Written evidence submitted by the UK Public Health Register (PHP0007)

Executive summary

UKPHR’s registrants form part of the core public health workforce capable of working with others to bring about the radical upgrade in prevention and public health called for in the NHS Five Year Forward View.¹ Over 600 Directors and Consultant grade Public Health Specialists are on UKPHR’s register, including half of England’s Directors of Public Health.

Local authorities’ public health functions operate to maximise the impact of policies and programmes on people’s health and wellbeing and reduce health inequalities, working with:

- Colleagues across their councils
- Commissioners in the council and commissioners in other organisations especially Clinical Commissioning Groups
- Their council’s partner organisations
- The wider workforce including unpaid carers; and
- Individuals and communities

Statutory regulation of all public health specialists and registration of the core public health practitioner workforce and the most directly-involved wider workforce would offer assurance of competence, continuing professional development and, from next year, regular revalidation. Many in practice are currently unregistered and unregulated.

UKPHR proposes there should be a common regulatory home for all who are involved in the delivery of public health interventions with, of course, arrangements to avoid burdensome dual registration. UKPHR as a voluntary register is funded almost entirely by its receipt of registration fees and receives no income from Central Government.

More information about UKPHR is given in the Annex.

General

1. UKPHR welcomes the Health Select Committee’s inquiry into the impact on public health post-2013 of the Health and Social Care Act (the 2012 Act) reforms.

2. As the accredited register for professionals working across the UK in public health practice UKPHR has knowledge of working practices in England and also in Northern Ireland, Scotland and Wales.

3. The 2014 report by the Centre for Workforce Intelligence (CfWI) Mapping the core public health workforce² showed that the number of core public health workers in England is in the range of 36,000 to 41,000 people of which 1,450 – 1,650 are specialists and up to 10,000 practitioners.

4. A new report, published by the CfWI and the Royal Society for Public Health, Understanding the wider public health workforce in England³ identified at least 15

millions of people employed in occupations that have the opportunity or ability to impact health and wellbeing through their work and approximately 5 million people providing unpaid care and support to family or friends due to disability, illness or poor mental health. The 15 million-plus people in paid work range from police and fire personnel, to opticians, pharmacists and housing officers.

5. UKPHR is an Accredited Register capable of assuring the competence of those who work in the core public health workforce as Specialists, Specialty Registrars and Practitioners. Accredited Registers are a new approach to regulation and are crucial to health and care service delivery.

6. Registration provides evidence to colleagues, employers and the public of an assured level of competence achieved by registrants. Beyond registration, competence is maintained through a system of annual renewal and a requirement for continuing professional development.

7. UKPHR is planning to introduce five-yearly revalidation of all registrants in 2016.

8. UKPHR is a not-for-profit company limited by guarantee. It is also a registered charity.

The delivery of public health functions

9. Public health comprises the three domains of Health Improvement, Health Protection and Healthcare Services and three underlying functions – public health knowledge & intelligence, academic public health and workforce development.

10. Prior to the establishment of the National Health Service in 1948, local authorities were the bodies responsible for public health interventions. Between 1948 and 1974, local authorities shared responsibility for delivering public health functions with the NHS. In 1974, the NHS was given the lead in public health – and it was this lead which was transferred back to local authorities (and Public Health England) by the 2012 Act.

11. There were few parts of the 2012 Act reorganisation that were uncontroversial, but the proposal to transfer the lead for public health in England from the NHS to upper tier local authorities did have support. Some in local government saw this as "public health coming home" but in reality both public health practice and local authorities’ approaches are very different from their pre-1974 practice.

12. It is true that local authorities have made major contributions to improvements in the public’s health and wellbeing. In Birmingham, where UKPHR is now based, Joseph Chamberlain used his three years as Mayor of Birmingham 1873-6 to transform the...
City through Corporation control of electricity, gas and water supplies and a radical land redevelopment. Birmingham’s improvement scheme covered an area of 93 acres. More widely, the great transformation in life expectancy and infant mortality was delivered through clean water and effective sewerage management rather than medical interventions.

13. A population-based approach that addresses the wider determinants of health requires local authorities to employ a wide range of policy and delivery levers to meet their public health duties. This means corporate action across council departments, community leadership by Councillors and genuine partnership working which includes NHS organisations and healthcare commissioners.

14. Lead responsibility for delivery of public health functions is now shared between local authorities and Public Health England. Before examining this relationship, it is worth giving more attention to the relationship between local authorities and the NHS.

