Strategy for developing the UK specialist public health workforce 2025 - 2030

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FACULTY OF PUBLIC HEALTH

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Introduction

The public health workforce is the backbone of our public health system. They work tirelessly to protect and improve the health of our population. They are on the frontline of our fight against infectious diseases, chronic diseases, and health inequalities. They are tireless advocates for health equity and addressing the social and structural determinants of health whilst ensuring high quality health and care contributes to improving population health and wellbeing.

The public health workforce is also one of our nation's most valuable assets. They are highly skilled and experienced professionals who have a deep understanding of the complex challenges facing our public health system. The COVID-19 pandemic demonstrated beyond doubt the importance of our workforce in responding to the biggest threat to population health in peacetime this century. Few can now doubt that public health is an integral part of the national health and social care system albeit that there are significant differences in the organisation of the public health services amongst the Four Nations of the UK.

Today, public health professionals play a vital role in protecting and improving the health of the population. They work in a wide range of settings, including local government, the NHS, and academia. Yet this vital workforce now faces a number of challenges, including an aging workforce, uncertain financial environments and increasing demands on services from growing population ill-health.

This framework for a UK Public Health Specialist Workforce Strategy, developed in partnership with the main UK public health partners, sets out a number of principles, priorities and actions that we believe can be taken to address these challenges and build a specialist public health workforce that is fit for the future.

The strategy naturally builds on previous work which describes the functions and standards of a public health system, and the skills needed to deliver them (Appendix IV).

It is accepted that there is a lack of consensus in the use of terminology in public health workforce nomenclature. These are long standing issues, and this strategy does not attempt to explicitly define terms such as specialist and core public health, but this strategy refers to those who have completed training and are on specialist registers for the General Medical Council (GMC), General Dental Council (GDC) or have specialist registration with the United Kingdom Public Health Register (UKPHR). It recognises that this will not please all readers!

Rationale

The ongoing repercussions of the COVID-19 pandemic and multiple, concurrent threats, the time is right for us to focus on the development of a coherent, realistic, affordable and desirable strategic plan for a robust **specialist public health workforce**:

- The health of the population for the first time since world war two is declining when measured by life expectancy and by increasing health inequalities
- Current and future demographic, economic and health trends suggest an increasing need for a diverse, well-trained core public health workforce working across national, regional and local systems
- The NHS long-term workforce plan has specific recommendations for public health, especially in secondary prevention and health care public health in England and Wales
- Scotland and Wales recognise the need for a public health workforce strategy
- Climate change is the biggest threat to global health and public health professionals are well placed to provide leadership and expertise in tackling this issue
- The wider public health system has been hampered by the lack of a clear career structure; a strategy which delivered accessible pathways and had the support of key

employers would help ensure that recruitment and retention of sufficient numbers of well-trained staff are available to provide a robust, high quality public health workforce

It has long been the conclusion of many authoritative reports (the Black Report and the Marmot reports) that a public health approach is likely to provide the most efficient, effective and cost-effective approach to improving population health and reducing health inequalities. Yet over the last few decades the urgent pressures in the system such as waiting lists and times, often have been prioritised over evidence-based sustainable public health measures.

Principles and values of the framework

This framework for a UK-wide **specialist public health workforce** strategy aims to inform a more strategic and inclusive approach to the development of this vital resource. Core principles underpinning the framework include:

- The primary focus is to improve the health of the population and reduce health inequalities
- Recommendations will be based wherever possible on good quality evidence
- The proposals should be cost-effective
- Implementation should be realistic, and structures should be efficient
- The strategy should be underpinned by information and intelligence systems which allow for meaningful monitoring and robust governance arrangements
- Sufficient numbers of well-trained public health staff to carry out the functions of a robust public health system.
- The public health workforce should reflect high standards of equality, diversity and inclusion.
- Clear routes for progression into the specialist workforce, including for public health practitioners.

Definitions

At the present time there remains debate on the definition of the public health workforce, nonetheless a proposed definition is set out in Appendix IV which it is hoped that partners will feel able to subscribe to. Partners need to be clear on the composition of the workforce. Many jobs require some public health knowledge, skills and/or responsibilities within their remit (e.g. general practice) but would not usually be regarded as part of the public health workforce. Others are more nuanced, such as nursing, where those with a Specialist Community Public Health Nursing (SCPHN) qualification or Masters in Public Health (MPH) would be seen as part of the core public health workforce, with the wider nursing profession playing an important part in the extended public health workforce.

This paper will mainly comment on the **specialist public health workforce**, the career pathways into specialist training and some of the key priorities in the development of career pathways with appropriate training and governance for the less specialist public health workforce. It is particularly important that public health practitioners are a valued core part of the public health workforce whether or not they aspire to become specialists. For those that do wish to become specialists, clear, flexible, high-quality pathways are needed.

Where are we now: the specialist public health workforce

Whilst the specialist public health workforce has a clear career pathway with robust governance and educational and training standards overseen by the FPH, there is a lack of coherent career pathways, governance, educational and training standards for other

elements of the public health workforce especially if their role does not also require registration with another health body (e.g. environmental health). Even when the evidence-basis for the role is clear, e.g. in smoking cessation, sexual health, immunisation and screening, the practitioner role in these areas is not well regulated.

