Faculty of Public Health submission to the Comprehensive Spending Review, September 2021

The UK Faculty of Public Health (FPH) is a joint faculty of the three Royal Colleges of Physicians of the United Kingdom (London, Edinburgh and Glasgow). We are a membership organisation for approximately 4,000 public health professionals across the UK and around the world and our role is to improve the health and wellbeing of local communities and national populations. We do this by supporting the training and development of the public health workforce and improving public health policy and practice in partnership with local and national governments in the UK and globally.

1. Recommendations

There is consensus that there needs to be an **increase in the capacity public health specialists**. The Faculty has previously set out the case for 30 public health specialists per million of the population working in all parts of the health and social care system across the UK. This expansion cannot take place unless there is an **increase in the number of public health specialist on the training scheme** and an increase in the number of public health practitioners moving onto the specialist register via a portfolio application.

We need to ensure there is **adequate capability and resilience in the system** to respond to current and future public health issues. COVID-19 has exposed important gaps in the multidisciplinary workforce needed to deal with all public health issues and upskilling of public health practitioners is needed, alongside the development of data science and health intelligence staff and the embedding of basic public health skills across the whole health and care workforce, maximising the use of eLearning and other digital tools

With this increase in recruitment there naturally needs to be an **appropriate level of resource and funding** provided to the public health system, and the Faculty of Public Health join with partners in calling for a **£1 billion restoration of public health funding** and a **percentage of NHS ICS spend on public health prevention**.

2. Workforce and capacity

The Covid-19 pandemic has shone a spotlight on public health and the role of local, regional and national teams led by the work of public health specialists. This workforce is small compared with other parts of the healthcare workforce such as nurses but critical, as it is the qualified senior consultant-level group from which key leaders such as Directors of Public Health and Regional Directors are recruited. Public health specialists have the technical skills and knowledge, combined with leadership abilities to deliver public health priorities at national, regional and local levels.

There is a crisis in capacity at senior level, with a critical shortage of senior specialists which needs to be dealt with urgently to prevent serious risks to the delivery of Government priorities. Three key areas of post-pandemic recovery at risk are:

- With the creation of the UK Health Security Agency (UKHSA), the strengthening of the health protection workforce to deal with current and future pandemics.

- Reducing health inequalities – the levelling up agenda – and the critical role of local authorities, supported by DHSC's Office for Health Improvement and Disparities in delivering this, alongside overall improvements in health (e.g., obesity, smoking, alcohol).
- An increased focus in the NHS on population health and prevention delivered through Integrated Care Systems to ensure the NHS can meet demand and treat everyone who needs it.

The Public Health Specialist workforce is critical, not only providing key leaders such as Directors of Public Health and Regional Directors but also it has the technical skills and knowledge in all domains of public health to deliver these priorities.

Without action now we will continue to be vulnerable to future pandemics and other health threats, will be unable to reduce inequalities effectively, and unable to prevent the burden of chronic ill health overwhelming the NHS.

The case for greater specialist capacity in the public health system

There is a clear need to build public health capacity and resilience in the UK, which has been made particularly apparent throughout the global COVID-19 pandemic. However, increased capacity and resilience is not only a requirement to control COVID-19 and future pandemics, but also in reducing health inequalities 'by levelling up', combating the major current and emerging population health threats especially from obesity, inactivity, poor air quality and the climate emergency, and ensuring the continued provision of proven public health services including screening and immunisation. The Faculty of Public Health have mapped the functions required for a robust public health system.

Public health knowledge and expertise is critical at all levels: national, regional and local. While there are many different roles in public health, public health specialists provide crucial leadership across all three main domains (health protection, health improvement, healthcare public health). The UK higher specialist training curriculum approved by the GMC and the training standards set and monitored by the Faculty of Public Health have provided a resource of consistently high standard of public health specialists which has been flexibly used between the home nations and between service and academic public health. This training programme had recently been recognised internationally as a model of excellence.

There is consensus throughout the system that there is a shortage of public health specialists. If it is the UK governments' wish to aspire to a world class system, then the Faculty of Public Health recommends aiming for 30 whole time equivalent public health consultants per million of the population. It currently ranges between 15 and 24 across the home nations. This figure of 30 is felt to be feasible, desirable and affordable. This recommendation addresses the need of both service and academic at local, regional and national levels. The configuration of posts is of course for each of the four nations to decide.

