The King's Fund

Ideas that change health and care

# Public health and population health

## Leading together

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# About this report

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# Key messages

- The new government has made a commitment to halving gaps in healthy life expectancy and delivering a 10-year plan for health. To achieve this, ministers must call on and support the expertise of the existing public health family and the new emphasis on population health taking root in ICSs.
- The Covid-19 pandemic saw the public health profession in general, and directors of public health (DPHs) in particular, rise in profile and influence in local government. At the same time, the advent of integrated care systems (ICSs) has seen an increasing focus on improving population health and the emergence of a new cadre of leaders – directors of population health. The public health and population health communities are stronger when leading together and in strategic alignment.
- People in new ICS population health roles have started to shape their roles and work with public health leaders in local government and in the National Health Service (NHS). There is no single blueprint for how this works – local context, including in terms of the scale and complexity of systems, means different arrangements work in different places.
- However, tensions and a lack of engagement between public health and population health leaders remain in some areas. Uncertainty over a common understanding of population health, financing and whether ICSs will continue their focus on population health in the long term is driving this. This tension and uncertainty is also affecting the next generation of leaders as they make their career choices.
- Action from national leaders is needed in a number of key areas, including to:
    - provide clarity on the definition of equitable population health (and its relationship with public health) and a facilitative framework for responsibilities and roles
    - provide medium- to long-term commitments on population health and public health capacity
    - allow structures to mature and reaffirm the principles of ICSs around population health and tackling health inequalities
    - actively share emerging practice and experience of population health and public health working effectively together
    - monitor and track progress over time and intervene where appropriate

- We also set out six principles for local systems, drawn from our findings from local good practice and wider insight. These include:
  - remaining focused on the goal, leading for population health outcomes
  - investing time and effort in developing shared system-wide understanding of models of public health and population health and the contribution of all partners
  - translating that into explicit agreements on who will lead on what, at ICS and other levels
  - supporting public health and population health workforce wellbeing.

# 1 Introduction

With life expectancy stalling (Raleigh 2024) and health inequalities widening (The King's Fund 2024), it is clear that the health of England's population is not where we want it to be. The country is also facing economic challenges and public services are under great pressure.

While confronting this requires national effort, it also requires strong, effective and cohesive leadership in public health and population health at the subnational level, through regional and local government, the National Health Service (NHS) and wider partners. This report summarises our work over the past year from a project, supported by The Health Foundation, on the future of public health and population health leadership.

Our starting position, despite the many health challenges our population and health and care system face, is an optimistic one. We believe that there is an important opportunity to be grasped, supporting and stimulating the coming together of existing public health leaders, with their expertise and experience, and an emergent cadre of population health leaders, as integrated care systems (ICSs) seek to fulfil their founding principle of improving population health and tackling health inequalities.

The new Labour government – with a 10-year health plan and a commitment to halve the gap in healthy life expectancy (Buck 2024b; Labour 2024a, 2024b) – will rely on this joint leadership community to help deliver its goals. It is therefore important to understand how these leaders are working together and the challenges and issues they face in doing so, and to share good practice to inspire others.

This report seeks to do just that. Its findings are based on extensive engagement with groups of public health and population health leaders; case studies at regional, ICS and local authority level; interviews with key stakeholders and insight from a range of professional organisations, networks and forums (*see* below and the Annex for further information on our methods.) We set out recommendations for change and principles for practice, which follow from our work.

## The context: change, challenge and opportunity

There are a number of contextual factors that need to be taken into account to understand some of our findings and the challenges and opportunities in relation to the future of public health and population health leadership. Some of these are about recent policy changes and current challenges, and some relate to the longer-term history and development of the public health profession.

### A population and public services under immense pressure

The immediate context in which this work sits is of a population, a health and care system, and wider public services under immense strain and pressure. Funding pressures on the NHS and local government, wider economic factors and inequalities in our society, the experience and consequences of the Covid-19 pandemic, and political uncertainty have all contributed to this. The health of England's population is fragile; we have recovered less well economically from Covid-19 than other countries and this is widely understood to be related to the less resilient health status of our population, our children's wellbeing is worse than in many countries, and health inequalities remain stark and are in some cases widening (House of Commons Library 2024a; House of Commons Library 2024b; Williams *et al* 2022; Maile E and Hargreaves D 2020). In this context, it is critical that those who lead in local systems and places for our population's health are supported to do so with adequate resources, permission and support. It is also important that those at national and system levels seek to work and lead together well, to tackle the challenges that the population faces in terms of their health.

### The experience of the public health profession over time – change and dislocation

Public health in England has a long history. But as a profession it has experienced dislocation and uncertainty and has not always felt supported or understood. In 1974, health reforms relocated public health doctors out of local government and into the NHS as consultants, in what came to be known as 'community medicine'. This meant that many ties to community were lost and the profession became more defined in relation to medical specialties within the NHS. There were also tensions about who could be recognised as a public health professional, and the training routes for non-medics into the profession. Later, as movements around health inequalities and health promotion began to emerge and behaviour change

and evidence-based medicine were developing, the Acheson report into the future development of public health was published (**Acheson 1988**). This led to a renewed recognition of the multidisciplinary nature of public health, reorientating again the focus of the public health profession, its role and identity.[1]

More recently, in 2013, many public health functions and people were transferred from the NHS back into local government, reversing the 1974 reforms. This re-emphasised the key role of local government in influencing the wider determinants of health. Our overall view on this shift, based on an assessment on the eve of the Covid-19 pandemic, is that the move was the correct one (**Buck 2020**). However, for some in the profession it was another experience of dislocation and separation, this time from clinical and health care public health in the NHS. It also led to many leaders being lost to other roles or early retirement.

This history of change has led to a heightened sense of professional identity and a wariness from some about change and the motives for it – and this applies to the emergence of the field of population health too. We will return to this later in this report.

### Covid-19 and the influence of directors of public health

Covid-19 and its aftermath are another important contextual factor, especially in terms of how directors of public health (DPHs) are perceived as leaders in local government. They and their teams were at the heart of the Covid-19 response in their communities. King's Fund work over the first year of the pandemic helped document this (**Ross *et al* 2021**). One of the consequences was a much greater appreciation of the role of DPHs as leaders in local government and in places, and a greater recognition of the wider role of local government in public health more broadly. One of the aims of this research was to explore how this dynamic has evolved as we have exited the period of crisis.

1 For more on this, *see* the excellent transcript of a Witness Seminar held by the Wellcome Trust Centre for the History of Medicine (Berridge *et al* 2006). We are thankful to Kate Ardern for sharing this.

### Integrated care system reforms, population health and population health management

The statutory introduction of ICSs in July 2022 was the culmination of the response to the NHS reforms of the coalition government. It marked a rebalancing away from a competitive view of the health and care system to a collaborative approach (between NHS organisations – through integrated care boards), built around a partnership model (with local government, businesses, the voluntary sector and others) in the form of the integrated care partnership.

While this may look like just another NHS reorganisation from the outside, it has the potential to be far more than that. For the first time in its history, the NHS is being expected to act as a system: to put organisational priorities second and system and population health needs and equity first, through the delivery of care but also through partnership with local government and others. As part of that, ICSs are expected to work on the basis of four key principles (Charles 2022):

- improving outcomes in population health and health care
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

These principles explicitly embed a population health approach. Part of the response to the principles has been an increase in roles in some ICSs and constituent organisations, with titles such as 'director of population health' – sometimes with words such as 'and health equity' or 'management' after them – signalling how these emerging roles are conceived, their scope and responsibilities. But as we will see in this report, who these people are, how they work and the relationship they have with existing public health leaders bring opportunities but also tensions and challenges.

### The government's health mission

Last but not least, the new government has set out big ambitions for the population's health, including the goal of halving the gap in healthy life expectancy and announcing a new 10-year plan for health (Labour 2024a, 2024b). While there is much to do to put flesh on those bones (Buck 2024b), a strong public health and population health leadership community, working together and in alignment at regional, ICS and place levels, will be crucial to success.

## What does this mean for the approach we took and for interpreting our findings?

These contextual factors shed light on why we heard what we did while doing this research, particularly around the evolving relationship between public health and population health leaders.