In recent years, the public health workforce has faced a number of challenges, including budget cuts, an aging workforce, and increasing demands on services. However, public health professionals have continued to deliver high-quality services and make a real difference to the lives of millions of people. The current **specialist public health workforce** situation can be summarised via a SWOT analysis:

Strengths	Weaknesses
• High political, professional and public recognition of the value of public health workforce due to pandemic • High demand for specialist training in public health and for public health-related academic qualifications including MPH, MSc both from UK and internationally • Well respected public health specialty training programme and public health CPD scheme • Many well respected, influential public health academics • Extensive evidence base demonstrating the effectiveness of many public health interventions	• Low workforce morale affecting retention • Many unfilled consultant posts; up to an estimated 30 per cent of posts unfilled in 2022, impacting different parts of the country in different ways • An ageing specialist workforce with many due to retire by 2030 • Unclear, poorly regulated practitioner career pathways • No coherent national public health workforce strategy • Integrated Care Boards (ICBs) have variable public health input in England • Lack of clarity re public health leadership in the system
Opportunities	**Threats**
• Good relationships between the various public health organisations in the UK • Ensuring public health training meets new health challenges, especially climate change • Improving IT systems allowing more timely, better quality public health intelligence	• System reorganisation, especially in England • Cost pressures to public health budgets. Significant real term cuts in public health budgets for last decade. Funding from central government has fallen by 24% since 2015/16 in England with similar reductions in the rest of the UK • Significant pay and conditions disparity between GMC and UKPHR registrants; an inequity which is difficult to justify for people who have undertaken the same specialist training pathway • Republic of Ireland offers much better consultant pay and T&Cs compared to Northern Ireland

Future public health practice: threats and opportunities

The UK public health workforce faces several challenges and opportunities in the coming years. Some of the key challenges are illustrated here:

- **An aging population:** The UK population is aging, and this is putting increased pressure on public health services. Older people are more likely to have chronic health conditions, and they are more vulnerable to the effects of infectious diseases.

- **Health inequalities:** Health inequalities persist in the UK, with people from lower socioeconomic groups experiencing poorer health outcomes. This is due to a number of factors, including poverty, poor housing, and lack of access to healthy food and physical activity opportunities.
- **Community cohesion, trust and confidence:** The COVID-19 pandemic highlighted the critical importance of understanding and maintaining public and community trust and confidence in government, health and care systems and professionals. The decades long decline of trust in government and other anchor institutions, combined with growing political polarisation, may further complicate the ways in which we are able to engage local communities on issues related to health, wellbeing and inequalities. The digital expansion of access to information and misinformation further complicates the identification, verification and utilisation of 'trusted sources' of data and information.
- **Climate change:** Climate change is already having a negative impact on public health, and this impact is only going to get worse in the coming years. Climate change is leading to more extreme weather events, such as heatwaves, floods, and droughts. These events can have a devastating impact on people's health, particularly the most vulnerable.
- **Global migration and population displacement:** May present significant challenges as specialists are called upon to address the complex health needs of society's most vulnerable, whilst addressing concurrent threats of social disruption, polarisation, populism and social exclusion/marginalisation.
- **Antimicrobial resistance:** Antimicrobial resistance (AMR) is a growing threat to public health. AMR occurs when bacteria, viruses, fungi, and parasites develop resistance to the antibiotics, antivirals, antifungals, and anti-parasitic drugs used to treat them. This means that infections are becoming more difficult or impossible to treat.
- **Emerging and re-emerging infectious diseases**: Emerging and re-emerging infectious diseases pose a constant threat to public health. Examples of emerging and re-emerging infectious diseases include COVID-19, Zika virus, mpox and Ebola virus.

Despite these challenges, there are also a number of opportunities for public health in the UK. Some of the key opportunities include:

- **Technological advances**: Technological advances have the potential to revolutionise public health. For example, new technologies can be used to improve surveillance and early warning of disease outbreaks, to develop new vaccines and treatments, and to deliver more personalised healthcare.
- **Increased awareness of public health**: There is a growing awareness of the importance of public health, both among the public and among policymakers. This awareness is creating a climate in which it is possible to make progress on public health issues.
- **Global collaboration**: Public health is a global issue, and there is a growing recognition of the need for global collaboration to address public health challenges. This collaboration can lead to the sharing of best practices and the development of innovative solutions.

A vision for the public health workforce in 2030

Public health can be usefully considered under the key domains of health protection, health improvement and reduction of disparities, health care public health and academic public health. Public health is also a medical specialty that is multi-disciplinary, benefiting enormously from the diversity and strength of the pool of specialists undertaking public health work. There are several regulatory bodies relevant to public health, reflecting the richness of the specialty

It is a core strength of public health training that the workforce has competency training in all these domains and can flexibly change task priorities as happened during the pandemic with an increased emphasis on health protection. We believe that flexibility should be maintained. The realistic desirable position for each domain of public health is now summarised and the overall implications are then addressed.

Health protection

The future public health workforce needs to be prepared for growing antimicrobial resistance and the threat of emerging and re-emerging infectious diseases, developing strong surveillance and early warning systems, by having plans in place to respond to outbreaks, and by investing in research and development. The COVID-19 pandemic demonstrated the critical need for a well-trained public health workforce to be in place prior to any outbreak and which could provide leadership and expertise at national, regional and local levels. The need for sufficient capacity in the system was recognised, as was the prudence of not being over-dependent on countries outside the UK, e.g. on testing capacity and PPE.

Given the many realistic threats of future pandemics, and learning from previous pandemics, there is a need to increase both the specialist and generalist health protection workforce. In England, this should include strengthening ICS workforce capacity & capability in EPRR, IPC, and immunisation. It is critical to investing in and prioritise workforce in vaccine preventable disease modelling, vaccine strategy, vaccine development and workforce capability and capacity for delivery. This will prevent a resurgence of vaccine-preventable disease, support outbreak response and reduce inequalities in coverage. There should be greater education/training to build capability to prevent and mitigate risks associated with antimicrobial resistance and healthcare associated infections through better infection prevention and control at all levels. This should extend beyond specialist public health consultants, with clear career pathways for people at levels 3 to 6 of the public health skills framework, addressing areas like contact tracing. There should be greater education and training on modelling and developments in vaccination and a role for specialist field epidemiology training (FET). UKHSA and the other national public health bodies in the devolved nations are well positioned to provide system leadership and subject matter expertise in this domain but greater co-ordination between the national, regional, and local levels is advocated with increased clarity on the role of directors of public health and local authorities, most notably in England.

