorship, more structured leadership development, and greater parity of esteem with other professions that receive more formal support after qualification.

Overall, the interviews suggest that the issue is not whether public health training is academically robust, but whether it equips future consultants for the authority, ambiguity, and operational leadership required to operate in the contemporary NHS.

Theme 9: Best practice, future models, and leadership at place

The interviews did not describe only deficits. They also identified examples of best practice, including embedded consultants in provider organisations, co-funded posts connecting ICBs with multiple Directors of Public Health, and arrangements where specialists were involved early enough to shape commissioning and redesign rather than comment on it after the fact.

These examples matter for two reasons. First, they show that strong public health contribution is feasible under current conditions. Second, they suggest practical design principles for neighbourhood working and emerging IHO development: strong DPH leadership at place, stronger embedded public health capacity within NHS organisations, and reciprocal partnership arrangements rather than transactional exchange.

Additionally, they acknowledged increase in population health language and structural inclusion of public health principles in the evolving system (for example, the development of integrated commissioning and neighbourhood/place based approaches) was celebrated as a success, but also acknowledged as a risk to the public health workforce. Several interviewees described increased awareness of health inequalities, and requirements to promote access or reach underserved groups being built into commissioning. These positive developments potentially had the less desirable consequence of 'ticking the box' of public health, and potentially making the additive value of public health expertise more difficult to justify.

Several practical examples emerged from the interviews and bear naming here as illustrations of what good can already look like.

- One ICB alongside three constituent upper-tier local authorities jointly co-funded a public health consultant post; the consultant holds a substantive role within the ICB executive's strategic commissioning team while retaining strong professional accountability to the local-authority DPH network.
- A large provider organisation has embedded an accredited consultant within its inclusion-health and elective recovery functions, where the role shapes commissioning and pathway redesign from the inception of strategy rather than commenting after the fact.

- A combined-authority public health team has built a hybrid model in which consultants rotate across NHS provider, ICB and local-authority functions to develop the next generation of senior leaders fluent across all three settings.

These examples are not yet the norm, but they show that the architecture this report calls for is feasible under current conditions and that the design principles are deliverable now.

Part 4 — Integration and Analysis

Section 8: Integrated analysis

8.1 Overall interpretation

Taken together, the policy review and qualitative interviews point to a clear and consistent conclusion: the NHS increasingly expects improved population health outcomes but does not yet consistently specify, secure, or support the accredited public health specialist capacity required to deliver them.

This is not principally a problem of rhetorical commitment. Across policy, population health, prevention, inequalities reduction, neighbourhood working, strategic commissioning, and service redesign are all increasingly prominent. The problem lies in the translation of these ambitions into population level health outcomes, workforce architecture, governance, professional standards, and day-to-day operational influence.

8.2 The central gap

The central analytical finding of this report is the gap between policy ambition and capability design. National strategy increasingly asks the NHS to work differently, but the operational and structural documents with greatest authority rarely specify what aligned workforce, including accredited public health leadership and expertise, should be present in order to do so safely and effectively.

This matters because public health is not simply a mindset or a generic strategic orientation. It is a defined body of expertise with recognised standards, trained judgement, and an integrative capability that brings together epidemiology, evidence appraisal, health economics, needs assessment, prioritisation, pathway redesign, and equity analysis. While it is important to recognise the successes of public health language and framing being more present than ever in health services, this is not a substitute for professional public health capacity.

8.3 Beyond prevention

A major theme across the evidence is that the role of public health in healthcare is often understood too narrowly. Prevention remains central, but the contribution of public health specialists extends considerably beyond health improvement functions and can be considered as part of the strategic apparatus of health service delivery.

Interviewees described distinctive potential value in interpreting system data in relation to population need, designing and evaluating pathways, supporting strategic commissioning, applying health economics, reducing unwarranted variation, bringing an explicit equity lens to service design, and connecting healthcare delivery with wider determinants and local

government. This wider contribution is both more accurate and has much more to offer than a narrow prevention-only framing.