The factors also explain why we took the approach to this inquiry that we did. We wanted to ensure we heard from a wide range of people, in different positions and with different roles and views, in theory and in practice. We did this through:

- a series of 'position' roundtables with specific groups including groups of – directors of public health; national public health leaders; directors of population health (and similar); and public health officers in local government.
- working with three specific sites of different scales (at regional, ICS and local authority level) to understand how the dynamics of public health and population health leadership were evolving over time (we held one roundtable in each area, and then checked in over a six-month period) – our case studies
- undertaking interviews with key stakeholders
- engaging with a wide range of professional organisations, networks and forums, including the Provider Public Health Network (PPHN) who also undertook a survey on our behalf, the Society of Local Authority Chief Executives (Solace), the Local Government Association's (LGA) Health in All Policies (HIAP) network and the NHS Confederation's ICS Public Health Forum.

*See* the Annex for further details about the methods. Throughout, we were guided by an advisory group of senior public health and population health leaders. We are grateful for their thoughtfulness and wise counsel.

## Structure of the report

In the next section (section 2), we start to explore our findings, in particular three core issues and current debates about them. We then look at how these dynamics are playing out in particular places in practice (section 3). Following this, we set out our recommendations for national leaders and offer some principles for success that cut across the areas of good practice we have identified (section 4). We then conclude the report (section 5).

# 2 Public health and population health: emergent and contested territory

Across our inquiry are three highly inter-related core issues:

- the debate over the distinction or otherwise between public health and population health
- the opportunities and challenges in integration and integrated care systems (ICSs)
- the changing role and experience of the director of public health (DPH) in this context.

It is important to be explicit about these if the public health and population health leadership communities are to work more effectively together.

## Issue 1: Are public health and population health meaningfully different?

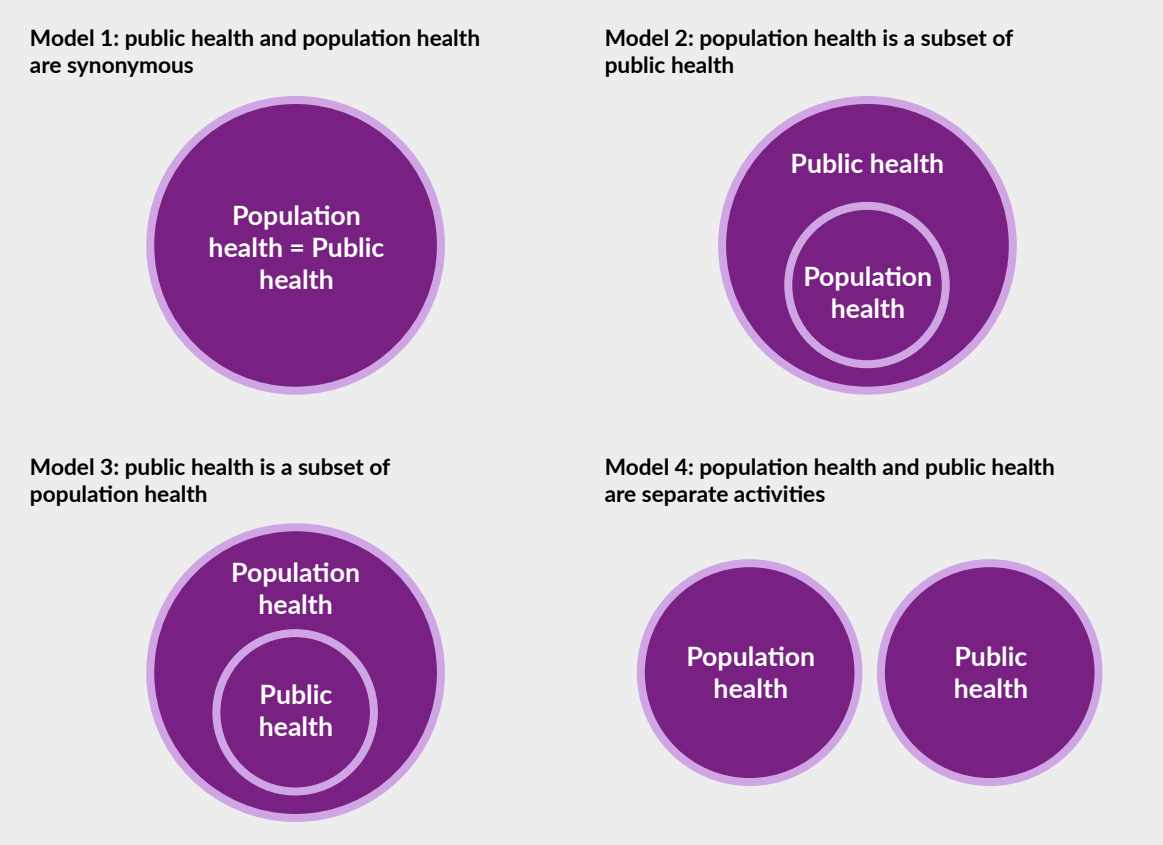
During the course of our research, we encountered a wide range of views on the question of whether public health and population health are meaningfully different. Sometimes, these views were hard to dissect from one another, as different people were using the same language about population health (and its relationship with public health) but meaning very different things. These differing views and confusion stand in the way of public health and population health leaders and their teams working well together in practice.

We found that there were four broad understandings, or models, of the relationship between public health and population health. These views were often tied up with people's opinions on related issues, such as:

- who was competent to undertake certain activities
- where certain functions should sit
- what was motivating the increasing focus on population health.

For example, for some of those who saw public health and population health as essentially synonymous (*see* model 1 in Figure 1), this was related to the suspicion that the NHS was seeking to 'reinvent' public health since the 2013 transfer of public health functions and people back to local government. Others regarded the relationship between public health and population health more functionally, for example holding the view that population health is 'population health management' – a discrete technical function, and discrete subset of public health (*see* model 2), rooted in the data analysis, skills and techniques required to support the NHS to better develop treatment pathways and tackle health inequalities. Still more saw population health as a broader term than public health, encompassing more of the determinants of health (*see* model 3), whereas others saw public health and population health as a result of the different training as essentially separate (*see* model 4) (or worse still, synonymous but with a big disparity in competency).

**Figure 1: Public health and population health – views on how they relate to each other**



### How important is the distinction? Does it matter, to whom and why?

As well as this diversity in terms of defining the concepts and their relationship to each other, we also saw a great deal of diversity of opinion in terms of how important this question of distinction is. Some saw it as vitally important, and views on this were related to our research participants' role. Typically, people working in public health roles, including those in key leadership positions, were more concerned, and some also in population health roles. Meanwhile, others, such as one local government chief executive we spoke to, told us that they were 'not particularly interested in differentiating between public health and population health' and viewed it largely as a semantic issue.

Those who saw the distinction as important tended to do so because they had concerns about the ways in which newer roles in population health were connected with the existing public health infrastructure. For example, some of the DPHs we spoke to had major concerns about new population health roles in ICSs related to:

- duplication of established public health positions
- people in the new roles undertaking public health activities without relevant competencies
- confusion about responsibilities – leading to inefficient working and, in the worst-case scenario, poorer care and outcomes.

Beyond this, there were also concerns about the ability of the NHS to act as a 'home' for population health. Some people felt that the NHS, with its traditional focus on acute care and disease, lacked an institutional understanding of prevention and therefore population health – however defined.

As one DPH put it: 'Our NHS colleagues are target driven and have kind of missed the public health point sometimes.' This meant that some, including people who worked in ICSs, worried that population health as currently being practised within the NHS was not capable of taking 'the most holistic approach to reducing inequality' that public health, it was argued, does. This concern was, to some extent, borne out when we spoke to ICS leaders, one of whom told us that population health was 'a side of the desk thing' they got to when they could, because the more pressing accountability pressures they felt from NHS England related to things such as acute care.

However, these perspectives were not shared by everyone. In particular, many people who were leaders in the population health community, including those who had formal public health training, felt that many of these fears were misplaced, that public and population health is a 'team game' and that the creation of new population health roles means an increase in resource availability and capacity. This, it was argued, is something that everyone should welcome.

Furthermore, it was put to us that population health, when housed in ICSs, can operate at a different geographic scale and co-ordinate different kinds of actors. We were told that this helps to bring about greater change and the contribution of those beyond public health, and can bring public health expertise (whether from the NHS or local government) into core decision-making at the right time. Finally, it is worth noting that, for the most part, DPHs' relationships with their population health colleagues in ICSs were reported as being relatively positive, with one DPH remarking that these relationships are 'much more harmonious than with ICB [integrated care board] colleagues [in general]'.