Health improvement and reduction of inequalities

The UK population is changing, and the public health workforce needs to be able to adapt to these changes. For example, the workforce needs to be able to respond to the needs of an aging population and to address the growing burden of chronic diseases. There is an emerging consensus that many societal health problems, e.g. obesity, drug misuse, gambling, alcohol and smoking/vaping require health policy with a much wider remit than a focus on the individual. This public health approach sometimes will lead to clear evidence-based action, e.g. on seat belts, and sometimes will represent the most likely effective policies given the available evidence. Public health knowledge and skills in this area are critical and likely to increase by 2030. It is recognised that there are and probably will continue to be some differences in approach in the four home nations.

The future workforce will need the capacity and capability to understand and respond to growing health inequalities by working to address the root causes of health inequalities, such as poverty and lack of access to healthy resources. They will need to work to protect the population from the health impacts of climate change. This can be achieved by developing adaptation measures, such as heatwave warning systems, and by working to reduce greenhouse gas emissions.

Healthcare public health

Healthcare public health (HCPH) is concerned with maximizing the population benefits of healthcare and reducing health inequalities while meeting the needs of individuals and groups, by prioritizing available resources, by preventing diseases and by improving health-related outcomes through design, access, utilisation and evaluation of effective and efficient health and social care interventions, settings and pathways of care. The Faculty has published in 2025 a discussion paper on the NHS role in prevention and this is a fast developing area.

There are many public health interventions, such as vaccination and screening programmes, oral health, value-based health care approaches which offer well recognised substantial benefits to the health of the population. Although such programmes are well established, there remains a need to ensure that the public health workforce remains available to manage these services and address undesirable variations in uptake. It should be anticipated that there will be an expansion of screening programmes and the scope of the vaccination programme by 2030.

The NHS long-term plan in England sets out a compelling case for secondary prevention and public health action. Much more effective and cost-effective care should be provided. Some of the future public health workforce implications are recognised in the NHS workforce plan, e.g. smoking cessation services.

Currently there is a patchy availability of public health staff, both specialist and practitioner, to NHS trusts and to the Integrated Care Boards in England and health boards and trusts. In addition, NHS strategic imperatives, including Core20Plus5, require stronger public health input in development and delivery of programmes to those in need. The aim by 2030 would be for all NHS trusts in England to have specialist public health input and operational public health capacity on issues like diet, exercise and smoking.

Scotland and Wales have different organisational arrangements to England, based around health boards, but similar principles apply.

Climate and ecological emergency

The consequences of climate change are far-reaching and complex, and public health specialists will need to play a critical role in both preventing and mitigating its health impacts. This will require a deep understanding of the science of climate change, as well as the expertise to develop and implement effective interventions. Public health specialists will also need to be able to work across sectors and with diverse stakeholders to build resilience to the health impacts of climate change. This includes working with urban planners to design more live-able and sustainable cities, and with policymakers to develop climate change adaptation and mitigation strategies. To meet the challenges of climate change, the public health workforce will need to be adequately trained and equipped. This means investing in public health education and training programs, as well as developing new tools and resources to support public health specialists in their work.

Data science and analytics

Data science and analytics are essential for public health specialists to be able to identify trends, patterns, and relationships in large and complex datasets. This information can be used to develop more effective interventions, target resources more efficiently, and evaluate the impact of public health programs. Public health specialists will need to develop their skills in data science and analytics to be able to effectively use these tools in their work. This includes developing skills in data collection, cleaning, analysis, and visualisation. Public health specialists will also need to be able to communicate the findings of their data analysis to a variety of audiences, including policymakers, the public, and other healthcare professionals. There is a need for both competence in data science and analytics as well as

‘soft skills’ including in communication. Public health intelligence staff will have a range of seniorities relating to their competences; if not managed by public health specialists, close working relationships will be essential.

There are opportunities for increased data set linkages with appropriate confidentiality safeguards relating to population characteristics, health experience, health and social care interventions, exposures and health behaviours.

Systems thinking and complexity science

Public health problems are often complex and interconnected. Systems thinking and complexity science can help public health specialists to understand these complex problems and develop more effective solutions. Systems thinking is a way of understanding the world as a complex system of interconnected parts. Complexity science is a field of study that examines the behaviour of complex systems. Public health specialists will need to use systems thinking and complexity science to understand the factors that contribute to public health problems, such as poverty, inequality, and environmental degradation. This understanding can then be used to develop interventions that address the root causes of these problems.

Community-centred approaches to health

Within the evolving realm of public health, community-centred approaches have emerged as a transformative force, emphasising the active involvement of communities in shaping their own health and well-being. This paradigm shift recognises that communities possess invaluable knowledge, resources, and resilience, making them indispensable partners in addressing health challenges. At the heart of community-centred approaches lies engagement, which cultivates active participation from community members, ensuring their voices and perspectives are heard and valued. This participatory process empowers communities to identify their unique health needs and priorities, fostering a sense of ownership and accountability. Beyond mere consultation, co-production, a cornerstone of engagement, involves communities in the design, implementation, and evaluation of interventions. This collaborative approach leverages community expertise, ensuring interventions are culturally relevant, tailored to local contexts, and more likely to succeed.

Communication and engagement

Public health specialists need to be able to communicate effectively with a wide range of stakeholders, including the public, policymakers, and healthcare professionals. This is essential for building support for public health initiatives and ensuring that interventions are implemented effectively. There will be an increasing need and competency for specialists to be able to communicate complex information in a clear, concise way, using a variety of traditional, digital and emerging tools. They also need to be able to listen to and understand the concerns of the people they are communicating with deeper skills and competency in community centred approaches to improving health.

