

# **Developing a regulatory pathway for public health practitioners**

**Report to UK Public Health Register Board**

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## Summary

This report summarises the progress to date in developing a regulatory pathway for public health practitioners and presents the results of the consultation on the draft standards for regulation and the proposals for a devolved assessment process.

The consultation has gained considerable interest from the field with over 50 electronic responses from individuals, groups and organisations, and over 200 individuals attending consultation events. The need to invest in the development of the practitioners to achieve a properly trained, effective and professional public health workforce has been stressed.

*‘There are a large number of public health workers who feel somewhat adrift in that they have no professional allegiance, no professional recognition, no career structure, nothing to aim for professionally – but we expect them to do a very professional job.’  
(from ADsPH response to consultation 2009)*

## **Background**

While the focus of UKPHR regulation has been at the specialist end of the spectrum, both for Generalists and Defined Specialists, the UKPHR Board has always recognised the importance of the practitioner workforce in delivering the public health agenda. Much of this workforce remains unregulated, was without a public health competency and assessment framework, and continues to be underdeveloped and underutilised in the delivery of public health goals and national targets.

The development of the Public Health Skills and Career framework in 2006 through the Sector Skills Council and the Public Health Resource Unit, and widely endorsed across the 4 UK countries, provides the concept of a single career framework for the whole public health workforce, from entry to Board level. Regulation has always been recognised as one of the key elements in the delivery of the PHSCF.

Potential outcomes identified from the successful collaboration to achieve delivery of the PHSCF include:

- A properly trained, accredited and, where appropriate, regulated workforce
- Practitioners recognised and valued for the work they could do, and more effectively deployed
- Employers / commissioners assured of competent public health delivery
- Career pathways identified attracting high calibre staff in the future
- Mobility facilitated within and across sectors responsible for delivery of public health goals
- Clearer focus for employer-led Personal Development Plans (pdps), CPD programmes, HEI developments and targeting of educational funds.

## **Public Health Practitioner regulation – implementation of a common framework**

The feasibility of developing a UK wide regulatory framework for public health practitioners has been already undertaken. This involved:

- A mapping of the existing regulatory landscape for public health practitioners
- Exploration of the benefits, feasibility and acceptability of having a common regulatory framework. This work was integrated into the work on the PHSCF which includes a regulatory dimension.
- Exploration of appropriate regulatory 'levels' for public health practitioners - reaching a consensus for PHSCF level 5 (practitioner) and 7(advanced practitioner)

We are very grateful for the close co-operation that developed with the many bodies involved in public health practitioner training, accreditation and regulation. Sufficient positive engagement has been achieved for the UKPHR Board to make a commitment with respect to the delivery of

this work and to highlight the need to develop a detailed implementation plan. This formed the basis of the UKPHR bid for 2007/08 to the 4 country health departments.

The UKPHR has developed three routes to the register for public health specialists (dual registration, registration via prospective training, registration via retrospective assessment), and it was envisaged that regulatory routes for practitioners would follow a similar structure. Therefore the implementation phase has included three elements:

- Working with other practitioner regulatory bodies – to learn from their developments and identify potential for dual/ flexible registration. This work resulted in a detailed report which has already been presented to the Board in October 2008.
- Working with FPH Practitioner Committee to ensure retrospective and prospective approaches are as coherent as is possible.
- Development of, and consultation, on standards for regulation and processes for retrospective assessment for those practitioners currently unregulated – the focus of this report.

### **Development of the standards for registration**

The standards for registration at both practitioner and advanced practitioner level were drawn directly from the PHSCF. However to develop standards for registration some interpretation was necessary – both to encompass statements at prior levels and to incorporate statements of knowledge and competence across the defined areas of practice within the PHSCF. It has been necessary therefore to conduct extensive consultation around this process.

### **INITIAL CONSULTATION**

The first consultation phase took place during the spring and summer of 2008 and aimed to:

- check the ‘understandability’ of the standards
- check the applicability of the standards to different individuals’ work.

This consultation tested two models of the standards at two levels – a ‘generic’ model that would apply to all practitioners (i.e. all components would be mandatory for any practitioner applying) and an essential plus additional model (which had some essential components that all practitioners would have to achieve and then a number of other statements which they could choose the most appropriate to their own work). These were tested at both Practitioner and Advanced Practitioner levels. A wide variety of practitioners from the NHS, local authorities and voluntary sectors and across all four countries were involved in a substantial number of interactive events.

Generally the statements within the standards were well accepted and were broadly seen to reflect public health at the different levels. A number of detailed points were made to improve general understanding and clarity as well as a number of gaps identified.

In terms of the different approaches the generic model was generally found to be more manageable and easy to understand. It was felt that it was more likely to lead to an integrated public health function and less likely to lead to discrimination within public health. It was more suited to those individuals who did not work in a set discipline and who had come into public health from a varied background or through various routes. Specifically the generic standards were felt to better support the protection of the public as it would be clear as to the standards that individuals needed to achieve to get onto and stay on the register.