The contribution of accredited public health specialists is best described as both art and science. Technical and analytical capability is the gateway to wider influence, particularly with clinical leaders and medical directors, but it is the integrative judgement and convening leadership, what some interviewees called the 'lens' rather than the discrete skill set, that delivers the value. The report should not be read as foregrounding the technical at the expense of the relational; both are required, and neither succeeds without the other.

8.4 Leadership readiness and training

Even where public health roles exist, the system is weakened if consultants are not consistently prepared for the operational, managerial, political, and executive realities of senior NHS leadership.

This means the workforce problem is twofold. The NHS lacks both sufficient clarity about where specialist public health capability should sit and sufficient support for how that capability is developed before and after qualification.

8.5 Variation, duplication, and fragmentation

This report identified a pattern of geographical variation and internal duplication. In some systems, specialist public health expertise is well integrated, linked to local authority leadership, and used constructively in commissioning and provider settings, while in others functions are fragmented across analytics, transformation, strategy, and inequality teams with no single locus of integrative judgement.

This creates both inefficiency and strategic loss. Data may be available without interpretation, inequality may be recognised without a route to redesign, and prevention may be discussed without the operational leverage to influence real decisions.

8.6 Architecture, place, and leadership

The strongest arrangements described in this study were those that recognised the unique and complementary contribution of public health functions in the NHS and in local government.

The Director of Public Health remains the leadership anchor at place, with democratic legitimacy, community connection, and a core statutory role in linking the NHS to local priorities and wider determinants. Nothing in this report should be interpreted as reducing that role.

At the same time, local authority public health teams cannot be expected to carry the whole burden of the potential health dividend from the complex array of NHS health services solely through a reach-in model alone. The most promising future models will reflect complementarity: strong DPH leadership at place, combined with embedded or hybrid

specialist roles within ICBs and NHS organisations, connected through partnership rather than transactional exchange.

8.7 The current policy window

The current policy context gives this analysis unusual urgency. The healthcare system is undergoing large scale reorganisation against a background of widening inequality in health outcomes, and stagnating and declining life expectancy. Reorganisation creates risk, but it also creates a rare opportunity to build public health capability into the next phase of NHS structures by design rather than by exception.

If the system wishes to make population health real, it must be clearer about the leadership, standards, and specialist expertise required to do so. Otherwise, it risks repeating the errors of earlier reforms by expanding expectations while leaving accountability and capability underdefined.

Part 5 — Conclusions and outputs

Section 9: Recommendations

9.1 Recommendation 1: Rebuild specialist public health leadership into NHS decision making across ICBs and providers.

The NHS should establish consistent access to accredited public health specialist leadership within ICBs and relevant provider organisations. This should include substantive roles with influence over strategy, commissioning, service redesign, inequalities work, and performance improvement, rather than marginal or purely advisory positions.

9.2 Recommendation 2: Continue to recognise Directors of Public Health as the leadership anchor at place

At a system level, Directors of Public Health are, and should remain, the statutory leadership anchor at place for population health improvement, connecting the NHS to local government, communities and the wider determinants of health. The next phase of NHS reform presents an opportunity to ensure that the DPH is positioned in such a way that their specialist public health expertise can support NHS system-level decision making, with visibility from the inception of strategy and commissioning rather than commentary at the end. As population based delivery models evolve into Integrated Health Organisations with responsibility for whole population planning and geographically defined budgets, this positioning reinforces the DPH's statutory leadership role for the populations they serve. Any expansion of public health capacity within the NHS should complement, not dilute, the core capability and leadership of local authority public health teams.

