The Association of Directors of Public Health Consultation Response

10 Year Workforce Plan

Objectives and scope

Following the publication of the 10 Year Health Plan for England, the Government is seeking evidence to inform the 10 Year Workforce Plan, which aims to take a different approach to workforce planning.

Instead of asking 'how many staff do we need to maintain our current care model over the next ten years?', the Government is asking 'given our reform plan, and our commitment to a sustainable NHS, what workforce do we need, what should they do, where should they be deployed, and what skills do they need to deliver better care for patients and citizens?'.

The call for evidence will contribute towards an understanding of:

- The professions, roles, and skills, including skills included and emphasised in training curricula, that will be critical to successfully implement the three shifts.
- How specific professions, roles, and skills may be impacted by the implementation of the three shifts and the wider policy ambitions of the 10 Year Health Plan, while maintaining quality care for patients.
- How the 10 Year Workforce Plan can support the Government growth and opportunity missions.

About ADPH

ADPH is the representative body for Directors of Public Health (DsPH), and is a collaborative organisation, working in partnership with others to strengthen the voice for public health, with a heritage which dates back over 160 years. ADPH works closely with a range of Government departments, including UKHSA and OHID as well as the four CMOs, NHS, devolved administrations, local authorities (LAs), and national organisations across all sectors to minimise the use of resources as well as maximise our voice.

ADPH aims to improve and protect the health of the population by:

- Representing the views of DsPH on public health policy.
- Advising on public health policy and legislation at a local, regional, national and international level.
- Providing a support network for DsPH to share ideas and good practice.
- Identifying and providing professional development opportunities for DsPH.

Section 1: The three shifts

Evidence is being sought on how the Government's three shifts are being implemented locally, and the impact on the workforce.

Examples of where new digital initiatives have improved patient care:

In Bristol, North Somerset, and South Gloucestershire (BNSSG), public health teams have commissioned an innovative sexual health contract where clinical services are delivered by the NHS Trust, a digital offer for initial contact and testing is provided by SH:24, and a health promotion offer is provided by Brook, a sexual health and wellbeing charity. These elements work as an integrated service offer and reflect the three shifts.

Examples of where a shift from hospital-based care to community care has already begun/taken place:

In Camden, a Consultant in Public Health worked with a Consultant Paediatrician on an analysis of paediatric emergency department visits at University College London Hospital which showed the incidence of frequent low acuity attenders. Qualitative analysis revealed that in most instances attendances were due to a lack of awareness of the wider community health offer, including general practice and family hubs. Further analysis revealed that in many instances underlying social issues related to welfare, housing, and safeguarding were driving attendance.

Some of these frequent attenders were proactively invited to a joint clinic in the hospital where paediatricians and health visitors (commissioned by public health) offered advice covering a range of health and social care issues. The clinic was attended by 100% of people invited but, by being located in the hospital, it was not encouraging families to engage with services in the community. LA early years colleagues have since supported the clinic's relocation to Family Hubs.

Close partnership working has demonstrated the opportunity to reduce healthcare demand, improve health literacy, and parental confidence.

Examples of where preventative care services are already available:

In BNSSG, partners across the public health system are working together to achieve a Smokefree BNSSG where less than 5% of the population smoke by 2030. The project aims to:

- Prevent initiation of smoking and support people to quit.
- Reduce use and harm and protect people who do not smoke.
- Build community capacity, improve outcomes and reduce inequalities.

They have started a Treating Tobacco Dependency Service (TTD) across the three pathways of acute inpatients, maternity, and mental health inpatients. In that time, they have achieved:

- A reduction in smoking in pregnancy measured at the time of delivery to 5.8% in 2024/25.
- Successful commissioning and hosting of Smokefree representatives, Smokefree Peer Support, and a Smokefree Behavioural Science Lead.
- Implementation of in-service offers resulting in 4,872 setting quit dates and 872 quitting via online portal since April 2025.
- Launching a smoking and ethnicity review.
- Successful trading standards enforcement against illicit products.

Which professions, roles and skills were critical to successful implementation for each example:

- Close collaboration and partnership working between DsPH and their teams, other LA experts (eg trading standards) and NHS staff.
- The availability and use of relevant data and evidence.
- Engagement with those with lived experience.
- Being able to work and lead in complex adaptive systems, using a social and community capital framework, and working across boundaries.

