

UKPHR response to the Department of Health and Social Care’s policy paper “Transforming the public health system”.

About UKPHR

The UK’s 2,000 public health leaders, including Directors of Public Health, specialists and consultants, must be registered with a recognised professional regulator. For doctors this is the General Medical Council, and for dentists the General Dental Council. Of these public health leaders, around 800 are from multidisciplinary backgrounds, including environmental health, nursing, sexual health, smoking cessation, planning, transport, science and statistics, who are accredited and registered as public health specialists with the UK Public Health Register.

Below this leadership level, professional registration is not compulsory in public health roles outside medicine and dentistry. The UK Public Health Register operates a voluntary registration process for those working in public health. Of the estimated 60,000 people working in UK public health below leadership level, some nursing and healthcare science practitioners are regulated by the NMC or HCPC, but around 10,000 public health practitioners from multi-disciplinary backgrounds need to be regulated by the UK Public Health Register in order to maintain standards and protect the public.

The UK Public Health Register works across the four nations of the UK. We work closely with other professional regulators in the health sector, including the GMC, GDC, NMC, HCPC and the PSA.

Our response

Securing our health: The UK Health Security Agency

- Question A1: What do local public health partners most need from the UKHSA?

UKHSA should require all its professional staff to achieve accreditation and registration as public health practitioners or specialists. For doctors, dentists and nurses, for example, this will be with the GMC, GDC or NMC. For public health specialists there is already a requirement for registration with UKPHR. For practitioners from other professional backgrounds, registration could be with the UKPHR. This will give UKHSA credibility, and ensure its staff are professionally knowledgeable and competent to do the demanding jobs required of them.

- Question A2: How can the UKHSA support its partners to take the most effective action?

UKHSA should work collaboratively across the four nations of the UK and with all stakeholders to support all those working in public health roles, so that there is a sense of a common profession, working to shared standards and goals. This must include supporting and strengthening a clearly

defined and accredited career structure, with staff registered with professional regulators, including the GMC and UKPHR.

- Question A3: How do you think the health protection capabilities we need in the future should differ from the ones we have had to date?

UKHSA should do more than now to promote the long-term training and career development of all public health practitioners as well as specialists. This will help to ensure that, if any new pandemic arrives in the UK, UKHSA and the wider public health workforce has trained staff in many roles and at all levels of seniority who are ready to respond, and have the training and support to do so.

- Question A4: How can UKHSA excel at listening to, understanding and influencing citizens?

UKHSA can ensure that all its staff are trained well in public health, including to understand the needs of local citizens and the importance of working collaboratively in partnership with other public health organisations. Encouraging or requiring UKHSA staff to become accredited and registered public health practitioners and specialists, including with the UKPHR, will help secure that outcome.

Improving our Health

- Question B1: Within the structure outlined, how can we best safeguard the independence of scientific advice to Government?

UKPHR welcomes that “the Office for Health Promotion will be a dynamic, multi-disciplinary unit that will oversee policy development, expert advice and implementation on prevention of ill-health, [and that] it will house a range of skillsets and expertise”. In establishing the OHP, the government should ensure that all its staff are appropriately trained, qualified and professionally accredited and registered. This will include scientists and those with a medical background. But others should work towards registration as public health practitioners or specialists, and registered by the UKPHR. This will ensure that the government receives the best possible advice from trained experts who are professionally regulated. This will help to improve both the quality of advice given to ministers and help to safeguard its independence.

- Question B2: Where and how do you think system-wide workforce development can be best delivered?

UKPHR notes that “DHSC will play a stronger role in workforce strategy development and oversight ... to ensure there is sufficient public health professional capacity to meet the needs of the whole system.” This is a demanding role for DHSC to take on, given that there are over 60,000 people working in public health, employed within the NHS, local authorities, charities and elsewhere. We would welcome further detail about how DHSC intends to meet this challenge.

UKPHR welcomes the assertion that DHSC “will ensure that professional revalidation systems remain robust” and we note that you “are reviewing whether delivery of other key workforce functions may best sit with other partners at national or subnational level.” PHE has played a key role in ensuring the professional revalidation of the multi-disciplinary public health workforce. It will be vital for

public health practitioners and specialists to know where and how this PHE role will be performed in future. The DHSC should convene a working group of professional regulators – GMC, UKPHR, NMC and GDC – to ensure that the design of the new system of professional regulation reflects the needs of the entire public health workforce and their employers.

- Question B3: How can we best strengthen joined-up working across government on the wider determinants of health?

With the abolition of PHE, there will be no organisation that can provide the government with independent advice on the performance of public health delivery systems across the UK. The CQC and its counterparts in Scotland, Wales and Northern Ireland focus on the performance of NHS institutions. The inspection of local authority services ceased with the abolition of the Audit Commission in 2012. The government therefore cannot know, independently, how well public health services are performing as local systems, nor how best central government can join up to support improvements in local delivery. This gap should be addressed, or it may not be possible for the government to know where there is good practice (and where not) in addressing the wider determinants of health.

- Question B4: How can we design or implement these reforms in a way that best ensures prevention continues to be prioritised over time?

UKPHR supports others who have urged the government to ensure that a proportion of health spending is explicitly directed towards the improvement of health and well-being, including the prevention of for example infectious diseases and other aspects of population health.

Strengthening our local response

- Question C1: How can we strengthen the local authority and Director of Public Health role in addressing the full range of issues that affect the health of local populations?

The government policy paper acknowledges the importance of a multi-disciplinary public health workforce and “the collective resources and strengths of the local system, the NHS, local authorities, the voluntary sector and others to improve the health of their area” and that this “has shown what we can achieve when we work together”.

UKPHR agrees and we urge DHSC to ensure that Directors of Public Health are given responsibility and funding to ensure that they can coordinate agencies to respond effectively to improve public health. This should include giving them responsibility and funding to shape the local public health workforce and all those working in public health are appropriately trained, accredited and registered, including with the GMC and UKPHR.

- Question C2: How do we ensure that future arrangements encourage effective collaboration between national, regional and local actors across the system?

UKPHR welcomes the aspiration to “place population health at the heart of local health and care systems, ensuring the NHS and local authorities work together to improve health in place.” We also

note that “ICSs, in partnership with local government, will be responsible for the health and social care needs of the population within their defined geography, and securing the provision of health services to meet the needs of the system population”. We agree that, “to be effective, ICSs must be a genuine ‘partnership of equals’ between NHS and non-NHS bodies in order to improve population health – with local authorities and the NHS taking decisions together”.

For this partnership of equals to be effective in practice, the government should recognise explicitly that the public health profession is multi-disciplinary and that practitioners and specialists in public health can enter the profession from various backgrounds. This is a key strength of the public health workforce. The HR teams in both the UKHSA and the OHP should therefore promote the professional registration of all their staff with the GMC, UKPHR or another professional register, and encourage all employers, including ICSs and local authorities, similarly to require their staff to work towards professional accreditation and registration.

- Question C3: What additional arrangements might be needed to ensure that regionally focussed public health teams best meet the needs of local government and local NHS partners?

The government should consider how best to regulate local public health systems, so that good practice can be identified and spread, and bad practice spotted early and corrected. The CQC and other health regulators can currently identify excellent and failing institutions; and the GMC and other professional regulators can ensure the fitness to practice of individuals; but there is no mechanism to examine and improve health systems, whether in public health or elsewhere. This is a regulatory gap that should be addressed.