9.3 Recommendation 3: Strengthen professional standards in senior roles public health and population health roles

Senior public health and population health roles should be underpinned by and adhere to the clear standards laid out by the Faculty of Public Health. Specifically, the Faculty of Public Health's March 2026 Statement on consistent professional standards in senior public health and population health roles should be adopted by NHS organisations as the operational benchmark for appointing, evaluating and supporting individuals into senior public health and population-health positions. ICBs, provider trusts, Integrated Health Organisations and emerging combined-authority public health functions should, within the next planning cycle, confirm their alignment with the 2026 standards or set out the steps and timeline to achieve

it. NHS England's successor body and DHSC should reference the 2026 standards within national workforce guidance.

9.4 Recommendation 4: Move beyond the Core Offer to a partnership model of healthcare public health

The Core Offer was originally designed to embed involvement in NHS decision-making from the outset. The argument of this report is therefore not that the Core Offer was poorly drafted; it is that the conditions under which it operates have changed. Financial pressure on local-authority public health teams, the proliferation of NHS organisations expected to act on population health, and the emergence of neighbourhood working and Integrated Health Organisations together mean that reach-in alone now under-uses the original design intent of the Core Offer. The FPH and ADPH therefore propose extending and operationalising that original intent through partnership, reciprocity, shared accountability and complementary capability, including embedded NHS-side specialist roles working alongside, not in place of, local-authority public health teams.

9.5 Recommendation 5: Reform training and post-CCT development so that future consultants are best prepared for operational, managerial, and leadership responsibility.

The Faculty of Public Health should make a substantive healthcare public health placement (minimum twelve months equivalent, embedded within an NHS organisation, ICB, provider or Integrated Health Organisation, and supervised by an accredited public health consultant) a mandatory requirement of the public health specialty training curriculum, rather than waiting for placements to emerge organically. Making the placement a requirement is itself a lever for the systematic development of the embedded posts the next NHS architecture needs.

Post-CCT development should be specified to a comparable standard to other senior professions: a structured first-five-years pathway, formal mentorship by an experienced consultant or DPH, access to operational and managerial leadership development through NHS Leadership Academy-equivalent routes, and a named regional or system-level lead accountable for early-career consultant development. The current absence of a defined post-CCT pathway is one of the report's central training findings and should be addressed in the curriculum review.

Training reform should explicitly prepare future consultants to operate in the inherent uncertainty of NHS environments: managing ambiguity, financial constraints, team leadership, organisational politics and the rapid translation of evidence into delivery under pressure. Technical and analytical rigour remains necessary; it is no longer sufficient on its own. Curriculum, assessment and placement design should each test for the practical capabilities needed to lead in complex, rapidly changing systems.

9.6 Recommendation 6: Build public health capability into neighbourhood working and emerging Integrated Health Organisation development.

Current policy priorities around neighbourhood health and emerging IHO development should be co-produced with healthcare public health professionals. Public health capability should be designed into these structures from the outset rather than treated as an optional add-on.

Where combined authorities and mayoral health duties apply, accredited public health leadership should be specified within their executive functions, including coordination with constituent Directors of Public Health and alignment with neighbourhood health and Integrated Health Organisation development across the geography.

9.7 Recommendation 7: Reduce fragmentation and duplication through integrative and system leadership

Systems should recognise that the public health and population health workforce is relatively small (with approximately 1,250 consultants nationally), and is distributed across a range of organisations, including local authorities, the NHS, DHSC, UKHSA and higher education institutions. To maximise impact, systems should review where population health functions are currently fragmented across multiple teams and whether this fragmentation is producing duplication, weak accountability, or loss of integrative judgement. The aim is not unnecessary centralisation but clearer alignment of analytics, needs assessment, strategy, inequalities, and service redesign functions around population outcomes.

9.8 Recommendation 8: Reframe healthcare public health as a broad strategic capability

Healthcare public health, and healthcare public health professionals should push for HCPH as a commissioned capability extending beyond prevention into pathway redesign, strategic commissioning, health economics (including value based care), operational improvement, service evaluation, equity analysis, and whole-system leadership. Narrow framing weakens both recruitment and utilisation.

