

Review of the Regulation of Public Health Professionals (November 2010)

Comments from the UK Public Health Register

1. The *Review of the Regulation of Public Health Professionals* report was published at the same time as *Healthy Lives, Healthy People: Our strategy for public health in England*. The public health White Paper asks for views on the report on the Review of Regulation and poses a consultation question on the most suitable organisation to provide a system of voluntary regulation for public health specialists.
2. This paper provides the UKPHR views specifically on the Review of Regulation.
3. The review was commissioned by DH England on behalf of the 4 UK countries and as such is relevant to all UK Countries. The UKPHR is separately responding to the consultation question posed by *Healthy Lives, Healthy People*.
4. Since it was established in 2003 the UKPHR has pursued its aim of promoting public confidence in specialist public health practice in the UK through independent regulation. Our primary objective has been to provide public protection by ensuring that only competent public health professionals are registered and that high standards of practice are maintained.
5. In its work the Register recognizes and includes specialists, both General and Defined, and currently has nearly 500 (491) specialists registered. In April 2011 the UKPHR will be registering properly assessed and verified public health practitioners. Registrants work across the three domains of public health as described by the Faculty of Public Health, in a variety of settings (health, local government, the third and voluntary sector and the private sector).
6. The UKPHR submitted its views to the Scally report in 2010 and highlighted the need to ensure that any recommendations made should be assessed against the impact on public health delivery. We would reiterate that necessity particularly at this time of substantial change to the public health delivery mechanisms across England.

The current Regulatory landscape

7. Since the commissioning of Dr Scally's review, the economic and fiscal climate has changed and regulatory policy has moved on. Many of these threads have been drawn together in the recent Command Paper *Enabling Excellence: Autonomy and accountability for health and social care staff*. The Secretary of State's Foreword to that paper sums this up:

Delivering safe and effective care will continue to be the driving principle behind professional regulation. Further, in the context of "any willing provider" being able to provide services to the NHS in England, the role of professional regulation, providing a set of standards which apply to all aspects of a health or social care professional's work, whether within the NHS, a local authority, or in a self-employed setting, will become all the more important in future, in most sectors of care.

This applies particularly to the regulation of Public Health professionals, in view of the widening public health role of local authorities in England.

8. As NHS structures continue to develop and, inevitably, diverge between the four countries of the UK, the broad thrust of the argument – that increasing diversity of service provision makes effective professional regulation even more critically important – is increasingly valid.
9. The challenge to regulators, set out in *Enabling Excellence*, is to provide effective regulation in ways which are increasingly efficient, minimising the burden which regulation imposes on individuals, employers and commissioners. To that end, *Enabling Excellence* gives powerful backing to the concept of "right touch" regulation, which is being championed by the Council for Healthcare Regulatory Excellence (CHRE).
10. The paper also quotes with approval the application of the subsidiarity principle to professional regulation, arguing that the most intrusive and burdensome forms of regulation (including statutory restrictions) should be kept in reserve for the mitigation of risks which cannot safely or effectively be managed at a lower level.
11. The recommendation of the Scally report, that public health specialists should be statutorily regulated through the Health Professions Council, therefore seems out of step with current thinking. The case for statutory regulation is not fully made, rather there is an assumption that only statutory registration can be the ultimate guarantor of standards. Yet seen in the light of the contemporary public policy agenda around regulation, an approach which builds on the current significant

success of the voluntary register, would in our view be equally effective and less disruptive to public health delivery mechanisms across the 4 UK countries than the proposed option. A model based on the UKPHR, as a prototype of quality assured voluntary regulation, working in partnership with CHRE offers the prospect of building an increasingly effective means of regulation for Public Health practice without having to resort to the additional burden of statutory registration at this time.