The case for increased training numbers

The information below summarises the evidence to support an increase in the training numbers and proposes a cost-effective solution to be implemented across the UK. It is written recognising the establishment of the UK Health Security Agency and the Office for Health Improvement and Disparities. This proposal is consistent with bids from PHE and the other nations for increases to the public health specialist workforce across the UK.

Demand for Specialists

Training as a specialist in public health is delivered through a five-year training programme. Training lasts on average 6¼ years, reflecting that many of the trainees are less than full time) and there about 540 trainees enrolled at any one time [England 458; Scotland 48, Wales 17, N Ireland 17]. Historically, around 75 trainees are recruited each year in the UK and approximately 60 Certificates of Completion of Training (CCTs) are issued by the Faculty of Public Health each year. There is currently full employment of those completing higher specialist training.

While we do not have fully comparable figures over time, the number of specialists across the UK seems to have fallen from 22.2 per million in 2004 to 18.6 per million in 2020. This is in contrast to the pattern in most other specialities where consultant numbers have risen over the same time period. There is some national and regional variation (see below).

England

The Health Education England survey of the specialist workforce in England at the end of 2019 – before the COVID19 pandemic – provides a useful baseline of the position at that point. The public health specialist workforce in England was around 1,007 WTE (around 17.9 per million population) and has increased by approximately 5% since 2017. It is distributed:

- 45% LAs
- 31% PHE
- 9% NHS
- 15% HEIs
- 66% are female and 46% are over 50 years of age
- 18% of local authority posts are vacant or unfilled – a shortfall of around 80 posts (67 consultant, 13 DPH).

The survey asked local authorities about expectations up to 2022. There is an anticipated growth of 5% in consultant posts in LAs and a possible small fall in DsPH, with significant regional variation. This means there was already a potential shortfall of over a year's supply of specialists, before COVID-19 demonstrated a need for greater public health capacity and resilience.

Scotland

The pre-COVID-19 consultant workforce in Scotland was 101.6 (18.5 per million). This excludes any SMO staff within the Scottish Government and academic appointments, so there are now an estimated 125 consultants, around 22.7 consultants per million.

Wales

Wales has 79.4 consultants across a full range on functions at national and local level, including academia. This is approximately 24.8 consultants per million. Additionally, 16.4 trainees are currently on the training programme.

Northern Ireland

Across Northern Ireland there are 29 public health specialists, which is around 15.3 Consultants per million.

Work is going on to increase the number of consultant posts, but no meaningful expansion in capacity can take place unless more specialists are trained and the supply line is increased. Therefore, training sufficient numbers of specialists for the future is critical. Although there is inevitably a lead-in time from increasing training numbers to increasing the number of trained specialists, trainees also make a critical service contribution to the public health function (equivalent to junior doctors in hospital) throughout their training and during COVID-19 have proved particularly flexible in their ability to move to different parts of the system.

Numbers of trainees required

We believe a robust service with surge capacity would require 30 consultants per million population: just over 2000 consultants across the UK. Currently the UK has around 18.6 per million population so is short of 750 consultants. We should aim to reach this level over the next 10 years. This would deliver an expansion of the specialist workforce of just over a third compared to current numbers.

Whilst short to medium term recruitment strategies may enable some areas to reach safe levels of consultants quite quickly, maintenance of this capacity and achieving the levels for a robust service with surge capacity, will require a similar trainee expansion of about one third to over 100 trainees a year.

We strongly recommend that recruitment to specialty training should increase by a third: from around 75 to around 100 posts per year across the UK. We are confident of sufficient applications and of training capacity. In 2020/21, for example, there were nearly 1,000 applications for 75 training places and between 2 and 3 appointable candidates for each place. The public health training programme has long been one for which there is intense competition to join, and the pandemic has strengthened that level of interest. Public health Heads of Schools are willing and able to take on more training places, and there is an excess of public health training locations.

Recruitment for the August 2022 intake is due to start soon so a decision needs to be taken now although costs will start in the next financial year. The Faculty estimate, based on a cost of £50K per trainee per year, is an extra £1.25m in 2022/23 rising to £6.25m in 2027/28 and stabilising at that level. Further detail on costs is provided below.

Costs of increases to number of trainees

The cost of a whole-time public health trainee (including salary and on-costs, educational support, study leave and associated costs) is approximately £50,000 per year. Public health training has a different funding pattern to GP and hospital specialties, with a higher proportion being included in the budget of the Statutory Education Bodies.