Some issues did remain however, particularly with communities such as the health intelligence, some of whom felt they might be challenged to meet the generic standards in full. It was felt that if the format of the standards could be improved and examples given on how standards might be met in different settings this would be helpful.

A report from the initial piloting phase was presented to the UKPHR Board and the Board supported the recommendation to proceed with the generic model into the next phase of consultation.

## **SECOND CONSULTATION PHASE**

The second round of consultations consequently included the revised generic standards at practitioner level, modified and amended in the light of comments received. The Advanced Practitioner level was placed on hold to await the outcomes of a national project being undertaken as part of the Regulation White Paper to define an Advanced Level of Practice across all health professions. This is still due to report.

This consultation round took place between autumn 2008 and spring 2009 (the final formal consultation event took place on 20 April 2009). This consultation included an invitation to comment on:

- the revised standards for practitioners
- the Code of Practice currently used by the UKPHR
- proposals for the devolved assessment process,

and an opportunity to identify and discuss the potential risks that incompetent practitioners or unethical practice might pose to individuals, groups, communities and populations.

Electronic responses were encouraged and a total of 51 were received from individuals, professional groups, committees and organizations. A list of contributors is provided in APPENDIX A.

In addition a number of specific consultation events have been held across the 4 countries. Details of these events, together with an indicative number of attendees, are provided in APPENDIX B. In brief these have involved:

- national events aimed at raising awareness and attracting the interest of a range of different practitioners and their managers
- events with specific health communities (public health intelligence, health protection, local government, smoking cessation, oral health promotion, sexual health advisers, local government sector and the voluntary sector ( events scheduled for June & Sept 2009))
- targeted events (employer – NPHS; quality assurance and control – UKPHR Assessors, led by UKPHR Moderator; regulators).

Over 200 individuals have attended these events.

It is worth stating that the extensive nature of this consultation could not have been achieved under the budget allocation, without the support of many of the stakeholder groups. In addition the numbers of participants at many of the events meant that extra facilitators were locally provided, as was additional co-ordination. We are very grateful for all this support.

### **To regulate or not to regulate?**

Although this question was not specifically asked in this round of consultations views were expressed. The majority of responses welcomed both the consultation and the work toward registration of practitioners, some with '*considerable enthusiasm*' and some regarding it as '*essential*' particularly in terms of enhancing the professional profile of public health. Some felt it was a useful basis for driving standards of practice forwards in the future.

However not everyone felt that regulation was needed. One response queried the wisdom of diverting limited resources to

*'...developing self regulation....when there is no evidence base to suggest existing NHS employment arrangements for public health practitioners present any significant risk to the public health'*

In others initial scepticism mellowed with discussion, leaving concerns but general support.

*'Many .....were initially highly sceptical about registration ...further discussion revealed that this was largely around the process and unintended consequences ...and a desire to avoid bureaucracy where possible. It is not a lack of support for the inclusion of practitioners in a robust professional framework.'*

Many responses included concerns about the need for employers and commissioners of services to be signed up to the benefits of regulation for the development to succeed. The voluntary nature of registration was seen as a drawback with only the better employers taking it up unless there is central guidance or national government steer on the importance of registration. Local champions will be important to ensure success.

Several responses noted that if registration was introduced as an employment requirement it would have to be done over a realistic time period or recruitment and retention could be seriously damaged. As with specialist posts job descriptions would need to specify that individuals were working toward registration.

It will need to be made very clear that registration does not by itself lead to increase in pay or pay-banding. Some felt though that the introduction of a registration process would result in additional costs, both to the HR function and in enabling practitioners to achieve registration. There were concerns expressed about where this additional funding would come from particularly at this time of financial constraint.

There was also concern raised that regulation might impede flexibility of staff moving into and out of public health, Public health regulation must not deter staff from other professional regulatory backgrounds entering the public health workforce.

Many consultation participants were already regulated through bodies such as the NMC, CIEH, REHIS, the Nutrition Society etc. and these bodies would want to assurance that this development was not seen as 'poaching' from other regulators.

Dual recognition would, however, be welcomed and there was an identified need for early clarity around dual recognition/ registration, how that might work and what the costs might be. Groups such as Oral Health Improvement and Sexual Health Advisers expressed a wish to hold initial registration through a public health body such as the UKPHR but would want links to be developed with the other regulators as soon as possible.

Despite these concerns, there was considerable support for regulation expressed through numerous responses, which identified regulation of practitioners as a valuable opportunity not just for those in the NHS and local government sectors, but also in the community and voluntary sector.

