

UKPHR

Public Health Register

A Comparative Analysis of Regulators

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Introduction

The UK Public Health Register is a voluntary register, opened initially to public health specialists and currently planning expansion to admit public health practitioners. To inform the development of a robust regulatory system, a series of interviews was held with a number of key regulatory bodies (see Appendix 1 for informants and Appendix 2 for list of relevant websites consulted) to identify both good practice and potential problem areas.

1. Aims of regulation and of regulatory bodies

The main aim of regulation is public protection. Box 1 shows statutory duties of any healthcare regulator¹, as given by the Council for Healthcare Regulatory Excellence (CHRE). The public health register is not necessarily going to be involved in all of these, although if statutory regulation is considered (see section 11) and has to be under the HPC umbrella, this might have to be revised.

Box 1: statutory duties for healthcare regulators

Statutory duties for any healthcare regulator include:

- Maintaining a register.
- Taking action when a registrant's fitness to practise is called in doubt.
- Assuring the quality of professional education.
- Setting and issuing standard and guidance for registered professionals.

(as given in CHRE press release notes to editors 13/6/08.)

2. Providing information to potential applicants and registrants

Several regulators stressed the importance of clarity on the purpose of the register and the differences between regulation and standard-setting. Some organisations do blur the functions. It is recognised that there is some confusion over the split between a regulatory body and a professional body.

Regulators also felt that the benefits of being on a voluntary register (and the differences between registers and membership bodies) needed to be stressed, both to potential registrants and to prospective employers.

¹ See Appendix 3 for list of the nine regulators of healthcare professionals

The majority of regulatory bodies make use of websites to provide information to applicants. The extent of information varies, as does the facility to apply on-line. The administrative burden for the register staff is very much reduced when relevant information is readily available on-line and it is easier to ensure that prospective applicants are seeing the most up-to-date information on application procedures or requirements. It is also quicker, cheaper and easier to update on-line documents (such as codes of ethics or good practice standards) than to ensure all registrants receive printed copies every time any changes are made.

3. Entry requirements

3.1. Academic qualifications

For some registers, there are very specific qualifications that allow entry, e.g. specific degrees or Masters courses, for example there is only one Masters course offered in the UK for pharmacists and there are only three accredited degrees for registration with the Royal Environmental Health Institute of Scotland and nine approved qualifications for the General Social Care Council. A restricted number of approved courses makes it far easier to assess the educational standards of applicants but is unlikely to apply to the public health practitioner register, with the diversity of professionals and employing organisations. It could prove helpful when addressing dual registrations or comparability of standards.

Some regulators have strong links with universities that allow them to influence course content or accredit a course. Some accredit only a very small number of courses. Although not feasible for public health with its wide range of potential registrant experience, this could be useful in assessing parity.

For dual registration or conversion, comparisons might include level of degree as mentioned earlier (some organisations use first degree plus training, others expect Masters degrees). Memoranda of Understanding might be appropriate between regulatory organisations (e.g. one being set up between forensic practitioners and vets)

At least one regulator (UK Council for Health Informatics Professions) is looking at becoming a certified accreditor (under the UK Accreditation Service, which accredits organisations that are certifying bodies).

3.2. Training requirements

There are, for some registers, limited approved training opportunities. For example, the Pharmaceutical Society of Northern Ireland requires one year pre-registration vocational training, with tutor appraisal and tutor sign-off of competencies (as well as an examination). As with restricted availability of approved courses, this makes it easier to assess the standard of applicants. For

some registers, there might be limited approved placement positions (localities and/or responsibilities)

3.3. Evidence of relevant experience

Evidence of experience sometimes provided in case studies (portfolio approach). Can vary according to role, for example some roles might involve many case studies over a short time period, others might involve one very long case study.

Some organisations stress the need for up-to-date experience. For example, the Council for the Registration of Forensic Practitioners requires casework relating to the last six months or the last two years, depending on the type of cases, and applicants are not registrable if they have no recent cases. (This type of restriction might be more important for some registers than others, as, for instance, courts recognise the value of recent forensic experience.)

