Royal Society for Public Health response to The Health and Social Care Committee's inquiry "Workforce: recruitment, training and retention in health and social care".

January 2022.

1. About the Royal Society for Public Health

1.1. Royal Society for Public Health (RSPH) is an independent health education and campaigning charity, committed to improving and protecting the public's health and wellbeing. We are the world's longest-established public health body with over 5000 members who are committed to supporting the public's health. Our activities include providing qualifications, e-learning, accreditation and programmes. We also campaign on a wide range of issues to support better health and wellbeing for the public.

1.2. RSPH membership is constituted of core and wider Public Health Workforce (PHW). This workforce works closely with communities, promoting health and health being, preventing morbidities and alleviating pressures on the NHS and the social care system. This workforce also delivers services such as sexual health, smoking cessation, obesity, and drugs and alcohol treatment. They help address social exclusion, therefore being important actors in the Levelling Up strategy. The PHW provides public health advice and supports efforts to tackle health inequalities which have been exacerbated by the Covid-19 pandemic.

1.3. RSPH works to support to the public health workforce, which is crucial for the UK to tackle inequalities, deal with the backlog and level up health across the country. In the past, we worked with the now extinct Centre for Workforce Intelligence (CfWI), supported by Department of Health (DoH), Health Education England (HEE) and Public Health England (PHE) to map the wider public health workforce[1]. Published in 2015, "Rethinking the Public Health Workforce" analysed the contribution of the wider workforce to public health. RSPH and PHE collaborated to identify the scale and scope of the wider workforce, highlighting their potential to improve and protect the public's health, across a settings and life course context.

2. About this submission

2.1. The Covid-19 pandemic has exacerbated inequalities, and in addition to that, it has created a public health backlog. As the Health and Social Care Committee itself stated, children are missing out on universal programmes delivered by schools[2]. Essential public health services were put on hold during Covid-19. And instead of increasing it, the public health grant will be maintained for the next three years, meaning it will decrease on a like-for-like basis. The Health and Social Care Levy overlooked the public health backlog and issues the PHW is facing. Most of the £billions raised will be used to help the NHS recover from the pandemic and deal with waiting lists however, no financial support was announced to public health. The consequences are PHW losing jobs and local authorities having to spread staff too thinly and being unable to deliver their services to the level they are intended to be.

2.2. We welcome the Health and Social Care Committee initiative to include the Public Health Workforce in their inquiry and would like to emphasise that members of the PHW are also frontline workers, acting in local authorities, schools, UK ports and borders, promoting and protecting the public's health. Despite it, their voices are seldom heard by political leaders and their needs do not receive the attention they deserve.

2.3. Our evidence for this response is based on our specialist expertise in designing and delivering training, qualification and accreditation programmes for the public health workforce; as well as direct input from RSPH members who work in a variety of roles in public health. To draw on this, we designed a survey (open in January) to capture the views of the public health workforce. In total, 413 people who worked in a variety of roles responded: health visitors, public health managers, public health practitioners, consultants in public health, lectures, occupational health, environmental health and directors of public health, to name a few. The majority worked for the NHS, education sector and local authorities.

3. Summary and key recommendations

3.1. Given RSPH work and interests, this Health and Social Care Committee Inquiry is extremely relevant to us. In line with our expertise, knowledge and responses to our survey, we are answering the following questions:

- What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?
- What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?
- What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?
- What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors?
- What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?
- What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?

3.2. **Key recommendations:**

- We recommend that **public health grants are reviewed and increased on a real term per capita basis for 2022/2023**. The Department of Health and Social Care should also take into consideration inflation, the challenges local authorities are facing and the public health backlog. Lack of funding has a cascade effect in recruitment, training and retention. It also prevents staff from delivering services to the quality and standard that they would like, demotivating them.

- We recommend **all governmental entities delivering public health services, such as the Department of Health and Social Care, NHS, local authorities (including Port Health authorities) work together and map the true size of the core and wider Public Health Workforce as soon as possible**. Without these numbers, plans to recruit and train extra staff will be flawed, because we do not know how many people are actually needed and which professions need extra personnel the most.

- We recommend that **workforce training providers** consider helping current and future students and apprentices to **have the right balance of theory and practice in their courses, via internships or practice-based learning experiences**.

- We also recommend that **education providers and workplaces facilitate apprenticeship routes, to help more people enter the public health workforce**. We advise that public health education is provided in a greater range of settings, so that everyone, from the general public to health professionals, has access to public health knowledge and skills.

- We recommend that **staff retention plans developed** by the government and employers are holistic and include plans **to support current staff with their health and wellbeing**. We also call on the government to ensure that the necessary funds go to public health, ensuring the workforce can deliver their services to the quality and standard they were intended and desire to do. We also recommend employers consider developing career plans and promotion schemes, so that staff feel valued.

- **We emphasise that Equality, Diversity and Inclusion (EDI) should be infused into all levels of the workforce.** The Public Health Workforce needs to be upskilled to apply an EDI lens when looking at their talent and leadership pipelines and training opportunities across the organisation. For example, epidemiologists need training—both formal educational programs and internal ones—in health equity to understand what questions to ask, where to ask them, and how to collect the right information.

4. What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?

4.1. **Cuts of public health grants have vast impact on public health workforce:**

4.1.1. Public health grants to local authorities have been consistently decreasing for the past 6 years. In 2019/20, the value of the grant was, on like-for-like basis, 15% less than in 2013/14[3]. For 2021–22, public health grant allocations represent 24% (£1bn) real-terms cut compared to 2015/16[4]. Consequently, public health staffing in some parts of the country have been scaled back to save money, and the remaining workforce spread too thinly across local authorities[5].