Any barriers to ensuring the right professions, roles and skills were involved, and how you overcame these barriers:

- Collaboration with BNSSG's public health system has included:
  - Co-locating support in hospitals.
  - Sharing communications strategies and materials.
  - Developing feedback loops from community services to support MECC link.
  - Adapting the Swap to Stop portal to implement improvements beyond TTD core services in the acute setting.
- Barriers in acute treatment – knowledge, ownership, and systems to support a trust-wide approach to TTD, historically built upon the biomedical model of lifestyle choice and siloed responsibilities for health, compounded by acute operational pressures.
- Approach to internally build capability, leadership, and culture change (these approaches were supported by BNSSG Smokefree Alliance and used the Smokefree 2030 model):
  - Induction/education sessions for staff.
  - Using Patient First quality improvement methodology.
  - Incorporating TTD into Trust health equity plans and metrics.
  - Regular updates to clinical leads.
  - Leadership on smoke free site to connect people into support.
  - Focussed support for staff who smoke.
  - Standardising coding and automating referrals using electronic systems.

Section 2: Modelling assumptions

In this section, evidence about specific assumptions used in workforce modelling - for example, how service redesign such as new community services or digital models of care might affect the numbers, deployment and/or skill mix of staff is being sought.

In public health, the complexity of multiple employers and roles has made workforce planning difficult, and Covid-19 emphasised the need to resolve this issue to ensure the resilience and flexibility of the public health system.

A viable national dataset on the public health workforce (including occupational definitions) must be developed and implemented to enable proper workforce planning. An effective data-driven system should be able to:

- Predict future capacity and capability requirements, identify and address gaps, and anticipate and avert bottlenecks.
- Optimise existing resource to ensure the right staff are in the right place at the right time.
- Anticipate future need so that the right staff can be recruited and trained.
- Establish alternative pathways to public health.
- Know the capacity and capability of the whole system to be able to rapidly deploy people in exceptional circumstances, such as a pandemic.

How that impacts on workforce supply and demand, including career and training pathways:

It is important to note that local government reform is likely increase the number of DsPH needed which further highlights the need to plan for the public health workforce.

Section 3: Productivity gains from wider 10 Year Health Plan implementation

In this section, evidence of digital initiatives - in the NHS, other sectors or internationally - that have successfully increased workforce productivity or reduced demand are being sought.

Examples are wanted where expectations have been changed and there has been an increase in patient participation in their care through digital tools:

In Barking and Dagenham, a GP Pop-Up initiative was designed to improve access to health services and reduce pressure on primary care by supporting residents in navigating both clinical and non-clinical support options. Delivered in a non-clinical community setting, the initiative aimed to build trust within the local population, connect individuals to wider activities and services across the borough, and promote healthier, happier lives. By educating residents on alternative sources of clinical support, such as voluntary sector organisations, the initiative also contributed to managing winter preparedness and aligning with the borough's broader health inequalities objectives.

Section 4: Culture and values

In this section, evidence and experiences are being gathered about what works in building a positive culture where leadership is strong, the quality of care is high, and staff are supported to thrive - and what must change to make that the norm everywhere.

N/A

Section 5: Any additional comments

Please include any other comments, information or evidence you would like to share as part of this call for evidence that you think would help deliver the ambitions of the 10 Year Health Plan.

Only 10-20% of health and wellbeing is determined by access to traditional health services. The remainder is shaped by economic, social, and environmental conditions including income, education, housing, transport, and air quality. The 10 Year Workforce Plan must look beyond the NHS and include the public health workforce:

- The number of public health specialists in training should be increased to ensure there is enough expertise in every LA as well as regionally and nationally.
- Public health workforce intelligence should be improved to support workforce planning and mobility.
- The number of appropriately trained public health analysts, with a grounding in epidemiology and wider public health, must be increased to ensure the availability of wider local intelligence to inform decision making in LAs and the NHS.
- Workforce mobility enabling and supporting public health professionals to take up posts in different sectors is critical to growing and maintaining the workforce.
- DsPH, as local leaders for public health, must have strong links with public health people employed locally and regionally by the NHS and as part of the DPH team. Similarly, specialist public health roles in the NHS must compliment and collaborate with those working in LA PH teams in order to effectively tackle health inequalities and prevention, enhance relationships for, and respond effectively to, emergencies, and avoid duplication.
- Investment in apprenticeship programmes is needed to address structural inequality and skill shortages, and produce innovative, skilled, adaptable future talent for public health and environmental health workforce pipelines.