To overcome any problems caused by long absence for family reasons or illness, regulators might require some kind of refresher course before registration.

3.4. Qualifications, training and fitness to practise in different countries

Even within the UK, some broadly comparable registers do require different qualifications or experience, though there seems to be work going on to ensure comparability.

European regulations seriously affect transfer to the UK from other EU countries. The importance of freedom of movement can mean that professionals with lower standards must be allowed to work here. The GMC has three groups of applicants – UK, people with European rights of freedom and the rest (international medical graduates). Similarly, the Health Professions Council has two main routes to registration (UK approved course routes and international) and a third temporary registration route for Europeans working perhaps part-time in the UK).

There are limits to the types of questions that UK registering bodies are allowed to ask Europeans. There is a particular issue over English language competence, as it seems to be impossible to ask Europeans to show proof of language as a requirement of registration, although this is possible for other internationals. Some organisations do not ask for language qualifications but ask whether applicants hold any qualifications in English and, if not, ask how they acquired their language skills. There is then a declaration stating that the applicant confirms their knowledge of language is adequate to work in the UK. It has been suggested that employers can ask for language competence as a prerequisite to employment

There are usually no concerns about basic standards of qualification in other European countries but sometimes the fitness-to-practise standards differ. If a medical professional is said to be in good standing in a European country this appears to have to be accepted in the UK. Where an applicant qualified before the country became part of the EU, they must provide a certificate of conformity from the relevant country or university.

Some registers, such as the UK Council for Health Informatics Professions, are specifically UK registers that judge applicants on whether they are fit to practise in the UK (regardless of where they live or what they currently do). This is easier to do when there are no comparable roles or professional institutions in other countries.

4. Assessors, submission and assessment of applications

Application submission processes differ between registers. Electronic submission is believed to be more cost-effective but is not always possible. For example, it might be possible if applications can be signed off by accredited professionals who know the applicant, so that the submission includes perhaps only details of qualifications and employment, along with signed forms (with some questions arising over the signing of forms related to electronic processes).

Assessment of applications is carried out in various ways. Examples include:

- Electronic checking of electronic submissions (or of limited sections of the application, with automatic generation of follow-up letters)
- Assessment by administrative staff member (usually of limited sections of the application, with subsequent generation of follow-up actions).
- Appropriate register staff or panels.
- Peer assessment, usually by external assessors (for either written submissions or electronic form submissions). The question arises as to whether they should be remunerated. (The Council for the Registration of Forensic Practitioners pays a small fee for each assessment.)

Cost can be a major factor in choosing a method. For example, convening panels or paying external assessors can prove very expensive.

The assessment process can include recommending further work (experience, training or qualifications) before the applicant can be admitted.

Many regulators commented on the need to ensure that good (robust and transparently fair) appeals processes were in place, even more so if the register becomes statutory.

Applications from outside the U.K tend to take considerably longer to process.

5. Levels of registration

The aims of the register will determine some of the categories of registration. Examples include:

- Some have student registration. Where professional training involves a lot of on-the-job training, registration might exist but practice be restricted to working only under the supervision of a fully registered professional. In such situations, legal issues such as responsibility need to be clarified.
- Associate (qualified and capable, but not experienced) and full registration (qualified and proficient) (for example the Nutrition Society).
- Full registration and a temporary registration possibility for professionals from elsewhere in Europe who work some time (e.g. a day per week) in the UK.
- Specialist branches/arms of registration (e.g. the NMC has three levels (nurses, midwives, specialists in community public health) and to get on the third arm a nurse has to be already on one of first two).
- Different levels according to experience/qualifications, e.g. a basic level of registration then additional higher accreditations, for example the UK Council for Health Informatics Professions. This approach could be linked to a career framework.
- Some organisations, for example the Pharmaceutical Society of Northern Ireland, have a practising and a non-practising register, allowing people to have career breaks but remain on. For this to work, there need to be very clear definitions of practising and non-practising and also mechanisms to move people from one register to the other, .e.g. a return-to-practise course (see also section above on relevant experience). CPD requirements might be different for any non-practising registrants.