4.1.2. This has impacted the workforce

4.1.2.1. A survey of RSPH members found that:

- 69% of people who work in public health agree their service is understaffed.
- 38% consider recruitment and retention is a concerning issue to their workplace.
- 59% report their team has struggled to hire staff for the past 6 months.

4.1.2.2. Covid-19 has stretched this workforce further. A survey of RSPH members found that:

- 90% consider public health challenges to be greater now than they were 2 years ago
- 85% of people who work in public health experienced an increase in demand for their service increased during the pandemic.
- 72% understand their service does not have enough personnel to respond to current demand.

4.1.3. The majority of public health workforce who took part in the RSPH survey considered the following actions could be be taken to recruit needed extra staff in the short, medium and long term:

- Increased funding for service provision (short term)
- Developing good workforce intelligence, such as career patterns and opportunities for professional development (short term)
- Increased Equality, Diversity and Inclusion training at all levels of the workforce (short term)
- Increased annual intake of participants in public health specialty training programmes (medium term)
- Strengthening the leadership pipeline with support to development of leadership skills at all levels of the workforce (medium term)
- Implementation of apprenticeships in public health at all levels (long term)
- Increased mobility of the public health workforce by diminishing bureaucratic barriers (long term).

4.1.4. **We recommend that public health grants are reviewed and increased on a real term per capita basis for 2022/2023. The Department of Health and Social Care should also take into consideration inflation, the challenges local**

authorities are facing and the public health backlog. Services can only be delivered properly if the workforce has financial means to work according to demand.

4.2. Establishing the size of the public health workforce:

4.2.1. Establishing the current size of the public health workforce is key to identifying gaps in skills and to recruitment planning. Currently, is it known that 1,355,780 people work for the NHS[6]. There are 93,000 vacancies open and shortages in nearly every specialty. Social care employs 1,540,000 people in England[7], and 105,000 vacancies are open[1]. The size of and gaps in the NHS and Social care workforce are well known. When it comes to the core Public Health Workforce, there are only estimates of its size, and we do not know how many vacancies are open in total.

4.2.2. The Department of Health and Social Care stopped collecting data after 2014, when the Centre for Workforce Intelligence (CfWI) report on the size of the core Public Health Workforce was published. Exception to this is the Health Education England (HEE) Capacity Review[8]. However, this only takes into consideration the Public Health Specialist Workforce, ranking on levels 8 and 9 of the Public Health Skills and Knowledge Framework (PHSKF). Professions ranking in lower levels are not considered in this capacity review. Roles on levels 5 to 7 include health visitors and environmental health professionals. Roles on level 2 to 4 include smoking cessation advisors and substance misuse workers. Health promotion and preventative care rely heavily on these professionals, therefore, knowing the size of this workforce is vital for service planning.

4.2.3. The CfWI report(year), the most robust and publicly available estimate on the size of the core PHW[i], puts forward that 40,000 people make up the “core”PHW workforce. RSPH used a methodology similar to CfWI to map the current size of the PHW, which unravelled that no coherent data exists to identify the number of

- some professional roles, such as public health managers, public health scientists and public health practitioners
- professionals working for the private and third sector
- Some professions across the UK, not England-only. (see Table 1, p.7).

4.2.4. This lack of precise data may lead to false conclusions. By simply considering the table, it seems the number of Public Health nurses has gone up. This is false. Since 2017, 840 registered Specialist Community Public Health Nurses (including health visitors and school nurses) left the register. The decline was shaper on the health visitors group. In 4 years, over 1,000 left the register.

[i] The Core Public Health Workforce was defined as “all staff engaged in public health activities who identify public health as being the primary part of their role” (CfWI, 2014, p09).

Table 1: Estimate numbers of the PHW reviewed by RSPH.

Role title	Total number of staff (CfWI 2014 estimate)	Updated RSPH estimate
Public health consultants and specialists	1,200–1,300, plus 250–350 registrars	1,617[9] plus 146 permanent defined specialists and 600 generalist specialists in the UKPHR [10]
Directors of Public Health (DsPH)	130	135[ii,11]
Public health clinical academics	200–300	148 in medical schools[12] + 34 in dentistry school[13]
Public health managers	600–1,200	600 – 1,200[iii]
Public health scientists	1,500–2,500	2,300[iv,14] + 351[15]
Intelligence and knowledge professionals	1,000–1,300[v]	230 (DHSC) 490 (PHE Knowledge and information) 60 statisticians (DHSC + PHE)[16] no data for local authorities.
Public health nurses[vi]	350–750	3,484[17]
School Nurses	4,000	4,083[17]
Health visitors	11,000	22,674[17]
Public health practitioners	Up to 10,000	448[4] officially registered[vii].
Environmental health professionals	5,500–8,500, including more than 4,000 in local authorities.	7,211[18] (3,240 and 3,360 fully qualified Environmental Health Practitioners in LA[19])
Total	36,000 to 41,000	Around 45,000

[ii] Either substantive, or interim or acting appointments 2021.
[iii] When carrying out its analysis, CfWI highlighted that public health managers work with multiple professional titles and roles. They work across the system and yet, there is no data available for this workforce. We took the CfWI figures as the most recent robust estimate to build our figures.
[iv] Number of scientists and engineers working for Public Health England.
[v] CfWI and RSPH estimates exclude data from local authorities. Only data made available by DHSC and PHE were used.
[vi] It is imperative we explain why numbers are so different for Public Health Nurses in our estimate. The CfWI used numbers published by PHE at the time (2014). They also included numbers published by the NMC in 2012. RSPH used Registration data reports published by the NMC in 2021. For Health Visitors, CfWI estimate included health visitors working for NHS England only. RSPH used numbers of Health Visitors on the Registration data reports published by the NMC in 2021. This 10-fold difference in the number of Public Health Nurses could also be a result of data error in the statistics provided to the CfWI at the time.
[vii] Exact number of public health practitioners is unknown. The UKPHR lists 448 on their register, however, since registering is not mandatory, numbers are higher. Precise numbers of Environmental health professionals are unknown as well.