9.9 Recommendation 9: Strengthen communication of the value and identity of accredited public health professionals.

Public health professional organisations, including FPH and ADPH, should take a more proactive role in articulating both the distinctive value and the professional identity of accredited public health consultants as senior system leaders for population health. This includes clearly communicating what defines a public health consultant as a profession, its

standards, accountability and integrative skillset, as well as the need for a public health workforce strategy.

Programmes of engagement with national and local policy makers, and a broad constituency with an interest in population health could encompass a bespoke communication to this effect. The purpose of these approaches will be to enable NHS leaders to understand, recognise and utilise the public health function for the value it can and does bring towards the 'health dividend' from the NHS.

Importantly, in articulating the distinctive value of the accredited public health profession, the FPH and ADPH should be careful not to disenfranchise the wider population-health workforce, including analysts, programme leads, public health practitioners and non-accredited specialists who are delivering valuable work across the NHS and local government. The professional identity statement should be coupled with a proactive invitation: clear pathways into the profession via UKPHR portfolio assessment, formal apprenticeships, post-qualification fellowships, and active membership of professional networks. The aim is to lead a wider movement, not to draw exclusionary lines around it.

9.10 Recommendation 10: Define and share best practice models for how accredited public health advice and leadership can be organised within and around NHS settings.

A follow-on piece of work should develop best practice frameworks for how public health advice and leadership can be organised within and around the NHS. These could include embedded models within provider organisations, hybrid co-funded roles spanning NHS and local government, commissioning-facing roles within ICBs, and arrangements supporting neighbourhood health and emerging IHO development.

Section 10: Conclusion

10.1 Closing interpretation

This report began with a concern that the NHS increasingly calls for population health approaches while failing to consistently recognise, deploy, and support the accredited specialist workforce required to deliver them. The combined evidence suggests that this concern is well founded.

Across policy and practice, population health is strongly endorsed as an ambition. Yet the architecture needed to realise that ambition remains incomplete, and specialist public health capability is too often diffuse, under-specified, or unevenly distributed.

The significance of this is not primarily professional. It is practical and public-facing: when the NHS lacks consistent access to high-quality public health leadership and advice, it is less well equipped to understand need, address inequalities, redesign services, improve value, and connect healthcare delivery to wider population outcomes.

10.2 Final message

The present period of system redesign gives this analysis unusual urgency in the presence of high need for health as well as health service. Reorganisation creates risk, but it also creates a rare opportunity to build public health capability into the next phase of NHS structures by design rather than by local chance.

If the system wishes to make population health real, it must be clearer about the leadership, standards, and specialist expertise required to do so.

Section 11: Next Steps

This report is qualitative and interpretive. Its findings should not be treated as the last word on the subject.

The next phase should include structured conversations with NHS executive leaders, Integrated Care Board leaders, Directors of Public Health, provider organisations, trainees and early-career specialists, and relevant national policy and professional bodies.

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Appendices

Appendix A: Policy Review Matrix

Document	Organisation	Year	Type	Top 3 challenges identified	Workforce classification	Technical value-add	Architecture
NHS Operational Planning and Guidance 2025/26	NHS England and	2025	Operational guidance	Elective backlog; financial deficit; vacancies	Generic PH demand	Minimal	Unclear
Model ICB Blueprint v1.0	NHS England and	2024	Structural specification	Financial sustainability; prevention gap; inequalities	Generic PH demand	Partial	Unclear
Health and Care Act 2022	UK Government	2022	Legislation	Fragmentation; NHS–LA separation; inequalities	Implicit generic	Minimal	Hybrid implied
BMA Statement on Public Health	BMA	2024	Advocacy	Role clarity; recognition; positioning	Explicit PH specialist	High	Hybrid advocated
FPH — The role of the NHS in prevention	FPH	2023	Guidance	Prevention deficits; NHS–PH separation; capability gaps	Explicit PH specialist	High	Embedded/r each-in

