accredited™ voluntary register

UKPHR
Public Health Register
Protecting the public – improving practice

UK PUBLIC HEALTH REGISTER

Response to Department of Health Consultation Paper on proposed statutory regulation of public health specialists

Contents: **Page number:**

October 2014

EXECUTIVE SUMMARY

In the public interest of a safe and effective public health workforce, delivering to consistent and appropriate standards, the time is right for a public health regulator to be created, building on UKPHR's existing registrant base, reach, networks and relations with other relevant regulators (including Memoranda of Understanding).

However, UKPHR opposes the Government's proposal of a Section 60 Order to implement statutory regulation of some public health specialists for the following reasons:

1. The proposal would further fragment the regulation of the public health workforce

2. There is a better policy option available that will ensure a more coherent approach to regulating the public health workforce as a whole in the interest of effective public protection

3. The proposal does not achieve its most important stated objective (equivalence for all the public health leadership group), in particular, there is no provision for revalidation

4. The proposal will cut across an intention to give a clearer roadmap for future career pathways and skills development

5. The proposal takes no account of practitioner registration and weakens the opportunity to ensure that practitioners are also fairly regulated to further support the public's safety

6. The proposal takes no account of developments in public health regulation since 2010 including accreditation of UKPHR's voluntary register under the statutory scheme put in place by the Government

These arguments are underpinned by the rationale for all such regulation, namely that protection of the public from harm should be paramount; they are expanded upon in this, UKPHR's formal response to the Government's consultation.

For any further information about this response and for correspondence generally CONTACT:

David Kidney, Executive Director,
UK Public Health Register,
18c, Mclaren Building,
46, Priory Queensway,
BIRMINGHAM B4 7LR

E; d.kidney@ukphr.org

T: 0121 296 4370

1. The proposed regulation

General points

Statutory regulation by the Health & Care Professions Council (HCPC) of just those public health specialists currently registered by UKPHR would cause additional fragmentation of the public health workforce. This is not in the public interest. It will not improve protection of the public from the risk of harm from public health malpractice.

UKPHR is not opposed to statutory regulation of the public health workforce but it opposes the proposal for statutory regulation of public health specialists by HCPC because this will cause fragmentation of the regulatory framework for the public Health workforce, not through criticism of the of HCPC.

Risk of fragmentation

The role of the UK's four Health Departments should be to unify the public health workforce to meet the Government's emphasis on the role of public health in prevention and health improvement and in reducing health costs.[1] The fragmentation that the Government's proposed course of action will cause is detrimental in itself but also undermines the Government's own stated policy for public health as a whole.

The current proposal adds another statutory regulator to a landscape already top-heavy with statutory regulators for what is a modest number of public health specialists (approximately 1,200 in the UK). This is not the way to proceed to secure the best outcome in terms of protection of the public from harm.

UKPHR currently registers approximately half of this leadership group. Some of these public health specialists are also already on statutory registers including the General Medical Council (GMC), General Dental Council (GDC), Nursing & Midwifery Council (NMC) and General Pharmaceutical Council (GPhC).

The registration regime operated by UKPHR is designed to be equivalent to GMC and GDC regulation for other public health consultants: this includes a revalidation process to ensure ongoing competence and a retrospective recognition of competence route, equivalent to the GMC's **CESR** (certificate of eligibility for specialist registration) route, to support the Department's public health workforce strategy aims, neither of which appears to be a feature of the proposed new statutory regulation with HCPC.

Potential for unified regulation

UKPHR registers public health practitioners alongside public health specialists and offers the potential for the comprehensive regulation of the entire spectrum of the public health workforce from practitioner to specialist by a single regulator.

There are advantages in regulating specialists and practitioners alongside each other. In UKPHR's experience, registrants are capable of learning from each other in matters of public health practice and continuous improvement.

[1] See for example Healthy Lives, Healthy People: Our strategy for public health in England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

Specialists also provide essential support to practitioner applicants acting as assessors, mentors and verifiers for the registration process. It is clear from feedback that registrants find this helpful: it gives a clear sense of identity, it aids greater understanding of points of practice and it strengthens interest in career development.

A case in point is the interest currently shown by registrants in proposals to develop recognition of an **Advanced Practitioner** status in public health practice. Managers of public health teams and practitioners in such teams alike are interested to learn how this development may benefit their teams' practice.

UKPHR is capable of working closely with other existing regulators, as has been demonstrated in its engagement with the GMC and GDC in respect of medical and dental qualified specialists. UKPHR has Memoranda of Understanding (MoU) with GMC and GDC and operates voluntary registration in a way that complements these existing forms of statutory regulation. This approach also enhances consistency in standards across the entire workforce.

If the case made by UKPHR is accepted by Government, GMC or GDC registrants who wish to register with UKPHR would continue to be able to do so.

UKPHR has had talks with the Nursing and Midwifery Council (NMC) and the General Pharmaceutical Council (GPhC) about similar MoU.

UKPHR has considered the recommendations made by the Francis Report [2] and has adopted a policy in respect of working with other regulators to enhance public protection consistent with the recommendations contained in the report.