Advantages of levels such as student level include additional income and increased likelihood of an individual wishing to sign up to full registration when appropriate.

Advantages to having memberships rather than just registrants include income (e.g. retired people who want to keep in touch. It was suggested that if people want to continue to benefit from a title they should be paying for it.

6. Continuing Professional Development (CPD) and revalidation

6.1. Compulsory CPD?

Annual CPD returns are compulsory for some organisations and voluntary for others (though the voluntary system might be linked with more comprehensive revalidation process which relies to certain extent on a record of CPD activity).

The Nursing and Midwifery Council states that registrants must comply with the CPD standards in order to maintain NMC registration. The Nutrition Society has mandatory evidence collection and reflection for their CPD process, which is tied to five-yearly re-registration. The GDC has compulsory CPD for dentists and this is to be extended to dental care professions from 2008. The Health Professions Council sets standards for CPD and all health professionals registered with it must undertake CPD to stay registered. If a Health Professions Council registrant provides false or misleading information in their CPD profile, the HPC would deal

with them under fitness to practise procedures, which could lead them to being struck off the Register and therefore unable to practise. Post registration training and learning (PRTL) is a key condition for continued registration with the General Social Care Council. The solicitors' CPD scheme (Solicitors Regulation Authority) is compulsory and non-compliance could lead to disciplinary procedures and/or to delays in the issue of a practising certificate.

The Chartered Institute of Environmental Health states that members who fail to comply could be in breach of the Code of Professional Conduct. The Pharmaceutical Society of Northern Ireland describes current CPD not as mandatory but as a professional requirement and the society has no power to remove a registrant who does not comply. The Royal Pharmaceutical Society of Great Britain is changing to mandatory CPD in autumn 2008.

GMC's 'Good Medical Practice' includes expectation that registrants keep their working knowledge and skills up to date throughout their working life and, in particular, take part regularly in educational activities which maintain and further develop their competence and performance..

If a registrant with the Royal College of Veterinary Surgeons fails to do CPD, in theory they could be brought up on disciplinary matters but the RCVS would only hear about it if there were some other complaint lodged.

Where there are strong links with academic training, competencies can be signed off and linked to CPD routines.

6.2. Revalidation and renewal

Regulators had mixed feelings on revalidation, with some very strongly stating that it was not a good idea! Disadvantages mentioned were that it can be expensive and very time-consuming. However, some feel it is something the public understand and want. CPD would be one component but might not always reflect registrants' true needs, e.g. being up-to-date in all areas of practice. There are also concerns that where there are no time limits on certification, someone (e.g. a locum) could practise with very out-of-date registration.

The Council for the Registration of Forensic Practitioners grants registration for four years at a time. Practitioners must then prove they are still fit to practise. Each year coming up to the four year revalidation, registrants renew their registration and are asked to submit a form recording their professional activity. The registration is revalidated every four years, the process being based on an assessment of recent casework.

The General Dental Council is looking at a three stage approach, including a portfolio after five years, peer review within the practice and further assessment if the earlier stages do not provide sufficient evidence.

A professional body, rather than a regulatory body, could be the mechanism by which a professional obtains revalidation.

6.3. Assessment of CPD

There is a very wide variation in approach to assessing or confirming CPD, for example:

- One register staff member looked at all 200 returns this year, considering all aspects and sometimes returning comments suggesting that registrant had done the same course two years running and querying the additional benefit of repeating the course.
- Some schemes require submission of evidence with returns. Others only ask for evidence in an audit. For example, the Faculty of Public Health (FPH) requires members to work out the points claimed and submit that number, then FPH audits a sample. The Health Professions Council uses a two-yearly random sample audit process, linked to registration periods. The Nursing and Midwifery Council also uses a sample audit.
- Some organisations, for instance the Council for the Registration of Forensic Practitioners, do not check returns until revalidation time, when they can check three years worth of CPD forms. Other schemes use a cycle approach, assessing registrants every so many years (e.g. five years. This might entail considering their CPD for the whole cycle period.)