The addition annual costs will be 25 x £50,000 = £1,250,000. We have used five years as WTE length of training to make estimates for simplicity. So, the total training cost for 25 trainees assuming a five-year training pathway is £6,250,000. The actual total investment over the five-year incremental increase in training places would be £18,750,000. There will need to be a permanent increase in revenue once numbers in training have stabilised at around 700. This is taking the current baseline number of public health trainees as 550 across the four nations of the UK.

Additional costs related to training

YEAR	Financial Year	Numbers in training	Cost of next cohort of 30	Additional annual cost
Year 1	2022/23	580	£2,250,000	£2,250,000
Year 2	2023/24	610	£2,250,000	£4,500,000
Year 3	2024/25	640	£2,250,000	£6,750,000
Year 4	2025/26	670	£2,250,000	£9,000,000
Year 5	2026/27	700	£2,250,000	£11,250,000
			Cost after Year 1	**£2,250,000**
			Total cost after Year 3	**£13,500,000**
			Recurrent additional costs after Year 5	**£11,250,000**

Retention

The total number of individuals registered in Public Health (GMC, UKPHR and GDC) is around 1,780. The COVID-19 pandemic has brought some back into the workforce on a temporary basis. There needs to be better understanding of what would encourage more registered and potentially re-registered trained public health professionals back into the workforce, in order to meet the shortfall in capacity until the additional higher specialist training places mature.

Senior careers are in public health tend to be relatively short, as it is often a 'late-entry' specialty with trainees starting their training in their early to mid-30s and completing training in their late 30s. Therefore, there is an average career length of little over 20 years (~40 to ~60). Increasing retention at 60 could therefore have a significant impact on numbers.

More also needs to be done to understand those working in independent public health practice as this may be a source of a significant number of public health specialists who can contribute to the mainstream public health workforce.

Other routes to registration

Specialist registration in public health is achieved by one of two routes:

3. The public health specialty training programme; or
4. Registration with UKPHR or GMC, via a retrospective portfolio, demonstrating equivalence to skills gained by successful completion of the training programme.

Public health is unique as a medical specialty in admitting people from a non-medical background to medical specialty training, and this training route remains highly competitive, with very limited numbers of spaces.

The alternative routes remain theoretically more accessible, but fewer and fewer applicants are gaining access to the public health specialist registers (GMC, GDC, UKPHR) through the portfolio routes. The GMC's certificate of equivalence for specialty registration (CESR) is very rarely used by medically qualified registrants for public health and the UKPHR has closed the defined specialist route (which produced 15 people a year, approximately 20 per cent of specialist registrants in a typical year). The new UKPHR Specialist Registration by Portfolio route has had very limited uptake, despite the potential demand being there. There will be opportunities to support people through these routes to increase the numbers on specialist registers, particularly in relation to the UKPHR route. While the training programme and should always be the default route, modest additional funding (£10,000 per nation/region per year) to support the transition of a limited number of public health practitioners onto the UKPHR register by the portfolio route would provide added capacity at least in the interim period before the training pipeline matures.

Additional costs related to portfolio route to registration

Jurisdiction	Number of regions	Additional annual cost
England	7	£70,000
Scotland	1	£10,000
Wales	1	£10,000
Northern Ireland	1	£10,000
	Cost after Year 1	**£100,000**
	Total cost after Year 3	**£300,000**
	Recurrent additional costs after Year 5	**£100,000**

5. Capability

Capability encompasses not only the public health specialist workforce but the public health practitioners and analysts who work for them. Capability includes the skills needed to ensure that the whole workforce can work effectively; for public health, this will include a focus on leadership to enable them to lead and direct the work of teams and to influence other parts of the organisation.

We need to ensure that not only do staff have the breadth of skills to respond to any public health issue, but also that there is depth of skills in important areas. COVID has exposed important gaps in the multidisciplinary workforce needed to deal with all public health issues.

6. Resilience

COVID has shown that we now need a workforce that is agile and robust. This requires a breadth of skills and experience and the ability to mobilise staff to wherever they are needed.

It is essential that during a public health career that staff can move between employers. This is to give breadth of experience and so ensure the ability to work across the system, particularly in leadership roles; to ensure staff can be moved between employers if functions are moved between sectors and to give resilience to the system if there is need for rapid redeployment of staff in an emergency.