15. In the transfer from the NHS to local authorities, some NHS organisations lost the NHS public health knowledge, expertise and capacity which they need to support actively the delivery of public health functions by others. The NHS needs effective public health interventions to “turn off the tap” of demand for acute care. Less obesity, a more exercised population with lower smoking prevalence living in a supported care environment can reduce the strain on healthcare services as set out in the Five Year Forward View (acute admissions avoidance and faster hospital discharges after treatment is completed).

16. NHS England receives public health advice and support from Public Health England. In local areas, Clinical Commissioning Groups (CCGs) and NHS organisations rely more on local authorities for advice and support. Relationships are not well developed (a few may even be antipathetical). Commissioning for some services like sexual health and under 5’s services is now split between local authorities, CCGs and NHS England. The best Health & Wellbeing Boards have created strong partnerships between local authorities and CCGs, and some CCGs even employ their own public health consultants, but overall we regret that there is plenty of scope for improving “joined up” delivery of public health services.

17. Public Health England has worked hard to build good relationships with local authorities. PHE manages the ring-fenced public health budget on behalf of the Department. Inevitably, there are those who complain that some local authorities have spent public health funds on other local authority services and that PHE has not been rigorous enough in identifying this. However, a greater challenge is facing local authorities when they, wisely, integrate public health considerations into all their policies, programmes and partnerships. Facing unprecedented budget cuts, they are increasingly hard-pressed to marshal cross-council interventions (to which public health funds should rightly contribute) which the evidence, including the evidence in their own joint strategic needs assessments, tells them would deliver the greatest

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4 The Five Year Forward View, October 2014, endorsed by NHS England’s partner organisations including Public Health England, sets out the changes needed in funding, organisation and future ways of working. It says this in relation to the contribution to be made by public health: The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.
improvements in health and wellbeing in their communities. One area of public health practice where PHE and local authorities are required to work together is in health protection. There have been troubling reports of some local authorities withdrawing services needed to maintain robust public protection arrangements, relying entirely on arrangements made by PHE.

The effectiveness of local authorities in delivering the envisaged improvements to public health

18. **All local councils**, not just the “upper tier” local authorities in England designated by the 2012 Act, are well placed to deliver a health and wellbeing strategy set locally but informed by the nationally determined Public Health Outcomes Framework. Levers available to local authorities include:

- **Statutory powers (regulation, inspection and enforcement)**
- **Representational positions (spending, listening and persuading).**

19. There are good **examples of good practice** demonstrating effective performances through which local authorities are reducing health inequalities and improving health and wellbeing in their communities. We admire the joint working by Warwick District Council and NHS Warwickshire combining rent arrears management with the NHS Stop Smoking Service. The Local Government Association has been prominent in collecting and disseminating these examples.  

5 UKPHR has developed its website in order to enable registrants to submit examples of good practice for sharing with other registrants and wider audiences.

20. Probably the most tangible delivery of effective interventions both “joined up” and public health focused is **Make Every Contact Count (MECC)**. This way of working has many models. It has its enthusiastic adopters in local authorities, NHS organisations and many other partners including many in the voluntary and not-for-profit sector. The Local Government Association has helped by organising briefings and conferences, bringing together partners and publishing examples of good practice.  

6 This approach deserves support as it genuinely promotes cross-organisation collaboration and focuses on the needs of individuals and communities. Health Education England is due to host a MECC conference in January 2016.

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5 See for example “Public health transformation twenty months on: adding value to tackle local health needs”
http://www.local.gov.uk/documents/10180/6869714/L15_15+Public+health+transformation+twenty+months+on_WEB_39693.pdf/7bb8060e-9a7b-4b85-8099-e854be74cfb5

6 “Making every contact count: Taking every opportunity to improve health and wellbeing”:
http://www.local.gov.uk/documents/10180/5854661/Making+every+contact+count+-+taking+every+opportunity+to+improve+health+and+wellbeing/c23149f0-e2d9-4967-b45c-fc69c86b5424
21. Local authorities’ effectiveness will be judged by the difference they make in local people’s health and wellbeing as measured by statistics for their localities relating to health inequalities and the two high-level outcomes set for them in the Public Health Outcomes Framework. Local authorities will have access to data enabling comparison with past performance in their own areas and with today’s performance of other local authorities. It is more likely that it is the transparency and accessibility of this data – especially accessibility for local communities – which will drive improvements in performance by local authorities rather than, for example, introduction of the Health Premium Incentive Scheme.

