Review of the Regulation of Public Health Professionals

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Letter to the Interim Chief Medical Officer, Dame Sally Davies

Dear Dame Sally

In early 2010 Sir Liam Donaldson, the then Chief Medical Officer for England, and his colleagues in the Devolved Administrations asked me to undertake a review of the regulation of public health professionals in the UK. It was hoped that this would be completed in April 2010 but it was not possible to accomplish this because of demands associated with the General Election. The delay has been advantageous in that it has allowed a clearer picture of demands likely to be made on the public health workforce in England in the future as a result of changes to the NHS outlined in *Equity and Excellence: Liberating the NHS*.[1]

It has been a major achievement of the public health community that it has skilfully managed the transition from being a group of professionals that was almost exclusively from a medical background to become a discipline that is valuably enriched by the variety of professions and backgrounds from which its current entrants come. It is perhaps inevitable in such a transition that some elements of change have been and will be easier to accomplish than others. The current pattern of regulation, a mixture of statutory and voluntary, and the growing number of routes to specialty registration are unsatisfactory. The time is right to bring quality and clarity to the approach to specialist regulation.

Central to the role of professionals in this modern age is the necessity of establishing and maintaining the respect of the public. For this purpose, a robust system of professional regulation is vital. This of course must operate alongside, and be dependent upon, a well-founded system of professional formation that includes an expert academic base and a rigorous system of training, assessment and qualification.

The extensive views expressed to the Review provided some clear messages. There was strong support for a system of statutory regulation and a desire to avoid the requirement for multiple registration with different regulators. Contributors stated a strong desire for a system that was both equitable and as simple as possible.

I would like to thank those who worked on the Review and all those who made a submission or gave of their time to advise and inform. This is a complex area and there are difficult issues that require addressing as a matter of some urgency if public health is to rise to the challenges that lie before it. I have made a series of recommendations that I believe will provide a sound basis for the future.
I commend them to you.

Dr Gabriel Scally
Regional Director of Public Health

Contents

1. Introduction

Purpose of the Review

Professional regulation, much like public health, has its worth proven by the absence of problems. Whereas for public health practice it is the absence of death from lung cancer, communicable disease or environmental hazard, for regulation it is the absence of morbidity or mortality resulting from poor professional practice.

The central purpose of this Review is therefore clear: to protect the public. The Review sought to ascertain the potential risk posed by those public health professionals who do not come within statutory regulation, and to assess whether such universal statutory regulation would be proportional.

The Review, through its Terms of Reference (provided at Annex A), answers the following questions:

- Are those individuals currently unregulated by a public health register, or sub-register, already regulated through a primary profession?
- For those individuals currently outside statutory regulation, what risk is posed by their practice not being statutorily regulated?
- What form of regulation, therefore, is most appropriate and proportional to the level of risk posed by public health practice?

Additionally, there are practical considerations about the effectiveness of regulation, even if it is supported. Specifically, these involve the proof of a prosecutable act, and the preparedness of the profession for regulation. The Review therefore also sought to establish:

- whether the types of risk presented to public safety are such that the individual responsibility and individual actions of public health professionals can be sufficiently linked to negative outcomes to make statutory regulation worthwhile; and
- whether the current thresholds of entry to the public health profession, public health training and education, and public health standards are at a level commensurate with a profession subject to regulation.

It is clear that one of the benefits of statutory regulation is that specific actions can be taken when professional misconduct or incompetence are identified and proven. These include the ability to require an individual to meet agreed professional standards; the ability to place conditions upon an individual's practice; and the ability to de-register an individual.

The Chief Medical Officer for England commissioned this Review, in conjunction with the Chief Medical Officers of the Devolved Administrations of the UK. Recommendations will be provided to the four countries' Chief Medical Officers.

The purpose, within the parameters set, is to consider the various available systems for the regulation of the public health workforce. The Review does this through appraising current regulatory frameworks, developments and regulatory policy within which the healthcare workforce operates. Informed by these, the Review advises on the legislative, resource and equality impacts of the regulatory options. Accordingly, the Review makes recommendations for the best regulation of public health professionals.

The case for change

Intended effects

In line with *Trust, Assurance and Safety*,[2] this Review considers the intended effects of regulation. These are to:

- improve the quality and safety of public health practice where decisions involving potential public risk and impacts on individual mortality and morbidity are taken by individuals holding public health consultant or specialist roles;
- promote and assure good practice, while protecting patients from bad practice, both at the individual and population level;
- narrow the regulatory gap between medically qualified and non-medically qualified public health professionals, thereby reducing the inequity of regulation of those holding roles of similar profile, strategic importance and content; and
- increase public and professional confidence in public health regulation and procedures.

Intended effects and the call for evidence

Consultation with professionals and professional organisations in the course of this Review indicated that the above intended effects were strongly supported. (For a summary of the responses to the call for evidence, see Annex C.) In addition, a majority of respondents wanted the effect of any change in regulation to increase cohesiveness within the profession, and lead to the equal treatment of different groups within public health. The rationale for this included equity, enhanced competence assurance and public safety; it did not consider human resources issues such as pay and conditions.

2. Background

History of public health regulation

Public health in the UK has always been an amalgam of disciplines. While public health medicine has been the major part of the public health workforce over the years, public health as a whole has multi-disciplinary roots.

Public health has been defined in various ways but the most widely accepted definition is 'the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society'.[3]

This definition, used by Sir Donald Acheson in his *Public Health in England* report in 1988, reflects the essential focus of modern public health.

Public health professionals work with other professional groups to monitor the health status of the community; identify health needs; develop programmes to reduce risk and screen for early signs of disease; control communicable disease; foster policies which promote health; plan and evaluate the provision of healthcare; and manage and implement change.[4] As well as being multi-disciplinary, these activities are increasingly taking place in a multi-agency environment.

Public health has been recognised as a specialist field of practice since the middle of the 19th century when the first Medical Officers of Health were appointed in England. In 1997, a group made up of the Faculty of Public Health (FPH), the Royal Institute of Public Health and Hygiene, and the Multidisciplinary Public Health Forum signed the Tripartite Agreement to take forward the development of a multi-disciplinary workforce.[5] This development has had a significant impact on the professional configuration of the public health workforce over the past 13 years. This was furthered in professional regulation by the establishment of the UK Voluntary Register for Public Health Specialists (UKVRPHS) in 2003.

In 2001, *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*[6] made strengthening the multi-disciplinary nature of the public health workforce a continuing priority. It articulated the standards of specialist practice within public health and provided for the implementation of the new specialist post within the NHS. One welcome result of this action has been that non-medically qualified specialists who are competent to do so can now hold high-level public health posts, such as Director of Public Health.

More recently, the Public Health Resource Unit and Skills for Health have delivered the *Public Health Skills and Career Framework*.[7] In line with the requirements set

out in the Chief Medical Officer's report, the framework pertains to the NHS, local authorities, the voluntary sector and the private sector. The framework addresses those skills that are required of public health specialists and others who make up the public health workforce.

The functions of regulators

A number of councils guide and oversee the regulation of health professionals in the UK. Health professional regulators have four core functions:

- setting and promoting standards for admission to the register and for remaining on the register;
- keeping a register of those who meet the standards and checking that registrants continue to meet those standards;
- administering procedures for dealing with the cases where a registrant's right to remain on the register has been called into question (fitness to practise); and
- ensuring high standards of education for the health professionals they regulate.

The Council for Healthcare Regulatory Excellence

The Council for Healthcare Regulatory Excellence (CHRE) (successor to the Council for the Regulation of Health Care Professionals) came into being in April 2003 and, following the arm's-length bodies review of 2010,[8] is undergoing a process of consultation on becoming a self-funding body.

The CHRE monitors how the health professions' regulators carry out their functions. Its stated mission is to protect the public by helping the regulatory bodies to improve their performance, setting and driving up standards for regulation, encouraging consistency, and developing the regulation of health professions. Its role is being extended to set standards for and quality assure voluntary registers.

There are nine health professional regulatory bodies that currently fall within the remit of the CHRE:

- the General Chiropractic Council (GCC) – which regulates chiropractors;
- the General Dental Council (GDC) – which regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists;

- the General Medical Council (GMC) – which regulates doctors;
- the General Optical Council (GOC) – which regulates optometrists, dispensing opticians, student opticians and optical businesses;
- the General Osteopathic Council (GOsC) – which regulates osteopaths;
- the Health Professions Council (HPC) – which regulates members of 14 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, and speech and language therapists; it is, subject to the will of Parliament, soon also to regulate social care professionals;
- the Nursing and Midwifery Council (NMC) – which regulates nurses and midwives;
- the Pharmaceutical Society of Northern Ireland (PSNI) – which regulates pharmacists in Northern Ireland; and
- the General Pharmaceutical Council (GPhC) – which regulates pharmacists and pharmacy technicians in England, Wales and Scotland.