COVID has also exposed a huge gap in workforce intelligence which hampered redeployment and must be urgently corrected. We need to be able to optimise what resources we have and plan future needs so the right staff can be recruited and trained. We must attract and keep the best people in public health careers. We must know the capacity and capability of the whole system to be able to rapidly deploy people in exceptional circumstances such as a pandemic.

The key actions are:

- Encourage movement round the system by the removal of bureaucratic barriers to changing employer, discrepancies in conditions of employment and making by it the common culture to gain broader experience
- Ensure we have common approaches across professions, such as a digital Public Health Skills and Knowledge framework to facilitate mobility
- Ensure we have good workforce intelligence, including career patterns and job markets to get the right people in the right place at the right time

7. Funding and public health positioning at government level

Local authority public health budgets have been underfunded for a number of years, and there has been a recognised £1.4 billion real term reduction in the public health grant. The most immediate impact has been on the UK's ability and readiness to tackle the COVID-19, but this is not the only challenge. There must be a restoration of cuts to public health budgets, and recognition of the return on investment in prevention measures. The Singapore Health Promotion Board has been cited by Government as an example of success for the Office for Health Improvement and Disparities (OHID) to model itself on, but its per head investment is more than double that currently in place in England. The disinvestment in local government has affected every area of local economies. At local level, the contribution of local government to the determinants of health is critical; less investment has led to cutting services, slower and reversing progress and poorer outcomes. The Institute for Fiscal Studies demonstrated that the greatest impacts of this fell on the most disadvantaged, and the Marmot Review 10 Years On highlighted the impact of the disinvestment on health and well-being.

Spend per capita at local level is a quarter per capita lower than it was at its high point in 2015/16. To ensure sufficient investment in public health services we recommend dedicating a percentage of NHS spending to investment in local public health. This aligns with the commitments set out in the NHS Long Term Plan to

improve prevention. The NHS should also define what their spend is on public health and inequalities and commit to increasing this over time.

The wider value of public health – whether in the midst of a pandemic or not – must be recognised to address the economic crisis and ensure a smooth recovery from COVID-19. Public health, local government and the NHS must all be placed on a sustainable footing. Additional funding for public health is required to meet the added demands on services built up over the course of the pandemic, so that we have a fully operational system with the required capacity and capabilities.

COVID-19 has made enormous demands on the public health community and particularly on Directors of Public Health and their usually small teams. The increase in demands and ambitions on public health means that a flat settlement, or even a modest funding increase, is in reality a cut to public health funding.

The restoration of the public health grant is also given added urgency by the need to address the impact of climate change on the nation's health. There are direct and measurable costs to the NHS in treating, for example, cardiovascular and respiratory diseases associated with cold homes, and tackling fuel poverty and improving the energy efficiency of homes would save the NHS money, as well as save lives. Air quality, closely linked with fossil fuels and climate change, is affecting human health now but there are other significant public health threats such as antimicrobial resistance, emerging infectious diseases and the biodiversity crisis. Local authorities will have to play a key part in tackling these multitudinous threats and will be unable to properly address them without the restoration of appropriate levels of funding.

8. Conclusion and Actions

There is a crisis in public health workforce capacity at the most senior level, with a critical shortage of public health specialists which needs to be dealt with urgently to prevent serious risks to the delivery of Government priorities. Without action now we will continue to be vulnerable to future pandemics and other health threats, will be unable to reduce inequalities effectively, and be unable to prevent the burden of chronic ill health overwhelming the NHS.

Key actions:

- Strengthen the specialist pipeline, by:
  - Increasing annual intake to the **public health specialty training programme** to close the gap in specialist capacity
  - Supporting **portfolio applications** to enable senior practitioners to register with UKPHR and GMC.
- Remove barriers to workforce mobility, enabling portability of continuity of service and alignment of terms and conditions.
- Supporting the use of apprenticeships in public health at all levels to increase public health skills in a wider workforce.
- Strengthen the leadership pipeline through developing system leadership skills at all levels
- Increasing diversity in terms of demography and skills – the Specialist/Consultant workforce should reflect the communities it serves.
- Retain expertise in the system by providing a pre-approved route for returnee to registers and ensuring those who returned can stay on them as long as needed enabling recent retirees to take on appropriate roles to strengthen the system.

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