### Is there, and should there be, a difference between the public health workforce and the population health workforce?

Another area in which we heard a wide range of views related to the differences in training, skills and experience required to take up roles in public health, as compared with those in population health.

#### Current leaders

For some of the DPHs we spoke to during our research, the fact that population health leadership roles do not necessarily require the same qualifications and experience as public health leadership roles was a cause for concern, and a reason to worry about the ability of people in population health posts to be effective and competent – particularly in areas such as tackling infectious diseases. As one DPH put it to us: 'You would not have a director of finance in an ICS that wasn't a qualified finance person… so why do we treat population health as a discipline any different?'

However, in the view of others – particularly those actually in population health leadership roles – these fears were borne out of a misunderstanding of the role they were undertaking. The focus was not on technical roles replacing or duplicating

public health roles but rather on 'leadership, assurance [and] enabling'. Many saw themselves as operators within the ICS, doing the work of 'system knitting' in terms of trying to bring people together from disparate parts of the system to address key issues such as health inequalities. This, it was argued, was what directors of population health need to be good at – calling on the expertise of public health colleagues, alongside others, rather than being subject matter experts per se.

We also heard a range of views about the pros and cons of people moving between public health and population health leadership roles. Some saw having someone move from a role such as a DPH into a role as a director of population health in an ICS as a good thing, as they could bring their understanding of public health and its ways of working into the new role and context and help bring together and integrate local government and NHS work and expertise. However, others worried about people taking this trajectory. While taking this route may be advantageous for the individual concerned, and there were no issues around skills and competency, for some this felt like a drain on the public health profession – with highly qualified people taking knowledge away from where it was perceived to be most needed and into a new organisational and professional context. As one national public health leader put it to us:

> *A whole load of people who used to be directors of public health have gone on to be population health specialists… there's less stress involved. There's more money. There's greater independence.*

**Future leaders**

Public health specialists go through a long, intense and holistic training programme, equipping them with the technical skills, experience and leadership development skills that they need to progress in public health roles, in the NHS, local government or elsewhere.

We spoke to a number of public health specialists and newly promoted DPHs during this research. They could see some of the benefits of the development of population health in the long run, but some were concerned about the short- and medium-term implications, including for the pipeline of future public health trainees – that is, would the current route be as attractive in future? – and their own career choices. In their view, the issue of definitions and language mattered a lot. In particular, they thought that the language of population health can be

perceived to 'mask', misinterpret the role of or devalue the skills of public health professionals. Other areas of worry related to relative pay (between the NHS and population health roles, and local government and public health roles), the status, and the competencies of those in population health roles, without formal public health training or accreditation.

## Issue 2: Integration and integrated care systems – opportunities and challenges

Intertwined with the above were views about integration and ICSs, the opportunities within them and how things were working in practice.

### The opportunity of integration for public health and population health

There was a general, if not universal, consensus from the roundtables we held for this research that the introduction of ICSs had brought a new set of possibilities for public health and population health. One ICS chief executive told us that by:

> *…forcing people to look at what they can achieve together, ICSs are making a real difference from previous iterations of health service organisation.*

The focus on health inequalities in integrated care boards (ICBs) and integrated care partnerships has been particularly important in this. For DPHs, this can help them share responsibilities and relieve capacity issues, as well as progressing the wider determinants of health and health inequalities agendas. Recent research suggests that ICSs are making some progress in delivering on this (**Buck 2024a**). And it is encouraging to see both the Integrated Care Strategies and the Joint Forward Plans having such a strong emphasis on the wider determinants of health, and on their role in health inequalities in regards to health care, and more widely.

Many of those we spoke to said that the introduction of ICSs had led to them initiating new projects and new relationships, and that the collaboration between DPHs and ICS leaders in population health had had a galvanising effect. For their part, national and regional leaders emphasised that integration aims to ensure a public health voice across the system, and ICB structures and ICS roles were designed with that in mind. However, there was recognition that there are difficulties with how this is being implemented.

## Challenges to integration in practice

Despite the opportunities inherent in the creation of ICSs, there are challenges to the integration of public health and population health in practice. Some of these challenges relate to the internal working of ICSs as they develop, but others relate to external pressures.

### Internal pressures – priorities

ICS partners have an explicit duty to collaborate. However, some of those we talked to thought that ICSs remain 'primarily NHS constructs' and that genuinely breaking down barriers between different partners remains a work in progress. This is particularly an issue for local government, and DPHs, who have in some cases found influencing within new integrated structures challenging.

Some DPHs we spoke to about this felt that this was a problem that was almost intrinsic to how the systems have been designed. NHS organisations tend to focus on downstream, health care-based activity, while DPHs are focused on the upstream wider determinants of health. When ICSs are not working well as partnerships together, this can lead to a separation of activity and lack of connection. Overcoming this requires capacity and effort from public health and population health leaders to 'map' NHS, local authority and other responsibilities and supporting mechanisms, and think about how they best complement one another and fit into a coherent whole. However, this is not always happening, and some DPHs we spoke to discussed the practical difficulties of working to different strategies across the NHS and local authorities where there has been insufficient attention to their alignment.

It was not only DPHs who faced challenges – people in population health leadership positions within ICSs also did. One person in such a role who we spoke to reported that they felt like people working in population health were often 'lonely voices' in their systems and that population health, health inequalities and prevention were slipping back down the agenda and at risk of being subsumed by other internal priorities. They thought that the buy-in of non-specialist roles, essential to make an impact, was being lost.

These internal pressures affect some places more than others. And a DPH noted that some ICSs are far more challenging from a system leadership and co-ordination perspective than others, largely due to issues of size and co-terminosity.

**External pressures – operating budgets, system finances and waiting times**

One of the overriding issues that our research participants raised was the impact of operating budget cuts that ICBs are having to implement. This is compounded by the fact that ICSs' primary pressure from the centre of government at the moment is to deal with crises in acute care, finances and waiting times.

As one ICB chief executive told us:

> *Having your finances under control… allows you to innovate and partnership work in a more confident way than if you're, you know, having to retrench and decommission and all of those difficult issues.*

Therefore, the uncertainty that ICSs are facing means that, at the moment, 'ICSs aren't as transformative as they might be'. This has knock-on effects and has led to concerns about whether the potential for furthering public health and population health agendas may wane as ICSs develop further. In particular, there was strong concern among our research participants that population health may be a short-lived area for the attention of the NHS. This affected those in leadership and wider population health roles, who in some cases were concerned about the longevity of their projects and own positions, often being on short-term contracts. It also affected some DPHs who were wary about investing time in building relationships and joint working if there was potential for the focus on population health to wane over time.

**Time needed – good practice is emerging**

Finally, the cultural and structural changes required to fully realise the opportunity of ICSs clearly need time to bed in. Our inquiry was conducted 18 months after ICSs gained full statutory powers and we heard optimism that, given time, resources, sufficient attention and bandwidth, ICSs will realise their full potential and we will see public health and population health working well together. We set out examples of this, and how relationships are developing in practice, throughout the rest of this report.

In our view, a long-term commitment to ICSs and the principles that underlie their creation in the first place, facilitated and supported by clear national leadership that helps resolve the challenges outlined above, will help further the integration of public health and population health approaches.

## Issue 3: The changing role and experience of the director of public health

The third inter-related issue is the role of the DPH and how it is changing in local government, and in relation to integration and the emergence of population health. As we set out in section 1, the history of the profession, the experience of the Covid-19 pandemic and the introduction of ICSs are all important context for understanding this and people's views on it.

### Influence since the pandemic

The Covid-19 pandemic led to an increase in both the influence and visibility of DPHs with their colleagues in local government, and helped in creating 'incredibly close working relationships' with local NHS colleagues. As one DPH put it:

> *When Covid hit, I think my skill base and the sort of technical skills that we bring – the expertise around public health – then became kind of more prominent and more important.*

How this would translate into a post-pandemic world was a question we asked DPHs in our work on the role of DPHs in the first year of the pandemic (**Ross *et al* 2021**). One of them then described the switch in emphasis as follows:

> *One of the… silver linings of the pandemic, if there are any, is that every council now understands what public health does and… values their public health team, their director of public health, and they understand practically why investing in public health is so important.*
> (**Ross *et al* 2021**, p 72)

In the present research, one ICB chief executive we talked to identified that the pandemic had stimulated a new type of public health leadership role for DPHs, identifying it as moving away from being defined predominantly around statutory responsibilities, and towards a more proactive and responsive role. Most of the DPHs we spoke to suggested that while this elevated role has decreased somewhat as other challenges have climbed the agenda since the pandemic, overall their level of professional influence in local government has resettled at a higher level than before the pandemic.