*'We look forward to the finalisation of the standards and processes for the regulation of practitioners, and are hopeful this will lead to the improved recruitment, retention, recognition and professionalisation of the public health practitioner workforce.'*

## **Public Health Practitioners and the risks they pose**

**UKPHR questions:** Consultation participants were asked to identify risks posed to individuals, groups, communities and populations by incompetent individuals or unethical practice. This not only provides a view from the field of the potential for harm this workforce poses, but also helped participants think about the purposes of regulation in terms of public safety as well as professional development. Participants were then asked if the risks they identified were currently addressed sufficiently without regulation.

**Response:** Although public health practitioners work in many diverse areas, from the population perspective of the information analyst to the clinical roles within health protection, responses identified many risks that were in common. These were particularly associated with incompetent practice leading to the provision of ineffective services and interventions, or in the worst case services and interventions that lead to harm.

- The provision of incorrect information or advice leading to the incorrect action being taken

- Failure to detect or to act on a problem early enough to prevent harm (*eg not spotting link between E coli O157 cases, until larger outbreak evident*). This can be at the individual, community or population level.
- Interventions may be given unnecessarily which, while incurring unnecessary costs can also lead to physical harm to individuals and disruption to communities.
- Interventions poorly planned and implemented leading to ineffective delivery and a potential to increase health inequalities (*eg. smoking cessation services failing to meet targets in deprived areas*)
- Inaccurate or inappropriate information being used as the basis of service commissioning decisions leading to inappropriately commissioned services.
- Lack of 'joined up thinking' across sectors leading to lack of sustainable development (*eg. Community workers not aligned with local public health departments*)

Incompetent and out of date practice was seen as important in terms of public confidence in services, in practitioners, and in public health itself. Policies may not be correctly implemented, inconsistent messages can be given to the public and to other professions and organisations, and community relationships can be disrupted.

Personal behaviour was felt to be important, particularly where practitioners meet with vulnerable individuals or interact directly with communities, and where inappropriate delivery styles or approaches lead to ineffective service delivery. Particular issues were identified around the importance of recognising an individual's rights and right to consent to intervention, taking proper account of their views and their culture, ensuring practitioners own beliefs are not allowed to conflict with practice and that personal opinions are not expressed.

A personal ethical framework was felt to be important for all public health practitioners to ensure

- a proper recognition of the limit of their practice
- maintaining professional integrity when trying to meet targets
- ensuring that resources are not misused for personal agendas.

Public Health practitioners should take professional responsibility for their role.

The role of regulation in minimising these risks was appreciated in most responses, although it was noted that regulation could not guarantee ethical standards of behaviour.

In well run organisations many of the risks identified may be addressed by organisational governance processes, (*eg selection processes at interview, appraisals, good management systems*), In less well-run organisations or where the public health skill base is very limited regulation would become more important. This was identified as a particular issue in the growing voluntary and multi-agency sectors, and as the workforce becomes increasingly mobile.

*'...registration would provide explicit assurance for the public and a sense of professionalism for the practitioner'*

## **Standards for regulation for public health practitioners**

### **Defining a public health practitioner**

**UKPHR proposal:** to use the definition of public health practitioner developed through the PHSCF.

**Response:** The layout of the consultation document was not sufficiently clear in this area and some responses indicated confusion as to what was being asked.

There was some disagreement from the assertion that practitioners 'generally.....work as part of a larger team led by someone working at a higher level' . It was pointed out that many practitioners spend much of their time working independently and may find that their direct line management is undertaken by staff who are not specialists in the practitioners' area of practice.

The term 'practitioner' itself was not welcomed by all and was indeed seen as confusing by some. In Scotland the term 'practitioner' would be unhelpful as it would blur existing roles, and a number of Information Specialists felt that the term 'practitioner' had clinical connotations that they felt excluded from.

**Next steps:** It will be important to achieve clarity about who will be eligible to apply for registration at the practitioner level.

### **Draft Standards for registration**

**UKPHR question:** The consultation asked if the draft standards for regulation were appropriate to the area of public health practice familiar to the respondents, and were they then sufficient to use in the context of public protection.

**Response:** Multiple respondents agreed that the standards were appropriate and relevant to their area of work and were sufficient to address risks, particularly in conjunction with the Code of Practice.

However a small number of responses from diverse areas including health promotion and information, felt the draft standards were not specific enough to their area of practice to provide public protection and one response in particular felt that

*'...information and intelligence staff require a dedicated set of defined standards which are likely to be different from other disciplines'*

- although this view was by no means universally held by other information and intelligence groups and individuals commenting in this area.

The fact that practitioners may be working across a diverse range of areas, focusing on populations, communities, groups or individuals became less of a problem when examples of how the standards might be met were provided in a relevant area of work. This highlights the

need to provide as exhaustive a set of examples as is possible in terms of background to the standards together with coherent guidance to registration.