4.2.5. Not only are the numbers imprecise, so is the list of professions. A core tenant of the public health workforce are people working across levels 1 to 4 of the Public Health Skills and Knowledge Framework that were not considered. These roles include social prescribing and link workers, dental health worker (schools), refuge worker, refuse worker, healthcare assistant, community pharmacy support staff, smoking cessation advisor, substance misuse worker, public health intelligence assistant, public health statistical assistant and health trainer.

4.2.6. Previous estimates on the PHW size does not cover the new and emerging roles that have been developed in response to COVID-19, such as the expanded vaccinator workforce. In order to deliver Covid-19 vaccinations at scale across the country, the vaccinator workforce was expanded, with the law amended to allow registered healthcare professionals who do not normally vaccinate to do so as part of the COVID-19 and flu vaccination programmes. As the government plans to push for the public to "live with COVID" it is necessary to permanently enable health professionals other than GP practice nurses and community pharmacists to administer adult vaccines[20]. To effectively expand the vaccinator programmes at times of high pressure and support catch-up programmes or deliver on-the-spot vaccinations to those who struggle to access immunisations, Health Education England should develop training modules to upskill health professionals who do not routinely administer vaccinations. In turn, local systems should assess where their coverage is lowest, and map potential touchpoints with health services which could become opportunities for vaccination. Health professionals involved in those contact points should then be supported to take up this training offer.

4.2.7. The wider Public Health Workforce must be remembered as well. Public Health England recently published a review of this professional group[21], highlighting their role in improving public's health outcomes. The review aimed to be strategic and estimating the numbers of the wider PHW was out of its scope, however, RSPH has expertise in working with this professional group and could be part of a taskforce to map its current size.

4.2.8. **It is essential that all governmental entities delivering public health services, such as the Department of Health and Social Care, NHS, local authorities (including Port Health authorities) work together and map the true size of the core and wider Public Health Workforce as soon as possible. Without these numbers, plans to recruit extra staff will be flawed, as we will not know how many additional people are required and in which professions there are the greatest shortages.**

4.2.9. The House of Commons Health and Social Care Committee noted that the Government decided to resist an amendment to the Health and Care Bill requiring it to publish an independently verified assessment of health, social care and public health workforce numbers at least once every two years[22]. **RSPH opposes this decision, aware that without knowledge of the current size of this workforce, estimates made for recruitment and training cannot be precise. This puts further pressure on the public health frontline workers dealing with the backlog and populational demand.**

5. What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?

5.1. Addressing recruitment issues:

5.1.1. **We recommend that current plans for recruitment need to consider increase funding for on-the-job training and alternative career pathways to allow more people to enter and progress in public health professions.** For 2021–22, public health grant allocations represent 24% (£1bn) real-terms cut compared to 2015/16[23]. Subsequently, public health staffing in some parts of the country were being scaled back to save money, and this workforce was spread too thinly across local authorities[24].

5.1.2. Cuts to public health grants have significantly impacted the workforce. When asked about recruitment, respondents to RSPH survey expressed that:

- 69% agree their service is understaffed
- 59% agree their team has struggled to hire staff for the past 6 months
- 38% have said staff retention is a concerning issue to their workplace.

5.1.3. Our results are consistent with a previous survey conducted by the Chartered Institute for Environmental Health (CIEH), which found that over half (56%) of local authorities had vacancies in their environmental health teams unfilled for 6 months or more, and 31% indicated that the delivery of some environmental health duties was at risk, due to resourcing issues in 2019/20[25].

5.1.4. The majority of our survey participants considered as actions that could be taken to recruit extra staff[viii] (see Figure 01, p10):

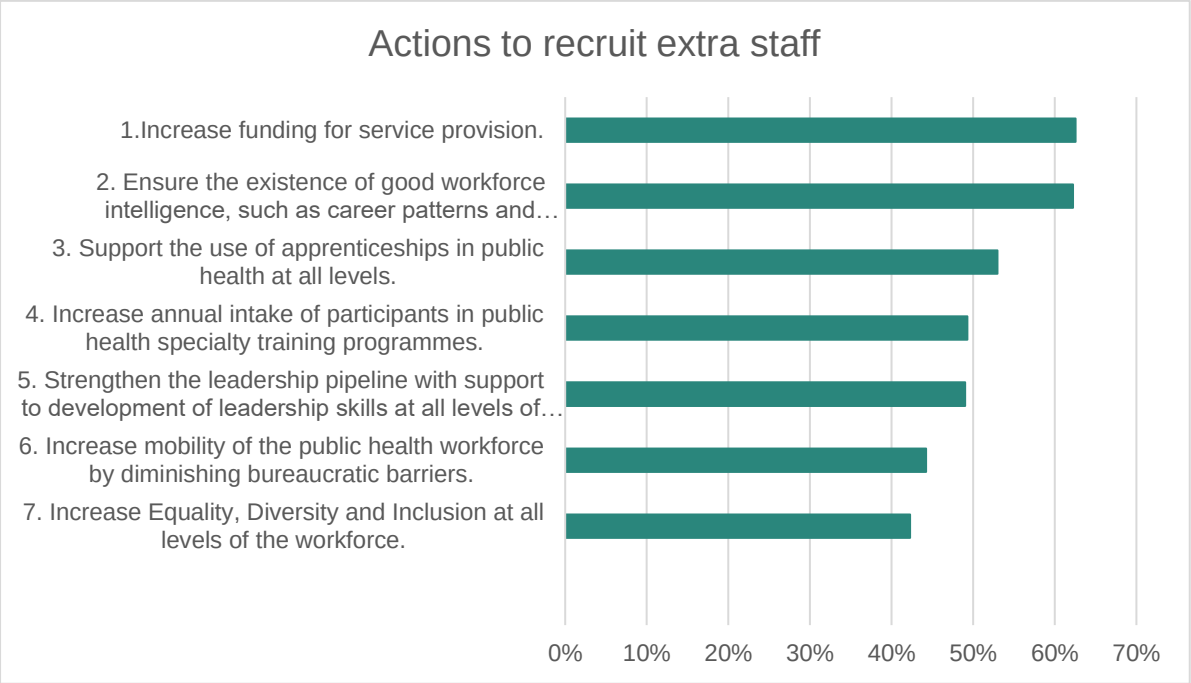
- increase funding for service provision (63%)
- ensure the existence of good workforce intelligence, such as career patterns and opportunities for professional development (62%)
- support the use of apprenticeships in public health at all levels (53%)
- strengthen the leadership pipeline with support to development of leadership skills at all levels of the workforce (49%)
- increase annual intake of participants in public health specialty training programmes (49%).