Thus, for most, the legacy of the pandemic has helped DPHs in their work in the past few years. However, we did hear concerns from some that, because of their (and their team's) work during the pandemic, there was a risk of them becoming seen in some places as the people who deal with crises, rather than experts with something to offer local government in 'normal' times.

### Developing 'health in all policies' approaches

One of the successes brought about by the 2013 reforms, and hastened by the experience of Covid-19, has been the development of 'health in all policies' (HiAP) approaches in local government, which aims to push public health thinking and influence into policy areas such as housing, transport and economic development. This is an extremely positive move in response to the challenge of the population's health and health inequalities. And it is very encouraging to see networks, such as the Local Government Association's HiAP network, and public health officer roles designed to bridge into other policy areas within local government, working well.

### The connection to the ICS

DPHs' influence within the ICS is derived in part from their formal roles – whether that is around the ICB or the integrated care partnership – and in part from their relationships and ways of working. For some, their interaction with the ICS was primarily through the integrated care partnership, which, while often productive, did not provide the access necessary for influencing public health decision-making across the ICS, particularly in terms of NHS activity.

Relationships can be key here. One DPH told us:

> *A lot of getting stuff done in that space is about relationships and just having to kind of let some of the chaos or perceived duplication or real duplication go a bit and just try and push where you can to influence and… just trying to move things forward and being happy with the wins that you've got.*

For others, however, relationships cannot overcome structural impediments:

> *You're banging your head against a bit of a brick wall for reasons that aren't about individuals but it's about the context?*

This is not all one-sided; one stakeholder indicated that DPHs need to earn their space within the ICB. The response for some DPHs was to focus on their 'local authority masters' rather than concern themselves too much with the ICS.

However, this is not inevitable. One ICS chief executive we spoke to had very clearly challenged those structural difficulties by: deliberately recruiting a 'system-minded' DPH for a joint appointment between the ICS and the council; empowering the DPH through ICS governance structures and resourcing strategies; and creating primacy of council structures – for example, by ensuring the NHS was involved in health and wellbeing boards where the DPH has a leading role rather than expecting the DPH to always 'come to' NHS structures.

### Stretch and wellbeing

Some DPHs expressed concerns about their morale and their future within the profession, including across their wider teams. These concerns were driven by a combination of: their capacity and being stretched and pulled in several directions; the funding situation in local government; uncertainty brought about by the emergence of population health as set out above; and differences in remuneration between NHS population health roles and local government public health roles.

Several DPHs expressed how the opportunity of seemingly better-paid, less-stressful population health roles was testing their long-standing commitment to their vocation.

Further, the experience of being at the heart of the Covid-19 response is still having an impact. For example, a recent survey in one region found that a third of local authority public health staff were still experiencing negative impacts since the pandemic, including anxiety and mental health problems, and almost half said that an increased expectation during the pandemic in terms of workload and pace had been sustained after it, leading to unfilled vacancies and staff turnover, among DPHs and others.

Some of these causal factors are endemic to the current public health set-up in local authorities, while others sit outside their direct control – an important consideration for any remedial action. But the key point is that, in combination, they are resulting in significant stress for DPHs and a challenge to their ongoing wellbeing, and this should not be underestimated.

### Restructuring?

One person observed that DPH budgets would have been better protected if they remained within the NHS. However, there was no real enthusiasm for any restructuring of the DPH role from the people we spoke to. There was a feeling that local government was the correct place for for DPHs and other public health and population health professionals to sit (rather than their previous home in the NHS) and that, if valued correctly and supported by wider systems and colleagues, DPHs could flourish in the context of all emerging policy agendas in health and local government. However, there was openness to the idea of joint appointments between the NHS and local government where they were appropriate.

# 3 Emerging practice: how are public health and population health leaders working on the ground?

The core issues discussed in the previous section emerged throughout our work for this report, but primarily from our roundtables with groups of different people in similar roles, and from the feedback we got from networks and individual stakeholders.

However, we were also interested in how things were actually working in practice. During the research we therefore conducted three workshops with specific sites to help better understand how some of the debates and dynamics were working out on the ground. We also checked in twice more over the period of the research with sites to understand any further changes. The successful practice that we saw in those sites informs this section, as does a wide array of other insight gleaned from stakeholders, engagement with professional networks (*see* the Annex for further details) and a survey that the Provider Public Health Network (PPHN) – a network of public health professionals working in NHS providers – undertook on our behalf. We also explore the roles of directors of population health in integrated care systems (ICSs) in more depth.

## Key themes

There was significant concern across areas about finances – for integrated care systems, for public health and for population health. With population health, funding for roles is often short term and fragile, and this, it was felt, was particularly unhelpful in terms of being able to facilitate long-term planning and getting the buy-in of key partners.

Overall, there was a general sense in the areas that the emergence of ICSs as organisations with a focus on population health could be a really positive development,

if pursued in the right way and through strong partnerships with those with public health expertise. As we argued in section 1, there is an opportunity here, but this means a focus on making progress in practice, and taking 'the heat out' of some of the debate about definitions discussed in the previous section.

The importance of people and stability in relationships over time was also frequently brought up, as was the need for data to create shared understandings of problems and potential solutions across geographies.

A final common theme was the recognition that co-terminosity between local government, the NHS and other geographic boundaries of public services is a huge advantage for the areas where it exists, as it cuts down the complexity of working together on public health and population health across organisations.

## Scale and configuration matter; there is no single blueprint

In this subsection, we offer vignettes from the three different areas, describing how things work at different scales and configurations. Rather than blueprints for others to follow, we intend these to provide insights that can help other areas think through what might work for them. In each one we discuss the specific context, the approach to working together and key challenges and solutions.

At the risk of being too clear-cut, at the highest scale of a large region with a multitude of ICSs, local authorities, other tiers such as combined authorities and complex boundaries, there was a sense of being very pragmatic (*see* case study 1), and making it work through lots of convening of expertise through action orientated partnerships on specific population health issues, the complexity of the organisational environment making more formal approaches harder to organise.

## Case study 1: A regional complex system – strategic partnership between region, ICS and place

### Context

The 'West Midlands' is a complex area with a large number of urban centres and more rural areas. It has six ICSs who are seen as the west midlands, as part of the larger NHS Midlands region, and a large number of local authorities. There is also a combined authority which covers three ICSs (in reality 2.5, as only Coventry is included of the Coventry and Warwickshire ICS) and seven upper tier local authorities. This brings a lot of multiple relationships and little co-terminosity. Approaches and models of population health and public health working together differ widely across the area, and there is no common approach. There is also no particular 'regional identity', which is thought to be important to help cohere effort. However, it was judged that one is slowly building over time.

### Approach

Given there is no single common approach to how population health and public health leaders work together there is a lot of effort spent on convening, information and intelligence sharing. The regional director of public health and their team, and the West Midlands Combined Authority (WMCA) play important roles in this, alongside networks of DPHs and others and regular whole-region training and connections days for future leaders, including public health trainees. As a result of this effort people do know where to go for different issues, who to speak to and where responsibility lies.

### Challenges and solutions

Funding remains a big challenge: many population health and public health pieces of work are being funded in time-limited projects and at small scale, which is recognised to be less effective and efficient. There are challenges around working out who should do what around population health and public health agendas, because with so many actors it can be hard to assign work, and it's hard to build a shared narrative. There are still risks with the complexity '…around role, responsibility and accountability. That's where things can feel quite confused'.

*continued on next page*

## Case study 1: A regional complex system – strategic partnership between region, ICS and place *continued*

The overall sense however was that there's no real way round the complexity, people 'get on with it' and a key part of the leadership role is getting good at building relationships and navigating; that included letting go of the focus on getting it right in the abstract and definitional and system neatness. Two examples of areas where strong partnerships at regional level and below have led to action are set out below. These draw on the strong regional collaboration between the WMCA and the Office for Health Improvement and Disparities (Midlands), which has significantly advanced the understanding and capability around population health, health inequalities, and the wider determinants of health in the West Midlands.