22. UKPHR’s assessment of the effectiveness of local authorities’ delivery so far is that where the core public health workforce is used to devise and support the delivery of health in all policies and programmes across local authorities and their partners, then those local authorities are set up to make major inroads in the years to come in reducing health inequalities and improving health and wellbeing. An excellent example of a whole-community strategic approach to working in this way is the “Devo Manc” public health strategy.

23. To improve effectiveness, we also need to help raise the performance of the poorer performers to the level of the best.

Concerns have been expressed that public health delivery is being undermined by resource cuts (for example, inadequate resource to tackle core issues such as diabetes) and the lack of value and/or importance some local authorities have placed on public health. There is concern that this will get worse once the ‘ring fence’ is removed - and the announcement that the ring fence will continue for two further years was well received. A lack of local authorities’ competent public health capacity is in some cases undermining the core offer to Clinical Commissioning Groups with, for example, a reduction in data analysis support. Communication, joined-up effort across the public health system and a concerted focus on quality education and training (as well after qualifying as prior to qualifying) are all required to meet these challenges. Here at UKPHR we very much wish to be part of a system-wide initiative to achieve the necessary improvement.

24. It is too soon to judge whether conferring the public health lead on some local authorities in England is a successful and effective model. Intuitively it ought to work but at times of financial constraint for local authorities we see disinvestment in preventative services, such as smoking cessation and sexual and reproductive health, leading to short term financial benefits and long term harm. This will impose more pressure on NHS primary and community care services. At UKPHR we want to be active in making the best of the transfer and evaluating its effect.

The public health workforce

25. The public health workforce identified by the Centre for Workforce Intelligence is small. It clearly needs to be multi-disciplinary because important though Medical Public Health might be it is only a relatively small part of the capacity required to improve public health as a whole. Professor Thomas McKeown made the point in his seminal textbook on "Social Medicine". It seems generally understood that this core public health workforce needs to be registered and/or regulated to assure employers.

7 http://gmhealthandsocialcaredevo.org.uk/news/pbamou-launch/
of competence and fitness for purpose. The Specialism of Public Health cannot anymore be dismissed if we are to satisfy NHS England’s aspiration for a sustainable healthcare system by 2020. Sustainability is just as much a key consideration in Northern Ireland, Scotland and Wales. The public health workforce, genuinely multi-disciplinary in its composition, will be an important component of a society-wide effort to improve public health and wellbeing and reduce health inequalities.

26. There have been inevitable distractions during the transition from a service that was NHS-led to one that is now firmly established in local authorities. Pay, pension, terms and conditions are not inconsiderable matters to resolve during a period of transition. The divide created by differences between NHS and local authorities pay scales has drawn many medically qualified public health specialists into employment with Public Health England whereas specialists in many other disciplines have mostly found employment in local government. The ease with which public health specialists can move across the public health system regardless of employer is a key part of a robust public health system and is being lost within England’s current multiplicity of employers.

27. Two reports\(^8\) this year demonstrated the extent and potential of the wider workforce – an army of paid workers and unpaid carers capable of contributing to the very step-change in our society’s approach to public health that we seek. There are exciting opportunities ahead for thinking and acting differently, making every contact count and harnessing more of the assets available in our communities.

28. The professionals UKPHR registers form part of the core public health workforce capable of working with others, across councils and their partner organisations, within communities and crucially with this wider workforce including unpaid carers to bring about the radical upgrade in prevention and public health called for so powerfully in the NHS Five Year Forward View.

29. Our public health success will be measured by how well the public health workforce is able to integrate effective public health ways of working into broader societal developments in governance, service delivery, community assets and public behaviour. UKPHR particularly emphasises the importance of all health and social care workers working to a clear ethical code of conduct and in this respect commends a culture of reflective practice. This reminds all staff of their personal responsibility for their actions and the need to be appreciative of the impact their conduct will have on public safety.

30. UKPHR has been a voluntary register for public health Specialists in the UK since 2003. Employers value the assurance of professional competence that registration demonstrates and require new recruits to be registered with UKPHR (unless already regulated by one of the statutory regulators General Medical Council or General Dental Council). We would support the statutory regulation of the public health specialists we register in the interest of equivalence with those medical and dental specialists who are already subject to statutory regulation. We would offer UKPHR as the appropriate choice of statutory regulator for this group of multidisciplinary public health specialists.

