UKPHR
Public Health Register
Protecting the public | improving practice

# Agenda

## UKPHR BOARD MEETING

***20 April 2022***

| ITEM | | | |
|---|---|---|---|
| 1 | Welcome, apologies and new declarations of interest- Chair | | |
| 2 | Minutes of Board meeting on 9 February- Chair | | |
| 3 | Actions and matters arising - Chair | | |
| 4 | Governance forward planner- Chief Executive | | |
| ***Substantive Items*** | | | |
| 5 | Reflections from Board Strategy Day | | |
| 6 | Committee recommendations for Board decision:<br>a. 22/23 annual pay rises (ARRC)<br>b. How specialists are recorded on the Register (RPG)<br>c. Issuing certificates (RPG) | | |
| ***Reports & updates*** | | | |
| 7 | Chief Executive's report (including Chair decisions and meetings) | CEO | *Item 7* |
| 8 | Registration report | Registrar | *Item 8a - Minutes of RAC*<br>*Item 8b Registration data*<br>*Item 8c Registration Policy Group minutes, 23 March 2022* |
| 9 | Audit, Risk and Remuneration report | ARRC Chair | *Item 9 - Minutes of ARR Committee, 30 March 2022* |
| 10 | Education and Training Standards report | E&T Chair & Registrar | *Item 10 - Minutes of E&T Committee 12 April, 2022* |

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| 11 | Any other business | Chair | |
| 12 | Date and time of next meeting- | | |

**UKPHR Board**

**Item 6a- Staff Pay in 2022/23**

**Confidential**

Issue

1. To agree the pay rise for UKPHR staff (excluding the Chief Executive) for 2022-23

Background

2. The ARR Committee must recommend to the Board any changes to staff pay before the start of each new financial year.

3. According to the Office of National Statistics, Consumer Price Inflation increased by 6.2% in the 12 months to February 2022- the largest increase since 1982.

4. The UK government has announced a pay increase of 3% to staff in the NHS. In response, many have suggested that this should be higher, considering the significant increase in CPI. CIPD projects an overall average pay rise of 3% in the UK across all sectors.

5. The 2022-23 budget was agreed by the Board in February 2022; at this point pay rises were not included in the overall budgeting exercise.

6. The Board agreed in 2021 to release £100,000 of reserves to cover increased salary costs and the IT upgrade. We anticipate to spend approximately £60,000 on the IT upgrade, and have budgeted for approx. £40,000 in increased salary costs as compared to 21/22.

7. The ARRC considered the following modelling in their discussions:

| **No rise** | **2%** | **3%** | **6.2% (CPI increase)** |
|---|---|---|---|
| 145,150 (+0) | 148,053 (+2903) | 149,505 (+4355) | 154,149 (+8999) |

8. The Committee acknowledged that they would ideally give staff a pay rise in line with inflation, but that a static income didn't allow that. They felt that aligning the pay rises with the average across the UK was reasonable. It was also noted that it could be a reputational risk to the UKPHR to raise wages much beyond national/health sector averages.

9. It was agreed that a 3% pay rise, with an additional .5% as a goodwill gesture, was appropriate and that the rise would be backdated to 1 April (for May payroll).

10. The Committee also discussed whether there was any other non-financial support UKPHR could offer staff. They noted that it was challenging to offer benefits that a larger organisation might be able to provide ie Employee Assistance Programmes and other benefit schemes, because of UKPHR's very small size.

11. It was agreed that rather than financial benefits, UKPHR should be focussing on other kinds of benefits ie development and support, a flexible/supportive working environment. JL noted that she was looking into several options that had the team's support, such as a flexitime schedule (this is being piloted and would be brought to the next meeting), more reflective and developmentally focussed appraisals, and offering training where possible. She noted that the team seemed positive about the organisation, but that she'd report back to the Committee on a staff survey to provide evidence of this. JL also agreed to test other ideas with the team, such as volunteer days or shadowing opportunities.

Recommendations

12. To agree the ARRC recommendation of a pay rise of 3.5% (3% benchmark, plus a .5% goodwill gesture). The pay increase should be backdated to 1 April 2022, as it won't be reflected until May payroll.

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**ITEM 6b- 20 April 2022**

## Summary

1. There are currently three routes to gain UKPHR specialist registration, which are all associated with different titles on the Register. The three routes vary in application type and time it takes from application for admission to the Register

   Standard Route – called **Generalist Specialists** on Register. These registrants have completed the public health specialty training programme

   Dual Registration – called **Dual** on Register- this is entirely optional for those already on the public health specialty register of either the General Medical Council (GMC) or General Dental Council (GDC)

   Specialist Registration by Portfolio Assessment (SRbPA) – When designing and implementing this new route in 2018, a decision was not made on what to call individual who successfully register via this route. Chair's action was taken to decide that these individuals will be called **Generalist Specialists** on the Register with the internal system recording them via SRbPA portfolio until a decision is made on the wider topic of specialists.

2. Previous routes to specialist registration included:

   Defined Specialist Portfolio Assessment - called **Defined Specialists** on Register. This was a retrospective portfolio assessment route

   Recognition of Specialist Status (RSS) – called **Generalist Specialists** on Register (internal system records via portfolio). This was an initial route to register specialists when UKPHR was formed. It later became a route which required applicants to apply to continue to be registered via this route.