As the CHRE notes, the purpose of all nine health professional regulatory bodies is to protect and promote the safety of the public.

The General Medical Council

The Medical Act 1983 regulates UK doctors. The GMC operates as the statutory regulator. The GMC has a Specialist Register for Public Health Medicine and, following an agreement in 2004 with the United Kingdom Public Health Register (UKPHR), there is the opportunity for those who have specialist registration in public health with the GMC to be dually registered.[9]

The GMC controls entry to and maintenance of the Medical Register and also the Specialist Register. The over-arching basic remit of the GMC can be said to have remained unchanged in that its core purpose continues to be the protection, promotion and maintenance of the health and safety of the community by ensuring proper standards in the practice of medicine.

The General Dental Council

Although the first Dentists Act was passed in 1878 and the first register of dentists established in 1879, it was not until 1956 that the GDC was established. Prior to 1956 the regulation of dentists was carried out under the auspices of the GMC. The GDC registers not only dentists but also a range of other dental care professionals, currently including clinical dental technicians, dental hygienists,

dental nurses, dental technicians, dental therapists and orthodontic therapists. There are approximately 36,700 dentists and 53,000 dental care professionals regulated by the GDC.

Both the GMC and the GDC record public health as a specialism on their respective registers. Under the concept of 'distributed regulation', medically and dentally qualified public health consultants remain with their existing regulator.[10] Dual registration on the UKPHR is available to individuals with appropriate medical and dental qualifications who are on the relevant registers of the GMC or the GDC.

The United Kingdom Public Health Register

In March 2003, the UKVRPHS was established as one outcome of the Tripartite Agreement, with the explicit requirement of promoting public confidence in specialist public health practice in the UK through independent regulation and voluntary registration. Although the register was transformed into the UKPHR, the functions of the register did not change and it continues to be independent. It undertakes the following:

- publishing a register of competent public health specialists;
- ensuring through periodic revalidation that public health specialists keep up to date and maintain competence; and
- dealing with registered specialists who fail to meet the necessary standards.

UKPHR registration is designed to inform the public and employers that multi-disciplinary specialists in public health are appropriately qualified and competent, meeting the expected standards of public health specialists.

Public health professional standards

The FPH of the Royal Colleges of Physicians is responsible for standard setting within the public health profession in the UK. Both public health consultant/specialist registration processes apply standards set by the FPH, which are recognised throughout the UK. It should be noted that, unlike medically qualified individuals, non-medically qualified public health consultants/specialists are not recognised within European Union professional legislation (including the right for the recognition of their profession in other Member States) because of their current regulatory status across Europe.

Public health education and the public health training pathway

Public health has an established, consistent and coherent educational system leading to the point of registration. There is an NHS public health training pathway that takes up to five years. This includes examinations set by the FPH

and often involves a Master's-level course within a higher education institution. The educational standards applicable to non-medically qualified specialists in public health during their training are the standards for public health consultants as set by the FPH and governed by the *Learning outcomes framework*.[11]

A common pathway to registration

Therefore, while a common pathway to registration operates through the prospective public health training pathway, this is currently not the case for those completing the retrospective portfolio route and those entering onto the defined registers. In Scotland, the Public Health (Scotland) Act 2008 sets out the health protection duties of the 'Competent Person'. These duties relate to the powers of Health Boards to exclude individuals from work and other settings, to restrict certain activities, to quarantine individuals and to detain in hospital. The training and experience for the 'Competent Person' is set out in Regulations made under the Act and experienced non-medically qualified professionals can meet the requirements set out in the Act. This role-based competency requirement aligns strongly with the principle of regulation on the basis of specific roles and functions fulfilled by the individual. A common pathway to registration for all senior public health post-holders will strengthen public protection and provide a clearer basis for regulation.

Employer-based regulation

Regulation of non-medically or dentally qualified public health professionals outside the framework of the UKPHR is complex. It is incumbent on public employers to ensure that all the professionals they recruit are appropriately qualified. When a statutory system of regulation is in place, there is a shared burden of legal responsibility for protecting the public. When a voluntary register is in place, this shared burden is less well defined. When no register exists, the burden lies solely with the local employer.

Fitness to practise

Where there are concerns about the professional practice of medically qualified consultants in public health, the GMC will consider fitness to practise.

Where an individual is voluntarily registered by the UKPHR but not by another register, the UKPHR has responsibility for ensuring that the individual is fit to practise.

One outcome of a fitness to practise hearing might be de-registration (removal from the register). Actions leading to de-registration may include financial misconduct, fraud and criminal activity.

Revalidation

Trust, Assurance and Safety sets out new proposals to ensure that all statutorily regulated health professionals have in place arrangements for revalidation of their professional registration through which they can periodically demonstrate continued competence. The GMC suggested in the 2010 consultation on revalidation that 'revalidation should be a single set of processes with a clear outcome, which doctors, their patients and those who employ or contract doctors' services can understand'.[12] The definitive process for revalidation is yet to be decided; however, the direction of travel is clear.

The proposed model for dental revalidation differs from the medical model. This process is in the consultation phase. The proposal is for a three-stage model, with each stage being increasingly stringent in its remedial actions: stage one is the production of a continuing professional development portfolio and related documents for assessment; stage two is a more rigorous assessment and support framework; and stage three is re-examination.

The FPH and the UKPHR have taken into account the need for all public health consultants and specialists (medically and non-medically qualified) to be revalidated but both recognise that there is currently no legal requirement for individuals registered on the UKPHR to do this. This inconsistency could be seen as adding weight to the argument that non-medically and non-dentally qualified public health specialists need to be brought under a statutory regulatory framework.

Current regulation of public health professionals

There are currently three systems under which public health consultants and specialists are regulated. As noted above, public health consultants with a medical or dental background are regulated under the statutory regulatory frameworks of the GMC and the GDC respectively. Non-medically or non-dentally qualified specialists are regulated under the voluntary and independent regulatory framework of the UKPHR.

Professionals from non-medical or non-dental backgrounds can be admitted to the UKPHR via three routes:

- the standard prospective route;
- the retrospective portfolio route; and
- the new developmental portfolio route.

The standard prospective route

This is the main route to registration and is via prospective education and training programmes influenced by two institutions: the FPH in respect of public health; and the Royal College of Surgeons (England) in respect of dental public health. These programmes are entirely consistent with other medical and dental specialist training programmes and are organised under the auspices of postgraduate deaneries or their equivalent. Entry to the programmes is through competitive assessment. Progression through this route is governed by the assessment of achievement and passing Parts A and B of the FPH examinations or, in the case of dental public health, the Diploma in Dental Public Health.

The retrospective portfolio route

Senior public health professionals who have been working in public health and are making independent decisions in their roles are invited to present retrospective portfolios demonstrating competence based on knowledge (knows how) and experience (shows how).

Since 2003, this route has been open to public health generalists as well as defined specialists. Generalists are public health professionals who can prove knowledge and experience of public health in all 10 key areas. When accepted onto the register, these individuals are known as generalist specialists.

Defined specialists and the new developmental portfolio route

In 2006, the UKPHR created the concept of a 'defined specialist', and a route to voluntary registration was opened. Entry is again based on knowledge and experience. Defined specialists are required to show competence in the core areas of public health surveillance and assessment of the population's health and well-being; assessment of evidence of effectiveness of health and healthcare interventions; programmes and services; policy and strategy development and implementation; and leadership and collaborative working for health. Defined specialists are required to show competence in most, but not all, other areas of public health. They are required to have advanced expertise in at least two areas of experience.

Defined specialists on the UKPHR develop their competence through a first or second degree and via a professional route before seeking admission to the register. Examples include dietitians, environmental health officers, health improvement professionals, health informatics professionals and pharmacists. Many (but not all) of these professionals are statutorily regulated either under a health professional regulatory framework or through an alternative regulatory framework. Dietitians and nurses are statutorily regulated by the HPC and the NMC respectively. Some other professionals, such as environmental health officers, are governed by virtue of the Royal Charter possessed by their professional body. Health informatics professionals and nutritionists are voluntarily registered but not statutorily registered. Other professionals, such as those working in health improvement, do not currently have a dedicated professional register.

For 'defined specialists' there is no formal training route to voluntary registration, and current UKPHR policy suggests that the retrospective portfolio route will remain open for the foreseeable future. The developmental portfolio assessment route to registration, formulated and managed by the Chartered Institute of Environmental Health, provides a new entry route whereby, rather than undertaking training and examination in the mainstream public health training scheme, an individual can submit a series of portfolios over time and be entered on the UKPHR as a 'defined specialist', thus becoming eligible for appointment to senior public health posts, including that of Director of Public Health.