Equity and inclusion

It is probable that the unacceptability of the population life expectancy continuing to fall will result in a new energy to address the underlying factors causing this problem and the widening of health inequalities. Public health specialists need to be committed to equity and inclusion. This means developing and implementing interventions that are culturally responsive and accessible to all members of the community. Public health specialists need to be aware of the social determinants of health, such as race, ethnicity, income, and education. They need to take these factors into account when developing and implementing interventions. Public health specialists also need to work to build trust and confidence with underserved communities, relying on robust partnership, movement and coalition building skills to help drive change at multiple levels in society.

Systems leadership, thinking and innovation

Public health specialists need to be able to lead and innovate to develop and implement effective solutions to the challenges facing public health. This will require creativity, adaptability, and a willingness to take risks. Future specialists will need to be able to think outside the box and develop new and innovative solutions to public health problems. They also need to be able to build coalitions and partnerships to support the effective development and delivery of public health programmes and policies at multiple levels within society.

Academic public health

Academic public health plays a vital role in advancing the field of public health. Academic public health institutions produce research that informs public health practice and policy. They also train the next generation of public health professionals. As the world faces new challenges, such as climate change and global migration, the role of academic public health will become increasingly important. Academic public health institutions will need to continue to produce high-quality research and train the next generation of public health professionals who are equipped to address these challenges.

Current FPH actions to address future workforce needs

The FPH is working in partnership with a wide range of organisations to address future workforce challenges. These partners include other professional bodies, government agencies, and academia. The FPH is engaging its members to identify and address the future workforce challenges and will continue to host workshops and events to discuss the future public health practice needs, workforce challenges and develop solutions. By delivering these actions, and alongside other FPH programs of work, FPH will develop a compelling narrative about the UK specialist public health workforce which supports our members whether they are working locally, regionally, nationally or internationally. Some ongoing actions are highlighted below.

Implications of age structure

The age structure of the specialist public health workforce means an early increase in training numbers is needed to prevent a reduction in trained staff due to retirements from an ageing workforce exceeding the number of newly qualified consultants. Current FPH actions include:

- Updating the FPH members survey to ensure robust data is available on the specialist workforce
- Development and updating of FPH membership database to connect and support members
- Work with NHSE WTE on workforce projections and planning in England
- Coordination between FPH, NHS, OHID and UKHSA, PHW, PHS, PHNI with public health partners on the future public health workforce

Retention of specialist staff

The public health workforce morale is low, although probably not dissimilar to other parts of the health service. There are recognized recruitment difficulties to attract and return Public Health Specialists for employers and different recruitment models emerging in the public health system. Staff retention is an important factor especially as it will take time for increases in the training programme capacity to train additional staff. There are already large

numbers of vacant consultant posts, perhaps as high as 30 per cent of all UK posts but as it is not clear if some posts, established for short periods of time, will be made recurrent it is more prudent to state that over 10 per cent of established consultant posts are unfilled. FPH have committed to improving our information systems to inform our workforce information, intelligence and planning. Current FPH actions include:

- Work with the Association of Directors of Public Health (ADPH) on identifying and responding to workforce challenges
- Empower regional FPH leads and FPH advisors to develop response strategies
- Working with colleagues in Scotland, Wales and Northern Ireland to develop plans to meet the specific workforce challenges in each home nation.

Expanded, recurrently funded training programmes

The aforementioned increased need for additional public health workers, both specialist and non-specialist, will require a larger increase in training numbers. These posts will require additional, recurrent funding. It is believed that training sites and trainers would be available to support the increase in training. In respect of the specialist public health capacity, it is recommended by the FPH that the target of 30 consultant specialists per million population is reached in all countries of the UK by 2030 (FPH Functions & Standards of a Public Health System, 2020). Current FPH actions include:

- Continued work with NHSE WTE and with workforce committees in other nations on opportunities to further increase intake in line with NHS Long Term Workforce Plan ambitions
- Work with regional training schools to ensure capacity for expansion is in place
- Increase the capacity of portfolio routes for specialist registration

Equitable treatment of public health consultants irrespective of background

A specialist public health workforce with equitable pay and terms and conditions for consultants from medical and multi-professional backgrounds is feasible and desirable and should help maintain retention. It is clearly appropriate that consultants in public health from a medical background enjoy similar pay and conditions to medical colleagues in other specialties and that as the specialist training of all public health consultants is identical, all consultants, whether from a medical or multi-professional background, should be offered identical or near identical pay and conditions. Current FPH activities include:

- Collaboration with BMA on understanding pay disparities and their impact
- Systematic review and collection of data from consultant adverts across the UK
- Assessment through member-facing surveys
- Promoting the expectation of Band 9 Agenda for Change banding for multi-professional consultants as has been achieved in Wales

Flexible training with other medical specialties

There are opportunities for increasing the public health workforce by making joint accreditation training with other medical specialties a quicker process. A scheme for joint accreditation with General Practice could be a model for other specialties.

- Explore opportunities to expand joint training and accreditation opportunities with other specialties, for example General Practice

- Explore innovative opportunities to expose registrars (trainees) in other specialties to public health training or experience, for example from Occupational Medicine and Pharmaceutical Medicine

Clearer pathways for the wider public health workforce

The size and regulation of the non-specialist public health workforce is not well understood and the precise manpower requirements for the public health are not clear. However, a few general points can be made:

- An increase in public health workforce capacity and capability will be strengthened by clear career pathways and stronger governance and regulation of all the public health workforce
- Promotion of UKPHR and Faculty membership to public health practitioners will improve their regulation
- Greater clarity is required on who has the responsibility for the training, education and regulation of the practitioner public health workforce. Undoubtedly many of the qualifications for levels 1-6 have been developed by the RSPH

A mobile and flexible workforce

The public health specialist workforce is a highly skilled, highly trained cohort operating in complex environments. There are significant differences in the structures of the public health systems in the nations of the UK, but public health practice remains consistent and the training programme and the portfolio pathways produce specialists able to move between varying systems. This is critical to maintain the mobility and flexibility of the specialist workforce and supports a rapid, scalable response in times of crisis and need.