5.1.5. Respondents also highlighted the importance of:

- Career pathways to allow a more diverse range of staff to enter and progress in public health professions
- Availability of flexible working patterns.

[viii] Participants could select as many answers as they thought applied to their case. Therefore, the sum result is not 100%.

Figure 01: Actions for the short, medium and long term to recruit extra staff.



Source: RSPH survey.

5.2. Addressing training needs:

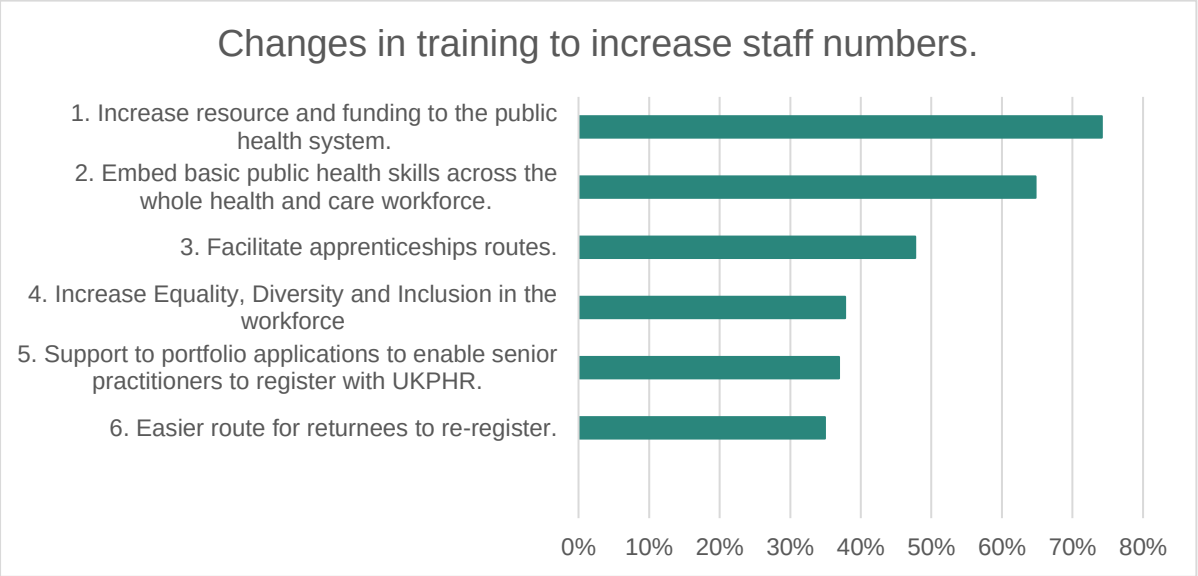
5.2.1. **Workforce training and development should take into account the increasingly aging public health workforce.** In 2019, within the Public Health Specialists group, 39% of Public Health Consultants are aged over 50 years old. 18% of Directors of Public Health are between 50 and 54 years old[26]. According to the General Medical Council data, 20% of public health consultants and specialists are age 60-64, and 14% are 65-69. Only 1.6% are 30-34 and 5.9% are 35-49. This has implications not only for future service delivery, but for training as well – clinical placements and practice-based learning need experienced clinicians and educators to supervise students and apprentices.

5.2.2. **We recommend that training explores models other than the 1:1 practice-based learning, such as peer-assisted learning, multiple mentoring and inter-professional placements[27], so that the supervision of students and apprentices are not jeopardised.**

5.2.3. Public health professionals who responded to RSPH survey highlighted the need for balancing theoretical and practical training, so that people entering public health professions have the right knowledge and skills needed for their roles. The PHW supports our view (See Figure 02, p.10) and think that increasing the PHW can be achieved by:

- Increasing resource and funding to the public health system (74%)
- embedding basic public health skills across the whole health and care workforce (65%)
- facilitating apprenticeships routes (48%).

Figure 02: Changes in training to increase staff numbers.[ix]



Source: RSPH survey.

5.2.4. In addition to the categories in the above chart, PHW members when freely answering about gaps in skills needed and capabilities required, emphasised 3 main training needs:

- a good balance between theoretical and practical training
- a general understanding of what public health is (both as a topic and as a professional career)
- soft skills (for example communication, teamwork and leadership).

5.3. Equality, Diversity and Inclusion:

5.3.1. Equality, Diversity and Inclusion (EDI) was also mentioned on our survey. A diverse workforce helps diminish the risk of potential biases and barriers to inclusion. Integrating EDI to all levels of training helps tackle health inequalities, through the provision of knowledge, tools and support for this workforce to assist diverse and marginalised communities with their health issues[28].