Public health practitioners

There is wide recognition, in line with the Chief Medical Officer's concept of the public health workforce,[13] that in the multi-disciplinary public health environment individuals work not only at specialist level but also at 'practitioner' level. In response to the need to regulate at practitioner level, the Public Health Practitioner Programme Management Group was formed in 2007, funded by the Departments of Health of all four UK administrations. The group is a collaboration between the FPH, the UKPHR, Skills for Health, the Public Health Resource Unit, the Royal Society for Public Health and Teaching Public Health Networks. As the potential voluntary regulator of public health practitioners, the UKPHR set up an internal Practitioner Development Committee to support the process.

Current registration of public health specialists/consultants

There are currently 1,470 individuals registered with the GMC under the public health specialty and 121 individuals registered with the GDC under the dental public health specialty.

There are currently 541 individuals registered with the UKPHR. These registrants are either individuals from professions other than medicine or dentistry, or members of the medical or dental professions who have chosen to take dual registration. Of those currently registered with the UKPHR:

- 74% are registered solely with the UKPHR (no other regulatory body or primary registration body);
- 13% are dually registered with the NMC;
- 7% are dually registered with the Chartered Institute of Environmental Health;
- 3% are dually registered with the GPhC;
- 2% are dually registered with the GDC;
- 0.5% are dually registered with the GMC; and
- 0.5% are dually registered with the Hong Kong Nursing Board.

3. Regulatory Policy

The purpose and principles of healthcare professional regulation

The report of the Working Group on Extending Professional Regulation[14] forms the backbone of current healthcare professional regulatory policy. This report established the principles and operational considerations for future regulation within UK healthcare, taking forward the recommendations in *Trust, Assurance and Safety*.[15] The Working Group report made recommendations in five areas: risk, costs and benefits of regulation, models of assurance, routes to regulation and involvement of other parties in regulatory policy.

Consistency and coherence of regulatory approaches across the four administrations of England, Scotland, Northern Ireland and Wales is stated as important, and continues to be so for professional, free movement and safety reasons. Regulation of public health professionals should be acceptable to the Devolved Administration legislatures, in order to provide a co-ordinated approach.

A reasoned and careful set of principles underpins the Working Group's approach to regulatory policy. Core principles, stated within the final report, are as follows:

- **The primary purpose of regulation is to secure safety**, effective and high quality care for the individuals who depend on healthcare staff.
- **Regulation should be proportionate to the risk** posed to patients and service users from practice.
- **Regulatory systems need the confidence of the public and registrants**.
- **Regulation should lead to improvements in quality of care** for healthcare users.
- **Proportionate regulatory systems need to apply equally well across sectors and employment contracts**.
- **Protected titles should be used where public common interest is promoted**, specifically where a prosecution would have a significant positive impact on maintaining community confidence.

Additionally, the Working Group specified that new regulatory systems need to take account of the wider matrix of regulation and governance systems, to minimise burdens and maximise benefit. These should add value, avoid unnecessary duplication of effort and minimise delays in taking action to protect

the public. This has been developed within broader Council for Healthcare Regulatory Excellence (CHRE) regulatory policy as the key concept of distributive regulation.

Distributed regulation

Distributed regulation describes an approach governed by the wish to minimise the burden on professionals by allowing them to remain registered with their primary regulators wherever possible. The concept of distributed regulation was first discussed in 2006 and confirmed in *Trust, Assurance and Safety* where systems were supported to enable professionals to remain with their existing regulator, rather than give up existing registration or hold dual registration.

The CHRE is currently consulting on the formal policy for distributed regulation. It suggests that a model of distributed regulation may mean that the primary regulator would continue to register the professional, but could seek advice from a relevant professional body to determine the standards that should be adhered to. Once these standards have been met, the register entry could be annotated accordingly. It has been suggested that the advantage of this model would be to provide a more co-ordinated approach to regulation and to reduce the cost and administrative burden of being registered with two different regulators. Potential disadvantages include adding a further layer of complexity to the regulation of health professionals, and making it less obvious which regulator the public should contact if there is reason to make a complaint.[16]

Drivers of arm's-length bodies

It is acknowledged that regulatory bodies fall within a statutory category of arm's-length bodies, whether set up in primary statute or operating as special health authorities set up in secondary legislation. Regulatory policy, notably on burdens, comes from the drivers of arm's-length bodies. Specifically, any new regulation should have appropriate impact for minimal burden.[17] There is a drive to promote efficiency of back office functions by regulatory bodies,[18] particularly maximising economies of scale, while meeting the purpose of each regulator. The recent *Liberating the NHS: Report of the arm's-length bodies review*[19] has confirmed the need to keep the number of arm's-length bodies to a minimum to reduce bureaucracy and costs.

Assessment of cost and cost-effectiveness

Trust, Assurance and Safety identified the real challenges involved in constructing a rigorous, comprehensive and robust assessment of the need for regulation of a professional group. The methodological and empirical challenges in the costing and the quantification of the risks and benefits of professional regulation are recognised as considerable.

Estimated costs of litigation, complaints and referrals to regulators are often used as proxies, but this leaves the definition of 'excessive cost' a matter of judgement. Any new statutory regulation must closely consider the cost of a professional's time and costs related to registrants' fees. Current regulatory policy emphasises the importance of the least use of taxpayers' money and the most cost-effective solutions.

Specialties and sub-registers

Many specialties and defined groupings are regulated through formalised sub-registers within professional registers, commonly in addition to registration based on achievement of a primary healthcare qualification. Within public health, three specialty lists or sub-registers of note operate: those of the General Medical Council (Public Health Specialty), the Nursing and Midwifery Council (Specialist Community Public Health Nursing) and General Dental Council (Dental Public Health). As with main registers, these operate in the interests of public protection, enabling members of the public and employers to identify professionals who are qualified and fit to practise.[20]

It is possible within the Health Professions Council (HPC) to differentiate within professions, although in this instance the individual is not part of a generic professional grouping but registered for their specialty. This is true for professions such as psychology that operate sub-categories within the profession, with nine distinct registers for their specialties (for example clinical psychologist and occupational psychologist).

Protected titles

Protected titles are enshrined in legislation and are used by health professionals to indicate their field of practice to patients and the public. Registration under a protected title authorises the use of that title; and use of the title while unregistered is a legal offence. This differs from legal protection of function, which refers to specific acts a practitioner undertakes. These are not mutually exclusive, as individuals practising under a protected title can, within their activity, undertake protected acts as part of their professional duties. In this instance, registration is required to undertake an act, and without registration the individual is practising illegally.[21]

Titles should be minimised where possible so as to reduce the potential harm to the public from individuals using variants of a title without needing to register.

The policy, therefore, is to keep the number of protected titles as low as possible[22] in order to:

- promote clarity in the field of practice to patients and the public;
- tackle title misuse;
- reduce the number of debated protected titles going through legislation (so increasing the likelihood of them being passed into legislation); and
- have register administration costs (registration costs) that are proportional to registrants' risk of causing harm.

Requirements for a profession to be statutorily regulated

Any given profession seeking statutory regulation is assessed against criteria that indicate its suitability, appropriateness and preparedness for regulation. The HPC operates a transparent process in support of these goals, indicating that any aspirant group wishing to be regulated must:

- cover a discrete area of activity displaying some homogeneity;
- apply a defined body of knowledge;
- have practice based on evidence of efficacy;
- have at least one established professional body that accounts for a significant proportion of that occupational group;
- operate a voluntary register;
- have defined routes of entry to the profession;
- have independently assessed entry qualifications;
- have standards in relation to conduct, performance and ethics;
- have fitness to practise procedures to enforce those standards; and
- be committed to continuing professional development.

4. Risk Assessment

Appraisal of risk should address those aspects of public health practice that are directly relevant in any regulatory system. These are risks associated with particular functions, so an appraisal would need to address those that could be affected by the specific benefits given by statutory regulation.

It was noted in *Good doctors, safer patients*[23] that the approach of risk-based regulation is generally sound. However, the report also contains the caveat that 'whilst risk-based regulation is an attractive concept, there are considerable difficulties in implementing it within medical regulation… the evidence base on differential risks posed by specific groups of practitioners is poor'.

Similarly, in the introduction to *Trust, Assurance and Safety*,[24] it is noted that 'empirical information on the prevalence of death, injury, disability and mental distress caused by inadequate professional competence or malicious, discourteous or abusive conduct is not available'. Furthermore, it questions whether the 'costs and burdens of accurately collecting these data [can] be justified'. The Chief Medical Officer points out the difficulties of 'capturing quantitatively the intangible dimensions of issues that sit at the heart of healthcare regulation'. To some degree, he notes, we can measure components such as public and professional confidence, the costs of litigation, rates of complaints and the number of referrals to regulators.