RCP Principles for Public Health	RCP	2023	Principles	Inequalities; prevention; evidence-based practice	Implicit	High	Not specified
FPH Healthcare Public Health Definition	FPH	2022	Definition	Role confusion; under-recognition; positioning	Explicit PH specialist	High	Not specified
NHS Confederation — Devolution Reforms	NHS Confederation	2024	Policy analysis	Fragmentation; NHS–LA separation; governance	Generic PH demand	Partial	Hybrid implied
BMA Submission to the NHS 10-Year Plan	BMA	2023	Submission	Workforce recognition; prevention; career progression	Explicit PH specialist	High	Embedded advocated
Abolishing NHS England	NHS Confederation	2024	Policy analysis	Governance; strategic coherence; accountability	Implicit	Partial	Hybrid/unclear
Fit for the future: 10-year health plan for England	DHS C/NHS England	2025	National strategy	Prevention deficits; financial sustainability; inequalities	Generic PH demand	Partial	Unclear
NHS Long Term Workforce Plan	NHS England	2023	Workforce planning	Pipeline deficits; recruitment; multi-professional balance	No PH demand	Minimal	Not addressed

A national framework for NHS action on inclusion health	NHS Engl and	2024	Framework	Inequalities; vulnerable populations; coordination	Generic PH demand	Partial	Unclear
Neighbourhood health guidelines 2025/26	NHS Engl and	2025	Operational guidance	Community engagement; prevention; neighbourhood structure	Generic PH demand	Minimal to partial	Unclear
A vision for population health	The King's Fund	2024	Think tank	Fragmentation; prevention deficits; inequalities	Implicit	High	Hybrid advocated
NHS priorities for 2025/26: our insights	The King's Fund	2025	Policy insights	Financial pressure; prevention underinvestment; inequalities	Generic PH demand	Partial	Unclear
Medium term planning framework 2026/27–2028/29	NHS Engl and	2025	Strategic planning	Financial sustainability; transformation; long-term prevention	Generic PH demand	Partial	Hybrid implied
Faculty of Public Health strategy 2025–2030	FPH	2025	Professional strategy	Role clarity; recognition; NHS integration	Explicit PH specialist	High	Embedded/r each-in

Defining essential public health functions	WH O	2 0 2 3	Interna tional guidan ce	System leadership; evidence- based governance ; equity	Implicit	High	Embedded standard implied
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Appendix B: Interview analysis matrix

Interviewee	Role type	Model described	Technical value-added view	Governance authority view	Substitution risk identified	Preferred future scenario
1	NHS England regional (healthcare PH)	Reach-in	High	Low	Yes	Hybrid
2	NHS England regional (inequalities)	Fragmented	High	Low	Yes	Embedded
3	NHS England regional (workforce)	Fragmented	Partial	Low	Yes	Explicit mandate
4	ICB Director (population health)	Embedded	High	Medium	Yes	Embedded + incentive change
5	ICB Director (PH strategy)	Fragmented	High	Low	Yes	Hybrid
6	ICB PH Lead (system integration)	Hybrid co-funded	High	Medium	Yes	Hybrid co-funded
7	NHS England Head of Profession	Fragmented	High	Low	Yes	Explicit mandate
8	NHS Trust Director (healthcare PH)	Embedded	High	Medium	Yes	Executive leadership

9	Local authority DPH	Reach-in	High	Low (in NHS)	Yes	Hybrid
10	Think tank (policy and economics)	Fragmented	High	Low	Yes	Incentive change + leadership development
11	Policy analyst (technical)	Fragmented	High	Low	Yes	Hybrid
12	Combined authority leader	Fragmented	Partial	Low	Yes	Explicit mandate
13	Regional system leader	Fragmented	Partial	Low	Yes	Incentive change
14	NHS Trust Director (specialist projects)	Embedded	High	Medium	No (in own org)	Embedded
15	BMA PHMC Chair	Reach-in / fragmented	High	Low	Yes	Explicit national mandate
16	Think tank (system architecture)	Fragmented	High	Low	Yes	Hybrid
17	Think tank (policy and workforce)	Fragmented	High	Low	Yes	Explicit mandate