Short- and medium-term proposals to support the 2030 objectives

In addition to the current activities underway, this section highlights key priorities that the FPH working with our partners would like to priorities in the short and medium term. These are included here to stimulate discussion and wherever possible, drive consensus towards the most critical and impactful actions that are needed to respond to the challenges and opportunities articulated above.

Short-term action by public health organisations (January - December 2025)

Workforce strategy

- Produce an FPH public health workforce strategy by no later than January 2025 (Action: All)
- Press politicians for a coherent public health workforce plan which would complement the NHS workforce plan; be able to articulate a clear rationale for key elements in the plan, i.e. it must be feasible, affordable, desirable. (Action: All)

Career structure and pathways

- Write to all ICBs in England drawing attention to the HSC and Hewitt reports requesting that all have independent senior public health input. (Action Lead: Public Health Medicine Consultative Committee (PHMCC))
- Routinely write to public health regulators/ROs regarding lapsed members in active consultant level public health practice. Ask regulators to be more vigilant that such people, especially DPHs, are maintaining their competencies (Action Lead: FPH)

- Encourage specialists to register with UKPHR and FPH by writing to DPHs, liaising with employers. (Action Lead: UKPHR, FPH)
- Request Agenda for Change (AfC) grading exercise for UKPHR-registered consultants in public health in Scotland and Northern Ireland (Action Lead: FPH)
- Introduce wellbeing support ideas including improved signposting to mentoring schemes, encouraging employers to facilitate and support effective working from home and promotion of special interest groups (Action Lead: PHMCC)
- Providing further model job descriptions for the specialist workforce e.g. public health principals

Public health data and intelligence

- Improve FPH intelligence systems to provide better quality and more timely data including real time information to identify numbers of filled and unfilled posts - routinely request information from DPHs and Regional Board members. (Action Lead: FPH)
- Create a database of public health academic courses in UK to create opportunities for improved communication between academic institutions, academic students (many of whom pursue careers in public health outside the UK) and other public health organisations including the FPH. (Action Lead: FPH)

Equality, diversity and inclusion

- The Faculty is developing a comprehensive programme to reduce and eradicate known inequalities in the specialty training programme, at the point of recruitment into the programme and through exams and training progression
- Obtain legal opinion on the likelihood of success of equal pay claim for multi-professional and medical consultants (Action Lead: PHMCC)

Medium-term actions by public health organisations (2025 onwards)

Workforce strategy

- Produce case for increase in recurrently funded public health training places supported by modelling of demand and capacity, a cogent case for public health expansion (Action Lead: NHSE WTE, FPH, PHMCC)
- Increase public health training on climate change and health (both service and academic), thereby recognising the increasing importance of this topic and equipping our workforce to be fit for the future (Action Lead: FPH; Regulators)
- Identify common workforce goals and shared narratives within public health organisations to underpin a coherent overarching public health strategy for the UK and each constituent nation (Action: All)
- Identify mechanisms for supporting workforce wellbeing and retention through policy, guidance, practice and the work of committees and special interest groups (Action: FPH)

Global

- Foster global links through greater partnerships with academic institutions especially those training many overseas students. (Action Lead: FPH)

Career structure and pathways

- FPH to consider playing a bigger role in standard setting for senior specialists, e.g. should FPH develop model job descriptions for senior specialists. (Action Lead: FPH)
- RSPH to take lead in producing education and training packages and governance proposals for priority areas of wider public health workforce – levels 1-6 (Action Lead: RSPH)

- Work in partnership with the Department of Health and Social Care, National Midwifery Council and the Royal College of Nursing to develop clearer public health pathways for nursing. (Action Lead: FPH)
- Additional partnership agreements between public health organisations – model could be CIEH/FPH agreement (All)

The key summary 'asks' of governments and employers

Partnership with the government is essential to the development of a future public health workforce strategy that meets the needs of the population. The government is responsible for setting the overall direction for public health policy and for providing the resources needed to implement that policy. Public health partners have a deep understanding of the challenges and opportunities facing the specialist public health workforce and can provide valuable input into the development of a future strategy. Priority actions for government include:

- Investment in additional recurrently funded training places
- Clarity of public health system leadership
- Including responsibility for education and training, governance of predominantly unregulated parts of public health workforce especially levels 1-6
- Employers utilise well-trained, accredited public health staff
- Equitable pay offered to public health consultants from medical and multi-professional backgrounds
- Real increase in public health grant funding

Summary

A compelling case has been made for an increased public health training capacity which will underpin and support efforts to increase the public health workforce. This will involve a greater focus on retention and the development of clearer, better regulated career pathways for public health specialists.

The next few years are likely to involve continuing attempts to improve health by promoting prevention, increasing cost effectiveness, increasing productivity and increasing care coordination. Although public health offers important solutions in all these areas, it is clear that these messages are not currently being sufficiently appreciated by key stakeholders. Too often public health has not been seen as a key solution to the challenge of delivering good health outcomes in a resource-constrained environment.

The new environment offers opportunities and the Faculty and partner public health agencies to accept and understand that there should be a desire amongst employers, training organisations and politicians to do things differently. The public health workforce needs to accept that some changes to current work practices will be desirable. We hope that this framework helps this process by identifying the strengths, weaknesses, opportunities and threats in the current public health system and proposing a realistic coherent vision for public health in 2030 with short and medium-term priority actions.