This Review has therefore used available evidence and contributions made following the public call for evidence to examine the level of enforceability required to protect the public from harm in respect of the provision of public health services, focused substantially at the population level, by public health consultants/specialists. A partial regulatory impact assessment is provided at this stage (see Annex B); a decision about undertaking a full assessment will be made at a later stage.

Data on poor practice

The Review posed specific risk questions to a variety of statutory and voluntary healthcare professional regulators, to government agencies dealing with risk and to the main healthcare professional defence unions. The evidence about concerns with regard to the public health function is set out below, grouped by organisation contacted. Taken as a whole, it demonstrates that the work engaged in by public health specialists does give rise to concerns about public harm, albeit not all that frequently but to the extent that autonomous voluntary

self-regulation at the highest levels of the public health profession would be an unwise regulatory model.

The General Medical Council

The fitness to practise database was reviewed from April 2006 onwards. On average the General Medical Council (GMC) received about 5,500 referrals per year. A total of 119 public health doctors were investigated during this period. The majority of concerns related to clinical care (45%) and relationships with patients (20%). Some of these concerns would not be comparable to the issues facing non-medically qualified public health specialists, but the issues surrounding relationships with patients included complaints of poor communications skills, which is a core competence for public health specialists as well as consultants.

Some 23% of the fitness to practise concerns related to probity, an area that covers the writing of false or misleading reports or giving false evidence. A core function undertaken by public health specialists/consultants is the generation, analysis and use of evidence; and weaknesses in this area could have significant effects on health interventions for populations. Such weaknesses could also have an impact upon the functions of a Director of Public Health, such as the requirement to produce an annual public health report for their population. Additionally, within the quality assurance of services, failures to correctly understand and act upon evidence could result in poor quality services that have substantial individual mortality effects (for example where the quality assurance of a breast screening service is poor).

The final category of allegations against those public health consultants investigated by the GMC involved working with colleagues, an area which includes working in teams and leadership skills, such as the ability to delegate work. This competence is certainly relevant to the roles of non-medically qualified public health specialists.

The National Clinical Assessment Service

In September 2009, the National Clinical Assessment Service (NCAS) of the National Patient Safety Agency published a review of its casework for its first eight years. It looked at referrals and assessments dealing with concerns about the performance of doctors, dentists and pharmacists.[25] The NCAS practitioner groupings include one for doctors, dentists and pharmacists working in the combined fields of public health medicine and community health services.

For the purposes of this Review, the NCAS was able to analyse data for nine years of cases in respect of those at consultant level (or equivalent) for public health groupings; it found 18 cases through to year eight and then two further cases from year nine – a total of 20 cases. NCAS staff scanned the case summaries to ensure that the case involved individuals working as public health officials. Some consultants who have a clinical specialty, in addition to their specialism in public health medicine or dental public health, continue to do clinical work.

Of the 14 cases that were pertinent to this Review, six cases involved behaviour issues, three were related to the health of the professional and five involved concerns about public health skills.

The areas where cases were found – these would apply equally to specialists and consultants – involved the management of measles, swine flu, rabies and *E. coli* (one case found in each category).

The NHS Litigation Authority

The NHS Litigation Authority (NHSLA) database contains in excess of 78,000 claims – mostly related to clinical injuries. Within this, there is coding for community medicine/public health and the NHSLA has recorded approximately 290 cases in this category. As such cases would also include birth injuries stemming from the work of a community midwife, such clinical events in the community would not be relevant to the work of a public health specialist engaged in non-clinical matters. Unfortunately, many of the 290 case files are now archived and unavailable for further review without disproportionate additional effort. Therefore no conclusions were drawn from the experience of the NHSLA.

Private insurers and indemnity groups

A number of medical and dental defence organisations searched their databases on behalf of this Review. In respect of public health professionals, issues complained about included:

- decisions about access to treatment;
- confidentiality; and
- evidence given in court or to public inquiries.

These are areas where poor practice would be of concern for both consultants and specialists in public health. However, while legal costs were sometimes incurred in dealing with such matters, few if any compensation payments were made by the defence bodies; this is because most claims related to positions held either in the NHS or in government, where responsibility for the matter rests either with the NHSLA or with (the insurers of) public bodies.

In essence, the various medical/dental defence bodies incur substantial costs only for cases in the private sector or independent practice of public health, which is a very small category.[26]

Public safety

Legislation concerning health professionals is enacted, and regulatory bodies established to oversee such professionals, for the purpose of protecting the public. In the context of the health professions, issues of protecting the public usually arise in relation to the provision of care to patients. This may be in the context of direct or indirect provision of care. For example, the provision of diagnostic services may frequently be carried out in the absence of any direct patient contact. Similarly, treatment planning or the correct calibration of complex machines may have a substantial impact on the well-being of individual patients but may not involve patient contact.

Senior public health professionals generally make or advise on decisions that affect the health of populations. Their professional activity may involve the action needed to respond to a serious public health problem affecting large numbers of people or the action needed to avoid such a problem occurring. The issues they deal with may be long term, such as in the case of chronic diseases, or of immediate importance, such as dealing with outbreaks of communicable disease.

Although many will only rarely be involved in direct clinical interventions with individuals, public health professionals are often in contact with individuals within communities, their civil society organisations and their elected representatives. Sometimes their advice is closely related to individuals, for example in respect of exceptional treatment requests.

The increased attention being paid to the development of resilience capability across civil society impinges on the work of public health professionals. Advising on the health consequences of long-term exposure to hazardous substances or dealing with the immediate health risks in the context of fires, explosions or natural catastrophes are growing components of contemporary public health practice.

There is, therefore, ample evidence that the activities of public health professionals can substantially impinge on the health of individuals and communities in both the short and long term.

There may be instances where professional probity is lacking or there may be instances of malfeasance in office or misconduct. Non-technical skills (both cognitive and social) are important in the work environment; issues such as an inability to engage in team-working or poor ability to communicate about risk

may be raised as a cause for concern. Public health specialists may, along with the rest of the population, suffer from behavioural difficulties (other than misconduct) and from physical or mental health problems (including substance misuse). Again, the public must have confidence that there are trustworthy mechanisms in place within a health profession for dealing with concerns about behavioural matters.

Two core public health functions where there are risks from poor professional practice are health protection and evidence-based resource allocation. General descriptions of the risks associated with these two functions are presented below.

Health protection

The health protection function includes the management of a wide range of communicable diseases and environmental hazards in addition to their surveillance at a population level.

Communicable diseases

Meningococcal disease (meningitis, septicaemia or other invasive disease, for example orbital cellulitis or septic arthritis): if contacts are not traced and given prophylactic antibiotics there is a risk of the individual or their contacts developing meningococcal disease – with the associated potential outcomes.

Food-borne infection: if the source of an infection such as salmonella or *E. coli* is not traced and dealt with appropriately, there is a risk of a greater number of the population developing infection – with the associated potential outcomes.

Environmental hazards

If an environmental incident takes place (for example the explosion at the Buncefield fuel depot) and the wrong public health advice is given about evacuating an area, there is a risk of mortality or morbidity among the public.

Effective surveillance

A failure to undertake effective surveillance holds significant risk, as poor surveillance leads to late ascertainment of outbreaks and has a potentially more harmful impact than poor control responses.

Evidence-based resource allocation

The resource allocation function within public health includes allocation of resources for specialist treatments and commissioning public and personal health service developments. If evidence is inaccurately assessed, there is a potential risk of mortality or morbidity to the individual patient who requires specialist treatment; or risk of increased levels of disability, morbidity or mortality in a population if incorrect choices are made about intervention programmes.

5. Case Studies of Professional Regulation

Other healthcare professions have developed systems of regulation for their workforces that cover a range of available routes, forms and scope of regulation. These examples are designed to highlight where extant or currently developing regulatory approaches could inform the approach taken to public health professional regulation for the consultant, specialist and practitioner workforces. Those dimensions of their regulatory approach found to be of particular interest to present public health regulation are highlighted in the boxes.

Regulation of pathologists

- **Pathologists are regulated by three separate bodies. Medically qualified pathologists are regulated by the General Medical Council (GMC); dentally qualified pathologists are regulated by the General Dental Council (GDC); and clinical scientist pathologists are regulated by the Health Professions Council (HPC).**
- Fellowship of the Royal College of Pathology is open to these three groups within the workforce (in addition to veterinary surgeons), and **there is parity and equal professional standing between the three groups** (currently 20% of the members of the Royal College are non-medically qualified professionals).
- **The NHS posts for which the three groups in the workforce are eligible vary:** medically qualified pathologists are eligible for consultant medical posts; dentally qualified pathologists are eligible for consultant oral pathology posts; and clinical scientists are eligible for consultant clinical scientist posts.