5.3.2. **We emphasise that EDI** should be infused into all levels of the workforce. The Public Health Workforce needs to be upskilled to apply an EDI lens when looking at their talent and leadership pipelines and training opportunities across the organisation. For example, epidemiologists need training—both formal educational programs and internal ones—in health equity to understand what questions to ask, where to ask them, and how to collect the right information.

[ix] Participants could select as many answers as they thought applied to their case. Therefore the sum result is not 100%.

5.4. Balancing theory and practice:

5.4.1. RSPH also **recommends that workforce training providers make sure that students and apprentices have the right balance of theory and practice in their courses**, to acquire the knowledge and develop the skill set necessary for their professions**.**

5.4.2. **We also recommend that education providers and workplaces facilitate apprenticeship routes**, **to help more people enter the workforce**. We also recommend that public health education is provided in a greater range of settings, so that GPs, clinicians and nurses, as well as the professionals whose work is impacting on nation's health, such as housing professionals, drug and alcohol treatment providers, can have the capacity and the skills to support action against health inequalities they deal with in their services.

5.4.3. Our recommendations build on our previous research about the wider workforce in 2015, where we recommended that Local Authorities, Department of Health and Social Care, Health Education England and Further and Higher Education institutions should[29]:

- Redefine and communicate who can be involved in supporting the public's health
- Provide education and training to the wider workforce ensuring that they are equipped with the requisite skills, competencies and confidence to deliver public health across a variety of settings.

5.4.4. There are examples of successful training schemes, demonstrating that the UK has got experience in offering multiple training routes. These are the cases of the Public Health Observatories training for Public Health Intelligence personnel[30,31,32] and the multidisciplinary programmes for training senior public health specialists[33].

5.5. Workforce retention to adapt to accommodate changes and morale issues imposed by Covid-19:

5.5.1. Retention plans need to adapt to accommodate changes and morale issues imposed by Covid-19. Responding to our survey:

- 85% of public health professionals shared that the demand for their service increased during the pandemic
- 90% consider public health challenges to be greater now than they were 2 years ago
- 72% understand their service does not have enough personnel to respond to current demand
- 47% have felt demotivated to do their jobs in the past 6 months
- 47% have also considered quitting their jobs in the past 6 months.

5.5.2. This reflects in staff turnover rates:

- 46% of public health professionals who took part in the RSPH survey agree that turnover rates at their workplace are high
- 46% agree turnover rates have been higher for the past 6 months.

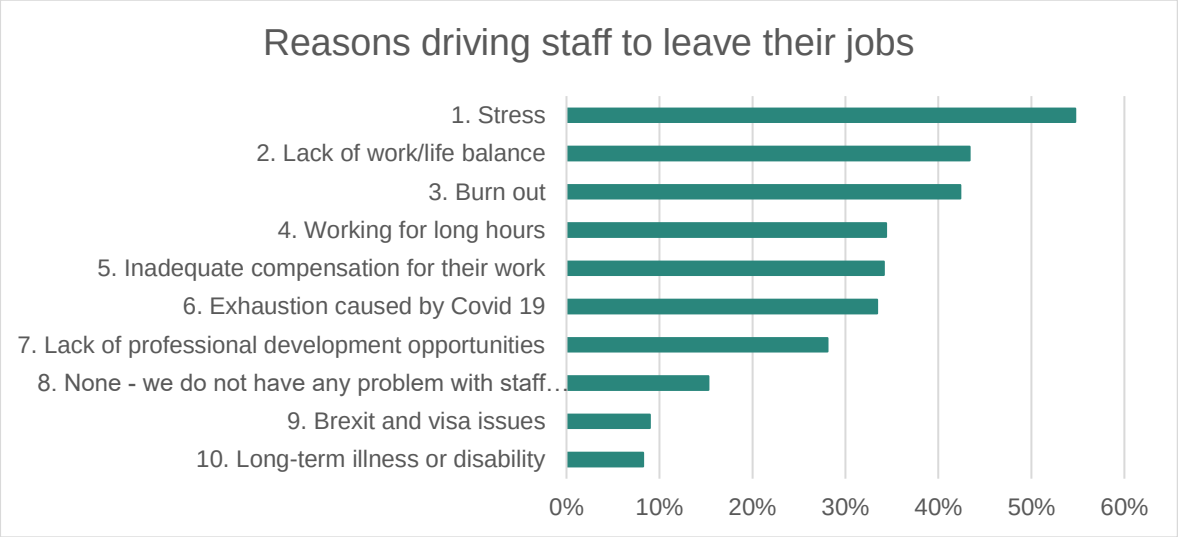
5.5.3. Public health professionals who took part in the RSPH survey expressed that top five reasons for them to consider leaving their jobs are: (See Figure 03, p.13)

- Stress (55%)
- lack of work and life balance (43%)
- burn out (42%)
- working for long hours and inadequate compensation for their work (34%)
- exhaustion caused by Covid 19 (33%).

5.5.4. Respondents who chose other concentrated their answers in 4 categories:

- Problems with the workplace (poor salary, lack of career promotion and opportunities for professional development, not feeling valued by employer)
- Problems with management (poor leadership, bullying and harassment)
- Problems with service delivery (feeling unable to support the population or provide gold standard services)
- Over reliance on fixed-term contracts.

Figure 03. Reasons driving staff to leave their jobs[x]



Source: RSPH survey.

5.5.5. In a nutshell, the Public Health Workforce is stressed, losing quality of life, feeling undervalued and unable to deliver the service to the standard they would desire. The British Medical Journal recently published a similar conclusion, stating that "for healthcare workers, the single worst stressor is the feeling of being lost in the (…) gap between the care that they want to deliver (…) and what they can actually provide.[34]"

[x] Participants could select as many answers as they thought applied to their case. Therefore the sum result is not 100%.