This activity demonstrates the requirement for, and practicability of, a single regulatory agency for the whole public health workforce including practitioners and appropriate specialists.

Selection of regulator

The Scally Report [3]in 2010 discussed the options in relation to selection of an appropriate regulator. Whilst the report's recommendation was that HCPC should become the statutory regulator of public health specialists, the report's author examined the option (Option 4 in the report) of making UKPHR the statutory regulator.

UKPHR has, since 2010, addressed the report's stated disadvantages against Option 4 as they applied directly to matters within UKPHR's power (for example, reducing "back office costs").

UKPHR endorses the report's stated advantages of Option 4:

UKPHR already has expertise in the registration of public health professionals, and minimal disruption to the profession would be involved in this option.

The attraction of 'minimal disruption to the profession' has particularly strong resonance now in the light of the publication of the **NHS Five Year Forward View** and its prominent focus on the need to do more to tackle the root causes of ill health by a radical upgrade in prevention and public health.

[2] The Mid Staffordshire NHS Foundation Trust Public Inquiry
[3] Review of the Regulation of Public Health Professionals, November 2010

UKPHR's evidence

UKPHR surveyed all its registrants about the Department's proposals during 2013. A total of 140 registrants responded, a response rate of 20 per cent. A majority of respondents supported statutory regulation of the public health workforce (53 per cent in favour, 27 per cent against and 20 per cent unsure). When asked who should be the regulator, a clear majority - 63 percent - said UKPHR with 16 per cent favouring HCPC and 11 per cent suggesting GMC.

The practice of public health is multi-disciplinary therefore it is inevitable that other professional regulatory bodies will have an involvement with some public health professionals.

That said, there are groups of public health practitioners who are entirely unregulated.

The extent of dually regulated and unregulated groups in the public health workforce was elucidated in the mapping report of the Centre for Workforce Intelligence.[4] The research has concluded that the number of core public health workers in England is likely to range from around 36,000 to 41,000 people. Groups described in the report having variable or no applicable regulation include "public health managers" and some "public health scientists", "intelligence and knowledge professionals", and "public health practitioners".

UKPHR's alternative approach

UKPHR's vision is a single regulatory home for the entire public health workforce including practitioners and appropriate specialists. This would be a regulator established by statute operating a single public health regulatory framework capable of differentiating the required level and intensity of regulatory activity according to risk of public harm.

GMC or GDC registrants who might wish to dual register with the UKPHR would continue to be able to do so.

UKPHR therefore argues that the Department's proposal should not go ahead as described.

Instead the public health partners, including the regulators with an involvement in public health practice, should work with the Department to design a more comprehensive regulatory framework for the public health workforce. This approach would fit with the ambition for this workforce set out in the Department's 2013 workforce strategy.

While in development, public protection would be maintained as UKPHR already registers the Department's target group. The effectiveness of this registration as a form of regulation is recognised by the achievement by UKPHR of accreditation of its voluntary register under the current Government's statutory scheme.

Risk of public harm

UKPHR commissioned a report about the risk of public harm from specialist and practitioner public health malpractice. That report, published in 2011 pointed out that a failure of public health practice at the strategic level could be catastrophic in terms of public harm. This factor justified, according to the report, statutory regulation of public health specialists.

[4] http://www.cfwi.org.uk/publications/mapping-the-core-public-health-workforce

The report pointed out that failure of public health practice by *individual* practitioners can also be harmful to the public. A practitioner's contribution to health protection, health improvement and equitable access to healthcare services can impact adversely both on individual and community health (morbidity and mortality) and well-being. In addition, given that practitioners work one-to-one with members of vulnerable groups, there is a real risk of serious harm to vulnerable individuals.

For these reasons, the report concluded that regulation of practitioners was justified and should reflect the level and intensity of their roles and responsibilities.

In the years since the report was published, UKPHR has registered the first 130 public health practitioners and established standards of regulation appropriate to the risk of public harm their practice represents.

UKPHR requires practitioner registrants to make the same annual declaration as specialists in terms of conduct. UKPHR has devised a CPD scheme applicable to all practitioners which is set at a different, albeit appropriate, standard from that of specialist registrants.

UKPHR is actively developing plans to establish revalidation for the practitioner workforce appropriate to their practice (and the level of risk of public harm) but consistent with the principles of revalidation for the specialist workforce.

Impact on practitioner registration

To deliver the Government's public health policy, support for practitioner regulation and development needs to be a much more significant feature of future planning. Public health professionals accept that public health will continue to rely (and may even increase its reliance) on a model of distributed practice and leadership.

This model relies on the ability of practitioners in the wider workforce, and specifically operating at levels 5 and above in the Public Health Skills and Knowledge Framework, to build partnerships, negotiate, work in ethical and professional ways and apply public health skills effectively. A unified register enables distributed leadership to work more effectively because it creates a professional 'family' with an intense focus on standards and goals for the further development of the profession.

UKPHR's vision of a single public health regulator would ensure that the model of regulation supports the model of practice.