The Royal College of Pathologists is one of the professional bodies for pathologists in the UK. The College's aim is to advance the science and practice of pathology, to provide public education and to promote research in pathology. In order to do this, it sets professional standards for trainees in the pathology specialties for the award of Fellowship of the Royal College of Pathologists (FRCPath). This is usually awarded through Part 1 and Part 2 examinations; however, Fellowship can also be awarded via other routes, including the submission of published works and by invitation of the College Council.

The FRCPath by examination is a prerequisite for entry to the Specialist Register for doctors applying via the Certificate of Completion of Training (CCT). However,

although the FRCPath by examination may be an integral part of securing a CCT, the FRCPath alone does not automatically deliver a CCT without documented completion of an approved training programme in the UK. The award of the CCT marks the end of a defined specialist or specialty training programme in the UK.

The FRCPath by examination is also a prerequisite for entry to the Specialist Register Certificate of Eligibility for Specialist Registration (CESR) through the combined programme route. For the CESR, doctors have to show evidence of success in the FRCPath or other specialty qualification. This is an alternative route to the Specialist Register for doctors who do not complete their training through an approved UK training programme. For trainees who satisfactorily complete specialist training in the UK, entry to the Specialist Register of the GMC will be dependent upon the award of a CCT, CESR or a CESR (Combined Programme). Entry on the Specialist Register will allow a doctor to take up a substantive, honorary or fixed-term NHS consultant post in the UK.

Clinical scientists account for around 20% of the membership of the Royal College of Pathologists and are eligible to become an FRCPath in their area of specialism. For example, clinical scientists are the principal professional group in laboratories in genetics, histocompatibility and immunogenetics and make up a significant proportion of the consultant body directing clinical biochemistry laboratories in the UK. Once clinical scientists have been successful in attaining Part 1, they are then eligible to undertake Part 2 and to be awarded a Fellowship. Clinical scientists generally take the Part 2 exams around eight years after attaining their first degree, whereas medical trainees are constrained by their training contracts and generally take the final examinations in the fourth year of specialty training. For clinical scientists, as with medical practitioners, FRCPath confers eligibility for independent working and appointment to a consultant clinical scientist post in their area of specialism.

The Fellowship route is open to medical practitioners, dental practitioners and clinical scientists. The College maintains parity and professional standards between all three routes to FRCPath. The College does not, however, regulate the profession. Regulation is via the GMC for medically qualified practitioners, the GDC for dentists and the HPC for clinical scientists. While the GMC recognises pathology as a specialty and annotates this on its register, neither the GDC nor the HPC currently has this function in their respective registers.

The HPC is working closely with the Council for Healthcare Regulatory Excellence (CHRE) on the issue of whether advanced practice should be regulated. The current arrangement requires employers to ensure that clinical scientists working as consultants are fit to practise in the role in which they are working. Although future plans are currently undefined, it is clear that clinical scientists under the umbrella of the CHRE are considering the regulation of advanced practitioners.

Clinical scientists who are FRCPath have access to continuing professional development (CPD), as do all members of the College; they are also required to undertake CPD as a requirement of registration with the HPC and are subject to CPD audit in order to stay on the register. While medically trained individuals with FRCPath will shortly be required to undertake revalidation, this is not a requirement for clinical scientists at present. This anomaly is not unique to pathologists, and several professions are tackling this issue.

Regulation of pharmacists

- A review of the regulation of this profession recommended the separation of **the standard-setting function and registration function**. This is being implemented for the pharmacy workforce in 2010: the General Pharmaceutical Council (GPhC) has been created as an independent regulatory body for pharmacists.
- Pharmacy operates a **common route to registration**, with an accredited degree and specified year of pre-registration training required before admission to the register.
- Within pharmacy, the legal responsibility for ensuring that pharmacists are competent to practise in the advanced and specialist roles is held by the employer, not the professional regulation body.
- **The regulatory bodies are considering the regulation of advanced practitioners.**

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional body for pharmacists in Great Britain. Until recently it was also the regulatory body for pharmacists and pharmacy technicians in England, Scotland and Wales (see below). The Pharmaceutical Society of Northern Ireland (PSNI) regulates pharmacists in Northern Ireland.

To take into account the principles of professional regulation as set out by the Secretary of State for Health in *Trust, Assurance and Safety*,[27] a working party chaired by Lord Carter of Coles was set up with the remit of reviewing professional regulation and leadership in pharmacy. Seven recommendations were made by the working party, the first of which was that the GPhC should be created as an independent regulatory body for pharmacists in the UK, and so move regulation away from the two professional bodies (the RPSGB and the PSNI). Regulation by the GPhC replaced regulation by the RPSGB in 2010. For Northern Ireland, the PSNI will remain the regulatory body for the foreseeable future.

Pharmacists in the UK gain admission to one of the two registers by attaining a relevant first degree from a validated university, followed by completion of one year of pre-registration training supported by a tutor. This process is being reviewed under the Medical Education England work programme Modernising Pharmacy Careers driven by the White Paper *Pharmacy in England: Building on strengths – delivering the future*.[28]

CPD is a mandatory requirement for registered pharmacists, and all pharmacists are required to keep a CPD record. Appropriate professional education development opportunities are currently offered to pharmacists via higher education institutions.

Pharmacists may choose to specialise in an area of practice after entering onto either of the two registers. These areas of specialist practice are not currently annotated on the registers, with the exception of prescribing. The Pharmacy Order 2010 details the powers of the GPhC and provides power to annotate entries to the register to denote specialisation if required in the future.

Pharmacists who choose to specialise at an advanced level can become eligible to apply for pharmacist with a special interest or consultant pharmacist roles; these roles have been developed based on local need. The competencies of consultant posts are defined in the Department of Health's *Guidance for the Development of Consultant Pharmacist Posts*[29] and are based on four main functions: expert practice, research, education and professional leadership.

A pharmacist with the appropriate skills and knowledge can choose to apply to be admitted to the United Kingdom Public Health Register (UKPHR) as a 'defined specialist'. If successful they will be dually registered on the UKPHR and GPhC/PSNI registers.

The current arrangement requires that employers ensure that pharmacists working as consultant pharmacists and pharmacists with a special interest are competent to practise in the role that they are performing. For pharmacists working in the NHS, this is managed via the Knowledge and Skills Framework and local governance arrangements. The future regulation of consultant and advanced practice in pharmacy via the registers is currently undefined. What is clear is that pharmacy, under the umbrella of the CHRE and in response to *Advanced Practice: Report to the four UK Health Departments*,[30] is considering regulation of advanced practitioners.

In parallel, the Modernising Pharmacy Careers Programme Board of Medical Education England will be delivering Developing Pharmacy Careers (Post Qualification). This will cover knowledge and skills development for pharmacists as they move towards advanced practice. These will be developed through careful consideration of the competencies required for annotation of entries to the register, if such annotations are put in place.

Regulation of physician assistants

- **Physician assistants operate at the practitioner level, but have clearly described 'dependent' status:** when qualified they work under the supervision of a fully trained doctor.
- Entry requirements for the profession of physician assistant are a life sciences degree and assessment of their character. **Agreed national standards of training and competence were a critical precursor to professional regulation of this group.**
- The exact process of regulation for new non-medical professional roles for this group is yet to be decided.

The model of the physician assistant role was developed in the US in the 1960s and developed by the Department of Health in pilot form in the early 2000s. The outcome of this work was the consultation document entitled *The Competence and Curriculum Framework for the Medical Care Practitioner*[31] and later published as *The Competence and Curriculum Framework for the Physician Assistant*.[32]

A physician assistant is defined as: 'A new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.'[33]

The publication of this competence and curriculum framework was a move towards professional regulation through agreed national standards of training and competence.

A physician assistant can undertake specific roles, including formulating and documenting detailed differential diagnoses; developing a comprehensive patient management plan; maintaining and delivering clinical management on behalf of the supervising physician; and requesting and interpreting diagnostic studies.

Individuals who are eligible and able to train as physician assistants have a life sciences degree and are required to be of 'good character'. When qualified, physician assistants are health professionals with a generalist medical education that allows them to work in a variety of settings. They have a 'dependent' status – that is, they work under the supervision of a fully trained doctor. Unlike a fully trained doctor, they are not legally able to prescribe drugs. The Agenda for Change evaluation of a newly qualified physician assistant role defined the role as Band 7.[34]

Physician assistant as a healthcare profession is very new to the NHS in the UK despite the long history of the role in the US. Over the past seven years, assistants

from the US have been working within the UK system. It is only in 2010 that assistants from the UK have begun to graduate from UK universities.