*Employment and health – partnership between region, ICS and place*
Through regional collaboration, one of the key successes has been the establishment of multiple programmes within employment, housing, and transport, supported by guidance from public health experts seconded from OHID. Notably, the Thrive into Work programme, part of the government's 'Individual Placement Support' in Primary Care initiative, has emerged as a national exemplar. Furthermore, the collaboration between WMCA, OHID and the three ICSs, supported by DPHs and their teams, led to successful bids for the WorkWell Vanguard programme. Three of the 15 bids selected nationally were from the WMCA footprint. This achievement underscores the region's leadership in linking employment and health initiatives, ultimately enhancing the economic activity and health outcomes – both physical and mental – of the West Midlands population. This case highlights the critical role of strategic partnerships in driving forward population health improvements in complex regional settings.

*Health Equity Advisory Council – region, ICS and places supporting the mayor*
The WMCA published a landmark *Health of the Region* report in 2020 (Martino *et al* 2020), revealing deep-rooted health inequalities that had been exacerbated by the Covid-19 pandemic and have continued to widen since. The urgency of this situation led to the formation of the West Midlands Mayor's Health Equity Advisory Council (HEAC), its purpose to address population-level health concerns and develop collective actions to reverse the troubling trends that have persisted for more than a decade. HEAC is chaired by the Mayor of the West Midlands, and includes the

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### Case study 1: A regional complex system – strategic partnership between region, ICS and place *continued*

mayor's political adviser, the WMCA's head of health, the chief executives of the three Integrated Care Systems (ICSs), the chairs of the three Integrated Care Partnerships (ICPs), the regional director of public health from OHID, and representatives from the directors of public health across the West Midlands. HEAC's initial focus has been on the region's low levels of physical activity, some of the lowest in the country, recognising its critical role in reducing cardiovascular disease and obesity – two of the leading causes of preventable death in the region. This in turn supports the regional ambition to improve health in the workforce, seeking to reduce economic inactivity through prevention.

Our second case study is at single ICS level, albeit one of the largest ICSs in terms of population and geography. Here a much more formal and explicit approach was taken, especially around clarifying where responsibilities lay between the 'public health family' as a whole and how it interacted with the integrated care board's (ICB's) senior leadership. In this ICS, there is an important senior leadership role in terms of a part-time director of population health management, and the public health community is explicitly brought in to work alongside this director and the ICB senior leadership. In this case study, external organisational support was also called in to help clarify and define roles and contributions.

### Case study 2: Being explicit about public health and population health roles and 'offers' in a complex system

#### Context

North East and North Cumbria ICS is a single ICS across a very varied geography with cities, towns and significant rural tracts covering 14 local authorities. There is a strong existing history of good relationships and challenging deprivation at urban and rural level.

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## Case study 2: Being explicit about public health and population health roles and 'offers' in a complex system *continued*

### Approach

From the inception of the ICS there was a strong desire to make the most of the expertise and contribution of the 'public health family', alongside a population health management function, including a part-time director. Being explicit about contributions and being transparent about tensions have been a key part of relationships and behaviours, alongside mechanisms to resolve them.

### Challenges and solutions

There is an existing and well-functioning network of DPHs who work jointly with the Office for Health Improvement and Disparities, the UK Health Security Agency, the Director of Population Health Management and NHS trust public health consultants on developing a coherent 'public health family' offer to the ICS.

In the wake of the creation of the ICS, effort and resources were put aside to develop explicit agreements between DPHs and the rest of the ICB leadership on: which issues the public health community would lead, advise and collaborate on; and what explicit system leadership principles and behaviours were expected from all parties. This included asking other key leaders in the ICS what they needed, and what public health could do differently.

The following represents what was agreed the public health family would do.

- Develop, adopt and deploy a shared public health family narrative, with agreement on roles, responsibilities and lines of communication.
- Invest in the public health family and in others – come together to share information and intelligence to operate more effectively, across the workforce not just specialist public health, helping new leaders to develop.
- Provide a clear position for, and with, the ICS – where the public health family lead, collaborate and advocate, focusing on population health gain, and provide clarity where public health input is required.
- Contribute to the ICS – setting out clearly what the public health offer is.

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### Case study 2: Being explicit about public health and population health roles and 'offers' in a complex system *continued*

The following is what was agreed the ICS needed to do, or do collectively, and differently.

- Focus on what it can do best – act systematically and at scale on health care inequalities, and be a strong partner on the wider determinants of health (for example, have an 'anchor' role).
- Take subsidiarity of place seriously – see place as the building block, with ICS action as required, working in partnership with other tiers (for example, combined authorities).
- Support and seek public health expertise as appropriate, timely and proportionate – go to the right people, at the right time, with the right issues.
- Ensure public health advice is given at the right level and contribute to public health infrastructure.

Investment in these agreements and the explicitness of them have strengthened trust and transparency. And while issues also arise, such as tensions around the allocation of resources, running cost cuts and the balance between disease prevention and wider determinants of health, they are openly and explicitly discussed and resolved. Critically, all partners have continued to develop and work at this over time.

This case study has been published as part of the Faculty of Public Health's good public health practice in ICSs and ICBs (**Faculty of Public Health 2024**), where more detail can be found, including on communicating and working more effectively to support the ICS, partnership working and the representation of public health in key decisions.

Our third case study is different again and is at the (metropolitan borough) local authority level. At place level there are currently no directors of population health or similar, but in this example there is such a role at ICS level. How this connection between the ICS and place, and between the NHS and local government in place, worked was the focus of this example.

## Case study 3: Population health at place level?

### Context

This is a mixed urban and rural local authority with challenges associated with deprivation. Given it is a local authority, there is no director of population health embedded, but there is one at the level of the ICS.

### Approach

This local authority is trying to use population health data to help it to plan service delivery and build a focus on inclusion health groups.[2] This has meant linking up with the newly formed ICS and taking seriously the impact that councils can have as delivery vehicles for public health and population health work, through their power over the wider determinants of health.

### Challenges and solutions

We heard that specific funded roles were being developed to help bridge the contribution of local government and the NHS, and reach across the level of place and the ICS. For example, a specific role for health inequalities had been created to do this. There was an active effort to develop the links and web of inter-relationships further between the NHS and local government at place level, and between the ICS and place around health inequalities, with the aid of the DPH, the director of population health and other partners.

Financial pressures were a major challenge to this work and ambition. There were also challenges over long-term planning, and the extent to which people felt able to trust that the current NHS focus on health inequalities and population health would endure.

2 This is a term used to describe people who typically experience multiple overlapping risk factors for poor health and are at risk of experiencing very poor outcomes – for example, people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

## The emerging role of director of population health within ICSs

The role of director of population health (as stated earlier, with variations including additional phrases such as 'and health equity' or 'management') is still emergent. During our research we heard many strong views about how this role should develop, what its responsibilities should be and who should be appointed to it. These views, predictably, reflected the debates about what the nature of population health is, as discussed above.

In practice, though, we found that what a director of population health's role is, and what it isn't, is decided by the context in which the director operates. As we have argued above, the scale and configuration of ICSs – and most directors of population health sit at this level, although some roles are starting to develop at trust level – mean that the role is likely to continue to vary in the future. The role is being interpreted pragmatically, to fill perceived gaps or needs in the pre-existing local public health and population health infrastructure.

We have not systematically evaluated job and role descriptions for this project. But we have seen the following areas of focus.

- A focus on bridging between complex geographies, organisations and communities. This is particularly true in larger ICSs where there are multiple boundaries, multiple DPHs and wider public health professionals and teams, but is present in different ways in smaller systems too. Through this approach, directors of population health can play a dual role: helping connect the expertise of public health colleagues and ICS leaders, as well as leading in more specific areas. In some cases this role also has a focus on bridging into and partnership with communities.
- A focus on health care public health. This is a narrower focus, and can be in an ICB or provider trust context, where the role is principally to lead on health care public health areas.
- A focus on population health management. A core function of some directors of population health (management) is to provide, develop and analyse data and present it to assist ICS and wider system decision-making. This can be focused on developing better pathways of patient care, connecting the NHS to local authorities for better planning or a combination of the two.