The Department has said, informally, that if the specialist registrants were to be transferred from UKPHR there would remain a valuable role for UKPHR in registering public health practitioners. As currently set up, UKPHR is only able to support practitioner registration because it can do so at marginal cost because the infrastructure for dealing with specialist registration is already in place.

UKPHR has become financially secure without any recourse to the public purse. This hard-won financial sustainability has come about because of the numbers of specialists and practitioners who choose to register and UKPHR's root and branch reform of its operations to maintain the quality of services in a demanding financial environment.

The Department's proposal to remove the majority of those registrants from UKPHR in a little over one year's time undermines this achievement of financial sustainability.

It is feasible that a voluntary register of public health practitioners alone could be operated in such a way as to be financially sustainable but the timetable proposed by the Department for removal of the bulk of UKPHR's income makes this less likely.

UKPHR would welcome discussion with the Department to examine this aspect of its proposal.

Public health workforce strategy

In order to deliver on some or all of the specific commitments set out in the Government's recent Public Health Workforce Strategy, the following additional actions are required of the Government (including via PHE):

- To ensure that the recommendation of the Scally Report (supported in the responses from the Faculty of Public Health and the Government's Health Protection Agency) that a revalidation process (such as that already in development by UKPHR and the Faculty, with support from the Department of Health) is introduced for statutorily registered public health specialists;

- To make a firm commitment to ensuring the continued implementation of practitioner registration, as part of its programme to strengthen the effectiveness and safety of the public health workforce;

- To ensure that there continues to be a mechanism for public health practitioners to be able to progress to registration as a public health specialist (currently the portfolio assessment route undertaken by UKPHR) to complement the Strategy's initiatives on developing a Skills Passport and updating the Public Health Skills and Knowledge Framework.

Should it be decided that the proposed transfer of the Specialist Register to HCPC is to be pursued, it is UKPHR's view that the timing should be delayed until 2017 to allow a safe transfer of the Specialist Register and the successful implementation of a voluntary Practitioner Register.

UKPHR would, of course, be pleased to continue to play a role in all the above areas, including administering the assessment of portfolios and/or the revalidation procedure on behalf of HCPC, either long-term or until HCPC can put effective internal mechanisms in place.

2. The draft Section 60 Order

An Order in the terms drafted would implement new and additional regulation, which will cause further fragmentation of the public health workforce.

It would entrench different approaches to the regulation of a single cohort of public health leaders.

UKPHR opposes the Section 60 Order as drafted.

Equivalence

Rather than bringing about equivalence to this public health leadership group, it would consolidate an artificial, demotivating and disruptive division.

Around 600 public health leaders (Directors of Public Health, Consultants in Public Health and Public Health Specialists) are already effectively regulated by the GMC and the GDC. Another 600, approximately, are registered by UKPHR.

GMC is required by law to operate a scheme of revalidation for its registrants once every five years. This applies to all its registrants including those whose registered specialty is public health medicine.

GDC is designing a revalidation scheme for its registrants. It is intended that this will apply to all its registrants including those whose specialty is dental public health.

UKPHR is not required by law to operate a revalidation scheme for any of its registrants. Nevertheless, in recognition of the importance of equivalence (in terms of consistency, public protection and the wishes of the public health leadership group as a whole), UKPHR is developing a scheme to match the GMC's system for revalidation in respect of its specialist registrants.

Together with the Faculty of Public Health, UKPHR successfully obtained grant funding from the Department of Health to design and successfully implement a revalidation scheme.

UKPHR is in a position to introduce revalidation for its specialist registrants, thereby ensuring equivalence with the GMC and GDC schemes.

The draft Section 60 Order does ***not*** require HCPC to revalidate those specialist registrants transfering, under its terms, from UKPHR to HCPC.

HCPC has no legal power to introduce revalidation for this group of public health leaders and it does not operate revalidation for any of its 300,000-plus registrants.

The proposal therefore fails to meet the Government's own objective "to ensure more consistent standards across the profession."[5]

[5] Government Response to the House of Commons Health Committee Report on Public Health (Twelfth Report of Session 2010–12) page 22
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215177/dh_132548.pdf

The purpose of the professional development and regulation of non-medical specialists was to achieve, and demonstrate, equivalence with medically qualified specialists. Without mandatory revalidation to an equivalent standard this equivalence cannot be achieved.

HCPC has made it clear that it has no intention of introducing revalidation for public health specialists unless mandated to do so by Government. Therefore this Order needs to include provisions for revalidation.

The 2010 Scally report recognised *'that there will be a need for consistent approaches to professional development and revalidation between public health specialists on the statutory registers and the Faculty of Public Health should have a central role in producing common frameworks".*[6]

The Faculty's response stated:

Revalidation of public health specialists from a background other than medicine:
A complementary issue to regulation is that of the revalidation of public health specialists from a background other than medicine. The two issues of regulation and revalidation complement each other and all specialists in public health should not only be statutorily regulated, but also be required to revalidate along similar systems underpinned by a single set of standards. Establishing a proportional and effective system for these individuals is essential for maintenance of standards and the protection of the public.
Recommendation: Specialists from a background other than medicine should be revalidated.[7]

The response by Health Protection Agency (now part of Public Health England) also supported this recommendation.[8]

This clearly supports the UKPHR position that the draft Section 60 Order directly contradicts the principle and maintenance of equivalence.