The physician assistant practitioner competence framework was developed with the Royal College of Physicians, the Royal College of General Practitioners, Skills for Health and the higher education institutions. The role of physician assistant is defined and practice and competence governed by the *The Competence and Curriculum Framework for the Physician Assistant*, which is linked to the NHS Knowledge and Skills Framework. The profession is currently not statutorily regulated; however, there are moves towards regulation via the HPC.

The regulation of the non-medical healthcare professions[35] consultation document recommends that one or more of the existing regulators should become the 'lead regulator' for new professional groups such as physician assistants. The lead regulator will set the standards that apply to everyone who registers as a physician assistant. This applies whether the professional is a direct entrant into the profession or from an existing profession. The exact process of regulation for new non-medical professional roles is subject to the outcome of the consultation.

Regulation of surgical care practitioners

- **Surgical care practitioners operate at the level below consultant or specialist.** The role, originally developed as a supporting role for surgeons, is now a registered professional group.
- **The original profession of the health practitioner who becomes a surgical care practitioner determines which register they are on.** Nurses who are surgical care practitioners are registered by the Nursing and Midwifery Council (NMC).
- Surgical care practitioners do not at present have any 'advanced practitioner' roles denoted on the registers; where individuals are operating in advanced surgical care practitioner roles, responsibility for their competency in that role rests with the individual and the employer.

A surgical care practitioner is defined as: 'A non-medical practitioner working in clinical practice as a member of the extended surgical team who performs surgical intervention, pre-operative and post-operative care under the direction and supervision of a consultant surgeon.'[36]

There are currently over 400 surgical care practitioners in the UK. Surgical care practitioners usually work at Agenda for Change Grade 8a or 7. Most frequently, they are individuals who have developed advanced practice and who are statutorily registered as nurses, operating department practitioners, physiotherapists or podiatrists.

The role of the surgical care practitioner is governed by the Department of Health's *Competence and Curriculum Framework for the Surgical Care Practitioner*. There are two career pathways to becoming a practitioner: by portfolio entry for existing surgical care practitioners; or by successfully completing a two-year surgical practitioner programme. The curriculum is delivered by a number of accredited universities in England, Wales and Northern Ireland. The accreditation is provided by the Royal College of Surgeons' Quality and Standards Committee. Accreditation of programmes within Scotland is at the discretion of the Scottish Surgical Royal Colleges.

All surgical care practitioners are currently health professionals who are registered as a result of their original training. The original profession of the health practitioner determines which register they are on. For example, a nurse will be regulated by the NMC and a professional allied to medicine will be regulated by the HPC.

Neither the HPC nor the NMC has advanced practitioner or specialist annotation on their registers for surgical care practitioners. The current arrangement requires employers to ensure that surgical care practitioners working with that title, or a title which is similar, are competent to practise in the role in which they are employed.

6. Options Appraisal

The conventional model of statutory professional regulation may be required for any workers currently unregulated or voluntarily regulated. There are, however, a number of alternative regulatory regimes that could be appropriate, and so merit consideration here. A summary of options and variables to consider is provided in Table 1.

One category was excluded – that of light touch regulation. This is where the individual patient or service user takes the primary responsibility for considering risk. Due to the population level activity associated with public health, individual patients or service users would not be in a strong position to do this, for example in the case of an incident such as a tuberculosis outbreak.

The options here are stated broadly in order of the scale of intervention or strength of regulation they provide.

Option 1: Mixture of statutory and voluntary self-regulation

No change to present system

It is possible to retain the current system, unamended, of the General Medical Council (GMC) and the General Dental Council (GDC) with the United Kingdom Public Health Register (UKPHR) running voluntary self-regulation. If this option were to be pursued, government could elect to enhance the structures and policies surrounding existing voluntary self-regulation, such as:

- **Employer-based action on minimum standards.** Future public health service circulars, directives and inspection standards related to public health staff roles in the public health service/local authority/NHS could provide for checks and balances within organisations.
- **Stronger voluntary register guidance to employers.** Consideration of powers related to organisations, so that guidance from the voluntary register (notably on the registration requirements of non-medically trained public health specialists) is strengthened.
- **Enhanced use of the Independent Safeguarding Authority (ISA).** Employers can be encouraged to use the ISA's systems to record when any employee or volunteer has harmed a child or vulnerable adult. Clearly, this is limited in application to public health as interventions are likely to be with individuals outside these groups, and operating at the population level.

This is not a stand-alone option: the above actions could be put in place in addition to other changes to regulation.

Advantages: This is an option costing approximately £100,000 annually, using existing systems for influencing employers.

Disadvantages: This option would operate within employing organisations, whereas individuals can choose to leave roles and bypass organisational systems or move from local government to the NHS or vice versa. This would require the use of multiple routes of influence, and organisational compliance, to improve accountability and standards. The new public health system will involve multiple providers, particularly for health improvement functions, and therefore the workforce will continue to be spread across private, third sector and other organisations, limiting the ability of employers to drive standards. Ongoing central funding would be in conflict with the approach to reduce top-down Department of Health decisions affecting workforces as articulated in *Equity and Excellence: Liberating the NHS*.[37]

Option 2: Fellowship model

Quasi-regulation

Some specialties have adopted a Fellowship model, where entry or acceptance into the profession, from a variety of routes, is signalled by the rewarding of a Fellowship. The organisation that awards the Fellowship then performs a quasi-regulatory role, monitoring and/or reassessing the profession. The title of Fellow is protected. Applying this option to public health, the Faculty of Public Health could operate quasi-regulation by awarding Fellowship status to those with membership of the Faculty of Public Health and those with registration on the UKPHR, and act as an enhanced professional body.

Advantages: Standards are policed by professional bodies rather than statutory regulators, potentially lowering compliance costs. This would allow for a consolidation of bodies within public health, and result in a stronger Faculty. This option would require investment in the development of a more robust and extensive Fellowship system.

Disadvantages: This option may provide little above the level of cover and assurance that the UKPHR currently gives (a possible increase only in title protection), and would require the functions of the UKPHR to be present within the Faculty of Public Health. It would therefore be unlikely to represent a cost improvement when compared with the current system.

Option 3: Chartered status

Quasi-regulation

Through amendment of an existing charter, or the application for a new charter, a body could offer chartered status to public health professionals. The chartered title would be protected. The Royal Society for Public Health, already an organisation with a Royal Charter, is a body that could develop this within the broad context of public health. The Chartered Institute of Environmental Health already applies this approach to environmental health officers.

Advantages: This option uses existing bodies and expertise in public health. If applied to a group that is not currently regulated, the formation of the quasi-regulatory machinery needed to operate the system would require standards and regulatory requirements to be applied to that group for the first time. Through this process it would also perform a role in formalising standards for the new group being regulated. Taking forward the chartered status option is likely to be faster than changes to primary or secondary legislation, and have low transition costs.

Disadvantages: If applied to non-medically qualified public health specialists, this option could be expected to incur approximately the same running costs as the current UKPHR and would need to be structured so as to make it a self-financing body; some transitional funding might be necessary for the administrative costs of amendment of an existing charter.

Option 4: Conferring upon the United Kingdom Public Health Register the status of statutory regulator

Statutory status within a new statutory regulator

Through legislation it would be possible to make the existing UKPHR a statutory regulator, with many of the same responsibilities as it currently has for registration but within a statutory framework. This would require legislation and would entail the formation of a new body, either with a relationship to the Department of Health (arm's length) or independent, and including the protection of a title for non-medically or non-dentally qualified public health specialists. Amendments to the operation of the UKPHR would be necessary to make it a self-financing body, but any other changes to its operation would be determined independently.

Advantages: The UKPHR already has expertise in the registration of public health professionals, and minimal disruption to the profession would be involved in this option.

Disadvantages: The creation of a new organisation would not be in line with the principles of back office efficiency set out in *Liberating the NHS: Report of the arm's length bodies review*.[38] The creation of a new statutory regulator would have significant administrative costs, as well as parliamentary costs to a greater or lesser extent (depending on the legislative vehicle).

Option 5: The General Medical Council registering public health specialists

Statutory status within an existing statutory regulator

Amendments to the Medical Act 1983 would be needed to extend the remit of the GMC (or possibly the GDC) to include public health specialists from a non-medical background. The processes and systems within the GMC would need to be amended to allow regulation of a group without primary medical qualifications. The GMC, however, is already undertaking major programmes of change and is unlikely to welcome a radical extension of its role beyond the medical profession in the foreseeable future.

Advantages: This would not require the creation of a new body and would promote efficiency of back office functions. It would allow the public health specialist workforce to be regulated by the fewest number of regulatory bodies. There would be ease of creating parity between professionals.

Disadvantages: Changes to the GMC remit have to be agreed by Parliament and may well be contentious. Any change would be subject to the timetable required by secondary legislation.