- A focus on health inequalities and equity and the wider determinants of health. Directors of population health are being asked to provide a cross-system perspective on health inequalities and to support health equity approaches in their areas. They are also supporting 'anchor approaches'[3] and the contribution of the NHS to work on wider determinants of health such as economic development and procurement.

What we have not witnessed or heard about is what some feared in theory – a current director of population health who is seeking to mirror or duplicate DPH roles directly. It is also important to say that there are some ICSs that do not have a director of population health or equivalent, and also that some directors of population health are present in large trusts and teaching hospitals.

One further example – from Cheshire and Merseyside ICS – is worth sharing, which in particular focuses on the bridging role outlined above. In this example, a former DPH from the region has filled the post of director of population health in a large ICS with a network of DPHs. The role was developed with the support of the area's DPHs, and is an example of distributed, shared and aligned leadership between population health and public health. The post-holder acts in many ways as a bridge between key ICS decisions and those at place level. This works well since there is a high level of trust, and clarity over role and purpose. Although unlikely to be directly and quickly replicable elsewhere, it shows the value of the bridging role in complex systems. More details are provided in the box below.

3 Anchor approaches are based on the recognition that large public institutions are 'anchored' in places and can therefore affect the health and wellbeing of communities over long periods of time through the impact they have on the wider determinants of health as well as through their direct delivery of care – for example, through their purchasing power, through shaping local economies, through active employment strategies to help unemployed people into work and through sustainability policies that improve the environment. For more on this role, *see* the **Health Anchors Learning Network (no date)**.

## Bridging role of a director of population health

### Context

Cheshire and Merseyside ICS is the second largest ICS in England, supporting a population of 2.8 million people. It faces numerous challenges. Many people in the sub-region's nine local authority areas are living in poverty and deprivation, which impacts health and wellbeing. Compared to the England average, life expectancy is lower for men and women, many areas have below average levels of healthy life expectancy, levels of fuel poverty are higher (since 2016), and alcohol and drug misuse is higher in many areas. There are more than 100,000 children aged under 16 years in Cheshire and Merseyside living in low-income families; the impact of poverty on child health is well known.

### Approach

The director of population health works in partnership with the nine DPHs, meeting regularly as the Cheshire and Merseyside Directors of Public Health and Population Health Executive Board. The board has developed over 20 years, pooled resources and received external funding to create the Champs Public Health Collaborative and run specific programmes of work, innovative pilots and behaviour-change campaigns. The directors are a distributed leadership team, influencing strategic policy-making sub-regionally and nationally. The Collaborative's work is supported by a dedicated team of public health, programme management and communications professionals – the Champs Support Team, hosted by Wirral Council.

The NHS Cheshire and Merseyside ICB director of population health (a former DPH in Cheshire and Merseyside) joined the Collaborative's board as an equal partner and 10th director in 2023. This appointment signals a complete alignment of public health priorities and population health leadership between local government and the NHS.

### Impact

This approach creates significant impact and demonstrates the value of DPHs and their teams working together, and with the director of population health, as a distributed leadership team. By working together, the model leads to change happening at a larger scale, enables opportunities for learning through a dedicated

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### Bridging role of a director of population health *continued*

continuing professional development (CPD) programme, and creates a culture of peer support and trust.

Cheshire and Merseyside's All Together Fairer programme is the sub-region's mission to reduce inequalities and improve health and wellbeing among its population, based on work with Sir Michael Marmot and University College London's Institute of Health Equity. A dedicated group of leads from across the local authorities meet regularly, enabled by the Champs Support Team, to drive forward their local plans and identify opportunities to work together. One example is a sub-regional approach to banning junk food advertising on council-owned advertising spaces, following a successful pilot from one area within Cheshire and Merseyside; another is the All Together Inspired online platform, which is for any professional in Cheshire and Merseyside (including in the private sector) to learn more about the social determinants of health and understand how they can reduce inequalities in their day-to-day work.

The ongoing success of the All Together Fairer programme has resulted in the ICB, supported by the director of population health, signing off on a significant distribution of national health inequalities funding to see through the sub-region's ambition to end smoking by establishing the All Together Smokefree programme, delivered on behalf of the ICB by the Champs Support Team. This will include a variety of elements, including behaviour-change campaigns, dedicated websites and digital solutions.

For more details on the Champs Public Health Collaborative, *see* **https://champspublichealth.com**

## Public health and population health: views from elsewhere

Our research included a wide range of engagements, and during it other surveys and case studies were also carried out and published, to add to the picture, including from the Association of Directors of Public Health (ADPH) and the Faculty of Public Health (FPH). We highlight some of this insight below.

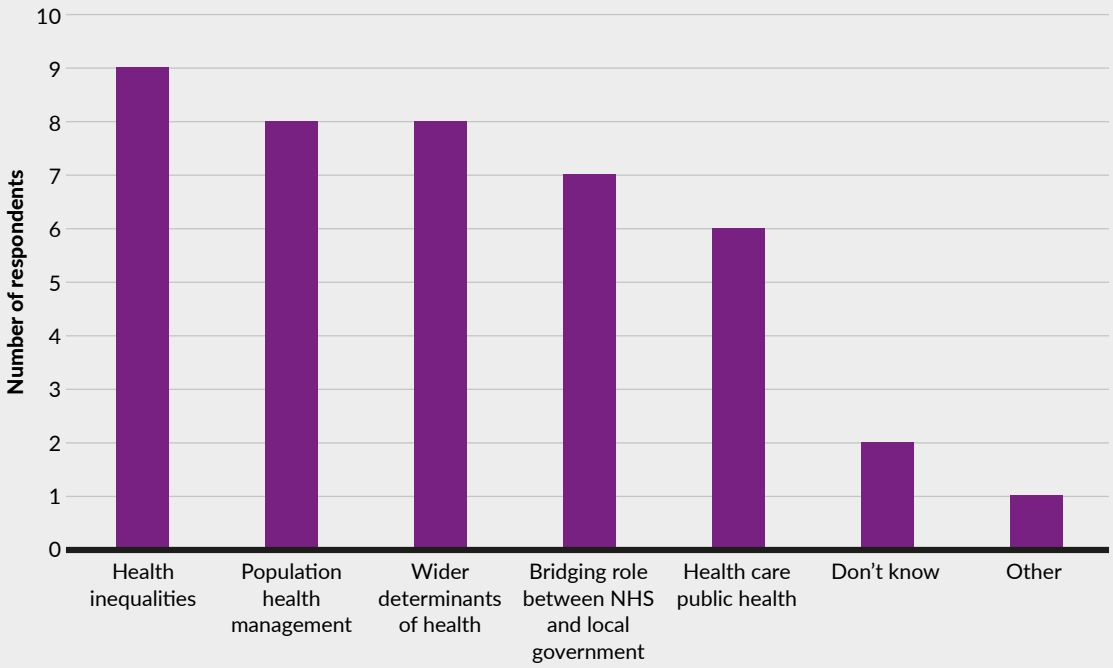
### The view from public health professionals within NHS providers

Despite the perception that public health is now 'in local authorities', the NHS still has – and will always have – a critical role to play in health care public health and there are many public health professionals in the NHS. Some of them are members

of the Provider Public Health Network (PPHN). The PPHN surveyed its members on our behalf to understand their views on how public health and population health were working in practice from their perspective. In total, 15 people with various roles responded, nine of whom were public health consultants either in an NHS trust or as part of an ICS more broadly.

Most of the respondents (11 of 15) said that there was a director of population health (or similar leadership role) operating at system level. We asked respondents what the main role of the director of population health (or similar leadership role in population health/health inequalities) was. Respondents were allowed to choose more than one role. There was a mix of roles and emphases, mirroring those set out above (*see* Figure 2).

**Figure 2: Main roles of directors of population health**




Source: Provider Public Health Network survey

Most of the sample worked with the director of population health at least monthly; only one reported never doing so. The types of interaction included:

- regular meetings on specific issues (for example, tobacco control or health equity)
- peer support of each other
- regional programme groups.

Most respondents reported that the interaction was generally or fairly positive (nine of 15), with two respondents saying it was fairly negative.

We asked for views on what would help enable ICSs to fulfil their principles in relation to population health, and how the future of public health and population health leadership in local systems needed to develop. People wanted a clear vision and leadership – reflected in documents such as the ICS Strategy and Joint Forward Plan – of public health and population health principles and greater clarity on the meaning of public health and population health and the distinction between them.