In addition, equivalence is also undermined for the Department's target group of public health leaders because of differences between HCPC's generic regulatory requirements compared to those operated by GMC, GDC and UKPHR. For example, the guidance given to the latter under Good Medical Practice and Good Public Health Practice is not matched by the generic standards applied by HCPC in respect of all the professions it regulates.

Furthermore, the requirements for continuing professional development (CPD) required by GMC, GDC and UKPHR are fundamentally different from those operated by HCPC for the professions it regulates.

Senior appointments

The proposed order will be ineffective in protecting the public, through the failure to replicate in the new system (non-NHS employers and HCPC registration) the position that was granted to UKPHR registration in Consultant appointments when the large majority of public health consultant posts were employed in the NHS.

---

[6] Ibid

[7] http://www.fph.org.uk/uploads/FPH%20response%20to%20the%20Review%20of%20regulation%20of%20public%20health%20professionals%20-%20FINAL.pdf

[8] http://webarchive.nationalarchives.gov.uk/20140714084352/http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1296684619955

The intended effect of statutory regulation is in danger of being frustrated because most consultant posts are no longer subject to the NHS Appointment of Consultants Regulations. These were designed to restrict appointments to specialists who were registered by one of the General Medical Council, General Dental Council and UKPHR.

Most of the posts were moved out of the NHS in the 2013 re-organisation and there is no statutory need for compliance by Local Authorities, PHE, Universities and the private and voluntary sector providers, only non-binding good practice recommendations.

Thus, although specialists will have to be registered, there is no requirement that the key posts within the public health system such as Directors of Public Health have to be undertaken by public health specialists, and these positions will not be restricted to the pool of those who are registered. The draft Section 60 Order should address this matter.

The 2010 Scally report said:

It is recommended that the title Consultant in Public Health be protected for individuals registered on the appropriate specialty registers or sub-registers of the General Medical Council and the General Dental Council, and the proposed public health register of the Health Professions Council. If it is not possible to protect the title of Director of Public Health then an alternative mechanism should be enacted to ensure that only consultants in public health could occupy such posts.[9]

The response from the Government's Health Protection Agency at the time stated:

The HPA strongly supports the proposal that all non-medically qualified public health 'specialists' should be placed on a statutory register as this should add significant, independently verified, protection to the public. All consultant posts in public health, including Consultant in Health Protection and Consultant Communicable Diseases Control (CDCC), should then be restricted to individuals on this statutory register or the appropriate GMC Specialist Register, as only they can be assumed to have demonstrated and maintained the necessary public health competences and professional standards.[10]

The Faculty responded:

The Advisory Appointments Committee process must be preserved and extended into new employment settings for public health specialists in order to quality assure the workforce.[11]
The Department's proposal conflicts with the Government's stated aim of improving career pathways for people who might choose to work in public health.

The draft Section 60 Order is therefore opposed. It should be withdrawn and a new proposal made which helps achieve equivalence between all the leaders of the public health workforce.

[9] Ibid
[10] Ibid
[11] Ibid

3. Fitness to practice

If the proposed transfer of specialist registrants from UKPHR to HCPC goes ahead, there will need to be arrangements in place for concluding fitness to practice cases which are ongoing at the time of transfer.

UKPHR would propose to work with HCPC in advance of the transfer to identify cases and ensure a smooth handover of them to HCPC.

Any registrants subject to investigation in the run-up to the transfer could be advised by UKPHR and HCPC jointly of the procedure which will be operated to determine the investigation and any potential subsequent fitness to practice proceedings.

4. Grandfathering

For the Department's target group of public health leaders, UKPHR operates four routes to registration: Standard, defined specialist, Recognition of Specialist Status, and dual registration.

Standard route is for those applicants who have successfully completed the specialty training programme. This is expected to be the sole or main route onto HCPC's register. This route does not need a grandfathering provision as there is a steady flow of applicants which can be managed as well before the transfer as after the transfer without interruption.

Defined specialist route involves retrospective portfolio assessment by two assessors. Once received by UKPHR, the assessment of such a portfolio may typically take 6 months - longer if the assessors require significant clarification or resubmission of evidence by the applicant.

As UKPHR's assessors are all senior public health professionals providing voluntary support, there are times when the demand for assessors exceeds UKPHR's supply. This factor inevitably increases the time taken for portfolio assessment.

If the proposed transfer should take place, it is very likely that there will be (i) portfolios held by UKPHR that have not been fully assessed and (ii) individuals who will be working on preparing a portfolio for assessment.

It is only fair to applicants in these two situations for there to be time after the transfer for them to have their portfolios assessed notwithstanding the change in regulator.