As well as many helpful detailed comments on the draft standards, some respondents identified particular areas they believed could be strengthened:

- the contribution to the recording of data and information, its maintenance and use particularly in identifying trends in health and well being
- contribution to public protection through the appropriate sharing of data and information
- role in reducing inequalities as an advocate or in enhancing own practice
- role as change agents and the influence on others that this requires
- greater emphasis on working with others, working with communities, communication and building relationships
- additional standards to reflect changing roles (eg commissioning, procurement, budget management)
- greater emphasis on awareness of own competence and knowing professional limitations.

**Next steps:** A number of examples of how practitioners might provide evidence against the draft standards have already been collected across a wide variety of settings, as part of this consultation phase. These examples will be collated and checked with experienced Register Assessors to be released alongside guidance for applicants and assessors.

The considerable constructive feedback indicated above will need to be incorporated into the standards, together with the more detailed comments received, before a final set of standards can be produced and submitted to the UKPHR Board.

It will be important to engage specifically with groups and individuals who expressed strong concerns during this consultation process.

## **Building from the PHSCF**

**UKPHR question:** As the PHSCF has been the building block of the regulatory framework, respondents were asked if they knew of it.

**Response:** The majority of respondents were familiar with the PHSCF but some had only heard of it and had no particular knowledge of it.

The PHSCF itself received several comments including queries over its relationship to KSF and AfC banding, but it was generally viewed as a helpful tool for workforce development although as with regulation, risks were identified around the potential to reduce flexibility and mobility.

Links between the PHSCF and the draft regulatory standards caused some confusion. The draft regulatory standards have been derived and adapted from the PHSCF and further refined following the initial consultation round in 2008.

A small number of respondents wanted to see exact replication of the PHSCF in the draft standards for regulation, whilst the majority commenting in this area understood the need for adaptation but felt the PHSCF should be more recognisable in the standards. This was particularly emphasised by the number of people confused over the nature of the 'generic' standards, thinking that they were solely drawn from the core areas of the PHSCF.

The knowledge statements that begin the framework were also found to be confusing and the fact that they did not apparently relate to any competence statements was thought to be insufficient. There was also some concern expressed that the draft regulatory standards may have been pitched at too high a level in some instances.

**Next steps:** the draft standards for regulation will be reviewed in terms of consistency with the PHSCF and in terms of layout to improve clarity in this area without reducing accessibility.

### **Regulation of Advanced practitioners**

**UKPHR proposals:** The Register has recognised the importance of putting this development into the context of the developments stemming from the Regulation White paper Trust, Assurance and Safety. A strand of this work, to define what is meant by Advanced Level of Practice across all health professions, is still due to report. Development of the definition of, and regulatory standards for, public health advanced practitioners will be informed by this report.

**Response:** Despite the national context, the need to develop standards and a regulatory route for advanced practitioners as a matter of urgency, was emphasised in a number of responses. Indeed in some it was felt that the UKPHR should have consulted on standards for Advanced Practitioners before practitioners.

Several responses highlighted the need for a clear pathway from registration at practitioner level to registration at advanced practitioner and then specialist level to facilitate career development.

**Next steps:** Draft standards for regulation of Advanced Practitioners have already been developed alongside the practitioner standards that have been consulted on. It will be necessary to finalise these standards for advanced practice to the same time frame as the practitioner standards, taking on board the findings from the national work as much as is possible.

### **Maintaining registration and CPD**

**UKPHR proposals:** the setting of standards for individuals to stay on the register once admitted is recognised by the UKPHR as an essential part of this development. This would primarily be through individuals undertaking appropriate CPD (with the caveat that there are discussions elsewhere about the introduction of some form of revalidation), and payment of a retention fee.

**Response:** Maintenance of competence was recognised by many as a very important part of regulation and the requirements to maintain registration (eg CPD/ revalidation) should be clarified at an early stage.

Questions were raised about FPH membership in relation to registration and whether it would be possible to develop similar on-line CPD facilities through the FPH as is provided for the specialist workforce. Linkages through to FPH committees was identified as important.

Concerns about the level of registration and retention fees for practitioners were raised in many responses. Although these should be kept as low as possible it was recognised that they should be reasonable in order for the Register to be sustainable, and in order to re-affirm the importance of registration to the profession.

**Next steps:** Agreement will need to be reached on CPD/ revalidation requirements well in advance of launch and the Register will work closely with the FPH as well as other professional and standard setting bodies to achieve this. Comments about fee structure will be taken on board in all business planning decisions.

### **Prospective training and accreditation**

**UKPHR proposes:** The Board is committed to develop the same range of routes to the register for practitioners as there are for specialists: retrospective route, prospective route and dual routes. The balance between retrospective and prospective routes will shift as time goes on.

**Response:** As regulation grows there will need to be support mechanisms developed for learning, both for maintaining competence and for prospective accreditation and registration.