31. Since 2011, UKPHR has also operated registration of public health Practitioners. It offers employers the same assurance of professional competence as for Specialists. As a result, some recruitment by employers refers to registration as a required or desired specification. UKPHR is working towards comprehensive practitioner registration coverage and consistent employer practice of looking for registration on recruitment.

32. As an Accredited Register, UKPHR is able to give assurance of the competence of members of the core workforce. We believe that all the core public health practitioner workforce, and all those in the wider workforce who in future are trained and deployed to deliver public health interventions, should be UKPHR-registered. This approach makes for a **common regulatory home and formal recognition of the significance of public health practice.**

33. Ideally, we believe that public health practice should attract **statutory public health regulation.** Drawn from a wide range of disciplines - from environmental health, nursing, pharmacy and health improvement to epidemiology, social policy and spatial planning - this inevitably means that some are already regulated by a statutory regulator. UKPHR would wish to work with others to design an innovative regulatory system for public health which enables us to respect dual registration and avoid imposing double requirements on registrants in terms of registration fees, continuing professional development, revalidation and fitness to practise.

34. UKPHR would welcome coordinated **regulatory action.** As a regulator itself, UKPHR wishes to have close, constructive relationships with other regulators of health and social care workers. We would welcome common standards to be applied by all relevant regulators for implementing the relevant recommendations of the Law Commissions’ report on health regulation and of Sir Robert Francis’ reports regarding Mid Staffordshire Hospitals Foundation NHS Trust and whistleblowing respectively.

### Public health spending

34. The **purpose of registration** is to protect the public and promote public confidence in public health practice. As a regulator, albeit not statutory, it is not for UKPHR to be involved in political issues and the issue of public health spending is inevitably interlinked in politics. UKPHR is also a registered charity in England and Wales⁹ (and in Scotland) and therefore has a duty to remain politically neutral. We can of course provide factual information about costs involved in assuring a competent, safe public health workforce.

35. The **Public Accounts Committee** reported¹⁰ on funding for public health as provided to local authorities by Public Health England. UKPHR would agree with this statement in the Committee’s report:

> Many local and national government actions contribute to improving public health, for example having good housing, good education and a job are fundamental to living a

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⁹ UKPHR is registered in England & Wales by the Charity Commission with charity number 1162895

long life in good health. The NHS and PHE have made good progress in placing a stronger emphasis on promoting good health and preventing poor health through their ‘Five Year Forward View’ which sets out the vision for the future health service.

Evidence to the Committee

36. UKPHR is willing to provide further comment and evidence in support and is willing to contribute oral evidence to the Committee if requested.

Annex - About UKPHR

UKPHR is an Accredited Register under the statutory programme operated by the Professional Standards Authority. Accredited Registers offer an assured workforce, ready and able to help relieve pressures on health and care services.

UK Public Health Register (UKPHR) was set up as a result of a Tri-Partite public health community initiative, supported by the Department of Health and the Chief Medical Officer, Liam Donaldson, in 2003. It is a Company limited by Guarantee operating a voluntary register of public health specialists and practitioners.

Since 2014, UKPHR’s register has been accredited by the Professional Standards Authority under the Accredited Registers Programme. This scheme was established under the Health & Social Care Act 2012.

In 2015 UKPHR became a registered charity both in England & Wales and in Scotland.

At its outset in 2003, UKPHR was intended to provide a regulatory home for public health specialists who were neither doctors nor dentists (and therefore not already statutorily regulated by the General Medical Council and the General Dental Council).

Twelve years on, the UK’s public health leaders are much more multi-disciplinary as a result of the 2003 initiative and employers, including local authorities, advertise top posts in public health as “must be registered by UKPHR or General Medical Council or General Dental Council”.

Approximately one-half of the 1,200 or so public health specialists working in the UK are today registered by UKPHR (625 as at February 2015).

UKPHR piloted practitioner registration in 2011, initially in 4 locations around the UK. Today, there are ten public health practitioner registration schemes in:

- East England
- Kent, Surrey & Sussex
- London North-Central & East
- North East England
- Thames Valley
- Wales (with arrangement for Northern Ireland practitioners to register also)
- Wessex
- West England
- West Midlands
West Scotland

As the list shows, not all the UK has access to practitioner registration currently. UKPHR believes this to be inequitable and wishes to establish UK-wide coverage as soon as possible. This necessitates establishing partnerships at a local level with public health bodies willing to co-operate in setting up, funding and providing ongoing support for more local registration schemes.