UKPHR supports the proposal for a two year grandfathering period to meet the needs of such applicants. The grandfathering period should be available both to applicants whose portfolios are already with UKPHR and to those individuals who are in the process of preparing a portfolio for delivery to UKPHR in support of application for specialist registration.

HCPC should ensure that it will have the capability and capacity to carry out the necessary assessments in line with UKPHR's established standards.

It is proposed by the Department that at the end of two years the grandfathering provision will end.

UKPHR would not agree that after two years the only route to register should be the training programme (UKPHR's Standard Route). There is a need to continue to recognise a diversity of leadership talents and variety in the ways in which those leadership talents are exhibited.

UKPHR would therefore argue that there needs to be more than one route for future applicants to establish that they meet the criteria for public health specialist practice. Assessment of a portfolio, and/or a CESR-type combination of assessment and examination as available currently through the GMC, should also be allowed as evidence of appropriate skill and knowledge. This allows for career flexibility and development within public health.

In addition to the decision which the Department and/or HCPC intends to make about the future of defined specialists, UKPHR strongly represents that attention should also be given to improving, not removing, its other current routes to register, *Recognition of Specialist Status* and *dual registration.*

5. Protected title

As an accredited voluntary register UKPHR is not able to offer registrants a protected title; this is a feature of statutory regulation attractive to regulated professionals.

When UKPHR surveyed its specialist registrants on the protected title in the event of the introduction of statutory regulation, there was no overall consensus. Responses were divided between the titles "public health specialist", "public health consultant" and "consultant in public health". The largest number favoured the first of these titles.

The 2010 Scally report recommended that there should be protected titles of "Director of Public Health" and "Consultant in Public Health".

UKPHR would support the introduction of three protected titles:

Director of Public Health
Consultant in Public Health
Public Health Specialist.

6. Defined specialist

UKPHR has always pursued equivalence within the public health leadership cadre both in terms of systems (code of conduct, CPD and revalidation for example) and value.

Whilst UKPHR's routes to register have enabled some leaders to achieve a status of "generalist specialist" and others "defined specialist", UKPHR has regarded both as being of equal value. This has been especially valuable for the retrospective assessment and recognition of the competence of existing senior staff with particular high level expertise in specific domains of public health practice (equivalent to experienced consultants in specialised posts) and bringing them in to a regulatory environment.

For those specialist registrants – generalist and defined – who have achieved registration following the retrospective assessment of a portfolio of evidence, the standards that have had to be met, and the assessment of them, has required proof of knowledge (know how) across all the areas of the Faculty's curriculum and application (show how). In the case of defined specialists, applicants will have shown "super knowledge and application" in at least one area of practice.

Defined specialists bring a diversity of talent and expertise to the public health leadership which will increase as Public Health becomes a more integral part of local government. Their success in achieving recognition through alternative career-based acquisition of the required skill and knowledge is a tremendous tribute to their work focus, personal determination and development.

The fact that around half of Directors of Public Health are its registrants, some being generalist specialists and others defined specialists, provides objective evidence and validates UKPHR's long-held confidence in the standards it upholds and the skill and knowledge of all its registrants.

UKPHR considers its specialist registrants are, by definition, fit for purpose - the leaders of a multi-disciplinary public health workforce playing their part in partnership with other professionals and communities in addressing the social, economic and environmental causes of health inequality and shaping population based interventions to address and overcome them.

Over 60 defined specialists have achieved registration with UKPHR; 40 applicants are currently being assessed and a further 50, since news of the Department's proposal was made known, have notified UKPHR of their intention to apply for registration.

These numbers represent an important contribution to meeting the need for public health leaders in the short-to-medium term. In UKPHR's view, a diversity of means of achieving a position as a public health leader will be necessary into the long term to ensure that there continues to be an adequate supply of such leaders.

In this respect it is of concern that HCPC is unlikely to consult on its proposal for future routes to register before the Department's consultation is concluded and the Section 60 Order is obtained.

It would be an unjust legacy of the Department's proposal for defined specialists to be relegated to the lower of two tiers of regulated professionals. The subsequent exclusion of defined specialists from the public health's leadership group would compound this legacy. This, however, appears to be the one of the two options on offer in the Consultation Paper.

A more fruitful area of consideration would be the unmet need for recognition within specific branches of the more senior members of the public health workforce currently outside the leadership cadre. Examples of groups with existing claims for greater recognition of their contributions include those working in:

- Health protection roles such as communicable diseases epidemiologists
- Knowledge & intelligence
- Nursing
- Public health academics who advise local and national government and the NHS on effective public health interventions
- Science

and potentially many other professionals who worked in local government prior to April 2013 as specialists in public health.

Many workers in these groups will legitimately regard themselves as too senior to be registered as practitioners. A category of “Advanced Practitioner” may meet the aspirations of some in these groups, but this status is currently being piloted and its development is some time off. However, registration as a specialist – by any route, including the existing defined specialist route – may be unrealistic given the required range of know-how and show-how that must be evidenced.

It would be interesting to investigate whether standards could be devised to meet aspiration for leadership roles among these groups in the public health workforce. Such an approach may have implications for this question about defined specialists. It may also have a bearing on the question about protected title.