Many responses identified that developing this should be a high priority but were concerned as to where the funding would come from to support accreditation. In terms of sustainability it will be essential to harmonise the standards for regulation with other frameworks such as the KSF and the NOS that currently exist.

In one response a 3-4 year prospective training route was suggested which would combine education, qualifications and learning in practice.

**Next steps:** the Register is already working closely with the FPH practitioner committee to ensure that processes developed for retrospective assessment and prospective accreditation are in line. This work will continue. Mapping of the standards for regulation against specific public health NOS (eg in health protection) will be carried out.

### **Code of good public health practice**

**UKPHR proposes:** The register currently uses as its Code of Practice, *Good Public Health Practice*, which was based on *Good Medical Practice* and drafted by the FPH. *Good Medical*

*Practice* was revised by the GMC and came into effect on 13 November 2006; the FPH is in the process of re-drafting Good Public Health Practice accordingly. It was therefore felt opportune to use the consultation to discover if there were particular issues with Good Public Health Practice that that would need to be addressed for practitioners, and to gather views from the field on the Code of Practice itself.

**Responses:** A number of detailed comments on the code were provided. In general terms the Code of Practice was enthusiastically welcomed by practitioners. Many of the negative comments related to the occasional medical term (*eg patient, treatment*) that appeared, and to the use of the 10 key areas of public health practice which are now outdated.

The length and complexity of the document was raised as a concern in many responses. This , many felt, would mean the document would not be regularly referred to. Others felt it needed to be detailed to be fit for purpose. A possible solution might be to issue a 'compact summary' alongside the main document for easy reference. This would be consistent with the revised version of Good Medical Practice.

Generally the Code was felt to be relevant to practitioners with only slight amendments in wording to indicate that not all practitioners, for example, carry out research and teaching duties. However there were some areas where respondents felt that the Code could be strengthened.

- The Code needs an opening statement confirming the ethical values and principles of public health
- A section is needed specifically to address working with communities and with the third sector.
- Strengthen areas relating to equality and diversity
- Reducing health inequalities and protecting the most vulnerable should be emphasised
- Areas covering working in partnership need expanding particularly with relation to accountability and trust
- Knowledge of your own professional limitations/ boundaries and the need not to express a personal opinion need strengthening
- Perceived gaps around data confidentiality, informed consent, need to keep accurate records and provide evidence when required to regulators
- Where the Code talks of receiving 'gifts of significant value' this was not felt to be strong enough or sufficient
- Greater clarity as to whom to report to if issues arise (*eg if line manager has delegated tasks to practitioners beyond their ability*).

**Next steps:** comments relating to the Code of Practice will be forwarded to the FPH and to the UKPHR Registrar, Fiona Sim, who will be leading the development of revalidation on behalf of the UKPHR Board.

## Devolved Assessment Process

### Overview

A centralised assessment process is considered to be unsustainable for extending regulation to public health practitioners, so the approach needs to be devolved, albeit with central support. A number of important issues concerning the proposed devolved assessment process were identified in the early stages of the consultation, in the light of which the UKPHR issued the paper “Further Consultation on Assessment Process” in February 2009, which developed the thinking further. This section is based on the UKPHR proposals made in that paper and the views expressed in response to them (see overview flow chart in Appendix D).

Only one response said that the UKPHR should carry out all assessments itself as with the Specialist assessment process. All other responding individuals, groups and organisations supported the proposed devolved process in principle, albeit with concerns or caveats which are discussed below. A large number of helpful and positive suggestions were made, which are summarised in what follows.

The importance of continuing communication was stressed and many suggestions made, including using public health networks and community health partnerships, running local workshops and roadshows, providing leaflets, FAQs, a helpdesk.

### Principles

**UKPHR proposals:** The “Further Consultation” paper stressed that the process by which individuals are assessed for admission to the UKPHR must be robust, consistent, proportionate, transparent, developmental for the applicant and embedded in the existing infrastructure for continuing professional development, so that the system is sustainable into the future.

**Response:** In agreeing with these principles, respondents stated that they want an assessment process that:

- Is consistent but flexible, allowing for workforce mobility and differences in culture between different sectors
- Is facilitative, supportive and practical
- Is relatively “light”, proportionate in its complexity to the benefits, but nevertheless contains independent verification
- Creates a pathway from practitioners to advanced practitioners to specialists
- Offers plenty of guidance from the outset
- Engages with employers and is workplace-based as far as possible, whilst also engaging with networks across and between sectors
- Provides equity of access – well-managed environments with a stable workforce and strong infrastructure may provide more opportunities and support, disadvantaging those on short-term contracts or in small organisations

**Next steps:** These important points can be incorporated into the next stages of work ensuring that further consideration is given to how to promote equity of access for applicants.