   Defined to Generalist Specialist conversion – called **Generalist Specialist/Defined Specialist** on Register. There was an option for Defined Specialists on the Register to submit a retrospective portfolio of the competencies they did not claim in their Defined portfolio

3. There is no differentiation between the different specialists in practice- UKPHR recognises all specialists on its Register of equal value, despite their different names. All specialists renew on the same date and pay the same annual renewal fee of £336. The revalidation requirements are equal for all specialist, with the exception of dual specialists, who can provide evidence of revalidating with the GMC or GDC. All specialists are eligible to apply for roles that require post holders to be registered at specialist level with the GMC/GDC/UKPHR, and the UKPHR registrant logo for specialists is one design which simply refers to UKPHR registered specialist.

4. On the 26th January 2022, the Registration Policy Group discussed what UKPHR should call those who have successfully registered via the new SRbPA route.

5. The Group agreed in principle to recommend to the Board to move to call all specialists on the Register as “Specialist”. The Group acknowledge that all specialists are eligible to apply for Consultant or Director of Public Health posts, and in reality there is no difference between how specialists are treated within the public health system. The Group acknowledged the previous sensitives surrounding this topic but felt that times had changed.

6. The Group also noted that other regulators do not differentiate and record registrants as being on their public health specialty register, regardless of route. For example, the GMC does not differentiate between those who are registered specialists via training or the CESR (portfolio) route. There was agreement that the back end of the Register should still be able to differentiate if a specialist registered via training, portfolio or dual route.

7. The Board are reminded of the discussion to protect *public health specialist* as a job title when the Governments was planning to proceed with their previous Section 60 order to transferred UKPHR specialists to statutory regulation with HCPC.

8. The perceptions of specialists from different routes on UKPHR’s Register vary across the UK and the difference in nomenclature supports this inequality. However, there has been progress to change these perceptions, most recently when PHE supported UKPHR with funding to speed up the assessment of defined specialist portfolios to increase the consultant capacity in response to the COVID-19 pandemic.

9. The implementation of a new IT registration software would provide an ideal opportunity to make any changes without additional manual intervention and provide sufficient notice to registrants of the upcoming change.

**Recommendation**

10. The Board is asked to consider a move to calling all specialists on the Register as “Specialist” from the start of using the new IT system, whilst making a distinction between route of registration (training, portfolio or dual) within the internal system.

11. The Board is asked whether they wish to engage in public consultation on this matter before reaching a decision.

Pav Johal, Head of Business Development and Improvement

March 2022

# Healthcare Regulation - deciding when statutory regulation is appropriate

UKPHR response- March 2022

**Do you agree or disagree that a qualitative and quantitative analysis of the risk of harm to patients is the most important factor to consider when deciding whether to regulate a health or care profession?**

Agree

UKPHR agrees with this statement. However, we'd suggest expanding the risk of harm to include populations and the public- some health professions have minimal contact with individual patients, but work to ensure the health of the public. For example, public health supports individuals, organisations, and society to tackle preventable disease, mortality and disability using:

- **Prevention: reducing the incidence of ill health supporting healthier lifestyle**.
- **Protection: surveillance and monitoring of infectious disease, emergency response and immunisation**.

Public health professionals protect the public in an upstream way, working to minimise the likelihood of individuals becoming patients.

It may also be helpful to understand how workforce requirements/ challenges impact the statutory vs non-statutory regulation debate, and how workforce issues may contribute to potential harm to the public and patients. For example, if an established healthcare profession is unregulated, but is experiencing significant workforce challenges that could threaten the health and wellbeing of the public, is this something that would be considered for potential statutory regulation?

**Do you agree or disagree that proportionality, targeted regulation and consistency should also be considered in deciding whether to regulate a health or care profession?**

Agree

However, statutory regulation does provide future-proofing for a profession, and can provide reassurance to the public during times of significant change. Healthcare organisations and landscape changes frequently. Statutory regulation can provide stability/consistency through periods of significant change. Horizon scanning and forecasting must also be taken into consideration.

**Do you agree or disagree that the currently regulated professions continue to satisfy the criteria for regulation and should remain subject to statutory regulation?**

Agree

However, we would appreciate clarification on the consultation statement that *the main risk, should a profession be considered for de-regulation, is that there may be a reduction in standards.* Is this referring to a reduction in standards across the profession, or a reduction in standards by the regulator? If the former, one could argue that there is an increased need for statutory regulation to bring practice standards back to where they should be. If the latter, this may not be a justified reason to bring a profession out of statutory regulation- if there is still a clear need for regulation of the profession (according to the DHSC guidance), support should be put in place to ensure the statutory regulator can raise standards and ensure effective regulation.

**Do you agree or disagree that currently unregulated professions should remain unregulated and not subject to statutory regulation?**

Agree

However, some clarity around the relationship between workforce requirements and challenges and statutory vs non-statutory regulation would be helpful. If an established healthcare profession is unregulated, but is experiencing significant workforce challenges that could threaten the health and wellbeing of the public, is this something that might be significant enough to consider whether statutory regulation might mitigate the workforce issues?

It would also be helpful to acknowledge that voluntary (ie unregulated) registers set and uphold standards in the same way as a statutory regulator. The term 'unregulated' can cover a broad range of professions, some of which have registers operating models similar to statutory regulators. Voluntary registers have a key role to play in protection of the public, ensuring workforce requirements of the NHS and other health agencies are met.