For these reasons, UKPHR strongly supports the maintenance of routes to specialist registration, not a single route, (the standard route), based only on completion of the training programme. There is scope to develop one or more routes based on CESR and/or portfolio assessment and UKPHR would welcome discussions with partners in an effort to settle an agreed set of routes to register going forward.

UKPHR contends therefore that more than one route to register is required. Individuals with the skill and knowledge to warrant posts as public health leaders should be allowed the means to satisfy appropriate standards either by completing the training programme or by other approved means.

7. Cost and benefit

In the past, the majority of public health leaders have been employees of public health agencies in the public sector. Examples of such employers are NHS and local authorities.

UKPHR has witnessed a shift in recent years.

Today there are specialist registrants employed by profit-making private sector employers, not-for-profit organisations in the private, public and voluntary sectors and self-employed specialists.

For some specialist registrants working in these settings, the proposed change to their regulatory framework is not as cost-free as the Consultation Paper suggests.

For those specialist registrants committed to retaining equivalence (especially if their employer or the clients who commission them impose requirements for CPD and/or revalidation beyond what will be required by HCPC), there will be costs involved in taking steps personally to seek to achieve equivalence.

For specialist registrants who have promoted their UKPHR registration and/or promoted that the register they are on is accredited, there will be a need to spend money to publicise the change in regulatory circumstances.

The Department's Consultation Paper does not address these costs.

8. Conclusion

The draft Section 60 Order fails to achieve stated Government policy aims and is materially deficient in several respects including the critical absence of any process for revalidation.

UKPHR opposes the Government’s stated policy objective.

UKPHR provides an alternative policy objective which would deliver stronger public protection, better regulation, and a more effective public health workforce.

9. Answers to the consultation questions

Question 1*: Do you agree with the Department's decision that the HCPC should be the statutory regulator for public health specialists from backgrounds other than medicine or dentistry? If not, why not?*

No.

UKPHR does not agree with the Department's decision for a Section 60 Order to implement statutory regulation by the HCPC of those leaders currently registered by UKPHR because instead of supporting equivalence between all public health specialists, it carries a real risk of creating divergence and fragmentation.

It is a decision which does not properly take into account UKPHR's achievement of Accredited Voluntary Register status under the statutory scheme put in place by the Government.

Additional unintended consequences include:

- It would cut across an intention to give a clearer roadmap for future career pathways and skills development;

- It takes no account of practitioner registration, and implementation of the Department's decision would weaken the value of practitioner registration;

It is the wrong policy option for the public health system in the UK, and there is a better option available – make UKPHR the statutory regulator - which UKPHR puts forward in line with the Government's own stated objectives of equivalence and consistency in regulation.

Question 2*: Do you think that public health specialists should be regulated by another body? If so, who and why?*

Yes.

A preferable way to proceed, to achieve equivalence, would be a single statutory framework for all public health specialists irrespective of their individual disciplines, building on UKPHR's existing approach to dual registration. This would be complementary to, but would not replace the existing regulation of medical and dental public health specialists undertaken by the GMC and GDC respectively.

Considering the public health workforce more broadly, a holistic approach will be to design a comprehensive form of regulation for the entire public health workforce, working with the grain of what already exists, improving both workers' experience of regulation (in many cases, by more than one regulator) and the effectiveness of public protection.

UKPHR's preferred position is the creation of a single regulatory home for the entire public health workforce, respecting the existing roles of other statutory regulators such as GMC, GDC, NMC and GPhC. It would be a regulator established by statute operating a single public health regulatory framework capable of differentiating the required level and intensity of regulatory activity according to risk of public harm. This regulator can now be UKPHR, building on the foundations of what UKPHR has already achieved.

***Question 3**: Do you agree that outstanding UKPHR fitness to practise cases at the time of transfer should be investigated and determined by the Health and Care Professions Council in accordance with the Health and Social Work Order 2001 (S.I. 2002/254)? If not, why not?*

If the transfer is implemented, yes.

UKPHR would work collaboratively with HCPC both before and after the transfer in order to ensure a safe handling of such cases so that protection of the public from harm is not compromised at any point.

***Question 4**: Do you agree that the grandparenting period for registration as a public health specialist should be two years?*

If the transfer is implemented, yes.

Two years should be a reasonable period within which members of the public health workforce could be expected to commence an application for registration as a public health specialist if their applications were not to be already underway at the time of the transfer. UKPHR has received over 50 expressions on intention to submit an application for registration as a public health specialist by retrospective assessment of a portfolio since the Department announcement of its intention to consult on its proposal. It may be therefore that the number of people in the public health workforce who may come forward and seek registration during the grandfathering period may be higher than the Department expects. HCPC would need to make arrangements to be able to carry out what may be a significant number of assessments.

***Question 5**: Is the impact of these public health specialists being required to register with the HCPC of significant consequence?*

Yes.