Review of regulation - Option appraisal

12. The Scally report considers 6 options the first of which would be to retain the current mixture of statutory (GMC, GDC, NMC etc) and voluntary (UKPHR) regulation, strengthened by guidance to employers. The report mistakenly identifies the need for continued central funding for this option. Whilst the UKPHR has benefited from pump priming funding, as well as project development support over the past 7 years, from 2011 it has recognized that no core central funding will be available. The UKPHR has planned for this and, with a combination of Specialist and Practitioner registration, is able to be self funding on this basis (see 3 year financial projections in Appendix A).
13. Options 2 and 3 of the Scally report relate to quasi- regulation and chartered status, something that the report recommends is looked at for public health practitioner regulation. While the option of chartered status may add to the perceived strength of a voluntary framework the view of CHRE is that it would neither help nor hinder an application for accreditation to CHRE as it does not of itself demonstrate compliance with the standards set by CHRE for accreditation. Accreditation by CHRE would be intended to provide assurance that the organization holding the register is competent to do so and is well governed whereas chartered status would of course be conferred by the organization on its registrants. Some professionals may of course find the chartered title attractive, although it is unclear as yet whether it will promote actual, as opposed to perceived, greater public protection. The issue of clarity to the public is also of fundamental importance: we already know that the public finds the array of titles used in the healthcare professions confusing.
14. Options 4, 5 and 6 all consider statutory regulation either by creating a new statutory public health regulator or by asking existing statutory regulators to cover the Specialist workforce. The preferred option from the report is to require the HPC to regulate public health Specialists. This, the report states would incur a one off fee from the HPC of £300,000 to establish depending on the size and

complexity of the register. While the number of registrants on the current UKPHR is around 500 a move of this sort is likely to be complex as the workforce covered is very senior indeed compared to the bulk of registrants currently regulated with the HPC, and may require review of HPC policy and practice in areas such as revalidation and Fitness to Practice. This may be very costly indeed.

15. We were disappointed that none of the options in the review took explicit account of the impact on public health delivery. In our response to the Review the UKPHR stressed the importance of providing a unifying regulatory landscape that supports the principles of an integrated, flexible yet rigorously quality assured professional public health workforce. It is not clear from the option appraisal how this would be best achieved through the recommended route.

Risk Assessment

16. The Scally review proposes statutory regulation only for Generalists currently on the UKPHR register. The case, it says, for those practicing in Specialist roles in 'Defined' areas of practice is regarded as not made as there is no perceived established training route, nor a compelling case for protection of the public.
17. Whilst the Generalists are by far the larger group of current registrants on the UKPHR, Defined registrants comprise a steadily growing minority with increasing numbers coming from health protection and health intelligence areas of practice.
18. The main focus of the risk assessment carried out for the Scally review was on public health consultants and Generalist Specialists, although Defined Specialists and practitioners were also considered. In response to the review the UKPHR commissioned an enhanced risk assessment to build on what was already done, to look in particular at Defined Specialists and practitioners and to work with CHRE on the development of the concept of *opportunity lost* in relation to professional regulation.
19. The enhanced risk assessment found that both General and Defined Specialists pose the same risk to the population and should be regulated under the same *Right-touch* approach, whether that be via statutory or quality assured voluntary regulation. The assessment of risk posed by practitioners suggested that this was likely to be less severe in consequence and the enhanced risk assessment agreed with the review conclusion that a voluntary approach to regulation would be appropriate here. The enhanced risk assessment also stressed that the

importance of a regulatory pathway that allows for practitioners to develop and become Specialists should be included in any approach to regulation.

20. The report of the enhanced risk assessment commissioned by the UKPHR is attached at Annex 1 to the UKPHR Board response.

Conclusion

21. The concern of the UKPHR is that there is a robust and effective regulatory mechanism to ensure that all public health professionals, both Specialist and practitioner, maintain high standards of practice, underpinning the delivery of public health goals and maintaining the confidence of the public. This means that they will need to be well trained, competent in what they do, committed to improving the health and well being of the communities that they serve and demonstrating the highest levels of professional conduct in whatever context they are working.
22. The regulatory structures that are in place must support this vision for the workforce and not produce unnecessary regulatory hurdles to development and professional flexibility.
23. We are not convinced that the Scally review fully took these issues into account when coming to the recommendations presented.
24. We see significant advantage in having the same regulatory body cover public health specialists (both general and defined) with otherwise unregulated public health practitioners (who represent a far larger number than those currently subject to professional registration). We believe the UKPHR is well placed to provide this regulatory framework.
25. The UKPHR is already working with CHRE in terms of external quality assurance and we continue to work very closely with the FPH particularly around the development of revalidation and the quality assurance of training. The RSPH is also an important partner for us in terms of public health practitioner registration, as is the CIEH. We have benefited from the extensive expertise of other regulators such as the GMC, GDC, NMC, CIEH and GPC who are all represented on the UKPHR Board and who work collaboratively with the UKPHR to set the strategic direction and promote the highest professional standards for Public Health. The UKPHR already has a good reputation and has a robust base on which to build.