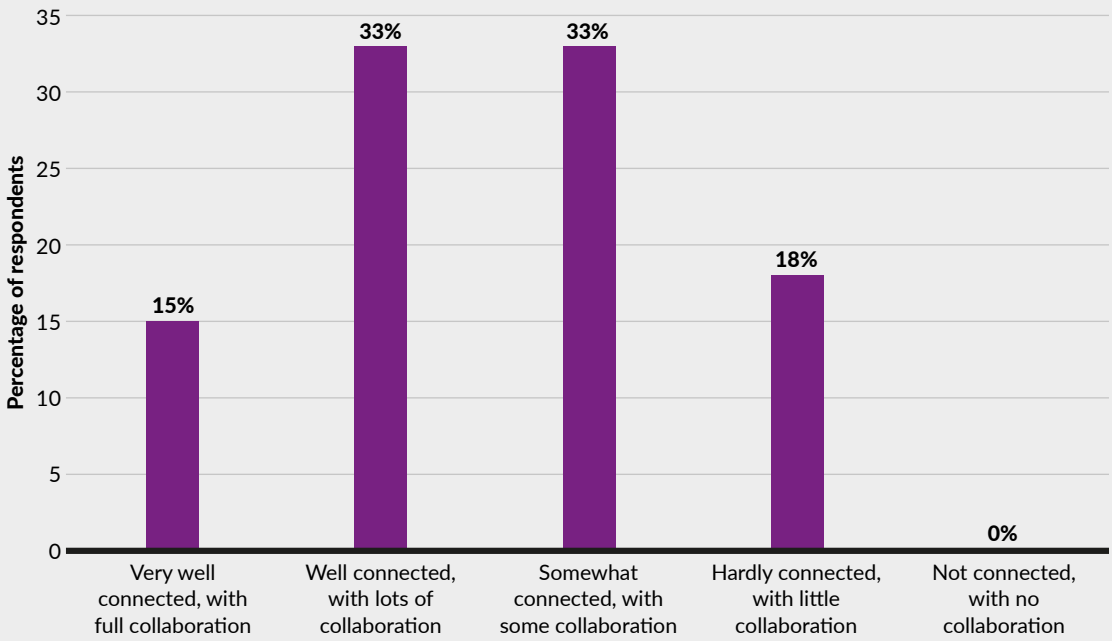
There was a concern about competencies, and whether a competency framework is required for population health or whether 'anyone can do it'. Around this there was a general view that more investment in people's skills was required. Some thought this meant that separate population health teams were not required, rather that existing public health teams and skills need to be considered as part of the wider system and resourced accordingly – as part of the integration of the NHS and local government. Others thought it was broader and meant investing in and drawing on the skills of all senior leaders, not just those with a public health role or background.

### The view from directors of public health: the ADPH survey of working in ICSs

The Association of Directors of Public Health (ADPH) has recently surveyed its members about their experiences of working with and in ICSs (**Association of Directors of Public Health 2024**). It has made a set of 10 recommendations, with a focus on appropriate resourcing, co-terminosity where possible, prevention and partnership. Most respondents had just one ICS in their area, though most of the ICSs covered more than one area; 1:1 co-terminosity is rare. As our work also shows, how each ICS works and the configuration with DPHs differ, so there is no blueprint for how population health and public health should work together.

Most DPHs (83%) in the ADPH survey said that their ICS had its own population health infrastructure, separate from the local government infrastructure. Most felt connected to this infrastructure, with no respondents saying there was no collaboration. Around half felt very well or well connected, and half less so (*see* Figure 3). Given that ICSs are new organisations, in our view this is positive, although clearly collaboration is working better in some areas than others. The ADPH has recommended that increasing the amount of joint working should be a key focus for ICSs.

**Figure 3: Collaboration between ICS and local government public health teams**




Source: Association of Directors of Public Health (2024)

The collaboration seen is achieved through relationships, joint areas of work and, in some cases, joint posts between the NHS and local government. Of DPH respondents, 58% said they had joint posts or strong links working with public health personnel employed locally and regionally. Many of these were directors of population health, and consultants in public health within ICSs. While the ADPH welcomes joint working, they also raise the risk of parallel and unco-ordinated competition for scarce public health expertise between local government and the NHS.

### The view from local government leaders: staying practical

We were fortunate to be able to speak to a range of local government chief executives and also interview other local government leaders and stakeholders. Our wider findings, including the tensions we found, resonated with this group, such as the strengthening of the DPH role in local government since the Covid-19 pandemic and that ICSs are still evolving and relative roles, powers and influence between system level and place are still being settled.

One particular area of nuance was the connection between ICSs and district councils. The King's Fund has previously explored the contribution that district councils make to the public's health (**Tiratelli and Naylor 2023**), existing examples of partnership working between ICSs and district councils, and the need to do more to strengthen this. The connection with ICS directors of population health is an underdeveloped area and one with great potential.

# 4 Recommendations and principles for success

Through the course of this project, we spoke to both specific places and to specific professional groups, in interviews, roundtables and through networks and forums. Common themes emerged that either underpin successful practice where it is currently occurring or are things that national leaders need to act on to support positive outcomes. In this section we outline recommendations for national leaders and principles for practice.

## Recommendations at the national level

Recommendations at the national level support each other. Moving forward on each one is necessary but not sufficient on its own, and the success of each one is dependent on the others. We therefore urge national leaders to see them, and respond to them, as a set and not a menu to choose from.

### Recommendation 1: Provide clarity on the definition of population health (and its relationship with public health) and a facilitative framework for responsibilities and roles

From the very first roundtable we held, the biggest and most contentious issue we heard about was a search for clarity on the concepts and definitions of population health, and how population health relates to public health.

The issue with these often-unspoken disagreements about language is not that one group is right and other groups are wrong. The issue is that the lack of a shared understanding leads to confusion, preventing effective system working and sometimes causing mistrust between colleagues in different roles.

From this flows many of the other questions and issues, including perceived or real duplication, issues of competency, and competition for scarce resources and

expertise. This lack of clarity gets in the way of good work, practice and intentions and, in our view, powerful joint leadership communities operating across the boundary of the NHS and local government to improve the health of the population and tackle health inequalities.

There is a real and urgent need for national-level leaders to provide clarity here. We heard different views on what 'the answer' was to this problem: from a top-down conceptual definition with a clear framework of responsibilities, to a more facilitative approach, setting out examples and possible roles in a broad framework. On balance, we believe the latter is more preferable, given the great range of contexts, scales and system architecture that exists in practice. But all those we spoke to are looking for leadership on this from national leaders.

As part of this, there needs to be more support for leaders in director of population health roles (and the teams around them). In our view, this can be a lonely and isolated position, and there is no current network, support system or infrastructure to bring them together as a community. Given these roles are principally located in ICSs (and starting to emerge in acute trusts), NHS England needs to address this in the first instance, with support from others.

**Recommendation 2: Provide medium- to long-term commitments on population health resources and public health capacity**

Most people we spoke to during our research saw opportunities in the NHS's embrace of population health. But we also heard that the status quo feels fragile in terms of resource commitment, as a result of things like short-term funding for population health support roles. We also heard how public health expertise is stretched, especially in terms of DPHs being asked to offer support into ICSs from local government. We also heard that there is a shortage of public health expertise (including in consultant roles) available across the NHS and local government, and across public health and population health roles. This can lead to damaging competition, especially where terms and conditions for public health and population health roles and/or sectors are asymmetric.

We recommend that the Department of Health and Social Care works with the key public health leadership bodies to tackle each of these issues, through:

- monitoring and, where appropriate, intervening to support the development of ICS population health and public health infrastructure
- further investing in public health capacity and training
- developing guidance on the expected behaviours from system partners in terms of relative terms and conditions between sectors and having a collaborative, system-wide approach to recruitment
- using the government's upcoming 10-year health plan to reaffirm a commitment to public health and population health approaches
- tracking evolving progress over time and intervening where appropriate to ensure it continues.

Action in these areas would help leaders in public health and population health in terms of their planning, alignment and ability to maximise their impact.

**Recommendation 3: Allow structures to mature and reaffirm the principles of ICSs**

Achieving public health and population health goals requires the co-ordination of efforts across a range of organisations and professional groups. Accordingly, establishing and bedding in ways of working between these different actors are crucially important.