UKPHR has received over 50 expressions of intention to submit an application for registration as a public health specialist by retrospective assessment of a portfolio since the Department announcement of its intention to consult on its proposal. The number of people in the public health workforce seeking registration during the grandfathering period may be higher than the Department expects. HCPC would need to make arrangements to carry out what may well be a significant number of assessments.

UKPHR's model requires two assessors to assess each portfolio. Assessors' reports are considered by a Registration Panel largely formed of other assessors. The Panel may reject the portfolio, seek clarification of matters in the portfolio, require resubmission of additional evidence or recommend the Registration Approvals Committee admit the applicant to the register. In the event of clarifications and resubmissions, the applicant is required to carry out further work in support of her or his application (which may take a considerable time) and the assessors will once again consider the applicant's clarifications/resubmissions. The assessors' reports are subsequently considered by the Registration Panel.

If the transfer is implemented, HCPC will need to ensure that arrangements are in place to respond accordingly to such applications and that there is sufficient capacity for their timely assessment. UKPHR would be willing to discuss with HCPC the arrangements needed and to help to implement them.

***Question 6**: Do you agree that "public health specialist" should become a protected title?*

No, not as the sole protected title.

UKPHR would support the introduction of three protected titles:
Director of Public Health
Consultant in Public Health
Public Health Specialist.

The latter of these three protected titles might need further discussion and consideration depending on other decisions as to whether there will be more than one route to registration and/or whether it might be thought desirable to establish different categories of public health specialists.

***Question 7**: Which of these options for defined specialists, if either, do you think is appropriate?*

Neither.

UKPHR maintains equivalence within the public health leadership cadre both in terms of systems (code of conduct, CPD and revalidation for example) and value. UKPHR therefore supports routes to register which enable public health leaders to achieve a status of "generalist" and/or "defined" specialist and regards both as being of equal value.

For these reasons, UKPHR strongly supports the maintenance of more than one route to specialist registration. There is scope to develop one or more routes based on CESR (certificate of eligibility for specialist registration) and/or portfolio assessment and UKPHR would welcome discussions with partners in an effort to settle an agreed set of routes to register.

***Question 8**: Do you agree that the requirement for a Council member to chair Registration Appeal Panels should be removed?*

Yes.

***Question 9**: Do you agree that a HCPC panel should have the power to make a striking-off order in a health or lack of competence case provided the registrant has been the subject of a continuous substantive suspension or conditions of practice order for at least two years?*

Yes.

***Question 10**: Is our estimate of the numbers of non-medical public health specialists working in the independent or private sector reasonable?*

Not unreasonable, but not accurate either.

UKPHR is aware that public health specialists are working in increasingly diverse environments but accepts that the numbers will nevertheless represent a modest proportion of the whole.

10. About UKPHR

The purpose of the UK Public Health Register is to provide public assurance for the provision of a competent workforce that contributes to a high quality public health service.

UKPHR holds the register for a single professional group encompassing the whole of public health practice, acting as the primary regulator. The multi-disciplinary nature of this group is central to the philosophy which underpins the register.

In 2003 UKPHR was set up to regulate all multi-disciplinary public health specialists (from backgrounds other than medicine and dentistry). From April 2011 the register also started to regulate public health practitioners.

UKPHR has a single, overriding objective: to promote public safety and public confidence in public health practice in the UK through independent regulation. The UKPHR seeks to achieve its objective by:

- Working with partners setting and promoting standards for admission to and remaining on the register
- Dealing with registrants who fail to meet the necessary standards
- Publishing a register of competent professionals

As part of achieving its objective, UKPHR has a role in ensuring that training is fit for purpose and to set the standards for professionals to adhere to. This is done in conjunction with the UK's Faculty of Public Health, in relation to professional curriculum, training and qualifications, and the General Medical Council and the General Dental Council in respect of their statutory regulation of public health doctors and dentists.

These standards define a clear knowledge base which underpins the whole of public health practice. UKPHR accepts specialist applicants who have completed the FPH training programme and specialist and practitioner applicants who demonstrate their skills and knowledge in a portfolio.

The Registrar has oversight of the UKPHR's assessors, fitness to practise panellists, members of the Registration Panel and Registration Approvals Committee. The Registrar's duties and procedures are independent of the UKPHR Board.

The UKPHR Board oversees the financial, governance and housekeeping aspects of the organisation. The independence of the Board is assured in the governance arrangements. As in other healthcare regulators, lay members have specific functions assuring accountability and promoting public confidence.

UKPHR receives and gives feedback through its UK-wide Consultative Forum, which contains representatives of a wide range of stakeholders.

Please see the Annexe for details of progress made by UKPHR since its foundation in 2003.

11. About AVR

The Professional Standards Authority is responsible for overseeing the UK's nine health and care professional regulatory bodies that regulate health and social care professionals in the UK, including the GMC and GDC. The Professional Standards Authority also runs an *Accredited Voluntary Registers* (AVR) scheme to provide assurance that accredited registers are well run and achieve high standards in the following areas: governance, setting standards for registrants, education and training, managing the register, complaints and information. Accredited registers require their registrants to meet standards of personal behaviour, technical competence and, where applicable, business practice.