## **Piloting and testing the assessment process and methods**

**UKPHR proposals:** It is essential to test the process for assessment before applying it more widely.

**Response:** There was strong support for piloting and testing the assessment process, with the engagement of employers. In so doing, respondents suggested other models from which the UKPHR might learn, for example:

- The NVQ process
- Provisional registration automatically open to all in level 5 posts, with full registration achieved later following assessment
- The GMS route of working in “Approved Practice Settings”
- Learning contracts for PhD supervision
- Practice teaching models in social work
- Some assessment should be undertaken by observation (e.g. of influencing and negotiating skills) as well as by gathering written evidence

Some issues were identified specific to occupational groups, for example stop smoking practitioners.

**Next steps:** Piloting and testing need to reflect the key concerns raised by respondents to consultation, and to consider different assessment methods; (see APPENDIX C: Programme Plan).

## **Assessor capacity and requirements**

**UKPHR proposals:** The practitioner will identify an individual to act as their Assessor. The assessor need not be a registered public health professional, but must meet the Assessor role specification laid out by the UKPHR and have successfully undertaken the required training.

**Response:** There was considerable concern about available capacity for assessment (and verification – see below). The public health specialist resource is stretched, but to have credibility the assessment process needs their input. Specialists and indeed other senior staff may line manage large teams of staff at practitioner level. It was important to avoid a bottleneck of applications due to shortage of Assessors and Verifiers. There were also concerns about the cost implications. The question was asked whether Verifiers and Assessors should be paid.

The following suggestions were made to maximise assessment (and verification) capacity:

- The pool could be UK wide to help with national capacity issues
- Co-operation between regulatory bodies and chartered organisations could enhance the pool of assessors, e.g. CIEH and NMC
- Advanced practitioners could assess practitioners. Could SpRs be Assessors?

- It will be particularly important to support Assessor and Verifier capacity in the voluntary sector

There was strong support for both Assessors and Verifiers being subject to a formal selection process against clear requirements, being trained and their work reviewed regularly. It was suggested that the UKPHR could work with Higher Education Institutions and Teaching Public Health Networks who could (if adequately resourced) provide training support and moderation of assessment.

It was thought that Assessors should have a minimum number of years' experience in public health at a specified level; and undertake a minimum number of assessments/verifications each year. Reviews of assessment processes and outcomes should be undertaken across sub-specialisms to ensure parity.

The need to support Assessors was identified by many respondents. One suggestion was that Assessors should have access to virtual panel experts with subject leads in specific areas. It was thought that professional networks need to be developed to support the process – Assessor panels, reflective practice, self-evaluation, audit review. Another suggestion was for an annual Assessors and Verifiers workshop/conference.

**Next steps:** The UKPHR proposals attempt to identify a wide pool of assessors, consistent with appropriately high assessment standards, and to limit the pressure on the Specialist workforce by deploying them at the Verification stage (see below). The piloting phase will test the feasibility of these proposals in depth, including selection and training processes for Assessors, and provision of support for quality assurance and motivational purposes (the original proposals suggested a telephone and email service). The relationship between the Register and Assessors and Verifiers needs to be clear.

### **Identification of Assessors by applicants**

**UKPHR proposals:** The Assessor may be drawn from the practitioner's workplace or elsewhere and, if appropriate, may be a part of the practitioner's line management, in which case the assessment may be seen as a part of ongoing professional development. Alternatively it may be more appropriate for the Assessor to be drawn from a recognised professional network, where there is an assurance that the Assessor has a sound working knowledge of the area of public health work of the practitioner.

**Response:** Overall, there was support for the UKPHR proposals. In order to make the process as practicable as possible, it was suggested that requirements for registration need to be embedded in routine personal development plans and continuing professional development and, in the NHS, the KSF (the standards need to be cross-referenced to the KSF). However, this would be difficult in the local government context.

Workplace-based assessment generated debate, particularly regarding the pros and cons of anonymity. On the one hand, the Assessor being the line manager is practical and integrates

the process with CPD etc. On the other hand, guidelines are needed on when it may be appropriate to select an Assessor who is not a line manager; it is more important that an assessor is skilled in assessment. Some felt that assessors should be at arm's length from the applicant, and be objective to avoid an "incestuous" relationship.

The balance between the formative and summative roles of Assessors needs clarification. If assessment is "part of ongoing professional development" and Assessors therefore provide mentoring support (see 'support for applicants' section below), assessment is necessarily formative as well as summative.

There was concern that Assessors and Verifiers would understand applicants' experience and background across the diversity of public health. Assessors need to be familiar with the applicant's area of work – but also to have an appreciation of the breadth of public health. Many felt that the Assessor should come from the same sub-specialism as the applicant and be a senior practitioner, thereby giving the process credibility and practitioner confidence, but there were a range of views, with some taking the opposite view and stressing the need for the independence of Assessors. One view was that the UKPHR's list of Assessors and Verifiers should give their specialisms.