Option 6: The Health Professions Council registering public health specialists

Statutory status within an existing statutory regulator

It is possible for the remit of the Health Professions Council to be extended to cover public health by creating a new part of the Council's Register for public health specialists or practitioners.[39] Legislation would be required for this option, too.

Advantages: The HPC operates an annual retention fee system, currently £76, so is self-financing thereafter. Indeed, the fee is considerably less than the annual retention fee levied by the UKPHR, currently £250. It promotes efficiency of back office functions as it is using an established regulator. The HPC has a proven track record of taking on the regulation of new professions, having done so in recent years with Operating Department Practitioners and Practitioner Psychologists, and they have generic procedures in place for handling conduct, health and other issues for a wide range of professions, which means their framework is very flexible and adaptable to the integration of a new profession.

Disadvantages: Regulation of the public health specialist workforce would sit across three main regulators; therefore, strong ongoing coordination across regulators, and a strengthened role for the Faculty of Public Health, would be required to promote consistent approaches to the workforce. The HPC would require a one-off fee to establish the register under its auspices; depending on the size and complexity of the register, this could be in the region of £300,000.

Table 1: Summary of regulatory options

Option	Description	Cost estimate	Fit with distributive regulation/ALB* policy
1. United Kingdom Public Health Register (voluntary self-regulation)	No change to the current system of voluntary regulation.	£100,000 annual cost	Fits with distributive regulation. No effect on ALBs.
2. Fellowship model (quasi-regulation)	Use professional organisations to take forward Fellowship as a protected title of the profession.	Uncertain administrative cost in establishment and costs associated with legislation.	If both medics and non-medics are Fellows, there would be duplication. This would not fit with distributive regulation. No effect on ALBs.
3. Chartered status model (quasi-regulation)	Through amendment of an existing charter, create a chartered status for non-medically qualified public health specialists.	Transitional funding for administrative costs of amendments to existing charter. Relatively low cost.	Fits with distributive regulation. No effect on ALBs.
4. United Kingdom Public Health Register as statutory regulator (statutory regulation with a new regulator)	Through legislation to establish the UKPHR as a statutory regulator.	Transitional funding for establishment of a new regulator. Costs of doing this vary widely, but this is a relatively large cost compared with using an existing regulator.	Fits with distributive regulation. Does not fit with ALB policy, which does not support the establishment of additional regulators.

Table 1: Summary of regulatory options continued

Option	Description	Cost estimate	Fit with distributive regulation/ALB* policy
5. General Medical Council (statutory regulation with an existing regulator)	Amend GMC statute to allow for regulation of non-medically qualified public health consultants/specialists.	Costs for administering new profession. Relatively low cost compared with establishing a new regulator.[41]	Fits with distributive regulation. No effect on ALBs.
6. Health Professions Council (statutory regulation with an existing regulator)	Legislation to create a new part in the Register maintained by the Health Professions Council for the registration of public health consultants/specialists.	Costs for administering a new profession. HPC makes a charge for new professions: in the region of £300,000.	Fits with distributive regulation. No effect on ALBs.

* Arm's-length bodies

7. Regulation of Public Health Practitioners

Developing a regulatory pathway for public health practitioners[42] provides a summary of the extensive work to date on regulatory standards, frameworks and routes to practitioner regulation in the UK. This, alongside other publications from the United Kingdom Public Health Register (UKPHR) and the Faculty of Public Health Practitioner Development Working Group, illustrates the significant groundwork already undertaken to advance education, training and assessment mechanisms for public health practitioners.

Practitioners' areas of activity

Practitioners have been defined[43] as those with a responsibility for specific areas of public health work, who continually develop their area of work and support others to understand it. Practitioners are likely to contribute to multi-agency and multi-disciplinary programmes of work. Generally, practitioners will work as part of a larger team led by someone working at a higher level. This definition intentionally aligns with, and was developed from, the *Public Health Skills and Career Framework*[44] for the overall public health workforce.

The areas of activity in which public health practitioners work cover a wide range of public health activity: health improvement, health protection and improving services. Public health practitioners work in public, private and third sector organisations.

Public health practitioner standards

Four standards for public health practitioners' practice exist, detailed in revised practitioner standards developed by the UKPHR. These standards are: professional and ethical practice; technical competencies in public health; application of public health competencies to public health work; and underpinning skills and knowledge. Each of these four standards is further described by indicators of effective practice that have been consulted upon and were developed to promote robustness and simplicity; they provide a focus on public health practice linked to assessment of risk and safe practice.

Public health practitioners' body of knowledge

Scoping and mapping of educational qualifications for public health practitioners have been undertaken.[45] There are an estimated 22 higher education institutions across the UK offering first degrees with public health, or a particular aspect of public health, in their titles at BSc, BA or Foundation degree level. The modules, choices and pathways within the programmes offered have yet to be mapped to establish the appropriateness of the content of the programmes for meeting the public health practitioner standards. There are 33 providers offering programmes in public health nursing designed to meet the Nursing and Midwifery Council standards for specialist community public health nursing.[46]

Assessment of public health practitioners

A proposed assessment process for public health practitioners has been developed[47] by the UKPHR and the feasibility of a UK-wide common framework has been considered.

Assessment is in the pilot phase, with trials of the process, assessor training and assessor development taking place alongside the first practitioner learning sets and local assessments. The pilots provide programmes of support as well as assessment of individuals against the UKPHR's revised practitioner standards. These programmes are ongoing in the South East Central Strategic Health Authority area of England and in Wales. Each assessment process is using independent assessors, and the identification of training and development needs is likely to have a positive impact upon career development and skills improvement.

Regulation of public health practitioners

The suitability of public health practitioners to become a regulated workforce can be assessed against many of the same criteria used for the regulation of new professions which have already been considered in this document in relation to public health consultants and specialists.

Additionally, there are considerations specifically related to practitioners. The *Career Framework for Healthcare Scientists in the NHS* (2005)[48] suggested that practitioners seeking entry to the Health Professions Council register fell into three categories that require regulation:

1. Practitioners with a limited scope of practice in a particular specialism, having been awarded an HNC/HND/Dip HE, Foundation degree or equivalent vocational qualification.

2. Practitioners who perform a broad range of clinical, technical or scientific procedures having been awarded a first degree (vocational) or equivalent.

3. Practitioners who provide a range of specialist services, having been awarded a postgraduate qualification equivalent to Master's level.

Consideration of these criteria indicates that, given the stage of development of public health practitioner regulation, the operation of quasi-regulation or voluntary regulation now seems a logical option to consider. Pursuing a form of quasi-regulation, such as chartered status or voluntary regulation, would promote stronger career structures, professional recognition and professional allegiance. It would improve quality assurance and quality control of the public health practitioner workforce. These objectives, however, are not dependent on statutory regulation.

Operation of quasi-regulation or voluntary regulation is in some instances a precursor to statutory regulation; alternatively, it can be deemed appropriate as the form of regulation for a workforce. Development of these forms of regulation would allow for valuable further consideration of requirements for the body of knowledge, prospective routes to entry, fitness to practise and continuing professional development elements of regulation, together with the learning from assessment pilots and the establishment of appropriate processes and systems.

8. Recommendations

This Review concludes that public expectation is such that, without the introduction of mandatory regulation of public health consultants and specialists by statutory health professional regulatory bodies, confidence would be lacking in public health professionals engaged at a high level in public health policy, planning and actions.

1. It is recommended that the Health Professions Council should regulate public health specialists as an additional profession, and that there is no substantial change in the roles of the General Medical Council, the General Dental Council and the Nursing and Midwifery Council in respect of public health.

2. It is recommended that the title Consultant in Public Health be protected for individuals registered on the appropriate specialty registers or sub-registers of the General Medical Council and the General Dental Council, and the proposed public health register of the Health Professions Council. If it is not possible to protect the title of Director of Public Health then an alternative mechanism should be enacted to ensure that only consultants in public health could occupy such posts.

3. It is recommended that there should be, as far as possible and allowing for dental public health, a single training pathway for specialist training in public health and that the Faculty of Public Health should carry out the central role in relation to public health education and standard setting. After an appropriate 'grandfathering' period, if such an approach were deemed necessary, formal training would be the single route to registration with minimum exceptions.

4. It is recommended that, as part of the Health Professions Council's arrangements coming into being, regulation should move as soon as possible to being entirely self-funded.

5. The case for statutory regulation of defined specialists is not made at present. The absence of required attributes of health professional formation, including established training routes and a compelling case for the protection of the public, means that these groups do not currently meet the criteria for statutory regulation of a profession.

6. During the course of the Review, the Royal Society for Public Health proposed a chartered route to professional recognition within public health. The possible advantages of developing chartered status for public health practitioners, as distinct from specialists, within the public health workforce are worthy of further exploration.