UKPHR has achieved AVR status

UK Public Health Register's voluntary register of public health specialists and practitioners has been accredited by the Professional Standards Authority for Health and Social Care under the Accredited Voluntary Registers (AVR) scheme.

The AVR scheme is managed by the Professional Standards Authority, an independent statutory body accountable to Parliament, and the vetting and approval process is very rigorous.

AVR status represents objective assurance that UKPHR's standards are robust and that the organisation meets modern standards of registration.

Government established the scheme under the Health and Social Care Act 2012 and it enables voluntary registers like UKPHR to be held to account for the standards they operate not just by their registrants but also by the public and the Professional Standards Authority.

For any further information about this response and for correspondence generally CONTACT:

David Kidney, Executive Director,
UK Public Health Register,
18c, Mclaren Building,
46, Priory Queensway,
BIRMINGHAM B4 7LR

E; d.kidney@ukphr.org

T: 0121 296 4370

ANNEXE

UKPHR progress 2003 - 2014

2003 UKPHR was set up as a Company limited by guarantee in 2003 with encouragement, assistance and financial support from the Department of Health.

UKPHR was created to provide a regulatory home for those multi-disciplinary leaders in public health (specialists, consultants and Directors of Public Health) who were not eligible to be regulated by the existing statutory regulators General Medical Council (GMC) and General Dental Council (GDC).

As UKPHR is a voluntary register, these leaders are free to choose whether or not to register. UKPHR established itself as a regulator alongside the GMC and GDC and recruitment of public health leaders now requires applicants for appointment to be registered with the GMC, GDC or UKPHR.

UKPHR's founders envisaged that UKPHR would expand to offer registration to all the public health workforce, not just specialists.

2006 The 4 UK Departments of Health commissioned UKPHR to scope a regulatory framework for practitioners for implementation in 2008. The implementation was postponed pending a review of regulation in 2009.

2010 UKPHR initiated a pilot of practitioner standards in several discrete geographic areas of the UK, and developed UKPHR registration processes to enable practitioner registration. All pilot areas continue to run practitioner registration programmes post-pilot and robust systems for registration are applied by UKPHR.

2012 Evaluations of practitioner registration pilots describe standards and processes as robust. Practitioners are increasingly engaging with the registration process and the profile of practitioner registration has been raised among employers.

The Department of Health funded the Faculty and UKPHR jointly to devise a scheme for revalidation for specialist registrants.

A new Chair was appointed in the summer of 2012 following a recruitment process involving advertisement, application and interview.

At the time of the new Chair's appointment, governance of the Company and its register was managed by a committee of 32 persons, many of whom attended as representatives of public health partners such as the UK Faculty of Public Health and the Chartered Institute of Public Health.

UKPHR's Directors attended the management committee as did the Registrar. The management committee involved itself in matters of policy, management and registration. The terms Executive Committee, Director and Trustee were all in use. There was an advisory panel of approximately 12 members, mostly drawn from the same organisations represented on the management committee.

2013 The new Chair overhauled UKPHR's governance structures, abolishing the management committee, Executive Committee and advisory panel.

The UKPHR recruited a new, small, and representative decision-making Board of 12 Directors to manage the Company. The Registrar's responsibility for the register and registration processes was re-asserted.

The Chair, with the support of the new Board, carried out a series of actions to modernise UKPHR and further develop its rigour as a regulator by:

- Commissioning an internal business review from the consultancy Total Improvement Ltd which made recommendations on staffing, procedures and IT systems, resulting in the recruitment of a Chief Executive

- Addressing the Company's finances to prepare for an end to grant funding from the Department of Health, and to develop strategies to contain expenditure so that the organisation will be self-sustaining

- Establishing a new Consultative Forum with members representing the Health Departments and Chief Medical Officers of the UK's four nations, public health agencies and bodies, other regulators, professional bodies, representatives of the workforce, and the lay public

2014 The Board reconfigured UKPHR staffing, relocated the office to Birmingham, and streamlined its IT and back-office systems. Expenditure is now reduced to a level below income. UKPHR can be financially sustainable up to and beyond 2017 strengthening its independent status as a regulator.

Clear policies and procedures guide UKPHR's regulatory operations.

UKPHR achieved accreditation of its voluntary register by the *Professional Standards Authority* under a statutory scheme established by the Health and Social Care Act, the same Authority that oversees the GDC and the GMC.

To date (September 2014) there are over 600 specialists on the UKPHR's register. This constitutes around half of the estimated 1,200 public health leaders in work in the UK; the other half being registered with GMC and GDC.

There are over 130 practitioners on UKPHR's register, with over 400 more currently preparing portfolios for assessment in order to achieve registration. There are now 10 practitioner registration schemes funded by local employers in the UK, including the original 4 pilot sites, with several more in development.

The *Centre for Workforce Intelligence* estimates that there are 36,000 – 41,000 people in England's public Health workforce (working between levels 5 and 9 as described in the *Public Health Skills and Knowledge Framework*).