The Royal Environmental Health Institute of Scotland (REHIS) specifically recognises the need to provide resources for CPD assessment, stating in its regulations that it shall ensure that sufficient staff are employed to administer the scheme of CPD.

If external assessors are used, payment for their time might have to be considered.

6.4. Approved CPD activity

Most schemes use a minimum number of hours of activity.

Some schemes specify types of activity, e.g. formal (e.g. externally validated) training, private reading etc. At least one does not currently accept private reading although it is reconsidering approved activities. The FPH, the REHIS and many others do accept private reading.

Other regulators, for example REHIS, state that there needs to be a certain proportion/number of hours of core competence activity and the rest can be supplementary areas. Core activities for REHIS include public health, food safety and other specific activities, whilst their supplementary activities include activities which broaden the skill base of the scheme participant in areas which indirectly relate to environmental health, such as information technology, financial management and general management. The GDC is using a five-year cycle with 4 domains for the standards (professional, management and leadership, clinical and communication), with a recommended set of core activities. The general feeling amongst regulators seems to be that for public health, both health and management-type activities are essential.

HPC does not have hours or points requirements for CPD (because it would be difficult for a lone practitioner working only two days a week) but has 5 standards

for CPD (very briefly: keep a record of CPD activities; demonstrate activities are relevant; ensure CPD contributes to quality of service; ensure benefits service user; present written profile on request).

There is a general move away from giving certificates for certain activity (stemming from the awareness that this could just be a certificate of attendance).

Regulators support schemes that can link with appraisal systems where possible. For example, for those with NHS roles it was suggested that they should be able to link CPD with appraisal system and skills frameworks.

6.5. Content of CPD returns

Some organisations require only a return specifying the number of hours completed (but registrants have to be prepared to produce evidence if asked). Others ask for more detail or for case studies to be submitted.

There is increasingly a greater focus on the lessons learned (or reflection, though this seems not to be a well-liked term). The Nutrition Society has produced a useful short guide to reflective practice.²

Some schemes require submission of personal development plan. The UK Council for Health Informatics Professions requires an annual renewal of registration, accompanied by both a CPD return and a CPD plan for the coming year. (The process asks the registrant to identify up to five areas where they intend to undertake activities and even if they actually do none of it but do other CPD it will not stop their registration as it is the cycle and reflection that are important).

6.6. Support mechanisms for CPD

For NHS staff, there might be funding available through existing schemes or through the Public Health Teaching Networks or Deaneries. There remain issues over non NHS public health staff.

6.7. Further information

Websites addresses for the various regulators and related organisations appear in Appendix 2 and 3.

7. Fitness to practise

Well-defined fitness-to-practise rules allow questioning of competence and, for statutory bodies, further investigation and potential action. There are difficulties in some professions in defining ‘practice/practise’. If public health regulation becomes statutory, legislation will have to be worded in such a way as to either define what public health practice/registrant is (similar to law regarding dentists) or to restrict

² A Guide to Reflective Practice. The Nutrition Society. www.nutritionociety.org

activities that can only be carried out by those on the register (the Medicines Act defines a list of privileges/activities that only those who are licensed can undertake).

Fitness-to-practise is sometimes the only way to remove someone from the register (see below).

8. Removal from register

8.1. *Reasons*

Regulators agreed that there needed to be clarity from the outset as to what constitutes acceptable behaviour and what does not, so that processes for removal (and subsequent actions) are understood and signed up to.

Reasons for removal might include financial misconduct and fraud, as well as ethical issues involving patients or clients. Sometimes the fitness-to-practise conditions are the only way to remove a registrant from the register (apart from death or voluntary self-removal).

It was suggested that it was well worth considering where complaints might arise against public health registrants. The source of complaints varies across organisations. For example, for the HPC most fitness-to-practise complaints are from employers. Other organisations might receive more complaints from the public.

Not all organisations have experienced problems with registrants acting against the code of conduct, so their processes might have never been challenged (if they were even developed in the first place).