7. It is recognised that there will be a need for consistent approaches to professional development and revalidation between public health specialists on the statutory registers and the Faculty of Public Health should have a central role in producing common frameworks.

9. Conclusion

Regulation of public health professionals forces a consideration of both general principles and the specific qualities of the profession. An increase in regulation can in some cases be deemed excessive and in others entirely warranted. The debate may have many layers: emotional, legal, philosophical, practical, economic, theoretical and ethical. It is clear, however, that tighter regulation of those in senior public health posts will both reduce future potential high-level risks and exercise the power of the state proportionally.

This Review found that public health regulatory issues were less about deterrence – there is little need for sticks – than systematically assuring a high-quality professional public health leadership. Acting to ensure that where good practice exists it is placed within a formalised regulatory structure will produce consistent rewards for population health. A move to statutory regulation is not intended to improve the standing or financial rewards for members of the profession. Public health professionals should understand that their regulatory status is not of importance for the profile alone, but because of the significant responsibilities and risks attached to their roles.

It is vital to ensure that this is not a rubber-stamping process, but an ongoing risk-management exercise. Improvements in regulation must sit within employment, performance, inspection and professional systems that collectively support and encourage high performance. Systems and structures need to assist those taking complex and high-profile decisions for both individuals and communities. As part of this preparedness and risk management, it is necessary to build both strong public confidence in public health and also the confidence of those working alongside individuals with high levels of influence and leadership. To have individuals in such positions who are not within statutory systems of professional regulation exposes the profession and responsible authorities to criticism, and most importantly it exposes the population to health risks.

It has been notable in this Review that there is a strong desire for the levelling of the playing field between medically and non-medically qualified public health professionals. The Review has taken the view that a levelling up is necessary; it proposes increasing quality through common routes to registration, coherence in approaches to revalidation and consistent use of protected titles.

Many within professional regulation, and within the profession, have been awaiting the recommendations of this Review. What began as a small voice advocating a fully multi-disciplinary profession has become a dedicated grouping of professionals leading the development of self-regulation. Without the groundwork and consistent efforts of the United Kingdom Public Health Register, its boards and working groups, the preparation of the profession for the next level of recognition and regulation for non-medically qualified individuals would not have been achieved. It is right to recognise that achievement.

This Review therefore advises the Chief Medical Officers for the four countries to act on its recommendations and take the opportunity to improve regulation and assurance within the public health profession in readiness for the challenges that lie ahead.

Annex A: Terms of Reference of the Review

1. The Review of Public Health Regulation will report in April 2010 to the Chief Medical Officer for England.
2. The review should consider the various available systems for regulation of the public health workforce.
3. The review should make recommendations on optimal systems for the public health workforce related to registration, de-registration, revalidation and regulation.
4. The review is required to:
    - primarily focus its scope on regulation of the specialist level workforce;
    - consider whether medical and non-medical public health specialists should be registered under a single system;
    - consider whether adjudications on public health registration should be undertaken by the Office of the Health Professions Adjudicator;
    - indicate a policy direction for defined specialists and for the practitioner workforce, but not address issues related to these workforces in their entirety;
    - indicate a policy direction on a common pathway to registration, but not address this issue in its entirety.
5. The review should provide an Impact Assessment of available options for public health regulation, explicitly covering advantages and disadvantages of options and equality of options.
6. The review should advise on the resource impact of the regulatory options.
7. The review should advise on the legislative impact of the regulatory options.
8. Review recommendations should be in line with current Council for Healthcare Regulatory Excellence policy and advice and with current best practice in workforce regulation.
9. The review should operate to a transparent set of principles in coming to its recommendations.

Annex B: Partial Regulatory Impact Assessment

Equity and fairness

Changes to the regulation of the public health specialist/consultant workforce will help to maintain and improve patient outcomes in all settings. The preferred option will include all public health specialists/consultants so should not affect any group disproportionately.

Small firms impact assessment

The preferred option will affect self-employed professionals, for example public health specialists/consultants working in private settings, although the parity of status and assurance that regulation would provide would benefit them in work. It is likely to impact more on those who are not maintaining records of professional development as work on revalidation develops.

Competition assessment

We do not believe that the preferred option will have any significant impact on competition.

Costs

Costs are relatively certain at this stage, since the costs of implementing the preferred option are likely to include both the maintenance of some of the functions of the United Kingdom Public Health Register until the alternative system is in place, and the regulation of a new profession by the Health Professions Council.

These represent 'policy costs' (the costs of complying with the proposed policy) and not the 'administration costs' (the costs of providing information associated with regulation), which would be financed through professional fees.

The costings have been done on a UK basis.

Economic assessment

Economic assessment of regulatory policy includes direct costs and administrative costs. Direct costs are incurred in establishing the regulator and running the registration and registers, as well as in preparing cases relating to fitness to practise and protected title misuse. These are covered within the options appraisal. Indirect costs include the taxation implications of professional fees being statutorily required, minimal in the case of public health specialists due to the relatively small number of individuals in this category. Following the precedent set by those professional groups who have recently been recommended for professional regulation, independent economic assessment of the case for regulation of public health professionals could be pursued; however, the cost of this independent modelling would need to be set against the anticipated small cost burden involved in regulating this group.

Annex C: Summary of Responses to the Call for Evidence

A large number of professionals and public health organisations contributed to the call for evidence. A number of core messages were communicated:

- **A strong majority supported statutory regulation of the public health specialist workforce. Greater equity and stronger assurance of competence were strongly desired in the regulation of the public health specialist workforce.**
- **Defined specialists should not be separated from 'generalist specialists', and the potential burden of dual accreditation should be avoided.**
- **A majority supported self-regulation of public health practitioners at this point to increase professional development, equity and public protection**, moving to statutory regulation in time. Heterogeneity, cost and less equity were perceived risks of self-regulation of the practitioner workforce.

Analysis of responses

Responses were invited to the proposal that: 'All non-medically qualified public health specialists currently on the UK Voluntary Register for Public Health Specialists should instead be placed on a statutory register. The wider public health workforce (i.e. those not eligible for inclusion on a public health specialist register) should be subject to a self-regulation register.'

The responses were analysed to establish views on:

- agreement and disagreement with statutory regulation of specialists;
- agreement and disagreement with voluntary regulation of the practitioner workforce; and
- perceived concerns about and benefits of statutory regulation and self-regulation of the public health workforces.

A total of 166 submissions were received in response to the call for evidence. Of these responses, 133 came from individuals, 8 came from groups and 25 were sent from organisations. A total of 141 (85% of the submissions) addressed whether public health specialists should be statutorily regulated, and 67 (40%) responded on regulation/self-regulation of the public health practitioner workforce.

Regulation of specialists

The majority of responses agreed, in principle, with the statement that non-medically qualified public health specialists should be on a statutory register. A small minority expressed clear disagreement (approximately 4%). The main benefit that respondents associated with such a change was that it would increase equity within the workforce. Other respondents felt this move would lead to enhanced competence assurance, public safety/protection, and professionalism.

Some 24% of respondents specified that they preferred a single, unified register for both medically qualified and non-medically qualified public health specialists, while 13% felt that multiple registers might be more appropriate. Respondents indicated a range of bodies that might be appropriate to oversee regulation of public health specialists; the most common preference was for the United Kingdom Public Health Register to take this role (28%), while the General Medical Council was considered to be an inappropriate option by 19%. A small number of respondents commented that the broad, multi-disciplinary nature of the public health workforce would make any standardised form of registration extremely challenging and/or inappropriate.

A commonly expressed concern with regard to this Review was the apparent delineation between defined specialists (as a group) and 'generalist specialists' (both medically and non-medically qualified). Some 25% of respondents stated that they were unhappy with such a separation, many commenting that this indicated an inappropriate lack of equivalence between these groups that was contradictory to previous policy. Another area of concern highlighted by some respondents was the potential expense that would be incurred and time that would be required if dual accreditation became necessary for those already registered with a professional regulator or organisation (such as doctors, pharmacists, dentists, nurses and environmental health officers).

Regulation of practitioners

Of the submissions indicating a view on regulation of practitioners, the majority agreed with self-regulation in principle, although a minority (10%) expressed clear disagreement. The benefit that some respondents associated with such a change was that it would create opportunities for professional development; others also indicated that public safety and equity would be enhanced.

Some 20% of all respondents specified that they preferred a single, unified register for public health practitioners alongside public health specialists. Around 13% supported initial self-regulation that would become statutory in time. A small number suggested that an accreditation system for practitioners would be more welcome than self-registration, as this would enable further improvements in the professional development of practitioners. Some respondents indicated that the current voluntary register is sufficient.

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