Appendix I: public health workforce data from HEE capacity report 2022

Whilst only relating to England and not identifying the significant number of public health workers with consultant level jobs working independently or for unaddressed employers (for example, charities and drug companies), the Health Education England (HEE) survey provides an insight into the state of the public health specialist workforce.

It estimates 11 per cent of consultant posts are unfilled, whilst the best more recent intelligence suggests the figure may be as high as 25-30 per cent.

In 2022, 1277 WTE posts were identified, an increase of 15.3 per cent on 2021.

The main employers are:

- Local authorities (LAs): 595 (48 per cent)
- United Kingdom Health Security Agency (UKHSA): 139 (19 per cent)
- Office for Health improvement and Disparities (OHID): 53 (4 per cent)
- NHS: 206 (17 per cent)
- Higher educational institutes (HEIs): 145 (12 per cent)

Registration summary

Local authorities	OHID	UKHSA	NHS	HEIs
• 68% UKPHR • 21% GMC • 19% Other	• 48% UKPHR • 44% GMC • 8% Other	• 7% UKPHR • 69% GMC • 24% Other	• 3% UKPHR • 86% GMC • 11% Other	• Not reported

Of the 2030 registered public health specialists, 1178 were on the GMC register, 762 on the UKPHR and 90 on the GDC. However, for recent cohorts of persons gaining their CCT, the numbers from medical and multi-professional backgrounds are similar.

If you are a female and a UKPHR registrant, you are much more likely to work for a LA in England than for the other major employers.

Appendix II: recommendations from Fit for the Future Report (2016)

Fit for the Future, a Review of the Public Health Workforce published in 2016 is arguably the last attempt to produce a strategic public health workforce plan. 31 recommendations were made:

Creating an attractive career		**Lead**
1	Increase the visibility of public health as a career to a wider range of people – for example by targeting 16- to 18-year-olds via youth health champion schemes, making use of opportunities to embed in careers advice and providing new or increased points of entry, such as apprenticeships	PHE and other partners
2	Continue to shape and build an appropriate, structured and consistent approach to develop those working at practitioner level, informed by the reviews carried out by CfWI and HEE	HEE, UKPHR
3	Clarify entry points and career milestones for those working in public health, and the roles of undergraduate and postgraduate public health qualifications as well as registration systems**	PHE, HEE, FPH, UKPHR, DH and other partners
4	Enable the development of portfolio careers in public health, supported by a skills and knowledge framework with a 'digital passport'. This needs to be embedded and used as a point of reference by employers and key organisations**	DH, PHE
5	Revise guidance on multidisciplinary teams in local government to reflect the current and future context	LGA, working with PHE, ADPH/FPH
6	Continue to build public health workforce planning tools and capabilities to allow proper succession planning, and early warning of emerging skills gaps	HEE, with support from DH, PHE, and others
7	Develop a set of employer standards for public health in local government. Demonstrate how employers are improving the health and wellbeing of their own workforce	ALL
8	Demonstrate how employers are improving the health and wellbeing of their own workforce	ALL
Developing a stronger social movement for health		**Lead**
1	Ensure public health is embedded in the undergraduate curriculum for all clinical training	HEE working with universities and regulators
2	Evaluate how best to develop and roll out wider workforce training 'at scale', learning from 'early adopter' groups such as Fire and Rescue**	PHE/DH, RSPH
3	Make systematic use of training and other toolkits such as All Our Health for healthcare professionals and other NHS staff	HEE, NHS England, PHE
4	Use a range of levers to embed prevention at all levels – individual to organisational, for example by including in job descriptions and provider contracts	LGA, NHS England, PHE

5	Explore with professional and regulatory bodies the levers for making prevention everybody's business through registration and revalidation processes	DH, PHE working with regulatory 6and professional bodies
6	Review and, if needed, develop/refresh local area networks for public health to strengthen communication and support between wider workforce groups, core public health teams and local academic organisations	PHE working with HEE and other partners
Building 21st century skills		**Lead**
1	Ensure healthcare public health skills, and the infrastructure to support application of those skills, remain embedded in the public health core workforce. These include health economics, prioritisation, resource management, people management, leadership in clinical settings, critical appraisal, evaluation, commissioning and commercial skills, and data interpretation. Training in NHS settings should be part of this	HEE, FPH, universities, NHS, local authorities
2	Local NHS organisations, working with local government, to consider how they can best secure public health input to all of its activities	NHSE, CCGs, NHS /foundation trusts, LGA, local authorities
3	Commission relevant training programmes: e.g. for healthcare scientists, or information analysts, that include new technical skills	HEE
4	Implement Doing, Supporting and Using Public Health Research, the PHE strategy for research, translation and innovation to develop public health academic careers and strengthen the academic/service interface	PHE supported by universities /other academic bodies
5	Explore opportunities to develop online /e-learning courses and qualifications that can be more readily accessed by the wider workforce e.g. town and transport planners, and support global public health training and development**	PHE/HEE/DH
Strengthening systems thinking and leadership		**Lead**
1	Consider how systems leadership training can be accessed by a wider group of people working in public health, such as those working in specialist roles**	PHE/DH
2	Strategic leadership for public mental health should be embedded in leadership development programmes	PHE/DH
3	Multidisciplinary training and other integrated approaches to training should become the 'norm'	HEE working with other partners
4	Further deploy the Skills for System Leadership programme with its emphasis on working in a political environment, aimed at public health teams in local authorities**	PHE, ADPH, LGA
5	Organisations should review the training and development offer to their employees to ensure that staff can (and do) access personal effectiveness skills e.g. negotiating, influencing, co-production approaches as appropriate, alongside more technical skills	ALL