Non-compliance with CPD requirements is generally not a prime cause for removal from a register, although it can be covered by clauses about keeping up-to-date in the fitness to practise rules (e.g. CIEH and HPC as mentioned earlier). The GDC has a legal ability to remove registrants for non-compliance with CPD requirements and other organisations are also looking to a legislative toolkit to allow removal of registrants from the register.

8.2. *Legal issues*

There are legal issues around notifying other organisations about a registrant being removed from the register. Some organisations can publish certain details, including reason for removal (notable exception being medical reasons). Some can append notes to the register if a registrant is under temporary suspension order.

Confidentiality problems have, in a few cases, become more complex with electronic registers. For example, GMC doctors objected to their addresses being included in an electronic (accessible) register though this was standard practice for the original written register.

At least one organisation has a section in its application form where applicants sign to agree to certain register fields being shown on the public part of the register.

8.3. Register maintenance

Electronic registers can have different levels of access, e.g. access by the public, access by prospective employers and access by register staff.

Regulators feel that the names of removed persons should be left on some form of the register (or related database) to show that they have been removed (including those that have retired or died, etc). Some registers only show current entitled-to-practise registrants but potential employers can make enquiries of the registration body.

8.4. Case consideration

Processes need to be in place to address any complaints that might lead to removal. Some regulators make use of panels with peers and lay members.

Fairness and transparency are vital, for example it was suggested that appeals panels should be totally separate from the original panel that recommended removal. It might be worth ensuring that an appeals panel contains at least one well-known reputable name

The HPC puts details of fitness-to-practise cases on its website four weeks before the final hearing.

Some organisations use a stepped approach to complaints, e.g.: firstly, checking whether it has any verity/ is there a potential case; secondly, case examination, including written evidence to decide if it is an arguable case; thirdly, a committee to decide if it is realistic, taking statements etc; finally an inquiry. The first stage alone can screen out a large proportion of complaints. The number of cases actually reaching the final inquiry stage can be very small, for example only 1% of complaints to the Royal College of Veterinary Surgeons reach inquiry.

Conduct hearings can prove extremely costly. Most will relate to civil standards rather than to criminal prosecution. Negligence tends to be a civil court issue whilst regulators might have to deal with it under an element of unsatisfactory performance. In-house legal teams for fitness-to-practise work might be cost-effective (as used, for example, by the NMC).

Delays in dealing with cases was one of the criticisms levelled at the NMC in the Council for Healthcare Regulatory Excellence's Special Report to the Minister of State for Health Services (March 2008). A related criticism was the absence of an IT-based case management system.

8.5. Alternatives to removal from register

Registrants can have conditions imposed on them if their transgressions are not serious enough to warrant removal from the register. These might include essential retraining in certain areas or restrictions on fields of expertise where they are allowed to practise. Other options include suspension or reprimand.

Decisions need to be taken as to how much of this information might appear on a public version of the register.

9. Resourcing the register

9.1. Finance

There will be a minimum income from fees necessary to fund administrative support for the register and registrants.

9.2. Staffing

There is huge variation in the regulatory staff size of the regulatory bodies, ranging from 2-3 to over 100.

A minimum number of staff will be required simply to deal with administrative issues and basic queries, etc.

The application assessment process and any assessment of CPD or revalidation will heavily influence the overall staff numbers needed. (See *assessors and assessment* section above).

Good website management is essential, possibly with an early heavy investment in a good system development followed by use of appropriately qualified/experienced website and/or database managers. As one interviewee said: *'You can run it with one woman and a dog because we have automated as much as possible.'* One electronic process generates sponsor forms, referee reports and assessor request automatically, as well as sets of reminders to registrants when it is coming up to annual re-registration time.

10. Competence-free registration

In general, competence-free registration was not well-regarded and was considered inappropriate for some, e.g. doctors or pharmacists, certainly if one is considering that the register is a register of people *currently* fit to practise unsupervised. However, some of the different levels of registration used in some organisations, such as student or training registrations, might fall into this category (described earlier).