5.6. **Considerations for long-term sustainability:**

5.6.4. Despite all odds, public health workforce is passionate about what they do. 48% said they did not think about moving to a new career and giving up working within public health. However, we cannot rely on individuals' commitments to the cause, and must take steps to address the increasing pressures on services, and plan for the long-term sustainability of public health.

5.6.5. Considering the long-term plans for service provision, the majority of our respondents (61%) shared that their workplace did not have plans to address future gaps. Workplaces that did have plans were investing in:

- Opportunities for apprenticeships and training on the job, and CPD for current staff
- More skill mix in teams
- Plans for work flexibility, career progression and promotion routes.

5.6.6. We therefore **recommend that staff retention plans are holistic and include plans to support current members with their wellbeing issues. We also call on the government to ensure that the necessary funds go to public health, enabling this workforce to deliver their services to the standard and quality they desire. We also recommend employers consider developing career plans and promotion schemes, so that staff feel valued.**

6. What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?

6.5. The last update on the UK shortage occupation list includes “Health services and public health managers and directors” (code 1181)[35]. The UK Visas and Immigration considers roles related to this occupation: director of nursing, health service manager and information manager.

6.6. The list currently does not sufficiently cover roles that suffer from shortages. Local authorities in England have reported shortages of fully qualified and experienced Environmental Health Professionals as well as difficulties in recruitment. For example, 56% of local authorities have reported that “vacancies in their environmental health team (…) were left unfilled for 6 months or more”[36].

6.7. Respondents to our survey also indicated that their workforce is struggling to hire. When asked about recruitment:

- 69% agree their service is understaffed
- 59% agree their team has struggled to hire staff for the past 6 months.
- 38% have said retention is a concerning issue to their workplace

6.8. Environmental health professionals are eligible for the Skilled worker visa (code 2463)[37], but they are not listed under the descriptor for “shortage occupation”.

6.9. We recommend that the Department of Health and Social Care works with the local public health teams to identify the true size of the gap in public health occupations, and coordinates action with the Home Office to ensure that this gap is filled, where appropriate through modifying and expanding the “shortage occupation” lists and special visa arrangements.

7. What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors?

7.5. **Politicisation of public health practice:**

7.5.4. The Covid-19 pandemic demonstrated that public health knowledge and understanding is needed by any health staff. More than disease monitoring and vaccine uptake rates, public health is about equity, social justice and participation[38]. The pandemic exacerbated how health inequalities affected health outcomes of Covid-19 patients. Socio-economically disadvantaged neighbourhoods and minority ethnic groups were more vulnerable to the disease[39]. Therefore, **we recommend that allied public health professionals have more disciplines relevant to public health, such as population health, public health practice, disease prevention, health inequalities and health promotion in their curricula.**

7.5.5. Embedding basic public health skills across the whole health and care workforce is an important step to increasing staff numbers.

7.5.6. In addition, politicisation of health and science information led to an erosion of trust in science, impacting the effectiveness of COVID-19 communication and increasing pressure on the PHW[40]. To ensure trustworthy and accurate reporting about vaccinations, academic and research institutions should maintain science press officer roles who can effectively engage with journalists. Additionally, the communication offices in government departments must ensure there is a clear demarcation between the communication of scientific research by academics and the officials, with those involved in the research itself being able to lead on releasing the findings, and the timing of the publications.

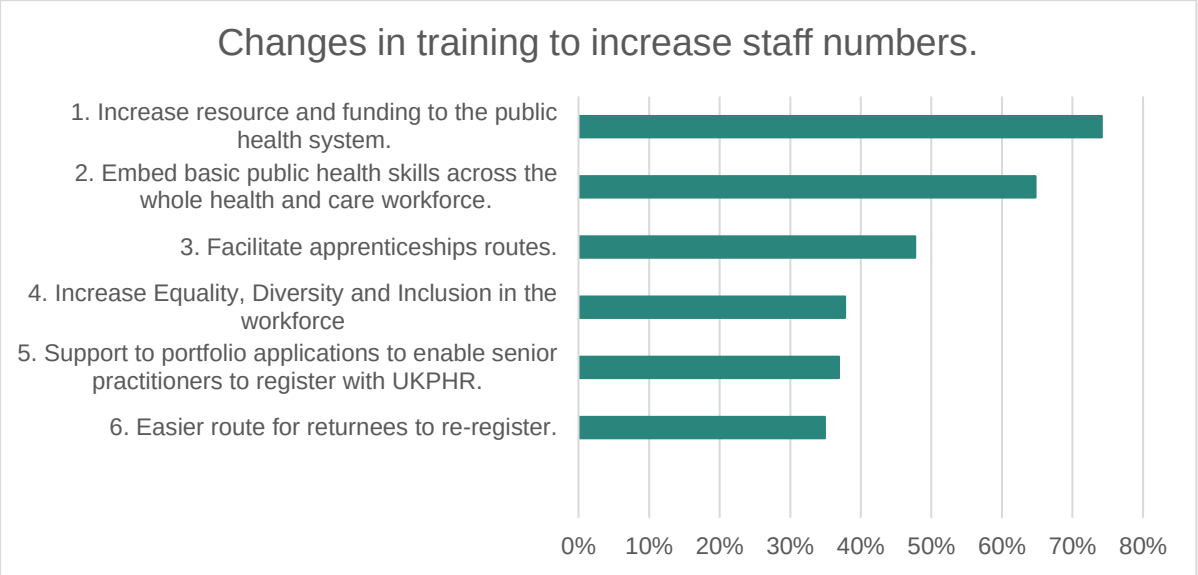
7.6. **Training needs for the public health need**

7.6.4. Respondents to RSPH survey highlighted the importance of a good balance between theoretical and practical training, so that people entering public health professions have the right knowledge and skills needed for their roles.