Ensuring resilience, flexibility and mobility		Lead
1	Explore the viability of a more responsive approach to public health training and accreditation, (e.g. a 'fast track' 2-year training scheme) to enable those with experience (e.g. existing local authority directors with some public health skills and experience) to become fully trained in public health, via a conversion course or 'top ups.' This would sit alongside the existing training scheme and be integrated into current routes to specialist registration	FPH, UKPHR
2	Review the potential of credentialing schemes as means of nurturing sub-specialisation as appropriate, building on core competences	FPH
3	Explore ways of ensuring that the workforce, and particularly those working as specialists, training to be specialists, or a at practitioner level, are able to gain experience of working in a wide range of settings in the system, including global health opportunities, through e.g. secondments or work placement linked to personal development and talent management planning	PHE working with others e.g. LGA, NHS England, ADPH
4	Placements for training schemes should include training in all settings in the system including the NHS, PHE, local government, third sector, and other parts of public sector, and include opportunities for international experience/global exchange opportunities	HEE, FPH
5	Key employers of public health specialists to consider the balance between more generalist and sub-specialist job roles, to ensure future workforce mobility and flexibility, while retaining a skilled workforce	PHE, ALL
6	Continue to review what action can be taken at national and local level to remove barriers to mobility linked to terms and conditions of public health staff	DH, PHE, LGA
7	Work with NHS Employers, the NHS Staff Council, the LGA, DH and relevant Unions to develop a plan for addressing continuity of service	PHE with other partners

Appendix III: congruence with NHS Long-Term Workforce Plan

The public health Workforce plan can be considered alongside the three main drivers of the NHS Plan.

Growing the Workforce

It is pertinent to public health that medical student places will increase to approximately 12,000 places by 2030. Cross-specialty training is supported and FPH and RCGP have already agreed a joint training programme. A 13 per cent increase in public health training places in 2023/24 is agreed.

Embedding the Right Culture and Improving Retention

There is a net outflow of specialist public health staff globally but the trends have not increased in recent years and represents a long-standing desire of public health specialists to work in global health often in developing countries. There has been an increase in early retirement and an increase in the number of unfilled posts especially since the start of pandemics predominantly due to an increase in the number of posts in the UK.

- The public health workforce strategy is committed to developing a fair and inclusive culture.
- Flexible working including working from home should aid retention.
- There is a clear commitment to population-centeredness and the reduction of health inequalities.
- There is a desire to increase opportunities for prospective retirees to improve retention.

Reforming working and training

There is a commitment to increasing productivity. Digital and technological innovations and working remotely are relevant to the practice of public health. There also needs to be a continued commitment to trainee needs.

Training placements in public health are inequitably distributed and this needs to be corrected. It should be possible to allocate additional public health posts to create a fair distribution without needing to diminish training capacity in any region. There is a lack of clear accessible career pathways and standards for the wider public health workforce which needs addressing inside and outside the NHS. Finally, the capacity of educators, supervisors and trainers needs to be sufficient to support the increase in training placements. Initial scoping in public health suggests that capacity can be increased.

Appendix IV: the UK public health specialist workforce

The public health workforce

Public health is essential to all aspects of health and wellbeing and is crucial to reducing health inequalities and influencing the wider determinants of health. It has come to greater prominence as a critical national resource during COVID-19. The Functions and Standards of a public health system have been well defined[i] as have the skills needed to deliver them[ii].

The public health workforce needed to deliver these functions and standards is complex as so many jobs require public health knowledge and skills (see RSPH Strategy 2023). However, there is an available model that is useful in thinking about workforce planning. Building on the Donaldson Report,[iii] the Centre for Workforce Intelligence (CfWI) divided the workforce into:

- The **core public workforce** which is *'All staff engaged in public health activities who identify public health as being the primary part of their role'*[iv]. This is divided between *Specialists* who are on the (GMC, UKPHR or GDC) specialist register and *Practitioners* some of whom are registered, others not. CfWi estimated around 1650 specialists (including those in training) in England and around 36,000 Practitioners. More recent estimates of the specialist workforce are used below.
- The **wider public health workforce** is *'Any individual who is not a specialist or practitioner in* public *health but has the opportunity or ability to positively impact health and wellbeing through their (paid or unpaid) work'* (CfWI and RSPH)[v]. Donaldson described this as 'most people', CfWI around half the national workforce (15 million) and RSPH have further refined this group[vi], as have WHO dividing the wider workforce between the healthcare workforce and others[vii].

The specialist public health workforce

Public health specialists work as system leaders at strategic or management level or executive level across a wide range of organisations. They come from a variety of professional backgrounds and are trained and developed to cover all aspects of Public and Population Health. To work in the UK, they must be registered specialists and are required to maintain registration throughout their careers through appraisal and revalidation [viii] [ix]. This action plan will be UK-wide and cover short (and some medium) term actions. It will cover all specialists registered with UKPHR and GMC (but not GDC) whether they have gained registration prospectively through Specialty Training, retrospectively through Portfolio routes or with a Combined Programme.

Where are we now?

Capacity

Unlike other specialties whose numbers have doubled between 1996 and 2016[x] Public Health numbers have remained level at around 1000-1500 specialists across the UK for several decades. There may be many reasons for this including:

- Public sector re-organisations leading to loss of staff (numbers usually drop after a reorganisation and gradually return)
- A tendency for governments to prioritise short term fixes over longer-term prevention
- Low profile and status for public health before COVID-19

FPH recommend that we should aim for 30 whole time equivalent (WTE) Public Health consultants per million population[xi]. This figure is feasible, desirable and affordable. The most recent figures suggest we are still some way off.