11. Statutory regulation

Regulators commented that obtaining statutory regulation would address many problems, such as: the scale of the organisation; the ability to draw in funds; greater degree of public protection; greater recognition amongst other professionals and possibly the public.

However there were also recognised problems, including: the length of time it could take; the variety of public health jobs and employers; arguments over whether employers should contribute to fees.

In future, health care regulation will come under the Health Professions Council (HPC guidance for occupations considering applying for regulation by the HPC is available on the HPC website³). However, with potentially many registrants from outside the health sector, the appropriateness/desirability of this would have to be considered. It is worth noting that some groups under the HPC do have many registrants in the private sector (e.g. physiotherapists). Also the Department of Health criteria for statutory regulation include the uniqueness of a profession and whether people are already regulated, with a preference for those who are not already regulated.

12. Public/patient involvement

Public/patient involvement is not too much in evidence. Some regulators have no plans for this, others have representation on committees and plan to extend. NHS organisations tend to be increasing public/patient involvement but other organisations might not have pressure to do so. This might need considering when looking at dual registrations

Jean Brown
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October 2008

³ www.hpc-uk.org

Appendix 1: informants

Organisation	Name
Chartered Institute of Environmental Health	Gary Telfer
Council for the Registration of Forensic Practitioners	Kate Horne
Faculty of Public Health	Di Roffe
General Dental Council	Ewen Macleod
	Amanda Little
General Medical Council	Ian Renfrew
	Neil Roberts
General Social Care Council	Rodney Brooke
Health Professions Council	Charlotte Urwin
Nursing and Midwifery Council	Marianne Cowpe
Nutrition Society	Jackie Landman
Pharmaceutical Society of Northern Ireland	Brendan Kerr
Royal College of Veterinary Surgeons	Gordon Hockey
	Christine Frazer
Royal Environmental Health Institute of Scotland	Kevin Freeman
UK Council for Health Informatics Professions	Di Bullman
UK Public Health Register	Sarah North
	Lillian Somervaille

Appendix 2: related websites

Chartered Institute of Environmental Health www.cieh.org
Council for the Registration of Forensic Practitioners <http://www.crfp.org.uk>
College of Pharmacy Practice www.collpharm.org.uk
Complementary and Natural Healthcare Council <http://www.fih.org.uk>
Faculty of Public Health <http://www.fphm.org.uk>
General Chiropractic Council <http://www.gcc-uk.org>
General Dental Council <http://www.gdc-uk.org>
General Medical Council www.gmc-uk.org
General Optical Council <http://www.optical.org>
General Osteopathic Council <http://www.osteopathy.org.uk>
General Social Care Council www.gsccl.org.uk
Health Professions Council www.hpc-uk.org
Nursing and Midwifery Council www.nmc-uk.org
Nutrition Society www.nutrition-society.org
Pharmaceutical Society of Northern Ireland www.psn.org.uk
Royal College of Veterinary Surgeons www.rcvs.org.uk
Royal Environmental Health Institute of Scotland www.rehis.org
Royal Pharmaceutical Society of Great Britain <http://www.rpsgb.org>
Solicitors Regulation Authority <http://www.sra.org.uk>
UK Council for Health Informatics Professions www.ukchip.org

Appendix 3: regulatory bodies of healthcare professionals

General Chiropractic Council (GCC) – regulates chiropractors.

General Dental Council (GDC) – regulates dentists, dental hygienists and dental therapists.

General Medical Council (GMC) – regulates doctors.

General Optical Council (GOC) – regulates dispensing opticians and optometrists.

General Osteopathic Council (GOsC) – regulates osteopaths.

Health Professions Council (HPC) – regulates arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists/orthotists, radiographers, speech and language therapists.

Nursing and Midwifery Council (NMC) – regulates nurses, midwives and specialist community public health nurses.

Royal Pharmaceutical Society of Great Britain (RPSGB) – regulates pharmacists.

Pharmaceutical Society of Northern Ireland (PSNI) – regulates pharmacists.