7.6.5. When asked about changes to training of staff in the public health sector to increase the number of personnel, RSPH survey's respondents chose as the most important actions (see Figure 02, p.17):

- Increasing resource and funding to the public health system (74%)
- embedding basic public health skills across the whole health and care workforce (65%)
- facilitating apprenticeships routes (48%).

Figure 02: Changes in training to increase staff numbers.[xi]



Source: RSPH survey.

7.6.6. When freely answering about gaps in skills needed and capabilities required, RSPH membership emphasised 3 main categories:

- A good balance between theoretical and practical training
- a general understanding of what public health is (both as a topic and as a professional career)
- soft skills (for example communication, teamwork and leadership).

7.7. **Equality, Diversity and Inclusion:**

7.7.4. A diverse workforce helps diminish the risk of potential biases and barriers to inclusion. Integrating Equality, Diversity and Inclusion (EDI) training at all levels would help tackle health inequalities, through the provision of knowledge, tools and support health and care workforce to assist diverse and communities experiencing exclusion with their health issues[41].

7.7.5. **We emphasise that EDI should be infused into all levels of the workforce. The Public Health Workforce needs to be upskilled to apply an EDI lens when looking at their talent and leadership pipelines and training opportunities across the organisation.** For example, epidemiologists need training—both formal educational programs and internal ones—in health equity to understand what questions to ask, where to ask them, and how to collect the right information.

7.7.6. We recommend that workforce training providers consider helping current students and apprentices to have the right balance of theory and practice in their courses, via internships or practice-based learning experiences.

[xi] Participants could select as many answers as they thought applied to their case. Therefore the sum result is not 100%.

7.7.7. We also recommend that education providers and workplaces facilitate apprenticeship routes, to help more people enter the workforce.

7.7.8. We recommend that public health education is provided in a greater range of settings, so that everyone, from the general public to health professionals, has access to public health knowledge and skills.

8. What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?

8.5. **The public health sector is now facing a considerable backlog**. As the Health and Social Care Committee itself stated, children are missing out on universal programmes delivered by schools[42]. Essential public health services were put on hold during Covid-19. And instead of increasing it, the value of the public health grant it will be maintained for the next three years, meaning a real term decrease on a like-for-like basis.

8.6. Public health grants to local authorities have been consistently decreasing for the past 6 years. In 2019/20, the value of the grant was, on like-for-like basis, 15% less than in 2013/14[43]. For 2021–22, public health grant allocations represent 24% (£1bn) real-terms cut compared to 2015/16[44]. Consequently, public health staffing in some parts of the country have been scaled back to save money, and the remaining workforce spread too thinly across local authorities[45]. .

8.7. **The Covid-19 pandemic imposed great challenges to this workforce**. Local authorities had to redistribute staff across the system, asking staff to cover for other roles. There are examples of health visitors supporting helplines, and officers with experience in infectious disease outbreak control supporting incident control teams[46]. Public health professionals who took part in the RSPH survey expressed significant pressures onstaff recruitment, training and retention with:

- 90% consider public health challenges to be greater now than they were 2 years ago
- 85% sharethat the demand for their service increased during the pandemic
- 72% understand their service does not have enough personnel to respond to current demand
- 47% have felt demotivated to do their jobs in the past 6 months
- 47% have also considered quitting their jobs in the past 6 months
- 46% agree that turnover rates at their workplace are high
- 46% agree turnover rates have been higher for the past 6 months.

8.8. Worsening the situation further is the hostility, abuse, and sometimes even aggression that this workforce faces when doing their jobs. Animosities were reported in vaccination centres across the country, perpetrated by people against Covid-19 vaccines. **Politicisation of health and science information** led to an erosion of trust in science, impacting on the effectiveness of COVID-19 communication and increasing pressure on the PHW[47].

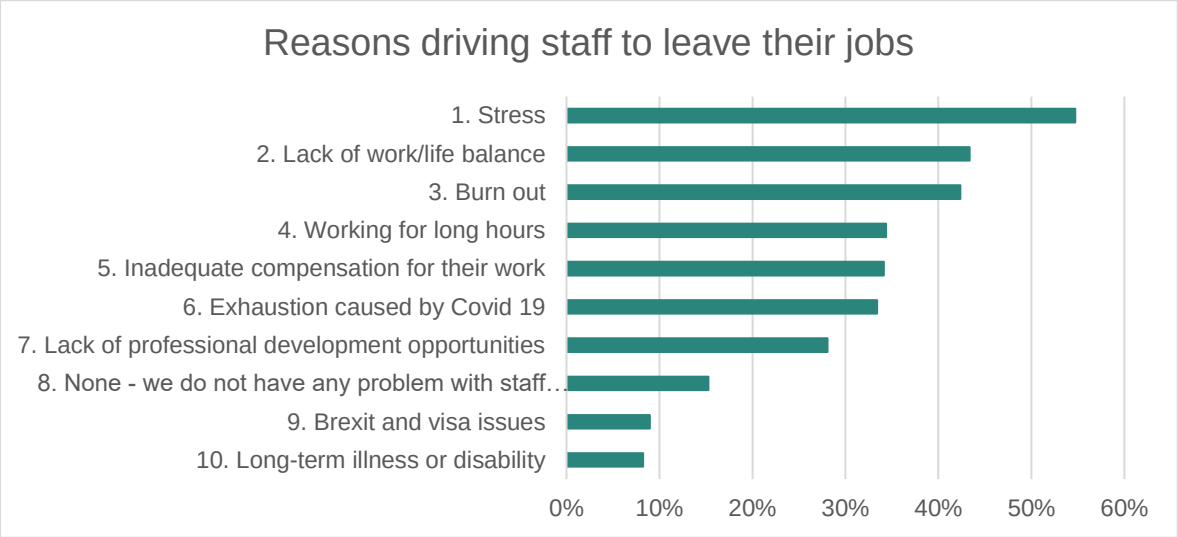
8.9. Feedback from the public health workforce on RSPH survey (see Figure 03, p.18) was clear that top 5 reasons for public health workers to leave their jobs are:

- stress (55%)
- lack of work and life balance (43%)
- burn out (42%)
- working for long hours and inadequate compensation for their work (34%)
- exhaustion caused by Covid 19 (33%).