Many respondents identified the matching of applicants to Assessors as an issue. The following suggestions were made:

- UKPHR could match applicants with Assessors
- Education and development leads in Strategic Health Authorities in England could hold lists of Assessors and allocate them to practitioners when they contact them
- Assessors could be identified by local public health networks
- In Scotland, a list of those available across the country could be distributed with local support

**Next steps:** The UKPHR proposals give an option of the line manager being an applicant's Assessor by mutual consent, if the line manager has been selected and trained by the UKPHR. This option is supported by some responses but the view is mixed. Not all line managers may wish to become Assessors or have the particular skills required, nor all applicants will wish to have their line manager undertaking their assessment. Therefore other ways for Assessors to be identified will be needed. The option of the Assessor being from the applicant's professional networks should meet the concerns about Assessors understanding applicants' particular experience and background.

The piloting phase should be used to develop guidelines on the identification of Assessors by applicants from within and outside the workplace setting; and to test the best ways of matching applicants to Assessors.

## Verification

**UKPHR proposals:** Once the Assessor is confident that all the standards have been met, the application is passed to the Verifier. The Verifier must be a Registered Public Health Specialist, must have met the role specification laid down by the UKPHR, and have successfully undertaken required training to be a Verifier. The Verifier checks that the standards have been met by ensuring the assessment has been carried out appropriately.

**Response:** Several responses made the point that Verifiers should be independent of the applicant's organisation and should not know the applicant.

There was much support for regional groups of Verifiers and the establishment of Verifier panels that meet regularly. A number of ideas were put forward on the convening and support of Verifier panels, with the need for clarity on responsibility: the UKPHR or regional or country agencies. In Wales, one view was that the Wales Centre for Health could support the verifier panel; in Northern Ireland, the new Public Health Agency could be responsible for the process. In Scotland, there could be two verifier panels. In England, one view was that the RDPHs should lead regional panels.

There was concern over what would happen to people who were deemed not competent. Importantly, appeals mechanisms would be needed at stages of verification and final registration.

**Next steps:** UKPHR guidance should state that Verifiers should not know the applicant. Verifier panels should be tested during the pilot phase. The UKPHR should retain responsibility for verification, reaching agreement with country and regional agencies as appropriate; these agreements should be reviewed regularly for quality assurance purposes.

A clear appeals mechanisms for applicants will need to be developed.

## Support for applicants

**UKPHR proposals:** The UKPHR will provide detailed guidance on the interpretation of the standards and examples of how the standards might be met in different public health contexts.

**Response:** It was agreed that high-quality guidance and submission templates were essential.

Strong views were expressed on the need for applicants to be given a lot of support, particularly the initial group who will act as role models for those to follow.

*'The success of the Register will depend on the support individuals receive through the process.'*

The response from the Association of Directors of Public Health stressed the importance of providing practitioners with access to training and support, even though their views on the process of registration were equivocal.

A range of suggestions were made for where support for applicants might come from, including: national bodies in the different countries, managers and employers, central top-up funding, specific modules, and strong links with CPD and PDPs through HR and workforce development structures.

Top-level organisational buy-in was considered important to gain support for practitioners. It was suggested that the Register should run workshops to support the application process and charge to cover the costs. It was noted that a good model of applicant support already exists in the South Central Region.

One key question was whether assessors should also act as mentors or whether mentoring arrangements should be separate. The need for support should also include follow-up, for example guidance on courses in the event of evidence not being acceptable.

**Next steps:** The UKPHR needs to conduct further discussions with all appropriate bodies concerning the provision of support for applicants, including follow-up for those unsuccessful in their application for registration. If assessment is part of continuing professional development within the workplace (see following sections), then Assessors may effectively undertake a mentoring role, with Verifiers providing the independent scrutiny of applications.

## **Moderation**

**UKPHR proposals:** Responsibility for moderation will be held directly by the Register and a sample of applications (of up to 100%) will be moderated before registration takes place. The Moderator role will include liaison with Assessors and Verifiers to provide support and to ensure early identification of problems. Guidance for Assessors and Verifiers will be continually be reviewed and circulated. Retrospective audit of both the application process and the assessment will also be an important part of quality control.

**Response:** These proposals were supported explicitly or implicitly in the comments on the assessment process generally.