A review of the data in 2021[xii] found that the number of specialists across the UK seemed to have fallen from 22.2 per million in 2004 to 18.6 per million in 2020. Scotland had around 22.7 consultants per million, Wales approximately 24.8 consultants per million, across Northern Ireland around 15.3 Consultants per million, England 17.9 consultants per million.

There has been an increase in numbers of consultants in England[xiii] – 2015: 939 WTE, 2017: 965, 2019: 1007, 2021: 1064, 2022: 1277. This is a 30% increase over seven years (although some may relate to better counting) In 2022, 1277 WTE posts were identified in England which is 21.2 per million, an increase of 15 per cent on 2021 suggesting some of the temporary increase during COVID-19 was maintained, but still well short of the 30 per million. We do not currently have equivalent numbers for Scotland, Wales or Norther Ireland, but assuming similar changes to England, in order to get to 2,000 UK consultants (30 per million) by 2030 we would need 150 new trainees per year[xiv].

There have been other successes. Training remains very popular with more than ten applicants per available training place. There has been an increase in numbers entering training across the UK – 2018: 78, 2019: 86, 2020: 77, 2021: 98, 2022: 93, 2023: 123)[xv] – more than a 50% increase over 5 years. However, these have been ‘non-recurrent’ so may not be sustained.

Vacancy rates remain high but are difficult to monitor as they are reported in different ways. In English local authorities there was a 4% vacancy rate (actively recruiting) and 11% unfilled post rate[xvi] although we have intelligence from some regions of 25-30% unfilled posts.

It is clear from the data above that one key bottleneck in specialist careers is specialty training. This has been compounded by the numbers coming through portfolio routes dropping. Between 2013 and 2020, 20% of new joiners to UKPHR and GMC registers came through portfolio routes[xvii]: now it is under 5%. The main reason is changes to the routes themselves, but lack of support for people undertaking the routes remains a significant issue.

Many people come to public health as a second career, so the workforce is generally older and careers shorter than other specialties. This is not a problem if there is sufficient replacement and good retention. Retention has declined, as in many specialties[xviii], with common factors such as pension concerns, moral distress, COVID-19 burnout and lack of flexible stepdown. This is another area for action to increase numbers. But beyond that there is a question of what roles late career and retired specialists can undertake in teaching, training, assessment, research and management.

Capability

The Specialty Training curriculum has recently been updated[xix] following a consultation on lessons learned from COVID-19. It will next be fully updated for 2027 and will be able to incorporate the results of the COVID-19 Inquiry as well as other new developments (such as in machine learning and genomics), and broad consultation on the capability needs of the profession. FPH keeps the curriculum under review and will be ‘de-colonising’ the curriculum to improve fairness in the near future.

Equality and Diversity

While the makeup of the public health specialist workforce approximates to the UK general population[xx], significant inequalities have been exposed in the recruitment process[xxi] and are starting to come to light in exams and appointments. Work has started to improve this[xxii], but there is still a way to go. There is a commitment from FPH to publish as antiracism action plan[xxiii].

There are a number of other dimensions of inequality for which data is only starting to become available. But of particular importance is the difference between those on UKPHR and GMC registers e.g. in terms of pay, for similar roles. There is also a question as to whether career tracks diverge, although this is difficult to interpret as the UKPHR has only been in place 20 years so there are different cohorts of specialists.

Wellbeing

The wellbeing of the workforce is critical, and we know that it has been damaged through the COVID-19 pandemic. The primary need is for employers to support and invest in the workforce. Where there are common issues there may be need for national action. Improving inclusion, equality and diversity and creating spaces for peer reflection on emotionally and ethically challenging experiences will help improve wellbeing. Improving wellbeing will help retention.

Future need

The likely need for increased public health capacity has long been recognised[xxiv]. There are several key drivers to this including:

- *Demography* – the growing population, its changing composition (e.g. by age and ethnicity), and its consequences for the make-up of the public health workforce itself
- *Technology* – advances in science and the management of public health, leading to new treatments, new skills within the workforce and new approaches to the use of technology
- Need to achieve *a radical upgrade in prevention* – delivery of public health interventions to reduce demand for acute services and the costs of managing long term conditions
- *Environmental and global health issues* – managing the consequences of climate change and other health related global issues, including delivery of the UK commitment to the universal Sustainable Development as well as the resulting changing burden of disease, antimicrobial resistance and new and emerging global health threats such as pandemics

The constraints will primarily be financial and public sector organisational, although ultimately this is an issue of prioritisation.

Recommended actions

From the forgoing there are a series of immediate actions for FPH to advocate for:

- A permanent investment to increase specialty training numbers to 150 places per year (**Statutory Education Boards (SEBs)[xxv]/ DHSC / Treasury**)
- Sustained support to people submitting portfolios in all regions (**employers / SEBs /OHID**)

- Work on flexible routes to registration including dual accreditation, combined programmes and future possibilities of fellowships and sponsorship (**FPH / GMC / UKPHR**)
- Continued work on improving the wellbeing of the workforce, including regular surveys of specialists (**employers / FPH**)
- Develop a plan for retention including clarity on roles that 'retired' members can take on with and without revalidation (**FPH / employers**)
- Sustained funding through public health grant, civil service, arms-length bodies (ALB) funding and devolved administrations to ensure a rebuilding of the public health infrastructure (**DH / Treasury / HMG**)

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[xii] https://www.fph.org.uk/media/3323/fph-submission-to-csr-2021-final.pdf

[xiii] https://www.hee.nhs.uk/our-work/public-health-specialist-capacity

[xiv] See FPH submission to CSR for assumptions. Career ~20 years. Currently 1500 UK Consultants post COVID-19 (up 25% on pre COVID-19). Increase of 500 needed 2024-30 + 450 retirements (75x6) -= 950 (~150 per year intake + some through portfolio)

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