A persistent worry that we heard from people across leadership positions in public health and population health was that organisational restructures in the NHS would set their work back or that their focus would be narrowed to access and finance goals. The message conveyed was that the current structures can deliver positive public health, better population health outcomes and improved equity if they are allowed to bed in and mature, but continued uncertainty can affect commitment to that. Similarly, where government policy is developing, for example around devolution and the role of combined authorities, things will be more coherent where they can align and engage with stable structures that are clear about principles and goals (Goodwin *et al*, forthcoming).

We therefore recommend that NHS England and the Department of Health and Social Care explicitly emphasise, communicate and support the principles of ICSs around population health, tackling health inequalities, public health in the NHS and the partnership with local government public health expertise. They could do this in a variety of ways, but again, the upcoming 10-year plan will be an important document for setting the tone in this regard.

**Recommendation 4: Actively share emerging practice and experience**

How public health and population health leaders work together and interact, the tensions and challenges this creates and the opportunities it offers, need to be more widely shared. There is no blueprint for this, which makes sharing experience, successes, trials and error all the more important if ICSs, local government and others are to deliver on their core principles to improve population health and tackle health inequalities. We heard many times that this is what people want in practice, and they are looking to national leaders to provide it.

While the Association of Directors of Public Health (ADPH) and Provider Public Health Network (PPHN) surveys are a start in this process, as is a recent list of case studies on public health contributions to ICSs that the Faculty of Public Health (FPH) has produced (Faculty of Health 2024), this is not sufficient and is piecemeal. We recommend that key leaders in NHS England, the Office for Health Improvement and Disparities (OHID), the UK Health Security Agency (UKHSA), the Local Government Association (LGA), the ADPH and the FPH (as a minimum) come together to co-ordinate this further and produce a range of further examples and learning over time. Beyond this, these organisations should jointly support collaborative capacity and capability building in, and between, public health and population health.

## Principles for leading and working together across public health and population health

We believe that action on the recommendations at the national level set out above will help local practice develop. But we are already encouraged that despite the challenges outlined in this report, in practice there are many examples of good and productive working, that DPHs have established themselves further at the heart of local government decision-making, and that population health leaders are making progress, in partnership with public health colleagues, through their roles in ICSs.

We set out below a set of principles drawn from what we have heard that may be helpful for others who have further to go.

### Principle 1: Remain focused and lead for population health outcomes

When multiple organisations and professions work together – especially at a time of uncertainty, financial pressures and change – a major risk to productive collaborative working is that people remain only focused on their own direct responsibilities, roles and accountabilities, and those of their organisation. From our wider work and facilitating and supporting many public health and population health leaders over time, we believe that each system should develop key principles around what it means to lead jointly for population health outcomes and health equity. Examples from systems we have worked with are available from the authors on request (subject to the agreement of those systems), but areas that they cover include developing shared 'I will' personal leadership principles on how to work for population-wide outcomes through:

- using own power and position
- supporting the organisational 'home'
- working in partnership with other public health and population health leaders
- sustaining effort over time.

### Principle 2: Develop a shared understanding of the conceptual and practical differences between public health and population health in your system

The national work recommended above should help enable public health and population health to work together more effectively, but if there is no clear and common understanding across systems of the conceptual and practical differences between public health and population health in systems, this will cause confusion and possibly duplication and gaps. We have seen across this research how, at all levels, a lack of a common understanding causes friction and issues. Successful systems are clear about the differences and the responsibilities and roles that follow (*see* below).

### Principle 3: Be explicit about who will lead on what through the ICS and other levels

ICSs are partnerships, reliant on the contribution of NHS organisations, local government, the voluntary and community sector and other partners. The most successful places we have seen in this research are those where the public health community, ICS population health leaders and wider leadership take the time to come together and reach explicit agreement about relative contributions.

That means being clear on the following.

- Who will lead on what area?
- In what areas is the principal role advice giving?
- In what areas is the principal role information giving and information sharing?
- In what areas is collaboration most important?

One of our case studies did this particularly well. In another area, one ICS chief executive we spoke to had supported the recruitment of a 'system-minded' DPH into a joint appointment between the ICS and the council, empowering the DPH through ICS governance structures and resourcing strategies and ensuring the NHS worked through existing structures – such as health and wellbeing boards – rather than assuming that it was the DPH and council's responsibility to integrate into NHS structures.

### Principle 4: 'Start somewhere, follow it everywhere'

Another message we heard from people we spoke to during this research was that a strategy that had enabled progress towards public and population health goals was to 'start somewhere, follow it everywhere'. Find somewhere to start; this may be a place that is easiest because it is clear that goals are shared or quick wins are available. Working in one area well builds confidence, helps develop relationships and ways of working and offers general lessons for other areas. Case study 1 is an embodiment of this principle: the more work it does in practice, the easier the complexities of a complex geographical system can be overcome.

### Principle 5: Pay attention to and support public health and population health workforce wellbeing

Workforce wellbeing was not a focus of our work in this project. But it has been clear through doing it how stressed the public health and population health workforce are due to a combination of well-known factors, including capacity issues, resource constraints and the long shadow of working through the Covid-19 pandemic. Resources are available from the Faculty of Public Health (**Faculty of Public Health no date**) and others to provide support with improving wellbeing, and we recommend that every area gets in touch with its regional lead if help is required.

### Principle 6: Plan for, and commit time to, being together beyond the day-to-day

Dedicating time and resources to implement these principles is a prerequisite for success across systems, regions and places. This takes time, effort and ultimately trust, and it is not an easy process. It can be achieved in several ways, but it requires leaders in public health and population health to recognise both the contribution of each other and the challenges and tensions that exist. This requires explicitness and seeing it as an ongoing process, not a quick fix. Some of the places we spoke to had hired people into specific 'system-knitting roles'; others brought in external facilitation, as in the North East and North Cumbria ICS. There is no right model. In highly stressed and uncertain times it is easier to not find the time or resources to do things. But that is a false economy.

# 5 Conclusion

Our starting position for this work was both an urgent and an optimistic one: that the health of the population in England has stalled and is worsening for many, while the health and care system and the people who serve in it are under significant stress and face many challenges. But also that the coming together of existing public health leaders, with their expertise and experience, and a new emergent cadre of leaders for population health, offers a positive response.

Our work has found that this optimism was justified and there is lots of good practice, happening in good faith, as the challenges are tackled. But this is not yet at its full potential and there needs to be stronger national leadership in some key areas, including:

- providing a clearer conceptual framework for how public health and population health relate together
- investing in workforce capacity and resources
- sharing good practice and emerging models of collaboration between public health and population health.

This would help give local systems certainty that national system leaders will support, encourage and facilitate them as they invest their time and effort in doing collaboration work locally.

# Annex: Methods

Our approach to this project was based around a series of roundtable discussions, interviews and engagements with professional organisations, networks and forums.

- First, in autumn 2023, we ran four 'position' roundtables with key professional groups involved in public health and population health leadership. These included: directors of public health (DPHs); national and regional public health leaders; emerging population health leaders; and related professionals in local government (people who work alongside DPHs in roles involving the wider determinants of health and bridging across into other local authority directorates). We selected attendees through a combination of professional networks and snowballing techniques, and we spoke to more than 25 people through these sessions.
- In early 2024, we ran three further roundtables with specific sites (our case studies) to explore how the dynamics we had heard about in the position roundtables were playing out in practice. We selected these three sites as areas where we had heard things were developing relatively positively. We also chose them as they represented three different spatial scales: a combined authority area, an integrated care system (ICS) area and a local authority area. In addition to convening a roundtable in each site, we checked in twice more over the course of the project to understand how the case studies were developing.
- To complement the roundtables, we conducted nine interviews with individuals representing groups we felt we had not heard from during the roundtables – primarily local government and ICS leaders. We purposefully selected these interviewees for their specific expertise.
- We used professional organisations, networks and forums to further expand the range of voices who could contribute to this project. We presented to and sought input from organisations such as the Local Government Association, NHS Confederation ICS Public Health Forum, and the Society of Local Authority Chief Executives (Solace). The Provider Public Health Network also offered to circulate a small number of survey questions from us to its members, which yielded more than 30 responses.
- We also convened an expert advisory group, which met three times during the project. This was comprised of key senior public health and population health leaders at national, regional and local levels.

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