Appendix C: Thematically Organised Interview Quotations

B1: On Workforce Architecture and System Positioning

"You need someone who can speak epidemiology, health economics, evidence synthesis, and service delivery at the same time. Finding people who do all three fluently is rare." — *Interviewee 4*

"We ended up with three separate teams doing what could have been done by two accredited consultants. Because the capability is fragmented, no one is doing the integrative work." — *Interviewee 5*

"Local authorities are co-funding a public health consultant post inside the ICB. The specialist has a line to the ICB director and dotted lines to three local authority DPHs. This gives them both insider status and system connectivity." — *Interviewee 6*

"Some systems have relatively advanced embedding. Others are patchy, dependent on local personalities, or lacking embedded capacity in the most deprived areas." — *Interviewee 6*

B2: On Role Misunderstanding

"There's quite limited understanding of what consultant public health can bring. Many people think it's just smoking cessation and weight management." — *Interviewee 3*

"One of the biggest misinterpretations is that population health data work is the same as population health practice. Data sits separately from strategic interpretation." — *Interviewee 11*

"Public health is seen as the function that says why you can't do this rather than how to make this work. It's seen as a brake rather than an accelerator." — *Interviewee 7*

B3: On Technical Value-Add

"A public health consultant is confident and competent to practice independently across any of the three domains — health protection, health improvement, healthcare public health." — *Interviewee 15*

"What public health people bring, at their best, is the ability to connect things — convening people around problems and bringing silos together." — *Interviewee 10*

"A public health consultant brings a trained eye for equity — who does this policy benefit, who does it harm? That's not automatic in other roles." — *Interviewee 2*

"In a system that's constantly reorganising, public health people represent continuity — the institutional memory that helps systems not lose everything when structures change." — *Interviewee 10*

B4: On Governance Authority, Influence, and Professional Independence

"On paper, I'm responsible for population health and inequalities. In practice, I arrive at strategic commissioning meetings after the major financial and operational constraints have already been set." — *Interviewee 6*

"Many public health consultants have formal posts in ICBs or trusts, but their authority is advisory. They're not on the real governance pathway where decisions get made." — *Interviewee 7*

"If you're in a porter cabin in the clinical audit team, you're going to be quite limited in your influence." — *Interviewee 8*

"Public health consultants are less visible than they should be. We're definitely not getting maximum use and value out of them." — *Interviewee 12*

B5: On Workforce Planning, Career Development, and Training

"If you look at the National Workforce Plan, there's no clarity that accredited public health specialists are needed. So ICBs think: this doesn't seem to be a priority nationally, so we won't prioritise it locally." — *Interviewee 15*

"NHS England has effectively acted as if public health is a local authority function. There's been a turnover of NHS leaders who've never worked with public health as part of their organisation." — *Interviewee 7*

"The training programme is rotational and supernumerary. You're not line-managing people or developing operational experience. But when you finish, suddenly you're expected to manage teams and drive change. The programme doesn't prepare you for that reality." — *Interviewee 10*

B6: On Future Scenarios

"We need clarity that public health consultants should be in place at every ICB, every large provider trust, every combined authority. Population health outcomes cannot be delivered without that capability." — *Interviewee 15*

"Rather than sitting in advisory roles, public health specialists should be targeting CMO, Director of Strategy, or executive director positions. That's where you get real influence." — *Interviewee 8*

"If NHS England made prevention and inequalities reduction core performance metrics — not just nice words — then organisations would naturally start recruiting public health specialists because they'd need them to hit targets." — *Interviewee 13*

"Co-funding public health consultant posts inside ICBs, with specialists maintaining strong links to local authority DPHs and networks. This gives you insider governance authority plus system-wide connectivity." — *Interviewee 6*