## **Conclusion: The UKPHR role in the assessment process**

The UKPHR should:

- Provide detailed guidance on the interpretation of standards, what constitutes evidence and portfolio exemplars
- Sample portfolios for the purposes of moderation
- Provide clear definitions of Assessor and Verifier roles
- Run selection and appointment processes for Assessors and Verifiers
- Hold a central register of approved Assessors and Verifiers
- Provide professional support, training and development to Assessors and Verifiers

- Provide guidelines on the identification of Assessors by applicants from within and outside the workplace setting
- Reach agreement on the convening and running of Verifier panels with regional and country agencies
- Regularly review the standards, registration process and Code of Practice
- Provide or support appropriate electronic/IT systems for applicants, Assessors and Verifiers
- Develop Appeals mechanisms at the stages of verification and final registration
- Work in partnership with other agencies regarding training, support and development for applicants, particularly to promote equity of access, and provide guidance in the event of evidence not being adequate
- Communicate widely as the process develops

**APPENDIX A – CONSULTATION ON PRACTITIONER REGULATION - ELECTRONIC RESPONSES** (number of responses 51 – 12 undisclosed)

<b><u>Group and organisations</u></b>	<b><u>Individuals</u></b>
Public Health Directorate, NHS Forth Valley	Sarah Fogarty ,Lecturer University Campus Suffolk
NHS Health Scotland's	Tim Fielding, (SpR)
Informing Healthier Choices: Information and Intelligence Workforce Steering Group	Luke Hounsome, Public Health Analyst
West Kent PCT Advanced Practitioner Learning Set	Helen Cooke, Senior Analyst SWPHO
Skills for Health	Claire Glazzard , Health Improvement Practitioner
University of Southampton, School of Health Sciences	Esther Higdon, Coventry PCT
Buckinghamshire Primary Care Trust (PCT)	Jos McLaren, Student School Nurse
School of Health Science, Swansea University	Sylvia Beacham, Kent PH Workforce Development Manager
Faculty of Public Health (FPH)	Jan Gill, St Catherine's Hospital Birkenhead
Association of Directors of Public Health (ADPH)	Rowan Ferguson, Senior Health Adviser
NHS South Gloucestershire.	Heather Wilson , Sexual Health Advisor
Nutrition Society	Margaret Rings. Senior health adviser
NHS Borders Health Promotion Department	Ian Boss Oxford Radcliffe NHS Trust
Public Health Resource Unit (PHRU)	Lesley Armitage, Consultant in Public Health Medicine
British Dietetic Association	
General Medical Council	
Joint response from the National Public Health Service and the Wales Centre for Health	
NHS Hastings and Rother/NHS East Sussex Downs and Weald – Health Improvement	
The British Association for Stop Smoking Practitioners (BASSP)	
East Midlands Public Health Intelligence Network (EMPHIN)	
SE Teaching Public Health Network	
Scottish Health Promotion Managers Group.	
British Association for Sexual Health and HIV (BASHH)	
NHS Lothian Health Promotion Service	
Health Protection Agency	

## APPENDIX B: CONSULTATION ON PRACTITIONER REGULATION EVENTS

(Total participants 245)

<b>National Events</b>	<b>Participants</b>
East Midlands – Nottingham 27 January 2009	45
London 25 February 2009	40
Scotland – Edinburgh 27 February	36
Scotland - Aberdeen & Inverness 6 March	15
North West England – Wigan 19 March	24
Northern Ireland – Belfast 24 March	11
<b>Events with Specific Health Communities</b>	<b>Participants</b>
Smoking Cessation – London	nk
Oral Health – London	5
Sexual Health Advisors – London	8
Public Health Intelligence – Exeter	19
Local Government – Leeds	22
Health Protection – Newcastle	14
<b>Targeted Events</b>	<b>Participants</b>
National Public Health Service for Wales -	nk
UKPHR Assessors – London	6

Appendix C: Programme Plan

	2009						2010							
	05	06	07	08	09	10	11	12	01	02	03	04	05	06
Standards for regulation														
Collate/check examples														
Finalise P/AP standards														
Mapping against PHSCF														
Mapping against HP NOS														
Production of glossary														
Piloting phase														
Agree criteria for pilot site selection														
Formal agreement with pilot sites														
Pilot sites identify applicants/ assessors/ verifiers														
Develop guidance material for Applicants/ Assessors/ Verifiers														
Develop role specification/ training material for Assessors/Verifiers														

<p>Develop Moderation processes</p> <p>Training of Ass/ Verifiers</p> <p>Assessment/ Verification in pilot sites</p> <p>Reporting from pilot sites</p> <p>Agreement on cpd/ revalid.</p> <p>Register open</p>	
<p>Code of Practice</p> <p>Collaboration with FPH/ as part of UKPHR revalidation development</p>	
<p>Appeals process</p> <p>Development</p> <p>Consultation/ testing</p>	
<p>Communication</p> <p>Work with agencies to provide applicant support</p>	
<p>UKPHR Infrastructure/ back office functions</p> <p>Scoping/ developing business plan</p>	
<p>DH review of PH regulation</p> <p>Interim report</p> <p>Full report</p>	

**APPENDIX D Overview of the proposed process for the retrospective route to registration**