8.10. Respondents to RSPH survey who chose "other" reasons for leaving their jobs, concentrated their answers in 4 categories:

- Problems with the workplace (poor salary, lack of career promotion and opportunities for professional development, not feeling valued by employer)
- Problems with management (poor leadership, bullying and harassment)
- Problems with service delivery (feeling unable to support the population or provide gold standard services)
- Over reliance on fixed-term contracts.

Figure 03. Reasons driving staff to leave their jobs[xii]



Source: RSPH survey.

8.11. **Equality, Diversity and Inclusion** (EDI) is important in retention too. A diverse workforce helps diminish the risk of potential biases and barriers to inclusion in service delivery, but diverse organisations are known to be more creative and engaging. Employing people from different backgrounds, experiences and ideas also leads to better problems solving and decision-making[48]. **Public Health Workforce from diverse backgrounds should feel welcome, valued in their workplace. Encouraging them to engage with peers and offering support is crucial for their presence and continuous contribution to the public health.**

[xii] Participants could select as many answers as they thought applied to their case. Therefore, the sum result is not 100%.

8.12. **Implications on workforce planning:**

8.12.4. Results from RSPH survey demonstrate that the Public Health Workforce is stressed, losing quality of life, feeling undervalued and unable to deliver the service to the standard they would desire. The British Medical Journal recently published a similar conclusion, stating that "for healthcare workers, the single worst stressor is the feeling of being lost in the (…) gap between the care that they want to deliver (…) and what they can actually provide.[49]"

8.12.5. Despite all odds, public health workforce is passionate about what they do. 48% of those who took part in the RSPH survey said they did not think about moving to a new career and giving up working with public health. However, we cannot rely on individuals' commitments to the cause, and must take urgent action to alleviate the increasing pressures on services, and plan for the long-term sustainability of public health.

8.12.6. Considering the long-term plans for service provision, the majority of our respondents (61%) shared that their workplace did not have plans to address future gaps. Workplaces that did have plans were investing in:

- Opportunities for apprenticeships and training on the job, and CPD for current staff
- More skill mix in teams[xiii]
- Plans for work flexibility, career progression and promotion routes.

Bearing all this in mind**, we recommend that staff retention plans developed by government and employers are holistic and include plans to support current staff with their wellbeing issues. We also call on the government to ensure that the necessary funds go to public health, ensuring the workforce can deliver their services to the quality and standard they were intended and desire to do. We also recommend employers consider developing career plans and promotion schemes, so that staff feel valued**.

[xiii] Skill mix is a term widely used in healthcare, and it means (1) the range of competencies possessed by an individual healthcare worker; (2) the ratio of senior to junior staff within a particular discipline; and (3) the mix of different types of staff in a team/healthcare setting. Nelson P, Martindale A, McBride A & et al. Skill-mix change and the general practice workforce challenge. British Journal of General Practice 2018; 68 (667): 66-67. DOI: https://doi.org/10.3399/bjgp18X694469

9. What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?

9.5. From 2022 onwards, Integrated Care Boards and Local Authorities will be statutory members of Integrated Care Partnerships. This means they are required in law to set up and run it[50]. It could become an opportunity for public health teams, as they will be able to work closely with NHS when addressing issues related to wider determinants of health such as housing, local planning and education[51].

9.6. However, this arrangement will only be successful if clear plans on how parties involved work together are agreed. Previous study analysing disease prevention in integrated health and care systems showed that evidence of this arrangement leading to better disease prevention is weak. Analysis showed that success depended on gaps in social determinants of health being filled[52]. This demonstrates how great public health contribution should be to ensure ICSs are successful.

9.7. For public health workforce recruitment and retention, this could be an opportunity to hard wire the public health system's contribution more coherently alongside the NHS[53] and prove the value of public health to the wider population, bringing prestige to the teams and motivating staff. Because tackling heath inequalities is at the core of the ICSs project, public health teams have a fundamental role in planning and delivering services that support vulnerable communities. But ICSs could also become a burden to public health staff if not well planned. The PHW is already tired and stressed, suffering from lack of work and life balance. They are dealing with a backlog caused by the Covid-19 pandemic and struggling to deliver services when Public Health grants have not increased in real terms.

9.8. This integration could mean that public health teams see more pressures and oversight on their work. ICSs need to consider carefully how an already exhausted staff will deliver the desired outcomes, risking losing more professionals still working for the team.

9.9. RSPH survey also highlighted that there are significant challenges in retention of PHW. It is still not clear what the functions of the public health teams will be and how NHS and local authorities work will integrate, nonetheless information so far provided demonstrated that public health is at the centre of these changes[31]. ICSs need to plan carefully the role of these public health teams, risking overwhelming staff with an already heavy workload.

9.10. **We recommend careful design on roles and responsibilities of Local Authorities and Public Health teams when planning ICSs**. We welcome that design and implementation of ICSs is locally led but highlight that attraction and retention of staff will only work if proper funding, wellbeing support, career pathways and promotion routes are in place and offered to the workforce. Changes should focus on boosting staff morale, and not hinder it with increased workload.

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